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Report to Congressional Committees

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HOMELESSNESS

Appropriate Controls Implemented for 1990 McKinney Amendments' PATH Program

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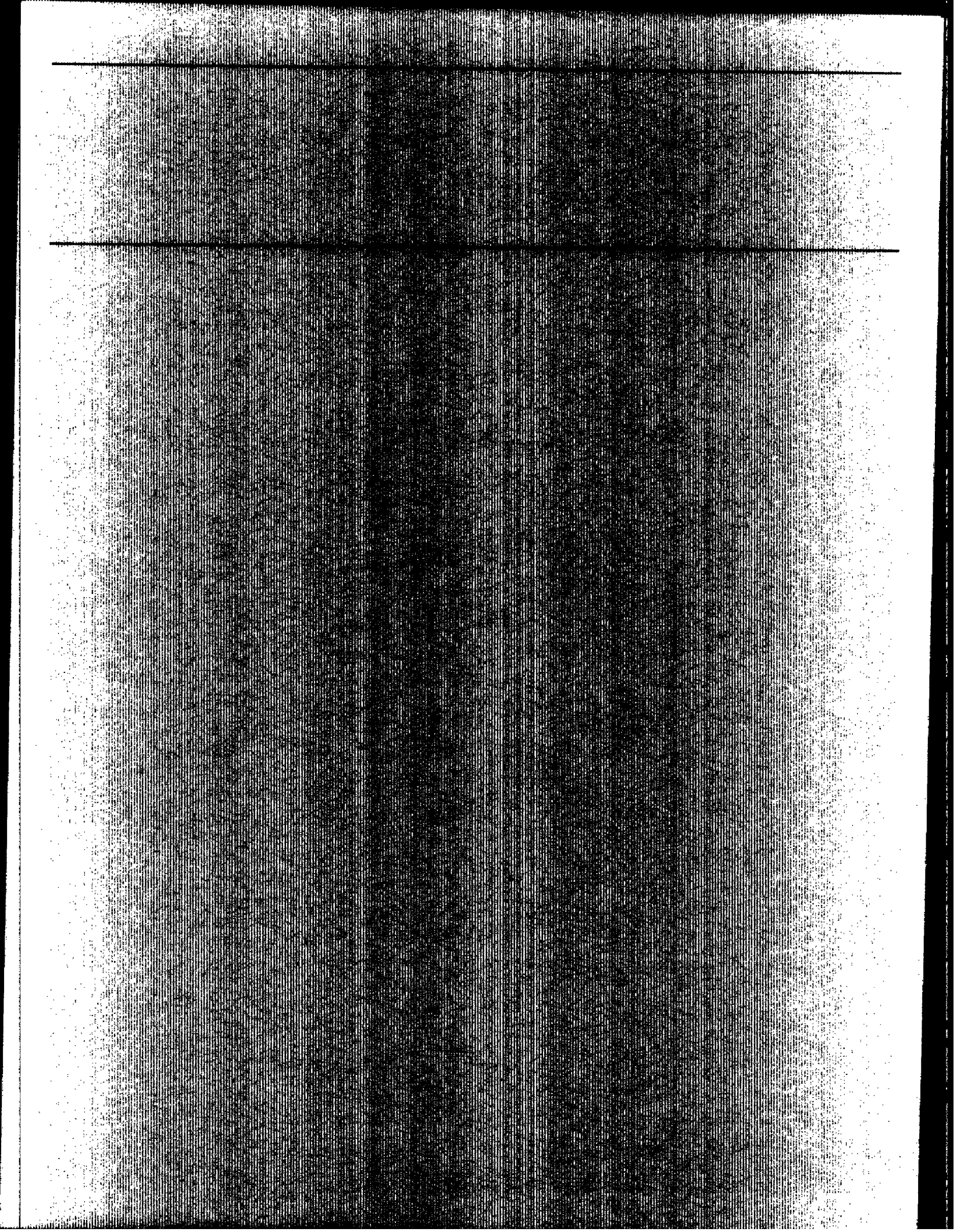

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United States
General Accounting Office
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Health, Education, and
Human Services Division

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February 22, 1994

The Honorable Edward M. Kennedy
Chairman
The Honorable Nancy L. Kassebaum
Ranking Minority Member
Committee on Labor and Human Resources
United States Senate

The Honorable Henry A. Waxman
Chairman
The Honorable Thomas J. Bliley, Jr.
Ranking Minority Member
Subcommittee on Health and the Environment
Committee on Energy and Commerce
House of Representatives

On any given night, up to 600,000 Americans are homeless.[1] About one-third of the adults in this population have a serious mental illness. The Department of Health and Human Services' (HHS) Projects for Assistance in Transition From Homelessness (PATH) program provides the states and territories with funds to serve homeless individuals who are seriously mentally ill or dually diagnosed with serious mental illness and substance abuse disorders.

The PATH program is authorized under the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (P.L. 101-645). Section 528(c) of the act requires us to report on the PATH program every 3 years. For this first report, we interviewed officials responsible for the program, reviewed documents, and visited two local providers. We specifically reviewed documents describing PATH program implementation in California, Florida, Illinois, New York, and Texas. (See app. I for more details on our scope and methodology.)

This report provides information on (1) how HHS ensures that PATH expenditures are consistent with the 1990 McKinney Amendments and (2) how HHS and the states ensure that PATH funds reach the target population. As requested, it also provides information on how local

[1]M.R. Burt and B.E. Cohen, America's Homeless: Numbers, Characteristics, and Programs that Serve Them (Washington, D.C.: The Urban Institute Press, July 1989). Many factors, such as states' definitions of homelessness, and undomiciled and unstable living conditions, prevent federal and state officials from obtaining an accurate count on the number of homeless. For example, see 1990 Census: Limitations in Methods and Procedures to Include the Homeless (GAO/GGD-92-1, Dec. 30, 1991).

providers assess the appropriateness of homeless individuals for receiving PATH services. In September 1993, we briefed your offices on the results of our work. As agreed, this report completes our initial work on the PATH program.

Background

Assistance programs for the homeless under the McKinney Act, as amended, provide homeless people with emergency food and shelter, transitional and permanent housing, primary health care services, mental health care, alcohol and drug abuse treatment, education, and job training. From fiscal year 1991 through fiscal year 1993, Congress appropriated about $92.5 million for PATH, of which HHS granted about $90.7 million to the 56 states and territories to support specific services for the target population.[2] These services include outreach, screening and diagnosis, training and retraining of independent living skills, community mental health care, alcohol or drug treatment, staff training, client case management, client supportive and supervisory services in a residential setting, referrals for primary health care, job training, and educational services. In addition, a state may allocate up to 20 percent of its PATH grant for housing services and up to 4 percent of the grant for administrative expenses. The 1990 McKinney Amendments do not require each state to provide all of the eligible services. They also do not permit expenditures for emergency shelters, housing construction, inpatient psychiatric or substance abuse treatment, or cash payments to recipients of mental health services.

States and territories must apply annually to HHS for PATH grants and provide year-end annual reports on clients and services delivered.[3] The PATH application asks the states for comprehensive budgetary and programmatic information on the states' planned local provider activities, as well as state-level implementation and oversight. As part of the application, states also must describe how they have coordinated planned PATH activities with the states' plans for comprehensive community mental health services.[4] The states must submit their year-end annual reports by January 31 to receive subsequent years' PATH grants. The annual reports include narrative and statistical reports on client services delivered.

[2]The remaining $1.8 million was used to fund the PATH program's technical assistance contracts.

[3]Organizationally, the PATH program is administered by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services.

[4]Among other activities, this federally financed planning process requires states to develop community-based outreach and support services for chronically mentally ill individuals who are homeless.

HHS awards PATH grants to the states according to a statutory formula based on a state's urban population. The 1990 McKinney Amendments require that HHS allocate to each state, the District of Columbia, and Puerto Rico no less than $300,000 and to each of the four territories—Guam, the Virgin Islands, American Samoa, and the Northern Marianas—no less than $50,000. Appendix II shows the funds allocated to states and territories for fiscal years 1992 and 1993. The amendments also require that states match PATH funds by providing $1 for every $3 of federal funds.[5] States award PATH grants to local providers that can be political subdivisions and/or nonprofit entities.

Nationally, from fiscal year 1991 to fiscal year 1992, states reported an increase in the number of local PATH providers from 167 to 382 and the number of clients served from about 53,000 to about 98,000.[6] (See app. III for information on the number of clients served by states and territories for fiscal year 1992.) According to the states' annual reports, PATH funds accounted for 1.3 percent of the local providers' total budgets in fiscal year 1991 and 0.7 percent in fiscal year 1992. Similarly, PATH clients constituted a small percent of the local providers' client enrollments—11 percent in fiscal year 1991 and 8.4 percent in fiscal year 1992. Although PATH is a small portion of providers' budgets, it is important because it allows them to target services for a difficult-to-reach population.

Results in Brief

HHS implemented appropriate program controls to help ensure that PATH expenditures are consistent with the 1990 McKinney Amendments. In the five states we reviewed, state grant procedures, financial oversight, and provider monitoring also help ensure that PATH services reach the target population. Local providers' mental health assessments further ensure that PATH services reach the target population.

Principal Findings

HHS Implemented Program Controls

HHS' PATH program controls help ensure that the states use PATH grants to fund eligible services for the target population. The program controls

[5]Under HHS regulations, Guam, the Virgin Islands, American Samoa, and the Northern Marianas are not required to meet HHS' cash or in-kind matching requirements for grants and cooperative agreements requiring $200,000 or less as a match.

[6]HHS' PATH Director estimates that the states' fiscal year 1993 data will closely resemble those from fiscal year 1992.

include the annual grant application review process and the annual state reports. In 1993, the PATH program added on-site monitoring to its program control measures.

Application Review Process

The PATH program has a three-step application review/follow-up process. First, grants management specialists use a checklist to review state budgets to ensure that they comply with the 1990 McKinney Amendments' 25-percent matching requirement and that PATH expenditures are within the housing and administrative cost limits. Second, a PATH program review panel of federal officials uses another checklist to identify unclear, incomplete, and inconsistent information in the states' applications.

The Director selects review panel members based on their familiarity with the PATH program or the target population. Experts serving on the 1993 review panel represented the Department of Housing and Urban Development and HHS' National Institute of Mental Health, Center for Substance Abuse Treatment, and Health Resources and Services Administration, as well as the Center for Mental Health Services (CMHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). After the panel members complete and discuss their application review findings, the PATH Director contacts the states' PATH coordinators to follow up on all unresolved issues identified by the grants specialist and program review panel.

The Director contacted the five states included in our review to follow up on their fiscal year 1993 applications. For example, the Director asked Florida officials to report on the impact of Hurricane Andrew on available PATH services and to define items included in the state's administrative costs. Florida officials reported that the hurricane disrupted PATH activities in three counties, including the cities of Miami, Key West, and Fort Lauderdale. State officials also revised the budget estimates to comply with the 1990 McKinney Amendments' administrative cost limit.

The Director also asked New York officials to clarify the state's planned use of PATH funds to support holding and housing beds. The New York officials explained that local providers would use PATH funds to hold a resident's bed in community housing programs in the event a resident is hospitalized for more than 15 days. New York officials further explained that supportive housing is a rental assistance program and that funds would be used for eligible services such as minor repairs and security deposits.

The Director also asked California, Illinois, and Texas officials, respectively, to submit intended use plans, identify the number of persons served, and define clinical terms. The PATH program has not denied states their allotments; however, PATH has delayed allotments until the states resolved open application issues.

Annual State Reporting

The 1990 McKinney Amendments require PATH grantees (the states and territories) to annually report the prior fiscal year's program activities and expenditures by January 31. The PATH Director, as well as other CMHS officials, wanted to use the year-end annual reports to compile statistics, to evaluate program effectiveness such as the number of homeless individuals reached, and to ensure that states and territories provided the services listed in their grant applications. However, HHS officials acknowledge that the early data collection format for the report was difficult for states to use and resulted in inaccurate or inconsistent information across the states, in some cases.

HHS allowed states to defer reporting of fiscal year 1991 activities until January 1993.[7] PATH officials also modified fiscal year 1993's reporting format to make the instrument easier for states to use and made more comprehensive revisions for fiscal year 1994 data. For example, the fiscal year 1994 annual report requires the states to report on the number of dually diagnosed persons served and demographics information for PATH clients; these statistics were optional information in prior years' reports.

In addition to requiring further statistical data, the PATH program is working to develop outcome or person-centered data. Such data would measure the impact of services on the homeless individual's life. In August 1992, the PATH Reporting and Evaluation Group—comprised of 23 representatives of state mental health agencies, local providers, mental health consumers, researchers, members of the National Association of State Mental Health Program Directors, and HHS—developed data collection and analysis principles on the type of person-centered information needed. A partial list of desirable outcome data includes information on client satisfaction and the impact of prevention efforts such as onetime rental payments or clinical crisis intervention. The group also recognized that the data should be relatively inexpensive to collect and should be useful for monitoring programs.

[7]HHS offered the states the option of postponing fiscal year 1991 reports until January 31, 1993—the due date for the fiscal year 1992 reports—because the Department did not distribute the fiscal year 1991 grants until the last quarter of fiscal year 1991.

On-Site Monitoring

HHS' on-site monitoring protocol includes observing selected local provider activities and meetings between the PATH Director and the state's PATH Coordinator concerning the state's organizational structure for delivering mental health services; techniques the state uses to ensure that local providers deliver services; and the state's working definitions of "homelessness," "serious mental illness," and "co-occurring mental illness and substance abuse disorders."

The PATH Director first tested the protocol in Tennessee in August 1993. She reported that on-site monitoring will augment her understanding of the states' and territories' PATH programs. The Director plans to visit six to eight additional states during fiscal year 1994; she is the only full-time PATH employee. The Director will address statutory and regulatory issues she identifies and will refer program implementation matters to a technical assistance contractor.[8]

State-Level Controls Are Designed to Help Ensure Program Integrity

State-level program controls that are designed to ensure program integrity include conducting a needs assessment and maintaining oversight of local providers' finances and programs. States are required to identify geographical areas with the greatest need for PATH services before selecting local providers. States also must develop their own methods for monitoring the financial and program performance of local providers.

The five states we reviewed identified high-need areas within their states before selecting local providers. Illinois distributed funds to four urban areas based on the percentage of poverty in the urban area, the number of persons in the urban area, and the percentage of overcrowded housing.[9] Florida distributed funds to 7 of its 11 service districts based on the estimated number of homeless persons in each district. New York based the PATH fund distribution on estimates of the number of homeless persons within the state and the statewide distribution of the homeless mentally ill. New York awarded 75 percent of the grant to New York City and equally distributed the balance among Long Island, the Hudson River area

[8]Under contract with HHS, the National Association of State Mental Health Program Directors provides PATH-related technical assistance to the states. The technical assistance contractor staffs a hotline to answer the states' programmatic and implementation questions, issues newsletters, conducts six 2-day workshops and training sessions annually, and plans and hosts periodic national meetings bringing all 56 PATH Coordinators together. Issues addressed in the newsletter include how to effectively deliver PATH services to homeless women and children, how to achieve state and local provider accountability, and how to provide client job training. The technical assistance contractor is most often asked to conduct workshops on delivering services to the dually diagnosed and developing and accessing housing for the homeless mentally ill.

[9]Illinois distributed PATH funds to providers located in Chicago, East St. Louis, Joliet, and Rockford.

(including Westchester County), and central and western New York. Texas chose to fund the state's seven largest urban areas, along with three nonurban areas. California distributed PATH funds to its counties based on a formula that included the number of households with incomes below 125 percent of the federal poverty level and the number of unemployed persons.

Financial and Program Oversight

States hold local providers accountable for appropriately delivering the agreed-to services by conducting periodic site visits and requiring providers to report their anticipated outcomes. For example, California, Florida, and Texas PATH Coordinators conduct site visits during the program year to validate local provider adherence to program requirements and to provide technical assistance. These states' providers must also submit expenditure reports documenting how they have used PATH funds. New York delegates oversight responsibilities to a local governmental unit or to the state's mental health regional office.

In Illinois, state officials visit local providers biannually. In addition, the state links Chicago-area local providers into a homeless mental health network. An Illinois PATH contractor, Systems Administrative Management Entity (SAM-E), oversees the network's activities. SAM-E visits a network provider weekly to identify problems, monitor and coordinate network services, and train network staff as needed. For example, SAM-E found that one local provider had not fully staffed the program in accordance with its PATH agreement and was not delivering the agreed-to services. When the provider did not correct the problem, the state did not renew its PATH contract.

Mental Health Assessments

The PATH program targets homeless individuals and at-risk populations with serious mental illnesses and those with co-occurring serious mental illnesses and substance abuse disorders. To ensure that the program serves the target population, many local providers perform mental health assessments. Typically, providers performing such assessments include nonprofit community-based mental health organizations and county departments of health. We visited two Chicago local providers to observe their assessment processes and determine how their assessments ensured the appropriateness of homeless individuals for receiving PATH services.

The Bobby E. Wright Comprehensive Community Mental Health Center, Inc., gets client referrals from three sources: hospitals, community-based agencies, and the public. The type of referral is the primary factor triggering the extent of mental assessment the Wright center will perform

on potential clients. Hospital referrals are the most comprehensive and typically include psychiatric and psychological test results and diagnoses. These diagnoses are based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R).[10] Community-based referrals are less comprehensive and have limited psychiatric information about the potential client. Usually the PATH screener reviews the available information on the potential client and can accept the information, request more data from the referring agency, or schedule the potential client for in-house diagnostic tests. Public referrals from the police, relatives, friends, and others are the least comprehensive of the three and usually require Wright staff to conduct a comprehensive mental health assessment on the potential client.

The Wright center's comprehensive assessment is a 30-day, three-step process leading to a DSM-III-R diagnosis. The caseworkers initially screen a potential client to determine whether he or she is homeless and whether the client appears to have a mental health disorder. If a client appears to meet the program criteria, he or she is provided with temporary housing. Caseworkers then collect data to develop a psychosocial history that could include historical information on the client's problems, illegal and legal drug use, medical recommendations, a tentative diagnosis, and other pertinent information. A psychiatrist also tests and observes client activities and gives the potential client a clinical diagnosis. At the end of 30 days, the caseworker, psychiatrist, and others review the case, confirm or revise the client's initial diagnosis, and then develop and help implement the client's individual treatment plan. An individual treatment plan is a customized strategy that outlines a client's needs and goals with a view toward helping the client become self-sufficient.

Thresholds Bridge Program-Mobile Assessment Unit receives referrals from the same sources as the Wright center. In addition, Thresholds identifies clients through street outreach. Two-person teams, consisting of a qualified examiner who is a licensed clinical social worker and an outreach worker, drive, bike, and walk around metropolitan Chicago to locate and identify potential clients.[11] Once the team identifies homeless

[10]Diagnostic and Statistical Manual of Mental Disorders: DSM-III-R, Third Edition, Revised (Washington, D.C., 1987). The manual includes more than 200 mental disorders and diagnostic criteria for each disorder.

[11]In Illinois, a licensed clinical social worker holds a license authorizing the independent practice of clinical social work under the auspices of an employer or in private practice. The licensed clinical social worker must apply for licensure with the State Department of Professional Regulations and must have either a master's degree in social work and at least 3,000 hours of supervised clinical professional experience or a doctorate degree in social work and at least 2,000 hours of supervised clinical professional experience subsequent to earning the degree.

individuals, the assessment process begins. The team talks with each homeless individual to assess his or her mental functioning and to obtain historical information on the person's medical and psychological condition, familial structure, and illegal and legal drug use. With this information, the team begins developing a DSM-III-R diagnosis.

If a potential client is in the midst of a medical or psychiatric crisis, the team calls for immediate services. When there is no crisis, the assessment process can take days or months depending on the potential client's willingness to receive services. According to the Mobile Assessment Unit's Director, it may take several visits with a homeless individual before the person develops enough trust to accept Thresholds' services.

We discussed a draft of this report with HHS' SAMHSA, CMHS, and PATH officials. They generally agreed with the information presented. We have incorporated their comments where appropriate.

We are sending copies of this report to other interested congressional committees, the Secretary of Health and Human Services, the PATH Director, and other interested parties. We also will make copies available to others on request.

Please call me on (202) 512-7119 if you or your staff have any questions concerning this report. Major contributors to this report are listed in appendix IV.

Mark V. Nadel

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Contents

Abbreviations

CMHS	Center for Mental Health Services
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders
HHS	Department of Health and Human Services
PATH	Projects for Assistance in Transition From Homelessness
SAM-E	Systems Administrative Management Entity
SAMHSA	Substance Abuse and Mental Health Services Administration

Scope and Methodology

To gather PATH program information, we interviewed HHS' Substance Abuse and Mental Health Services Administration and Center for Mental Health Service officials responsible for policy and program oversight, and the PATH program Director. We also interviewed officials from the National Association of State Mental Health Program Directors—the PATH program's technical assistance contractor, Illinois' PATH Coordinator and two Chicago-area providers: the Bobby E. Wright Comprehensive Community Mental Health Center, Inc., and the Thresholds Bridge Program-Mobile Assessment Unit. We reviewed HHS' program application, monitoring, and reporting guidance.

We also reviewed fiscal year 1991-93 grant applications from California, Florida, Illinois, New York, and Texas and follow-up on the states' applications. Further, we reviewed the five states' fiscal year 1991 and 1992 annual reports. These five states received over 34 percent of fiscal years 1991-93 PATH allotments and accounted for 62, or 16 percent, of the nation's fiscal year 1992 local PATH providers. We did not test the adequacy of the five states' financial controls, nor are the results of our work projectable to other states. In addition, we contacted state PATH officials in Florida, Nevada, and New Hampshire to obtain information on PATH local providers and clients in fiscal years 1991 and 1992 missing from HHS' data. Our review concerned use of federal funds and program monitoring only; we did not assess the effectiveness of the programs.

We performed our work from May to November 1993, except where noted, in accordance with generally accepted government auditing standards.

Fiscal Years 1992 and 1993 State and Territory Allotments for PATH Program

State	Fiscal year allotment (rounded) 1992	1993
Alabama	$300,000	$300,000
Alaska	300,000	300,000
American Samoa	50,000	50,000
Arizona	396,000	386,000
Arkansas	300,000	300,000
California	3,800,000	3,705,000
Colorado	355,000	346,000
Connecticut	366,000	357,000
Delaware	300,000	300,000
District of Columbia	300,000	300,000
Florida	1,519,000	1,481,000
Georgia	487,000	474,000
Guam	50,000	50,000
Hawaii	300,000	300,000
Idaho	300,000	300,000
Illinois	1,265,000	1,233,000
Indiana	402,000	392,000
Iowa	300,000	300,000
Kansas	300,000	300,000
Kentucky	300,000	300,000
Louisiana	332,000	324,000
Maine	300,000	300,000
Maryland	534,000	521,000
Massachusetts	706,000	688,000
Michigan	867,000	846,000
Minnesota	354,000	345,000
Mississippi	300,000	300,000
Missouri	415,000	405,000
Montana	300,000	300,000
Nebraska	300,000	300,000
Nevada	300,000	300,000
New Hampshire	300,000	300,000
New Jersey	989,000	964,000
New Mexico	300,000	300,000
New York	2,106,000	2,054,000
North Carolina	375,000	366,000
North Dakota	300,000	300,000

(continued)

State	Fiscal year allotment (rounded) 1992	1993
N. Mariana Islands	50,000	50,000
Ohio	993,000	968,000
Oklahoma	300,000	300,000
Oregon	300,000	300,000
Pennsylvania	1,075,000	1,049,000
Puerto Rico	317,000	309,000
Rhode Island	300,000	300,000
South Carolina	300,000	300,000
South Dakota	300,000	300,000
Tennessee	331,000	323,000
Texas	1,697,000	1,654,000
Utah	300,000	300,000
Vermont	300,000	300,000
Virgin Islands	50,000	50,000
Virginia	571,000	557,000
Washington	480,000	468,000
West Virginia	300,000	300,000
Wisconsin	368,000	359,000
Wyoming	300,000	300,000
Total	**$29,400,000**	**$28,874,000**

Source: HHS.

Fiscal Year 1992 Number of PATH Clients Served, by State/Territory

State	Number of PATH clients[a]
Alabama	1,091
Alaska	79
American Samoa	200
Arizona	493
Arkansas	915
California	47,723
Colorado	776
Connecticut	667
Delaware	199
District of Columbia	105
Florida	2,157
Georgia	1,027
Guam	37
Hawaii	518
Idaho	357
Illinois	1,442
Indiana	1,171
Iowa	697
Kansas	635
Kentucky	653
Louisiana	211
Maine	845
Maryland	452
Massachusetts	1,302
Michigan	1,527
Minnesota	803
Mississippi	166
Missouri	2,417
Montana	1,338
Nebraska	260
Nevada	1,003
New Hampshire	1,976
New Jersey	2,630
New Mexico	231
New York	2,570
North Carolina	594
North Dakota	642

(continued)

State	Number of PATH clients[a]
N. Mariana Islands	45
Ohio	2,407
Oklahoma	584
Oregon	194
Pennsylvania	2,068
Puerto Rico	457
Rhode Island	603
South Carolina	791
South Dakota	355
Tennessee	635
Texas	3,362
Utah	486
Vermont	893
Virgin Islands	26
Virginia	1,978
Washington	762
West Virginia	762
Wisconsin	1,833
Wyoming	213
Total	**98,363**

[a]The 1990 McKinney Amendments do not require the states to provide clients with all eligible PATH services nor do they require states to emphasize all eligible services equally.

Source: HHS.

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Related GAO Products

Homelessness: McKinney Act Programs and Funding Through Fiscal Year 1991 (GAO/RCED-93-39, Dec. 21, 1992).

Homelessness: Single Room Occupancy Program Achieves Goals, but HUD Can Increase Impact (GAO/RCED-92-215, Aug. 27, 1992).

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