

Treatment and Prevention Services for Persons
with Alcohol and other Drug Disorders who are Homeless

A Review of State Services

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NASADAD's partnerships and ongoing collaboration with a number of agencies and individuals has been central to the successful completion of this analysis and report. In particular, the close working relationships that exist between the association and the nation's State Alcohol and Drug Abuse Agencies has permitted this exploration of the nature and scope of treatment and prevention services developed and delivered to persons with alcohol and other drug use disorders who are homeless or at risk of homelessness.

The National Association of State Mental Health Program Directors (NASMHPD) has recently completed a similar analysis of the services to persons who are mentally ill and homeless (or at risk of homelessness) that are provided through State Mental Health Agencies. This project has benefitted from close collaboration with key personnel involved with that project, including Bruce Emery, who served as primary author of both reports.

In addition, NASADAD appreciates the interest and contributions of Robert Reeg of the National Coalition for the Homeless, who provided valuable suggestions regarding the data elements that needed to be explored in order to appropriately review alcohol and other drug services available to the homeless population.

The development and delivery of alcohol and other drug services to persons who are homeless or at risk of homelessness through the nation's State Alcohol and Drug Abuse Agencies is a complex and challenging task. We are pleased to contribute this analysis of existing services to the ongoing work of the many providers, policy-makers, consumers and advocates who are committed to improving the lives of these citizens.

Robert Anderson

Director, Research and Program Applications

Executive Summary

Introduction

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) conducted this study because of its interest in the complex problem of homelessness among individuals with alcohol and other drug use disorders. The report touches briefly on an array of federal responses to the challenge of homelessness, including regional Policy Academies sponsored by the Departments of Health and Human Services and Housing and Urban Development; the Homeless Families Program; Cooperative Agreements for Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Homeless Persons; Targeted Capacity Expansion Program; Group Homes; Stewart B. McKinney Homeless Assistance Act; Programs in Assistance from Homelessness; and Demonstration Projects for Homeless Individuals.

The report explores in detail the varied responses of forty separate State Alcohol and Drug Abuse Agencies in developing and financing treatment and prevention initiatives for persons with alcohol and other drug use disorders who are homeless or at risk of homelessness. These responses demonstrate that although there are no systemic requirements to provide services or to capture data regarding treatment targeted to this population, State agencies are engaged in an impressive array of initiatives and services for the homeless. Finally, it enumerates a series of observations and recommendations designed to underscore the need to strengthen the nation's treatment and prevention services response to persons with alcohol and other drug disorders who are homeless or at risk of homelessness.

Methodology

Data that are presented in this report were derived from three key sources:

- (1) A *Consultation Document* developed specifically to identify state-level program development and financing activities;
- (2) The *Treatment Episode Data Set (TEDS)*;
- (3) The NASMHPD Research Institute *State Mental Health Agency Profile System*.

Data elements to be considered on a state-by-state basis were identified in consultation with federal agency representatives, state staff, association staff and homeless program advocates. A comprehensive list of 25 separate data elements were selected for review, spanning the general categories of special population designation; information systems and data collection; service development and delivery; service financing; discharge policies; program planning and evaluation; organizational support and consumer involvement.

Findings

Data applicable to fiscal year 1999 were obtained from 40 states. The following were among the report's key findings:

- ❑ Approximately 600,000 individuals throughout the country are homeless at any given point in time. Research suggests that up to 70% of them have been homeless for less than two years.
- ❑ Families comprise 38% of the urban homeless population and an even higher percentage in rural America.
- ❑ Alcohol and other drug abuse are major factors in homelessness. Estimates of alcohol and other drug abuse among persons who are homeless reach as high as 70%.
- ❑ The rates of addiction and mental illness among persons who are homeless have significantly increased in recent years.
- ❑ 31 states utilize the TEDS definition of homelessness, while nine states identify persons with alcohol and other drug use disorders who are homeless or at risk of homelessness as a high priority population.
- ❑ Fifteen states have conducted needs assessments of the number of persons with alcohol and other drug use disorders in the general population who are homeless or at risk of homelessness. The range of assessed need varies widely. No comparability is possible from state to state because of variability in needs assessment mechanisms.
- ❑ Many state-level incentives and initiatives are underway to strengthen development and delivery of treatment and prevention services to persons with alcohol and other drug use disorders who are homeless.
- ❑ Measures of homelessness are not yet in widespread use as outcome and performance indicators by State AOD agencies.
- ❑ The most commonly-delivered treatment service is free-standing residential detox, followed by long-term residential rehabilitation and intensive outpatient services.
- ❑ States that deliver services to homeless individuals with alcohol and other drug use disorders offer a relatively wide range of services – i.e., four or more service modalities.
- ❑ The percentage of persons admitted to treatment services who meet TEDS or TEDS-like definition of homelessness ranges from 1% to 21%.
- ❑ A majority of states rely primarily on general AOD funds, SAPT block grant and other federal sources to support treatment services for this population.

Observations and Recommendations

This study bolsters the findings of others conducted in recent years that explore the needs of persons who are homeless. While much has been done to respond to the needs of persons with alcohol and other drug use disorders who are homeless or at risk of homelessness, the nature and complexity of the problem presents a significant ongoing challenge to State Alcohol and Drug Agencies who are already trying to cope with limited resources and increasing demand. The following general observations and recommendations are offered.

Observations

- ❑ Existing data systems frustrate the ability to examine alcohol and other drug treatment and prevention services among persons who are homeless. State-by-state comparisons of need, services and financing are problematic.
- ❑ Competition for scarce resources is fierce and will increase as the present demand increases.
- ❑ Federal funding has been critical to program development and growth.
- ❑ Program and service technology offers important guidance in developing and strengthening treatment and prevention services.

Recommendations

- ❑ Increase funding for needed treatment and prevention services expansion.
- ❑ Support collaboration among local, state and federal partners in developing treatment and prevention programs and strengthening service systems' response.
- ❑ Improve management information systems capacity and comparability across states.
- ❑ Disseminate best practices in developing alcohol and other drug services for persons who are homeless or at risk of homelessness.

Introduction

The Nature of the Problem

Homelessness in the United States is both a visible and a costly problem. Experts suggest that at least 600,000 single adults are homeless at any given point in time (Burt & Cohen, 1989). A recent federal study estimated that the episodic and recurrent nature of homelessness results in 1 million individuals actually being homeless in the course of any year (O'Brien, Johnson & Rickards, 2000). During the five year period from 1985 - 1990, an estimated 7 million people experienced homelessness (Link, et al., 1994).

Reaching an understanding of some of the key characteristics of the homeless population is useful in planning an effective response to their complex needs, including their needs for alcohol and other drug abuse prevention and treatment. Research suggests that 40% of the homeless population have been homeless for less than six months and that 70% have been homeless for less than two years (Burt, 1997). A study completed for the U.S. Conference of Mayors examined statistics collected from 26 cities between November 1, 1992 and October 31, 1993, as well as data from Census Bureau and Bureau of Labor Statistics. Contrary to popular myth regarding the nature of homelessness and persons who are homeless, that study found that families comprise 38% of the urban homeless population (U.S. Conference of Mayors, 1996). Other research further supports this finding for rural areas, as well, noting that homeless families actually comprise the majority of homeless people in rural areas (Vissing, 1996).

The causes of homelessness are complicated. They include unemployment, poverty, the lack of affordable housing, substance abuse, mental illness, family disintegration and domestic violence, the lack of adequate social support networks, inadequate education, migration and immigration and personal choice.

Substance abuse ranks as one of the leading causes of homelessness. More than half of the 30,000 homeless individuals who participated a Health Care for the Homeless project (1994) identified alcohol and drug abuse as the single most important factor (32%) or a major factor (22%) leading to the loss of their housing. Substance abuse was noted as a problem for 48% of the individuals who took part in that project.

Investigating the prevalence of alcohol and other drug abuse among the homeless, James Wright of Tulane University found that 38% of homeless people are identifiable as alcohol abusers,

as opposed to 10% of the general population (Wright, 1989). He also points out that 13% of homeless people abuse drugs.

Contemporary research suggests that rates of addiction and mental illness among persons who are homeless have significantly increased in recent years. Leading a team of researchers from the School of Social Work at Washington University in St. Louis, David E. Pollio examined data from three studies of homeless men and women conducted in St. Louis in 1980, 1990 and 2000, finding that rates of drug use among persons who are homeless increased 600% over the twenty-year period (Reuters News Service, 10/24/01). Nearly 60% of the homeless population studied were diagnosed with drug addiction at some point in their lives. According to the research team, the rate of alcoholism among homeless women doubled during the period, to about 40% being diagnosed with an alcohol problem in 2000 (rates of alcoholism among homeless men remain unchanged). The researchers also found increases in the rates of major depression, bipolar disorder and schizophrenia.

Co-occurring mental health and substance use disorders among the population of persons who are homeless is a problem that has long been recognized by providers, professionals and advocates. Research indicates that it is becoming a more complex and pervasive problem. The National Comorbidity Survey conducted in 1991 notes that co-occurring mental illness and substance abuse disorders are experienced by about 14 percent of the American population between the ages of 15 and 54 years of age. About 5 percent experienced a co-occurring mental health and substance abuse disorder in the past year (Rouse, Ed., 1995).

Among persons who are homeless, general estimates of the rate of alcohol and other drug abuse are striking, reaching as high as 50 - 70% or more (Ross, Glaser & Germanson, 1988; Center for Mental Health Services, 1994). The co-occurrence of multiple disorders is generally regarded as a complicating factor in effectively treating disorders. Multiple disorders generate greater difficulty in obtaining and maintaining housing, employment, social linkages and health care. According to Fisher (1990), homeless clients who are dually diagnosed are more likely to be unemployed and homeless for longer periods of time than individuals diagnosed with one disorder. "Co-occurring mental health and substance use disorders experienced with homelessness can severely and negatively impact every aspect of an individual's life" (O'Brien, Johnson & Rickards, 2000, p. 2)

While these and other research findings are crucial to our understanding of the nature and extent of alcohol and other drug abuse among persons who are homeless or at risk of homelessness, it should be noted that the nature of homelessness itself makes it difficult to fully assess the problem. Traditional census methods focus on household units as the unit of measurement. Since, by definition, homeless individuals and families are excluded from this unit of measurement and because of the transient nature of their living situations, a case can be made that current estimates of the extent of homelessness and substance abuse actually understate the extent of the problem.

The Nation's Response

The nation's response to the challenge of homelessness has historically been to rely on a

network of emergency shelters, emergency rooms, detox centers and institutionalization – all expensive and essentially crisis-driven services that are costly and largely ineffective in the long-term.

Despite the confirmed linkage between homelessness and substance abuse, relatively few recovery resources are available. Deinstitutionalization of state psychiatric hospitals during the 1970's and 1980's contributed to creating a population of homeless individuals with mental illness and substance abuse disorders (Hope & Young, 1986). While treatment is seen as critical to ending the cycle of homelessness, programs designed to assist persons who are homeless are often unavailable to those with alcohol and other drug use dependencies (Oakley & Dennis, 1997; Baum, 1993).

In a guest column to the Washington Post (12/5/93), former Secretary of Housing and Urban Development Henry Cisneros maintained that the root causes of homelessness cannot be adequately addressed with just a hot shower, a warm meal and a bed. Cisneros suggested that homelessness is the result of substance abuse, drug abuse, mental illness, disability, chronic illness and “just plain hard times.” According to a report in U.S. News and World Report (November 8, 1993), “just giving money, food, and housing [but no therapy]...makes us enablers. What the damaged street population needs is *treatment*, and any rational society would bring pressure and perhaps pass laws to being about it.”

Federal Initiatives

Recognizing that states play a pivotal role in determining eligibility of persons who are homeless for access to Federal and State-funded health and human service programs, the Department of Health and Human Services and the Department of Housing and Urban Development are partnering to sponsor two regional *Policy Academies* during this fiscal year. Targeted toward overcoming barriers to accessing mainstream services for homeless families with children and for persons who are “chronically” homeless, the academies will bring together State-level teams comprised of individuals with policy-making influence with a nationally-recognized faculty to develop a State-specific Action Plan. Designed to also identify promising practices in addressing homelessness in states and communities, the academies will involve participating teams from as many as 21 states.

The Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP) and the Center for Mental Health Services (CMHS) of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) have helped to create and support a wide range of effective treatment responses to address the problem of alcohol and other drug use among persons who are homeless or at risk of homelessness by implementing a series of significant programmatic and fiscal strategies.

The *Homeless Families Program* is a knowledge development effort that spans five-years and is designed to document and evaluate the effectiveness of time-limited and intensive intervention strategies for providing treatment, housing, support and family preservation services

to homeless mothers with psychiatric and/or substance abuse disorders who are caring for dependent children. CSAT's *Targeted Capacity Expansion* (TCE) Program supports expansion of substance abuse treatment in communities with serious unmet need and emerging drug problems. Funding is provided to support programs that demonstrate sound, scientifically-based theory or empirical evidence of effectiveness. In FY 1999 and FY 2000, CSAT specifically included a focus on projects designed to serve homeless substance abusers.

Under current law, each State must provide for the ongoing operation of a revolving fund to make loans covering the costs of establishing recovery housing in which individuals recovering from alcohol and drug abuse may reside in *Group Homes*. The homes are self-run, self-supported and provide an opportunity for recovering persons to live in a supportive peer environment as long as they do not relapse.

The Center for Substance Abuse Treatment and the Center for Mental Health Services have collaboratively issued *Cooperative Agreements for the Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Homeless Persons*. Begun last year, the program – funded at \$9 million this year and \$10 million next year – is a special initiative designed to augment the provision of substance abuse services to persons who are homeless and respond to the need to create a more effective response to co-occurring mental health and substance abuse disorders.

Funding provided through the *Stewart B. McKinney Homeless Assistance Act* in 1987 made significant federal support available to states in their efforts to assist persons who are homeless or at risk of homelessness. The McKinney program authorizes and provides financial support for a wide range of services in response to the needs of persons who are homeless, including outreach, prevention, crisis shelter, transitional, supported housing and permanent housing, health care – including substance abuse and mental health care – and education and job training. The Department of Housing and Urban Development has managed the McKinney program since its creation.

SAMHSA's Center for Mental Health Services (CMHS) has for some years operated the *Programs for Assistance in Transition from Homelessness (PATH)*, a formula grant program facilitated by a national coordinating center. PATH funds and the required state match provide a broad range of services for people who are mentally ill and or homeless or at risk of homelessness. The PATH program funds only those agencies that agree to address the needs of individuals with co-occurring substance abuse and mental health disorders in a coordinated fashion. With a steadily increasing federal funding allocation (i.e., 6 % from FY 2000 to FY 2001), the PATH program has proved to be an invaluable resource in encouraging states to develop and expand their services for persons who are mentally ill and homeless or at risk of homelessness.

CSAT and CMHS collaborated in funding a three-year *Demonstration Project for Homeless Individuals* that ended in 1997. The program was designed to evaluate promising integrated treatment interventions for individuals with serious mental illnesses and alcohol or

other drug disorders who were homeless. Sixteen sites participated in the program's first phase, begun in 1993. Following completion of Phase I in 1994, six of these sites received awards for 2 additional years of funding. One of the more important cross site findings reported from the project included reductions in homeless days/nights experienced by participating program clients.

State Initiatives

There is no set-aside in the SAPT Block Grant program that specifically targets the homeless population. Nor has any program similar to PATH been authorized that would provide the funding to allow State Alcohol and Drug Authorities to respond to the specialized alcohol and drug abuse treatment needs of persons who are homeless or at risk of homelessness. Consequently, states have been limited in their ability to finance treatment and prevention services for persons with alcohol and other drug use disorders who are homeless or at risk of homelessness. With or without a set-aside for services targeting the homeless population – and it should be noted that set-asides run counter to states' ability to determine their own priorities – funding is simply not sufficient to provide the type and scope of services required by this difficult and challenging population.

Despite these funding limitations, however, State Alcohol and Drug Abuse Agencies have developed and implemented a range of prevention and treatment initiatives and services that are designed to respond to the complex needs of this challenging population. The nature and scope of those services are the focus of this report.

Methodology

Data Sources

Consultation Document

The data that are included in this report and analysis were developed from several sources. Project staff depended primarily upon direct contact with State Alcohol and Drug Authorities through written, electronic, telephone and fax communications. A consultation document was developed to guide discussions with state agency staff and ensure that the data elements listed in the following section were addressed. Discussions continued over a period of several months to elicit information and clarify staff's understanding of state activities in providing prevention and treatment services for persons who are homeless or at risk of homelessness.

Two additional sources of data have supplemented the direct communications with states that represented the project's chief source of data : (1) *The Treatment Episode Data Set (TEDS)* and (2) the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) *State Mental Health Agency Profile System*.

Treatment Episode Data Set (TEDS)

The Treatment Episode Data Set system incorporates selected data that are routinely collected by states to better understand the activities and performance of their substance abuse treatment systems. Data items are collected and presented in a standardized fashion to permit national analyses of alcohol and drug abuse treatment episodes. Approximately 1.5 million admissions to treatment in facilities that report data to State systems are represented in the latest TEDS Report (1998).

A TEDS Minimum Data Set comprised of 19 items is collected by nearly all States. For purposes of this report, it should be noted that the Minimum Data Set does not include a data element on individual client housing status upon either admission to or discharge from treatment. A Supplemental Data Set of 15 data elements is collected by some States, which does include "status of living arrangement upon admission" as one data element. Of the 52 states and territories participating in the 1998 Treatment Episode Data Set, 20 (39%) reported no supplemental information regarding living status upon admission. The remaining 32 states and territories that did report living arrangement for some or all admissions, represented just over three-quarters (i.e., 76%) of total admissions during the reporting period.

SAMHSA is currently expanding its data collection efforts through TEDS to include discharge data, so that information will be available on entire treatment episodes. This expansion is likely to permit a more complete understanding of the nature of homelessness among individuals with alcohol and other drug use disorders.

NASMHPD Research Institute (NRI) State Mental Health Agency Profile System

The NASMHPD Research Institute maintains the centralized, computer-based State Mental Health Agency (SMHA) Profiling System to meet state and national needs for comparable information on state mental health agencies. Because approximately half of the nation's State Mental Health Agencies also bear some responsibility for the delivery of substance abuse services, the SMHA Profiling system offers a supplemental source of information regarding delivery of alcohol and other drug use services for persons who are homeless or at risk of homelessness.

The SMHA Profiling System includes both quantitative data (e.g., services data, revenues and expenditures data, etc.) and non-quantitative information (e.g, policies, administrative practices, etc.). Two data items are especially relevant to this report:

- ❑ Approximate number of adults with serious mental illness are homeless over the course of an entire year
- ❑ Approximate number of adults with serious mental illnesses are homeless each day

A significant number of those individuals included because of their serious mental illness are also diagnosed with a co-occurring substance abuse disorder, as has already been discussed. Review of profile system data resulted in the incorporation of relevant data and information into this report.

The 2001 round of data collection for the State Profiling System is currently underway.

Data Elements

At the start of this project, staff developed a list of data elements with the recognition that the availability of state-specific information gleaned from several different sources would contribute to the report's substantive content. The following data elements were seen as the most likely to present a reasonably comprehensive picture of the treatment and prevention activities delivered through State Alcohol and Drug Abuse Authorities to persons with alcohol and other drug abuse disorders who are homeless or at risk of homelessness.

Priority Identification

- states that designate persons with alcohol and other drug use disorders who are homeless as a special priority population to receive substance abuse prevention and treatment services
- the mechanism used to establish this priority
- date of the population's priority designation

Data Collection

- states that collect information on persons with alcohol and other drug use disorders in the general population who are homeless/at risk of homelessness
- strategies utilized for data collection

- estimates of and time frame for data collection
- states that collect data on services delivered to persons with alcohol and other drug use disorders who are homeless
- states that require community providers to collect data on the housing status of persons receiving substance abuse services

Service Development and Delivery

- % of persons receiving substance abuse prevention and treatment services who are also homeless or at risk of homelessness
- services provided, by service area and level of service (duplicated/unduplicated count)
- strategies used to encourage the development of targeted substance abuse treatment and prevention services for persons with alcohol and other drug use disorders who are homeless
- states with specialized treatment and prevention programs (e.g., diversion of homeless persons from criminal justice to substance abuse) and populations served (e.g., women with children; male alcoholics; high risk youth)

Service Financing

- primary sources of funds for prevention and treatment services to persons with alcohol and other drug use disorders who are also homeless
- annual expenditure for persons with alcohol and other drug use disorders who are homeless, by source of funds
- annual expenditure for persons with alcohol and other drug use disorders who are homeless, by service
- annual Substance Abuse Prevention and Treatment Block Grant allocation
- states with identified set-asides for substance abuse services to homeless persons, amount and source

Discharge Policies

- existence of discharge policies from public facilities and provider agencies
- nature of discharge policies

Program Planning and Evaluation

- states whose substance abuse prevention and treatment plans include explicit attention to services for persons with alcohol and other drug use disorders who are homeless or at risk of homelessness
- specific mechanisms used to evaluate the effectiveness of services to persons with alcohol and other drug use disorders who are homeless (outcome assessment, consumer satisfaction, other)
- availability of evaluation results

Organizational Support

- states with an identified (full- or part-time) staff person responsible for housing-related matters related to persons with alcohol and other drug use disorders

Consumer Involvement

- mechanisms used to involve consumers in planning substance abuse treatment and prevention services
- involvement of homeless/formerly homeless person(s) in developing, implementing and evaluating the substance abuse prevention and treatment system

Data Limitations

From the start of this project, staff anticipated that exploring the availability of the identified data elements would shed light not just on services but also on the capacity of state information systems to collect and compile the desired information. That expectation has been fulfilled. The findings presented in this report vary as a function of: (1) states' activities in developing treatment and prevention services for persons with alcohol and other drug abuse disorders who are homeless or at risk of homelessness; and, (2) state's capacity to collect and provide information on those services.

Data have been aggregated through the diverse and dissimilar data collection systems of Single State Agencies (SSA's) for substance abuse treatment and prevention. While states have cooperated in the process of data gathering and analysis and to a limited field review of draft findings, the uniqueness of each state's management information system leads to significant differences in data collection and comparability among states. Consequently, the reader is advised to compare state services and financing with caution. It is clear that future efforts to generate more complete and accurate data will affect the ability to both understand state-specific activities and to generate a national picture of treatment and prevention services for persons with alcohol and other drug use disorders who are homeless or at risk of homelessness.

Findings

The findings presented throughout this section are based on information available from 40 of the 55 states and territories (73%). Data are unavailable from 15 states and territories. The extent of the data which is available to review as part of this analysis and the accuracy of the information, as assessed by the states themselves, varies as a function of state activities in developing treatment and prevention services for persons with substance abuse disorders who are homeless or at risk of homelessness and of their ability to generate information that accurately describes those services.

In some states, longstanding efforts of State Alcohol and Drug Agencies to develop services for the population of persons who are homeless have resulted in a robust and effective service array that is reflected in this report. States such as Connecticut, Massachusetts, New York and New Jersey, among others, demonstrate a wide range of programs and services designed to respond to the needs of the population. Some states, such as Florida, have recently moved strongly toward creating a service system that has broad department and legislative support. In other states, the unique and complex nature of the population's needs continues to present challenges and opportunities for creative state action.

Unless otherwise specified, all data presented in this report are for Fiscal Year 1999.

Use of Treatment Episode Data Set Definition of Homelessness

The Treatment Episode Data Set employs a simple definition of homelessness: “no fixed address, includes shelters”. The Department of Housing and Urban Development utilizes the more detailed definition outlined in the McKinney Homelessness Assistance Act of 1987:

A client is deemed homeless if, prior to entering treatment, the client was either:

- (1) Living in the streets, in a car, or other inappropriate place (i.e., parks, abandoned buildings and places not fit for human habitation).
- (2) Living in a shelter/mission or in a residence that is part of an established shelter system.
- (3) Living in transitional housing or supportive housing (not permanent) program and originally came from the streets or the emergency shelter system.
- (4) At immediate risk of homelessness, i.e.,
 - (a) in an institution, with a length of stay over 30 consecutive days, and a discharge date within the week and unsuccessful attempts to secure other housing.
 - (b) if due to a pending verifiable “court-ordered” eviction (i.e., an eviction imminent within one week) and unsuccessful attempts to secure other housing.

Table 1 indicates that of the 40 states that contributed to the data base for this project, 31 (78%) utilize the *TEDS* definition of homelessness. The remaining states use either the HUD definition or one of their own.

Table 1. State Use of TEDS Definition of Homelessness

State	TEDS	Alternate Definition
Alabama	Yes	
Alaska	Yes	
Arizona	Yes	
Arkansas	Yes	
California	No	“One who lacks financial resources or community ties to provide for his/her own shelter.”
Colorado	Yes	
Connecticut	Yes	
Delaware	Yes	
Florida	Yes	
Georgia	Yes	
Hawaii	Yes	
Illinois	Yes	
Iowa	Yes	
Kansas	Yes	
Louisiana	No	“Persons... who have as their primary residence a shelter for the homeless, an institution providing temporary residence or a place not ordinarily used for sleeping accommodations for human beings.”
Maine	No	[Persons who] “sleep...in places not meant for human habitation.”
Maryland	Yes	
Massachusetts	No	McKinney Homelessness Assistance Act definition
Michigan	No	Not available
Minnesota	Yes	
Mississippi	Yes	
Missouri	Yes	
Nevada	Yes	
New Hampshire	Yes	
New Jersey	Yes	

State	TEDS	Alternate Definition
New York	No	“A person or family who is undomiciled, has no fixed address, lacks regular night-time residence and either a) circulates among acquaintances, or b) is residing in a place not designed/intended as regular sleeping accommodations for human beings, or c) is residing in some type of temporary accommodation(e.g., hotel, shelter)...”
North Carolina	Yes	
Ohio	Yes	
Oklahoma	Yes	
Oregon	Yes	
Pennsylvania	Yes	
Rhode Island	Yes	
South Carolina	Yes	
Tennessee	Yes	
Utah	Yes	
Vermont	No	No alternate definition
Virginia	Yes	
West Virginia	Yes	
Wisconsin	No	“Unsheltered: sleeps in a place not designated for sleeping” “Sheltered: sleeps in an emergency, transitional or youth shelter”
Wyoming	Yes	

Designation of Persons with Alcohol and Other Drug Use Disorders who are Homeless as a Priority Population

Table 2 addresses the question of whether or not states and territories have identified this population as a special priority. As the table indicates, 9 of the participating states (23%) have created such a designation.

Table 2. Designation of Persons with Alcohol and other Drug Use Disorders Who Are Homeless as a Priority Service Population

AL	No	CO	No	HI	Yes	ME	Yes	MS	No	NY	Yes	PA	No	VT	No
AK	No	CT	Yes	IL	No	MD	No	MO	No	NC	Yes	RI	No	VA	No
AZ	No	DE	Yes	IA	No	MA	Yes	NV	No	OH	No	SC	No	WV	No
AR	No	FL	No	KS	No	MI	No	NH	Yes	OK	No	TN	No	WI	No
CA	No	GA	Yes	LA	No	MN	No	NJ	No	OR	No	UT	No	WY	No

States vary in terms of the mechanisms that have been used to identify persons with alcohol and other drug use disorders who are homeless as a special priority population for service. They may also choose more than one mechanism to so designate the population. Among those specific mechanisms noted by states, the following were the most commonly mentioned:

<i>Court or Executive order</i>	Maine, Maine			
<i>State AOD Agency Policy</i>	Connecticut, Massachusetts, North Carolina			
<i>Planning & Funding</i>	Georgia	(through the provider manual)		
	New Hampshire	(through legislative funding requests)		
	New York	(through local services plan guidelines)		
<i>Not Specified</i>	Delaware, Hawaii			
<i>Year of Designation:</i>	1990	Delaware	1996	Massachusetts
	1994	Maine	1999	North Carolina
	1995	Hawaii	NA	Connecticut
		New Hampshire		Georgia

Estimates of Persons with Alcohol and other Drug Use Disorders in the General Population who are Homeless

States have experienced significant difficulties in their efforts to estimate the number of persons in the general population who are homeless. Information is gathered from a number of different sources – such as service coalitions, shelters or advocates – and is often inconsistent. The availability of reliable national data is a concern that should be addressed. This concern was also in evidence with State Departments of Mental Health, in a similar study conducted recently of mental health services for persons who are homeless or at risk of homelessness (Emery, 2001).

The Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention have provided support to states to conduct treatment and prevention needs assessments. While several states indicate that they have, in fact, completed statewide estimates of need with federal support, those studies do not appear to have successfully captured the population of homeless individuals with alcohol and other drug use disorders as a subset of the general population. These states suggest that technical assistance to specifically assess the presence of and address the needs of persons with alcohol and other drug use disorders in the general population would fill this knowledge gap.

For those states that are able to provide information, Table 3 indicates that estimates of need, the time period for their collection and methods of estimation vary widely, raising the

question of reliability of any comparisons across state systems.

As the table indicates, 15 of the 40 participating states (38%) report that they conduct a needs assessment that in some fashion identifies the number of persons in the general population with alcohol and other drug use disorders who are homeless. Of those 15 states, all but two provided an estimate – derived from a number of different sources – of persons in need that the State Alcohol and Drug Abuse Agency uses for planning purposes. For the most part, estimates of need were relatively recent, having been developed within the last four years or less.

The range of persons in need varied widely, from a high of 35,226 in New York to a low of 2,350 in Arizona. Since these rates were not applied to the states' general population census, and because an assortment of estimating methods were used by states, it is not possible to compare state rates of persons with alcohol and other drug abuse disorders in the general population who are homeless.

It is possible, however, to note that needs estimates were often conducted within individual states by homeless advocates or state agencies with responsibility for some homeless services (e.g., Department of Social Services). Point in time surveys – especially of shelters – are common. There do not appear to be a significant number of states who have utilized either CSAT or CSAP funds to conduct needs assessments. While this finding may be a function of the current report effort, it might be noted that State Mental Health Agencies also encountered difficulties in their efforts to assess the needs of persons in the general population with mental illness who were homeless. It appears that behavioral health agencies would benefit from further technical assistance in conducting valid and comparable estimates of need.

Table 3. Estimates of Persons with Alcohol and other Drug Use Disorders in the General Population who are Homeless

State	Data Collected	Prevention Needs Assessment	Treatment Needs Assessment	Other Needs Assessment	Method	Time Period for Estimate
Alabama	NA					
Alaska	No					
Arizona	Yes			2,350	Dept. Economic Security PIT shelter survey	one night
Arkansas	No					
California	No					
Colorado	Yes			2640 (>12 yrs)	Denver PIT homeless survey	CY 2000
Connecticut	Yes			NA	Dept. Social Svcs Annual Homeless Demographic Report	Oct 1998-Sept 1999
Delaware	No					
Florida	Yes			21,238	PIT data provided by 20 state-funded homeless coalitions	FY 99
Georgia	No					
Hawaii	No					
Illinois	Yes			Transients/SRO: 5,728 Homeless: 3,615	1997 Lakefront SRO 1990 Homeless Survey DASA	
Iowa	No					
Kansas	No					

State	Data Collected	Prevention Needs Assessment	Treatment Needs Assessment	Other Needs Assessment	Method	Time Period for Estimate
Louisiana	No					
Maine	Yes		5,082			1999
Maryland	No					
Mass	No					
Michigan	No					
Minnesota	No					
Mississippi	No					
Missouri	Yes			31,500	MO Association for Social Welfare	1998
Nevada	Yes			3,565	PIT (NB: est may not be complete)	2000
New Hamp	No					
New Jersey	Yes		7,860			1998
New York	Yes			35,226	State Consolidated Plan	2000
N Carolina	Yes		NA			
Ohio	Yes				Behavioral Health Module to produce data beg. 2002	
Oklahoma	Yes		8,528			1997
Oregon	No					
Penn	No					
R Island	Yes				Tx needs assess. data avail. Fall 2001	
S Carolina	No					
Tennessee	No					

State	Data Collected	Prevention Needs Assessment	Treatment Needs Assessment	Other Needs Assessment	Method	Time Period for Estimate
Utah	No					
Vermont	No					
Virginia	No					
W Virginia	Yes			NA	Provider data	
Wisconsin	No					
Wyoming	No					

“PIT” = point in time “NA” = No response or information not available

State Incentives and Initiatives to Develop Treatment and Prevention Services for Persons with Alcohol and Other Drug Use Disorders who are Homeless

States use a variety of targeted incentives and initiatives to encourage the development of treatment and prevention services for persons with alcohol and other drug use disorders who are homeless. These include technical assistance; financial incentives that provide targeted funding or revolving loan arrangements; capacity building activities; demonstration projects; and other mechanisms.

The nature and extent of the special incentives and initiatives used by states varies. For example, contracts with service authorities or providers in **Georgia** specify that outreach services to persons with alcohol and other drug use disorders who are homeless should be provided. In **South Carolina**, programs are eligible to apply for funds that support special population services such as runaway youth or homeless children. The State of **Pennsylvania** uses Memoranda of Understanding with the Departments of Public Welfare in both Pittsburgh and Philadelphia. The State of **Maine** provides funds for the purchase of vans to support transportation of clients in emergency shelter programs. The **Mississippi** Department of Alcohol and Drug Abuse funds a residential treatment facility for dual diagnosed persons who are chronic users of substances and homeless. **Missouri** makes technical assistance services available through its state office housing staff to assist localities in their program development efforts. It also makes available a revolving loan fund to support development of Oxford Houses. The State of **Ohio** builds treatment capacity in the state through 7 pilot projects totaling \$70,000.

Some states devote quite substantial resources to encourage the development of programs for persons with alcohol and other drug use disorders who are homeless.

In **Connecticut**, the Corporation for Supportive Housing (CSH) and the Department of Mental Health and Addiction Services (DMHSAS) launched a major new supportive housing production initiative called the Supportive Housing Pilots Initiative in 1998. The goal of the Pilots initiative is the creation, over a 4-year period, of close to 600 new units of service-supported housing serving homeless or at-risk families and individuals with mental illness or chemical dependency. Pilots is a statewide, multi-phased initiative that is focused on:

- (5) increasing the capacity of the nonprofit community to plan and implement housing approaches that meet local needs;
- (6) securing State and Federal funding for this housing; and
- (7) successfully developing and operating these housing units.

As a result of technical assistance and advocacy efforts, the Connecticut General Assembly appropriated \$2.1 million in DMHAS funding of Phase I of the Pilots initiative in May 2000. The appropriation is funding support services for 240 families and individuals living in housing units created through the initiative. Within two weeks of the appropriation, DMHAS selected 50 providers statewide to be recipients of Pilot service funding. With assistance from

CSH, many of these providers used the State's commitment as match to apply for rental subsidies through HUD. As a result, in December 2000, HUD awarded over \$6 million in rent and operating subsidies for Pilots participants through its Continuum of Care and mainstream Section 8 programs.

In June 2001, the Connecticut General Assembly and the Governor significantly expanded funding for the Pilots Initiative. The state's biennial budget adds \$3 million to the DMHAS budget for support services. This will increase the number of people to be served by the Pilots Initiative to 570. The budget also directs over \$25 million in capital financing to Pilots, which will be administered by the Connecticut Housing Finance Authority. With this funding, community-based service and housing providers will be able to develop over 300 new supportive apartments through the purchase and rehabilitation or new construction of housing units.

In 2001, the **Florida** Legislature passed Senate Bill 446, an act relating to homelessness. The bill creates a State Office on Homelessness within the Department of Children and Family Services (DCF), authorizes the Governor to appoint an Executive Director for the office and allows for Council membership selection. The act also created a State Council on Homelessness and provided grants to expand the homelessness continuum of care and award housing assistance grants.

By June 30 of each year, Florida's DCF will submit a report to the Governor and legislature an annual report that consists of a compilation of data collected by local coalitions; reflects progress made in the development and implementation of local homeless assistance continua of care plans in each district; details local spending plans; describes programs and resources available at the local level; and makes recommendations for programs and funding.

In addition, this comprehensive legislation establishes guidelines for discharging persons at risk for homelessness from facilities serving persons with mental illness or substance abuse, provides appropriations for Challenge grants and for positions in local homeless coalitions, and designates December 21 as the Homeless Persons Memorial Day.

In 1992, the homeless population in **Hawaii** was estimated to be 5,300. This number does not include the "hidden homeless" who are transiently domiciled among relatives or friends and others who are at a very high risk for homelessness. The Hawaii Housing Authority reports serving 12,629 persons in their programs for persons who are homeless across the state in Fiscal year 1996, most of whom live on Oahu. Given these large numbers of homeless persons and high rates of substance abuse disorders among the population (estimated at approximately 20%), there may be several thousand homeless persons who are in need of treatment for their substance abuse disorders.

The State of Hawaii is now engaged in a special project to discern the actual level of need for substance abuse treatment services for persons who are homeless on Oahu and to provide the services needed. Activities related to the project include analysis of a series of needs

assessments, including: (1) The Hawaii 1995 Adult Household Survey; (2) The 1996 Hawaii Student Alcohol and Drug Use Survey; (3) The 1996 Blind Study of Substance Abuse and Need for Treatment Among Women of Childbearing Age in Hawaii; and (4) the 1996 Study of Substance Abuse and Need for **Treatment Among New Arrestees**

In **Illinois**, there are two state-funded initiatives specifically targeting homeless persons, both of which involve collaboration between a substance abuse treatment provider and a homeless service provider. One provides an integrated continuum of substance abuse treatment services, including detoxification, residential and outpatient treatment that are linked to a full range of supportive housing services. It involves one of the state's largest treatment providers, Cornell Interventions, and the state's largest provider of supportive housing, Lakefront SRO Corporation. The second project links Family Guidance Centers with (FGC) with Chicago Christian Industrial League (CCIL), a longstanding Chicago homeless service provider. Under the initiative CCIL operates a recovery home for persons who are homeless who access substance abuse treatment services at FGC and a full array of supportive services at CCIL. Both projects are funded under a state initiative called the Male/Family Reunification initiative. The initiative targets males who do not meet federal or state priority population requirements and therefore typically have more difficulty accessing services than priority populations. The initiative requires provider organizations to address a number of issues in a gender-specific manner, including parenting, domestic violence, job readiness and job development.

Illinois has also begun encouraging collocation agreements between substance abuse treatment and homeless service provider organizations. Under these agreements, treatment providers assign staff who will work on site at homeless service provider organizations. In some cases, the role of the treatment staff will be limited to screening, assessment and referral to services off-site. In other cases, actual treatment services may be provided on-site at the homeless service provider organization through an "off-site" exception which allows staff from a licensed treatment program to provide services at a non-licensed site.

The legislature of the State of **Maryland** provided funds to the Alcohol and Drug Abuse Administration (ADAA) to target the needs of addicted persons who are homeless. The project supports four regional demonstration projects to provide comprehensive addictions treatment and other services to the health departments in Carroll County, Prince Georges County and Worcester County, as well as to Baltimore Substance Abuse Systems for a total of 90 "slots" at a cost of approximately 1.4 million dollars.

In addition, the Baltimore City Health Department receives \$95,000 from ADAA to fund Dayspring, Inc., a homeless program that provides a continuum of alcohol, tobacco and other prevention activities which include an after-school program, a health education program for teens, a preschool program, respite care for children birth to age 10, parenting groups and mentoring for school-age children at a local shelter.

Massachusetts' commitment to treatment and prevention services for persons who are homeless has been established through a variety of programs and services, including:

- (1) The *Homeless Blanket* program funds specific Recovery Home beds for certified homeless individuals as well as some street outreach.
- (2) *Aggressive Treatment and Relapse Prevention (ATARP)* offers relapse prevention management services and housing to homeless individuals who are dually diagnosed with a serious and persistent mental illness and co-occurring substance abuse disorder. This McKinney Supportive Housing Program is a collaboration between the Department of Mental Health (DMH) and the Department of Public Health's Bureau of Substance Abuse Services. DMH currently contracts with five vendors to provide permanent housing and intensive recovery support services to fifty-five individual and five families.
- (3) *Transitional Support Services* are short-term residential support services for substance abusing men and women. Known as "Next Step" programs and designed to bridge the gap in the service continuum between acute treatment services and residential services or other aftercare, services provide stabilization, intensive case management and comprehensive discharge planning to individuals who require a safe and structured environment to support their post-detoxification recovery process. Post Detox/Pre-Recovery Programs (PDPR) target these services to homeless clients.
- (4) *Family Substance Abuse Shelters* provide safe and supportive treatment environments for homeless families to support and sustain sobriety and obtain permanent housing. These programs include substance abuse counseling, housing, coordination of services and case management.
- (5) *Supportive Housing* programs provide permanent alcohol and drug-free housing. These settings promote a culture of recovery by encouraging residents to coalesce as a community, share responsibility for maintaining the living environment and support each other in recovery. Residents are assisted in recovery through case management services and a structured milieu that reinforces appropriate behavior and the development of independent living skills. The Bureau of Substance Abuse Services funds case management services within supportive housing programs. Individuals, in conjunction with the case manager, develop Individual Services Plans (ISP). Residents receive assistance in seeking and accessing needed services and they are encouraged to develop interests and employment opportunities outside the program. While many participants in supportive housing programs may choose to move on, some programs offer the option to stay long-term.
- (6) The *Community Housing* program provides supportive housing for previously homeless families and individuals in recovery and is a joint effort of the Department of Public Health, the Department of Housing and Community Development, the Massachusetts Housing and Finance Administration, the Department of Social Services and other agencies. As a "Shelter Plus Care" program, it links federal rental assistance from HUD with state-funded substance abuse treatment and case management services. This demonstration project is located in five sites in Central and Western Massachusetts.

- (7) Through the *Sober Housing for Addiction Recovery Environment (SHARE) Loan Program*, Massachusetts and the federal government provide funds to make loans for the cost of establishing housing programs for individuals recovering from alcohol or drug abuse. These group homes include a minimum of six individuals. The program has been operating in the state for 11 years.
- (8) *Substance Abuse Shelters for Individuals (SASI)* provide shelter for substance abusing homeless individuals who, due to their intoxicated state, present as behaviorally difficult to manage and less appropriate for shelter in the general shelter system. These facilities, in addition to providing emergency shelter, also maintain stabilization beds for consumers who demonstrate an interest in seeking a referral for substance abuse treatment and demonstrate a desire to remain substance free.
- (9) *Substance Abuse Education, Assessment and Referral Coordination for the Homeless (SEARCH)* Programs provide substance abuse outreach to homeless individuals in and around shelters. A substance abuse assessment is made during these outreach efforts and referral to treatment agencies, as appropriate. Access to education groups is provided, which includes information in substance abuse, motivation for substance abuse treatment, prevention of homelessness and information on access to public services and health insurance.

In **New York**, treatment services initiatives and incentives include technical assistance that is made available to local agencies in developing and administering HUD Shelter Plus Care projects, the Community Transition Services Initiative demonstration project and special funding that supports the delivery of case management of Shelter Plus Care services. The state Office of Alcohol and Substance Abuse Services (OASAS) funds prevention services to children in school who are homeless. The Children’s Aid Society in New York City is funded to deliver prevention services to young people and their families. The Single Parent Resource Center – also in New York City – provides services to women and children in homeless shelters. Although the majority of children in need is estimated to be in New York City, several schools upstate also provide prevention and support services to children and assist their families, as well.

New York State has two new prevention demonstration projects that target the needs of homeless children and their families. Both the New York State Incentive Program and the “Communities That Care” process assess the needs of a particular community and then identify appropriate services to meet their needs. If so identified, services would be delivered to children who are homeless and their family members with alcohol and other drug use disorders.

OASAS currently works with 35 nonprofit services providers to implement *Shelter Plus Care* projects. OASAS provides administrative, fiscal and programmatic oversight of the program; participating providers (i.e., sponsors) own or lease the housing provided under the program. Sponsors also provide AOD treatment and supportive services, including outreach, case management, counseling, life skills and health-related services to participants. The OASAS Shelter Plus Care program supports permanent housing services through about 1,000 rental units each year. The annual total of HUD funding administered by OASAS is approximately \$8.5

million. A number of treatment providers in the state have also independently pursued and received HUD supportive housing awards and Section 8 rental subsidies to further assist clients with the transition from treatment to independent, substance-free living in the community.

In addition to various HUD-funded initiatives, treatment providers also utilize both State local assistance funding and federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds to provide specialized services to homeless substance abusers within their programs. For example, through a special OASAS initiative launched in 1999, 30 providers received a total of \$2 million in SAPT block grant funds to provide for case management of clients participation in homeless/housing programs. The goal of this initiative is to assist clients coming out of residential placement with the transition to outpatient services and supportive living or Shelter Plus Care housing. Also, a new state pilot program - Community Transition Services - will be launched sometime in 2001. The goals of this effort are to support women and children by assisting with their continued chemical dependence recovery, employment and job retention, completion of community reintegration and financial independence and placement in independent living.

At the discretion of the **New Jersey** State Alcohol and Drug Abuse Authority, 4 grants are made to homeless shelters to provide screening and assessment of shelter residents for substance abuse. These grants provide crisis intervention, referral to detox and/or other medical care, emergency assistance with food, clothing and temporary housing. As soon as possible these clients are assigned to case managers who design an individualized program off substance abuse treatment, self-help group participation coordinated with client appointments for application to welfare, housing assistance, follow-up medical and psychiatric care (if needed.) These plans are aimed at developing client sobriety, social stabilization and employment. If clients remain in treatment long enough to become ready to undertake work activities, they are provided with life skills training, vocational education or training, work therapy, job readiness/job coaching and job placement assistance.

New Jersey's *Work First Program* serves a high proportion of single parent welfare families who are facing the termination of benefits and a high probability of imminent homelessness. It provides referrals to substance abuse treatment. With successful completion of treatment, clients receive continuing support for job preparation activities and transportation, health insurance, and child care for a limited time after employment is obtained.

In FY 1999, \$13,869,108 in federal funds were allocated in **Ohio** to maintain, improve and expand 92 alcohol and other drug abuse programs and services designed for women, especially pregnant women and women with dependent children. Most if not all of these providers serve homeless women and children. Of the funded programs, 33 were residential, 40 provided outpatient services and 19 sustained outreach, interim and prevention programming. Treatment services are available to all women in Ohio through this comprehensive statewide network of providers.

PASSAGES, part of the Mahoning County Chemical Dependency Programs (MCCDP), is an ODADAS certified alcohol and other drug treatment program for homeless men and women in Youngstown. The program also provides transitional housing, housing for homeless single men and women and supportive services which include case management, primary health care, mental health counseling and representative payeeship services.

SAPT Block Grant Applications

Although not required to specifically address the needs of persons with alcohol and other drug use disorders who are homeless as part of the Substance Abuse Treatment and Prevention Block Grant application, several states (i.e., Delaware, Hawaii and Mississippi) have included this group in their application in order to underscore the population’s needs and encourage the development of treatment and prevention programs that effectively respond to them.

State Alcohol and Other Drug Abuse Service Systems Application of Outcome and Performance Measures Related to Homelessness

Recent years have witnessed the development of a wide variety of national and state-based efforts to identify outcome and performance based measures of the effectiveness of alcohol and other drug abuse prevention and treatment services. State experience varies widely in the development and application of these measures to the population of homeless persons with alcohol and other drug use disorders, which most generally taking the form of measures such as “prevented homelessness”, “reduced homelessness” or “increased residential stability”. Table 4 delineates the use of these measures in the nation’s addictions prevention and treatment systems.

Table 4. State Use of Homelessness-Related Outcome and Performance Measures in Alcohol and other Drug Abuse Prevention and Treatment Systems

State	Prevention System	Treatment System	Comments
Alabama			
Alaska	X	X	
Arizona		X	measures included in TOPPS study
Arkansas			
California			
Colorado		X	changes in living arrangements are captured through the client database
Connecticut		X	TEDS outcome measure
Delaware		X	performance measures are not yet fully implemented
Florida			
Georgia			

State	Prevention System	Treatment System	Comments
Hawaii		X	TEDS outcome measure
Illinois		X	housing status at admission and discharge are captured for selected levels of care
Iowa			
Kansas			
Louisiana			
Maine			
Maryland	X	X	State is in the process of developing a statewide outcome and performance measurement system
Massachusetts		X	
Michigan			
Minnesota			
Mississippi			
Missouri		X	length of time in living arrangement
Nevada		X	
New Hampshire		X	TEDS and TOPPS
New Jersey			
New York		X	required by HUD of providers receiving Shelter+Care
North Carolina		X	TOPPS
Ohio			
Oklahoma		X	measures of change/improvement in housing
Oregon			
Pennsylvania			
Rhode Island		X	measures not yet utilized
South Carolina		X	
Tennessee		X	
Utah		X	
Vermont			
Virginia		X	measure of “out of homelessness”

State	Prevention System	Treatment System	Comments
West Virginia			
Wisconsin			treatment measures expected by 2002
Wyoming			

Discharge Policies of Public Residential or Inpatient Treatment Facilities

This project sought to understand the degree to which States – either through separate policies or through standards and regulations – address client housing needs as part of the process of planning for discharge from publically-supported residential or inpatient treatment facilities. The linkage between these facilities and the communities they serve represents an important feature of the nation’s behavioral healthcare system’s “safety net”.

While a number of State Alcohol and Drug Abuse Agencies mandate discharge planning from *publically-supported treatment facilities*, the majority of them do not require that housing concerns be addressed. Among those 14 states that do (35% of participating states), the vehicle or mechanism for including housing in the planning process takes different forms. For example, several states indicate that their state-funded alcohol and drug programs are required to use American Society of Addiction Medicine (ASAM) criteria for placement, continued stay and discharge, whose Dimension 6 criterion addresses the “Recovery Environment” – i.e., housing. The states of Connecticut, Kansas, Massachusetts, New York and West Virginia, for example, appear to require that all discharge plans address housing needs. Kansas specifically states that discharge will not occur “until an appropriate placement is secured.” Service contracts with providers in some of the 14 states who report the inclusion of housing in their discharge planning policies – both in managed care environments as well as not – necessitate that the housing needs of individual clients be addressed. Still other states leave planning for housing entirely up to the discretion of the treatment provider, encouraging that it be addressed “as necessary.”

Table 5 presents those states whose Alcohol and Drug Abuse Agency discharge planning policies include guidance that housing needs should specifically be addressed.

Table 5. Inclusion of Housing in AOD Agency Policy Regarding Discharge Planning from Publically-Supported Treatment Facilities

State	Discharge Policy Incl. Housing	Comments
Alabama		
Alaska		
Arizona		

State	Discharge Policy Incl. Housing	Comments
Arkansas	X	Housing is addressed “as necessary” in individual discharge plans
California		
Colorado	X	State managed care contracting and monitoring process mandates a structure to assure coordination between Alcohol and Drug Abuse Division and Supportive Housing and Homeless Program
Connecticut	X	All discharge plans include housing
Delaware		
Florida		
Georgia	X	Discharge address may include personal care homes or shelters
Hawaii	X	ASAM PPC are employed: Dimension 6 - Recovery Environment
Illinois		
Iowa	X	Policy states housing must “be stable”
Kansas	X	Discharge does not occur “until [an appropriate] placement is secured.”
Louisiana		
Maine		
Maryland		
Massachusetts	X	Vendor agencies are required to provide post treatment housing referrals when wanted/needed. Discharges to the streets/shelters are discouraged as inappropriate.
Michigan		
Minnesota		
Mississippi		
Missouri	X	“Certification standards require that safe and appropriate housing options be explored”
Nevada		
New Hampshire	X	Administrative rules require assistance in obtaining appropriate housing
New Jersey	X	Discharge planning re: housing is required of all licensed treatment agencies if housing is identified an issue.

State	Discharge Policy Incl. Housing	Comments
New York	X	Discharge planning is required to include “identification of the type of residence, if any, that the patient will need after discharge.”
North Carolina		
Ohio		
Oklahoma		
Oregon		
Pennsylvania		
Rhode Island		
South Carolina		
Tennessee		
Utah		
Vermont		
Virginia	X	Community Service Boards are responsible for discharge plans involving housing
West Virginia	X	Individuals must be discharged to a “place of residence.”
Wisconsin		
Wyoming		

Few of the 40 states that participated in this study currently use program or facility licensure and accreditation standards as an incentive to either encourage or require that treatment providers have policies regarding the discharge of homeless individuals from treatment facilities. National accrediting organizations such as the Commission on Accreditation of Rehabilitation Facilities (CARF) require that treatment providers have a policy requiring discharge, but those regulations do not specifically state that the discharge needs of homeless individuals be addressed. While a number of states encourage that treatment providers or regional authorities (e.g., Virginia’s “Community Service Boards”) plan “appropriately” for discharge, they may only sporadically mention the needs of homeless individuals as a discrete group.

General Organizational Support

To the extent that prevention and treatment programs designed to respond to the needs of a specific population are assigned to responsible staff and provided other organizational support, those services may be more organized, more extensive and more visible. While not a guarantee, the availability of staff or others who can advocate both internally and externally for persons

with alcohol and other drug use disorders may increase the likelihood that an effective response to identified need can be offered.

From the perspective of internal staff assignment, half of the states participating in this study (N = 20), have identified a staff person who bears the responsibility for representing the needs and interests of persons with alcohol and other drug use disorders who are homeless. Although it is not possible, at this time, to discern the level of other staff assignments carried by these individuals (and therefore the extent to which their time is available to devote to the issue of homelessness) these individuals have the potential to serve as the core of a national network of professionals who could combine their skills and experience in order to generate creative ideas for funding, planning, and implementing services for this population.

In addition to the internal representation and advocacy that is provided by identified agency staff, each State Alcohol and Drug Agency continually engages in the process of external public review as it goes about planning, financing, implementing and evaluating the services that are delivered under its auspices. Although not required by statute, some states annually conduct public hearings during which concerned individuals with definite interest in this population are invited to participate and lend their expertise to the discussions and recommendations that result. These individuals are likely to be members of the general public, family members, homeless advocates and service providers who, while they may have the best interests of the population at heart, are not themselves homeless nor have they necessarily had direct experience of homelessness themselves.

It does appear that a limited number of states arrange for the direct participation of persons who are homeless or previously homeless in the development, implementation and evaluation of the state's alcohol and other drug prevention and treatment system. State Alcohol and Drug Agencies in Alabama, Delaware, Georgia and Massachusetts indicate that they include a person with primary current or previous experience as a homeless person in their formal processes of public review and comment.

<i>Alabama</i>	Representation of patients on advisory councils
<i>Delaware</i>	Represented on the Advisory Committee that develops overall systems plan
<i>Georgia</i>	Some regional board members have a history of homelessness
<i>Massachusetts</i>	The MASS Dept of Public Health through the Commissioner's Office has initiated bi-monthly meetings of the MASS Homeless Task Force which includes homeless service agencies, homeless advocates for men, women, families and the elderly, public officials and others.

Prevention and Treatment Services Delivery and Financing

The process of gathering accurate information regarding the extent to which state prevention and treatment services systems respond to the needs of persons with alcohol and other drug use disorders who are homeless is central to the ability to improve public services for this

population. States' capacity to collect and provide information regarding this population's admission to treatment services and the primary sources of funding for prevention and treatment services for the population are presented in the following tables. Information and data for treatment and prevention services are displayed separately.

A. *Treatment Services*

Data are included in Table 6 only for those individuals with alcohol and other drug use disorders who are homeless that were admitted to treatment services. The absence of a number in any service category for any state may mean that the service is not utilized by persons with alcohol and other drug use disorders who are homeless or that the service is utilized by the population but information is not collected on admissions to the service, either duplicated or unduplicated.

State capturing of service data on a "duplicated" or "unduplicated" basis varies state by state, depending on the nature and capacity of the state's management information system. Information is presented in Table 6 as: 1) the number of admissions to services that are duplicated and 2) the number of those admissions *in parentheses* that represents an unduplicated count of the total persons with alcohol and other drug abuse disorders who are homeless that were admitted for service. Where two figures are listed, the figure in parentheses – the unduplicated figure – will always be equal to or less than the total number of admissions, since there cannot be more individuals admitted to service than there are admissions for the period.

For example, in the State of California 17,940 admissions occurred to residential detoxification services throughout the state during FY 1999. A total of 8,730 separate individuals accounted for those admissions, an average of just over 2 admissions for each client during the year. In the case of hospital inpatient detoxification, 20 different individuals with alcohol and other drug disorders in California who were also homeless accounted for the 20 admissions in the course of the year, and so on. According to these figures, each admission to hospital inpatient detox in the state during the year was for a separate individual.

In Massachusetts, 13,583 admissions occurred to residential detox during the reporting period. No information is available on the unduplicated number of individuals who accounted for those admissions. In Maine, on the other hand, 264 individuals were admitted to residential detox services during the reporting period, all of whom represented separate individuals. While it is possible to sum across the service columns for each state and reach a total number of admissions for the period, readers are cautioned that duplication across service areas remains within each state.

As is evident from the information available on service admissions, 12 states (or 30% of those participating in the data base for this project) are unable to provide any information that outlines utilization of services by persons with alcohol and other drug use disorders who are homeless. It is relatively common that states (14 of the 40 total participants) collect information regarding admission to services on a duplicated rather than on an unduplicated basis. A total of

11 participating states (California, Delaware, Florida, Maine, Maryland, Minnesota, Missouri, Oklahoma, Oregon, South Carolina, and Tennessee) collect unduplicated service data for this population.

The nature and extent of services delivered to persons with alcohol and other drug disorders who are homeless varies among states. Because of the fact that some states collect duplicated data and some unduplicated data, it is not possible to combine available figures and determine the total individual persons with alcohol and other drug use disorders who are homeless that are receiving services through state alcohol and drug treatment systems.

It is possible, however, to discern a series of basic patterns among states and the services utilized by the population. The most commonly delivered service, by far, is free-standing residential detox, with a majority of states (72%) who report admissions to service indicating that this was their most frequently used service modality at 93,868 episodes of care. Virtually equal in most frequently used services are long-term residential rehabilitation and intensive outpatient services, with just over 28,000 episodes of care each.

There appear to be no patterns of admissions that distinguish relatively large states from smaller states or one geographic region from another. Not surprisingly, large states such as California and New York head the list with respect to total service admissions. With few exceptions (e.g., Rhode Island and Vermont), states that deliver services to homeless individuals with alcohol and other drug use disorders offer a relatively wide range of services – i.e., four or more service modalities. No state other than California (of those reporting in this project) makes significant use of outpatient detox services for the population.

Table 6. Admission to Treatment of Persons with Alcohol and Other Drug Use Disorders who are Homeless,
by Type of Service (FY 99)

State	Resid Detox	Hosp IP Det	OP Detox	Hosp Non- Detox	ST Res/ Rehab	LT Res/ Rehab	OP	Int OP	Other
Alabama	58				80	331		494	
Alaska									603
Arizona									
Arkansas									
California	17,940 (8,730)	20 (20)	2,500 (810)		2,060 (1,010)	13,470 (6,410)	8,820 (7,420)	1,080 (670)	
Colorado	12,262				628	9	513	47	
Connecticut	2,152	508	8	258	310	346	220	9	
Delaware	(330)				(60)	(22)	(23)	(10)	
Florida	(5,319)		(6)		(862)	(2304)	(2247)	(770)	
Georgia									
Hawaii	387					224	30	38	
Illinois	3,158					2,761	2,742	377	
Iowa									
Kansas									
Louisiana									
Maine	(264)	(37)		(8)	(52)	(488)	(134)	(36)	
Maryland	313 (297)		87 (85)	11 (11)	782 (755)	246 (238)	820 (806)	465 (422)	

State	Resid Detox	Hosp IP Det	OP Detox	Hosp Non-Detox	ST Res/Rehab	LT Res/Rehab	OP	Int OP	Other
Massachusetts	13,583					1,791	1,553	170	1,814
Michigan	724				744	823	807	1,141	
Minnesota	(6,007)				(589)	(537)	(589)		
Mississippi									
Missouri	(859)			(71)	(367)	(108)	(164)	(304)	(7)
Nevada	1,469				780	663	902	358	
New Hampshire	561				103	139	108		
New Jersey	253	1,471	52	216	351	738	136	178	266
New York	19,677	7,819	1		6,334	3,211	6,030	183	
North Carolina	411	99	3	61	91	30	306	36	
Ohio									
Oklahoma	(206)		(142)		(246)	(16)	(676)		
Oregon	(2,939)				(909)		(1216)	(1056)	
Pennsylvania									
Rhode Island	1,118								(540)
South Carolina	(450)				(110)	(27)	(112)	(59)	(57)
Tennessee	(289)				(349)	(12)	(139)	(125)	
Utah	3,139				36	239	190	88	
Vermont									(399)
Virginia									

State	Resid Detox	Hosp IP Det	OP Detox	Hosp Non-Detox	ST Res/Rehab	LT Res/Rehab	OP	Int OP	Other
West Virginia									
Wisconsin									
Wyoming									

Column Header Key:

“Resid Detox”	Free-standing Residential Detoxification	“LT Res/Rehab”	Long-term Rehabilitation/Residential
“Hosp IP Det”	Hospital Inpatient Detoxification	“OP”	Outpatient
“OP Detox”	Outpatient Detoxification	“Int OP”	Intensive Outpatient
“Hosp Non-Detox”	Hospital Rehabilitation/Residential (other than detox)	“Other”	Unable to Identify Modality
“ST Res/Rehab”	Short-term Rehabilitation/Residential		
“Dup/(Undup) Count”	Duplicated Count: Admissions are aggregated , regardless of the number of individual persons admitted to the service (Unduplicated Count): Number represents separate individuals admitted to the service		

A number of states indicate that publicly-funded treatment service providers are required to collect information on the living arrangements of individuals with alcohol and other drug use disorders who are homeless that enter treatment, either through the Treatment Episode Data Set (TEDS supplemental data) or a similar mechanism that can be cross-walked to TEDS. Of the 40 states participating in this study, 25 (63%) fall into that category and are able to aggregate that information on a state level. Table 7 provides a grasp of the percentage of total admissions to treatment who were homeless, by state. Those states whose providers either do not collect information on living arrangements (e.g., Arkansas, Mississippi) or whose publicly-funded treatment service providers collect information that is not available to the state (e.g., Georgia, Ohio) are noted as “na”.

The percentage of persons admitted to treatment services who met TEDS or TEDS-like criteria ranged from a low of 1% in West Virginia to a high of 21% in Colorado, with a full range in between the two boundaries. It is not possible to tell from available data the reason for this dramatic range of total admissions to treatment who are homeless. One possible explanation may be that different states have significantly different levels of homelessness among their citizens that is somehow correlated to total admissions. Another might be that persons who are homeless in some locations are more likely to access treatment services – suggesting greater service availability and accessibility – than in others. The wide range might also be an artifact of the data collection mechanisms utilized by various states.

Table 7. Percentage of Total Admissions to Treatment Defined as Homeless

State	% Total Adm Homeless	State	% Total Adm Homeless	State	% Total Adm Homeless	State	% Total Adm Homeless
Alabama	5.4	Hawaii	na	Mississippi	na	Penn	na
Alaska	8.5	Illinois	7.5	Missouri	7	Rhode Is	9
Arizona	na	Iowa	na	Nevada	37	So Car	na
Arkansas	na	Kansas	14.6	New Hamp	14	Tenn	13
California	na	Louisiana	na	New Jersey	6.7	Utah	na
Colorado	21	Maine	9.7	New York	7.7	Vermont	7
Conn	7	Maryland	5	No Car	2.5	Virginia	na
Delaware	8.8	Mass	16	Ohio	na	West Va	1
Florida	11	Michigan	6	Oklahoma	7.5	Wisconsin	na
Georgia	na	Minnesota	2.4	Oregon	8.8	Wyoming	na

Financing of Treatment Services

Available data suggest that the majority of states rely most heavily on funding from the State Alcohol and Other Drug Agency, the SAPT Block Grant and various federal (e.g., HUD) and local sources to support treatment services for persons with alcohol and other drug use disorders who are homeless. However, since fiscal and client data systems typically are not interactive or linked in a way that would permit tracking of funds specifically for the homeless population, estimates of actual annual expenditures for persons with alcohol and other drug use disorders who are homeless are generally not consistently available.

In some cases, state agencies other than the Single State Authority provide financial support for and track expenditures for persons with alcohol and other drug abuse disorders who are homeless and receiving services through Medicaid, public health and welfare departments, housing authorities, child and family services, education systems, shelters and others. In still other cases, the state AOD agency does not allocate any special funds for persons with alcohol and other drug abuse disorders who are homeless at all – other state agencies are entirely responsible for working with the population.

Table 8 reflects the level of reported expenditures in fiscal year 1999 for treatment services for persons with alcohol and other drug use disorders who are homeless, by source of funding. While the limitations mentioned above suggest that this information should be viewed with caution, several observations are possible.

- The largest single source of funds to support treatment services for persons with alcohol and other drug disorders who are homeless is State Alcohol and Drug Abuse Authorities (33%), followed by the SAPT Block Grant (25%), then by Other State Agencies (16%);
- The proportion of other federal and local funds to support the population is roughly equal;
- Medicaid does not represent an important source of funds for alcohol and drug abuse treatment services;
- The majority of participating states use multiple sources of funds to finance treatment services for persons with alcohol and other drug use disorders who are homeless.

In Table 9, SAPT Block Grant final allocations for FY 1999 are listed by state (territories are not included, since none participated in the data base for this project). During FY 99, the SAPT Block Grant allocation for all states totaled \$1,483,163,956. The SAPT Block Grant allocation for those states participating in this study *that also reported expenditures to support services for persons with alcohol and other drug disorders who are homeless* totaled \$408,062,193. Of that amount, \$26,050,213 – 6.4% – was identified as financing services for the homeless population. Given the tentative nature of management information systems' ability to differentiate services and expenditures, this figure provides at best a general sense of financing of services for persons with alcohol and other drug use disorders who are homeless from the SAPT block grant allocation.

Table 8. Financing of Treatment Services for Persons with Alcohol and other Drug Abuse Disorders who are Homeless

State	Source of Funds							
	AOD Agency	Other State	SAPT BG	Other Federal	Medicaid	County/Local	Other	Total
Alabama	1,151,251							1,151,251
Alaska	na							
Arizona	na							
Arkansas	na							
California	na							
Colorado	na							
Connecticut	856,395		247,295	289,214				1,392,904
Delaware	598,433		289,820	77,781				966,034
Florida		6,240,878	6,179,718	1,831,500	849,278	6,665,434		21,766,808
Georgia	na							
Hawaii			42,000					42,000
Illinois	13,788,669		6,791,444					20,580,113
Iowa	na							
Kansas	na							
Louisiana	na							
Maine	182,000		238,000				82,000	502,000
Maryland	na							
Massachusetts	10,922,835	5,726,000	4,578,284	1,980,252				23,207,371

	AOD Agency	Other State	SAPT BG	Other Federal	Medicaid	County/Local	Other	Total
Michigan	na							
Minnesota	3,274,000	4,750,000	2,313,000		292,000	5,034,700	116,940	15,780,640
Mississippi	na							
Missouri	1,364,442		948,469	3,424				2,316,335
Nevada	na							
New Hampshire	na							
New Jersey	2,854,252	223,622	2,322,183			187,112	1,001,081	6,588,250
New York			2,000,000	8,500,000			500,000	11,000,000
North Carolina	na							
Ohio	na							
Oklahoma	na							
Oregon	na							
Pennsylvania	na							
Rhode Island	na							
South Carolina	na							
Tennessee	100,000		100,000					200,000
Utah	na							
Vermont	na							
Virginia	na							
West Virginia	na							
Wisconsin	na							
Wyoming	na							
Total	35,092,277	16,940,500	26,050,213	12,682,171	1,141,278	11,887,246	1,700,021	105,493,706

Table 9. Allocation of Substance Abuse Prevention and Treatment Block Grant, by State (FY99)

Alabama	\$21,666,850	Kentucky	19,105,313	North Dakota	3,817,151
Alaska	3,440,623	Louisiana	24,828,318	Ohio	65,062,211
Arizona	27,127,147	Maine	5,943,750	Oklahoma	16,185,602
Arkansas	11,280,281	Maryland	29,389,161	Oregon	15,114,749
California	216,995,385	Massachusetts	33,214,336	Pennsylvania	57,670,348
Colorado	20,297,398	Michigan	56,510,128	Rhode Island	5,943,750
Conn	16,405,600	Minnesota	20,877,637	South Carolina	18,527,032
Delaware	5,553,544	Mississippi	13,142,417	South Dakota	3,529,799
DC	4,952,603	Missouri	24,121,029	Tennessee	25,624,806
Florida	80,256,078	Montana	\$5,584,314	Texas	122,543,553
Georgia	40,710,806	Nebraska	7,472,914	Utah	13,729,782
Hawaii	6,810,019	Nevada	9,441,768	Vermont	3,774,105
Idaho	5,943,750	New Hampshire	5,943,750	Virginia	39,245,298
Illinois	61,138,459	New Jersey	45,115,909	Washington	30,769,108
Indiana	32,509,147	New Mexico	8,261,541	West Virginia	8,434,108
Iowa	12,542,219	New York	104,711,026	Wisconsin	24,530,479
Kansas	10,996,215	North Carolina	33,404,937	Wyoming	2,452,377
				Grand Total*	1,483,163,956

* excludes SAMHSA set-aside and territorial allocations, since no territories participated in this study.

- *Prevention Services*

Detailed information regarding the key prevention strategies that states utilize on behalf of homeless persons who are at risk of developing alcohol and other drug use disorders is difficult to access due to information system limitations. In exploring states' use of prevention strategies such as information dissemination, education, alternatives, problem identification and referral, environmental and community-based processes, only two states— New Jersey and Oklahoma – estimate the number of persons who are homeless and at risk of developing alcohol and other drug use disorders that are impacted by prevention activities. New Jersey indicated that its information dissemination, education and alternatives prevention efforts reached 100, 103 and 48 high-risk youth, respectively. In Oklahoma, information dissemination reached an estimated 874 primary and secondary school children, while 1,457 among the same population were reached through the state's education efforts.

With regard to financing, only two of the states participating in this project had access to financial information that permitted them to identify the level of expenditure that targeted selected prevention services to this at-risk population. Georgia indicates that it expended \$25,000 during the fiscal year from unspecified federal funds for services to persons who are homeless and at risk of developing alcohol and other drug use disorders. The state of Maine spent \$95,248 this year from its SAPT Block Grant to support prevention services for persons who at risk of developing alcohol and other drug use disorders.

This general absence of this information may be due to: (1) the fact that prevention services specifically for the state's population of homeless individuals who are at risk of developing alcohol and other drug use disorders are generally not funded as a specific expense that can be monitored; (2) the limitations of state data systems that do not allow for tracking of the funds that actually are allocated; or (3) the fact that prevention funding and responsibilities are delegated to local (i.e., county) authorities who design and deliver prevention services to the population based upon local priorities. In these cases, services may not be reported to the State Alcohol and Drug Abuse Authority (e.g., California).

General Observations And Recommendations

This study bolsters the findings of a number of others conducted in recent years that explore the needs of persons who are homeless for services and supports. Taken together, these efforts present a relatively consistent picture of the ways in which the nation's substance abuse and mental health systems might strengthen the programs and services designed to work with this population.

The identified needs of persons with alcohol and other drug use disorders who are homeless or at risk of homelessness include, among others:

- Safe, affordable and permanent housing
- Long-term, stable and competitive employment
- Food, clothing and emergency shelter and support services
- Supported and transitional housing
- Outreach, case management, information and referral
- Advocacy
- Educational assistance at all ages
- Financial assistance
- Treatment and counseling, including for co-occurring substance abuse and mental health disorders
- Physical and dental health care
- Transportation and child care

Exploration of the services and supports that are currently in place and available to persons with alcohol and other drug use disorders who are homeless or at risk of homelessness suggests that while much has been done to develop treatment and prevention services that respond to their needs, much more remains for to do if providers, advocates, consumers and funders are to construct a system that individuals in need can consistently look to for support in their recovery.

Observations

- As was the case with the recently-completed companion study conducted by the National Association of State Mental Health Directors (NASMHPD), existing data systems frustrate national-level efforts to examine services and supports developed for persons with alcohol and drug abuse disorders who are homeless or at risk of homelessness. Variability among state information systems makes state-by-state comparisons of need, services and financing problematic.
- Competition for extremely limited resources is significant and will become more so as need becomes greater. Nonetheless, many state alcohol and drug abuse agencies have been effectively involved at some level in the design, development, delivery and financing of services and supports for persons with alcohol and other drug use disorders who are homeless or at risk of homelessness.

- Federal funding (e.g., Homeless Families Program, Targeted Capacity Expansion, Recovery Group Homes) has been instrumental in strengthening the nation's treatment system for the nation's population of homeless persons with alcohol and other drug use disorders.
- Program and service technology is available to assist states in their efforts to expand treatment and prevention activities for this population.
- Prevention services targeting the needs of persons who are homeless and at risk of substance abuse are either quite limited or unavailable for inclusion in state information systems, or both. Both the level of treatment services provided and the systems' capacity to capture treatment service delivery and financing are greater, although limited.

Recommendations

- *Increase funding* available to states to expand services and supports to persons with alcohol and other drug use disorders who are homeless or at risk of homelessness, including the development of affordable housing. Adding the homeless population to current set-asides in the SAPT Block Grant without increasing the total funding available is not a constructive response.
- *Facilitate collaboration among key partners* in developing treatment and prevention services for the population at local, state and federal levels. This could be accomplished by providing technical assistance and support to states in inviting and organizing the contributions of homeless advocates, providers, homeless consumers and others into the process of planning and delivering treatment and prevention programs for the population.
- *Improve management information system capacity* to accurately and consistently identify need for services as well as to track the delivery and financing of services being delivered.
- *Disseminate best practices* in developing and delivering treatment and prevention services for persons with alcohol and drug use disorders who are homeless or at risk of homelessness in ways that enable state alcohol and drug abuse authorities to make more effective use of limited resources. CSAT's TIP series could prove to be an effective vehicle to disseminate best service practices for persons with alcohol and drug use disorders who are homeless or at risk of homelessness.

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Appendix A
 State Alcohol and Drug Agency Staff Contacts for Homeless Services

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New Hamp			

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