



Position Paper of the
Homeless Action Committee

2010

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Executive Summary

The Homeless Action Committee (HAC) is a standing committee of the Illinois Department of Human Services (IDHS), Division of Mental Health (DMH), Region 1 Advisory Council. The mission of the Homeless Action Committee is to integrate existing services and supports, and to strategically stimulate the creation of resources in the Chicago area for the purpose of strengthening the network of care for individuals who are homeless and have a serious mental illness.

The specific recommendations outlined in this paper speak to the need to pay special attention to the multitude of barriers faced by individuals who are homeless and have a mental illness. Once achieved, the committee believes that the entire Chicago area will be better positioned to make significant strides toward helping individuals who are homeless and have a mental illness or a co-occurring mental illness and substance use disorder gain access to needed services across the city and break the cycle of homelessness.

Recommendations

Best Practices

The Homeless Action Committee endorses the use of best practices – the recovery paradigm, harm reduction, integrated dual diagnosis services, Housing First, integrated systems of care, and cultural and linguistic competency – in meeting the needs of individuals who are homeless and have a mental illness and may have a co-occurring substance use disorder.

Outreach and Engagement Services

Increasing the availability of comprehensive outreach and engagement services to individuals and families who are grappling with the issues of homelessness and serious mental illness is the root component of facilitating the journey to recovery. The Homeless Action Committee strongly encourages state, local, and federal funders to increase dedicated funding for homeless outreach services, increase training opportunities on engagement strategies, recognize the value of outreach workers' active participation in collaborative networks involving local homeless service providers, and expand the definition of "Outreach and Engagement" to include re-engagement activities for individuals who are known to the mental health system and cycle in and out repeatedly.

Emergency Services

While the Homeless Action Committee endorses the Housing First model, we recognize there is a shortage of permanent supportive housing within the city and the development of permanent supportive housing is a lengthy process. The Homeless Action Committee recommends that DHS/DMH advocate for the continued operation of local emergency services as a means of meeting basic needs and to facilitate linkage to permanent supportive housing.

Assertive Community Treatment (ACT) and Community Support Team (CST) Services

The Homeless Action Committee recommends that the Division of Mental Health provide the leadership to direct all existing ACT and CST teams to function as local service platforms from which outreach and engagement to people who are homeless can be mounted. The Committee also recommends that the Division modify its Continuity of Care Agreement to include language supporting the use of both ACT and CST services as a tool for fighting homelessness among people with serious mental illnesses.

Permanent Supportive Housing

Permanent supportive housing has been found to be one of the most successful and cost effective models of housing for individuals who are homeless and have a mental illness. The Homeless Action Committee recommends the creation of additional permanent supportive housing units, greater housing accessibility and broader eligibility requirements, and adequate funding for supportive services.

Presumptive Eligibility for Mental Health Consumers

The Homeless Action Committee recommends the establishment of presumptive eligibility that would grant Medicaid benefits to people with an obvious serious mental illness. The committee supports an expansion of the current presumptive eligibility SSI Pilot Project, as well as the Illinois SSI/SSDI Outreach, Access, and Recovery (SOAR) initiative.

Addressing the Needs of Specific Groups within the Target Population

Within the group of individuals who are homeless and have a mental illness and co-occurring substance use disorder, there are other subsets, such as youth, individuals with families and children, veterans, and individuals who have been involved in the criminal justice system. Each of these groups face unique barriers to accessing and receiving services and housing, and providers of mental health, substance abuse treatment and homeless services need to be aware of their special needs. The Homeless Action Committee recommends that specialized funding and technical assistance be developed for these special populations.

The Homeless Action Committee has approximately 30 members. Membership includes representative from the mental health, vocational rehabilitation, substance abuse, housing, homeless services, primary health care, and benefits and entitlements systems.

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Background

The Homeless Action Committee (HAC) is a standing committee of the Illinois Department of Human Services (IDHS), Division of Mental Health (DMH), Region 1 Advisory Council. The mission of the Homeless Action Committee is to integrate existing services and supports, and to strategically stimulate the creation of resources in the Chicago area for the purpose of strengthening the network of care for individuals who are homeless and have a serious mental illness.

The Committee has its roots in the Access to Community Care and Emergency Supports and Services (ACCESS) demonstration project funded by the Center for Mental Health Services. Since 1994, administrators from multiple service delivery systems have met to identify and overcome barriers, fill service gaps, and enhance collaboration to the benefit of individuals who are homeless and have a serious mental illness and may have a co-occurring substance use disorder. The systems represented include: mental health, vocational rehabilitation, substance abuse, housing, homeless services, primary health care, and benefits and entitlements. Participants span many levels of government and the service delivery systems. A complete list of participating entities is attached to this paper as an addendum.

The Homeless Action Committee believes that consideration for the needs of individuals who are homeless and have a mental illness or co-occurring mental illness and substance use disorder in system and service planning is crucial, now more than ever.

Extent of Need

Historically, efforts to count the number of homeless persons in the city of Chicago have yielded variable results. For example, while the Chicago Coalition for the Homeless estimates the homeless population in Chicago to be 21,078 homeless individuals on any given night,¹ the Chicago Department of Family and Support Services estimate the homeless population to be 6,420.² According to a study conducted by the University of Illinois at Chicago,³ approximately 166,000 people experience homelessness in the Chicago metropolitan area each year. Although estimates of the homeless population vary, it is clear that homelessness in Chicago is a significant issue.

Individuals with a serious mental illness, substance use disorder, or a co-occurring mental illness and substance use disorder are significantly overrepresented among the homeless population. While only 4% of the U.S. adult population suffers from a serious mental illness, 20-25% of adults who are homeless have been diagnosed with a serious mental illness.⁴ In addition, 34% of homeless adults have a substance use disorder.⁵ Individuals who are homeless with a mental

¹ Chicago Coalition for the Homeless (2006). *Homelessness: Facts and figures*. Available at www.chicagohomeless.org

² Chicago Department of Human Services (2009). *The 2009 City of Chicago Homeless Point in Time Count Executive Summary*. Chicago, IL.

³ University of Illinois at Chicago (1999). *For rent: Housing options in the Chicago region*. Chicago, IL.

⁴ Rosenheck, R., Barruk, E., & Salomon (1999). A special population of homeless Americans. In L. Fosburg and D. Dennis (EDS), *Practical Lessons*. Washington, DC: Department of Health and Human Services and U.S. Department of Housing and Urban Development.

⁵ U.S. Conference of Mayors (2001). *A status report of hunger and homelessness in American cities*. Washington, DC.

illness and substance abuse disorders are likely to be more severely impaired, homeless for longer periods of time, and more reluctant or unable to seek treatment than their cohorts who are housed.⁶

Local data suggests that, consistent with findings nationwide, homeless individuals in Chicago are much more likely to have a serious mental illness and substance use disorder. In a 2005 City of Chicago survey, 27% of homeless individuals surveyed self-reported having a mental illness, and 37% reported substance use. For individuals living on the street, as opposed to a shelter, numbers were even higher, with 47% reporting mental illness and 74% reporting substance use.⁷ Due to symptoms of mental illness and substance use, and the stigma attached with self-reporting, it is likely that the percentage of individuals who are homeless with a mental illness and substance use disorder in Chicago is even greater.

A review of the literature indicates that homeless individuals with mental illness, and those with co-occurring substance use disorders, are more likely to be homeless for longer periods of time and to face more obstacles than other homeless people.⁸ Due to the nature and complexities of the barriers faced by this population, efforts to improve systems integration, coupled with an evidence-based approach to treatment, are essential elements in the fight to end homelessness.

Overview of the Committee's Recommendations

In preparing the recommendations set forth in this position paper, the Homeless Action Committee consulted the expertise of its membership, along with a review of the literature related to best practices in working with individuals who are homeless and have a mental illness. In addition, the committee examined environmental factors currently impacting systems and service provision for this population. Based upon extensive research, the committee offers cited evidence in support of the recommendations made to address barriers and gaps in systems and services for individuals with a mental illness experiencing homelessness.

The specific recommendations listed below speak to the need to pay special attention to the multitude of barriers faced by individuals who are homeless and have a mental illness. Once achieved, the committee believes that the entire Chicago area will be better positioned to make significant strides toward helping individuals who are homeless and have a mental illness or a co-occurring mental illness and substance use disorder gain access to needed services across the city and break the cycle of homelessness.

⁶ Federal Task Force on Homelessness and Severe Mental Illness. (1992). *Outcasts on main street: report of the federal task force on homelessness and severe mental illness*. Washington, DC: Interagency Council on the Homeless.

⁷ Chicago Department of Human Services. *Summary of Findings of the Point-in-time Count of Chicago's Homeless*. June 2005. Chicago, IL.

⁸ Tessler, R.C., & Dennis, D.L. (1989). *A synthesis of NIMH-funded research concerning persons who are homeless and mentally ill*. Rockville, MD: National Institute of Mental Health.

Recommendations

Best Practices

The Homeless Action Committee endorses the use of best practices in meeting the needs of individuals who are homeless and have a mental illness and may have a co-occurring substance use disorder. The committee makes the following recommendations based on best practices in the field.

Recovery Paradigm - The President's New Freedom Commission on Mental Health defines recovery as "the process in which people are able to live, work, learn, and participate fully in their communities."⁹ Elements of a recovery-oriented approach include giving priority to personal choice, a focus on each person's strengths, and intervention strategies that emphasize the role of hope in the process of setting and pursuing life goals. When operationalized, the recovery paradigm means that agencies do not exclude individuals based on their willingness to participate in services.

The Homeless Action Committee strongly recommends the adoption of the recovery-oriented paradigm, as evidenced by the inclusion of recovery language in provider vision and mission statement, as well as by flexible, voluntary, consumer driven services. In addition, the committee recommends that individuals with mental illness who are homeless or have experienced homelessness be included in decision- making and system planning at all levels, to ensure that the needs of the population are adequately addressed.

Harm Reduction – Harm reduction is "a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence,...meet[ing] drug users 'where they're at,' addressing conditions of use along with the use itself."¹⁰ Values of the harm reduction philosophy include being nonjudgmental, avoiding preconceived goals, providing consumers with choices and valuing their input, building rapport and trust, and emphasize consumer's strengths and personal responsibility for outcomes. In practice, harm reduction is about not excluding individuals from housing or services based on sobriety requirements. The philosophy recognized that individuals need supports, including housing, before they are able to examine their substance use behaviors and mental illness. The values of harm reduction compliment those of the recovery paradigm.

The Homeless Action Committee recommends that DMH, DASA, and other funders adopt the harm reduction philosophy and provide incentives for those agencies that incorporate it in their work. The committee also recommends that DMH and DASA hold regularly scheduled trainings and teleconferences on harm reduction tools and strategies for providers and consumers.

Integrated Dual Diagnosis Services - While only 4% of the U.S. adult population suffers from a serious mental illness, 20-25% of adults who are homeless have been diagnosed with a serious mental illness.¹¹ Among individuals who are homeless with a mental illness, substance abuse is

⁹ New Freedom Commission on Mental Health, *Subcommittee on Housing and Homelessness: Background Paper*. DHHSPub. No. SMA-04-3884. Rockville, MD: 2004.

¹⁰ Harm Reduction Coalition. <http://www.harmreduction.org/article.php?list=type&type=62>.

¹¹ Rosenheck, R., Barruk, E., & Salomon (1999). A special population of homeless Americans. In L. Fosbusrg and D.

the most common and clinically significant co-morbid diagnosis.¹² In addition to homelessness, individuals with serious mental illness and co-occurring substance use disorder have increased rates of hospitalization, relapse, and incarceration.^{13 14 15} In light of these statistics, it is critical that individuals who are homeless with a mental illness and co-occurring substance use disorder have access to evidence-based, Integrated Dual Disorder Treatment (IDDT). The IDDT model integrates mental health and substance use treatment, often through the use of multidisciplinary teams. The model provides consumers with both services in one location or by one provider. The IDDT model has been shown to complement the ACT model and the benefits of providing IDDT through an ACT model have been well documented. The implementation of IDDT, when delivered by an ACT team, has been found to produce increased benefits in terms of substance abuse and some quality of life outcomes when compared to IDDT services delivered by more traditional case management.¹⁶

The Homeless Action Committee recommends that DMH and DASA fund on-going IDDT trainings and services to individual agencies or through consortiums.

Housing First - Housing first, as described in the National Alliance to End Homelessness 10-year plan, is an approach in which individuals struggling with homelessness are quickly provided permanent housing and linked to needed services¹⁷. The “housing first” model has been embraced by the Chicago Alliance to End Homelessness, and fits with its collaborative plan to end homelessness.¹⁸ For most, the strategy strives to foster long-term self-sufficiency, but recognizes that for some, lifelong support may be necessary to prevent a return to homelessness. The provision of safe, affordable housing is a key component in the implementation of evidence-based ACT and IDDT, and housing first fits well with these treatment models. Programs using a housing first model have been shown to be extremely effective, particularly at maintaining housing and reducing costs to surrounding communities.^{19 20} These programs have also shown more success at helping chronically homeless individuals maintaining long-term housing than programs requiring sobriety before entering into the housing program.²¹

Dennis (EDS), *Practical Lessons*. Washington, DC: Department of Health and Human Services and U.S. Department of Housing and Urban Development.

¹² Drake, R.E., Essock, S.M., Shaner, A., Carey K.B., Minkoff, K., Kola, L., Lynde, D., Osher, F.C., Clark, R.E., & Richards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52(4), 469-476.

¹³ Swofford, C.D., Kasckow, J.W., Scheller-Gilkey, G., & Inderbitzen, L.B. (1996). Substance use: a powerful predictor of relapse in schizophrenia. *Schizophrenia Research*, 20, 145-151.

¹⁴ Abram, K.M., & Teplin, L.A. (1991). Co-occurring disorders among mentally ill jail detainees: implications for public policy. *American Psychologist*, 46, 1036-1045.

¹⁵ Caton, C.L., Shrout, P.E., Eagle, P.F., Opler, L.A., Felix, A.F., & Dominguez, B. (1994). Risk factors for homelessness among schizophrenic men: a case-control study. *American Journal of Public Health*, 84, 265-270.

¹⁶ Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.B., Xie, H., Miles, K., & Ackerson, T.H. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry*, 68, 201-215.

¹⁷ National Alliance to End Homelessness (2000). *A plan: not a dream. How to end homelessness in ten years*. Washington, DC.

¹⁸ Chicago Continuum of Care (2002). *Getting housed, staying housed: A collaborative plan to end homelessness*. Chicago, IL.

¹⁹ Pearson, C., Montgomery, A.E., & Locke, G. (2009) Housing stability among homeless individuals with serious mental illness participating in housing first programs. *Journal of Community Psychology*, 37(3), 404-417.

²⁰ Larimer, M.E., Malone, D.K., Garner, M.D., Atkins, D.C., Burlingham, B., Lonczak, H.S., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *Journal of American Medicine*, 301(13), 1349-1357

²¹ Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless

The “housing first” model stipulates that the right to housing is not to be denied based upon on an individual’s unwillingness or inability to accept mental health treatment or meet sobriety requirements. Although this model differs significantly from more traditional housing programs, studies have indicated that consumers with dual disorders are able to maintain independent housing without adverse affect on psychiatric or substance abuse symptoms.²²

The Homeless Action Committee recommends that DMH and other funders adopt a “housing first” philosophy and provide incentives for those agencies that use it.

Integrated Systems of Care – Individuals who are homeless and have a mental illness or a co-occurring mental illness and substance use disorder experience a complex set of barriers to receiving services and treatment that is often offered by a multitude of different providers and systems, leaving the individual to coordinate their own care. The result of these disjointed systems is that individuals who are experiencing homelessness are more likely to suffer from acute, life-threatening medical conditions than individuals who are housed and are at significantly higher risk for mortality than the general population.^{23 24}

In addition to integrating mental health and substance use services for individuals who are homeless, efforts must also be taken to integrate other services that address the needs of this population – such as health care, housing, vocational and educational support, and income supports and entitlements.

The Homeless Action Committee endorses the model of comprehensive, integrated systems of care. The committee recommends that all divisions of the Illinois Department of Human Services participate in systems and service integration initiatives in partnership with community providers. The committee also recommends that DMH, DASA, and other funders provide incentives to agencies that provide services through integrated systems of care.

Cultural and Linguistic Competency - According to the U.S. Conference of Mayors Report, the national breakdown of homeless individuals by race is as follows: 50% African American; 35% White; 12% Latino; 2% Native American; and 1% Asian.²⁵ In Chicago, the percentage of homeless individuals who are African American has been shown to be even higher, reaching 67% in 2005.²⁶ Although predominantly African American, the diversity of the homeless population in Chicago clearly indicates that service provisions for this population must be culturally competent and representative of the population to be served. Issues of race, gender, ethnicity, disability, language, socioeconomic factors, and stigma related to substance abuse and mental health treatment must be addressed.

individuals with a dual diagnosis. *American Journal of Community Psychology*, 32, 305-317.

²² Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.

²³ Kraybill, Ken and S. Morrison. Homelessness and Health. Homelessness Resource Center (2009). Available at [http://homeless.samhsa.gov/\(S\(hwht5kyuzjhzjeq23eua4n2i\)\)/Resource/Homelessness-and-Health-Care-32852.aspx](http://homeless.samhsa.gov/(S(hwht5kyuzjhzjeq23eua4n2i))/Resource/Homelessness-and-Health-Care-32852.aspx).

²⁴ Hwang, Stephen W., and James J. O’Connell (1998). Risk Factors for Death in Homeless Adults in Boston. American Medical Association, Archives of Internal Medicine: July 13, 1998. Available at http://www.commonground.org/?page_id=789.

²⁵ U.S. Conference of Mayors (2001). *A Status Report of Hunger and Homelessness in American Cities*. Washington, DC.

²⁶ Chicago Department of Human Services. *Summary of Findings of the Point-in-time Count of Chicago’s Homeless*. June 2005. Chicago, IL.

Additionally, a serious cultural and linguistic barrier exists for immigrants and refugees who are homeless. Training and technical assistance in cultural competency needs to be an on-going process to ensure appropriate services for homeless individuals from minority groups. Linkage of homeless immigrants and refugees to their respective communities as a support system is also crucial for a more effective outreach.

It is the recommendation of the Homeless Action Committee that IDHS create an ethnic, cultural, and linguistic competence addendum to contracts and apply best practices in cultural and linguistic competency to more effectively deliver services to individuals experiencing homelessness. It is our recommendation that IDHS establish and enforce accountability guidelines that require all funded agencies to establish policies and procedures that are evidence based and linguistic and culturally competent. Agencies could achieve this through a variety of ways, including: formal linkage agreements with culturally appropriate service providers; providing on-going trainings to staff; providing translation services and having translated documents available; and conducting surveys to assess the need for more ethnically, culturally, and linguistically appropriate services. Agencies should also be able to demonstrate a cultural and linguistic competent workforce. This is critical in order to achieve a successful transformation in behavioral healthcare services. We request that IDHS agree to provide the necessary technical support.

Outreach and Engagement Services

Increasing the availability of comprehensive outreach and engagement services to individuals and families who are grappling with the issues of homelessness and serious mental illness is the root component of facilitating the journey to recovery. As staff from programs specializing in street outreach will attest, the provision of effective services to individuals who are homeless requires a specific skill-set and the ability to develop relationships based on trust, respect and a shared desire to increase access to resources. This gradual process takes time, patience and tenacious perseverance to accomplish.

Examples of programs that provide much needed funds for this level of care and assistance include: Streets to Home, a strategy which targets unsheltered individuals who are homeless and provides government subsidized permanent housing with follow-up supports, and Projects for Assistance in Transition from Homelessness (PATH), which is a federally funded formula grant program designed specifically to address the crisis of homelessness among individuals who are homeless with serious mental illness and may have a co-occurring substance abuse disorder.

In FY 2008, the eighteen Illinois PATH providers collectively served a total of 3,077 individuals and families throughout the state. People meeting the eligibility criteria received the following services: screening and diagnostic treatment, habilitation and rehabilitation, linkage with community mental health services, referrals to primary health services, case management, supportive and supervisory services, support with planning, coordination and technical assistance in the acquisition of housing.²⁷

²⁷ PATH State Summary Report for FY2008, Illinois.

The Homeless Action Committee strongly encourages state, local, and federal funders to consider the following recommendations:

- 1) Increase the amount of funds allocated towards intensive outreach services on behalf of individuals and families who are homeless,
- 2) Increase training opportunities on engagement strategies and techniques when working with individuals who are homeless and have a mental illness.
- 3) Recognize the value of outreach workers' active participation in collaborative networks involving local homeless service providers. This practice enables providers to cultivate mutually beneficial alliances that eliminate system gaps.
- 4) Expand the definition of "Outreach and Engagement" to include re-engagement activities for individuals who are known to the mental health system and cycle in and out repeatedly. Recovery often does not occur the first time services are made available.

Emergency Services

Research has shown that emergency shelters are not effective solutions for moving individuals out of homelessness. In fact, individuals facing multiple barriers to housing can often get trapped within emergency service systems and fail to move into permanent housing. For this reason, Chicago's Ten Year Plan to End Homelessness has called for the dismantling of traditional emergency shelters and recommends an investment in homeless prevention and permanent supportive housing. Unfortunately, while these options are much more sustainable solutions to homelessness, they often fail to meet immediate needs of safety and warmth until housing can be secured.

Chicago's emergency service system is not adequately meeting the current need for shelter. Out of surveyed shelter residents, 22% reported being turned away from shelters and given no additional option, and an additional 22% reported being turned away from the City of Chicago's emergency shelter hotline.²⁸ In 2005, Chicago shelters tracked 14,746 turn-aways from adult emergency shelters.²⁹ It appears as though the number of individuals in need of immediate shelter continues to grow as the economy struggles and employment opportunities are few. December of 2008, 71% of state funded providers of emergency and transitional shelter reported serving more individuals than 6 months earlier, and over a third of these agencies reported an increase of over 110%³⁰.

While the Homeless Action Committee endorses the Housing First model, we recognize there is a shortage of permanent supportive housing within the city and the development of permanent supportive housing is a lengthy process. The Homeless Action Committee recommends that DHS/DMH advocate for the continued operation of local emergency services as a means of meeting basic needs and to facilitate linkage to permanent supportive housing.

²⁸ Chicago Coalition for the Homeless (2006). *Unaddressed: Why Chicago's 10-year plan to end homelessness will not work*. Available at www.chicagohomeless.org

²⁹ Chicago Coalition for the Homeless (2006). *Unaddressed: Why Chicago's 10-year plan to end homelessness will not work*. Available at www.chicagohomeless.org

³⁰ Housing Action Illinois (2009). *Emergency food and shelter program service provider survey results*. Chicago, IL.

Assertive Community Treatment (ACT) and Community Support Team (CST) Services

ACT is an evidence-based service proven to reduce symptoms of psychiatric illnesses and substance abuse disorders, reduce use of emergency rooms and psychiatric hospitalization, reduce incarcerations and court involvement, and reduce homelessness. ACT studies show improvement to quality of life and consumer satisfaction.^{31 32 33 34}

The Illinois Division of Mental Health has successfully introduced the Community Support Team (CST) service model, which incorporates many of the strong features of ACT into a less costly program model. In fact, many of the state's existing ACT programs converted to this model when it was first introduced in 2007.

The Homeless Action Committee recommends that the Division of Mental Health provide the leadership to direct all existing ACT and CST teams to function as local service platforms from which outreach and engagement to people who are homeless can be mounted. The Committee also recommends that the Division modify its Continuity of Care Agreement to include language supporting the use of both ACT and CST services as a tool for fighting homelessness among people with serious mental illnesses. The Continuity of Care Agreement is a wonderful opportunity to assure that the public mental health service network has an ACT and/or CST program accountable for conducting outreach to people who are homeless and have a serious mental illness.

Permanent Supportive Housing

Individuals with a severe mental illness, substance use disorder, or with a co-occurring mental illness and substance abuse disorder are overrepresented among the population of individuals experiencing homelessness.³⁵ In fact, there are more individuals with mental illnesses that are currently homeless than there are in hospitals receiving treatment.³⁶ Many of these individuals fit the definition of "chronically homeless," meaning that they will continually cycle through shelters, jails, streets, prisons, hospitals, and other institutions and will remain homeless for a long period of time. While the chronically homeless are a relatively small percentage of the larger homeless population, the chronically homeless are a high-risk group who has been shown to use over 50% of a community's emergency resources (emergency rooms, hospitals, jails, prisons, shelters, mental health and substance abuse treatment facilities).³⁷ Ultimately, when individuals with a severe mental illness are homeless, this occurs at a huge expense to public

³¹ Phillips, S.D., Burns, B.J., Edgar, E.E., Mueser, K., Linkins, K., Rosenheck, R., Drake, R.E., & McDonel Herr, E.C. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52(6), 771-779.

³² Bond, G.R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001) Assertive community treatment for people with severe mental illness: critical ingredients and impact on consumers. *Disease Management and Health Outcomes*, 9, 141-159.

³³ Burns, B.J., & Santos, A.B. (1995). Assertive community treatment: an update of randomized trials. *Psychiatric Services*, 46, 669-675.

³⁴ Bond, G.R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001) Assertive community treatment for people with severe mental illness: critical ingredients and impact on consumers. *Disease Management and Health Outcomes*, 9, 141-159.

³⁵ U.S. Conference of Mayors (2001). *A status report of hunger and homelessness in American cities*. Washington, DC.

³⁶ Chicago Coalition for the Homeless (2006). *Homelessness: Facts and figures*. Available at www.chicagohomeless.org

³⁷ National Alliance to End Homelessness (2007) *Chronic Homelessness*. Available at www.endhomelessness.org/

systems of care.

Permanent supportive housing has been found to be one of the most successful models of housing for this population.³⁸ The combination of services and housing has been effective in providing housing stability and treatment retention for chronically homeless individuals.³⁹ In addition to providing housing stability, this model is also significantly cheaper than the alternative of allowing homeless individuals with a severe mental illness to remain homeless. Studies have shown that by providing housing to homeless individuals with a mental illness, communities have experienced a significant reduction in service costs.^{40 41 42}

Recognizing the many barriers that individuals experiencing homelessness with a severe mental illness face and the resulting expense to the public, the Homeless Action Committee recommends creating additional supportive housing units for the Chicago metro area, mandating that current units be as accessible as possible to ensure that individuals experiencing homelessness with a mental illness are able to take full advantage of available housing, and prioritizing funding for supportive services that help participants maintain housing and avoid re-entry into homelessness.

Creation of additional housing units - With the introduction of the Chicago Ten Year Plan to End Homelessness, there have been many changes to the housing and shelter systems in Chicago. Despite attempts to create new housing options and adopt a “housing first” model, the housing system in Chicago is unable to keep up with the current need. In 2005, Chicago shelters tracked 14,746 turn-aways from adult emergency shelters.⁴³ While an increase in the permanent and interim housing stock should reduce the need for emergency shelters, it is apparent that there is still a large population of unsheltered individuals without available housing options.

In order to meet the continually growing need, the Homeless Action Committee recommends the creation of additional permanent supportive housing units for homeless individuals with a mental illness. This model has been shown to be successful, cost effective, and ultimately the best option for housing this high risk population. A combination of local, state, and federal funds should support creation and maintenance of these additional units. The committee supports models similar to the Chicago Coalition for the Homeless “Sweet Home Chicago” campaign, which designates 20% of tax increment financing (TIF) funds generated each year for the creation of affordable housing, as a means to re-distribute funds so more permanent housing can be developed. The committee also recommends that DMH set aside at least 10% of the Bridge subsidy units for homeless individuals. DMH should track the housing status of those applying to

³⁸ National Alliance to End Homelessness (2007) *Chronic Homelessness*. Available at www.endhomelessness.org

³⁹ Pearson, C., Montgomery, A.E., & Locke, G. (2009) Housing stability among homeless individuals with serious mental illness participating in housing first programs. *Journal of Community Psychology*, 37(3), 404-417.

⁴⁰ Gilmer, T.P., Manning, W.G., & Ettner, S.L., (2009) A cost analysis of San Diego County’s REACH program for homeless persons. *Psychiatric Services*, 60, 445-450.

⁴¹ Larimer, M.E., Malone, D.K., Garner, M.D., Atkins, D.C., Burlingham, B., Lonczak, H.S., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *Journal of American Medicine*, 301(13), 1349-1357

⁴² Martinez, T.E., & Burt, M.R. (2006). Impact of permanent supportive housing on the use of acute care health services by homeless adults. *Psychiatric Services*, 57, 992-999.

⁴³ Chicago Coalition for the Homeless (2006). *Unaddressed: Why Chicago’s 10-year plan to end homelessness will not work*. Available at www.chicagohomeless.org

the Bridge program and the housing status of those who are accepted into the program to ensure equitably access of homeless individuals into the program.

Housing accessibility and broader eligibility requirements - The accessibility and flexibility of available housing is a crucial factor when working to move individuals with a mental illness and possibly a co-occurring substance disorder off of the streets. Many individuals with a mental illness who are homeless may be unable to commit to the many restrictions attached to programs that require housing readiness.⁴⁴ For many, sobriety, mental health treatment, and even hygiene and life skills are impossible achievements when first exiting homelessness.

The Homeless Action Committee believes that supportive housing programs should have the broadest possible eligibility requirements to ensure that all homeless individuals can qualify for housing. Currently, the Chicago HUD process for determining permanent supportive housing grant renewals incentivizes programs with broad eligibility requirements. The Homeless Action Committee applauds this effort, and encourages more funding sources, such as DMH and DASA, to provide incentives to programs that adopt a “housing first” model and that are willing to accept all applicants, regardless of criminal, substance abuse, or mental health treatment history.

The Homeless Action Committee specifically recommends that housing programs work to house active substance users and ex-offenders. An estimated 26% of homeless individuals currently abuse substances.⁴⁵ When housing programs require sobriety at entry, they eliminate a high-risk group of individuals from eligibility. In addition, there are an estimated 7% to 15% of individuals with serious mental illnesses currently incarcerated.⁴⁶ Since federal law states that ex-offenders can be barred from public housing,⁴⁷ supportive housing providers must be willing to accept this population to ensure they are not left without housing options. The Homeless Action Committee recommends that funders provide incentives for agencies that work to house ex-offenders, former sex offenders, active substance users, and other individuals who face multiple barriers to housing.

Adequate funding for supportive services - Supportive services have been shown to be both effective and cost efficient in helping homeless individuals achieve stability in their lives.^{48 49} Services such as housing, mental health treatment, life skills support, substance abuse treatment, medical evaluation, and job training help to ensure that individuals are able to maintain their housing. While services in “housing first” programs are voluntary, they are crucial for helping individuals maintain housing. When we inadequately fund supportive services, we increase the potential for individuals to re-enter homelessness.

⁴⁴ Pearson, C., Montgomery, A.E., & Locke, G. (2009) Housing stability among homeless individuals with serious mental illness participating in housing first programs. *Journal of Community Psychology*, 37(3), 404-417.

⁴⁵ Chicago Coalition for the Homeless (2006). *Homelessness: Facts and figures*. Available at www.chicagohomeless.org

⁴⁶ The American Psychiatric Association. (2004). *Mental illness and the criminal justice system: Redirecting resources toward treatment, not containment*. Arlington, VA: The American Psychiatric Association

⁴⁷ Chicago Coalition for the Homeless (2006). *Homelessness: Facts and figures*. Available at www.chicagohomeless.org

⁴⁸ Pearson, C., Montgomery, A.E., & Locke, G. (2009) Housing stability among homeless individuals with serious mental illness participating in housing first programs. *Journal of Community Psychology*, 37(3), 404-417.

⁴⁹ United Power for Action and Justice (2003). *Lessons learned: Breaking the cycle of homelessness*. Available at www.luc.edu/curl/pdfs/Policy_Brief.pdf

Due to the necessity of supportive services to ensure the efficacy of housing programs, the Homeless Action Committee recommends that the Chicago Planning Council on Homelessness revise the current rule stating that all new HUD Permanent Supportive Housing projects may only dedicate 10% of their budgets to supportive services. The designated 10% of funding is insufficient when supportive services are the key to helping individuals maintain housing stability. For this reason, the Homeless Action Committee recommends that HUD increase this percentage, allowing new Permanent Supportive Housing Projects to dedicate up to 50% of their budgets to supportive services. The cost of homelessness has been well documented. By effectively funding supportive services, ultimately we reduce costs to already taxed public systems of care.

The Homeless Action Committee also recommends that the state of Illinois work to fund homeless specific demonstration projects that creatively use service funding to end homelessness for individuals experiencing mental illness. In a time where budgets are strained, we must remember that supportive services are crucial to eliminating homelessness and prioritize this expense accordingly. Ultimately, demonstration projects that work to provide wraparound services to clients will achieve greater outcomes in reducing homelessness. The Homeless Action Committee also recommends that funders provide incentives for mental health and substance use providers who partner with housing providers in the delivery services and vice versa.

Presumptive Eligibility for Mental Health Consumers

Presumptive eligibility allows critical health care coverage and disability benefits to be quickly made available to certain vulnerable populations who are currently awaiting the eligibility determination process. Qualified health providers are allowed to “presume eligibility” based on a certain set of criteria. Temporary benefits are then awarded to the applicant, until a determination is made, allowing them to receive needed services. Presumptive eligibility may significantly help to improve health status and outcomes.⁵⁰ Presumptive eligibility is currently used in Illinois by the All Kids program, the Community Care program, and the Family Care program, among others Medicaid programs and is being piloted at two community mental health agencies. Preliminary research from the Chicago presumptive eligibility pilot project (known as the SSI Pilot Project) reports that 100% of clients recommended for presumptive disability were awarded benefits.⁵¹

The Homeless Action Committee recommends the establishment of presumptive eligibility that would grant Medicaid benefits to people with an obvious serious mental illness. The Homeless Action Committee also recommends that DMH identify administrative staff to work with the Division of Rehabilitative Services and the Bureau of Disability Determination to remove barriers and expedite the benefits process, as well as ensure that determinations are being made in a timely fashion. The Homeless Action Committee supports an expansion of the current presumptive eligibility SSI Pilot Project, as well as the Illinois SSI/SSDI Outreach, Access, and Recovery (SOAR) initiative – a national initiative focused on expediting the SSI and SSDI application process for individuals who are homeless and have a mental illness.

⁵⁰ Governor's Commission on Home and Community-Based Services. Indiana Family and Social Service Administration. Available at <http://www.in.gov/fssa/disability/community/presumptiveelig.html>.

⁵¹ SSI Homeless Outreach Project, January 1, 2007-September 30, 2007. Corporation for Supportive Housing.

Addressing the Needs of Specific Groups within the Target Population

Within the group of individuals who are homeless and have a mental illness and co-occurring substance use disorder, there are other subsets, such as youth, individuals with families and children, veterans, and individuals who have been involved in the criminal justice system. Each of these groups face unique barriers to accessing and receiving services and housing, and providers of mental health, substance abuse treatment, and homeless services need to be aware of their special needs. The Homeless Action Committee recommends that specialized funding and technical assistance be developed for these special populations.

Youth - Homeless youth, aged 16 to 24, often suffer from illnesses directly related to their lifestyle on the streets, including traumatic injury, substance use, psychiatric disturbances, chronic depression, and developmental disorders.⁵² In addition, as youth age out of the Department of Children and Family Services (DCFS) system, they often do not make the connection to DMH services, resulting in homelessness and untreated mental health concerns.

Among homeless youth, LGBTQ (lesbian, gay, bi-sexual, transgender, and questioning) youth are overrepresented. An estimated 20-40% of all homeless youth identify as LGBTQ, while only 3% to 5% of the U.S. population does.⁵³ LGBTQ homeless youth must face the combined trauma of homelessness and the stigma related to their sexual orientation. This trauma has an impact on mental health, with LGBTQ homeless youth showing more symptoms of mental illness, including more suicide attempts and depression, and more frequently using substances than their heterosexual counterparts.^{54 55 56 57} LGBTQ youth report being discriminated against and assaulted within homeless shelters and housing programs by staff and peers.⁵⁸

The Homeless Action Committee recommends the development of more youth-specific housing, including housing for youth with children. This housing should offer trauma-informed services and should include a continuum of both permanent supportive housing and emergency housing.

⁵² Organizing Health Services for Homeless People: A Practical Guide. Marsha McMurray-Avila, 2nd Edition, 2001, National Health Care for the Homeless Council.

⁵³ The National Gay and Lesbian Task Force. (2007). *Lesbian, Gay, Bisexual, and Transgendered Youth: An Epidemic of Homelessness*. Available at http://www.thetaskforce.org/reports_and_research/homeless_youth

⁵⁴ The National Gay and Lesbian Task Force. (2007). *Lesbian, Gay, Bisexual, and Transgendered Youth: An Epidemic of Homelessness*. Available at http://www.thetaskforce.org/reports_and_research/homeless_youth

⁵⁴ Cochran, B. N., Stewart, A. J., Ginzler, J.A., & Cauce, A.M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health*.92(5).773-777.

⁵⁵ Cochran, B. N., Stewart, A. J., Ginzler, J.A., & Cauce, A.M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health*.92(5).773-777.

⁵⁶ Kruks, G. (1991). Gay and lesbian homeless/street youth: Special issues and concerns. *Journal of Adolescent Health*, 12(7). 515-518.

⁵⁷ VanLeeuwen, J.M., Boyle, S., Salomonsen-Sautel, S., Baker, D.N., Garcia, J.T., Hoffman, A. & Hopfer, C.J. (2005). Lesbian, gay, and bisexual homeless youth: An eight city public health perspective. *Child Welfare* 85(2), 151-170.

⁵⁸ The National Gay and Lesbian Task Force. (2007). *Lesbian, Gay, Bisexual, and Transgendered Youth: An Epidemic of Homelessness*. Available at http://www.thetaskforce.org/reports_and_research/homeless_youth

Staff at agencies serving the LGBTQ population should undergo training to ensure that all homeless and mental health services are safe and culturally competent for LGBTQ clients.

The committee recommends that the DMH strengthen the current system of care through the development and implementation of a transitional support services model targeting homeless youth between the ages of 16 through 25. It is recommended that this model be developmentally appropriate, comprehensive, and provide a continuous array of services capable of supporting youth who meet the eligibility criteria. DMH should consider utilizing the TIP model currently being used by the SIRSS and Thresholds' Transitional Youth Pilot projects, which have demonstrated degrees of measurable success. It is the committee's recommendation that these services be added to the Medicaid services taxonomy to provide a pay incentive for community mental health service providers to improve system coordination of services.

Families - According to the National Center on Family Homelessness, families with children are among the fastest growing segment of the homeless population, with 1.35 million children experiencing homelessness during a year's time.⁵⁹ In a Chicago Coalition for the Homeless 2001 study, *Putting Families First: Ending Family Homelessness in Illinois*, it is reported that families, primarily women with children, make up 40% of the homeless population in Illinois.⁶⁰ Homelessness among children can cause physical, mental, and emotional health issues.⁶¹ Coupled with this fact is the raising rate of mental illness among homeless mothers that makes homelessness among families complex to overcome.⁶² However, recent changes to the McKinney-Vento legislation are making ending family homelessness more feasible. In the new legislation, families are now included in the definition of chronic homelessness and "doubling up" or couch surfing individuals and families are now included in the definition of homelessness. These changes will bring much needed resources to this population.

The Homeless Action Committee recommends that continuums of care integrate as quickly as possible the newly expanded rules and regulations of McKinney-Vento homeless assistance programs. The committee also recommends that providers expand their programming to include those that are captured in the expanded definitions. In addition, the committee recommends that DMH include families in their supportive housing programs.

Veterans - Current national estimates suggest that about 131,000 U.S. Veterans are homeless on any given night. Almost twice as many Veterans experience homelessness at some point during the course of a year, making Veterans over-represented in the homeless population. The majority of homeless Veterans are male. Similar to the general population of homeless adult males, about 45% of homeless veterans suffer from mental illness and slightly more than 70% suffer from alcohol or other drug abuse problems.⁶³

⁵⁹ The National Center on Family Homelessness. Available at <http://www.familyhomelessness.org/facts.html>.

⁶⁰ Chicago Coalition for the Homeless. *Putting Children First: Ending Family Homelessness in Illinois*. December 2001. Available at <http://www.chicagohomeless.org/factsfigures/statesurvey.pdf>.

⁶¹ Chicago Coalition for the Homeless. *Putting Children First: Ending Family Homelessness in Illinois*. December 2001. Available at <http://www.chicagohomeless.org/factsfigures/statesurvey.pdf>.

⁶² Weinreb, Linda F., MD, John C. Buckner, PhD, Valerie Williams, MA, MS and Joanne Nicholson, PhD. "A Comparison of the Health and Mental Health Status of Homeless Mothers in Worcester, Mass: 1993 and 2003." *American Journal of Public Health* 1444-1448. August 2006, Vol 96, No. 8.

⁶³ United States Department of Veterans Affairs: <http://www1.va.gov/homeless/page.cfm?pg=1>.

The Homeless Action Committee recommends that all DMH providers cultivate a relationship with the Department of Veterans Affairs as a way to maximize the impact of mental health outreach efforts. The committee also recommends that housing options for Veterans with access to services, which addresses their unique needs, be increased. Service providers offering mental health and addictions treatment should be encouraged to screen for eligibility for veterans benefits and to develop formal linkages with Veteran's Administration services.

Persons involved in the criminal justice system - All too often individuals experiencing mental illness and homelessness become involved with the criminal justice system. A study by Abram and colleagues found that 6.4% of men and 15% of women admitted to Cook County Jail had a serious mental illness.⁶⁴ In addition, an internal audit of Cook County Jail conducted in 2000 by Cermak Health Services indicated that 54% of detainees entered the jail homeless, and the same number exited the jail homeless.⁶⁵ For individuals with a severe mental illness who are exiting the criminal justice system, having access to mental health treatment, housing, and supportive services at discharge can be effective at preventing recidivism.^{66 67}

Even with excellent wrap-around services, individuals who have exited the criminal justice system with a felony conviction on their record face huge obstacles to finding housing. Most housing providers require a criminal background check and restrict housing availability from individuals with felony records, leaving fewer housing options for ex-offenders upon release. While the dearth of housing options can negatively impact an ex-offender's' reintegration into their community, this affect is particularly staggering for sex offenders with a mental illness. Most city, state, and federal subsidized housing programs prohibit housing sex offenders, and when coupled with residency and reporting requirements, this leaves few housing options for this group of individuals.

To address the needs of this population, the Homeless Action Committee recommends increased collaboration between social service providers and the Illinois Department of Corrections (IDOC) in order to ensure linkage to mental health services, housing, and other services prior to release. The committee also recommends that funders support the development of housing options that have few or no restrictions on criminal backgrounds and that DHS/DMH advocate to remove housing restrictions for ex-offenders who are actively seeking mental health treatment.

Conclusion

The Homeless Action Committee is committed to the integration of existing services and supports and to the creation of resources in the Chicago area for the purpose of strengthening the network of care for individuals who are homeless and have a serious mental illness. Please contact one of the Committee Chairs below for additional information about the committee.

⁶⁴ Abram, K.M., & Teplin, L.A. (1991). Co-occurring disorders among mentally ill jail detainees: implications for public policy. *American Psychologist*, 46, 1036-1045.

⁶⁵ Homeless Action Committee. *Toward a Better Count of People who are Homeless and are Incarcerated at Cook County Jail: a Report of a Special Workgroup convened by the Homeless Action Committee*. March 21, 2001.

⁶⁶ Lamberti, J. S. (2007). Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services*, 58(6), 773-781.

⁶⁷ Lamberti, J.S. (1999). Prevention of jail and hospital recidivism among persons with severe mental illness. *Psychiatric Services*, 50(11), 1477-1480.

Addendum

The Homeless Action Committee has approximately 30 members. Membership includes representative from the mental health, vocational rehabilitation, substance abuse, housing, homeless services, primary health care, and benefits and entitlements systems, including representatives from the following agencies:

Bobby E. Wright Community Behavioral Health Center
Chicago Department of Family and Support Services
Chicago Department of Public Health
Cermak Health Services of Cook County
Community Mental Health Council
Counseling Centers of Lakeview
Deborah's Place
Heartland Health Outreach
Illinois Department of Human Services
InterFaith House
Mandel Legal Aid Clinic
Maine Center
Mercy Housing Lakefront
Next Steps
Northwestern Memorial Hospital
Renaissance Social Services, Inc.
Stroger Hospital
Social Security Administration
Thresholds
University of Illinois at Chicago
YMCA — Lawson House

For additional information regarding the Homeless Action Committee, please contact:

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