

Addiction, Mental Health, and Homelessness

Summary of Recommendations:

- **Appropriate at least \$2.5 billion for SAPT and \$500 million for CMHS in FY10**
- **Strengthen the Treatment for Homeless Persons (THP) and Projects for Assistance in Transition from Homelessness (PATH) programs**
- **Establish policies and programs that incorporate a broad recovery model of behavioral health care**
- **Establish federal policy that requires all public and private health insurance plans to cover behavioral health services in parity with coverage for other services**

Addiction and mental illness—which are frequently co-occurring—often lead to and prolong homelessness and tend to be exacerbated by the experience. Among surveyed homeless people, 39% report a mental health problem, 38% report alcohol use problems, and 26% report problems with other drugs.¹ In a 2008 survey conducted by the U.S. Conference of Mayors, 26% of homeless individuals had a serious mental illness, compared to 6% of the U.S. population. The top three causes of homelessness among singles identified by the 25 cities responding to this survey were: substance abuse (cited by 68% of cities), lack of affordable housing (60%), and mental illness (48%).² Among homeless veterans, the need for mental health and substance use treatment continues to grow. According to the U.S. Department of Veterans Affairs, 45% suffer from mental illness, and half have substance abuse problems.

Homelessness presents serious barriers to treatment for these conditions. People without stable housing often are impoverished, uninsured or underinsured, and alone. Lack of documentation, lack of transportation, and difficulty adhering to treatment regimens prevent many homeless individuals from succeeding in mainstream behavioral health care. In 2004, homeless individuals accounted for more than 175,300 admissions to addiction treatment facilities (13% of all such admissions). People who are homeless are more than twice as likely as their housed counterparts to have had five or more previous treatment episodes.³ Untreated addictions and mental illnesses present serious barriers to employment and permanent housing, perpetuating an ever-worsening cycle of poor physical health, hospitalization, social dysfunction, useless incarceration, poverty, and homelessness. Without stable housing, even those who are *recovering* from addiction or are *managing* a mental illness often will return to the same high-risk environment following release from incarceration or hospital discharge, thus increasing the potential for relapse (See Policy Statement on Institutional Discharge and Homelessness, www.nhchc.org).

Mainstream behavioral health care that is universally affordable, readily accessible, and linked to housing would reduce the incidence of homelessness; achieving this goal must be paramount. People who are already experiencing homelessness, however, present complex challenges for which mainstream providers may be ill equipped or untrained. To reach and treat these individuals, adequate funding for targeted programs such as THP and PATH is essential.

Recommendations

1. Appropriate at least \$2.5 billion for SAPT and \$500 million for CMHS in FY09. Early and prompt intervention is critical when treating persons with addiction and mental health disorders. Due to monetary constraints and limited understanding of homelessness, however, many mainstream service providers are unable to offer the full range of care necessary to address the complex needs of people experiencing homelessness. The Federal government attempts to meet these needs through a safety net system for people without insurance. The Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Community Mental Health Services (CMHS) Block Grant, and various state programs form the core of the behavioral health safety net, but current funding for these block grants fails to provide adequate addiction

¹ "Homelessness – Provision of Mental Health and Substance Abuse Services." Substance Abuse and Mental Health Services Administration. March 2003. <http://mentalhealth.samhsa.gov/publications/allpubs/homelessness/>

² U.S. Conference of Mayors. *Hunger and Homelessness: A Status Report on Hunger and Homelessness in America's Cities, A 25-City Survey*. December 2008. www.usmayors.org/pressreleases/documents/hungerhomelessnessreport_121208.pdf

³ "Homeless Admissions to Substance Abuse Treatment: 2004." *The DASIS Report*, Issue 26. Office of Applied Studies, SAMHSA. 2006. <http://www.oas.samhsa.gov/2k6/homeless/homeless.pdf>

and mental health services to the uninsured and the homeless. Interagency collaboration also must be prioritized, including the integration of behavioral and primary care (SAMHSA/HRSA) and the integration of preventive and treatment services in shelters, respite care programs, and supportive housing programs (HHS/HUD).

2. Strengthen Treatment for Homeless Persons (THP) and Projects for Assistance in Transition from Homelessness (PATH). Recognizing that homelessness restricts access to mainstream addiction and mental health services, Congress established the THP (PHSA Section 506) and PATH (PHSA Title V, Part C) programs to provide these services specifically for people experiencing homelessness. Insufficient funding for the two programs, however, prevents many people in need of treatment from receiving services. SAMHSA is redirecting half of THP funds to services in Permanent Supportive Housing—reducing treatment resources for those currently homeless. **We urge Congress to appropriate at least \$100 million for THP and \$75 million for PATH. Congress also must affect statutory changes through SAMHSA reauthorization to improve these programs:** First, Health Care for the Homeless grantees—already required by statute to provide addiction services—should be added as preferred entities for THP grants. Second, effective THP grantees whose funding would otherwise expire should be prioritized for renewal. Third, SAMHSA must include “harm reduction” models of addiction treatment among its “best practices” and encourage such approaches within an array of treatment strategies for THP grantees and others providing addiction treatment for homeless persons. Lastly, to end perpetual flat funding for rural and frontier populations, the minimum PATH allocations for States and territories must be doubled to \$600,000 and \$100,000 respectively.

3. Establish policies and programs that incorporate a broad recovery model of behavioral health care. Public education has produced positive outcomes in reducing the demand for illicit drugs. For many, however, the narrow focus upon abstinence-only programming within the publicly funded addiction services system is a barrier to successful recovery. Effective treatment systems must include outreach and engagement, “harm reduction” strategies, a “housing first” approach with appropriate supports, multidisciplinary treatment teams, integrated treatment for co-occurring disorders, motivational enhancement interventions, risk reduction, and the active involvement of consumers in planning and delivery of services. We urge Federal, State, and local governments to establish policies and programs, consistent with emerging evidence-based practices, that respond to the needs of the full range of people with addiction.

4. Establish federal policy that requires all public and private health insurance plans to cover behavioral health services in parity with coverage for other health services. Restrictions imposed by private insurers on the duration and scope of treatment for behavioral health and addiction services often force people to utilize publicly-funded services despite having other insurance. This trend has contributed to significant increases in the public share of spending for mental health and addiction treatment. Responding to insufficient coverage for behavioral health coverage, Congress passed the Mental Health Parity Act of 2008, which partially addressed this inequity. To strengthen this initiative, we urge Congress and the Administration to require all health care plans, including state Medicaid plans, to cover behavioral health services in parity with medical care. For poor and disabled individuals lacking private insurance, Medicaid benefits also must include the full scope, amount, and duration of necessary addiction and/or mental health services. We urge Congress and the Administration to amend the Medicaid statute to designate behavioral health services as mandatory rather than optional benefits and to direct State administrators to assist Federally Qualified Health Centers in obtaining funding for mental health services from all available revenue streams, including block grants and Medicaid billing.