Mentally Ill and Homeless

Needs, Gaps, and Project Suggestions
Mentally Ill & Homeless

- Lack Housing
- Difficult to locate, identify and treat
- Are not connected to resources provided by the community that can help them

In addition to

- All the other challenges of coping with the symptoms of their mental illness
Some Local Statistics

• Each year, approximately 10% of the 2,000+ homeless individuals attending the Stand Down for the Homeless have been diagnosed with a mental illness
• An average of 14% of them have attempted suicide, and another 25% had thought about suicide
• 1 in 5 report struggling with Depression
More Local Statistics

• The 1999 UNLV Homeless Demographic Survey found that
  – Most homeless people (54.2%) do not regularly “hang out” or travel with another person during the day
  – 1 in 5 homeless individuals approached for the interview were too incoherent to continue
  – In the end, 502 homeless individuals were interviewed and their data is presented here
More Local Statistics

- The 1999 UNLV Homeless Demographic Survey also found that
  - 16.9% of the 502 who were coherent enough to be interviewed had been diagnosed with a mental disability
  - 20.8% said they had received a “dual diagnosis”
  - Yet, only 65% are receiving SSI benefits.
Mentally Ill and Homeless

Possible Projects
Crisis Response Teams

- Respond with on-site intervention, assessment and connection to housing and services – particularly state mental health services
- A central telephone number, provided to businesses and residents in high-saturation areas, to dispatch a team within 15 minutes
- Transportation provided – either by automobile, taxi, or ambulance, as appropriate
Crisis Response Team

Best Practice:
- Pine Street Inn’s NBOR program in Boston, Massachusetts

- 17% of chronic homeless moved into Emergency Shelter system
- 16% moved on to transitional settings
- 10% enrolled in formal treatment programs
- 31% successfully living in permanent housing

65% of the 1,022 persons served did not maintain contact; figures above reflect outcomes of the 35% that did maintain contact
Crisis Response Team

Best Practice:
- Pine Street Inn’s NBOR program in Boston, Massachusetts

Lessons Learned:
- Need on-street nursing (Nurse Practitioner)
- Nursing liaisons in the shelters
- Case management Liaisons at the shelters
- Taxi vouchers for those who could travel on own
- Hire formerly homeless
SSI Outreach Team
SSI Outreach Team

- Outreach to “bushes”, but also respond to referrals from other agencies
- Pair each client with an advocate to assist with the complicated application process
- The advocate is primarily responsible for “managing the paper”
- Best if can arrange with SSA to offer “presumptive” benefits for up to 6 months for those most visibly disabled
SSI Outreach Team

Best Practice:
• SSI Outreach Project
  Baltimore, Maryland

• Staffed by a Project Director, 2 Counselors, and 1 Admin Assist
• Annual Budget of approximately $200,000
• Serves a minimum of 100 homeless persons each year
• Clients benefit from linkages to other county services
SSI Outreach Team

Best Practice:
- SSI Outreach Project
  Baltimore, Maryland

Lessons Learned:
- Target severely mentally ill people living on the streets
- Require Team to see each client within three days of a phone call, with preference for “home” visits
SSI Outreach Team

Best Practice:
- SSI Outreach Project
  Baltimore, Maryland

Lessons Learned:
- Project Director should be licensed clinical social worker qualified to prepare the Disability Report for SSA
- Arrange for “presumptive” eligibility benefits
  - In 6 years, only 2 of the 450 clients “presumed eligible” were denied SSI
Housing First
Housing First

- Move chronic homeless persons directly from the streets into private market housing
- Pair each client with an Assertive Community Treatment (ACT) Team to deliver services to the client at least twice each month in her/his home
- Use TBRA or Section 8 to pay for rent
- Adherence to sobriety rules is not a condition to maintaining housing
Housing First

Best Practice:
• Pathways to Housing
  New York, NY

• Serves over 400 people annually, at a cost of approximately $20,000 per yr

• Staffing pattern:
  – 4 Housing Counselors
  – 5 Team Leaders
  – 2 Psychiatrists
  – 2 Nurses
  – 1 Vocational Specialist
  – Service Coordinators, each with a particular expertise
Housing First

Best Practice:
• Pathways to Housing New York, NY

• Each ACT Team sees approximately 70 clients
• ACT Team is responsible for meeting the basic needs, enhance the quality of life, increase social skills, and increase employment opportunities
Housing First

Best Practice:
• Pathways to Housing New York, NY

Lessons Learned:
• Have 2 transitional apartments for use by clients who haven’t yet found an apartment of their own
• Have HQS Inspection capabilities on staff
• Only Requirements: meet twice each month with ACT Team and enroll in a Money Management program
Housing Resources

• Tenant-Based Rental Assistance (TBRA)
  – Section 8 vouchers
  – HOME
  – HOPWA
  – SHP
  – S+C

• Partner with nonprofit Housing Developers

• Build your own housing
  – HOME and LIHTF
  – Section 811
  – SHP, S+C and Section 8 SRO
  – Section 515
  – YouthBuild
  – CDBG
  – Loans

Please see hand-out for more details
Creating Homes Initiative
Creating Homes Initiative

- Capitalize on available housing funds and opportunities to develop and expand permanent housing options and services for persons with mental illness
- Obtain a base incentive amount ($2 million) from the State budget to act as leverage for other sources
Funds Available for CHI

- Dept. of Mental Health and Developmental Disabilities
- HUD Continuum of Care programs
- HUD HOME funds
- HUD Section 811
- HUD Section 8 Vouchers for Persons with Disabilities
- HUD Section 8
- HUD CDBG
- Federal Home Loan Bank
- Nevada Low Income Housing Tax Credits
- Local Foundations
- Fannie Mae
- Kresge Foundation
- Robert Wood Johnson Foundation
Creating Homes Initiative

- Request that the State’s Housing Division target its housing development resources for housing for the mentally ill
- Create and execute local strategies to expand the menu of needed permanent housing and supportive service options for each community
- Have a CHI Task Force or Steering Committee review, rank and recommend housing proposals to the Housing Division for funding
Creating Homes Initiative

- Direct new resources to increasing housing options
- Category changes of current programs or buildings to permanent housing
- Utilize non-traditional buildings (churches, downtown hotels, etc.) as permanent housing options for persons with mental illness
Creating Homes Initiative

Best Practice:

• Tennessee Dept of Mental Health and Developmental Disabilities Commission

• Receives annual allocation of $2.5 million and has leveraged over $29 million in new federal, other state, and local funds to produce permanent housing: supervised and partially-supervised group housing, private/public market rental housing and homeownership
Creating Homes Initiative

**Best Practice:**
- Tennessee Dept of Mental Health and Developmental Disabilities Commission
- Hired 7 Regional Housing Facilitators to work with locally-based CHI Task Forces
- Goal: 2,005 housing units by 2005
- Accomplishment: 1,937 by June 2002
Other Needed Services

• Safe Haven drop-in center for homeless mentally ill
  – No compliance with rules or medication required
  – Open-door policy
  – Overnight accommodations, day sleeping okay
  – No limits on length of stay
  – Facility design and program goal must be to reduce the intimidating barriers homeless people with severe mental illnesses encounter with the care system
Other Needed Services

• Maintain an ideal number of Licensed Clinical Psychologists to reduce wait time for diagnosis
• Significant increases in Nevada’s Intensive Case Management services
• Increased Crisis Observation beds
• Build a forensic services facility in Southern Nevada — and fully staff it
• Significant increases in all the other programs of state mental health
Other Needed Services

- Alcohol and Drug Abuse Treatment specialized for those with co-occurring mental illness
- Residential treatment settings for clients prone to violence
- Medication management and education – including “depot medications” that allow for one injection of time-released medication
- Specialized service for clients with the diagnosis of borderline personality disorder
Other Needed Services

- More Representative Payee services – particularly specialized for this population
- Alternatives to acute hospitalization – be available to preadmission consultation to community and hospital providers who are considering an acute hospital admission
- Specialized service for clients with the diagnosis of borderline personality disorder
Other Needed Services

- Continuity of Care – the ongoing relationships between the client and the psychiatrist and case manager are particularly important.
- Increased focus on clients’ family members, friends and other community resources (shelter providers) as part of treatment. Programs should use the term “partner” rather than “manage” to build the trust
Mentally Ill & Homeless

- Lack Housing
- Difficult to locate, identify and treat
- Are not connected to resources provided by the community that can help them

In addition to
- All the other challenges of coping with the symptoms of their mental illness