

## MEMORANDUM

TO: Regional Steering Committee on Homelessness and Housing

FROM: HomeBase

RE: A Background Briefing on Emerging Trends in Mental Health Policy: The National Transformation of America's Mental Health Service Delivery System

DATE: July 29, 2005

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### RSC's Prior Work on This Topic

The RSC continuously has demonstrated its commitment to developing and fostering effective methods of serving homeless people living with mental illness. Members of the RSC played a pivotal role in the passage of the PATH program (Projects for Assistance in Transition from Homelessness) in the early 1990s, thereby securing increased access to mainstream and targeted community-based services for homeless people with serious mental illness. Numerous RSC communities established programs using PATH funds, and subsequently expanded those programs with outreach planning under federal programs such as SAMHSA (Substance Abuse and Mental Health Services Administration) and the SafeHaven Program. Furthermore, for nearly two decades the RSC has dedicated efforts to creating new and expanding existing comprehensive services and funding sources for homeless people with mental illness. Today, we will take an in-depth look at the national transformation taking place in the mental health service delivery system, and briefly examine California's recent actions in response to the transformation.<sup>1</sup>

### Background

In February 2001, the President announced the New Freedom Initiative to support augmented access to employment and educational opportunities for individuals with disabilities. The Initiative also encourages fuller access to community life for persons with disabilities. As part of the New Freedom Initiative, President Bush created the New Freedom Commission on Mental Health. President Bush instructed the Commission to study the drawbacks and pervasive problems in the mental health service delivery system, including public and private sector providers, and to recommend improvements "to enable adults with serious mental illness<sup>2</sup> and children with serious emotional disturbances<sup>3</sup> to live, work, learn, and participate fully in their communities."<sup>4</sup>

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<sup>1</sup> See "Comprehensive Services for Homeless People with Mental Illnesses," 07/27/01 RSC Memorandum; "Best Practices in Substance Abuse/Mental Health and Homelessness," 11/21/03 RSC Memorandum.

<sup>2</sup> As used in the Commission's Final Report, adults with a serious mental illness are people age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual for Mental Disorders-III-R*, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

<sup>3</sup> As used in the Commission's Final Report, a serious emotional disturbance is defined as a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the *Diagnostic and Statistical*

Upon concluding a year-long study, complete with extensive research and comprehensive testimonials, the Commission released the findings in its Final Report, *Achieving the Promise: Transforming Mental Health Care in America*, in July 2003. As the Final Report notes, the study surfaced three main obstacles preventing Americans with mental illness from getting the quality care necessary to achieve the New Freedom Initiative's goal of full participation in community life:<sup>5</sup>

- (1) Public stigma surrounding mental illness;
- (2) Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance; and
- (3) A fragmented mental health service delivery system that frequently allows people with mental illness and children with serious emotional disturbances to fall through the cracks.

To elucidate the third obstacle, the Commission found America's mental health service delivery system to be disjointed, disorganized, and insufficient, and therefore adverse to individual opportunities for recovery and fuller participation in community life. However, the Commission declared that recovery from even severe mental illness is a realistic possibility, provided that certain changes in the mental health service delivery system took place.

The Commission's Final Report recommended a fundamental transformation of America's approach to mental health care, with particular emphasis on mental health services actively facilitating recovery versus merely managing symptoms. Accordingly, the Commission proposed a replacement of unnecessary institutional care with efficient, dependable, convenient, and seamless community services tailored to the specific needs of individual mental health care consumers.<sup>6</sup> Further, the Commission strongly suggested integrating programs that are fragmented across levels of government and among numerous agencies in an effort to create a more uniform system of mental health care.<sup>7</sup>

As explained in the Commission's Final Report, successful transformation of the mental health service delivery system relies upon two tenets: (1) Services and treatments must be consumer and family centered versus bureaucratically centered; and (2) Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience as opposed to simply managing symptoms.<sup>8</sup> In view of that, the Commission identified certain requirements for a system transformation:<sup>9</sup>

- (1) Incentives must change to encourage ongoing improvement in agencies that provide care;

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*Manual for Mental Disorders-III-R* that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age.

<sup>4</sup> Presidential Documents, Executive Order 13263 of April 29, 2002. Federal Register, Vol. 67, No. 86. 05/03/2002

<sup>5</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. p. 1.

<sup>6</sup> *Ibid.* at 3-4.

<sup>7</sup> *Ibid.*

<sup>8</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. p. 5.

<sup>9</sup> *Ibid.*

- (2) New, pertinent research findings must be methodically conveyed to front-line providers so that they can be applied to practice rapidly;
- (3) Cutting-edge strategies must inform researchers of the unanswered questions of consumers, families, and providers;
- (4) Research and treatment approaches must be sensitive to the diversity of Americans;
- (5) Treatment and services that are based on proven effectiveness and consumer preference must be the basis for reimbursements; and
- (6) The Nation must invest in the infrastructure to support emerging technologies and integrate them into the system of care (thereby enabling consumers to collaborate with service providers, assume an active role in managing their illnesses, and move quickly toward recovery).

With these findings and recommendations as a backdrop, the Commission announced their vision statement as: “We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.” The Commission’s six fundamental goals for the transformation process, individually outlined below, align with this vision statement, as each goal prioritizes recovery and community living for everyone within a new mental health care delivery system that provides consumers and family members with access to timely and accurate information that promotes learning, self-monitoring, and accountability.<sup>10</sup>

Goal One: *Americans Understand that Mental Health is Essential to Overall Health*<sup>11</sup>

- In a transformed mental health system, the Nation will take steps to ensure that individual citizens’ mental well-being is maintained through learning, self-monitoring, and accountability. Informed consumers of mental health services will learn to identify symptoms and will seek care immediately. Marginalized groups, such as older adults, children/adolescents, ethnic minorities, and uninsured or low-income consumers, who are treated in public health care facilities will receive care for mental illness.
- Stigma surrounding mental illnesses and seeking care for mental illnesses will be reduced and/or eliminated as an obstacle through national education initiatives about myths versus truths regarding mental illness. These educational campaigns will be targeted at comprehensively diverse audiences.
- The transformed system will provide collaborative care to bridge the gap between mental health care and general medical care systems, thereby improving overall services for individuals with mental illness. Effective mental health treatments will be more readily available for more common mental illnesses and will be better used in primary care settings. Primary care providers will have the requisite time, training, and resources to treat mental health problems.
- Mental health problems will be addressed with the same urgency as physical health problems.

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<sup>10</sup> *Ibid.* at 4.

<sup>11</sup> *Ibid.* at 7.

Goal Two: *Mental Health Care is Consumer and Family Driven*<sup>12</sup>

- In a transformed mental health system, a diagnosis of a serious mental illness will trigger a well-planned, detailed, coordinated array of services and treatments defined in a single, individually tailored health management plan of care. The plan will incorporate treatment, supports, and other assistance to enable consumers to better integrate into their communities. This plan of care will be at the core of the consumer-centered, recovery-oriented mental health system.
- Consumers and families will actively partake in designing and developing the health management program of care in which they are involved. The funding for mental health services will be under the management of consumers and families, thereby enhancing their choices and giving people a vested economic interest in using resources wisely to obtain and sustain recovery.
- The burden of coordinating care will rest on the system not the families or consumers.
- States will develop a comprehensive mental health plan to outline responsibility for coordinating and integrating programs. The State plan will create new partnerships among the Federal, State, and local governments. States will have the flexibility to combine Federal, State, and local resources in creative and more efficient ways, circumventing the bureaucratic boundaries between mental health care, employment, supports, adequate and affordable housing, and the criminal justice system.

Goal Three: *Disparities in Mental Health Services are Eliminated*<sup>13</sup>

- Under a transformed mental health system, mental health care will be highly personal and culturally competent, respecting and responding to individual differences and backgrounds. The workforce will include members of ethnic, cultural, and linguistic minorities who are trained and employed as mental health service providers.
- People who live in rural and remote geographic areas will have access to mental health professionals, advanced treatments, and other such resources. Service providers in rural areas will be available to help create a consumer-centered system.
- Mental health education and training will be provided to general health care providers, emergency room staff, and first responders, such as law enforcement personnel and emergency medical technicians, in order to overcome the uneven geographic distribution of psychiatrists, psychologists, and psychiatric social workers.

Goal Four: *Early Mental Health Screening, Assessment, and Referral to Services are Common Practice*<sup>14</sup>

- Under a transformed mental health system, early detection will be an expected and typical occurrence. Quality screening and early intervention will occur in both readily accessible and low-stigma settings.

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<sup>12</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* p. 8-9.

<sup>13</sup> *Ibid.* at 10.

<sup>14</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* p. 11.

- At the first sign of difficulties, preventative interventions will be started to keep problems from escalating. Thus, early detection will be linked automatically to assessment, treatment, and supports.
- Service providers will also routinely screen for co-occurring mental illnesses and substance use disorders.

Goal Five: *Excellent Mental Health Care is Delivered and Research is Accelerated*<sup>15</sup>

- A transformed mental health system will accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- Improve and expand the workforce providing evidence-based mental health services and supports.
- Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

The Commission selected Family Critical Time Intervention in Westchester County, NY as a model program in reaching the fifth goal because of its work with homeless families.

<b>Critical Time Intervention with Homeless Families<sup>16</sup></b>	
<b>Program</b>	Family Critical Time Intervention Model (FCTI). The program is jointly funded by NIMH and the Center for Mental Health Services/Center for Substance Abuse Treatment Homeless Families Program.
<b>Goal</b>	To apply effective, time-limited, and intensive intervention strategies to provide mental health and substance abuse treatment, trauma recovery, housing, support and family preservation services to homeless mothers with mental illnesses and substance use disorders who are caring for their dependent children.
<b>Features</b>	The Critical Time Intervention model (CTI) was developed in New York City as a program to increase housing stability for persons with severe mental illnesses and long-term histories of homelessness. Its principle components are rapid placement in transitional housing, fidelity to a Critical Time Intervention CTI model for families (i.e., provision of an intensive, 9-month case management intervention, with mental health and substance use treatments), a focused team approach to service delivery, with the aim of reducing homelessness, and brokering and monitoring the appropriate support arrangements to ensure continuity of care.
<b>Outcomes</b>	Data indicate that mothers in this group tend to be poorly

<sup>15</sup> *Ibid.* at 12-13.

<sup>16</sup> Reproduced from New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* p. 73.

	educated, have meager work histories, and face multiple medical, mental health, and substance use problems. Their children’s lives have lacked stability in terms of housing, education, and periods of separation from their mothers. African-American and Latina women were over-represented in study sites in proportions greater than the national average for homeless populations.
<b>Biggest Challenge</b>	The CTI model for families challenges the assumption that homeless mothers with children who have mental health or substance use disorders require confinement and extended stays in congregate shelter living before they can independently manage their own households. This can be addressed by acquiring buy-in from collaborators and involved agencies, acquiring needed housing resources, evaluating the project with respect to model fidelity, and attaining ongoing involvement of practice innovators to establish thoughtful compromises within local contexts.
<b>How Other Organizations Can Adopt</b>	The program is transferable to any community that can align resources needed for housing and conduct relevant training for providers in a CTI model for families.
<b>Sites</b>	Westchester County, NY
<b>For Additional Information</b>	See <a href="http://www.rfmh.org/csipmh/">http://www.rfmh.org/csipmh/</a>

Goal Six: *Technology is Used to Access Mental Health Care and Information*

- A transformed mental health service delivery system will use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- Will develop and implement integrated electronic health records and personal health information systems.

Relevance to Homelessness and Housing

Much of what we have looked at so far is very relevant to homelessness and housing. The Commission also recognized this connection, and explained that affordable housing alone is insufficient, for people with serious mental illnesses frequently require flexible, mobile, individualized support services to stabilize them in their housing. As a matter of fact, the Commission’s Final Report identified the shortage of decent, safe, affordable, and integrated housing that meets the needs of people with mental illness as one of the more significant hurdles to their full participation in community life.<sup>17</sup> The shortage of affordable housing with accompanying stabilization services causes many people with mental illness to rotate among institutions, shelters, jails, and the streets.<sup>18</sup>

<sup>17</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* p. 30.

<sup>18</sup> *Ibid.*

The Final Report surfaced a few reasons for the shortage of affordable, supportive housing for people with mental illness. First, very few mental health systems use resources to ensure that people with mental illness have adequate housing with accompanying support services. The Commission attributed this downfall to the lack of mental health staff members who are knowledgeable about public housing programs and issues. Moreover, the Commission pointed out the lack of partnerships and collaborations between public housing authorities and mental health systems. Finally, the Commission's Final Report noted that highly categorical Federal funding streams ("silos") for mental health, housing, substance abuse, and other social welfare programs contribute to the fragmentation and failure to broadly address the many needs of people with mental illness.<sup>19</sup>

The Commission recommended a few different approaches for making affordable housing more accessible to people with serious mental illness.

To begin, in partnership with the Interagency Council on Homelessness, the Department of Housing and Urban Development should develop and implement a comprehensive plan designed to facilitate access to 150,000 units of permanent supportive housing for consumers and families who are chronically homeless. During the next ten years, this initiative should develop cost-effective approaches, strategies, technical assistance activities, and actions to be implemented at the Federal, State, and local levels. Expanding and ensuring a continuum of housing services would represent positive elements to include in such a plan. ...individuals who have a history of serious mental illnesses [should] be given fair access to these 150,000 units of supportive housing.<sup>20</sup>

The Commission further recommended that States and communities should commit to the goal of ending chronic homelessness and develop the means to achieve it.<sup>21</sup> As part of this commitment, the Commission strongly urged HUD to collaborate with HHS, VA, and other similar agencies to supply national leadership and guidance to the States and local communities to improve housing options for people with mental illness.<sup>22</sup> "HUD should aggressively pursue administrative, regulatory, and statutory changes to existing mainstream housing programs; e.g., Section 811 Supportive Housing. Input from stakeholders to identify existing barriers to accessing housing should be an integral part of HUD's considerations."<sup>23</sup>

Having recognized that housing and homelessness are major concerns that need to be addressed concurrently with the transformation in order for the New Freedom Initiative to achieve success, the New Freedom Commission on Mental Health appointed a Subcommittee on Housing and Homelessness, along with fourteen other subcommittees.<sup>24</sup> Based on research and advice from national experts, the Subcommittee on Housing and Homelessness produced a Background Paper

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<sup>19</sup> Entire paragraph: New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* p. 31.

<sup>20</sup> Entire paragraph: New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* p. 43

<sup>21</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* p. 43.

<sup>22</sup> *Ibid.*

<sup>23</sup> *Ibid.*

<sup>24</sup> Some of the other Subcommittees created were on topics such as: Rural Issues; Acute Care; Evidence-Based Practices; and Criminal Justice.

in June 2004. The Subcommittee's Background Paper states that in order for States and local communities to help people with mental illness who are either homeless or at risk of becoming homeless, mental health systems must call on the leadership, commitment, resources, and efforts of all stakeholders in both the mental health and affordable housing systems.<sup>25</sup>

According to the Subcommittee, addressing the housing and homelessness problems that confront people with mental illness requires examining six key issues, each of which will be briefed in turn:

- *Housing Affordability*<sup>26</sup>  
The combination of a decline in the number of affordable housing units and the fact that frequently adults with severe mental illness rely on minimal Social Security Income (SSI) benefits leaves many with insurmountable obstacles.
- *Correlations Between Mental Illnesses and Homelessness*<sup>27</sup>  
The effects of serious mental illness frequently increase one's vulnerability to homelessness. Without sufficient services and support systems, persons with mental illnesses can exhibit behaviors and symptoms that threaten housing stability, which could ultimately lead to eviction. According to the Subcommittee, fragmentation, a lack of resources, and the continuation of traditional models of service delivery have all contributed to the difficulties that mental health systems have meeting the multiple needs of mental health consumers who are homeless.
- *Increased Housing Demand from the Olmstead Decision*<sup>28</sup>  
The 1999 US Supreme Court Case Olmstead v. LC suggested clearly that State discharge policies that result directly in homelessness could violate the Americans with Disabilities Act. The suit involved two women who, despite being deemed by their treatment team to be ready to live in the community, continued to be confined to a Georgia State psychiatric hospital. The High Court's broad decision, which held that Georgia could be violating Title II of the Americans with Disabilities Act if it provided care to persons with disabilities in a forced institutional setting when they could be appropriately served in a community-based setting, has caused mental health authorities to face a greater demand for community-based housing and support services from people living in institutions, overly restrictive board and care homes, nursing homes, homeless shelters, and other such settings.
- *Stigma, Discrimination, and NIMBY (Not In My Backyard) Attitudes*<sup>29</sup>  
Despite the intended protection of laws such as the Fair Housing Amendments Act of 1988 and HUD regulations enforcing Section 504 of the Rehabilitation Act of 1973, all of which are supposed to combat housing discrimination, persons with disabilities continue to face housing discrimination. According to the Subcommittee, HUD's fair-housing

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<sup>25</sup> New Freedom Commission on Mental Health, *Subcommittee on Housing and Homelessness: Background Paper*. DHHS Pub. No. SMA-04-3884. Rockville, MD: 2004. p. 2.

<sup>26</sup> *Ibid.* at p 3-4.

<sup>27</sup> *Ibid.*

<sup>28</sup> New Freedom Commission on Mental Health, *Subcommittee on Housing and Homelessness: Background Paper*. p. 4-5.

<sup>29</sup> *Ibid.*

enforcement efforts dwindled in the 1990s. Moreover, while there are available, HUD-produced guidelines and resources to promote enforcement of Section 504, this information has not been widely distributed to people or entities affected by the law.

- *Response from the Affordable Housing System*<sup>30</sup>

As you know, HUD administers most of the nation's housing programs and policies. Very few States dedicate their own funding for extremely low-income people. However, during the 1990s, the Federal government delegated decision-making for the majority of housing programs to State and local housing officials, State Housing Finance Agencies, and Public Housing Agencies who may not prioritize the needs of low-income people with mental illness. While this is not the case for all States and cities, as some have created policies to assist people with the most severe disabilities, others need assistance in developing relevant and responsive policies. Moreover, government housing programs are frequently complex, difficult to navigate, difficult to access, and incredibly competitive. Disappointingly, State and local mental health agencies sometimes find it challenging to establish effective partnerships with housing agencies.

- *Response from the Mental Health System*<sup>31</sup>

State and local mental health systems do not always prioritize supportive housing for consumers or general needs of their homeless consumers. "Conventional categorical funding streams, bureaucratic program requirements, administrative approaches to resource allocation and management, and even staff skills are often not geared toward rigorously supporting consumers in normal housing." As the Subcommittee points out, mental health care coverage gaps present a number of critical concerns.

- First, mainstream payers who cover mental health services usually prefer traditional office-based care. This approach fails to provide the flexibility and mobility necessary to sustain consumers in their housing.
- Second, traditional case managers must deal with larger caseloads, leaving them less able to provide the more intensive support frequently required by persons with serious mental illness.
- Third, even though Medicaid law permits States to cover a full plethora of comprehensive, community-based services, many States have not employed options such as targeted case management and rehabilitation as housing supports.
- Fourth, categorical (silo), uncoordinated, inflexible funding streams make it difficult to serve the needs of people who are both homeless and seriously mentally ill.
- Fifth, the mental health system in practice has duplicate support programs—one for consumers receiving mainstream mental health services and another for consumers who are homeless. As consumers with mental illness become chronically homeless, the mainstream mental health service system does not have the readiness, flexibility, or desire to remain involved. Moreover, if consumers who are homeless actually manage to secure permanent housing, mainstream staff are often unprepared to deliver services that are necessary for them to maintain stable housing.

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<sup>30</sup> *Ibid.* at 5-6.

<sup>31</sup> *Ibid.* at 6-7.

- ♣ Sixth, people who are homeless and mentally ill are typically eligible for an array of mainstream health, social services, and income-support programs that are available for all low-income people. However, barriers such as the lack of a permanent address frequently prevent enrollment. Partially this is because the adult mental health system, unlike certain other health care providers, does not have the State authority to presumptively enroll individuals who appear to be eligible in Medicaid.
- ♣ Seventh, consumers who are homeless can wait as long as six months or more to be enrolled in Medicaid, and meanwhile they may be unable to access permanent supportive housing and/or the services provided in permanent supportive housing.
- ♣ Finally, the mental health system has not been terribly responsive to a client-centered approach to service delivery. Many mental health systems are based on a medical model and do not view housing as their responsibility.

As the Subcommittee noted, SAMHSA's Center for Mental Health Services indicates two policies that highlight the gravity of the concerns listed above: (1) Consumers prefer a housing-focused approach that houses the individual or family immediately and involves aggressive outreach, placement in permanent housing, and the availability of appropriate supportive services; and (2) Consumers are much more responsive to accepting treatment after they have housing in place.

Issues to Consider:

With which of these concerns does your community struggle?  
Has your community devised creative solutions?

With the above six key issues serving as the foundation, the Subcommittee put forth a number of consumer housing preferences and strategies for ensuring consumer access to affordable housing and stabilization supports in its Background Paper. The Subcommittee, after reviewing extensive consumer preference studies, noted that consumers prefer to live in their own home and to live alone or with family/friends, as opposed to staff. Moreover, consumers strongly prefer outreach staff support that is available on call, and the consumer preference studies emphasized the importance of rental subsidies, telephones, employment opportunities, and transportation for community living.<sup>32</sup>

The Subcommittee also noted that many mental health systems use resources to fund residential treatment programs, to facilitate links to affordable housing programs for consumers, and to provide the services and supports necessary to maintaining the housing once it is acquired. However, mental health systems have not used their funds to leverage supportive housing options for a number of reasons, including: (1) Difficulty unbundling the mental health-funded contracts that pay for both housing and services in residential treatment programs; (2) Resistance from providers/operators of group homes or board and care facilities; (3) Long waiting lists for Federally subsidized housing; and (4) Lack of capacity to re-configure mental health system

<sup>32</sup> New Freedom Commission on Mental Health, *Subcommittee on Housing and Homelessness: Background Paper*, p. 9.

funding to better leverage government housing programs that expand the mobile and flexible supports that consumers need to live in homes of their own.<sup>33</sup>

Given this, the Subcommittee declared that, in order to ensure that consumers have access to affordable housing and supports, mental health systems need:<sup>34</sup>

- (1) More access to government housing programs and successful partnerships with housing agencies at the State and local levels;
- (2) Stronger housing expertise within the mental health system;
- (3) Mental health system investment to leverage affordable housing resources;
- (4) Access to new permanent supportive housing (including new construction, acquisition, rehabilitation, leasing, and rental assistance) to address the needs of people with mental illnesses who are chronically homeless;
- (5) Rigorous enforcement of Federal fair-housing laws and effective anti-stigma campaigns to combat housing discrimination and NIMBY attitudes;
- (6) An expansion of Assertive Community Treatment (ACT) model service teams;
- (7) The creation of infrastructure at the State level to foster collaboration;
- (8) The use of Medicaid options at the State and local levels to cover supportive housing services; and
- (9) Technical assistance to orient services funding and implement these strategies.

Included in the Background Paper are reviews of ten innovative strategies for ensuring consumers access to affordable housing and supports.<sup>35</sup>

- *Robert Wood Johnson Foundation (RWJF)/HUD Demonstration Program on Chronic Mental Illness (1986-1992)*
  - ♣ Nine-city program established local mental health authorities and required that each city create a separate nonprofit housing corporation to develop permanent housing. HUD gave the PHA in each city 125 Section 8 subsidies that were targeted to people with mental illness.
  - ♣ More than 2,500 units of permanent supported housing were created in total, which demonstrated the effectiveness of leveraging housing resources for people with mental illnesses through the affordable housing delivery system.
- *Center for Mental Health Services Access to Community Care and Effective Services and Supports (ACCESS) Demonstration Program (1993-1998)*
  - ♣ Funded by SAMHSA's Center for Mental Health Services
  - ♣ Program was designed to test the hypothesis that integrated systems (spanning several domains) will improve functioning, quality of life, and housing outcomes for people with serious mental illnesses who are also homeless.

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<sup>33</sup> *Ibid.* at 9-10.

<sup>34</sup> *Ibid.* at 10.

<sup>35</sup> The following list contains some direct quotes from the *Subcommittee on Housing and Homelessness: Background Paper*. p 10-13.

- ♣ Provided funds to enhance services, particularly outreach and case management, for eighteen sites in nine States. One community in each State, the experimental site, was given additional funds to support system integration activities to enable creating formal working relationships across and between systems.
- ♣ As a result of these programs and the innovative work of some State and local mental health authorities, a series of replicable best practices are available for State and local mental health authorities to use to expand affordable housing opportunities for people with mental illness.
- *Mental Health System/Housing System Partnerships Targeting HUD “Mainstream” Housing Resources*
  - ♣ State and local mental health systems are learning to use HUD “mainstream” housing programs (e.g. elderly/disabled public and assisted housing, Section 8, and the HOME program) to provide permanent housing for consumers.
  - ♣ Through the HUD-Mandated Consolidated Plan and Public Housing Authorities Plan, mental health officials are engaging State and local housing officials and PHAs to make them aware of the housing needs of consumers and to suggest solutions. Existing successful partnerships include: (1) Memoranda of Understanding implemented between mental health agencies and PHAs to expand mental health services in public housing and to set aside units for key populations groups, such as frail elders with mental illnesses (Cuyahoga and Lorain Counties in Ohio); (2) Formal and informal agreements implementing tenant selection preferences or other facilitated access to Section 8 waiting lists for consumers (Anne Arundel County, Maryland; Honolulu, Hawaii; and Baltimore, Maryland); and (3) State-level partnerships between housing and mental health system officials resulting in targeted resources for people with mental illness leaving institutions or other settings covered by the Olmstead decision (Massachusetts, Alabama, and Arkansas).
  - ♣ These partnerships also help to eliminate the stigma associated with mental illnesses by educating housing agencies about mental illnesses, consumer housing choices, and the services and supports that assist consumers with housing issues.
- *Mental Health Authority Investment in Housing*
  - ♣ Two strategies that some mental health authorities have devised to use their dollars to leverage housing funding include: (1) Creating “bridge” rent subsidies to link consumers to Section 8 vouchers; and (2) Using mental health capital funds to leverage other Federal and State financing for housing development.
  - ♣ These two strategies can leverage three to five times the funding invested and produce real systems change in local and State housing policies.
  - ♣ Bridge subsidy programs in Ohio, Oregon, Connecticut, Hawaii, and other States have resulted in access to thousands of new Section 8 subsidies for consumers.
  - ♣ Mental health system capital funding for housing (including re-investing land or funds from State psychiatric hospital disposition activities) has been combined with Federal capital financing (i.e. HOME and Community Development Block Grant capital, Low Income Housing Tax Credit equity, and Section 811 funding)

in Maryland, Oregon, Ohio, and Rhode Island to produce thousands of affordable rental apartments for consumers.

- *Expanding Permanent Supportive Housing for Consumers Who Are Chronically Homeless*
  - ♣ Permanent supportive housing is an effective solution to chronic homelessness among people with serious mental illnesses, is a very effective homelessness-prevention strategy, and is cost-effective when compared to the cost of homelessness.
  - ♣ Based on this, the Administration has announced a ten-year effort to end chronic homelessness. The Millennial Housing Commission and homeless advocacy groups have called for creating 150,000 units (via acquisition, rehabilitation, new construction, rental assistance, and leasing) of permanent supportive housing in the next ten years and are working to identify the capital, operating subsidy, and support services funding that will be needed.
  - ♣ A number of private philanthropic organizations are providing support for the public policy and capacity-building efforts needed to significantly expand the development of new permanent supportive housing.
- *Using Nonprofit Organizations to Expand Housing Opportunities for Consumers*
  - ♣ Nonprofit housing corporations can expand affordable housing for consumers by adding capacity within mental health systems to develop new permanent housing and administer both temporary “bridge” subsidies and HUD-funded permanent rent subsidies for people with mental illnesses.
  - ♣ This is accomplished by partnering with PHAs and State/local housing officials to obtain resources, or if necessary, fill the gap created when the housing system does not respond.
  - ♣ Numerous mental health agencies have created a specific type of housing nonprofit called a Community Housing Development Organization (CHDO), which helps access funding from HUD’s HOME program.
  - ♣ The housing developed is permanently made available for consumers, including those who may not qualify for other Federal housing programs (i.e. those with criminal backgrounds) through long-term use restriction agreements.
- *Funding Housing Coordination Staff in Mental Health Authorities*
  - ♣ Some State and local mental health authorities have strengthened links between the two systems by dedicating one or more full-time staff members to work exclusively on housing and homelessness issues.
  - ♣ This staff should have the expertise to facilitate partnerships with housing agencies, track housing program and policy changes, identify new sources of housing funding, and provide training and technical assistance on housing issues.
  - ♣ Housing staff in mental health authorities should have policy-making responsibility and easy access to agency leadership, as key decisions about housing resources and policies are made at a very senior level. State mental health authorities with demonstrated leadership in this practice are Connecticut,

Kentucky, Massachusetts, Ohio, and Oregon.

- *Support Services and Housing*
  - ♣ The Subcommittee reviewed evidence that suggested consumers are best served when flexible support services are available either on-site or off-site.
  - ♣ These services are defined in the CMHS Supported Housing Initiative as: (1) Designed to maximize independence; (2) Flexible and responsive to individual needs; (3) Available as and when needed; and (4) Accessible where the individual lives.
- *Intensive Multi-disciplinary Case Management Teams*
  - ♣ Homeless people with serious mental illness have complex needs that require comprehensive, multi-disciplinary services that are flexible and mobile.
  - ♣ These “wrap-around” services are available 24 hours a day, seven days a week, and are based on consumers’ changing needs rather than on a pre-set treatment plan.
  - ♣ Good example of this approach: Assertive Community Treatment (ACT), which provides a full range of comprehensive, community-based services to people with serious mental illnesses and those with co-occurring substance use living in community housing. ACT team members cover most of the necessary service domains, are not office-based, have low caseload, and are available 24/7. The teams use mobile outreach and are well adapted to working with consumers who are homeless and who need housing assistance.
- *Integrated Systems of Care*
  - ♣ Partnerships across multiple systems (i.e. housing, employment, etc.) can increase residential and clinical stability and prevent homelessness.
  - ♣ System integration requires creating a system of care that is seamless to the individuals it serves.
  - ♣ The concept of “no wrong door” is the core of this system and allows consumers to enter anywhere in the service system, be assessed, and have access to the full complement of comprehensive services and supports they need.

Moreover, the Subcommittee felt that the public/private housing partnership approach is promising as one strategy for achieving the permanent supportive housing commitment goals. The Subcommittee’s faith in this model was rooted in the way the public/private housing partnership blends private-sector capital and housing development expertise with government and nonprofit housing and support service resources.<sup>36</sup> Two public/private partnerships that the Subcommittee identified as successful are:

*Vancouver, Washington*<sup>37</sup>

Land was made available through the VA Enhanced Use Leasing program to develop a 124-unit SRO that provides supportive housing to both

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<sup>36</sup> New Freedom Commission on Mental Health, *Subcommittee on Housing and Homelessness: Background Paper*, p. 15.

<sup>37</sup> *Ibid.*

veterans and non-veterans who are homeless, including people with mental illnesses.

*Honolulu, Hawaii*<sup>38</sup>

Eighty units of permanent supportive housing were developed for people who are homeless and have mental illnesses on the former Naval Air Station at Barber's Point by U.S. Vets, a public/private partnership created to fill gaps in the continuum of care for veterans who are homeless.

The Subcommittee also discussed the importance of improved Federal interagency coordination and clearly targeted incentives within Federal programs, as it deemed these essential to attract private-sector investment and make available the housing, support services, and technical assistance resources needed in States and local communities.

The Subcommittee not only endorsed the ten-year plan to end homelessness, but also believed that this coordinated Federal interagency, comprehensive approach—when combined with appropriate incentives in Federal mainstream housing and supportive services programs administered at the State/local level—could create a framework for the Federal government's efforts to address the housing and support services needed by people with serious mental illness.<sup>39</sup> To further the Administration's policy goals of ending chronic homelessness and sustain successful efforts already underway, the Subcommittee proposed the following eight policy options:<sup>40</sup>

- Policy Option 1: *Facilitate Access to 150,000 Permanent Supportive Housing Units*
- Policy Option 2: *Facilitate Use of Mainstream Resources to Expand Housing Access*
- Policy Option 3: *Reform and Improve Section 811 Supportive Housing Program for Persons with Disabilities*
- Policy Option 4: *Complete the Mental Health Action Plan*
- Policy Option 5: *Preserve and Sustain Subsidized Housing Resources*
- Policy Option 6: *Develop and Implement an Integrated Strategy for Enforcing Disability Rights and Grantee Compliance with Fair Housing Obligations*
- Policy Option 7: *Promote Evidence-Based Practices for People with Mental Illnesses who are Homeless or at Risk of Homelessness*
- Policy Option 8: *Employ Medicaid Financing Mechanisms that Effectively Serve People with Mental Illnesses who are Homeless or at Risk of Homelessness*

### California's Role

According to the National Association of State Mental Health Directors, California's activity under the New Freedom Commission as of April 1, 2005 is as follows. "California is in the midst of reorganizing its mental health system due to the recent enactment of Proposition 63. As a result, California is attempting to incorporate \$750 million worth of new funds into its mental

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<sup>38</sup> *Ibid.* at 16.

<sup>39</sup> *Ibid.* at 15.

<sup>40</sup> Appendix B provides a comprehensive review of these goals, including action steps and strategies.

health system. An integral portion of Proposition 63 is the inclusion of the values and visions of the six New Freedom Commission goals. California also has a number of specific programs of note, including: (a) needs assessment community planning; (b) investing \$12.5 million in process to educate, involve, and engage ALL stakeholders at the local and Statewide levels; and (c) Service plans to embody all the principle of evidence of effectiveness, efficiency, client-centered, etc.’’<sup>41</sup>

### What Lies Ahead

The Public Policy Coordinator at the Mental Health Association of San Francisco provided the following update on the California Prop 63 local level process. Currently, most counties are in the process of seeking stakeholder input and developing their plans for submission to DMH and the MHSA Oversight and Accountability Committee. The OAC was formed earlier this month and is currently holding meetings. Some counties may have already completed its stakeholder process and submitted its plans to the state. San Francisco is still in the midst of its process. The funding does not come to the counties until the Oversight and Accountability Committee have approved the submitted plans.

Issue to Consider: Where is your county in the Prop 63 process?
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There are a few upcoming conferences worth noting:

1. SAMHSA’s National Training Conference Addressing Homelessness for People with Mental Illness and/or Substance Use Disorders, held every two years, is scheduled for October 26-29, 2005 in Washington, DC. This year’s conferences is titled “Planning for Change: Knowledge and Choice,” and will be incorporating many of the principles of the President’s New Freedom Initiative.
2. *Housing California’s First Annual Mental Health and Housing Conference*  
Monday, Dec. 5 - Wednesday, Dec. 7, at the Pasadena Hilton in Pasadena, CA.  
About the conference: In California, the programs established by Assembly Bill 2034 and The Mental Health Services Act (Proposition 63), create the resources for both the mental health and affordable housing community to partner and provide services in new, innovative ways. Through discussion and interactive presentations, the goal of the Mental Health and Housing Conference is to help policymakers, service providers and advocates to make connections and build alliances.  
For more details, see [http://www.housingca.org/conference/mh\\_conf.php](http://www.housingca.org/conference/mh_conf.php)
3. CA Institute for Mental Health Housing is hosting:  
Housing & Homeless Coordinators 8th Annual Meeting - *Mental Health Services Act*

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<sup>41</sup> See <http://www.nasmhpd.org/>

*(MHSA) Strategies for Housing & Employment: Seizing the Opportunity!*

Date: July 31, 2005 - August 2, 2005

Location: Embassy Suites 4130 Lake Tahoe Boulevard South Lake Tahoe, California

For more information, see: <http://www.cimh.org/>

4. SAMHSA is holding a *National Policy Academy on Co-Occurring Mental and Substance Abuse Disorders* Conference in Philadelphia, PA on September 12, 2005. See [www.samhsa.gov](http://www.samhsa.gov) for more details.
5. SAMHSA is holding a *National Policy Academy on Homeless Families* Conference in Los Angeles, CA on November 1, 2005. See [www.samhsa.gov](http://www.samhsa.gov) for more details.
6. SAMHSA's next *Transforming State Mental Health Systems Regional Meeting* will be in Los Angeles, CA on September 21, 2005.

*HomeBase summer intern, Tara O'Neill, student at UC Hastings College of the Law, prepared this memorandum. If you have questions or comments, please contact HomeBase staff attorney Piper Ehlen, 415-788-7961 x304, or HomeBase Executive Director, Marty Fleetwood, x312.*

## APPENDIX A

### ISSUES TO CONSIDER

#### Programs

- Does your county's mental health care system have a well-planned, detailed, coordinated array of services and treatments defined in a single, individually tailored health management plan of care?
- Does your county's mental health care system have any of the following readily accessible: quality screening, early detection, and/or early intervention?
- Do consumers have decent access to government housing programs?
- Does your community use Medicaid options at the local level to cover supportive housing services?
- Does your community use nonprofit organizations to expand housing opportunities for consumers, specifically by partnering with PHAs and State/local housing officials to obtain resources?
- Has your community's mental health agency created a Community Housing Development Organization (CHDO), which helps access funding from HUD's HOME program?
- Does your County offer support services that are (1) designed to maximize consumer independence, (2) flexible and responsive to individual needs, (3) available as/when needed, and (4) accessible where the consumer lives?
- Does your community have wrap-around services available 24/7, which are based on consumer's evolving needs rather than on pre-set treatment plans?

#### Policies

- Does your county prioritize a comprehensive, coordinated, integrated program of mental health care?
- Do the mental health care consumers and families in your county actively partake in designing and developing the mental health management program of care in which they are involved?
- Do the primary care providers in your county have the requisite time, training, and resources to treat mental health problems?
- Do the mental health service providers in your county routinely screen for co-occurring mental illnesses and substance use disorders?
- Does your county's mental health care system have strong housing expertise? Specifically, the staff have the expertise to facilitate partnerships with housing agencies, track housing program and policy changes, identify new sources of housing funding, and provide training and technical assistance on housing issues?

- Does your county promote consumer access to permanent supportive housing (e.g. new construction, acquisition, rehabilitation, leasing, and rental assistance)?
- Is your community expanding permanent supportive housing for consumers who are chronically homeless?
- Does your county have a “no wrong door” policy that allows consumers to enter anywhere in the mental health care services system, be assessed, and have access to the full complement of comprehensive services and supports they need?

### Partnerships

- Does your county have a public-private partnership that implements and advances evidence-based practices via dissemination and demonstration projects?
- Does your county’s mental health care system have a working partnership with your county’s PHAs?

## APPENDIX B<sup>1</sup>

- Policy Option 1: *Facilitate Access to 150,000 Permanent Supportive Housing Units*
  - ♣ HUD, in partnership with HHS and the VA, should develop and implement a comprehensive plan designed to facilitate access to 150,000 units of permanent supportive housing for chronically homeless individuals over the next ten years.
  - ♣ The approaches, strategies, and actions steps included in this plan should provide: (1) an identification and analysis of the capital, subsidy, support service, and technical assistance resources needed to provide for 150,000 permanent supportive housing units; (2) An analysis and recommendations leveraging potential savings and “off-sets” from other public systems, such as health care for the homeless, shelters, and correctional facilities; and (3) Strategies for creating more public/private supportive housing partnerships that include government, nonprofit, and faith-based groups; PHAs; philanthropic organizations; and the private sector.
  - ♣ HUD has already begun taking leadership in developing this plan by developing an intra-departmental task force charged with examining barriers to mainstream housing resources for people who are homeless and the organizations that work with them.
  - ♣ HUD is also in the process of developing an action plan to end chronic homelessness. As part of this planning process, the Subcommittee proposes that HUD contact comprehensive research of “gap-financing” for affordable and permanent supportive housing to identify improvements to existing financing packages and develop new financial tools.
  
- Policy Option 2: *Facilitate Use of Mainstream Resources to Expand Housing Access*
  - ♣ To promote better targeting of HUD’s mainstream resources for people with mental illnesses, including those who are homeless and those living in restrictive settings covered by the Olmstead decision, the Subcommittee proposed that HUD undertake a comprehensive initiative providing education, guidance, and technical assistance to State and local housing officials and PHAs on effective strategies to address these housing needs.
  - ♣ The mainstream resources would include:
    - HUD programs such as:
      - Community Development Block Grant
      - HOME
      - Section 8 Housing Choice Voucher program
      - Emergency Shelter Grants
      - Housing Opportunities for Person with AIDS
      - Federal Low Income Housing Tax Credit program, and
      - Federal Home Loan bank programs
    - Veterans Administration programs, and resources from the private sector

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<sup>1</sup> Much of the list below is taken directly from *Subcommittee on Housing and Homelessness: Background Paper*. p 16-23.

- ♣ The technical assistance should:
  - Encourage Federal, State, local, and private investment in housing for people with serious mental illnesses;
  - Promote the participation of State and local mental health systems, consumers, and stakeholders in Federally mandated State and local housing planning activities;
  - Provide guidance on using flexible Federal housing funds;
  - Expand public/private partnerships
  - Mitigate local resistance and overcome NIMBY responses to siting permanent supportive housing; and
  - Include specific monitoring and outcome measurement activities to determine its effectiveness.
  
- Policy Option 3: *Reform and Improve Section 811 Supportive Housing Program for Persons with Disabilities*
  - ♣ HUD officials should work in partnership with HHS, mental health housing advocates, and Congress to reform and improve the Section 811 Supportive Housing Program for Persons with Disabilities.
  - ♣ Included in this effort should be a waiver granted by the HUD Secretary to ward all new Section 811 tenant-based rental assistance subsidies to nonprofit disability organizations based on their administrative capacity as a mechanism to expand access to permanent supportive housing.
  - ♣ Reforming the Section 811 program would help expand the production of new units by making it easier for nonprofits to leverage other housing funding, including private capital.
  - ♣ New Section 811 legislation should authorize:
    - Permanent supportive housing for people with the most severe disabilities;
    - Housing production as its primary purpose, including construction, acquisition, rehabilitation, and rental assistance;
    - Nonprofit administration of all Section 811 funding based on their capacity to administer the program;
    - More flexible capital funding, as well as long-term subsidy funding; and
    - More flexible rental assistance activities.
  - ♣ Greater flexibility is needed in Section 811 capital funding to encourage more public/private partnerships and increase the ability of nonprofit groups to leverage Federal low-income housing tax credit equity, HOME funds, and State/local capital financing in Section 811 projects.
  
- Policy Option 4: *Complete the Mental Health Action Plan*
  - ♣ The Subcommittee believes that the Mental Health Action Plan<sup>2</sup> can be used as a

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<sup>2</sup> Appropriations language in the FY '99 HUD budget included Section 517, Mental Health Acton Plan: The Secretary of Housing and Urban Development, in consultation with the Secretary of health and Human Services, the Secretary of Labor, and appropriate State and local officials and representatives, shall—(1) develop an action plan and list of recommendations for the improvement of means of providing severe mental illness treatment to families

policy tool to strengthen the efforts of HUD, HHS, VA, and DOL to promote better systems integration strategies on behalf of people with serious mental illnesses.

- ♣ Specific goals of a new effort should include:
  - Creating policy incentives within the (a) Community Mental Health Services, (b) Substance Abuse Prevention and Treatment, and (c) Community Development Block Grant programs to promote housing/services system integration activities at the State level;
  - Disseminating successful system integration strategies, including those identified in the ACCESS program; and
  - Identifying existing HUD, HHS, DOL, and VA resources and technical assistance that can be used to assist States in improving the integration of housing, mental health and substance abuse treatment, and employment policies and programs.
  
- Policy Option 5: *Preserve and Sustain Subsidized Housing Resources*
  - ♣ To advance the Administration’s goal of preventing homelessness among people with serious mental illnesses:
    - HUD and the Office of Management and Budget adopt policies to preserve and sustain subsidized housing resources already targeted to people with mental illnesses and other disabilities, including eligible McKinney/Vento projects, Section 811 subsidies, and Section 8 subsidies set-aside for those affected by “elderly only” housing policies, and
    - HUD take the necessary steps to ensure proper implementation of Federal “elderly only” designation policies by Federal public- and assisted-housing providers.
    - The Administration should work with Congress to develop a more secure budget-neutral funding stream for renewals of McKinney/Vento and Section 811 subsidies. More secure renewal policies are needed so that permanent supportive housing developers will be able to attract other sources of sustainable public and private funding for their projects.
    - HUD should promulgate regulations for the public- and assisted-housing programs covered under Title VI of the Housing and Community Development Act of 1992 to improve compliance with Federal “elderly only” housing designation laws and protect the rights of non-elderly people with disabilities according to these laws.
  
- Policy Option 6: *Develop and Implement an Integrated Strategy for Enforcing Disability Rights and Grantee Compliance with Fair Housing Obligations*
  - ♣ This effort should be developed and implemented by HUD and DOJ, but led by

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and individuals receiving housing assistance under the United States Housing Act of 1937, including public housing residents, residents of multi-family housing assisted with project-based assistance under section 8 of such Act, and recipients of tenant-based assistance under such section; and (2) develop and disseminate a list of current practices among public housing agencies and owners of assisted housing that serve to benefit persons in need of mental health care.

- HUD's Office of Fair Housing and Equal Opportunity (FHEO) and should include:
- Short- and long-term strategies for improving interagency coordination and enforcement;
  - The development of mechanisms to coordinate the work of FHEO with other HUD program offices and DOJ;
  - Mechanisms to improve communication within HUD, between HUD and DOJ, and externally to consumers and HUD grantees; and
  - The development of a systematic plan to improve HUD's response to Section 504 complaints.
- ♣ In order to improve Fair Housing education and assist HUD regional offices and State/local enforcement agencies, FHEO should also develop a system to identify and disseminate best practices on such topics as:
    - Community outreach and education efforts,
    - Intake and case processing,
    - Investigative and compliance strategies, and
    - Successful technical assistance initiatives, including those of private fair housing groups.
- *Policy Option 7: Promote Evidence-Based Practices for People with Mental Illnesses who are Homeless or at Risk of Homelessness*
    - ♣ HHS should establish funding policies to ensure that initiatives related to evidence-based practices and the integration of Federal and State funding resources are tailored to people with mental illnesses who are homeless or at risk of homelessness.
    - ♣ Evidence-based practices that are known to be effective in assisting people with mental illnesses who are homeless to gain and sustain independent living in the community include:
      - Assertive community treatment,
      - Integrated services for people with co-occurring substance use disorders and mental illnesses,
      - Supportive employment, and
      - Illness self-management
    - ♣ The combination of financing evidence-based practices and Federal efforts to coordinate and integrate funding streams will result in service design, financing strategies, and incentives at the State and local levels that make mainstream resources more responsive and effective in meeting the needs of people with mental illnesses who are homeless and at risk of homelessness. These actions will also help them attain permanent housing, employment, and community integration. Examples of cost-neutral strategies include:
      - Establishing a direct policy and planning link at the State level between the SAMHSA Community Mental Health Block Grant and the SAMHSA Projects for Assistance in the Transition from Homelessness (PATH) grant;
      - Requiring States to specifically address how PATH and Mental Health Block Grant funds will be:
        - Coordinated to ensure that increased mainstream services linked with

supportive housing are targeted to people with mental illness who are homeless,

- Linked with other Federal and State supportive housing funding to leverage additional resources, and
  - Coordinated and integrated with other mainstream resources to enhance supportive housing development. HUD's Continuum of Care and Consolidated Plan processes are good examples of this type of planning mechanism.
  - Refining HHS discretionary grant programs to include homeless and supportive housing strategies in larger science-to-services and evidence-based practice implementation and evaluation efforts;
  - Requiring States to specifically address how they will allocate a portion of any discretionary grant funding to be dedicated to providing services in supportive housing and create incentives for grantees to establish partnerships with permanent supportive housing providers;
  - Setting aside a portion of current SAMHSA/CMHS/Center for Substance Abuse Treatment (CSAT) discretionary grant authority to be used for specific State or local strategies to implement evidence-based practices specifically tailored to people with mental illnesses who are or who have been homeless and are in or moving toward supportive housing;
  - Ensuring coordination and joint planning among Federal mainstream funding sources to reinforce State-level integration of resources and targeting of mainstream resources to supportive housing for people with mental illnesses who are homeless. These activities may include, but are not limited to, allowing expenses such as developing system collaboration infrastructure, hiring system integrators, flexible fund reserves, incentive funds, and developing strategic plans to build partnerships across systems; and
  - Ensuring that all Federal efforts to increase the flexibility of Federal service funding and eligibility requirements are tailored to people with mental illnesses who are homeless and who are moving to supportive housing and employment in the community. Likewise, inform States about current Federal flexibility and service coordination opportunities involving person with mental illnesses in these circumstances. Any new Federal waiver authority or new discretionary grant fund programs should include funding and evaluation activities related to new service delivery and/or financing approaches and incentives related to supportive housing for people with mental illnesses who are homeless or at risk of homelessness.
- Policy Option 8: *Employ Medicaid Financing Mechanisms that Effectively Serve People with Mental Illnesses who are Homeless or at Risk of Homelessness*
    - ♣ HHS and its Centers for Medicare and Medicaid Services (CMS) should improve and expand the ways in which Medicaid funding is used to maximum effectiveness in serving people who are homeless, at risk of homelessness, or moving from homelessness to permanent supportive housing.
    - ♣ Strategies need to be implemented to:
      - Increase the flexibility of current Medicaid financing;

- Increase the participation of State Medicaid programs in intergovernmental initiatives to reduce homelessness and expand permanent supportive housing; and
  - Improve the access of people with mental illnesses who are homeless to Medicaid benefits.
- ♣ These strategies include:
- Encouraging State Medicaid agencies to implement evidence-based or promising practices, such as assertive community treatment, supportive employment, integrated services for people with co-occurring disorders, and illness self-management services, that can be effective in assisting people with mental illnesses in their move from homelessness to permanent supportive housing;
  - Requiring State Medicaid agencies to document in any State plan amendment or waiver request how the plan amendment or waiver could positively or negatively affect people with mental illnesses who are homeless; and how it will increase access to Medicaid benefits and/or support the implementation of new evidence-based or promising service models expected to assist people with mental illnesses who are homeless or at risk of homelessness;
  - Encouraging CMS to issue guidance and provide technical assistance to State Medicaid agencies to ensure their participation in joint planning and implementation of integrated strategies to increase permanent supportive housing. Such activities should include providing information on Medicaid-qualifying services that have proven to be effective in meeting the needs and choices of people with mental illnesses who are homeless or at risk of homelessness; and providing information on joint Medicaid and other State agency strategies that have been successfully used in permanent supportive housing;
  - Urging CMS to provide guidance to provider agencies that typically work with people with mental illnesses who are homeless or at risk of homelessness to fully implement the mental health elements of the Medicaid Early, Periodic Screening Diagnosis and Treatment (EPSDT) program for youth who are homeless or at risk of homelessness;
  - Advising CMS to encourage States to implement Medicaid presumptive eligibility guidelines for people with mental illnesses who are likely to be categorically and financially eligible once the eligibility and/or disability adjudication processes are completed. Presumptive eligibility should be encouraged for people with mental illnesses who are homeless or at risk of homelessness;
  - Urging CMS to implement strategies that can assist homeless service providers and other non-traditional community service providers to become Medicaid providers and to bill Medicaid for services rendered. Such strategies include:
    - Developing streamlined Medicaid provider certification for providers who do not fit within Medicaid or State licensure or certification categories,
    - Establishing daily or monthly rates and corollary documentation requirements as opposed to brief service increments and encounter-by-encounter documentation, and

- Providing for supervision rather than credentialing of paraprofessional and peer staff members.
- and, Encouraging CMS and other HHS agencies to facilitate and support State efforts to use creative financing mechanisms and blended funding strategies to provide positive incentives and flexible approaches for delivering services to people with mental illnesses on a path from homelessness to permanent supportive housing. Such strategies could include milestone payments as opposed to fee-for-service payments, risk sharing arrangements, such as case rates and/or sub-capitation mechanisms; and blended funding models, such as global budgets with performance incentives.

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