



**National Association of State Mental Health Program Directors**  
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## **Assessment #6**

# **Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness**

**August 2018**

**Alexandria, Virginia**

**Sixth in a Series of Ten Briefs Addressing: Bold Approaches for Better  
Mental Health Outcomes across the Continuum of Care**

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# Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness

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## Executive Summary

Serious mental illness (SMI) is a significant risk factor for homelessness, and the loss of housing can exacerbate existing medical and mental health conditions and create new ones. Of the 553,742 people who are documented as homeless on a given night, 20 percent have an SMI. There are numerous reasons for homelessness among those with SMI, including unpredictable behavior that limits employment, strained relationships with family and friends, and homeless services programs that are difficult to navigate. Living on the street brings a wide range of risks to health and well-being, such as violence, injury, illness, and higher mortality.

Housing affordability and homelessness are inextricably linked. Goals to eliminate homelessness among those with SMI will not be achieved unless the crisis in affordable housing is addressed. State Mental Health Authorities (SMHAs) have a significant interest in preventing and ending homelessness in this population because they have poor health, high rates of health care system utilization (and related costs), and poor outcomes. State mental health authorities are well-positioned to take action on this issue because they have influence over funding priorities, Medicaid and other health policy changes, hospital protocols, and contractual requirements for local jurisdictions and community providers. To that end, the Interdepartmental Serious Mental Illness Coordinating Committee created under the 21<sup>st</sup> Century Cures Act<sup>1</sup> recommended in its first report to Congress<sup>2</sup> that agencies should make housing more readily available for people with SMI and serious emotional disturbance (SED).

While the lack of affordable housing is the primary cause of homelessness, housing alone will not be adequate to prevent and end homelessness among those with SMI. The recommendations contained in this report focus on specific actions in the areas of health, housing, income, support services, criminal justice systems, and children and youth. State mental health authorities can build elements of these recommendations into contracts, establish performance measures, conduct data analysis, and build capacity for these improvements across systems. Strong leadership and a dedicated vision is needed on these activities at the state level to meet the goal of preventing and ending homelessness among those with SMI.

## Mental Illness among People Experiencing Homelessness

Serious mental illness (SMI) is a significant risk factor for homelessness, and the loss of housing can exacerbate existing medical and mental health conditions and create new ones. The experience of homelessness also complicates engagement in treatment and the ability to be successful in recovery. The U.S. Department of Housing and Urban Development (HUD) estimates 553,742 people were homeless on a single night in

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<sup>1</sup> Pub. L. No 114-255, § 6031.

<sup>2</sup> Interdepartmental Serious Mental Illness Coordinating Committee (December 13, 2018). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Available at: [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/ismicc\\_2017\\_report\\_to\\_congress.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf).

January 2017, and 1.4 million people used shelter and housing programs throughout 2016.<sup>3,4</sup> Of those homeless on a single night, 111,902 (20 percent) reported having an SMI—of which nearly half (48 percent) were living on the street, a third (36 percent) were staying at an emergency shelter, and 16 percent were living in a transitional housing program.<sup>5</sup> Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 4 percent of people with SMI *who were in treatment* were homeless or staying in a shelter in 2016 (191,204 individuals).<sup>6</sup> The U.S. Conference of Mayors reported that 29 percent of homeless adults were seriously mentally ill, and cited mental health and the lack of needed services as one of the leading causes of homelessness.<sup>7</sup>

Despite many studies and estimates, it is difficult to get an exact number of people who are homeless due to the changing nature of housing status, the reality that not everyone is counted in annual street surveys, and not everyone uses publicly funded services systems that record client-level data. Hence, these estimates are likely undercounts of the actual number of people experiencing homelessness who have mental illness, but they still point to a significant proportion of very vulnerable people who are living without stable housing.

There are numerous reasons for homelessness among people with SMI, particularly when it is untreated. Unpredictable behavior can limit employment and the ability to earn an income that is sufficient to afford housing, as well as strain relationships if living with family or friends. In the homeless services system, shelters tend not to serve this population well. Many programs will ban individuals for minor infractions of rules (common even in “low barrier” models).

Shelters can be crowded, chaotic places that are extremely disturbing to those struggling with mental health problems that tend not to offer spaces to safely store medications or personal belongings. Many transitional housing programs require abstinence from drugs/alcohol and compliance with treatment plans and house rules, which may be more difficult for those with serious mental health conditions. While supportive housing works well, there is not nearly enough capacity in those programs to meet the need. These reasons help explain why people with SMI are at high risk of street homelessness.

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<sup>3</sup> U.S. Department of Housing and Urban Development (HUD) (December 2017). *The 2017 Annual Homeless Assessment Report (AHAR) to Congress: Part 1: Point-in-Time Estimates of Homelessness*. Available at: <https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf>.

<sup>4</sup> HUD (December 2017). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress PART 2: Estimates of Homelessness in the United States*. Available at: <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf>.

<sup>5</sup> HUD 2017 Continuum of Care Homeless Populations and Subpopulations Report (December 2017). Available at: [https://www.hudexchange.info/resource/reportmanagement/published/CoC\\_PopSub\\_NatlTerrDC\\_2017.pdf](https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2017.pdf).

<sup>6</sup> U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). 2016 Mental Health National Outcomes Measures: Uniform Reporting System. Available at: <https://www.dasis.samhsa.gov/dasis2/urs.htm>.

<sup>7</sup> U.S. Conference of Mayors (December 2015). *Hunger and Homelessness Survey: A Status Report on Hunger and Homelessness in America's Cities*. Available at: [https://www.tuw.org/sites/tuw.org/files/US%20Conference%20of%20Mayors%20Hunger%20and%20Homelessness%20Survey\\_2015.pdf](https://www.tuw.org/sites/tuw.org/files/US%20Conference%20of%20Mayors%20Hunger%20and%20Homelessness%20Survey_2015.pdf).

Living on the street brings a wide range of risks to health and well-being. Physical violence, sexual assault, theft, exposure-related injuries or illnesses (such as frostbite, heat stroke, pneumonia, etc.), sleep deprivation, and hunger are common. All of these factors will exacerbate medical and mental health conditions and create additional vulnerabilities. Homelessness increases the risk of arrest—usually for minor crimes—so that cycling in and out of jails and detention centers is common.<sup>8</sup> Premature death is also a reality among people who are homeless, particularly those with SMI, where life expectancy is shortened by 20 to 30 years compared to the general population.<sup>9</sup> Though living on the street can present direct risks to health and safety, involuntary commitment remains—understandably—a difficult and controversial option to pursue.

## Housing Affordability in the U.S.

Housing affordability and homelessness are inextricably linked. Goals to eliminate homelessness among those with SMI will not be achieved unless the crisis in affordable housing is addressed. In part, this is because only one in four low-income, eligible households receives housing assistance. In 2015, 8.3 million renters had a “worst case housing need,” meaning that they were very low income, lacked housing assistance, and paid more than 50 percent of their income toward housing. One in six of these households (17 percent, or 1.4 million households) included a nonelderly person with disabilities.<sup>10</sup> For those receiving Supplemental Security Income (SSI), affordable housing means only \$250 a month is available for rent, which is far below the national average rent of \$931 for a one-bedroom unit.<sup>11</sup>

Among low-income renters, nearly 28 percent were recently unable to pay their full rent and 3.7 million Americans experienced an eviction at some point in 2017 (most of whom were in households earning less than \$30,000 per year).<sup>12</sup> When mayors were asked to identify what was most needed to reduce homelessness in their cities, the overwhelming response was more mainstream housing assistance and/or affordable housing.<sup>13</sup> Local nuisance laws make it possible for landlords to evict tenants for disorderly conduct,

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<sup>8</sup> U.S. Interagency Council on Homelessness (August 2016). *Reducing Criminal Justice System Involvement among People Experiencing Homelessness*. Available at:

[https://www.usich.gov/resources/uploads/asset\\_library/Criminal\\_Justice\\_Involvement\\_08\\_2016.pdf](https://www.usich.gov/resources/uploads/asset_library/Criminal_Justice_Involvement_08_2016.pdf).

<sup>9</sup> Baggett, T., et al. (February 2013). Mortality Among Homeless Adults in Boston: Shifts in Causes of Death Over a 15-Year Period. *JAMA Internal Medicine* 173 (3): 189-195. Available at:

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1556797>.

<sup>10</sup> HUD (August 2017). *Worst Case Housing Needs: 2017 Report to Congress*. Available at:

<https://www.huduser.gov/portal/sites/default/files/pdf/Worst-Case-Housing-Needs.pdf>.

<sup>11</sup> For rent to be affordable, not more than 30% of income is allocated toward housing costs. National Low Income Housing Coalition (June 2018). *Out of Reach: the High Cost of Housing*. Available at:

[http://nlihc.org/sites/default/files/oor/OOR\\_2018.pdf](http://nlihc.org/sites/default/files/oor/OOR_2018.pdf).

<sup>12</sup> Salviati, C. (October 20, 2017). *Rental Insecurity: The Threat of Evictions to America's Renters*. Apartment List. Available at: <https://www.apartmentlist.com/rentonomics/rental-insecurity-the-threat-of-evictions-to-americas-renters/>. Note: the number of evictions includes formal, court-ordered instances as well as "soft evictions," in which tenants leave under the threat of a formal eviction but before the actual notice had been given.

<sup>13</sup> U.S. Conference of Mayors (December 2016). *Report on Hunger and Homelessness 2016*. Available at: <https://endhomelessness.atavist.com/mayorsreport2016>.

repeated presence of police or other emergency vehicles (or for other reasons), creating an added risk for housing stability. For those struggling with mental health conditions, earning sufficient income to consistently pay rent and identify the needed supports to live successfully in the community are two very significant challenges.

## Why this Issue for State Mental Health Authorities?

SMHAs have a vested interest in preventing housing instability and ending homelessness among individuals with SMI. Lack of housing is associated with significantly more inpatient psychiatric, emergency, and health care services than with those who are not homeless.<sup>14</sup> People who are homeless also tend to have poorer health, less access to health care services, and increased risk of premature mortality.<sup>15</sup> Those who are both homeless and have mental illness have a double risk factor—making this combination especially hazardous to health and well-being.<sup>16</sup>

NASMHPD issued a statement on housing and supports for individuals with mental illness, recognizing that “individuals with mental illness must have the option of living in decent, stable, affordable, integrated, and safe housing that reflects individual choice and available resources.” This position statement asserts that mental health authorities:

*should exercise leadership in the housing arena, addressing housing and support needs and expanding affordable housing stock. This is a broad responsibility shared with consumers, housing authorities, and all levels of government. Additionally, it requires coordination and negotiation of mutual roles of mental health authorities, public assistance and housing authorities, and the private sector.*<sup>17</sup>

SMHAs are well-positioned to influence funding priorities, Medicaid and other health policy changes, hospital protocols, and contractual requirements for local jurisdictions and community providers. They are also strong voices across the entire health care system, and have relationships with other state agencies (such as housing, education, labor, social services, criminal justice, etc.) and are often asked by state legislatures to make recommendations such as those contained in this report.

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<sup>14</sup> Kuno, E., *et al.* (August 2000). Homelessness Among Persons With Serious Mental Illness in an Enhanced Community-Based Mental Health System. *Psychiatric Services* 51 (8): 1012-16. Available at: <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.51.8.1012>.

<sup>15</sup> Montgomery, A., *et al.* (October 2016). Homelessness, Unsheltered Status, and Risk Factors for Mortality. *Public Health Reports* 131 (6): 765-772. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5230839/>

<sup>16</sup> Liu, N., *et al.* (February 2017). Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry* 16 (1): 30-40. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5269481/>.

<sup>17</sup> NASMHPD (July 2005.) Position Statement on Housing and Supports for Individuals with Mental Illness. Available at: <https://www.nasmhpd.org/sites/default/files/Housing%20Position%20Statement.pdf>.

## Recommendations

While the lack of affordable housing is the primary cause of homelessness, housing alone will not be adequate to prevent and end homelessness among those with SMI. The following recommendations focus on specific actions in the areas of health, housing, income, support services, criminal justice systems, and children and youth. The breadth of actions is intended to illustrate the wide range of initiatives that would help improve health and housing stability for this population. Program Directors all face unique circumstances in available resources, partnerships, opportunities to act, policy priorities, and political environments. Selecting those initiatives that align with feasible implementation opportunities can help the system move toward the goal of preventing and ending homelessness among those with SMI.

### Health

Improving access to comprehensive, high-quality health care is likely the greatest area of direct influence for SMHAs. The range of recommendations in this area is broad, reflecting the myriad of aspects in the health care system that can be improved to better serve a population struggling with both homelessness and SMI.

1. **Expand Medicaid and ensure assertive efforts to conduct outreach, enrollment and engagement to this population.** Expanding Medicaid to low-income, non-disabled adults improves access to care and financial security, and confers economic benefits for states and providers.<sup>18</sup> A substantial body of research has documented the benefits of Medicaid expansion under the Affordable Care Act (ACA) on coverage, access to care, utilization, affordability, health outcomes, and various economic measures.<sup>19</sup> It is much more difficult to access and coordinate care, share data, and improve health outcomes without comprehensive health coverage. States that have yet to expand Medicaid to low-income, non-disabled adults should advocate for this benefit to be extended as soon as possible. Even though those who qualify for disability receive Medicaid, comprehensive health coverage is vital for those who are trying to demonstrate disability, allowing them to access care and possibly receive earlier interventions so that conditions do not deteriorate to the point of homelessness. Recent federal guidance<sup>20</sup> that limits eligibility for Medicaid (such as work

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<sup>18</sup> Rudowitz, R., and Antonisse, L. (May 23, 2018). *Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence*. Kaiser Family Foundation. Available at: <https://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence/>.

<sup>19</sup> Antonisse, L., Garfield, R., Rudowitz, R., and Artiga, S. (March 28, 2018). *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*. Kaiser Family Foundation. Available at: <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>. Note: This issue brief summarizes findings from over 200 studies of the impact of state Medicaid expansions published between January 2014 and February 2018.

<sup>20</sup> U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (January 11, 2018). *Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries* (SMD 18-002). Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

requirements, service limitations, lock-out periods, premiums/copays for those below poverty, more frequent eligibility determinations, etc.) will likely see reduced health coverage for this population. While those who are disabled will have protections, people who are homeless with SMI have significant barriers to determining disability and would likely have difficulty meeting reporting requirements.

Insurance coverage among those who are homeless varies widely, influenced largely—but not exclusively—by Medicaid eligibility. Among patients at Health Care for the Homeless programs in 2016, 25 percent of patients in Medicaid expansion states were uninsured while 70 percent of patients in non-Medicaid expansion states lacked coverage.<sup>21</sup> Outreach and enrollment efforts that specifically focus on very vulnerable people, like those who are homeless with mental illnesses, should be a regular part of community provider activities in all states, with the goal of connecting individuals to the benefits for which they qualify and the care that they need.

2. **Promote state Medicaid waivers to fund housing supports/supportive services.**

Identifying resources to help obtain and retain housing can be a significant challenge, but using a Medicaid §1115 or §1915 waiver or state plan amendment can help maximize state-level funding. A 2015 CMS Informational Bulletin identifies which housing-related activities and services can be incorporated into a Medicaid benefit design for individuals needing long-term services and supports, and in state strategies for transforming systems to improve community integration.<sup>22</sup> These include specific activities and services that are outlined across three key areas:

- **Individual Housing Transition Services:** Conducting housing assessments, developing housing support plans, identifying resources, assisting with a move, etc.
- **Individual Housing & Tenancy Sustaining Services:** Identifying/intervening when behaviors might jeopardize housing, coaching on maintaining relationships with landlords, etc.
- **State-level housing-related collaborative activities:** Developing agreements and relationships with housing and community development agencies, working with housing partners to identify additional housing options, etc.

A number of states are using such waivers to pay for support services, which creates a more stable funding source and maximizes grants and other funding streams for non-reimbursable services.<sup>23, 24</sup>

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<sup>21</sup> National Health Care for the Homeless Council (May 2018). *Health Insurance Coverage at HCH Programs, 2016*. Available at: <https://www.nhchc.org/wp-content/uploads/2018/05/health-insurance-hch-programs-2016.pdf>

<sup>22</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMCS Informational Bulletin (June 26, 2015). *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>

<sup>23</sup> Clary, A. (March 2016). *State Strategies to Improve Health Through Housing Services*. National Association of State Health Policy (NASHP). Available at: <https://nashp.org/state-strategies-to-improve-health-through-housing-services/>.

<sup>24</sup> A prior NASMHPD report found that most states are using Medicaid in some way to fund housing supports. Schultz, D. (September 2015.) *NASMHPD State Survey on Medicaid Funding for Housing*

3. **Support integrated care models.** A prior NASMHPD report discusses the need for integrated care, but this approach is even more critical for people who are homeless because of their significant health needs.<sup>25</sup> The high rate of premature death among those with SMI is often caused by chronic illnesses such as cardiovascular disease, cancer, and chronic obstructive pulmonary disease.<sup>26</sup> Because of this, there remains a specific need to ensure access to integrated medical care that includes cancer screenings and smoking cessation services (among other preventive services). States have long been striving to integrate primary care and behavioral health, but challenges remain in delivering whole-person care. Three barriers have been noted to truly transform systems of care: organizational failure to sustain integrated care; limited support for co-occurring disorder treatment training; and diagnostic and billing restrictions.<sup>27</sup> These barriers limit community providers' ability to deliver patient-centered care that meets the breadth and depth of patient needs.
4. **Promote harm reduction and trauma-informed approaches to care.** Engaging vulnerable people into care and retaining them in treatment can be a long and delicate task, especially when they are experiencing homelessness. Poor experiences with service providers and pervasive histories of trauma can create significant levels of mistrust and fear to engage. Unfortunately, this can also result in individuals being labeled "treatment resistant." All mental health providers should be trained in harm reduction and trauma-informed approaches to care, learning how to engage in a non-judgmental manner and facilitate client-centered goals.<sup>28, 29</sup> Trauma-informed care increases consumer engagement and daily functioning, and decreases hospitalizations, psychiatric symptoms, and substance use.<sup>30</sup> Funding and performance measures identified for this population should recognize the significant amount of time it takes to build trust and therapeutic relationships, and allow for smaller caseloads. This recommendation extends beyond

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*Support and Services.* Available at:

[https://nasmhpd.org/sites/default/files/Assessment%20%232\\_NASMHPD%20Housing%20State%20Survey.pdf](https://nasmhpd.org/sites/default/files/Assessment%20%232_NASMHPD%20Housing%20State%20Survey.pdf).

<sup>25</sup> Lerch, S. (August 2017). *The Role State Mental Health Authorities Can Play in Delivery of Integrated Primary and Behavioral Health Care for People with Serious Mental Illness, Including Those with Co-occurring Substance Use Disorders.* NASMHPD. Available at:

[https://www.nasmhpd.org/sites/default/files/TAC.Paper\\_.6.IntegratedCare\\_Final.pdf](https://www.nasmhpd.org/sites/default/files/TAC.Paper_.6.IntegratedCare_Final.pdf).

<sup>26</sup> Olfson, M., *et al.* (December 2015). Premature Mortality Among Adults With Schizophrenia in the United States. *JAMA Psychiatry* 72 (12): 1172-81. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/26509694>.

<sup>27</sup> Padwa, H., *et al.* (May 2015). Barriers to Serving Clients with Co-occurring Disorders in a Transformed Mental Health System, *Psychiatric Services* 66 (5): 547-550. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/25686812>.

<sup>28</sup> SAMHSA resources on trauma and trauma-informed care can be found at the National Center for Trauma-informed Care and Alternatives to Seclusion and Restraint. Available at:

<https://www.samhsa.gov/nctic>. Resources on harm reduction can be found at the Harm Reduction Coalition, available at: <http://harmreduction.org/>.

<sup>29</sup> NASMHPD (January 2005). Position Statement on Services and Supports to Trauma Survivors. Available at:

<https://www.nasmhpd.org/sites/default/files/NASMHPD%20TRAUMA%20Positon%20statementFinal.pdf>.

<sup>30</sup> Hepburn, S. (August 2017). *Quantitative Benefits of Trauma-Informed Care.* NASMHPD. Available at: [https://www.nasmhpd.org/sites/default/files/TAC.Paper\\_.5.Quantitative\\_Benefits\\_TraumaInformed\\_Care\\_Final.pdf](https://www.nasmhpd.org/sites/default/files/TAC.Paper_.5.Quantitative_Benefits_TraumaInformed_Care_Final.pdf)

individual care practices, and should be incorporated at the organizational level to inform larger policies, practices, and procedures.

5. **Implement evidence-based practices like ACT and CTI models of care.** Assertive Community Treatment's emphasis on multi-disciplinary care teams and intensive services have been shown to be effective in reducing homelessness and improving mental health.<sup>31, 32</sup> Similarly, Critical Time Intervention as a care coordination model for people with SMI transitioning from institutional care to community settings is specifically designed to prevent homelessness and other negative outcomes.<sup>33</sup> SMHAs should ensure providers receive training in these approaches to care, as well as the appropriate resources to successfully implement them, particularly in areas of high need. Both these models emphasize limited caseloads, which is a vital element in achieving desired outcomes.
6. **Improve and standardize institutional discharge protocols.** All health care systems are facing pressures to reduce inpatient admissions, lengths of stay, and readmissions. At the same time, for individuals who have SMI and are homeless, it can be difficult for providers to find appropriate discharge placements in the community, leading to longer and more frequent hospitalizations. This reality can also lead to inappropriate discharges to the street, homeless shelters, or other settings that violate federal law or ethical medical standards (and contribute to patient lack of trust in the system, making future attempts to engage in care even more difficult). Hospital discharge personnel should have close relationships with community providers, coordinate a discharge care plan, and communicate the plan clearly with all those involved in the patient's care.<sup>34</sup> State mental health programs can establish model policies, standardize them across many venues of care, and require adherence to these standards as a condition of contractual agreements. Regularly evaluating discharge outcomes can shed light on where targeted improvements (and resources) are needed.
7. **Promote medical respite care programs as an option for discharge.** Identifying a safe environment for post-acute care can be difficult when patients lack housing, but medical respite programs are a vital tool to provide medical care, social services, and a safe place to recuperate for people experiencing homelessness. These programs serve as a stabilizing venue to further develop a longer-term care plan, apply for

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<sup>31</sup> Coldwell, C., and Bender, W. (March 2007). The Effectiveness of Assertive Community Treatment for Homeless Populations With Severe Mental Illness: A Meta-Analysis. *American Journal of Psychiatry* 164 (3): 393-399. Available at:

<https://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.2007.164.3.393>

<sup>32</sup> SAMHSA (October 2008). *Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT*. Available at: <https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>.

<sup>33</sup> SAMHSA, National Registry of Evidence-based Programs and Practices. *Critical Time Intervention*. Available at: <https://nrepp.samhsa.gov/ProgramProfile.aspx?id=1278>.

<sup>34</sup> National Health Care for the Homeless Council/Clinicians' Network (October 2008). Tools to Help Clinicians Achieve Effective Discharge Planning. *Healing Hands* 12 (5). Available at: <https://www.nhchc.org/wp-content/uploads/2011/09/Oct2008HealingHands.pdf>.

benefits, and identify permanent housing options.<sup>35</sup> Medical respite is cost-effective because of its ability to reduce lengths of inpatient stay, emergency department visits and re-admissions.<sup>36</sup> SMHAs can bolster the use of medical respite programs for those with SMI by ensuring funding and staff training so that their state is prepared to accommodate those with significant behavioral health needs (e.g., have a trained master’s level staff onsite with access to a psychiatrist offsite). Medicaid can reimburse for eligible medical care, behavioral health services, and care coordination activities, and serve as a more sustainable funding mechanism for these programs (complementing other funding streams).<sup>37</sup>

8. **Increase community capacity along a continuum of care.** Community providers need the training, funding and physical space to accommodate appropriate services for the most critically ill. This goes beyond simply calling for “more beds” and is intended to be a broader focus on the range of care needed to manage and address the most challenging patients in the community.<sup>38</sup> Developing a statewide plan for what services are needed—at various levels of care—can then serve as a blueprint for collective action to achieve those goals. This includes short-term crisis response and long-term residential stability, as well as workforce training to increase skills and prevent burnout. Safety net providers such as Federally Qualified Health Centers and community mental health centers (among others) are critical partners who can help identify needed resources and strategize where additional capacity could have the largest impact.
9. **Ask about housing status and code for homelessness in inpatient and community settings.** Asking about housing status is vital in order to capture relevant clinical and social information and to prepare appropriate discharge plans. Adding the ICD-10 code Z59.0 for homelessness into the electronic health record helps other service providers understand client needs. Using this code, along with other methodologies for identifying homelessness, allows SMHAs to more accurately assess system-wide needs (and costs), and permits policymakers to better understand the number of people needing housing in order to set state goals for the number of units

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<sup>35</sup> More information about medical respite care can be found at the National Health Care for the Homeless Council: <https://www.nhchc.org/resources/clinical/medical-respite/tool-kit/>, to include a list of defining characteristics, a directory of current programs, program standards, and financing approaches.

<sup>36</sup> Shetler, D. & Shepard, D. (May 2018). Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage. *Journal of Health Care for the Poor and Underserved* 29 (2): 801-813. Available at: <https://muse.jhu.edu/article/694367/summary>.

<sup>37</sup> National Health Care for the Homeless Council (June 2017). *Medical Respite Care: Financing Approaches*. Available at: <https://www.nhchc.org/wp-content/uploads/2017/07/policy-brief-respite-financing.pdf>.

<sup>38</sup> NASMHPD (October 2017). Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care. Available at: [https://www.nasmhpd.org/sites/default/files/TAC.Paper\\_.1Beyond\\_Beds.pdf](https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf).

needed.<sup>39, 40, 41</sup> Having information such as housing status can also be important in areas that are implementing (or considering) value-based payment methodologies where providers who treat patients with higher acuity factors may qualify for increased reimbursements. This approach can yield a greater number of providers willing to treat a high-need patient population, as well as bring more resources to support an intensive level of care.

10. **Increase workforce development and training.** Individuals who are homeless and have SMI are among the most challenging to treat. Patients deserve dignity and respect regardless of their clinical presentation, but providers need the training and support to be able to deliver high-quality care. Emotional exhaustion, cynicism, and lack of empathy are all signs of burnout and lead to lower quality of care, high staff turnover, and worse patient outcomes.<sup>42</sup> Provide regular training opportunities to help address burnout, help with engagement and de-escalation, and ensure appropriate caseloads. Collaborate with professional schools (medical, nursing, social work, etc.) to build higher level skills development into classroom curriculums, residencies, and practicums so that graduating health care professionals are better prepared to treat very challenging patient populations.

## Housing

Housing is the basis of residential stability, and serves as a platform to receive health care and recovery support services. The Interdepartmental Serious Mental Illness Coordinating Committee included housing in its recent report outlining actions that agencies can take to better coordinate mental health services for adults with SMI and children with SED. In the chapter focusing on treatment and recovery, the report stipulates:

***Make housing more readily available for people with SMI and SED.***  
*Housing is an essential prerequisite for effective treatment and a life in recovery. Develop consistent federal policies to support and require adequate housing as a standard part of recovery-oriented treatment for people with SMI and SED, with special emphasis on providing housing, including supported housing, to those exiting jails and prisons, youth who have been estranged from their families, those who experience homelessness, and those aging out of foster care. Have the Department of*

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<sup>39</sup> National Health Care for the Homeless Council (October 2016). *Ask and Code: Documenting Homelessness Throughout the Health Care System*. Available at: <https://www.nhchc.org/wp-content/uploads/2016/10/ask-code-policy-brief-final.pdf>.

<sup>40</sup> Vickery, K., et al. (June 2018). Identifying Homeless Medicaid Enrollees Using Enrollment Addresses. *Health Services Research* 53 (3): 1992-2004. Available at: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/1475-6773.12738>.

<sup>41</sup> Zech, J., et al. (May 2015). Identifying Homelessness using Health Information Exchange Data. *Journal of the American Medical Informatics Association* 22 (3): 682-7. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25670759>.

<sup>42</sup> Morse, G., et al. (September 2012). Burnout in Mental Health Services: A Review of the Problem and Its Remediation. *Adm Policy Ment Health* 39 (5): 341-352. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3156844/>.

*Housing and Urban Development issue guidance for state and local housing authorities on establishing tenant selection preferences for non-elderly people with SMI, consistent with federal fair housing requirements. Target resources such as Housing Choice Vouchers for individuals with SMI experiencing chronic homelessness or transitioning from settings such as correctional facilities, nursing homes, or board and care homes.*<sup>43</sup>

The housing action items below are intended to align with this recommendation, presenting numerous options to advance housing for those with SMI. While significant housing resources have traditionally come from HUD, SMHAs should not wait for federal action, instead taking more direct steps to increase housing.

1. **Promote supportive housing programs.** Combining health care and support services with non-time-limited housing is an evidence-based practice effective in improving health, reducing total costs of care, and decreasing the use of inpatient psychiatric hospitals.<sup>44, 45</sup> Currently, 75 percent of adults in supportive housing have a mental health condition, a substance use disorder, or a dual diagnosis.<sup>46</sup> SMHAs should be working to integrate supportive housing into community-based services, encouraging local agencies and provider organizations to partner with housing providers/developers to match high-need individuals with housing. Contractual requirements can stipulate how this should happen, the performance measures to collect and report, and the evaluation to conduct in order to ensure these partnerships are effective. SMHAs can work with housing authorities and local homeless continua of care to ensure protocols for prioritizing housing opportunities include those with SMI.
2. **Allocate funding for rental assistance directly to community providers.** There is a critical shortage of funding for traditional housing assistance programs such as public housing and Housing Choice/Section 8 vouchers. SMHAs may want to consider funding rental assistance directly by partnering with outpatient providers who are already coordinating care and providing case management to those who are homeless. Patients who are frequent users of inpatient psychiatric hospitalizations or who have recently been approved for disability because of a mental health disorder (or other criteria established) could serve as candidates for direct housing assistance. Having funds to pay for housing will also be of great help to community providers who often

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<sup>43</sup> SAMHSA (December 13, 2017). Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Recommendation 3.6, page 86. Available at: <https://store.samhsa.gov/shin/content/PEP17-ISMICC-RTC/PEP17-ISMICC-RTC.pdf>.

<sup>44</sup> A wealth of studies have been conducted on supportive housing. Numerous literature reviews on various aspects of study results are available at <http://www.csh.org/supportive-housing-facts/evidence/>.

<sup>45</sup> Kerman, N, *et al.* (March 2018). The Effects of Housing Stability on Service Use Among Homeless Adults with Mental Illness in a Randomized Controlled Trial of Housing First. *BMC Health Serv Res* 18 (1): 190. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29558927>

<sup>46</sup> HUD (December 2017). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress, Part 2: Estimates of Homelessness in the United States*. Available at: <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf>.

do not have adequate access to housing and subsequently struggle to provide case management and health care to clients who are very unstable because they are living on the street. Evaluating such approaches may show these are cost-effective investments that yield improved health outcomes.

3. **Consider unused state property for housing opportunities.** HUD creates a list of unneeded federal properties to determine if they are suitable for homeless program use, and publishes suitable properties online on a weekly basis.<sup>47</sup> Before these properties may be sold, federal law gives the right of first refusal to non-profit groups, state agencies, and local governments to obtain the properties to assist persons experiencing homelessness. Through this provision of law, empty warehouses, office buildings, and vacant land can be acquired at very low cost and turned into housing opportunities for people who are homeless.<sup>48</sup>
4. **Partner with state housing authorities to develop a housing plan.** States can determine the number of affordable housing units needed across the state, and map which jurisdictions have the highest need. The analysis should specify a number of subpopulations, including those with SMI, who are at increased risk of homelessness and the analysis should indicate how many units are needed for each group. Of particular importance is for the plan to identify the number of units needed by income group, ensuring that the lowest income levels (SSI level and below) are specifically highlighted. A comprehensive plan will acknowledge the wide range of housing types needed to meet the needs of a diverse population. SMHAs can take an active leadership role in developing a housing plan that emphasizes the needs of people with SMI, and also can provide critical data for evaluation and analysis.
5. **Advocate for additional housing development at the federal, state, and local level.** SMHAs have a strong interest in more affordable housing development, especially for those at the lowest income levels. Use state data to illustrate how greater investments in housing will yield better, more cost-effective outcomes. Meet with housing authorities to advance funding for housing, as well as to address regulatory or policy barriers that may inhibit housing (e.g., violations of the Americans with Disabilities Act, zoning restrictions, etc.). As federal HUD funding is determined each year, illustrating the value of housing may help increase appropriations.

## Income

Homelessness is the result of extreme poverty. Establishing some form of income can be a critical factor in ensuring rent and utilities are paid. Even small increases in income can

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<sup>47</sup> HUD. *Title V - Federal Surplus Property for Use to Assist the Homeless*. Available at: <https://www.hudexchange.info/programs/title-v/>. There is a 30-day holding period from the date the property is posted on the HUD Exchange to allow homeless service providers the opportunity to contact the U.S. Department of Health and Human Services (HHS) to express interest in suitable and available properties listed.

<sup>48</sup> National Law Center on Homelessness and Poverty (2017). *Public Property/Public Need: A toolkit for using vacant federal property to end homelessness*. Available at: <https://www.nlchp.org/documents/Public-Property-Public-Need>.

allow an individual to pay for a few nights in a motel or find a more stable housing option. Below are four possibilities that could increase income for those who are homeless with SMI:

1. **Support SOAR programs.** The SSI/SSDI Outreach, Access and Recovery (SOAR) program increases access to Social Security disability benefits for people with behavioral health issues experiencing (or at risk of) homelessness, often providing benefits much more quickly than traditional programs. SAMHSA has facilitated many resources to support SOAR programs, and now all 50 states participate in some way.<sup>49</sup> State mental health authorities can help fund staff (either directly or indirectly), incentivize SOAR participation in service contracts, and support SOAR programs by providing training and recognizing successes at the local level. In states that have not yet expanded Medicaid to adults without disabilities, qualifying for disability benefits through SSI may be the only option for obtaining health insurance. In these cases, individuals gain both an income and access to comprehensive health care, each helpful for stability. States can promote housing stability for this population by automatically qualifying individuals receiving SSI for housing assistance programs.
2. **Support representative payee services for the most vulnerable.** For those who have Social Security or SSI income but have difficulty managing finances, a representative payee can help allocate funding toward housing and other human needs in order to mitigate homelessness.<sup>50</sup> Family or friends can serve as a “rep payee,” but for those who do not have trusted support systems, a community service provider can serve in this role. However, the role of rep payee can be a time-consuming and difficult task, particularly for providers who may already have full caseloads and little time to negotiate money management with high-need clients. SMHAs can encourage providers to take on this role by allocating additional grant funding to compensate for the time needed to appropriately serve in the role.
3. **Promote supported employment programs that work with homeless populations.** Many people with SMI who are experiencing homelessness want to work, but have numerous barriers to employment. For those for whom employment is feasible, supported employment programs are an evidence-based practice that can help link individuals to an income, which in turn can help establish a path out of homelessness.<sup>51</sup> While employment should not be a requirement for accessing health care, mental health authorities can integrate employment services with mental health services by distributing grants to enhance community capacity for these programs, and by establishing performance measures and benchmarks for achieving successes.<sup>52</sup>

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<sup>49</sup> SAMHSA provides trainings, toolkits, resources, and technical assistance on their website: *SSI/SSDI Outreach, Access, and Recovery (SOAR)*. Available at: <https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/soar>.

<sup>50</sup> The Social Security Administration provides numerous resources for representative payees on their website: *Representative Payee*. Available at: <https://www.ssa.gov/payee/index.htm>.

<sup>51</sup> SAMHSA (February 2010), *Supported Employment Evidence-Based Practices (EBP) Kit*. Available at: <https://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365>.

<sup>52</sup> The ICA Group (2012). *Employment Outcomes and Performance Benchmarks for Programs Serving Homeless Job Seekers: Report to the Butler Family Fund*. Available at: <http://ica-group.org/wp>

States can also improve these programs by ensuring connection to meaningful, dignified work that builds upon client strengths and skills.

- 4. Advocate for higher SSI benefit levels.** The current national monthly SSI benefit is \$750 for an individual, which is far below the federal minimum wage of \$7.25 per hour and represents only a fraction of the income needed to afford rent. The fair market rent for a one-bedroom apartment is greater than \$750 in 220 housing markets across 40 states and the District of Columbia, which leaves no additional resources for other basic needs (like food).<sup>53</sup> Because of the low benefit level, individuals with SMI have great difficulty finding affordable housing and are at high risk of homelessness. Raising the federal benefit level (or creating a state supplement) for those who have been deemed too disabled to work would lift more individuals with disabilities out of poverty, and allow more individuals to attain housing.

## Support Services

Housing absent the appropriate support services will not facilitate recovery for those with SMI, and support services in the absence of housing will not end homelessness. Ensuring these work together can maximize the effectiveness of both interventions.

- 1. Support funding and programs for street outreach and intensive case management.** The National Institutes of Mental Health estimate that 35 percent of individuals with SMI are not receiving treatment for their mental illness (approximately 3.7 million people).<sup>54</sup> A subset of this population is likely already homeless, but even more are at significant risk of homelessness (where early intervention and prevention is vital). SMHAs should ensure local communities have adequate resources for trained personnel who operate outside traditional clinical environments. This includes street outreach to areas where people who are homeless congregate (encampments, public libraries, soup kitchens, shelters, etc.) and the ability to engage in intensive case management and care coordination. While not all programs need to operate at the clinical intensity level of an ACT team, community providers need staff who can locate individuals who have disengaged from treatment, engage them back into care, and help with care coordination. These activities can include transportation assistance to appointments, help filling out benefit applications, medication management, or other tasks that help support clients with SMI. When establishing goals and performance measures for case management, it is critical to ensure that caseloads are appropriate for the level of acuity being addressed.<sup>55</sup>

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[content/uploads/2015/01/Homeless-Job-Seekers-Employment-Outcomes-Benchmarks-Full-Report1.pdf](https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154790).

<sup>53</sup> National Low Income Housing Coalition (2018). *Out of Reach: the High Cost of Housing*. Available at: <http://nlihc.org/oor>.

<sup>54</sup> National Institute of Mental Health (2016). *Statistics on Mental Illness*. Available at: [https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part\\_154790](https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154790)

<sup>55</sup> National Health Care for the Homeless Council (April 2016). *Vital Role of Case Management for Individuals Experiencing homelessness*. [Author: Claudia Davidson, Research Associate]. Available at: <https://www.nhchc.org/wp-content/uploads/2016/05/in-focus-case-management-hrsa-approved-final-version.pdf>.

2. **Develop programs that promote peer specialists, community health workers, and other supportive roles.** States should have formal programs that recognize and train a wide range of support staff, and integrate that staff into community models of care as part of their evidence-based practices.<sup>56</sup> SMHAs should identify which services are reimbursable through Medicaid, advocate for adding these services to the State Medicaid Plan, and supplement funding for other services with grant funding. Peer specialist and other support roles are particularly effective when filled with people who have the lived experience of those they serve—whether they were previously homeless, are someone in recovery or who has an SMI (or both).<sup>57</sup> Building career ladders with these types of positions can also help bolster further employment opportunities as skills and experience develop (this aligns with the employment recommendations above).

## Criminal Justice Involvement

People with SMI experiencing homelessness have frequent contact with the criminal justice system.<sup>58</sup> Incarceration disrupts community-based treatment and makes it more difficult to re-establish stability after discharge. All too often, community providers are advised to “have him/her arrested” in order to activate appropriate crisis response and longer-term services for individuals in acute distress. This is not only an inefficient use of police and court systems, but it is also an unjust response to vulnerable people in need of appropriate health care services.

1. **Increase diversion activities.** Mental health courts and other initiatives that can identify individuals with mental health disorders and connect them to needed treatment in the community are effective alternatives to incarceration. Oversight from judges and others from the court system can help ensure follow-up care is established.<sup>59</sup>
2. **Ensure coordinated, high-quality mental health care while in detention.** Not only does incarceration disrupt treatment, but it frequently prohibits community providers from relaying important clinical information and helping to coordinate care plans and medication regimens. Changing or discontinuing medications and treatment routines can contribute to decompensation and poor clinical outcomes. Establishing protocols that allow corrections health care providers to share information with established community providers can help increase quality of care and better manage mental health conditions during detention.

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<sup>56</sup> Daniels, A. S., Tunner, T. P., Powell, I., Fricks, L., Ashenden, P., (March 2015). *Pillars of Peer Support – VI: Peer Specialist Supervision*. Available at:

[https://www.nasmhpd.org/sites/default/files/Assessment%20%231\\_Pillars%20of%20Peer%20Support.pdf](https://www.nasmhpd.org/sites/default/files/Assessment%20%231_Pillars%20of%20Peer%20Support.pdf).

<sup>57</sup> National Health Care for the Homeless Council/Clinicians' Network (Fall 2013). Speaking from Experience: The Power of Peer Specialists. *Healing Hands* 17 (3). Available at:

<https://www.nhchc.org/wp-content/uploads/2013/11/healinghandsfall2013.pdf>.

<sup>58</sup> Roy, L. (June 2014). Criminal Behavior and Victimization Among Homeless Individuals With Severe Mental Illness: A Systematic Review. *Psychiatric Services* 65 (6): 739-750. Available at:

<https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201200515>.

<sup>59</sup> U.S. Department of Justice, Bureau of Justice Assistance. *Mental Health Courts Program*. Available at: [https://www.bja.gov/ProgramDetails.aspx?Program\\_ID=68](https://www.bja.gov/ProgramDetails.aspx?Program_ID=68).

3. **Improve discharge policies.** Uncoordinated discharges contribute to a cycle of homelessness, hospitalization, and re-arrest.<sup>60</sup> There are a wide range of policies and protocols that states can enact that will help make transitions back to the community smoother and more successful, especially for those who are struggling with homelessness and SMI. Suspend (rather than terminate) Medicaid and Social Security benefits of an incarcerated recipient—and ensure these benefits are re-established just prior to release. Connect individuals transitioning back into the community to a community health care provider (ideally, the same provider treating the individual before detention) and set up an appointment as soon as possible after release (not just providing a referral form or list of “community resources”). Dispense at least 30 days of medication and needed medical supplies on discharge (not just a prescription). Ensure individuals have an official state-recognized identification card. Identify stable housing options or placement in a residential program to prevent homelessness after discharge. On a statewide basis, track and evaluate outcome data to determine where discharge policies need to be improved, and replicate initiatives that are working well.

## Children and Youth

Children and youth are among the fastest growing populations experiencing homelessness. Violence and trauma, family instability, frequent school absences, multiple relocations, and involvement with social services or juvenile justice systems are all risk factors that contribute to SED. On a single night in 2016, 57,971 families with children were counted both on the street and in the homeless services system (totaling 184,661 people—one-third of all people counted) as well as 40,799 unaccompanied youth under age 25.<sup>61</sup> Over the course of the year, 147,355 families with children were documented in the nation’s shelter systems (totaling 481,410 people).<sup>62</sup> Just over 1.2 million children were documented as experiencing homelessness in the Kindergarten through Grade 12 school system during school year 2015-2016.<sup>63</sup> Federal policies that prioritize housing assistance to the most vulnerable may inadvertently overlook the needs of youth and families who do not meet the criteria for housing assistance. While this report has largely focused recommendations targeted at adults, SMHAs can improve systems that serve youth with SED as a way of preventing poor outcomes as they grow older.

1. **Promote school-based clinics with the ability to identify and treat mental health issues early.** Schools are the ideal place to provide health care for school-age children

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<sup>60</sup> Blandford, A., and Osher, F. (November 2013). *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*. SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation

and the Council of State Governments Justice Center. Available at:

<https://csgjusticecenter.org/mental-health/publications/guidelines-for-successful-transition/>

<sup>61</sup> HUD (December 2017). *The 2017 Annual Homeless Assessment Report (AHAR) to Congress: Part 1: Point-in-Time Estimates of Homelessness*. Available at:

<https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf>.

<sup>62</sup> HUD (December 2017). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress Part 2: Estimates of Homelessness in the United States*. Available at:

<https://www.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf>.

<sup>63</sup> *Ibid.*

because these services can be integrated with an educational curriculum and are delivered in close proximity to where children are already engaged. Prevention and early intervention services are especially critical, with teachers, school administrators, and others working together with mental health providers and linking to broader community resources.<sup>64</sup>

2. **Increase capacity in the treatment system to serve low-income children and youth.** Among children experiencing poverty who are in need of mental health care, less than 15 percent receive services, and even fewer complete treatment. Strategies to improve access to care include training and education for a wide range of providers, improving clinical infrastructure that addresses barriers to care, and implementing multi-disciplinary teams that can provide comprehensive care.<sup>65</sup>
3. **Link support services to the entire family.** Broader supports are often needed to help low-income children and youth struggling with SED. Connecting families to housing assistance and other benefits, providing family therapy, and coordinating care plans with a broader focus on family stability can help the entire household. For unaccompanied youth who may be separated from their family for numerous reasons, SMHAs should ensure policies are in place to allow youth to consent to their own care.

## Conclusion

There are many ways SMHAs can make systemic improvements to prevent and end homelessness among those with SMI, as illustrated by the breadth of recommendations in this report. Increasing access to health care, housing, income, and support services can be achieved through funding and policy changes, program improvements, partnerships with other state and local agencies, and/or state-level advocacy. Specific attention should be paid to those who are involved with the criminal justice system, as well as children and youth. Elements of these recommendations should be built into contracts, performance measures, and data analysis, so that capacity can be built for these improvements across systems. Strong leadership and dedicated vision on these issues is vital to ensuring the most vulnerable in our communities receive the care they need.

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<sup>64</sup> School-based Health Alliance. *Mental Health*. Available at: <http://www.sbh4all.org/school-health-care/health-and-learning/mental-health/>.

<sup>65</sup> Hodgkinson, S., et al (January 2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics* 139 (1). Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192088/>.

## Appendix

### Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness

#### RECOMMENDATIONS

##### Health

- Expand Medicaid and ensure assertive efforts to conduct outreach, enrollment and engagement to this population.
- Promote state Medicaid waivers to fund housing supports/supportive services.
- Support integrated care models.
- Promote harm reduction and trauma-informed approaches to care.
- Implement evidence-based practices like ACT and CTI models of care.
- Improve and standardize institutional discharge protocols.
- Promote medical respite care programs as an option for discharge.
- Increase community capacity along a continuum of care.
- Ask about housing status and code for homelessness in inpatient and community settings.
- Increase workforce development and training.

##### Housing

- Promote supportive housing programs.
- Allocate funding for rental assistance directly to community providers.
- Consider unused state property for housing opportunities.
- Partner with state housing authorities to develop a housing plan.
- Advocate for additional housing development at the federal, state, and local level.

##### Income

- Support SOAR programs.
- Support representative payee services for the most vulnerable.
- Promote supported employment programs that work with homeless populations.
- Advocate for higher SSI benefit levels.

##### Support Services

- Support funding and programs for street outreach and intensive case management.
- Develop programs that promote peer specialists, community health workers, and other supportive roles.

##### Criminal Justice Involvement

- Increase diversion activities.
- Ensure coordinated, high-quality mental health care while in detention.
- Improve discharge policies.

##### Children and Youth

- Promote school-based clinics with the ability to identify and treat mental health issues early.
- Increase capacity in the treatment system to serve children and youth.
- Link support services to the entire family.