NATIONAL ALLIANCE TO END HOMELESSNESS ISSUE BRIEF

STRATEGIES OF STATE MENTAL HEALTH AGENCIES TO PREVENT AND END HOMELESSNESS

National Alliance to End Homelessness

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Introduction

State mental health agencies have varying reasons to address homelessness among people with serious mental illness.

Over the past 30 years, mental health services for people with serious mental illness have shifted from institutional settings (e.g., state mental hospitals) to care in the community. This shift is largely due to deinstitutionalization, the effectiveness of new treatments, and federal financial incentives for community-based care through federal programs such as Medicaid.

This transformation has been beneficial for millions of people and led to advances in how our society treats those living with mental illness. Unfortunately, there is still a gap that leads to homelessness for far too many people. This gap has resulted from mental health agencies' historical lack of expertise or ability to adequately address consumers' housing needs; and conversely, housing

Permanent Supportive Housing, *Housing First* and Housing Service Models

Permanent housing, combined with supportive services and a ***Housing First*** approach, has been found to be one of the most effective models for ending homelessness for individuals who are chronically homeless. The federal government's definition of chronic homelessness includes homeless individuals with a disabling condition (substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability) who have been homeless either continuously for one whole year or four or more times in the past three years.

Permanent supportive housing combines affordable rental housing with supportive services such as case management, mental health and substance abuse services, health care, and employment services. It is typically implemented in two ways: single site, whereby housing and some, if not all, services are onsite with the housing; and scattered site, whereby consumers rent apartments throughout the community and are linked to services. ***Housing First*** refers to a housing approach in which participation in treatment or preparatory institutionalization is not a prior condition in order to obtain housing. A landmark study found that providing supportive housing significantly reduced public service system costs for homeless mentally ill people across different service systems by $16,282 per person.

Numerous service and program strategies have been advanced to address chronic homelessness for people with serious mental illness. Effective supportive services are ones that maximize independence, provide flexibility and responsiveness to individual needs, maintain 24-hour accessibility, and are accessible where the individual lives.

Sources: National Alliance to End Homelessness, ***Supportive Housing is Cost Effective Brief*** (Washington, DC, January 2007); Corporation for Supportive Housing, ***Corporation for Supportive Housing: What is Supportive Housing?*** (Washington, DC, September 2007); U.S. Department of Housing and Urban Development, ***SuperNOFA for Continuum of Care Programs: Fiscal Year 2008*** (Washington, DC).

providers' (including the homeless services community) inability to effectively address mental health service needs. But this gap is closing, largely due to the emergence of the ***Housing First*** concept and the permanent supportive housing model for serving people with intensive service needs, such as those with serious mental illness.

Research and practice have shown that permanent supportive housing and ***Housing First*** work because housing is an essential part of treatment. People with serious mental illness need safe, stable, and affordable housing before their mental health needs can be fully addressed and recovery truly realized. As an added bonus, many localities are also showing that the provision of housing to this population is cost-effective. People with mental illness experiencing homelessness often cycle between emergency rooms for temporary treatment, mental health facilities, jail, and the streets, costing the taxpayers money. For example, in Portland, Oregon, a chronically homeless individual averages $42,000 in health care and incarceration costs per year.

After enrolling in permanent supportive housing, these same clients cost the city and Multnomah County $27,069, including the cost of housing.[1]

With this evidence that providing housing can work, partnerships between the housing and homelessness communities and state mental health agencies are emerging across the country.

This issue brief highlights the work of ten state mental health agencies with exemplary efforts in this area (California, Connecticut, Massachusetts, Maine, Michigan, New Jersey, New York, Oregon, Tennessee, and Washington), along with recommendations on how states can implement these efforts themselves. While each state agency is unique in its approach to addressing homelessness, numerous key strategies emerged from guided interviews with state mental health agency directors and their staffs. These strategies include:

- Making housing a priority, beginning with top elected leadership.
- Taking responsibility for housing within the state mental health department.
- Partnering with other agencies and organizations.
- Engaging in state and local plans to end homelessness.
- Providing technical assistance to community agencies and providers.
- Maximizing federal, state, county, and private resources.
- Using data to advance housing initiatives.[2]

[1] City of Portland, Bureau of Housing and Community Development, ***Home Again: A 10-Year Plan to End Homelessness in Portland and Multnomah County*** (Second Year Report, 2007).

[2] Many of the strategies highlighted by the states that were surveyed for this issue brief are consistent with approaches outlined in the federal report, ***Blueprint for Change: Ending Chronic Homelessness for People with Serious Mental Illnesses and Co-Occurring Substance Use Disorders***, produced by the Substance Abuse and Mental Health Services Administration.

Making Housing a Priority, Beginning with Top Elected Leadership

At some point in their lives, as many as two-thirds of all Americans with serious mental illness will experience, or be at risk for homelessness. Many of these individuals will become one of the estimated 124,000 chronically homeless people, meaning that they will be homeless either repeatedly or for a long period of time. A mental health system in which clients live on the street for years or decades is not recovery-focused. Therefore, it is important for states to establish housing as a top priority for the mental health system, beginning with the Governor's office.

This principle was reflected in the states included in the study. They have found that leadership on housing issues, particularly at the gubernatorial and mental health commissioner level, is critical to advancing housing-related policies and programs. Gubernatorial leadership has resulted in the creation of state task forces and workgroups on housing, development of work plans to guide decision-making about policy and programming, and increased resources targeted towards the creation of housing options for people with serious mental illness.

Select Examples from Study States

The ***New Jersey Home to Recovery Initiative*** is an effort of the state Division of Mental Health Services (DMHS) to decrease the length of stay in state psychiatric hospitals and prevent unnecessary admissions through the development of supportive housing and other community supports. The agency aims to create 200 new supportive housing opportunities annually for people being discharged from state psychiatric hospitals and 100 new supportive housing opportunities for those in the community at risk of hospitalization and/or homelessness.

The Home to Recovery Initiative is the outgrowth of numerous factors, including gubernatorial and commissioner-level leadership to transform the state's mental health system. The initiative is funded by appropriated service funding and a $200 million Special Needs Housing Trust Fund for capital, which was established under former Governor Codey. It continues to be supported by the current Corzine administration.

The ***New York*** commitment to supportive housing was underscored in 1990, when New York State and New York City officials signed the historic New York/New York Agreement. This partnership formalized the state and local governments' commitment to reduce street and shelter homelessness

in New York City. Many participants were housed using a housing first approach and referred to housing directly from the streets. This initiative is called "Streets to Home" and currently approximately 30 percent of New York/New York clients enter housing through this program.

Initial funding under the Agreement created over 3,600 new supportive units. Based on the success of this partnership, the NY/NY II Agreement (1,500 units) was signed in 1999, and the NY/NY III Agreement (9,000 units) was signed in 2005.

Lessons Learned for Implementation

Gubernatorial Leadership is Important. The Governor can establish the priority of housing and require cross-department cooperation. Investments in one department leading to savings in another department may require a broad perspective that only state leadership possesses.

Housing First* Works**. Implement a ***Housing First approach and develop permanent supportive housing and other permanent housing strategies that integrate mental health and other social support services.

Taking Responsibility for Housing within the State Mental Health Department

Many state agencies have responsibility for addressing homelessness in people with mental illness. Yet, typically, no one state agency or entity sees this group as its primary focus or target population. "The failure to identify homelessness as a major issue and housing as a targeted strategy within the state mental health agency can result in nothing happening," reports one state commissioner of mental health. This makes it essential for the mental health agency to take ownership of the issue and, in many cases, lead state efforts to improve housing strategies for those living with mental illness.

Several study states stressed the importance of creating a targeted housing program within the state mental health agency. To accomplish this, most of the study states have a designated lead housing staff person (e.g., a housing director) located within the state mental health agency.

Additionally, many of the study state agencies have created a formal, discreet housing function or division within the state mental health agency, created other staff positions in addition to a housing lead, and promoted capacity building in regional and/or county mental health systems (e.g., regional funding for a housing staff position).

Select Examples from Study States

In ***Oregon***, the state legislature established a Community Mental Health Housing Fund with the proceeds from the sale of a former state hospital property. Since the fund was established in 2004, four rounds of housing awards totaling $2 million have assisted 25 housing projects valued at $35.6 million in 24 counties. Project developers have leveraged significant federal, state, and local resources to complete financing of these projects. Oregon has a unit within its Addictions and Mental Health Division that coordinates the application process for these and other housing investments and manages the state funds for community housing projects.

As part of its Creating Homes Initiative (CHI), the ***Tennessee Department of Mental Health and Developmental Disabilities*** hired seven Regional Housing Facilitators to implement CHI throughout the state. Regional staffing enabled the state mental health agency to enhance its capacity to provide technical assistance on developing permanent, safe, quality, affordable, supported housing opportunities to community mental health agencies and providers. These agencies and providers brought ongoing support services to these projects. In addition, the Regional Housing Facilitators were charged with establishing and facilitating new CHI task forces in local communities across Tennessee. These task forces included representatives from community mental health agencies, local housing authorities, community organizations such as the United Way, banks, realtors, landlords, and the faith-based community. The CHI task forces' activities included: creating a steering committee that reviews, ranks, and recommends housing proposals to the mental health agency; conducting local permanent housing assessments; creating and implementing local strategies to increase housing options; and developing and updating local housing resource opportunities based on the housing assessment.

Tennessee applied a continuum approach to creating housing options for people with mental illness. The continuum includes: home ownership, rental housing (home or apartment), independent congregate living, partially-supervised group housing, and supervised group housing. Foremost, the agency is promoting permanent, supported, quality, safe, affordable housing.

State mental health agency administrators credit two program components, in particular, as critical to the effectiveness of this initiative: state funding for regional housing development staff and the promotion of local housing CHI task forces. An initial investment of $2.5 million has leveraged over $198 million to date in new federal, state, local, and private funds, resulting in the creation of over 7,000 permanent housing units for people with mental illness.

Lessons Learned for Implementation

Make Housing Part of Mental Health Systems Change. Address housing needs during efforts to change mental health systems. Housing is a key to successful treatment of people living with mental illness and is thus a necessary to consider as states improve their mental health services delivery system.

Housing Is Essential to Recovery. Create a formal, discreet housing function or division within the state mental health agency, create lead staff positions (e.g., housing director), and promote capacity building in regional and/or county mental health systems (e.g., funding to regions for a staff position).

Break Down Funding Silos. Maximize and promote the creative use of federal, state, and local funds in support of housing initiatives for this population.

Partnering with Other Agencies and Organizations

Partnerships are essential to engaging key stakeholders who can help make the elimination of homelessness a top priority, create housing initiatives, and maximize and leverage scarce resources. As stated above, the responsibility of addressing homelessness falls under the jurisdiction of many state agencies and often depends on the particular needs of the homeless client or family. Each agency must bring resources, expertise, and provider networks to the table.

All of the state mental health agencies in the study states are engaged in partnerships with state housing agencies or organizations that work with local housing authorities and with other key groups (e.g., other key state agencies, advocates, consumers) to some degree. These partnerships can include involvement on statewide task forces, development of joint work plans, the transfer of funds between agencies in support of housing initiatives, and other efforts.

One particular partnership – coordination between mental health agencies and housing authorities – was highlighted by many study states. State mental health directors noted that their work with the state and local housing authorities and housing finance agencies has recently improved. These states credit this change both to necessity and to recognizing the importance of partnerships for ending homelessness.

In addition, most of the study states are working with advocacy and consumer groups and stressed the critical role that these groups play in advancing housing initiatives. These states clearly recognize the important and unique role that advocacy groups play, and they have engaged them as partners. Advocates and consumers can bring a "real world" voice to the issue, guide and lend credibility to strategies that are being advanced at the state and community level, and help advance issues and ideas with federal and state legislators.

Select Examples from Study States

Public-private partnerships and interagency collaboration have been the hallmark of Connecticut's efforts to advance housing initiatives for chronically homeless people including people with serious mental illness. ***Connecticut's*** Next Steps Initiative is funded through a unique interagency agreement between the Connecticut Housing Finance Authority, the Department of Mental Health and Addiction Services, the Department of Social Services, the Department of Children and Families, the Department of Economic and Community Development, and the State Office of Policy and Management (OPM). The initiative is in its third year of funding supportive housing development. The Connecticut Housing Finance Authority serves as the lead agency for the initiative and administers a single-point Request for Proposal. Supportive housing has been a priority for the state since the mid-1990s, and services are fully funded by state general revenue funds.

The Next Steps Initiative grew out of a 2004 Executive Order issued by Governor M. Jodi Rell creating an Interagency Council on Supportive Housing and Homelessness, "in recognition of the significant impact of homelessness on Connecticut residents and to improve the state's ability to prevent homelessness and help homeless individuals obtain and maintain themselves in permanent housing."[3,4] Central to the Council's findings was the importance of supportive housing: affordable and permanent supportive housing is the most effective way to reduce homelessness and it is essential to recovery for individuals with mental illness. With this as a backdrop, the Council outlined a plan for increasing the supply of supportive housing by 1000 units over three years to address long-term homelessness among three core populations: families who are repeatedly homeless, young adults who are homeless or transitioning from youth systems, and adults with serious mental illness or chronic chemical dependency. The Commission's Plan created the Next Steps Supportive Housing Initiative (Next Steps). The partner agencies have designed the Next Steps Initiative to create permanent, affordable, service-enriched housing opportunities for individuals and families who are homeless or at risk of becoming

[3] Interagency Council on Supportive Housing and Homelessness, ***Report*** (January 2005). Accessed at: http://www.hrsa.gov/homeless/state_pages/pa5/ap/ct_ap.pdf .

[4] The Commission is comprised of the commissioners of the Departments of Social Services, Economic and Community Development, Mental Health and Addiction Services, Public Health, Correction, Children and Families, and Veterans Affairs, the Secretary of the Office of Policy and Management, the Director of the Office for Workforce Competitiveness and the Executive Director of the Connecticut Housing Finance Authority.

homeless, particularly persons experiencing chronic, repeated, or persistent homelessness. Supportive housing for the adult population is created through leasing of scattered-site existing apartments and through the development of housing units through acquisition, new construction, or rehabilitation.

The ***Massachusetts Department of Mental Health's*** (DMH) statewide housing system is the outcome of a longstanding statewide partnership between DMH, local DMH Area Housing Coordinators, DMH service providers, private developers and landlords, and federal, state, and local housing agencies. In particular, DMH has several joint housing development initiatives with the Massachusetts Department of Housing and Community Development, MASS Housing (formerly the Massachusetts Housing Finance Agency), and the Community Economic Development Assistance Corporation.

In addition to accessing state housing funds, Massachusetts DMH has used its services funding to leverage significant federal capital for development, as well as rental assistance funds, primarily from HUD's Section 811 and McKinney programs.[5]

The ***New York State Office of Mental Health***, in partnership with four other state agencies and five New York City agencies, participated in the NY/NY I, II, and III agreements. Through this effort, initiated in 2005 by (former) Governor George Pataki and Mayor Michael Bloomberg, the state and city committed to develop capital funding for 9,000 units of supportive housing for persons who are homeless. This agreement (explained in more detail earlier in this document) includes 1,125 units targeted for people living with serious mental illness. These targeted units and the accompanying services funding are anticipated to serve 5,550 individuals. Of this housing, 425 units opened in 2007, 658 units opened in 2008, and almost 400 units are planned to open in 2009.

Lessons Learned for Implementation

Engage and Utilize Partners. Build and sustain partnerships with the state housing agency and other key state agencies (e.g., health, social services), consumers, advocates, private foundations, and other groups.

Educate Stakeholders and General Public. Craft clear and understandable messages that help key stakeholders (e.g., policymakers, the general public) understand the importance of housing to individuals with mental illness.

[5] Massachusetts Department of Mental Health, ***Overview of DMH Housing Operations*** (2008).

Engaging in State and Local Plans to End Homelessness

Plans are critical blueprints for what state agencies and other key stakeholders see as essential components to transforming the homeless assistance system. Having mental health agencies at the table from the beginning is essential for a variety of reasons. First, state and community planning should drive how money is allocated. Next, the planning process often reveals key partners that can aid in accomplishing the plan's goals. Finally, since agencies are serving the same clients, coordinating programs will improve efficiency and hopefully make accessing services easier for the client.

Mental health agencies can either engage in ongoing state and local planning efforts, such as the creation of Ten-Year Plans to End Homelessness, or lead the creation of housing plans specific to individuals with mental illness. Regardless of the approach, plans have proven effective in bringing about change.

Select Examples from Study States

Michigan was one of the first states in the country to promote a community planning process. In 2006, Michigan announced a statewide initiative to end homelessness. Sixty community plans were written by local collaborative groups to address the specific needs of homeless people in all 83 counties of Michigan. These plans and groups have been organized into regional councils to maximize limited resources. Alongside the local plans, an unprecedented collaborative approach among several state agencies (including the state Mental Health and Substance Abuse Administration) and private partner organizations was created to innovate, initiate, and coordinate over 40 different statewide programs designed to provide valuable resources that will ultimately put an end to homelessness in Michigan.[6] Michigan serves as an example of mental health agencies joining and actively participating in program efforts at both the state level, by coordinating resources, and local level, by participating in the county plans.

The ***Washington Mental Health Housing Action Plan*** was completed in 2007 and is part of the state's Mental Health System Transformation Initiatives. The Plan calls for creating 760 units of permanent supportive housing between 2007 and 2010, including 500 units developed

[6] Michigan's Campaign to End Homelessness website accessed at: http://thecampaigntoendhomelessness.org/

through acquisition and rehabilitation or new construction and 260 units leased from existing housing stock and made affordable with rent subsidies.[7] The model combines an apartment or single-family home leased by the consumer with supportive services and includes the ***Housing First*** approach. The estimated capital financing needed to build or acquire 500 units is $115 million, 60 percent of which is committed.[8] This is an excellent example of how state mental health agencies can lead the development of housing plans.

Lesson Learned for Implementation

Planning and Implementing Plans Make Change. Promote, develop, and advance state and local plans for addressing homelessness among people with serious mental illness. In developing state and local plans, take a strong policy position with regard to permanent supportive housing, and identify specific resources for its development.

Providing Technical Assistance to Community Agencies and Providers

States can help community agencies and organizations become more competitive in their applications for federal and state housing resources, and be creative about funding housing and supportive services. Technical assistance also ensures that, as communities implement housing programs, they are adhering to the principles that make permanent supportive housing an evidence-based practice. To accomplish this, states in this study provide technical assistance to community mental health providers and county and local mental health agencies on how to create, advance, and implement housing options for people with mental illness. This technical assistance takes many forms in the states – trainings, state institutes, and regional technical assistance facilitators – and covers a range of housing issues, including community planning, financing, and supportive services.

[7] Washington State Common Ground, Mental Health Housing Action Plan (October 2007).

[8] Ibid.

Select Examples from Study States

Maine has had its own Technical Assistance Consortium (TAC) for over 13 years. This effort, led and staffed by Coastal Enterprises Inc., regularly convenes representatives from the state's Office of Adult Mental Health, Office of Economic and Community Development, Maine State Housing Authority, U.S. Rural Development, the City of Bath, and the Community Action Agencies. Traditionally, members of this group have directly provided and/or organized technical assistance (which may include seed money) for local initiatives and projects.

Much of the work of the TAC involved a regular (quarterly) safe meeting environment for information sharing. In addition, the TAC often coordinated and directed hands-on interventions by one or more of its members. With just over $300,000 over a 15-year period, Maine's TAC had a leverage ratio of more than 100:1 in direct cash outlays. The TAC assisted 302 new units of development during this period, valued at more than $40 million. In addition, its members coordinated, hosted, and occasionally staffed a multitude of trainings and workshops, including: McKinney-Vento Continuum of Care application trainings; Homeless Management Information System (HMIS) and HUD electronic data submission trainings; Annual Progress Report trainings; Housing Quality Standard trainings; Lead-Smart workshops; Tax Increment Financing workshops; and Asset Management and Financial Management workshops for the Section 202/811 programs. The TAC recruits nationally-recognized nonprofit housing developers and service providers to Maine.

Unfortunately, the TAC was not funded in the most recent state budget. Despite the loss of funds, the TAC intends to continue to meet over the next year in order to consider its options in continuing to share information and to provide some level of technical assistance, if possible. The TAC may consider expanding its membership to include other nonprofits and government agencies and will investigate possible alternative funding.

The ***Oregon Addictions and Mental Health Division*** (AMH) convenes bi-monthly "housing technical assistance" meetings. These meetings provide a forum for sharing information about available resources and allow local program representatives to network and share their experiences with housing projects. AMH also sponsors sessions at the annual conference of the Oregon Coalition on Housing and Homelessness and has a housing development coordinator on staff who provides technical assistance and helps support project implementation when AMH has awarded a housing development grant.

In ***Washington State***, a partnership between the Department of Community, Trade, and Economic Development, the Department of Social and Health Services/Mental Health Division, and Washington Families Fund has resulted in the development of the Supportive Housing Institute (SHI). SHI provides several months of targeted technical assistance to participating development teams of community stakeholders. For each community, SHI trained and supported a team whose members represented housing authorities and organizations; social, health and support service providers; housing development organizations; and county government. The first institute team training was held in 2008. SHI now provides eight county teams from across the state with strategies and skills to create permanent supportive housing for homeless individuals, families, and those experiencing mental illness and other barriers to housing.

Lesson Learned for Implementation

Help Community Mental Health Agencies Understand Housing Resources. Provide technical assistance to regional and county mental health systems, agencies, and providers on how to address homelessness among individuals with serious mental illness and maximize federal and state funding streams.

Maximizing Federal, State, County, and Private Resources

The study states identified several factors as critical to investing in housing initiatives. Foremost, they recognize the importance of leveraging federal, state, local, and private funding sources. State mental health agency investments in housing can get the attention of other potential partners and can make a significant impact on housing initiatives and activities. Also, other private and public partners can be influenced if they see the mental health agency has made a financial investment, even if that investment is small.

States note the importance of sustaining investments once housing initiatives for people with mental illness are established. State or federal housing initiatives are often merely pilot or demonstration projects, especially funds focused on providing mental health, substance use treatment, employment, or other services. Hence, it is essential that mental health agencies help providers to develop and immediately implement sustainability plans, because fundraising takes time. Of course, states should also create funding streams that are sustainable and dependable.

In most cases, state mental health agencies in the study states have invested state funds (including state general revenue funds) in housing initiatives; a few states have done so at significant funding levels. Additionally, they are also using private funding sources (e.g., corporations, foundations).

A few of the study states are using Medicaid, predominantly the rehabilitation option under Medicaid, to fund supportive services for supportive housing activities. This strategy, however, is certainly not universal among the study states. Individuals with mental illness need active engagement and case management services, which are not always covered by Medicaid. Some of the study states indicated they had made a strategic decision to not rely on Medicaid given that this funding source is largely diagnosis- (rather than intervention-) driven. Other states indicated they are exploring use of Medicaid funds for supportive services.

Select Examples from Study States

California's Mental Health Services Act (MHSA), also known as Proposition 63, which was passed into law in 2005, imposes a one percent income tax on personal income in excess of $1 million to create a Mental Health Services Fund. The MHSA contains five components of services and supports for which its funding may be spent: community services and supports for children, transition-age youth, adults and older adults; workforce education and training; capital facilities and technological needs; prevention and early intervention; and innovative programs.

A new housing program, the MHSA Housing Program, was established using $400 million of MHSA funds. These funds are available to finance the capital costs associated with development, acquisition, construction, and/or rehabilitation of permanent supportive housing, as well as some capitalized operating subsidies for individuals with mental illness and their families, particularly homeless individuals with mental illness and their families.[9] MHSA Housing Program funds are distributed through a partnership with the California Housing Finance Agency.

Sacramento County became the first to apply for the MHSA Housing Program. Of the $12.3 million available to it, Sacramento County's initial project proposes to use $5.1 million of MHSA funds to develop 33 units of permanent supportive housing for Sacramento County residents with serious mental illness.[10]

[9] California Department of Mental Health website. Accessed May 1, 2008 at: http://www.dmh.cahwnet.gov/Prop_63/MHSA/Housing/default.asp

[10] California Department of Mental Health, Mental Health Services Act Progress (May 2008). Accessed June 3, 2008 at: http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/ProgressReports/MHSA_Progress_May2008.pdf

Maine leverages Maine Care, its Medicaid managed-care system, and in particular the Medicaid Rehabilitation Option, to support the provision of community-based mental health services. Many of these services, funded under Private Non-Medical Institutions (PNMIs) and Community Supports, are increasingly consumer-driven. The PNMIs typically consist of group living arrangements, as well as clustered apartments. They provide intensive 24/7 rehabilitative treatment and support. Community Supports represent services that follow the person. Combined with the Office of Adult Mental Health's (OAMH) rental assistance voucher programs, this affords the consumer choice and control with respect to service providers and particular services, as well as choice and control in location of housing throughout the state. Additionally, Maine continues to explore other Medicaid options, including the Home and Community-Based Waiver program.

OAMH has long recognized that recovery can only begin in a safe and secure environment, ultimately in a place one can call home. This is evidenced through Maine's growing emphasis on access to housing resources. Partnerships with local Public Housing Authorities and the Maine State Housing Authority have lead to newly state-created Section 8 MaineStream vouchers, and to modifications in the Administrative Plan prioritizing homeless persons with mental illness. OAMH has also seen increased funding for their Bridging Rental Assistance Program (BRAP) in very tight fiscal climates. BRAP is a housing program developed by Maine's Department of Health and Human Services. It provides a tenant-based, portable housing voucher available to persons with psychiatric disabilities. Within BRAP, there are four priority populations, with homeless people being the second priority behind hospital discharges. OAMH also receives support from Maine's three Continuums of Care, which continue to approve new Shelter Plus Care vouchers targeting homeless people with mental illness.

As the ***New York Office of Mental Health (OMH)*** has become more sophisticated on housing financing issues, it has been able to creatively use funds to support housing initiatives that target people experiencing homelessness. In particular, OMH created integrated service housing models, including permanent supportive housing. With the help of tax experts, OMH has developed a financing strategy to use a combination of private activity bonds and a four percent low-income tax credit to support the development of supportive housing.

Lesson Learned for Implementation

Invest State Mental Health Dollars in Housing. Dedicate state general revenue funds and state mental health agency resources to developing and advancing housing initiatives for people with mental illness.

Using Data to Advance Housing Initiatives

Using data, particularly outcome measures, is an important strategy for promoting, developing, and advancing housing initiatives for people with serious mental illness who are homeless. Furthermore, federal initiatives and acts such as the Government Performance and Results Act of 1993, which requires agencies to set specific performance standards and measure outcomes, have placed greater emphasis on the need for, and use of, outcome measures for federally-funded state and local programs.

The study states have used data to demonstrate the prevalence of homelessness among people with serious mental illness, engage key stakeholders – particularly policymakers – on this issue, demonstrate impact and outcomes, enhance programming, and secure additional investments in housing initiatives from funders. In fact, some states indicated that data was a central factor to their success in garnering support, both political and financial, for housing initiatives.

Selected Outcome Measures for People with Serious Mental Illness Who Are Homeless

Measures of improved functioning for people with serious mental illness who are homeless include the following.

- ***Housing status*** (e.g., days homeless or in housing, length of time in most recent housing placement, possession of housing subsidy)
- ***Mental health status*** (e.g., psychiatric emergency admissions, days in inpatient treatment)
- ***Substance use status*** (e.g., days drinking and/or using drugs)
- ***Employment*** (e.g., days employed, days lost to mental health symptoms or substance use)
- ***Income*** (e.g., monthly income, public benefits)
- ***Health status*** (e.g., self-report of health status, private or public health insurance)
- ***Consumer satisfaction*** (e.g., housing, mental health, substance use, health care)

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), ***Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders***. DHHS Pub. No. SMA-04-3870, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Rockville, MD, 2003).

Select Examples from Study States

Use of comprehensive data has been a longstanding component of the ***California Department of Mental Health's*** (DMH) efforts to increase resources and strengthen programs that provide mental health services and supports for people with serious mental illness. In particular, the success of AB 2034, legislation initially passed in 1999 as Assembly Bill 34 and later passed as Assembly Bill 2034, which addressed homeless people, parolees, and probationers with serious mental illness, provided an important foundation for subsequent efforts to pass the state's Mental Health Services Act (MHSA). Data gathered from AB 2034 programs demonstrated that the initiative was successful in reducing inpatient hospital stays, homelessness, andvincarceration among people with serious mental illness, as well as demonstrating that investments were cost-effective.

DMH collects MHSA data from three major sources: a state data collection and reporting system; consumer perception surveys; and client and service information.[11] Data on the demographics of DMH clients, as well as on the impact of programs, is regularly made available to a wide range of key stakeholders, including policymakers. Additionally, the state includes information about DMH data systems and programmatic data as part of its MHSA newsletter, ***By the Numbers***.

The ***Oregon Addictions and Mental Health Division***, like most states, supports its housing initiatives through a mix of federal, state, and county funds. The Division has succeeded in consistently securing state general revenue funds for its housing initiatives mainly due to legislative knowledge of, and support for, this work. In the 2007-2009 biennium (the Oregon legislature operates on a biannual basis), the state allocated $6 million in general revenue funds and Community Mental Health Housing Fund grants to county mental health agency housing initiatives, resulting in the creation of 42 new housing projects. The Division has collected, analyzed, and used data on how state funds have been spent and the impact of its investments. As a result, state policymakers are supportive of the Division's housing initiatives and have continued to invest state general revenue funds in this work, even in difficult financial times. Oregon considers people who have been civilly committed to its state hospitals a "mandatory" population to be served by the state and allocates funding each biennium to develop community resources for individuals assessed to be ready for discharge, but for whom there is no capacity in existing community resources.

Lesson Learned for Implementation

Ground Decisions in Data. Use client outcome data on housing and homelessness to inform decision-making about policy and programming and to educate policymakers about the housing needs of people living with mental illness. In addition, integrate data collection to coordinate with multiple service systems.

Ending Homelessness among People Living with Mental Illness

Addressing homelessness among people experiencing mental illness can appear to be overwhelming. The key is finding a place to start, and the promising practices highlighted in this report are meant to provide suggestions and resources to help state mental health agencies develop a course for action. State mental health agencies have a significant role to play in ending homelessness, and the strategies highlighted in this report explain how to fulfill that role.

While the advances states have made are clearly significant, states recognize that these initiatives cannot be taken to scale without further federal and state investments in housing, housing supports, and services. States need funds for capital development, rental subsidies, and services in order to comprehensively address housing issues and to fully meet the needs of people with serious mental illness who experience or are at risk of homelessness.

[11] Ibid.

SELECTED STATE MENTAL HEALTH AGENCY SYSTEM CHARACTERISTICS TO ADDRESS HOMELESSNESS

	STATE MENTAL HEALTH SYSTEM	INTERAGENCY INITIATIVES, AGREEMENTS, COLLABORATION	TEN-YEAR STATE PLAN TO END HOMELESSNESS* OR OTHER STATE PLAN	STATE SUPPORT FOR LOCAL OR REGIONAL PLANNING	TECHNICAL ASSISTANCE ON HOUSING TO LOCAL OR REGIONAL AGENCIES	LINKAGES WITH HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)
California Department of Mental Health	County-based system: five state-operated mental health hospitals	Mental Health Services (MHS) Oversight and Accountability Commission to oversee implementation of the MHS Act; partnership between DMH and CalHFA (state housing finance agency) for the MHSA Housing Program	Yes – in process	Community Program Planning to assist counties in determining the best use of MHS Act funds	DMH has allocated funding to support technical assistance; CIMH and Corporation for Supportive Housing partner to deliver training around the state	Yes
Connecticut Department of Mental Health and Addiction Services	State-based system: five regions, 15 local mental health authorities, four state-operated mental health hospitals	Governor's Interagency Council on Supportive Housing and Homelessness, and State Interagency Working Group	Yes	Yes	Funds Corporation for Supportive Housing to provide technical assistance to community agencies on housing creation and leveraging resources	Homelessness Management Information System implemented by Connecticut Coalition to End Homelessness
Maine Office of Adult Mental Health (OAMH) Services	State-based system: three regions, seven Community Service Networks, two state-operated mental health hospitals	Statute-driven Statewide Homeless Council; Three Regional Homeless Councils created as a component of Maine's Plan to End Homelessness	Yes	Regional Homeless Councils and Three Continuums of Care	Office of Adult Mental Health Funds Local Administrative Agencies to coordinate and deliver state and federal rental assistance vouchers	One statewide HMIS system coordinated across all three Continuums of Care. OAMH is currently working on non-McKinney participation in HMIS such as PATH and the state funded program, BRAP
Massachusetts Department of Mental Health	State-based system: Six regions divided into Local Service Sites that receive DMH funds for state-operated and contracted services including four state mental health hospitals	Newly-formed Interagency Council on Housing and Homelessness; Interagency agreements with Department of Transitional Assistance and Department of Public Health to develop supportive housing services	Yes	DMH Area Staff involved in the development of housing plans at the regional level	Yes, through DMH offices and/or local housing partners	Yes (initial stages of development)
Michigan Mental Health and Substance Abuse Administration	County-based system: 46 community-based Mental Health Services Programs, three state-operated mental health hospitals	Partnership with state housing authority to collaboratively develop housing for individuals who are homeless and mentally ill	Yes	Yes (through Michigan State Housing Development Authority)	Yes	Yes – all PATH, Shelter Plus Care, and Supportive Housing Programs

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SELECTED STATE MENTAL HEALTH AGENCY SYSTEM CHARACTERISTICS TO ADDRESS HOMELESSNESS

	STATE MENTAL HEALTH SYSTEM	INTERAGENCY INITIATIVES, AGREEMENTS, COLLABORATION	TEN-YEAR STATE PLAN TO END HOMELESSNESS* OR OTHER STATE PLAN	STATE SUPPORT FOR LOCAL OR REGIONAL PLANNING	TECHNICAL ASSISTANCE ON HOUSING TO LOCAL OR REGIONAL AGENCIES	LINKAGES WITH HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)
New Jersey Division of Mental Health Services	State-based system: five state-operated mental health hospitals and contracts with over 120 community agencies to provide services	Interdepartmental Housing Needs Committee to collaboratively plan on housing issues across key state agencies; leveraging state rental assistance through Department of Community Affairs	Yes	Development of systems mapping on county-wide level through County Mental Health Administrators	State Mental Health Authority provides technical assistance on state, county, and local levels in coordination with CSH and state supportive housing association	State Mental Health Authority coordinates with Housing and Mortgage Finance Agency, host of the statewide HMIS
New York Office of Mental Health	State-based system: 16 state-operated mental health hospitals and oversight of more than 2500 programs	Agreements between New York State and New York City to develop homeless housing; over $350 million capital investment and $100 million in services funding have been invested	Yes	New York State Office of Mental Health (OMH) provides technical assistance and oversight through its five field offices located regionally throughout New York	OMH staff participated in CoC coordination and work closely with county mental health departments	OMH Planning and Information Technology staff track information on homelessness and work closely with local governments
Oregon Addictions and Mental Health Division	County-based system: 36 counties comprising 32 community mental health authorities; two state-operated mental health hospitals	Significant collaboration with state housing agency (Oregon Housing and Community Services Department); work closely with local government programs and community nonprofits	Yes	Bi-monthly Housing Technical Assistance meetings and housing development coordinator on staff	Bi-monthly Housing Technical Assistance meetings and housing development coordinator on staff	Minimal linkages currently exist
Tennessee Department of Mental Health and Developmental Disabilities	Region-based through seven regional planning councils; state contracts directly with local MH service providers; five state-operated mental health hospitals	Governor's Interagency Council on Homelessness; Creating Homes Initiative (CHI), a strategic plan to partner with communities to create housing options for people with mental illness; Partnership Resolution with Federal Home Loan Bank of Cincinnati	Yes (Homeless Policy Academy Report)	Yes, plus support to communities for building coalitions focused on housing (i.e., Creating Homes Initiative Task Forces) and active participation in all 10 Continuums of Care	Funds for a designated staff position at the regional level (i.e., regional housing facilitators) whose responsibility is to develop housing; state investment of $520,000 for regional staff has leveraged $198 million since 2000; implemented three regional three-day Housing Academies with national consultants for all stakeholders	Regional Housing Facilitators use CoC HMIS data in CHI Task Forces and forward composite data to Governor's Interagency Council
Washington Mental Health Division/ Department of Social and Health Services	County-based system: County government agencies and 145 private and non-profit organizations organized into 13 Regional Support Networks with two state hospitals	Collaborating with the state housing agency and a private foundation to jointly support a supportive housing institute for teams in eight counties	Yes	Yes	Technical assistance to community mental health providers to become more knowledgeable about, and competitive in, creating supportive housing	HMIS being implemented statewide with all agencies receiving homelessness funding

*In 2000, the National Alliance to End Homelessness announced A Plan, Not a Dream: *How to End Homelessness in Ten Years*, a national campaign initiative to promote ten-year planning at the state and local level to end homelessness. The Alliance's initiative focuses on communities using data and collaborative partnerships to plan for outcomes, prevention programs, coordinate services and re-house individuals and families.

SELECTED STATE MENTAL HEALTH AGENCY HOUSING RESOURCES

	RESOURCE	DESCRIPTION	FOR MORE INFORMATION
California	1. Mental Health Services Act Resources 2. DMH Information Notice 3. Department of Mental Health 4. Mental Health Services Act Housing Toolkit	1. Documents, resources and description on MHSA 2. Housing funds distribution memo 3. State mental health agency website 4. Toolkit for housing providers using MHSA funds	http://www.dmh.cahwnet.gov/Prop_63/MHSA/default.asp http://www.dmh.cahwnet.gov/ http://www.dmh.ca.gov/DMHDocs/docs/notices08/08-12.pdf http://www.dmh.cahwnet.gov/Prop_63/MHSA/Housing/docs/MHSAToolkit-Final.pdf
Connecticut	1. Report of the Interagency Council on Supportive Housing and Homelessness 2. Department of Mental Health and Addiction Services	1. State Council recommendations 2. State mental health agency website	http://www.hrsa.gov/homeless/statefiles/ctap.pdf http://www.ct.gov/dmhas/site/default.asp
Maine	1. State of Maine Action Plan to End Homelessness: A Ten Year Plan 2. Housing Resource Matrix 3. Housing Resource Manual 4. Office of Adult Mental Health Services	1. State Ten-Year Plan 2. State overview of federal and state housing resources 3. State manual of housing resources 4. State mental health agency website	http://www.endhomelessness.org/section/tools/communityplans http://www.maine.gov/dhhs/mh/Housing/matrix/index.html http://www.maine.gov/dhhs/mh/Housing/manual/index.html http://www.maine.gov/dhhs/mh/index.shtml
Massachusetts	1. The Commonwealth of Massachusetts State Plan to End Family Homelessness 2. Update on Homelessness in Massachusetts 3. Department of Mental Health	1. State plan 2. State update 3. State mental health agency website	http://www.mass.gov/pageID=eohhs2constituent&L=2&L0=Home&L1=Researcher&sid=Eeohhs2 (click on: Basic Needs, Housing and Shelter) http://www.mass.gov/
Michigan	1. Michigan's Campaign to End Homelessness 2. Mental Health and Substance Abuse Administration	1. State campaign including state plan 2. State mental health agency website	http://www.thecampaigntoendhomelessness.org/ http://www.michigan.gov/mdch/0,1607,7-132-2941---,00.html
New Jersey	1. New Jersey State Policy Academy Team Preliminary Action Plan to End Homelessness in New Jersey 2. Division of Mental Health Services	1. State Ten-Year Plan 2. State mental health agency website	http://www.endhomelessness.org/section/tools/communityplans http://www.state.nj.us/humanservices/dmhs/home
New York	1. Comprehensive Statewide Plan for Mental Health Services 2. Office of Mental Health	1. State Mental 5.07 Health Plan 2. State mental health agency website	http://www.omh.state.ny.us/omhweb/Statewideplan/childrens_mental_health_act/oct2007_update.pdf http://www.omh.state.ny.us/
Oregon	1. Oregon Real Choice Housing Fund Report 2. State Housing Plan 3. Addictions and Mental Health Division	1. A report on a demonstration project assisting mental health consumers to obtain and maintain integrated community housing. 2. State housing plan 3. State mental health agency website	http://www.oregon.gov/DHS/mentalhealth/housing.shtml http://www.ehac.oregon.gov/ http://www.oregon.gov/DHS/mentalhealth/index.shtml
Tennessee	1. Department of Mental Health and Developmental Disabilities website 2. Housing Within Reach website 3. Department of Mental Health and Developmental Disabilities	1. State mental health resources linkages 2. Searchable database of housing opportunities and other housing resources 3. State mental health agency website	http://state.tn.us/mental/ http://www.housingwithinreach.org/ http://www.state.tn.us/mental/
Washington	1. Mental Health Housing Action Plan 2. Division of Mental Health	1. State plan 2. State mental health agency website	http://www.dshs.wa.gov/mentalhealth/sti_housing_action_plan.shtml http://www.dshs.wa.gov/mentalhealth/index.shtml

STATE MENTAL HEALTH AGENCY HOUSING CONTACTS

	DESIGNATED LEAD FOR HOUSING ISSUES WITHIN STATE MENTAL HEALTH AGENCY	HOUSING CONTACT	TITLE	PHONE	E-MAIL
California	Yes	Stephen Mayberg	Director, Department of Mental Health	(916) 654-2309	Stephen.mayberg@dmh.ca.gov
Connecticut	Yes	Elliot Stone	Director, Housing and Homeless Services, Statewide Services, Department of Mental Health and Addiction Services	(860) 418-6942	Elliot.stone@po.state.ct.us
Maine	Yes	Sheldon Wheeler	Director of Housing Resource Development, Office of Adult Mental Health Services	(207) 287-4226	Sheldon.Wheeler@Maine.gov
Massachusetts	Yes	Walter Jabzanka	Director of Community Systems	(617)-626-8068	Walter.Jabzanka@state.ma.us
Michigan	Yes	David Verseput	Administrator, Division of Community Living, Mental Health and Substance Abuse Administration	(517) 335-6019	verseput@michigan.gov
New Jersey	Yes	Patti Holland	Assistant Director, Division of Mental Health Services	(609) 777-0746	Patti.Holland@dhs.state.nj.us
New York	Yes	Mike Newman	Director, Bureau of Housing Development and Support Community Housing, Employment and Supports Manager	(518) 474-5191	MNewman@omh.state.ny.us
Oregon	Yes	Joseph Yedziniak	Director, Housing and Homeless Services	(503) 945-9722	joseph.yedziniak@state.or.us
Tennessee	Yes	Bob Currie Marie Williams	Assistant Commissioner, Department of Mental Health and Developmental Disabilities	(615) 532-4651 (615) 253-3051	Bob.currie@state.tn.us Marie.williams@state.tn.us
Washington	Yes	Frank Jose	Program Administrator, Mental Health Division	(360) 902-0790	Josef@dshs.wa.gov

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