Creating Integrated Service Systems for Homeless Persons With Mental Illness: The ACCESS Program

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The Access to Community Care and Effective Services and Supports (ACCESS) demonstration program was initiated in 1993 by the U.S. Department of Health and Human Services as part of a national agenda to end homelessness among persons with serious mental illness. Demonstration projects have been established in nine states to develop integrated systems of care for this population. This paper provides an overview of the ACCESS program and presents definitions of services integration and systems integration. Evaluating the effectiveness of integration strategies is a critical aspect of the program. The authors describe the evaluation design and the integration strategies being evaluated and summarize findings from a formative evaluation of the project's first two years. The evaluation revealed several problems that were addressed by providing technical assistance to the states. States were helped to articulate a broader mission of addressing system-level barriers, develop an expanded plan, strengthen the authority of interagency councils, involve leaders at the state and agency levels, and develop joint funding strategies. (*Psychiatric Services* 48:369–373, 1997)

People who are homeless and mentally ill have complex needs and require a broad array of resources, such as housing, mental health and substance abuse treatment, health care, and income supports and entitlements. Most of these services are provided by different agencies across many systems.

Coordination among agencies to facilitate access is hampered because of different funding restrictions, service eligibility requirements, geographic boundaries, treatment or service philosophies, and administrative policies. As services are now organized in most communities, the burden of gaining access to services and integrating them often falls on the homeless person, who also has to overcome transportation barriers, complicated application forms, and long waiting lists. In addition to service fragmentation and inefficiency, communities also lack or have a low supply of critical resources and services such as affordable housing and assertive outreach and case management services.

Background

In 1992 the federal task force on homelessness and mental illness was convened to develop a national agenda to end homelessness among people with serious mental illness. Representatives from the Departments of Health and Human Services (DHHS), Housing and Urban Development, Labor, Education, Agriculture, and Veterans Affairs recognized the need for creating integrated service systems that would allow homeless persons with mental illnesses to gain access to the full complement of services they required regardless of their point of entry (1). To stimulate the development of integrated systems of care, the task force recommended a national demonstration program. It would identify innovative approaches to developing integrated systems to ensure that comprehensive services are available, accessible, appropriate, and accountable for homeless people with serious mental illness.

In 1993 the Access to Community Care and Effective Services and Supports (ACCESS) demonstration program was initiated by DHHS to accomplish two goals—to identify promising approaches to systems integration and to evaluate their effective-

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ness in providing services to this population.

This paper provides an overview of the ACCESS program, the evaluation design, the integration strategies being evaluated, and a summary of findings from a formative evaluation of the first two years of operation (2). Baseline information about characteristics and performance of the service systems in the communities where the demonstrations projects are operating and characteristics of the population enrolled in the study are presented in accompanying articles in this issue (3–5).

Definition of services integration

The term "services integration" has been used broadly in the human services field to refer to a range of service delivery and systems reform initiatives aimed at improving outcomes for people with complex needs (6). An important assumption underlying the concept of services integration is that categorically structured human service delivery systems are less able to address the needs of people with complicated problems. The goals of integration are to improve clients' access to comprehensive services and continuity of care; to reduce service duplication, inefficiency, and costs; and to establish greater accountability (7).

Services integration can be defined in terms of the different service system levels toward which activities are directed. Kagan (8) identified four levels of services integration: the direct service delivery level, the program level, the policy level, and the organizational level. At the direct service delivery level are activities that meet the needs of individuals without altering the systems in which the services are provided. The purpose of services at this level is to provide care to individual clients, as in case management.

The other three levels of services integration can be defined collectively as systems-level integration (or systems integration) because they include activities that attempt to improve the service system for a defined population as a whole. The program level emphasizes linkages between agencies and programs within a local service system, the policy level involves linkages between agencies across state and local service systems, and the organizational level involves reconfiguring or consolidating agencies.

Systems integration may vary and can be viewed as a continuum rather than as a binary state. For example, integration can be conceptualized as interagency relationships in terms of their intensity (ranging from loosely organized alliances to highly integrated organizations) and formality of governance (from informal or verbal agreements to formal policies, rules, and procedures) (9,10).

Konrad (10) describes five levels of integration: information sharing and communication, cooperation and coordination, collaboration, consolidation, and integration. Information sharing and communication represent the most informal level of integration. These activities include sharing information about the program or clients through newsletters and brochures, presentations, or interagency meetings. Cooperation and coordination activities entail more organized efforts by agencies to work together to establish improvements in the service system. Such activities include joint planning, joint applications, and verbal agreements for client referral or expedited application processing.

Collaborations are more structured and are characterized by written agreements or formal procedures that define how different agencies work together to achieve a shared goal. Examples include joint funding, staff cross-training, and a shared information system. Consolidation occurs when different agencies are reorganized under one organization but continue to operate independently. The organizational structure facilitates sharing of information, cooperation and coordination, and collaborations among the agencies while maintaining agency autonomy. Integration represents the final stage and is characterized by single authority, pooled funding, a comprehensive range of services, a single application and assessment, and individualized services. A multiservice center that is administered by one authority and provides a variety of social services and supports represents integration at this level.

The purpose of the ACCESS program is to determine if integration initiatives implemented at the program, policy, and organizational levels will improve outcomes for homeless persons with serious mental illness. It is hypothesized that through development of information sharing, cooperation, coordination, and collaboration among agencies, and through consolidation or full integration of services and supports at the systems level, persons who are homeless and have a serious mental illness will experience improvements above and beyond those attributed to integration at the direct service delivery level—that is, to case management.

Program design

The demonstration program was designed as an evaluation study to address several questions. What are the different systems integration strategies that promote the development of an integrated service system? What factors facilitate or hinder the development of an integrated service system? What are the various roles that federal, state, and local governments and private organizations perform in developing integrated service systems? What impact do systems integration strategies have on service systems? What impact do systems integration strategies have on persons who are homeless and have a serious mental illness?

To answer the questions, the demonstration program is structured as a quasi-experimental design that includes experimental and comparison conditions. For consistency with the design, the applicants, who are state mental health authorities, had to identify two comparable sites that could participate in the demonstration. The two sites had to be matched as closely as possible in terms of the estimated number of homeless individuals with mental illness, local housing stock, population size, median income, and type of community. Also, each site had to have enough homeless persons who have a serious mental illness to enroll 100 persons annually for four years in the evaluation study.

Both sites were required to submit a plan for creating an integrated service system in their community. The plan had to include strategies that

would link mental health and substance abuse services, housing, health care, and income supports and entitlements. Applicants were asked to incorporate at least some of an array of different strategies into the plans. The strategies include interagency coalitions, task forces or steering committees, cross-training, joint planning, interagency agreements or memorandums of understanding, co-location of services, flexible funding, joint funding, joint program administration, uniform applications and assessments, shared information systems, and consolidation of programs, agencies, or departments.

After applications were approved, sites were randomly assigned by federal ACCESS staff to either an experimental or a comparison condition to avoid selection bias by the applicants. The experimental and comparison sites received similar amounts of funds to provide outreach and case management services, to create parity in resource capacity between the two sites, and to annually enroll 100 homeless persons with serious mental illness. In addition to this funding, the experimental sites have received funds to support systems integration initiatives. Beginning in 1993, between $1.7 and $2 million in cooperative agreement grants were awarded each year for five years to the nine states and 18 communities shown in Table 1.

Approximately 65 percent of the funds awarded to the states are spent on providing outreach and case management services across the two sites. Fifteen percent is for systems integration activities at the experimental site; 5 percent is for state-level project administration; and the balance is for client data collection. Other funds are awarded to contractors for conducting the evaluation.

Table 1

ACCESS program demonstration sites

State	Experimental site	Comparison site
Connecticut	Bridgeport	New Haven
Illinois	Chicago, Edgewater-Uptown	Chicago, Lincoln Park–Near North
Kansas	Sedgwick County	Shawnee County
Missouri	St. Louis	Kansas City
North Carolina	Mecklenburg County	Wake County
Pennsylvania	Philadelphia, West	Philadelphia, Center City
Texas	Fort Worth	Austin
Virginia	Richmond	Hampton–Newport News
Washington	Seattle, Uptown	Seattle, Downtown

Evaluation methodology

The evaluation of the demonstration program focuses on both the systems level and the client level. At the systems level, community attributes that could influence the implementation of systems integration (such as political, organizational, historical, and service system characteristics, processes, and program resources) are documented, the implementation process of the integration approaches is chronicled, implementation barriers and facilitators are identified, and system outcomes are measured. At the client level, data are collected about demographic characteristics, history of homelessness and mental illness, employment experiences, drug and alcohol use, health and legal status, victimization, extent of social supports, service use, service needs, and service barriers.

Many methods are used to gather data at both the system and the client levels. At the systems level, annual site visits provide essential information on the implementation of the projects and the community context in which the projects are being implemented. Semiannual reports from the grantees provide more information on their progress and describe critical events that might affect progress. Focus groups are conducted with service providers and clients during the second and fifth year of the demonstration to provide subjective assessments of system performance.

Data from the site visits, semiannual reports, and focus groups that are hypothesized to have an impact on integration efforts are summarized in a project-level database. Logic models are developed from the original applications to describe the relationship among systems integration activities, community characteristics, intermediate outcomes, and long-term outcomes. The logic models are revised annually to document how the concept of integration changes in each project over time.

Finally, an interorganizational network study is conducted during the first, third, and fifth years of the demonstration program to determine the extent to which the service systems become integrated over the five years of the project. The network study forms the quantitative core of the systems-level evaluation and consists of a three-part questionnaire that is administered to representatives of approximately 50 organizations in each community. Besides measuring systems integration, the network study assesses agency characteristics and service system performance.

The client-level evaluation includes four annual cohorts of 100 subjects at each site who are assessed at several time points: first outreach contact, referral to case management, baseline (entry to case management), and three and 12 months after baseline. In addition, information is collected about services provided by the case managers, referrals made to other agencies, and referral outcomes. Clinical staff screen potential subjects and provide brief assessments at the first contact and later when the individual has agreed to accept case management services. Project-level evaluators collect baseline and follow-up data through interviews with subjects who agree to participate in the study. They also maintain a computerized tracking system that records referrals made by case managers and generates letters that are sent to the referral agencies requesting feedback on referral outcomes.

The evaluation also includes a formative component in which observations from the evaluators and the federal staff about the projects' progress are reported back to the sites with the expectation that corrections will be made. A major goal of the evaluation is to contribute to the success of each ACCESS project by providing feedback on progress made and arranging

for assistance with overcoming problems. Using a variety of formal and informal methods, the formative evaluation seeks to improve the implementation of each project.

At the systems level, feedback information includes logic models, site visit debriefings and reports, reports from the interorganizational network study, and reports from federal monitoring activities. At the client level, feedback is provided through monthly conference calls with all sites, data reports, and information from the client tracking systems. Annual evaluation reports also provide a summary of the progress of program implementation.

Target population

The study population includes persons 18 years of age and older who are homeless and have a serious mental illness, with a special emphasis on those who have alcohol and drug use disorders. Homelessness is defined as lacking a fixed, regular, and adequate nighttime residence. Also included in the definition of homeless persons are those whose primary nighttime residence is a supervised public or private shelter designed to provide temporary living accommodations, an institution that provides a temporary residence for individuals not intended to be institutionalized, or a public or private place not designed for—or ordinarily used as—a regular sleeping accommodations for human beings. Persons with serious mental illness are those who have a persistent mental or emotional disorder (such as schizophrenia, schizoaffective disorder, mood disorders, and severe personality disorders) that significantly interfere with their ability to carry out primary daily life activities such as self-care, household management, interpersonal relationships, and responsibilities at work or school.

Projects and strategies

The nine states participating in the demonstration program are geographically spread across the country, with slightly less than half located along the East Coast (Table 1). The 18 communities representing the demonstration sites are mostly large urban centers with ethnically diverse populations. In six states the communities constitute different cities or counties, while in three states they represent different parts of a city (Chicago, Seattle, and Philadelphia).

Most of the sites are either implementing or planning to implement a variety of strategies, described below.

Interagency coalitions. Interagency coalitions are groups composed of representatives from several agencies who address common concerns. Their purpose ranges from general information exchange and coordination of services to needs assessment and formal agreements on reducing barriers to services, eliminating duplication of services, and promoting access to comprehensive services. All of the experimental sites are implementing some form of interagency coalition, although functions and membership vary from site to site.

Interagency teams for service delivery. Teams composed of interdisciplinary staff from several agencies are designed to provide multiple services to clients with many special problems in an integrated manner. Staff may be funded by different agencies to work together or by one agency that pays other agencies for the staff positions. Two of the ACCESS sites have implemented interagency service delivery teams using ACCESS funds to pay for the staff. The teams use other integration mechanisms, such as joint staff meetings and shared intake and record keeping.

Interagency management information systems and client tracking systems. Computer tracking and management information systems can be used to link participating agencies, promote interagency sharing of information, simplify interagency referrals, minimize paperwork, reduce duplication of services, and facilitate access to services by clients. This strategy has proved difficult to execute; none of the four sites that proposed this strategy have made substantial progress.

Cross-training. Cross-training involves training staff about the objectives, procedures, and services available at other agencies. Five of the experimental sites have developed cross-training programs that allow their staff, as well as other service providers, to expand their knowledge of existing services. Some sites have developed broad-based training programs involving the agencies they work with most closely, while others have narrowed the focus to training staff in procedures for expediting application processes.

Interagency agreements or memorandums of understanding. Formal or informal agreements made between agencies may include agreements to collaborate, make or accept referrals, share client information, or coordinate services. Four of the experimental sites have implemented interagency agreements or memorandums of understanding in an effort to coordinate referrals, streamline and expedite application processes, or formalize commitment to planning and funding services for the homeless population.

Pooled or joint funding. This funding strategy combines or layers funds to create new resources or services for special populations. Three sites have proposed to create funding packages that draw on diverse sources to support a service or program component.

Flexible funding. Flexible, noncategorical funding can be used to purchase expertise or coordinate the acquisition of additional resources to further systems integration. Only one site is using flexible funds to serve a variety of functions, including leveraging other funds or resources for service development, paying for consulting services, and hiring staff with expertise in particular areas.

Uniform applications, eligibility criteria, and intake assessments. This strategy involves a standard process or form containing information used by participating agencies that an individual completes only once to apply for or receive a range of services. Three of the experimental sites have plans to develop mechanisms for coapplication and coeligibility across agencies.

Co-location of services. A multiservice center can be established in a single location to provide a variety of services, including health, mental health and substance abuse treatment, housing assistance, and entitlements. The majority of the experimental sites are using this systems integration strategy. Most of the co-located services, which usually include some mental health, substance abuse, housing, and primary care services,

are purchased from several agencies using ACCESS funds. The agencies providing services continue to maintain administrative responsibility for staff who work at multiservice sites.

Interim findings

At the end of the second year of program operation, the formative component of the evaluation revealed that many of the experimental sites were struggling to implement their systems integration plans. Five major problems were identified. First, most of the sites did not have a clear vision of what they wanted to achieve. Many were focusing their reform efforts at the direct service delivery level, improving case management services and opening drop-in centers. Few had a broader mission of addressing system-level barriers. Second, systems integration plans were not adequately developed. Once plans had been approved for federal funding, the sites did not expand them further to identify specific activities and resources required to implement the systems integration plan. In particular, many projects had not identified a staff person dedicated to working on the plan.

Third, interagency councils were constituted with minimal responsibilities. Most of the sites realized the importance of establishing interagency committees but viewed them as advisers and not as change agents. Furthermore, the committees had representation from mental health and homeless provider services but not from housing, health, substance abuse, and social service agencies. In addition, committee members were mid-level staff who did not have power to bring about change in their own agency or in the service system.

Fourth, many of the sites lacked involvement by the leadership at the state and agency levels to facilitate systems integration. Although state and local agencies supported the concept of systems integration, they did not actively participate to address barriers impeding the development of systems integration. Finally, lack of joint funding or sharing of financial resources has been a problem. Although information sharing, and to a lesser extent client sharing, was relatively extensive, financial resources remained Balkanized and guarded.

In response to these problems, the Center for Mental Health Services sponsored a series of technical assistance workshops for the experimental sites. The workshops were targeted to staff who brought with them leaders from their communities. The workshops provided tools for defining a vision for systems integration, identifying barriers, establishing priorities, drafting effective strategic plans, building support among stakeholders, and implementing the systems integration plan. At the end of the workshops, staff were required to submit a revised systems integration plan. An analysis of these plans indicated that the workshops were successful in helping the sites develop a focus on systems integration in addition to services integration. Recent visits to the sites also have indicated that most have made significant progress in implementing their plans.

Conclusions

The ACCESS program will provide important information about effective approaches to developing integrated systems for ensuring that comprehensive services are available, accessible, appropriate, and accountable for persons who are homeless and who have serious mental illness. The evaluation will also describe models of systems integration that can be replicated in other communities nationally.

Interim results from the evaluation suggest that funding alone is not a sufficient catalyst for promoting systems integration. Developing an integrated service system is a complex undertaking that requires interagency planning and consensus building, knowledge about how to make different integration strategies work, adequate resources, and substantial time. States and communities need technical assistance to help them in this undertaking. The need for such assistance was also evident in other systems change demonstrations, such as the Robert Wood Johnson Foundation Program on Chronic Mental Illness and some of the McKinney homeless demonstration projects (11,12). For the ACCESS program, the federal government and its agents have provided the technical assistance. The ultimate impact will be assessed over the next three years as the ACCESS demonstration continues to be implemented. ♦

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