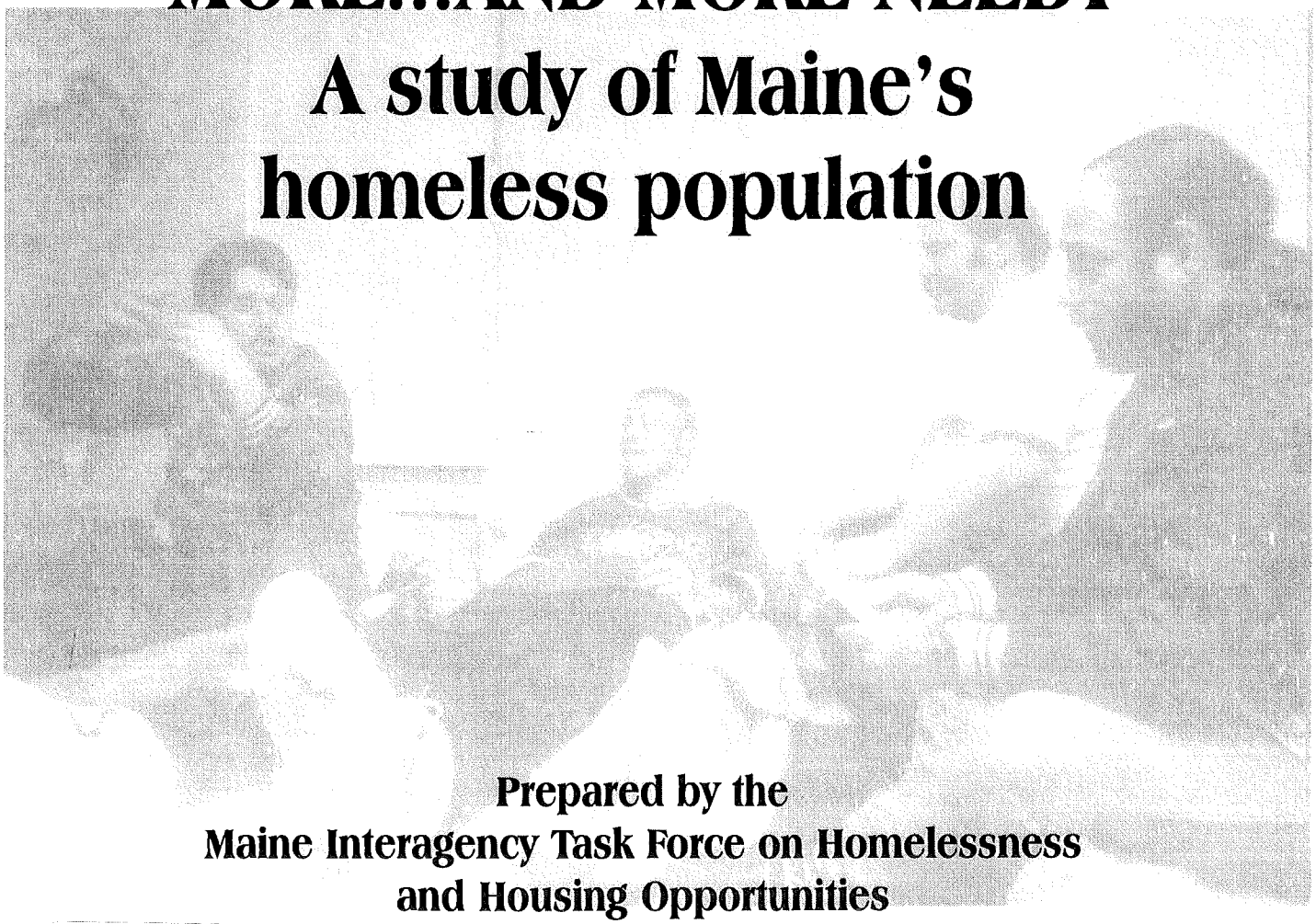
MORE...AND MORE NEEDY
A study of Maine's homeless population



Prepared by the
Maine Interagency Task Force on Homelessness
and Housing Opportunities

November 1997

INTERAGENCY TASK FORCE ON HOMELESSNESS AND HOUSING OPPORTUNITIES

Membership - November 1997

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EXECUTIVE SUMMARY

In June 1997, legislation was enacted requiring the Interagency Task Force on Homelessness and Housing Opportunities to recommend to the Governor and Legislature "how best to provide" affordable housing and shelter services to homeless persons with mental illness or substance abuse problems. This Report complies with that mandate.

In the last three years, occupancy in Maine's shelters for homeless persons has increased by 33%. This is the result of an increased number of homeless persons, combined with longer stays in shelters. In 1997 approximately 55% of shelter residents suffer from mental illness, a substance abuse problem, or both.

The only consistent financial support which the state provides to shelters is the Shelter Operating Subsidy administered by the Maine State Housing Authority. This annual appropriation is $500,000, the same as it was when it was created in 1989.

Today, Maine's shelters lack the financial resources to train or retain the staff that is necessary to effectively serve the guests at the shelters. In short, while there are more homeless persons, and more of those homeless persons have challenging disabilities, the capacity of Maine's shelters to meet the needs of shelter residents is declining.

The Interagency Task Force recommends several initiatives to address this critical problem:

- Increase the state Shelter Operating Subsidy to $3,150,000. This will allow the shelters to hire the necessary staff to attend to the increased number of occupants. It will also enable shelter staff to get the training needed to work with the increased number of guests with mental illness or substance abuse problems. The recommended funding level is equal to $18.50 per guest per night.

- Require Maine's mental health and substance abuse delivery system (largely a state funded system operated by non-profit contract agencies) to provide greater outreach to homeless persons and greater training to shelter staffs.

- Require shelters to provide greater training to, and interaction with, mental health and substance abuse agencies.

- Authorize the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Maine State Housing Authority to withhold funds to mental health providers and homeless shelters respectively until the providers and shelters have submitted acceptable plans to serve homeless persons with mental health or substance abuse problems.

- Coordinate housing and service activities so that Maine State Housing Authority assumes administrative responsibility for providing housing services and Department of Mental Health, Mental Retardation, and Substance Abuse Services assumes responsibility for identifying housing needs (with appropriate supports) for persons with mental illness or substance abuse problems.

BACKGROUND

History of the Interagency Task Force on Homelessness and Housing Opportunities

In 1989 the Maine State Legislature created the Interagency Task Force on Homelessness and Housing Opportunities. This Task Force was created as a result of the state's recognition that homelessness was a problem in Maine and that homeless persons needed services and assistance. The early days of the Task Force were quite productive. This was the first time that policy makers from The Departments of Education, Labor, Housing, Human Services, Mental Health, and Corrections collectively acknowledged that homelessness did exist in Maine. Explicit in the creation of the Task Force was the recognition that homeless persons would need support from all of the applicable agencies in order for persons to transition their way out of homelessness. The Task Force provided an opportunity for all of the policy makers to learn what homeless persons needed and to then craft programs responsive to their needs. In 1991, the Task Force issued its initial report: By Sundown. This report fully explained the needs of Maine's homeless citizens and acknowledged that there were many persons, in fact, that were homeless.

After the completion of By Sundown, the activity of the Task Force became less focused. By the late 1980's, housing prices were increasing, housing opportunities were limited and housing affordability was a major problem facing all Maine citizens. With the recession of the early 1990's, however, housing affordability became less of a problem as prices leveled off, and in fact, the perception that Maine had an affordable housing crisis ended. Also during the 1990's much of the state housing legislation enacted in the 1980's was repealed. Several specific plans and programs which were to be reviewed by the Task Force were repealed, leaving the purpose of the Task Force somewhat uncertain. In 1991 the composition of the Task Force changed. The representatives on the Task Force were increased so that the state officials would not dominate the agenda at the perceived expense of the non-state officials. In 1993 legislation was passed that required the Task Force to complete a study on the feasibility of consolidating all services that could help homeless persons into a single state agency. This study was submitted to the legislature on October 31, 1995.

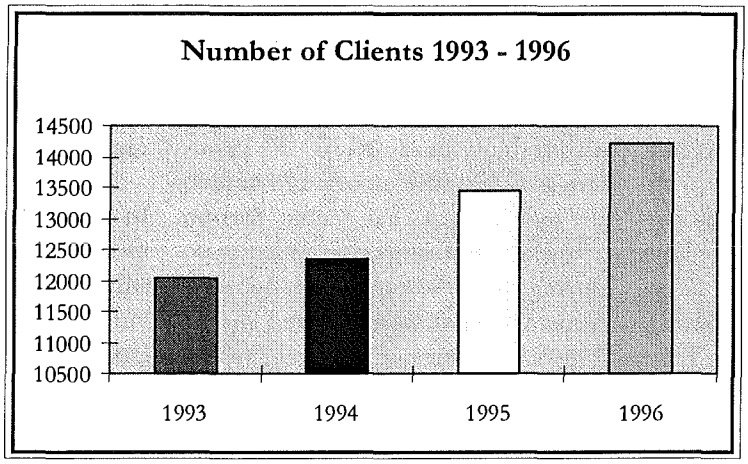
The Homeless Task Force continued to meet regularly to identify key policy issues in the area of homelessness. The Task Force attempted to work with state agency policy makers in dealing with the identified issues. By 1997 it became increasingly clear that the Interagency Task Force on Homelessness lacked both a specific role and specific authority. At the same time it became clear that the amount of support available for shelters for homeless Mainers was increasingly inadequate.

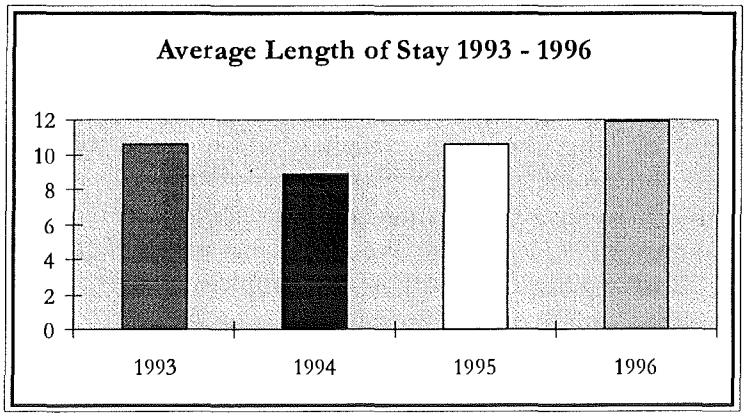
In 1997 legislation was introduced to increase the Shelter Operating Subsidy, the primary state funding provided to shelters in Maine. This legislation was defeated, but legislation did pass which reconfigured the Interagency Task Force on Homelessness. The membership on the Task Force was redefined to require key state policy makers, including relevant state commissioners and deputy commissioners, to be represented on the Task Force. Membership of the Task Force was set at a more workable 12-member group, rather than the previous 21 members. The Task Force also was given three specific mandates: to recommend how best to provide homeless and housing assistance services to homeless persons with mental illness or substance abuse problems; to identify and make recommendations on what the future role, if any, should be for the Interagency Task Force on Homelessness; and to study and make recommendations related to licensing requirements for the homeless shelters. This report is submitted in response to these legislative mandates.

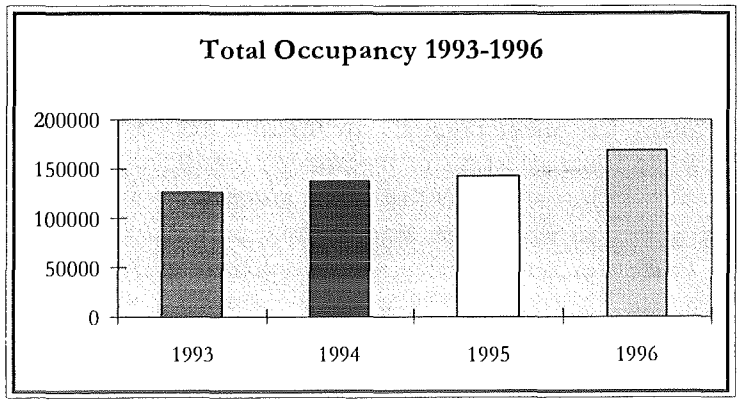
The State of the Maine Homeless Population

Shelter growth trends. Since 1993, the occupancy in Maine's homeless shelters has increased significantly. Occupancy in 1996 was 33% higher than 1993's occupancy. This increase occurred during a period in which Maine's overall population increased by just 1.3%. The 1993 to 1996 period is also a period characterized by economic improvement, employment growth and a general upswing in business activity. The increase in homelessness during this period strongly suggests that many of the very poor in Maine have not benefited from the overall economic improvements. Increased occupancy in Maine's homeless shelters is the result of two factors in the 1993-1996 period. The two factors are the increased number of homeless persons and the increased length of stay by each homeless person. From 1993 to 1996 the number of homeless persons increased by 18% (12,031 to 14,219). The average stay during this period increased by 12% from 10.6 nights to 11.9 nights. Total occupancy increased from 127,031 bednights in 1993 to 169,167 bednights in 1996.

Changes in Shelter Activity 1993 -1996				
	1993	1994	1995	1996
Clients	12031	12351	13442	14219
Average Stay	10.6	8.9	10.6	11.9
Total Occupancy	127031	138203	142492	169167







The increase in homelessness has placed additional pressure on the emergency shelters. There are now 767 available beds in the 37 homeless shelters. Occupancy rates within the shelters have continued to grow, with the state average now at over 60%. Many of Maine's urban area shelters are averaging in excess of 80% occupancy, considered to be a density difficult to manage by shelter workers. General shelters that serve multiple populations (e.g., Greater Bangor, Tedford, York County Shelters) are also very full, with occupancy rates approaching 80%.

People in need of low skill employment often gravitate toward urban areas of the state. This migration towards urban areas has resulted in a disparity between bed location and bednights provided.

Homeless persons who are mentally ill or have substance abuse problems. There are a variety of indicators that describe who the homeless citizens of Maine are and what they look like. One key indicator is the high percentage identified by intake staff as having mental illness or problems with substance abuse. In 1997, homeless shelter staff identified 55% of guests as having mental illness, substance abuse problems, or both. In 1996, shelter staff identified 45% of guests as having mental illness, substance abuse problems, or both. The prevalence is consistent with national trends. In 1990, the Federal Interagency Council on the Homeless identified that 30% of the shelter population suffer from disabling mental illness while another 35% suffer from chronic alcohol problems.

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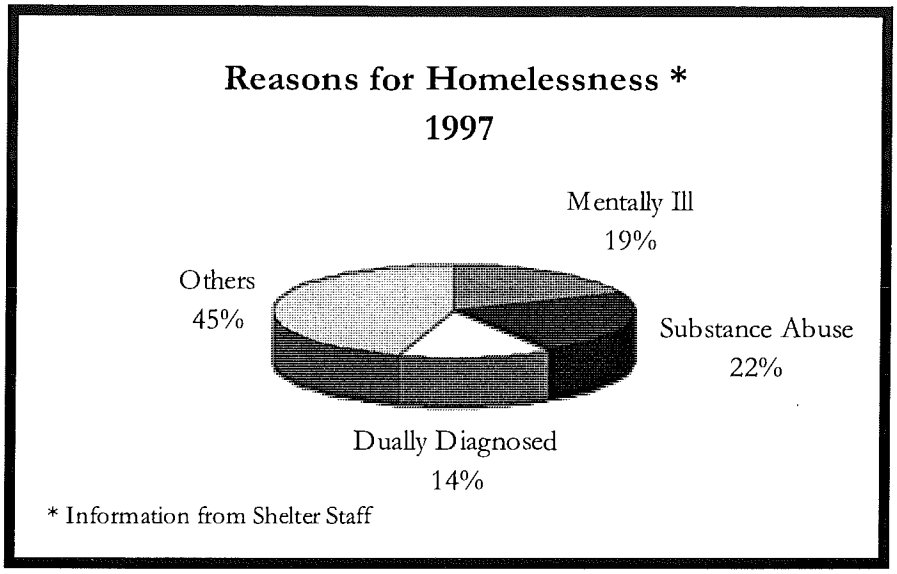
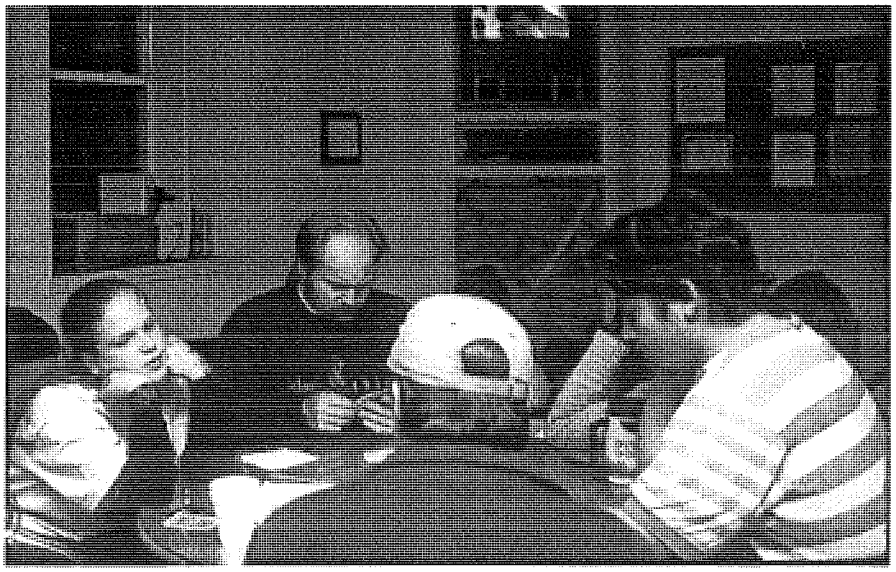


One of the unique problems facing shelter providers is that homeless individuals do not necessarily recognize or choose to identify mental illness or substance abuse as a problem. During recent years, the homeless guests at shelters have self declared that they have mental illness or a substance abuse problem anywhere between 22 and 51% of the time. It is definite (based on the available data and shelter staff testimony) that a sizable portion (30-60%) of shelter guests suffer from mental illness, substance abuse problems or both.

It is likely that the mentally ill or substance abuse group represents the largest number of repeat visitors. Previous analysis conducted by MSHA suggests a strong correlation between repeat visitors to shelters and reasons for homelessness such as mental illness, substance abuse and both (Continuum of Care, 1996).



General demographic indicators for homeless persons. The largest demographic group in the shelter is the unaccompanied male, comprising 51% of the shelter population. The next largest group is the family headed by a single female, comprising 17% of the population in the shelter. Unaccompanied females make up the next largest segment.

Age is playing an increasing role in the design of services that must be provided for by the shelters. A steady growth has occurred in those who are less than 18 or between 40-49 in age, with a slight growth in those between 18 and 29 years of age. In both cases, growth mirrors the statewide baby boom and boomlet trends and is expected to continue over the next five years.

Shelter clients come from three primary residences. For those who are frequent guests to the shelter, their last residence is often the shelter itself. Nineteen percent of the clients move to the shelters from their own apartments. Twenty eight percent come to the shelter from a family or friend's residence. Educational attainment among shelter guests is much lower than the Maine average. Over 50% of the shelter guests do not have a high school diploma. This lack of education and life skills make obtaining permanent work difficult.

Homeless persons as a part of a larger population. In 1996, 400 families, identified as near homeless but not staying in a shelter, were surveyed. The survey pointed to a number of similarities between homeless and near homeless persons. Over 70% of both groups have incomes under $6,000; over 83% have high school degrees or less; and over 37% are between 18 and 30. Half the sampled families lived in their current address for fewer than six months; one in five were there only one month.

Given that assessment, data suggest that there exist 27,000 households (and over 60,000 persons) in Maine that make less than $6,000 and are therefore living on the edge of homelessness, potentially contributing to the shelter population. One third of this population consists of only one person, while the larger families tend to live in the rural areas of Maine.

"... data suggests that there exist 27,000 households (and over 60,000 persons) in Maine ... living on the edge of homelessness ..."

Current Funding

	1991	1996	% Change
Average guests/shelter/night	**8.92 persons**	**12.14 persons**	**+36%**
Average SOS/guest/night	**$4.18**	**$2.91**	**-30%**
Average SOS/guest/night (adjusted inflation)	**$4.18**	**$2.45**	**-41%**

The state of Maine continues to pay $500,000* of Shelter Operating Subsidy (SOS) to the Maine State Housing Authority per year to support the operations of shelters for homeless persons. The Shelter Operating Subsidy was established as part of the 1989 Affordable Housing Legislation. In the initial draft of the legislation, $2,000,000 was proposed to be set aside for roughly 7 shelters. The $500,000 level was ultimately approved to serve roughly 33 shelters. In 1996, each of the 37 shelters received an average annual grant of $13,248, and had an average occupancy of 12.1 guests per night. The SOS funds therefore provided $2.91 per guest per night in 1996. There are no other state funds which have a singular specific purpose of paying homeless shelters to house homeless persons.

The cost to the shelters to house the guests, according to data collected by MSHA, averages $37.25 per night. This amount enables the shelters to provide a bed, access to sanitary facilities, and in most cases, a supper and breakfast. Additionally, the shelter provides some degree of supervision and security to its guests. For guests with mental illness or for victims of domestic violence the costs are substantially greater.

The challenge to the shelters is to fill the financial gap between the $2.91 of revenue and $37.25 of costs. There are numerous sources which cobbled together help close the gap. The typical sources include:

- Private contributions;
- United Way;
- Municipal contributions;
- Federal Emergency Management Agency;
- Municipal General Assistance Funds channeled through municipalities;
- HUD Emergency Shelter grants channeled through MSHA;
- HUD Financial Assistance Funds channeled through MSHA;
- Various DHS foster care or domestic violence grants which can partially support residential costs; and
- Various DMHMRSAS crisis, clinical, or substance abuse program funds which can partially support residential care costs.

It is important to recognize that no two Maine homeless shelters receive the same blend of money and the only state funds that go to all 37 shelters are the Shelter Operating Subsidy funds.

The 37 shelters have experienced a fair degree of success in filling their financial gaps. However, it must be recognized that there remains a substantial gap. Some shelters are behind in paying their monthly bills, e.g., food, utilities, payroll, taxes, and maintenance, and many have financial liabilities far in excess of assets.

The amount of funds that the State's General Assistance program pays to shelters varies greatly from town to town. It is estimated that General Assistance pays a total of approximately $1.1 million to shelters for homeless persons each year. The city of Portland, alone, accounts for $984,000 of this amount and DHS reimburses nearly 90% of Portland's costs.

In 1991, the guest per night SOS allotment was $4.18, a rate which, as noted, had decreased to $2.91 by 1996 because of the increase in bednights. Adjusting for inflation the per night cost is further reduced to $2.45 per night, or a 41% decline in real per night SOS reimbursements to the shelters since the program was established.

*In 1989 the SOS appropriation was $500,000. In the early 90's this allocation was twice reduced when across-the-board cuts of 1% were applied. In 1997 the allocation returned to $500,000.

HOMELESSNESS, MENTAL ILLNESS & SUBSTANCE ABUSE

Inter-Relationship

The legislative charge to this Task Force is to recommend "...how best to provide affordable housing and homeless shelter services to those homeless persons with mental illness or substance abuse problems." The following sections to this report describe Maine's shelter delivery system and mental health delivery system.

Homelessness, mental illness and substance abuse issues are all problems faced by many Maine residents. These problems often co-exist. For the individual it is difficult to separate the problems, and individuals thereby often expect the remedies to be combined. While consumers may combine their human needs into a single problem, state government and human service providers work in an environment which separates financial resources, administrative responsibilities, and the delivery of various related but discrete programs.

Each night there are about 470 persons who stay in Maine shelters. Approximately 55% of shelter clients suffer from mental illness, substance abuse problems or both. As noted, this percentage is consistent with national trends and is consistent during the past several years.

The challenges to the shelters which serve this group are numerous. The expertise of shelter staff to respond to the challenge is, at best, inconsistent. Some shelters essentially serve only persons with mental illness or substance abuse problems and are more expert in helping their clients. Other shelters serve many different types of clients so the specialized expertise is lacking. Some of the shelters offer on site or nearby services for persons with mental illness or substance abuse problems. These shelters can often link the guests to residential care or outpatient services quite easily. For other shelters the transition into the appropriate services is more difficult, and at times impossible.

The challenge to community mental health agencies which serve this group is equally difficult. The expertise or resourcefulness of mental health case workers to identify homeless persons with mental illness and link them to needed services is inconsistent. Many case workers have existing caseloads too large to effectively manage, so seeking new clients often may be counterproductive. In all cases, moving shelter residents into more suitable housing, while connecting the guests to necessary services is a difficult and delicate process.

To complicate the work of both service provider networks, there are multiple reasons for homelessness that are difficult to detect and understand. Some individuals with substance abuse issues may be self-medicating and masking mental illness issues. Victims of domestic violence, for example, include both the victim and other family members. Often children suffer from trauma, developing mental illness over time.

Individuals do manage to live independently with the problems identified above. However, all too often financial resources, family support or social interaction evaporate and the individual lands in the hands of shelters and the mental health network.

"Approximately 55% of shelter clients suffer from mental illness, substance abuse problems, or both."

Homeless Shelter System

Emergency shelters, when created in the mid-1980s, were largely volunteer, church-based organizations. The shelters attempted to provide warm meals and respite from the elements to those who had a "run of bad luck." Shortly after opening, it was recognized that many other more complex issues, like mental illness and substance abuse, were involved in homelessness.

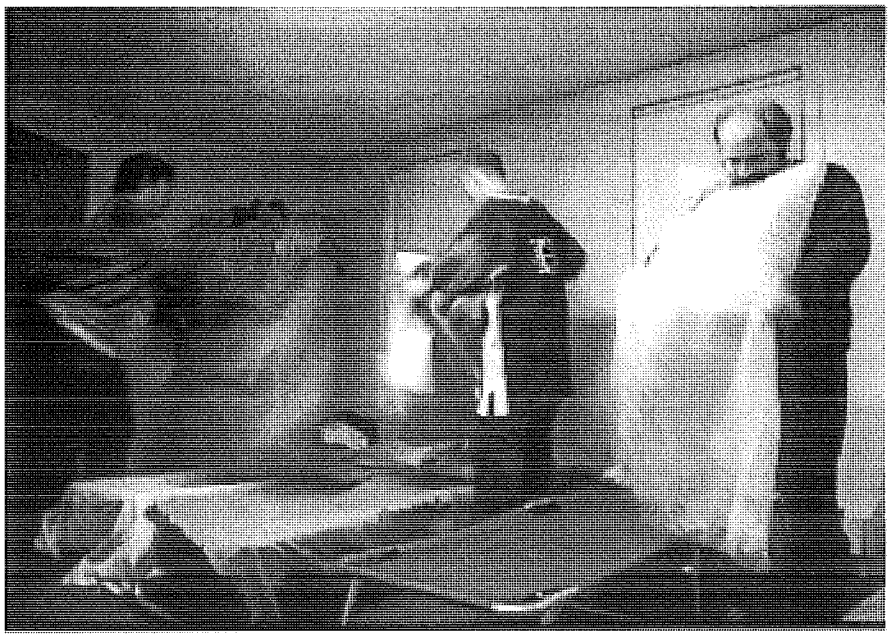
Today, Maine shelters include shelters for victims of domestic violence, youth, mentally ill persons, substance abusers and the general population. Each of these shelters is an independent entity and, except for the domestic violence network, not part of any unified delivery system. No single government agency administers funding for shelters, leaving each shelter to compete against the others for scarce resources located in different state and private agencies.

The day to day operations also vary from shelter to shelter. Shelters such as the Mid-Maine Homeless Shelter in Waterville, Oxford Street Shelter in Portland, Mid-Coast Hospitality House in Rockport, and Hope Haven Gospel Mission in Lewiston are only open from evening to morning while closed during the day. HOME, Inc. in Orland, Temporary Shelter for the Homelessness in Presque Isle, York County Shelters in Alfred, and the Maine domestic violence shelter network are open 24 hours a day but not always with staffing. Other aspects such as intake procedures and number of staff also vary greatly from shelter to shelter.

The screening and assessment process varies from shelter to shelter. Some ask a few simple questions to screen out persons under the influence of alcohol or substance abuse. The specialized shelters focus their questions on domestic violence, alcohol or drugs to screen persons in and to start some series of interventions. The various shelter screening and assessment staff range from minimally trained to skilled clinicians.

Shelters are also unique in appearance. Examples help to illustrate this point. Guests at the shelters of the Maine Coalition for Family Crisis Services find themselves in a home-like atmosphere complete with individual bedrooms, a dining room, a living room and an area in the backyard for children to play. The Oxford Street Shelter in Portland is located in a house with rows of cots lined up in room after room. Guests at Oxford Street confront a sign that limits each person to two blankets. Some shelters are not located in a shelter *per se*, but operate safe home networks or utilize hotel rooms or both.

While these shelters are all unique in appearance they all provide one common service: emergency shelter. It is important to realize, however, that providing emergency shelter is much more complicated than finding a building and opening it up to people in need. Providing emergency shelter includes basic tasks such as making beds, cooking meals and doing laundry. It also includes complicated tasks such as preparing bud-



gets, recruiting and managing staff, coordinating volunteers and fundraising.

Providing emergency shelter also means serving people with varying needs. It often means a need for support services. Needed services range from transportation to physical health care to child care to psychiatric counseling. Recently, the increase in the number of homeless persons with a mental illness and/or a substance abuse problem has required shelters to improve their assessment and support service capabilities. This increase has also led some shelters to limit the intake of persons with a mental illness or a substance abuse problem because of a lack of capacity and skills. Other shelters have added staff to provide mental health and substance abuse services to their guests.

Serving mentally ill individuals has created complications because many shelter operators are not trained to recognize mental illnesses, have no background in administering medication nor are trained in how to react to aggressive individuals in a crisis situation. Persons with mental illnesses have longer lengths of stays in the shelters and come back more frequently, largely because of poor assessment practices and unsuitable alternatives for them in the community. In some cases, shelters replace family and reduce social isolation.

Most of Maine's shelters have recently indicated that attracting and retaining staff has become increasingly difficult due to the demands of the job and the low pay. Shelter staff tend to be finding employment alternatives.

Maine's Mental Health System

Overview

The Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services operates through a central office and three regional offices. Within each region are a variety of mental health agencies and organizations providing adult mental health services. Within these regions, DMHMRSAS also contracts for services to children with mental health disorders, for services to adults and children with mental retardation, and for substance abuse services. For adults with mental illness, DMHMRSAS provides direct services in its two state mental health institutes (Augusta and Bangor Mental Health Institutes), through its Intensive Case Management Program in each of the three regions, and through the mobile outreach component of the comprehensive crisis stabilization services in three of the seven service areas. DMHMRSAS also provides case management services in each region for adults with mental retardation, and children with special needs.

Through contracts with nearly 70 community organizations and agencies, DMHMRSAS supports a variety of adult mental health services throughout the state, including rehabilitation-oriented day treatment, case management, crisis intervention, vocational/employment, geriatric services, outpatient, inpatient, residential, in-home supports, consultation and education, and other supportive services. Nine of the 39 general hospitals in the state have psychiatric inpatient units (5-15 beds), and there are two private psychiatric inpatient facilities in the state.

"Serving mentally ill individuals has created complications because many shelter operators are not trained to recognize mental illness, have no background in administering medication nor are trained in how to react to aggressive individuals in a crisis situation."

Shelter Type	# of Beds	Bednights
General/Family	459	64,300
Youth	102	13,479
Substance Abuse/Mental Illness	51	9,626
Domestic Violence	122	7,895

Components of the System

Adult mental health services in Maine are provided through four major types of entities:

1) **Public Agencies**: In addition to its broad contract management, technical assistance, resource development, and coordination responsibilities, DMHMRSAS provides Intensive Case Management services to adults with mental illness and especially complex needs in each of the three regions, and the mobile outreach component of the comprehensive, privately administered crisis stabilization services in the York County, Portland, and Augusta/Waterville areas.

The two state psychiatric facilities, Augusta and Bangor Mental Health Institutes, have changed considerably in the last twenty or so years with a combined average daily census currently of about 200 patients, down from 3,400 in 1958.

The Department of Labor, through the Office of Rehabilitation Services, provides vocational rehabilitation services throughout the state. The Department of Human Services administers a variety of programs which have a direct impact on persons with mental health problems, including Temporary Assistance to Needy Families, support services, transportation, child and adult protective services, boarding homes, and Medicaid funding for community psychiatric units and professional outpatient services from private practitioners.

The Department of Education provides, through the secondary school years, for a variety of special education, counseling, specialized residential programming, vocational rehabilitation services, and professional treatment services. In addition, the Department of Corrections is working increasingly closely with the mental health system in community settings with persons involved in both systems, and makes provisions for limited mental health services for both adults and juveniles within its institutions.

2) **Private Not-for-profit Agencies:** These agencies are funded at least in part by the Department of Mental Health, Mental Retardation and Substance Abuse Services and/or other public funds. Contracting for services is the primary way in which DMHMRSAS meets the needs of its clients. Through its three regional offices, DMHMRSAS contracts with a wide variety of agencies to provide a broad array of needed services and supports for the persons that it serves. In addition to the Department funding, mental health agencies also receive a variety of other funding - including other state funding, fees charged for services, local public funding, federal moneys, and other.

3) **Private Practitioners and Private Proprietary, Agencies/Organizations:** The organizations may receive payment from Medicaid, client fees, or third-party insurers. There are throughout Maine, though largely concentrated in southern and more densely populated areas, mental health professionals in private practice. These include social workers, professional counselors, psychologists, psychiatric nurses, and psychiatrists. The state has two private psychiatric hospitals, one in Portland and one in Bangor.

4) **Volunteers and Informal Caregivers:** Family members, friends, peers, and clergy, who receive little or no reimbursement for the mental health services they provide, are frequently providers of mental health services.

"The two state psychiatric facilities ... have changed considerably in the last twenty or so years with a combined average daily census currently of about 200 patients, down from 3,400 in 1958."

Three Models for Case Management

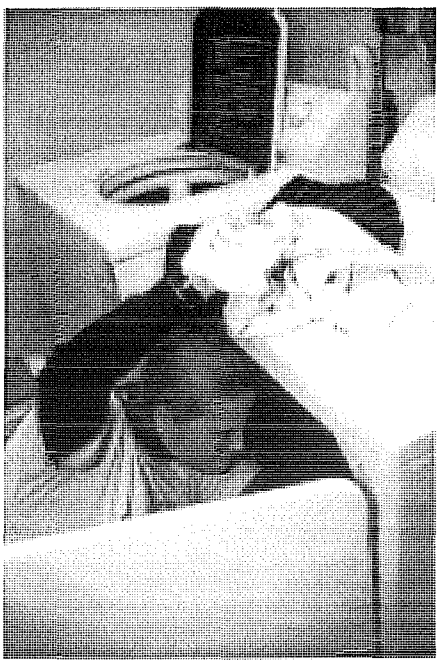
The community support systems across the state utilize three models for case management: Community Support Workers (CSW), Intensive Case Management (ICM) and Assertive Community Treatment (ACT). The model for all three is psychosocial rehabilitation.

The predominant model is Community Support Workers. CSWs help consumers assess their needs, identify unmet needs, formulate individualized service plans, and carry out the linkages to supports and services. In addition, CSW's work with consumers to review progress toward goals, reassess needs, and provide advocacy and action to assure that those needs are met. The average caseload of a CSW is 20 clients, with 4,850 clients being served (up 25% from the previous year).

The second model is the Intensive Case Management Service (ICM). Provided to clients with higher intensity of need where no other interventions have worked, ICM'S work most commonly with individuals who may not seek out services or who actively resist services. The individuals are commonly trauma survivors. The ICM provides case management, support and other direct service intervention. ICMs also provide outreach to shelters, soup kitchens and other places within the homeless network. ICMs carry a case load of about ten consumers.

The third model of case management is Assertive Community Treatment (ACT). It is a multidisciplinary approach that provides case management in the context of treatment services, including medication monitoring. A typical ACT team includes a psychiatrist, case managers, and a psychiatric nurse. Some teams also employ occupational therapists or counselors. Some teams include consumers as part of the team. This is a high intensity model with daily contact for such purposes as medication management and assistance in daily living.

Through the ACT and ICM teams, 840 clients were served in 1997. There are six ACT teams statewide, 60 ICMs and 242 case managers contracted through various community based agencies.



Homeless Persons with Mental Illness

Homelessness continues to be a significant problem particularly for persons with mental illness throughout the state of Maine. The situation has been complicated by an extremely high occupancy rate in the southern portion of the state for rental housing.

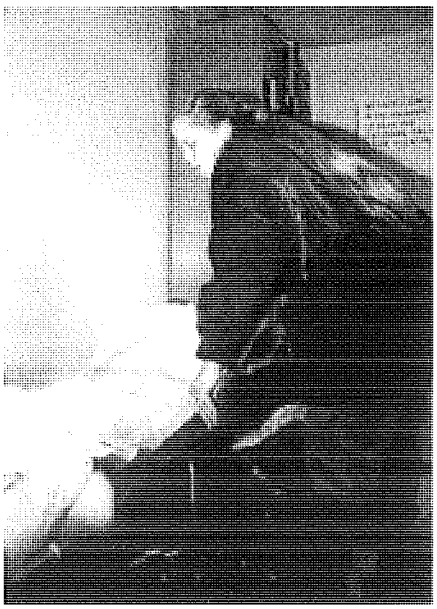
The adult mental health program specifies that persons who are homeless and mentally ill have priority. This priority is implemented through definitions and contract provisions.

The Maine DMHMRSAS has radically transformed its mental health system in the past year or two. It has created regional offices that can work with local communities to better meet community needs. The down sizing of its institutions has been accompanied by major expansions to its community care systems. However, there continues to be a need to expand the range of services and supports to people to prevent or eliminate their homelessness.

In recognition of the fact that adults with mental illness are not the only clients of DMHMRSAS who may become homeless, the regional offices have the capacity to look at the needs of children and families, adults with mental retardation, and those for whom substance abuse is a major complicating factor. As a part of the community, the regional offices have the ability to work with others in the community care system to serve and advocate for all its clients and to broaden services to meet their needs.

Other Housing Resources

Other housing resources available to homeless persons with mental illness or substance abuse problems. There are a variety of resources and programs designed to serve homeless mentally ill or substance abusers extending beyond the emergency shelter. To add to the confusion, different entities, e.g., HUD, DHS, DMHMRSAS, United Way, MSHA, and municipalities, all use different terms to describe very similar types of housing. The consumer will need to weave through a web of multiple agencies, including MSHA, DMHMRSAS and others to obtain financial support for that housing. Housing supports are in short supply. Many of the housing sources are also designed as a transition form of housing for a person with more or less personal service need. Depending on the program and funding source, each housing choice generally requires at least three licenses: the controlling agencies, the Fire Marshal's office and local codes review.



The Three Primary Types of Housing

- Group Homes: This setting requires the greatest amount of individualized services, generally including 24 hour care and medication management. Basic individualized services are provided on site. Services include case management, counseling, psychopharmacology, money management, recreation, vocational training, food preparation and wellness promotion. DMHMRSAS will contract directly with local agencies to provide housing and support services. MSHA often provides the financing for construction of the building. Consumers generally need the residential care and are often not capable of choosing and controlling their own housing.

- Supervised Apartments: In supervised apartments, the individualized services that may be provided are the same as group homes without necessarily having the medication management or 24 hour care. In supervised apartments, the services are generally provided at the site. DMHMRSAS will contract with local agencies to provide both housing and support services. In this setting, needs are semi-structured and placed within the community. Twenty four hour supervision may be required at times.

- Independent Housing: In independent housing, the consumer lives on their own, receiving individualized services in any community setting. In independent housing, the consumer typically has the right to choose and control their housing, has access to flexible support services and has a high probability of recovering from mental illness or substance abuse problems. In this administrative structure, DMHMRSAS contracts with local agencies to provide only the support services. The housing is typically paid for through certificates and vouchers that are available through MSHA, DMHMRSAS, or local housing authorities.

"To add to the confusion, different entities ... use different terms to describe very similar types of housing."

The financing for these housing programs includes many types of resources from many different entities. Group homes and supervised apartments are usually owned by private, non-profit agencies. These agencies usually receive a loan from MSHA and/or other financial institutions combined with a grant that help pay for the building. The grants come from either MSHA or DMHMRSAS. The larger the grants, the smaller the loans and debt that must be carried by the project in the future. DMHMRSAS concurrently contracts with a private non-profit agency to provide the myriad of on-site services to the residents. Additional money, through DMHMRSAS or through revenue associated with the consumer, is used to help pay for any debt on the building.

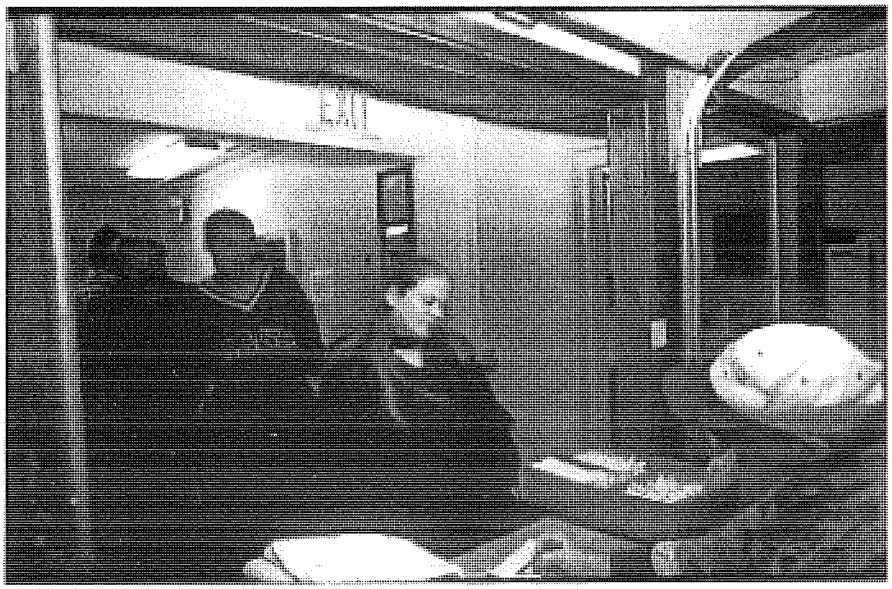
Independent housing is financed very differently. This housing is owned by a private landlord. The consumer is given a voucher to pay for the rent that the landlord charges. DMHMRSAS has contracted with the Shalom House to provide about 1,000 vouchers to mental health consumers around the state. As part of this voucher system, Shalom House also arranges specific services to be available to consumers.

MSHA contracts with six sub-contractors to provide about 3,200 vouchers to low income persons in rural parts of the Maine, some of whom may be individuals who were homeless or had mental illness or substance abuse problems (homeless families receive priority rating for MSHA vouchers). There are an additional 17 housing authorities located in municipalities around the state that provide another 7,000 vouchers to poor people around the state. Again, a portion may include those that have been homeless (homelessness is not necessarily a priority rating at the local level).

There are limits to the above resources. There exist only 1,364 units and beds through DMHMRSAS's housing program. With the AMHI consent decree, DMHMRSAS has had to direct its housing attention to AMHI patients. Available supply to those in shelters has been minimal, especially with limited housing markets in the southern part of the state. BRAP remains the largest of these resources, providing over 700 vouchers that are provided to DMHMRSAS by the Maine General Fund and distributed to the consumer through a contract with Shalom House.

While the number of housing units for persons with mental illness or substance abuse problems has increased in recent years, there has not been an accompanying decline in shelter occupancy; in fact, occupancy is up. Some of these vouchers may not continue in the future. This will exacerbate the problem of housing persons with mental illness or substance abuse as supply falls further behind demand.

"While the number of housing units for persons with mental illness or substance abuse problems has increased in recent years, there has not been an accompanying decline in shelter occupancy; in fact, occupancy is up."



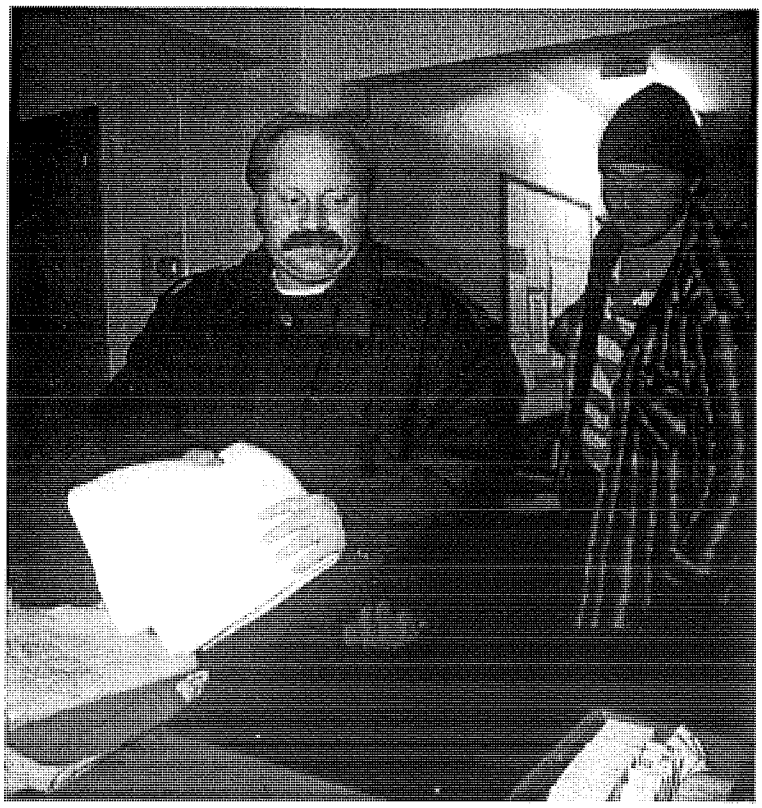
LICENSING

Introduction. The legislation that guides this report requires that this study include an inventory of the safety and health requirements, licenses and permits applicable to homeless shelters. The Task Force, in developing the following, depended largely on the work of the Physical Licensing Committee. This ad hoc committee was established by MSHA, DHS and DMHMRSAS to work cooperatively to identify the barriers created by licensing in the supportive housing field. The recommendations are also drawn from that committee's findings.

Licensing issues. Issues related to licensing are driven by the type of shelter and the services being provided. The Maine State Housing Authority does not require emergency shelters to have licenses but does require shelters to agree to the following in order to receive funds:

- Maintain financial records on the use and expenditure of funds received from MSHA;
- Provide a minimum of 15 bednights per month with a minimum of 6 beds available at any time;
- Provide monthly and biannual reports on shelter visitors;
- Maintain shelter property such that all local and HUD HQS standards are being met; and
- Provide 24 hour response capacity to someone needing emergency shelter.

Transitional shelters and supportive housing, on the other hand, are often required to meet a plethora of licensing requirements to satisfy DMHMRSAS and DHS requirements. The type of license required is dependent on the clients served by the facility. The Departments of Human Services and Mental Health, Mental Retardation and Substance Abuse Services promulgate licensing rules for the facilities which serve their clients. The licensing requirements are detailed and sometimes inconsistent. For example, each department requires a different room size for housing 2 adults in one bedroom. Licenses from both departments are required for many transitional operations. Multiple licenses are sometimes required from the same department (separate program and physical licensing). As part of their licensing procedure, the divisions also conduct annual inspections of each transitional housing project as long as they are in operation.



In addition to these Department reviews, other code officials' approvals are required. The Fire Marshal's office within the Department of Public Safety requires approval and annual inspections consistent with the life safety code. Where MSHA funds are used for construction, MSHA requires review by its technical services division and an inspection that occurs between 1 and 3 years, depending on funding mechanisms. Any community with a local building code will require multiple inspections consistent with that building code. There is no universal building code in the state of Maine.

CONCLUSIONS

1. **Funding for shelters has been flat since 1989.** Shelter Occupancy Subsidy (SOS) funds have not increased from the original appropriation of $500,000 made in 1989. In the meantime, the value of the dollar has decreased and the number of occupied beds has increased. The value of the SOS contribution has decreased over 40%.

2. **Individuals with mental illness, substance abuse issues or both are more difficult to assist and are increasing in numbers.** The homeless bednight population has increased by over 30% over the past five years. Those who are mentally ill or have substance abuse problems have increased from 30% reported in early homeless surveys to 55% in 1997. Their crisis and service needs are greater than other shelter guests.

3. **Individuals with mental illness, substance abuse problems or both have either a longer stay or greater number of visits to shelters than others.** Those who are mentally ill or substance abusers tend to stay a longer period or return to the shelter a number of times. Often the shelter replaces family and reduces social isolation.

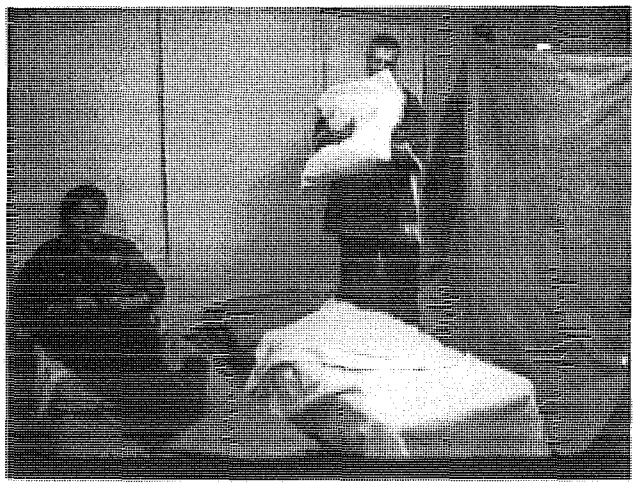
4. **Homeless shelters are often unable to connect clients with mental illnesses to services.** The pattern of longer or multiple stays is fueled by inadequate staffing and connection to community services. Inadequate financial support has led to inconsistent staff levels throughout the state. The constant need to meet a variety of demand within a shelter makes it impossible to develop sound, consistent plans to address mental illness and substance abuse issues. Often, staff are poorly paid and inadequately trained, which lead to high staff turnover. The result is poor intake assessment and inadequate links to the mental health service community.

"Funding for shelters has been flat since 1989 ... The homeless bednight population has increased by over 30% over the past five years..."

5. **The Mental Health Service staff are often unable to reach and serve guests at shelters.** While continuing to expand the caseworker network and developing new community-based programs, there is also a need to link these services to the emergency shelters. Resources to provide for appropriate planning and team building remain needed. However, the ACT teams, the community support workers and the ICMs provide the fundamental base to make this network work in the future.

6. **Some new housing has been added but it has had little overall effect on the number of homeless persons.** Despite the addition of over 600 units of rental vouchers, new group homes, and new transitional units, the demand for housing by homeless persons is even greater. Additionally, future federal resources that have supported the expansion in vouchers are in jeopardy.

7. **The provision of housing is fragmented and inconsistent.** Housing supply for homeless persons with mental illness and/or substance abuse issues is available through multiple sources, each with its own separate complexities. Available housing resources are inconsistent and fragmented across different areas of the state. There exist multiple delivery systems for essentially the same programs.



RECOMMENDATIONS

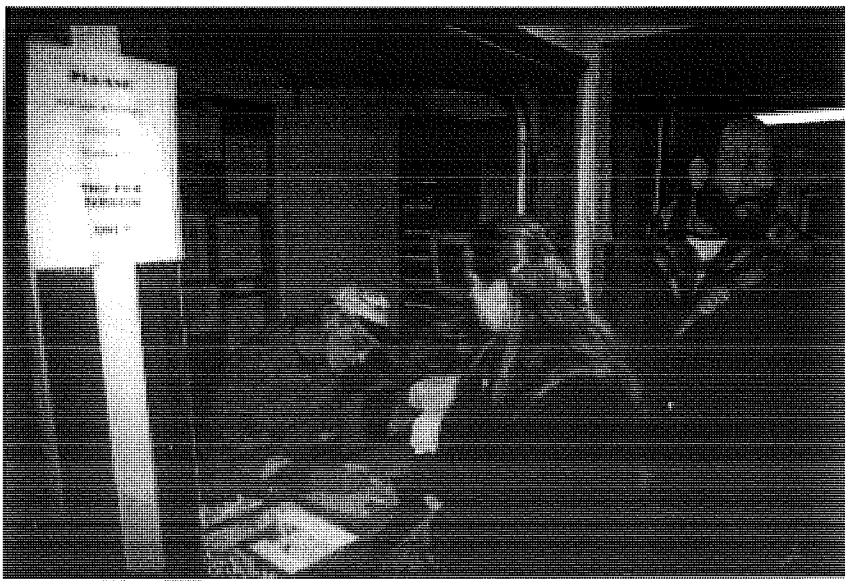
1. **Increase the amount of SOS funding to the shelters from $500,000 to $3,150,000.** This increase is necessary because the roughly $3.00 per night is inadequate to cover the average bednight cost and provide critical services to the mentally ill or substance abusers. Raising the funding level will equate to a bednight reimbursement of $18.50 or roughly half of the total bednight cost. Additional monies will also permit stabilization of staff at shelters and provide necessary expertise to address multiple reasons for being in a shelter.

2. **Provide a base of training for shelter workers.** The DMHMRSAS should provide improved training for shelter intake staff to address mental illness or substance abuse problems. Training should include, at a minimum, improved recognition of the problem, identification of available resources to bring to the problem and improved capacity to address immediate crisis and manage multiple populations.

3. **Provide a base of training for mental health case workers assisting homeless persons.** MSHA should provide training to DMHMRSAS case workers which includes, at a minimum, improved recognition of the problem, identification of where homeless persons are staying (including places other than the shelter), the cultural issues associated with extreme poverty, the network they survive within, and the efforts of the shelters and the resources that can be obtained through the shelter network.

4. **Require shelters to develop annual plans which describe how guests are connected to mental health and substance abuse services.** Each homeless shelter should develop a plan which explains how the guests at the shelter will access mental health and substance abuse services. Technical assistance will be made available when necessary. The plan must be reviewed and approved by the local DMHMRSAS regional office with the involvement of the Qualaity Improvement Councils (QIC). MSHA will not provide funding or enter into SOS contracts or other funding contracts with homeless agencies until the shelter's plan has been approved by the local DMH office.

5. **Require mental health agencies to develop annual plans which describe how mental health and substance abuse services will be connected to persons in homeless shelters.** Each mental health and substance abuse provider should develop a plan which explains how its mental health or substance abuse services will be delivered to persons in homeless shelters. Technical assistance will be made available when necessary. The provider shall involve the QIC in the plan development. DMHMRSAS shall not provide funding or enter into community mental health block grant contracts or other funding contracts with mental health or substance abuse providers until the providers plan has been approved by the homeless shelters in the region.



6. **Provide for a Seamless Housing System.** DMHMRSAS should continue to work with MSHA to provide housing where the homeless mental health and substance abuse needs are prevalent. The two agencies should consolidate at MSHA the housing vouchers and certificate systems, developing a memorandum of understanding on the delivery of housing units and services. They should also work with other housing authorities who control other supply of vouchers and certificates. Further development of independent housing and transitional housing should be performed by MSHA and based on the regional need identified by DMHMRSAS mental health and substance abuse providers and the homeless shelters.

7. **Licensing.** This report's recommendations regarding licensing are consistent with that of Physical Licensing Group, a study group created through the Governor's Cabinet and facilitated by the Maine State Housing Authority. The goal of that study is to streamline the review process, establishing single review processes and agency responsibility wherever possible. It is further recommended that common building standards for all projects be established to reduce costs associated with change in use. It is also recommended that the task force review and make recommendations related to program licensing. All of the above can be most easily achieved through the establishment of a single, statewide building code and building code review process. No additional licensing for emergency shelters is recommended beyond what agencies require now in order to access funds.

8. **Encourage the Development of Supported Housing.** There is a need for a variety of housing that will assist homeless persons to move out of shelters to higher quality housing. Resources and development capacity are needed to continue this assistance. The task force will work with public officials to review the adequacy and continuation of federal resources to assist with homeless programs.

The data summarized in this Report has been collected by the Maine State Housing Authority from the 37 shelters that receive SOS funds. There are several additional small shelters in Maine that receive no funding from MSHA. All photographs were taken at the Oxford Street Shelter, Portland.

9. **Future of the Task Force.**

A. The membership of the Task Force should be continued as is.

B. The Task Force should review the legislative and governmental action resulting from this report by March 15, 1998 and submit a brief follow up report to the legislature.

C. The Task Force should annually review the training plans referenced in recommendations #2 and #3.

D. The Task Force should have the authority and be responsible for resolving disputes arising from recommendations #4 and #5.

E. The Task Force should annually report on the capacity of the homeless shelters to provide emergency shelter to those in need of shelter. The report should include information on the physical condition of shelters and the need to raise standards or require licenses.

F. The Task Force should annually report on the number of homeless guests. The report should include:
   1. occupancy at each shelter,
   2. number of guests with mental illness and/or substance abuse problems,
   3. average length of stay at each shelter, and
   4. number of homeless persons that receive mental health or substance abuse services.

G. The Task Force should develop and review any applicable plans and services that may help Maine's homeless citizens whenever a majority of its members vote to do so.

H. The Task Force should work with federal elected representatives in order to maintain funding for necessary programs.

I. The Task Force should submit a report by December 1, 1998 on the impact of welfare reform on homeless families.

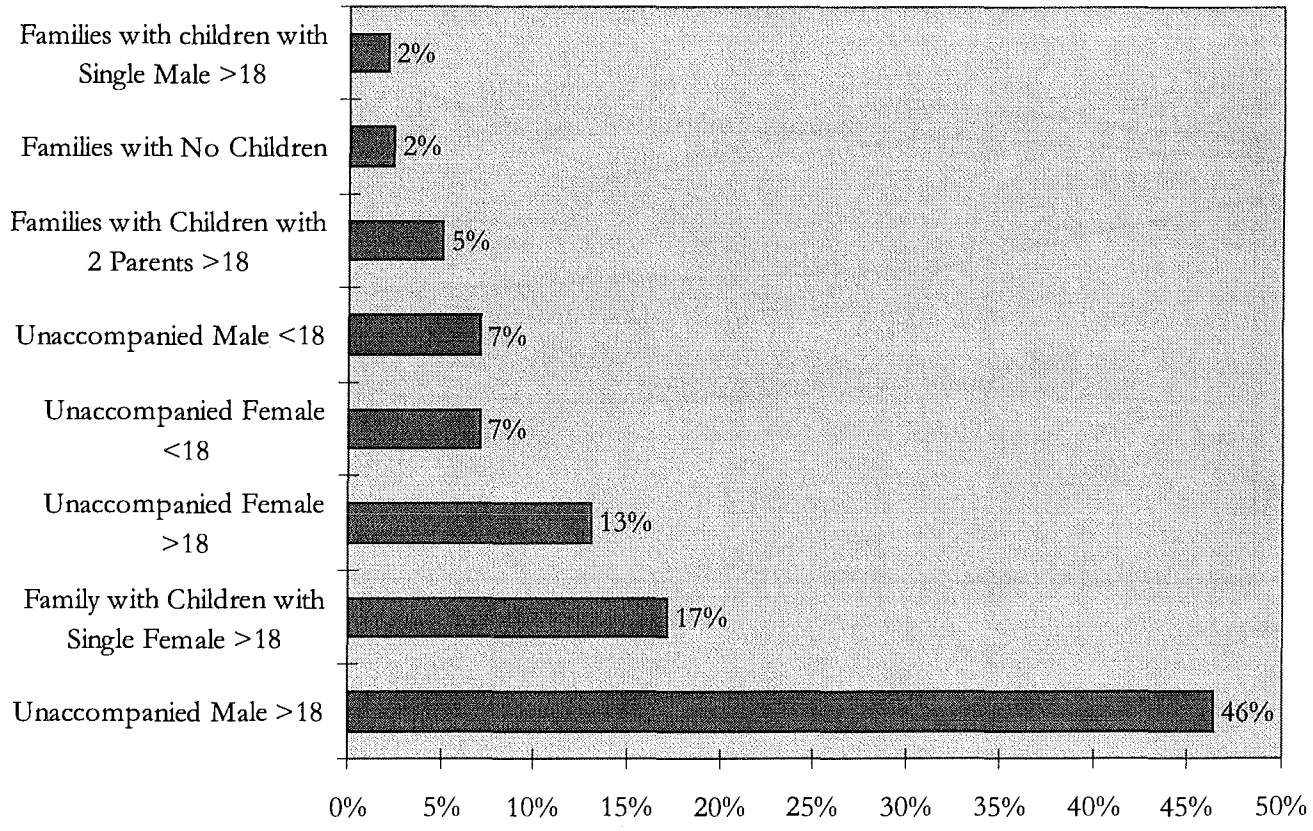
J. The task force should explore applicable program licensing and standards.

APPENDICES

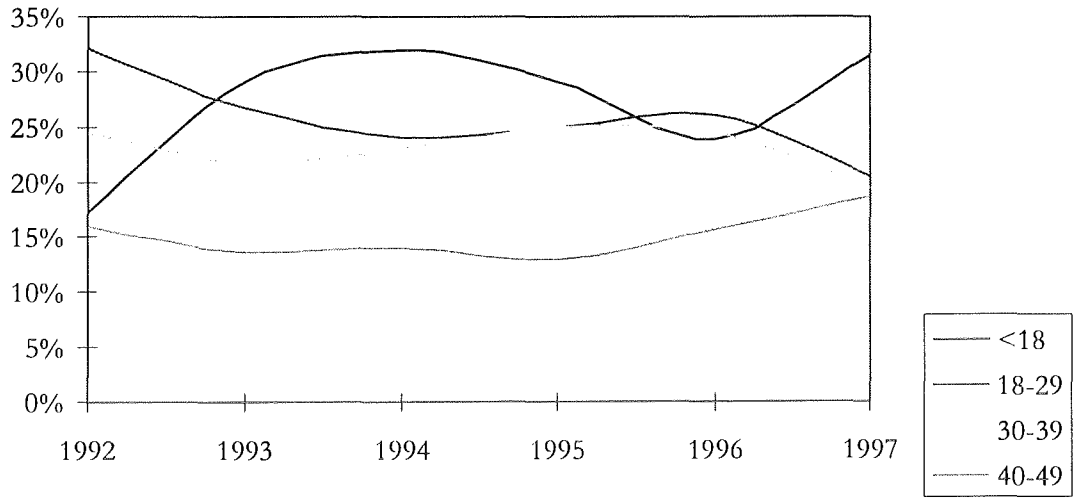
1997 Emergency Shelters by Type		
Shelters/Project Name	Location	Beds
General/Family Shelter		459
Rural Community Action Ministries	Leeds	17
Tedford Shelter	Brunswick	30
Hope Haven Gospel Mission	Lewiston	33
City of Portland Family Shelter	Portland	41
Greater Bangor Area Shelter	Bangor	32
Chisolm Family Shelter	Rumford	7
St. Michael's Center	Bangor	20
York County Shelters, Inc./Within	Alfred	56
Mid Coast Hospitality House	Rockport	13
Emmaus Center	Ellsworth	18
Bread of Life Shelter	Augusta	10
Mid Maine Shelter	Waterville	11
HOME Inc.	Orland	39
YWCA of Portland/Fair Harbor	Portland	25
Oxford Street Shelter	Portland	62
Salvation Army Shelter	Portland	16
Temporary Shelter for the Homeless	Presque Isle	30
Youth Shelter		102
Shaw House	Bangor	16
Youth and Family Services	Skowhegan	10
Youth Alternatives of Southern Maine	South Portland	12
Rumford Group Home	Rumford	20
New Beginnings, Inc.	Lewiston	12
Ingraham-Bridge/Mainestay	Portland	24
My Choice	Portland	8
Substance Abuse/Mental Illness Shelter		51
Arnie Hanson Center	Portland	19
Hope House, Inc.	Bangor	22
YANA, Inc.	Scarborough	10
Domestic Violence		122
Abused Women's Advocacy Project	Auburn	15
Family Crisis Shelter	Portland	18
Spruce Run Association	Bangor	17
Womancare/Aegis	Dover-Foxcroft	4
Womankind, Inc.	Machias	12
Caring Unlimited	Sanford	15
Battered Women's Project	Caribou/Houlton	25
Family Violence Assistance Project	Augusta	16
New Hope for Women, Inc.	Rockland	1

1997 Shelters by Region		
Shelter/Project Name	Location	Beds
Androscoggin		76
Rural Community Action Ministries	Leeds	17
Abused Women's Advocacy Project	Auburn	15
Hope Haven Gospel Mission	Lewiston	33
New Beginnings, Inc.	Lewiston	12
Aroostook		55
Battered Women's Project	Caribou/Houlton	25
Temporary Shelter for the Homeless	Presque Isle	30
Portland		214
YWCA of Portland/Fair Harbor	Portland	25
Oxford Street Shelter	Portland	62
Arnie Hanson Center	Portland	19
City of Portland Family Shelter	Portland	41
Family Crisis Shelter	Portland	18
Ingraham - Bridge/Mainestay	Portland	24
Salvation Army Shelter	Portland	16
My Choice	Portland	8
Remainder of Cumberland		52
Tedford Shelter	Brunswick	30
Youth Alternatives of Southern Maine	South Portland	12
YANA, Inc.	Scarborough	10
Hancock		57
HOME Inc.	Orland	39
Emmaus Center	Ellsworth	18
Kennebec		37
Bread of Live Shelter	Augusta	10
Mid Maine Shelter	Waterville	11
Family Violence Assistance Project	Augusta	16
Knox		14
New Hope for Women, Inc.	Rockland	1
Mid Coast Hospitality House	Rockport	13
Oxford		27
Chisolm Family Shelter	Rumford	7
Rumford Group Home	Rumford	20
Penobscot		107
Greater Bangor Area Shelter	Bangor	32
Hope House, Inc.	Bangor	22
Shaw House	Bangor	16
Spruce Run Association	Bangor	17
St. Michael's Center	Bangor	20
Piscataquis		4
Womancare/Aegis	Dover-Foxcroft	4
Somerset		10
Youth and Family Services	Skowhegan	10
Washington		12
Womankind, Inc.	Machias	12
York		71
Caring Unlimited	Sanford	15
Youth County Shelters, Inc./Within	Alfred	56
	State Totals	720

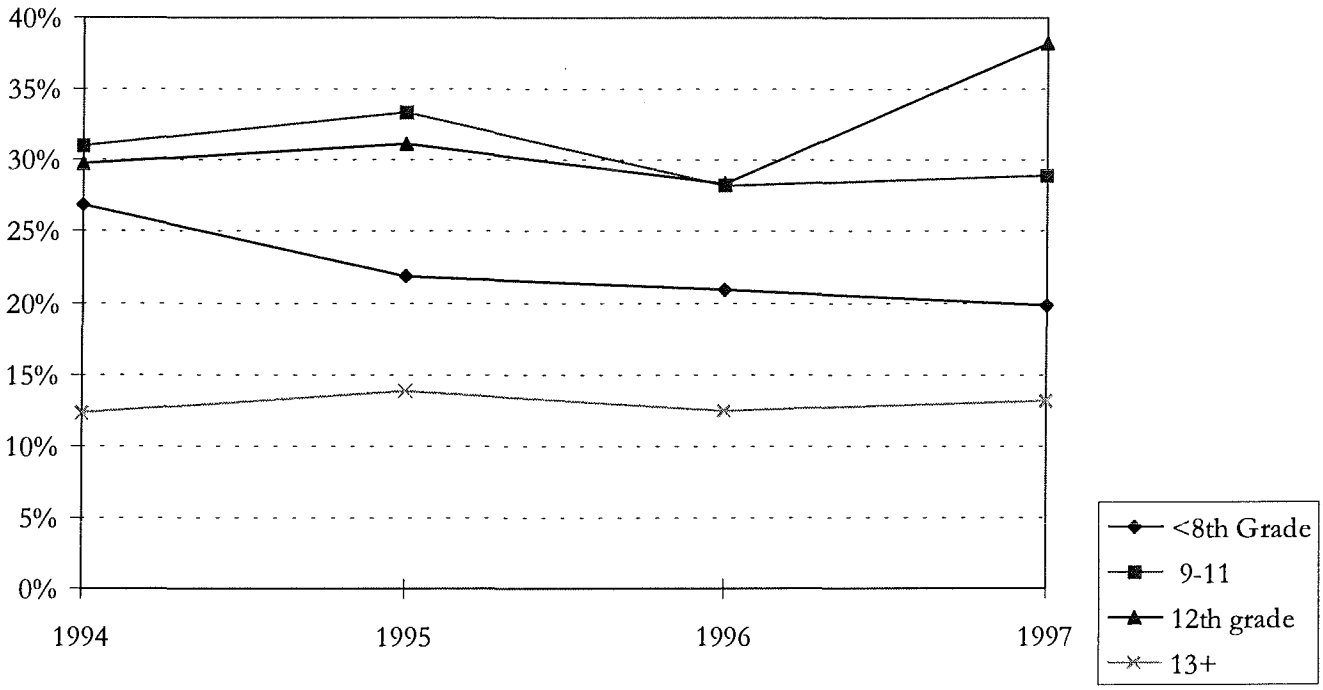
Percent of Homeless Persons by Sex and Family Type

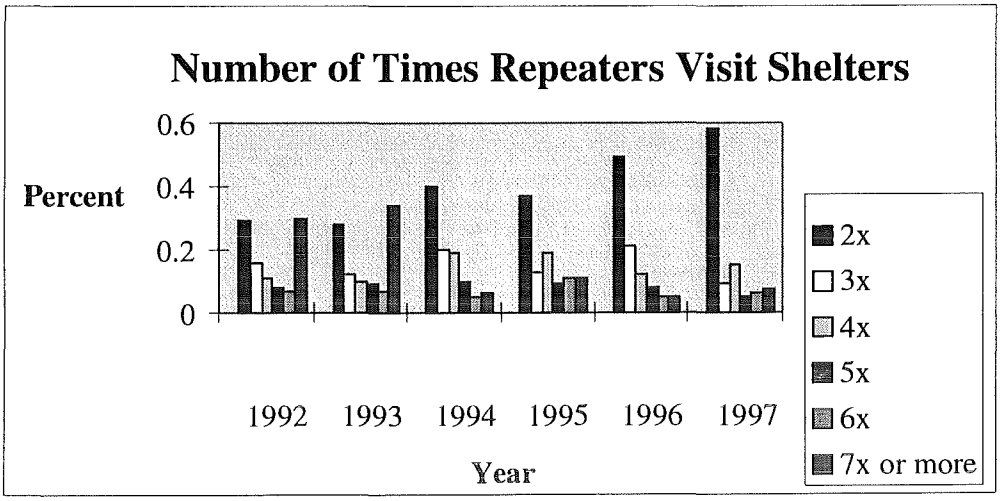


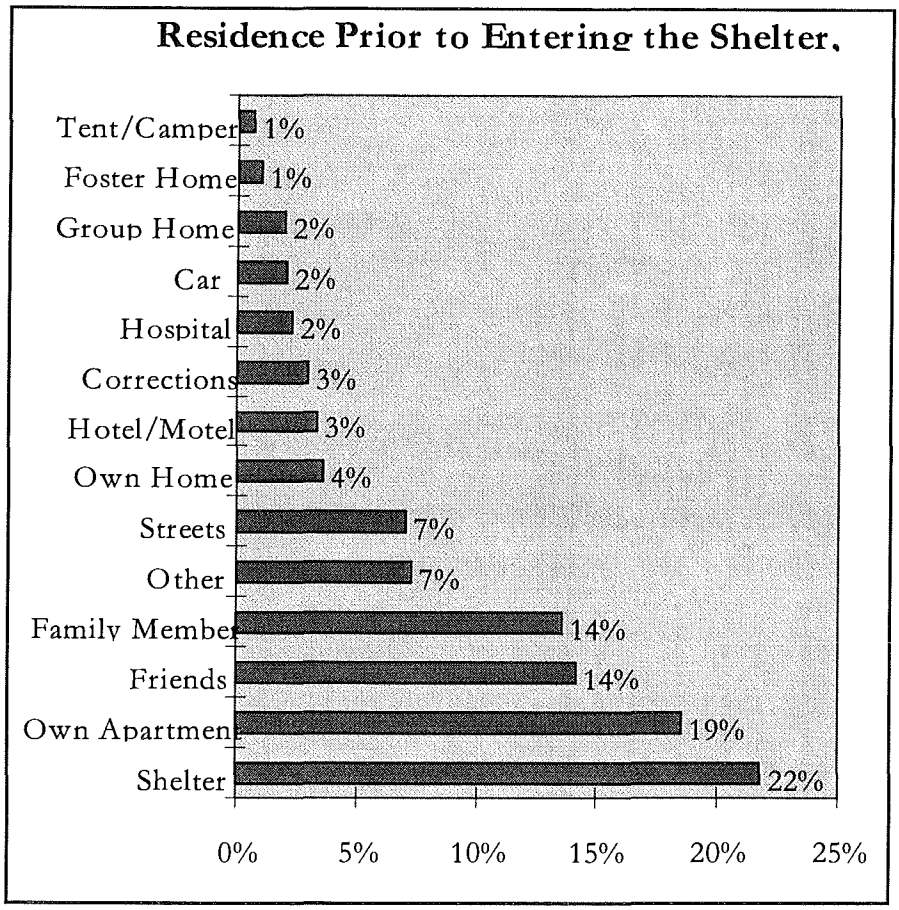
Percent of Shelters by Four Primary Age Groups; 1992-1997



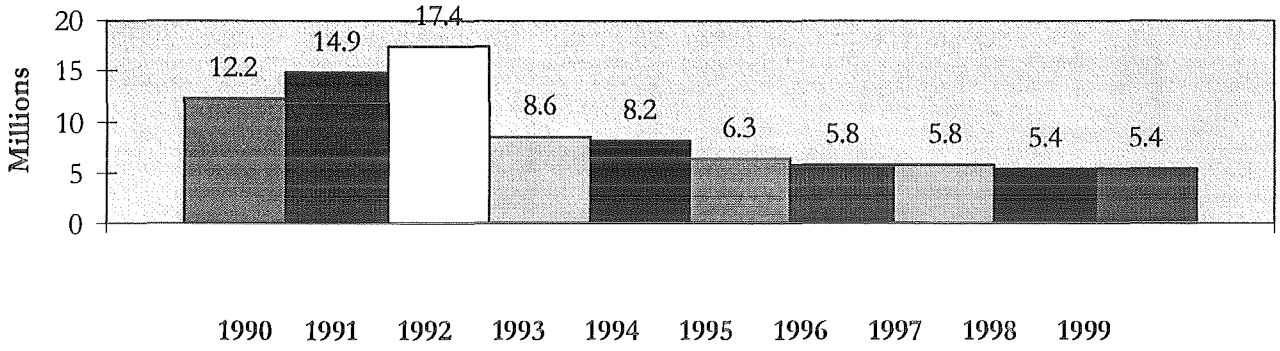
Changes in Educational Attainment for Homeless Persons







STATE OF MAINE
General Assistance Appropriations



APPROVED
JUN 12 '97
BY GOVERNOR

CHAP
552
PUBLIC

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-SEVEN

H.P. 660 - L.D. 913

An Act to Provide Additional Operating Funds for Homeless Shelters

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 30-A MRSA §5042, sub-§1, as amended by PL 1995, c. 560, Pt. K, §82 and affected by §83, is further amended to read:

1. Membership. The Interagency Task Force on Homelessness and Housing Opportunities consists of 21 12 people appointed as follows:

A. The commissioners, a deputy commissioner or their designees an associate commissioner of each of the following departments:

(1) The Department of Human Services;

(2) The Department of Labor;

(3) The Department of Corrections; and

~~(4) The Department of Education;~~

~~(5) The Department of Economic and Community Development;~~

(6) The Department of Mental Health, Mental Retardation and Substance Abuse Services; and

~~(7) The Department of Agriculture, Food and Rural Resources;~~

B. The director or deputy director of:

(1) The Maine State Housing Authority;

C. Five Three persons appointed jointly by the President of the Senate and the Speaker of the House of Representatives as follows:

(1) One member to represent a community action agency;

(2) One member to represent a nonprofit agency providing shelter to the homeless; and

~~(3) One member to represent a nonprofit housing development corporation;~~

(4) One member to represent municipalities; and

~~(5) One member to represent low-income people; and~~

D. Eight Four persons appointed by the Governor, at least ~~4~~ 3 of whom must be chosen from a list of nominations provided by a statewide coalition for the homeless to represent homeless and formerly homeless people and low-income tenants.

Sec. 2. 30-A MRSA §5044, as amended by PL 1991, c. 610, §19, is further amended to read:

§5044. Duties

The interagency task force shall advise the state authority with respect to the implementation of this chapter and the development of affordable housing. The task force shall:

~~1. Assist in the development of affordable housing plan. Assist the state authority with the development of the affordable housing plan under subchapter I;~~

~~2. Make recommendations. Make recommendations to the state authority, the Governor and the Legislature with respect to policies, programs and funding under this chapter;~~

~~3. Review programs and policies. Review and examine the plans, programs, policies and funding to determine their effectiveness. The task force shall provide the findings of its review to the persons and organizations set forth in subsection 2;~~

4. Serve as coordinator of information. Serve as a coordinator of information and communication among state agencies and among the state, municipal and private sectors with respect to this chapter; and

5. Assistance to homeless. In cooperation with the state authority, identify the resources available to the homeless and persons with special needs, identify the gaps in delivery services to this population and make recommendations concerning the policies and programs serving this population.

Sec. 3. Study. The Interagency Task Force on Homelessness and Housing Opportunities shall study and provide recommendations to the Legislature and the Governor by December 1, 1997 on:

A. How best to provide affordable housing and homeless shelter services to those homeless persons with mental illness or substance abuse problems; and

B. The future role and responsibilities, if any, of the interagency task force.

The study must include an inventory of the current safety and health requirements, licenses and permits applicable to homeless shelters, including shelters for families, adolescents, adults and victims of domestic violence.