SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

BEHAVIORAL HEALTH SERVICES FOR PEOPLE WHO ARE HOMELESS

Introduction

According to the Department of Housing and Urban Development's (HUD) 2020 Annual Homeless Assessment Report (AHAR) to Congress, on a single night in 2020, there were approximately 580,000 individuals experiencing homelessness in the United States. People experiencing unsheltered homelessness (e.g., those sleeping outside or in places not otherwise meant for human habitation) were typically concentrated in large cities, followed by suburban areas. Thirty percent of homeless people were members of a family with at least one adult and one child under 18 years of age, and most homeless people in families were sheltered. Twenty-seven percent of those who were homeless and residing in shelters were children under the age of 18, while 87.8 percent of unsheltered people were aged 24 or older. Over 60 percent of all people experiencing homelessness in 2020 were males while African Americans comprised nearly four in 10 homeless individuals, and 37,252 people experiencing homelessness were veterans (HUD, 2021).

Ending homelessness is an important public health issue in the United States. Many experiencing homelessness have high rates of chronic and co-occurring health conditions, mental and substance use disorders. Individuals who are homeless also may be dealing with trauma, and children experiencing homelessness are at risk for emotional and behavioral problems (Perlman et al., 2014). Additionally, research has shown that individuals who are homeless have a risk of mortality that is 1.5 to 11.5 times greater than the general population (Gambatese et al., 2013). Preventive services, including mental health, substance use, medical care, and social supports, are needed for people who are homeless, irrespective of whether they present with diagnosable conditions.

According to data collected as part of the 2015 AHAR, over half of adults living in permanent supportive housing either had a mental disorder or co-occurring mental and substance use disorder (HUD, 2016). Further, people experiencing homelessness are at high risk of overdose from illicit drug use (SAMHSA, 2020). To further compound these already significant problems, data show that adults aged 65 and older who are homeless also have a higher prevalence of unmet needs for substance use and mental disorder treatment compared with their younger adult counterparts (Kaplan et al., 2019). Providing housing to people experiencing homelessness can help prevent the exacerbation of substance use and mental disorders; however, separate treatment and housing considerations must be accounted for when working with this population.

This Advisory is based on SAMHSA's Treatment Improvement Protocol (TIP) 55, *Behavioral Health Services for People Who Are Homeless*. It addresses the fundamentals of how providers and administrators can effectively employ approaches to address the complex challenge of providing comprehensive, integrated, and trauma-informed treatment services to clients experiencing homelessness.

Key Messages

- People who are homeless are at elevated risk for experiencing substance use disorders (SUDs), mental disorders, trauma, medical conditions, employment challenges, and incarceration.
- People experiencing homelessness present unique treatment challenges, as both treatment and housing needs must be concurrently addressed for treatment to be most effective.
- Preventive services for people experiencing homelessness, including mental health, substance use, medical care, and social supports, are critical for mitigating risks of SUDs and mental disorders and improving health outcomes.
- Treatment providers must be knowledgeable about and help clients identify available housing resources.
- Person-centered prevention and trauma-informed treatment practices are essential when working with people experiencing homelessness and help prioritize and address the complex issues clients face.
- Providers should work with federal, state, and community-based agencies to secure permanent supportive housing placements for their clients.
- Clinicians must know how to help individuals access federal or local benefits to improve housing stability.

Defining Homelessness

Homelessness exists on a continuum and is categorized in three ways (Burt, Aron, Lee, & Valente, 2001; Gabrielova & Veleminsky, 2015):

1. Transitional homelessness: ranges from weeks to months, but less than a year, and includes people recently leaving prison or jail.
2. Episodic homelessness: refers to periods where individuals enter and leave homelessness repeatedly and is common among those with unstable housing situations.
3. Chronic homelessness: refers to a period of homelessness lasting at least a year—or occurring repeatedly—while struggling with a disabling condition such as a serious mental illness (SMI), SUD, or physical disability (HUD, 2015).

Environmental and Individual Risk Factors for Homelessness

Poverty and high housing costs that exclude individuals from the local housing market, the removal of institutional supports for individuals with SUDs, and decreased job options for individuals with only a high school education are just some of the environmental factors identified as contributing to homelessness (Burt, 2001; Tuller, 2019). Individual contributors that increase the likelihood of experiencing homelessness include: cognitive impairment, preexisting medical conditions, unemployment, and family instability (Giano et al., 2020). Additionally, traumatic experiences early in life have been identified as a pathway into homelessness (Woodhall-Melnik et al., 2018).

Of people who are homeless and in substance use treatment, 68 percent of men and 76 percent of women reported experiencing a trauma-related event (Christensen et al., 2005; Jainchill et al., 2000). Cognitive impairment also increases the risk for homelessness. Up to 80 percent of people who are homeless show some signs of cognitive impairment, which impacts their ability to learn new skills (Spence, Stevens, & Parks, 2004). Co-occurring medical conditions like HIV/AIDS, hepatitis B and C, cardiovascular conditions, dental problems, asthma, diabetes, and other medical problems are more prevalent among people who are homeless and individuals with SUDs compared to those who are housed (Fazel et al., 2014; Noska et al., 2017; Bagget et al., 2018; Kolla et al., 2020; Mejia-Lancheros et al., 2020).

Preventive Services for People Who Are Homeless

Preventive services may include medical care, housing support, and other social and supportive services (e.g., employment, educational supports for children). These services help a client work toward housing stability and support retention in substance use and mental health treatment and long-term recovery.

Preventive services can be categorized as:

- ***Universal:*** targeting entire populations (e.g., community, state, or country)
- ***Selective:*** targeting subsets of the population considered at risk
- ***Indicated:*** targeting and delivered to individuals exhibiting early signs of problem behavior

Preventive services are often provided in clinical settings, such as primary care, hospitals, or counseling centers. They include life skills development, stress and anger management, anticipatory guidance, parenting programs, and screening and early intervention. These programs may be designed to directly prevent substance use and/or promote mental health and may strengthen individuals and families and enrich quality of life to build resiliency. Providing housing and other preventive services to people experiencing homelessness can help prevent the exacerbation of substance use and mental disorders or transition from normal functioning to the first phases of problem development.

Update on Housing First

Housing First programs place individuals experiencing homelessness into permanent housing and makes supportive services available throughout the housing placement process. Per the Housing First philosophy, housing placement is not contingent on use of available services or engaging in treatment for substance use and/or mental disorders. Beginning in the early 2000s, the Housing First model was widely adopted by various federal, state, and local government agencies to reduce the number of individuals experiencing homelessness and provide substance use, mental health, and medical services through the use of case managers and multidisciplinary teams (Tsemberis, Gulcur, & Nakae, 2004; Tsemberis, 2011). However, recent research suggests that Housing First programs prioritizing housing placement without concurrent treatment engagement and adherence have not been effective in reducing homelessness (Tsai, 2020; U.S. Interagency Council on Homelessness, 2020). To effectively reduce homelessness, the U.S. Interagency Council on Homelessness (USICH) states that programming models should engage and assess people experiencing homelessness using a trauma-informed approach to address the root causes of their homelessness.

Screening and Evaluation

In general, the first step in providing preventive services to an individual experiencing homelessness involves initial observations and decisions about care. It is important to determine if the client is in imminent danger to health or safety and requires immediate help. Providers should collect primary care records and information on the following: substance use and SUD, mental disorders, effects of specific symptoms, co-occurring disorders, and exposure to trauma. They should also evaluate the onset of homelessness, current ability to maintain stable housing, and criminal justice involvement.

Client retention and continuity of care is a significant challenge to address among individuals experiencing homelessness. For those living with chronic homelessness, the task of addressing health care, financial needs, criminal justice issues, and housing security is daunting. Therefore, client retention requires the development of short-term, realistic treatment and prevention goals. Goals should be set collaboratively with clients to include specific milestones within a defined time period and rewards (contingency management) to increase retention.

Relapse prevention and recovery management present unique challenges for providers, as clients with mental and/or substance use disorders are at a higher risk of relapse (Andersson, Wenaas, & Nordfjærn, 2019) and subsequent loss of housing (Pringle, Grasso, & Lederer, 2017). Common strategies to manage recovery and prevent relapse effectively include:

- ***Wellness self-management/Illness self-management:*** supports the management of disease and development of skills related to health and wellness (Mueser et al., 2006; Parsell et al., 2018).
- ***Assertive community treatment:*** provides intensive and integrative community-based mental health services for high-risk individuals (Coldwell & Bender, 2007; Morse et al., 2017).
- ***Motivational interviewing:*** counseling approach focused on achieving behavioral change by determining and increasing an individual's motivations to make positive choices (Berk-Clark et al., 2015; Robinson et al., 2016).
- ***Contingency management***: therapeutic approach based in the principles of operant conditioning that rewards positive behaviors while withholding privileges when negative behaviors are exhibited (Munthe-Kass et al., 2016; Rash et al., 2019).

For more information on the use of motivational strategies when working with clients with SUD, please refer to SAMHSA's TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment*.

Housing Considerations

Housing services are a vital component of treatment for individuals with substance use and/or mental disorders who are experiencing homelessness. For example, immediate access to housing and support from a mental health team has been shown to decrease inpatient days for homeless individuals with schizophrenia or bipolar disorder (Tinland et al., 2020). Housing services can come in the form of emergency shelters or temporary and transitional housing placements, with the needs of each client being different based on the severity of their illness and the client's readiness to change.

For clients with SUDs, three housing types are utilized based on the individual's readiness to change:

- ***Wet housing*** permits the use of legal substances and is suited for pre-contemplation or contemplation stages and includes engagement in treatment services.
- ***Damp housing*** meets the basic needs of a safe shelter and increases the client's readiness to accept services; it is suited for contemplation and pre-preparation stages.
- ***Sober housing*** includes group housing options and is best suited for clients in the action or maintenance stages of change.

Permanent Supportive Housing

Permanent supportive housing is a housing placement and support model widely used for individuals experiencing homelessness who have an SMI or other disability. It provides additional supports, as needed, to help individuals live stably in the community. This type of housing offers a combination of housing and services, and is an established solution for clients experiencing chronic homelessness (Aubry et al., 2020). The ultimate goals of permanent supportive housing models are to offer housing choices, de-emphasize institutional care, prevent relapse, and reduce discrimination and stigma of people with mental and substance use disorders. SAMHSA's *Permanent Supportive Housing Evidence-Based Practices (EBP KIT)* lists 12 elements of permanent supportive housing programs that form the core guiding principles of these programs and differentiate them from other forms of housing assistance:

1. Leases are in the tenants' names and provide full rights, including protection from eviction.
2. Leases have the same provisions held by people without psychiatric disabilities.
3. Participation in services is voluntary, and refusal does not result in eviction.
4. If there are house rules, they are similar to those for people without psychiatric disabilities.
5. There is no time limit on housing with a renewable lease.
6. Tenants are offered a range of housing choices that would be available to others at the same income level.
7. Housing is affordable—no more than 30 percent of the tenant's income.
8. Housing is integrated, allowing the opportunity for tenants to interact with neighbors.
9. Tenants are given choices in the support services they are provided.
10. Support services are dynamic and can change as needs change over time.
11. Support services are focused on recovery to help tenants choose, obtain, and keep housing.
12. Housing and support services are delivered separately.

Recovery Housing

Recovery housing is an intervention that addresses a recovering individual's need for safe housing while providing the requisite recovery and peer support (SAMHSA, 2019). In 2018, the Support Act was passed, which requires the development of best practices for the operation of recovery housing.

The resulting report includes ten guiding principles:

1. Have a clear operational definition that delineates the types and intensity of the services provided.
2. Recognize that SUDs are a chronic condition that require a range of recovery and supports.
3. Recognize that co-occurring mental disorders often accompany SUDs.
4. Assess applicant (potential resident) needs and the appropriateness of the residence to meet these needs.
5. Promote and use evidence-based practices to best support recovery.
6. Develop written policies, procedures, and resident expectations in a resident handbook to ease transition and ensure compliance.
7. Ensure quality, integrity, and resident safety by making safety the chief priority in all recovery houses.
8. Learn and practice cultural competence so staff can work with individuals on a personal basis and respect differing beliefs and backgrounds.
9. Maintain ongoing communication with interested parties and care specialists, including resident's family, vocational programs, and criminal justice professionals.
10. Evaluate program effectiveness and resident success to assess how each house is performing in delivering quality care to residents.

Addressing the Needs of Special Populations

Some groups experience homelessness at higher rates than the general population, and may need to be considered differently when receiving homeless services. Veterans are at increased risk for experiencing homelessness, but are also eligible for additional programs offered by the Department of Veterans Affairs (VA). While it is often assumed that single adults in urban areas are the most common population experiencing homelessness, families and rural populations are also at risk, and often need, but may not have access to, mental health, substance use, and homelessness services.

- **Veterans:** Individuals experiencing chronic homeless are more likely to be veterans than those residing in shelters or with stable housing (Levitt et al., 2009) and often have worse treatment outcomes (Buchholz et al., 2010). In one study, 60 percent of homeless veterans had a diagnosed SUD (Tsai et al., 2014). Another study found that 77 percent of veterans entering transitional housing had a least one previously diagnosed co-occurring disorder (Ding et al., 2018). The VA operates a number of homeless programs for veterans to determine benefits eligibility, provide temporary shelter, and secure permanent housing placements. The VA also houses the National Center on Homelessness among Veterans, which was developed to identify, evaluate, and promote recovery-oriented care models for veterans who are homeless or at risk for homelessness.
- **Families:** Families who are impacted by homelessness face additional challenges that include an increased risk of traumatic experiences and interpersonal difficulties. Special services and resources for families are available, such as family-only shelters and child-specific healthcare options. The vast majority (98 percent) of homeless families are sheltered but in need of

stable housing (HUD, 2020). It is important to treat families as a separate subpopulation with their own specific needs. For additional information and resources regarding family homelessness, please refer to the HUD Exchange for a number of available resources.

- **Rural Populations:** Available housing and treatment centers can be limited in rural areas (Robertson & Myers, 2005). Individuals experiencing homelessness in these areas are typically less visible, so outreach and engagement efforts may require a different approach than efforts deployed in urban areas. The availability of job opportunities, shelters, health services, and social programs are often limited. The National Health Care for the Homeless Council has collected a number of available resources for working with rural homeless populations.

Considerations for Program Administrators and Senior Staff Developing Services for People Experiencing Homelessness

Homelessness represents a significant case management challenge for treatment program administrators and other staff members who are responsible for finding housing resources. Some considerations that must be addressed include:

- Limited resources for housing people in early recovery from substance use and/or mental disorders
- Time required to find and evaluate potential resources
- Collaboration efforts involved in working with other community agencies
- Limited funding available for housing services

In addition to addressing these considerations, administrators and treatment providers will need to ensure that individuals who are homeless are able to participate and remain engaged in ongoing services and care. They will need to work with clients to manage transportation, mental health, SUD, healthcare, financial, criminal justice, and employment issues complicated by homelessness. However, the reality is that an individual who is homeless is in crisis and has immediate housing needs that must be addressed in a limited period of time. For more information on the use of effective case management strategies when working with clients with SUD, please refer to SAMHSA's TIP 27, *Comprehensive Case Management for Substance Abuse Treatment*.

Intraorganizational Needs Assessment

To determine the treatment organization's ability to assist clients experiencing homelessness, a number of initial questions must be addressed. An intraorganizational needs assessment is a process that includes staff and stakeholder discussions at an organizational level to better understand the program's ability to assist this special population. Key steps in the process include:

- Evaluating the basic demographics of the target population. This includes gender, ethnicity, racial makeup, criminal justice experience, family status, language, and the nature of homelessness.
- Determining if these demographics and characteristics are reflected in the frontline staff providing services.
- Identifying gaps in the continuum of care. This requires the organization to ask basic questions about client retention, referrals from other services, client access to primary care providers and medication, and program difficulties working with clients who have substance use or mental illness.
- Identifying organizational policies and procedures that contribute to the gaps identified in the continuum of care. Policies that affect client eligibility for services is an example of a policy that could be changed to better meet client needs.

- Identifying larger community-level issues to be addressed. These issues could include legislation that handles homelessness through arrest, lack of affordable housing, and insufficient mental health, substance use, or medical care services in the community.
- Identifying potential opportunities to partner with other providers in the community and leveraging resources to improve services for people experiencing homelessness.

Integration of Substance Use and Mental Disorder Treatment with Homelessness Services

Throughout the continuum of care and services, clients experiencing homelessness will likely engage with multiple care providers. It is important that all programs have shared goals and standards of quality of care with the understanding that addressing homelessness in the community requires strategic coordination on the part of all providers. Use of a coordinated and integrated approach to care and service delivery is recommended throughout each phase of rehabilitation from homelessness and is described below.

Outreach and engagement

This first phase includes building relationships with individuals with substance use and mental disorders who are also experiencing homelessness. Administrators can assist by establishing collaborations with community organizations, forming interdisciplinary teams, increasing staff availability off-site, ensuring proper training of staff, developing outreach tools, and providing funding for practical goods that can be offered to potential clients.

Transition to intensive care

After a client agrees to accept care, housing, and other services, an administrator can support this phase in several ways. This includes formalizing recordkeeping policies, providing tangible benefits, assigning case managers, offering supportive services like employment and financial benefits, ensuring staff are familiar with local community housing resources, and developing protocols from transition planning.

Intensive care and treatment

When an individual engages in a clinic, shelter, outpatient, or residential treatment program, they begin the intensive care phase (McQuistion et al., 2008). In this phase, developing a memorandum of understanding (MOU) with housing resources, providing screening by behavioral health professionals, increasing engagement and retention, and developing strategies to improve treatment compliance are essential steps an administrator can take. Comprehensive healthcare services are also required in this phase of rehabilitation for clients who meet the criteria for outpatient treatment.

Transition to ongoing rehabilitation

This phase occurs gradually and has the highest risk for dropout or relapse. Building recovery skills, encouraging community involvement, and providing transitional housing until a permanent housing placement is identified are all strategies to utilize in this phase. This includes programs like recovery education centers in mental health treatment that have been successful in supporting recovery to transition out of homelessness (Khan et al., 2020).

Ongoing rehabilitation

The final and open-ended stage occurs when the client is no longer identified as homeless and actively works to maintain recovery (McQuistion et al., 2008). Administrators can support staff as they provide ongoing rehabilitation and the means for clients to contact the organization if there is a relapse of substance use or an increase in the severity of mental disorders. This ongoing support can include regular follow-up in the form of meetings or phone calls.

The Health Care for the Homeless program provides additional resources and funding to health centers to better serve individuals experiencing or at risk for homelessness. Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) is a trauma-informed, time-limited treatment intervention that integrates co-occurring disorder treatment, Critical Time Intervention (CTI) case management, and peer support programming for homeless, veteran, and justice-involved populations. A number of MISSION manuals and workbooks are available for providers and administrators to use when working with these populations.

Resources

- **Substance Abuse and Mental Health Services Administration**
  - Homelessness Programs and Resources
  - Permanent Supportive Housing Evidence-Based Practices (EBP KIT)
  - Recovery Housing: Best Practices and Suggested Guidelines
  - TAP 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice
  - TIP 27, Comprehensive Case Management for Substance Abuse Treatment
  - TIP 35, Enhancing Motivation for Change in Substance Use Disorder Treatment
  - TIP 55, Behavioral Health Services for People Who Are Homeless
  - TIP 59, Improving Cultural Competence
- **Corporation for Supportive Housing (CSH)**
- **Center for the Advancement of Critical Time Intervention (CTI)**
- **Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION)**
- **National Alliance to End Homelessness**
- **National Association of Community Health Centers**
- **National Health Care for the Homeless Council**
- **U.S. Department of Housing and Urban Development (HUD)**
  - HUD's Definition of Homelessness: Resources and Guidance
  - HUD Exchange
- **U.S. Department of Veterans Affairs (VA)**
  - Homeless Programs
  - VA Health Benefits
  - Housing Navigator Toolkit
  - HUD-VASH Resource Guide for Permanent Housing and Clinical Care
- **U.S. Interagency Council on Homelessness (USICH)**
  - Expanding the Toolbox: The Whole-of-Government Response to Homelessness

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