ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

Housing as a Platform for Treatment and Recovery

Opportunities for Title V at the Intersection of Stable Housing, Mental Health, and Substance Use

ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

Introduction

Homelessness is a pervasive barrier to health and well-being that disproportionately affects women and children. This issue brief provides an overview of the scope and impact of homelessness; the association between homelessness, mental illness, and substance use disorders (SUD); states' efforts to integrate health care and housing services; and strategies that the Title V Maternal and Child Health Services Block Grant can use to serve vulnerable women and families facing homelessness and behavioral health disorders.*

Background: Homelessness as a Public Health Challenge

On a single night in 2019, more than a half-million people experienced homelessness in the United States, according to the U.S. Department of Housing and Urban Development's (HUD's) point-in-time count. Roughly 33 percent of the U.S. homeless population were families with children.[1] The lack of affordable housing stock—and a long history of racist housing policy in the U.S.—has exacerbated the homelessness crisis. For every 100 low-income households in the U.S., only 28 units of affordable housing are available.[2] Conditions are worse in densely populated urban areas where housing costs are steep, and social service agencies are often unable to meet the demand for housing assistance. Various types of housing instability are described in the insert *(below)*.

Defining Housing Instability[9]

According to Healthy People 2020, housing instability is a social determinant of health and encompasses a range of conditions:

- **Rent-burdened:** Spending more than 30 percent of household income on housing

- **Severely rent-burdened:** Spending more than 50 percent of household income on housing

- **Overcrowded:** Living with others in overcrowded conditions, to avoid actual homelessness

- **Episodic homelessness:** Cycling in and out of homelessness

- **Chronic homelessness:** Having a disabling condition, such as mental illness or SUD and being homeless for a year or longer, or having experienced a combined total of 12 months of homelessness during the previous three years.[10]

Access to affordable housing and other needed social, economic, and environmental supports strongly influenceshealth outcomes, such as life expectancy and chronic disease rates, and increases the risk of interpersonal violence.[3, 4] In the absence of safe and stable housing, those with mental illness and/or SUD are particularly vulnerable.[5]

Homelessness and high health care utilization are closely associated.[6] Individuals experiencing homelessness often have co-occurring medical and behavioral health disorders as well as social barriers that include transportation and child care challenges, social isolation, and lack of health insurance.[7, 8] In a comparison study of Medicaid beneficiaries enrolled in Boston's Health Care for the Homeless Program and stably housed Medicaid enrollees, the homeless population averaged 2.5 times more health care spending than the comparison Medicaid population.[7] This statistic suggests that access to safe, stable housing can contribute to improved health outcomes and decreased health care costs for this population. For these reasons, tackling homelessness is a high priority public health challenge.[6]

Homelessness and the Implications for MCH Outcomes

Research shows that homelessness and housing instability have a negative impact on the health of infants, children, adolescents, and pregnant and parenting women. Pregnant women who are homeless are more likely to deliver preterm and low birthweight babies.[9, 11] Stable, safe housing before, during, and after pregnancy is critical to promoting positive maternal and infant health outcomes.[12]

In young children, low weight and developmental risks are troubling outcomes of housing instability. For children and adolescents, housing instability and multiple moves are associated with increased behavioral problems, poor school performance, higher incidence of teen pregnancy, and greater likelihood of developing a mental illness.[13] In addition, any child younger than 18 who experiences homelessness is at a heightened risk for early substance use, in addition to the myriad of other developmental risks.[12] Policies and programs that address family homelessness take a proactive approach to SUD, because these programs mitigate the risk that children and adolescents will misuse substances at a young age.

For parenting women, homelessness is associated with poorer health and more depressive symptoms than those who are stably housed. Women who are homeless are more likely to forgo needed health care in order for family members to receive the care they need.[12] There are additional maternal and child health (MCH) implications. As one example, postpartum depression is a risk factor

---

for housing instability. Research has demonstrated that women who experience postpartum depression during the first year after birth are more likely to become homeless or experience evictions in the three to four years postpartum.[14]

In addition to family homelessness, youth homelessness presents a significant MCH challenge. In the U.S., there are 2 million homeless youth. Homeless youth are unaccompanied individuals age 12–24 or older with no family support. This segment of the population is three times as likely to become pregnant or already have a child as their stably housed peers. Homeless youth are also more likely to develop a mental illness and SUD.[6] This reality underscores the need for Title V programs to align their efforts with housing programs. Many poor health outcomes for MCH populations can be alleviated or mitigated through access to safe, stable housing, which is an inherent protective factor.[15]

Mental Health, Substance Use, and Housing Instability

Overview

As described previously, mental illness and SUD are common among people experiencing homelessness. Nearly 20 percent of these individuals have a serious mental illness[†] and more than 30 percent have either a mental illness and/or SUD.[6] Major depression, bipolar disorder, and schizophrenia are the most diagnosed mental illnesses in this population.[16] The homeless population is not homogenous, and homelessness is most frequently a result of economic factors and not solely an outcome of an individual's behavioral health disorders.[17]

Because nearly half of the homeless population are facing a serious mental illness and/or SUD, it is useful to consider the nature of the relationship between mental illness, SUD, and homelessness.[18] Research shows that the relationship between these factors often is bidirectional. In other words, mental illness and SUD increase a person's risk of experiencing homelessness; likewise, homelessness exacerbates mental illness and increases a person's risk of substance misuse.[17, 19] Homelessness makes treatment and recovery extremely difficult, which is one reason why people with mental illness are more likely than others to cycle between institutionalization and homelessness.[20] Furthermore, those with SUD are more likely to be homeless for longer periods of time and become homeless at an earlier age than individuals without SUD.[5] The outcomes for adults experiencing homelessness and mental illness and/or SUD are startling. This population is nine times more likely to die from an opioid overdose than stably housed

adults[5] and suicide rates are 10 times higher among homeless individuals than the general population.[4] Studies have found that providing housing, however, can prevent the worsening of mental illness and SUD and importantly intervene before normal functioning deteriorates into the first phase of problem development.[19]

The connection between mental illness, SUD, and homelessness is especially amplified for those served by the public health system. Research bears out the following statistics:

- More than 1 in 10 individuals seeking treatment for mental illness or SUD through the public health system in the United States is homeless.[21]

- Mental health diagnoses are significantly more common in the homeless population than in the general Medicaid population.[6]

- Young, single women with young children typically are the head of the household for homeless families,[22] and the prevalence of mental illness and serious mental illness is higher among women than men.[23]

These statistics accentuate the need to address the intersection of homelessness and behavioral health in MCH programs. In families experiencing homelessness, caregivers' mental illness and SUD often go unaddressed.[15] Thus, providing a safe, stable environment supports the caregiver's mental illness and SUD recovery; providing the family's basic survival needs can allow caregivers to seek treatment.[24]

Figure 1. *SAMHSA's Four Dimensions of Recovery from the [Promise Recovery Network](#)*

Four Dimensions of the Recovery Process

♥ *Health*
Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way

⌂ *Home*
A stable and safe place to live

Community
Relationships and social networks that provide support, friendship, love, and hope.

Purpose
Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.

Housing Instability and the Road to Recovery

Housing instability, mental illness, and SUD may seem like insurmountable challenges with homelessness placing obstacles on the path to recovery. Stable housing is a necessary component to achieving health and long-term recovery from mental illness and SUD.[25, 19] The Substance Abuse and Mental Health Services Administration (SAMHSA) delineated the four dimensions that support individuals in recovery *(see figure 1)*. One dimension of recovery support is to have a "home, a stable and safe place to live." [26]

Although the public generally recognizes the prevalence of drug overdose, fewer people understand that recovery commonly occurs. SUD is a chronic brain disorder from which people can and do recover. Approximately 50 percent of adults who once had a SUD, or about 25 million people, are currently in stable remission, defined as one year or longer of sobriety.[27]

Treatment Considerations

A significant body of literature discusses treatment considerations for the homeless population on the road to recovery. SAMHSA's Behavioral Health Services for the Homeless guide notes that all issues facing homeless individuals with mental illness and SUD must be addressed concurrently for treatment to be effective.[19] Treatment needs to combine stable housing with therapy, support services, and employment, if possible.[16] Treatment options for behavioral health conditions generally include counseling, psychotherapies, medications, or a combination of these approaches tailored to individual needs.[28] Case management and coordination of individuals to medical, psychological, and social services is also critical to successful treatment.[29] The insert *(bottom)* describes one effective inpatient SUD treatment program that supports pregnant and postpartum women.

Research indicates that coordinating housing services with behavioral health services is more likely to promote progress. In addition, the provision of housing during and after treatment has been shown to reduce relapses and improve outcomes.[30, 31]

Individuals experiencing homelessness in need of psychiatric services are often reluctant to establish long-term relationships with providers for a variety of reasons:

- Extensive trauma histories
- Difficulties getting to appointments due to transportation or financial constraints
- Lack of health insurance or the financial resources needed to access treatment
- Constraints related to an inadequate supply of psychiatric prescribers for homeless populations.[6]

In response to these challenges, behavioral health providers must take creative approaches in conducting outreach and consider unconventional treatment sites with flexible opportunities to access services. Integrating primary care with addiction services can also increase treatment accessibility for this population.[8]

Inpatient Treatment and Recovery for Pregnant and Postpartum Women and Children in Los Angeles County

[CLARE Foundation's SAMHSA-funded program](#) provides residential SUD treatment for pregnant and postpartum women and their children up to age 17 in Los Angeles County. This county has one of the highest rates of homelessness in the country. The program reaches many families affected by both homelessness and substance use disorders and offers clinical treatment and community support. Professionals facilitate client connections to housing and social services once they are discharged. The goal is improved birth outcomes and MCH well-being.

Assertive Community Treatment (ACT): ACT is an evidence-based intervention widely used as a treatment method for people who are homeless and have a mental illness.[32] It is a client-centered, recovery-oriented mental health service delivery model that utilizes team-based treatment to provide 24-hour multidisciplinary support to people with mental illness. Studies show that the intensive ACT services increase treatment adherence, reduce hospitalization rates, and increase housing stability. ACT has also been shown to reduce psychiatric symptoms for individuals with co-occurring mental illness and SUD. Research suggests that ACT is more effective than a standard case management approach when working with individuals experiencing homelessness and mental illness.[33] The insert *(below)* describes an effective ACT program for homeless youth in San Diego County.

Assertive Community Treatment Program for Homeless Youth with Serious Mental Illness

Funded through San Diego County Health and Human Services Agency and the Mental Health Services Act, the Catalyst Program is an Assertive Community Treatment program. Catalyst provides services to youth ages 16 to 25 with a serious mental illness who are homeless or at risk of becoming homeless in San Diego County. The program serves pregnant youth who meet this criterion. Services are provided through a team case management approach and no time limit is imposed for services. The program aims to help youth achieve stability, independence, and success by connecting them to mental health services and housing supports.

Medication-Assisted Treatment (MAT): Housing instability not only impedes an individual's ability to access health care, it also impedes his or her ability to maintain treatment once prescribed.[15] Due to the many treatment barriers that individuals facing homelessness endure, it is not surprising that those without stable housing are less able to engage in MAT, an evidence-based practice that consistently proves to be effective in treating opioid use disorder.[5] Studies confirm that initially, homeless patients who are connected to housing and clinical supports become just as likely as stably house patients to successfully complete MAT.[34] Thus, to maximize the effectiveness of treatment it is necessary to ensure that potential housing insecurity and housing needs are considered in treating SUD and in prescribing MAT. This requires housing providers and health care systems to collaborate. The insert *(top, right)* describes a comprehensive housing and treatment program for pregnant and parenting women.

Co-locating Housing and MAT Services for Pregnant and Parenting Women

Founded and operated by the Department of Obstetrics and Gynecology at the University of North Carolina Chapel Hill, the Horizons Program is a SUD treatment program for pregnant and parenting women and their children. Comprehensive recovery services include MAT for opioid use disorder. The program offers a residential treatment option for pregnant and parenting women, whereby each family lives in a rent-free apartment at a local apartment complex and women receive MAT, individual and group counseling, prenatal and obstetrics and gynecological care, and help finding employment and housing upon leaving the program. The Horizons Program works closely with North Carolina's Title V program, including Pregnancy Care Management Services and the Care Coordination for Children program. The Horizons' staff also receives training from the Title V-funded Triple P— Positive Parenting Program.® In collaboration with Title V, the team at UNC Horizons was asked to help develop and provide training on a life plan approach to reproduction for those working in the treatment programs and in the health departments.

Housing Models

There are a variety of interventions to assist individuals and families experiencing housing insecurity. The following models, from prevention to permanent supportive housing, highlight common housing programs and their effectiveness. Title V should consider supporting these models locally by partnering to offer services to families in these programs.

Homelessness Prevention

Homelessness prevention programs are more cost effective than intervening once an individual or family becomes homeless. Prevention efforts typically include holistic case management that ensures a family is connected to health insurance, food access, child care, and health care services, including treatment for mental illness and SUD. Homelessness interventions exist on a continuum: the longer a person is homeless, the more difficult and expensive it becomes to help them achieve housing stability.[17] The Department of Housing and Urban Development funds Emergency Solutions Grants, which include funding for homelessness prevention. This program gives families

facing an imminent risk of homelessness access to financial assistance for security deposits, short-term rental assistance, moving costs, or other housing-related needs. The program is effective in helping families maintain housing stability.[35] The aforementioned promising practices still entail significant challenges in identifying women and families at risk for homelessness. Mental health advocates recommend screening for housing insecurity in behavioral health care settings[18] as a proactive way to reach people who are at risk of becoming homeless and connect them to services.[36] Similarly, the American Academy for Pediatrics recommends asking screening questions during pediatric visits to determine a family's risk factors related to the social determinants of health, including housing instability.[37]

Supportive Housing

Overwhelming evidence indicates that when chronically homeless individuals with SUD and other complex needs are paired with services customized to their needs, they can attain stability and improved health in supportive housing.[38] Supportive housing models combine affordable housing assistance with wraparound services for people who experience homelessness in addition to mental illness or SUD, physical disability, or other chronic medical conditions. According to SAMHSA, supportive housing is an effective intervention to stabilize people with mental illness and/or SUD who are also homeless.[17] Supportive housing program have several elements that have demonstrated effectiveness, including: [5, 39]

- Non-time-limited housing assistance
- Peer support specific to substance use and homeless experience
- Co-location or close location of MAT/health care services and housing
- Self-determination in housing model and treatment

Affordable housing alone is not sufficient to meet the needs of people with mental illness and/or SUD. Linking health care services and case management with permanent, affordable housing produces better outcomes than providing services in programmatic silos.[20] Studies show that supportive housing interrupts cycles of institutionalization and homelessness. Individuals living in supportive housing programs have been shown to reduce their use of substances and improve sustained abstinence, improve their mental well-being, increase their housing stability, and spend significantly fewer days in hospitals and jails; these outcomes also reduce the associated burden on public systems.[19, 39] Strategies for supportive housing programs include providing rental assistance, reinvesting savings created by supportive housing programs that reduce use of health and correction services to increase supply of rental assistance, and making greater use of Medicaid services for supportive housing.[20] The insert *(bottom)* describes how the Title V program in Hawaii works with its housing authority partner to connect with families in supportive housing programs.

The following models, recovery housing and Housing First, fit along a continuum of supportive housing models. They both value client choice, connection to clinical services, and permanent, stable housing. The main difference between the two is that recovery housing programs almost always require sober living and many mandate recovery activities as a condition for housing; in contrast, Housing First programs have completely voluntary treatment options.[40] Recovery from mental illness and SUD looks different and varies greatly among individuals. The key to supporting individuals in recovery is to ensure they can choose their own pathway, which includes the type of housing program model and support most suitable.[27, 41]

Title V Program Connects with Families in Supportive Housing in Hawaii

Hawaii's child welfare system and housing authority partner to offer resources to families in Hawaii's Public Housing Authority's supportive housing programs. Title V plays a critical role as participants in the program's Community Cafés. The cafés connect families to community resources, including schools, faith-based institutions, family support centers, early childhood programs, health organizations, and childcare services.

Title V programs should connect with their state and local supportive housing programs to offer resources directly to families and connect them to MCH services.

Recovery Housing

Also referred to as sober living homes or three-quarter houses, recovery housing programs are often a step down from inpatient or residential SUD treatment. They refer to a range of alcohol and drug-free living environments where individuals work to improve their well-being and strive for recovery.[40] Recovery housing typically provides a safe, sober living arrangement driven by peer supports and mandated sobriety.[5] These programs offer an alternative to housing models with no prerequisite of sobriety and attract people who prefer a housing environment that is focused on abstinence and peer support. Although recovery housing programs are not federally funded nor are they federally regulated, HUD has developed some general guidelines for these programs, as follows:

- Program participation is self-initiated.
- Recovery services are peer-based.
- Individuals are provided assistance in achieving housing stability and employment.
- Relapse is not automatic grounds for eviction; when an individual has a relapse, he or she should be offered support.[42]

One of the barriers preventing recovery housing from becoming a more widespread model is that it lacks federal funding and regulations. However, recovery homes should remain an option, as much as possible, to respect the self-determination of people transitioning from homelessness.[41] The insert *(top, right)* describes the first-in-the-state recovery housing program in Maine where parenting women can live with their children during their recovery process.

Housing First

The National Alliance to End Homelessness describes Housing First as emanating from the notion that "homelessness is a problem with a solution, and the solution is housing." The Housing First philosophy is that housing assistance should be available to all people in need with no limitations. This means that individuals who have a criminal history or have yet to complete SUD treatment are not disqualified because they are often the ones who need housing assistance and support services the most.[20] The Housing First approach was developed in the 1990s to provide assistance to people with mental illness who were living on the streets.[43]

Housing First is a flexible approach that offers permanent housing, without barriers or treatment/sobriety requirements. The program works in conjunction with support services tailored to the individuals' needs. SAMHSA has found that housing programs utilizing Housing First approaches are effective for people with a serious mental illness, SUD, or co-occurring mental illness and SUD. These programs

Recovery Housing for Women and Children in Washington County, Maine

In Washington County, Maine, community-based organizations are opening the first-in-the-state recovery housing where parenting women can live with their children. Maine's State Housing Authority is funding this housing program. Residents of the recovery housing will be offered MAT, supportive services, and will be expected to pay a portion of rent. The program emphasizes the importance of keeping mothers with their kids during the recovery process.

Many recovery homes across the country serve women and their children. Research has shown that having children in the program supports a positive living environment for the recovery of house members. Title V programs can consider partnering with recovery housing programs in their state to offer services and support to families in recovery.

have consistently demonstrated better housing stability, significantly decreased rates of substance use, and increased adherence to MAT compared to housing programs with treatment requirements.[44, 45] Housing First participants are also far less likely to drop out of services. One study suggests this outcome is a result of having a permanent and non-conditional place to live, which is a stronger motivator to control substance use than alternative models that emphasize abstinence. The evidence that Housing First can promote SUD recovery suggests that this approach can serve as a stepping-stone for full mental health recovery.[45]

Although support services are voluntary in Housing First models, the majority of participants do use the voluntary services provided. More clients participate in job training, attend school, discontinue substance use, and spend fewer days in the hospital than those who do not participate in support services. One study found Housing First program participants save $23,000 per person compared to people using shelter programs. Another study showed an average cost savings for emergency services of $31,545 per person over a two-year period in a Housing First program.[46] Housing First increases individuals' self-reported levels of autonomy, choice, and control while simultaneously increasing housing stability, improving health outcomes, and decreasing public costs. The insert *(next page, top)* describes a Chicago Housing First program for families along with its successful outcomes.

Cross-System Collaborations: Health Care and Housing Partnerships

Health care reform and transformation impacts vulnerable populations in several ways. The Affordable Care Act enhanced health insurance accessibility and affordability for people experiencing homelessness by offering affordable private health plans on the Health Insurance Marketplace and through Medicaid expansions in many states. With increased health care coverage, families have increased protection from economic hardships that in part had resulted from exorbitant health care expenses, which could ultimately lead to homelessness. In addition, the Affordable Care Act ensures coverage of services essential to helping homeless populations, including behavioral health care and rehabilitative services.[47] Health care coverage and access improvements are critical to promoting mental illness and SUD recovery for people experiencing homelessness.

According to the U.S. Interagency Council on Homelessness, a key strategy at the intersection of behavioral health crises and homelessness is strengthening partnerships between housing and health care providers to offer tailored assistance.[38] A variety of existing health care and housing partnerships target the homeless population. These models

recognize the importance and effectiveness of coordinating housing services with health care services to promote positive health outcomes and housing stability. Title V programs can replicate these partnerships locally and consider how to strengthen relationships and programming with state Medicaid, housing authorities, child welfare, and behavioral health agencies to support families experiencing homelessness *(see figure 2)*.

Medicaid and Housing Partnerships

Medicaid is the nation's largest payer for behavioral health services, which includes care for people with mental illness and SUD. Medicaid covers more than 20 percent of adults with mental illness and 17 percent of adults with SUD. In comparison, Medicaid covers just 14 percent of the general adult population.[48] Among adults with mental illness and/or SUD, Medicaid coverage is associated with improved mental health status and increased access to treatment in comparison to those without insurance.[49] The prevalence of mental illness and SUD in the Medicaid population and the positive effects of Medicaid coverage for those with behavioral health concerns is an impetus for ensuring targeted Medicaid services for those experiencing housing instability. Medicaid cannot directly fill the need for affordable housing and supportive housing programs; however, it can build partnerships with state housing authorities, behavioral health agencies, and Title V programs to coordinate care for people with multifaceted needs and bridge gaps between often siloed, complex systems. These partnerships can improve health outcomes, stabilize housing for consumers, and reduce the costs of serving this population.

North Carolina's section 1115 Medicaid demonstration waiver is one illustration of Medicaid's flexibility to support women experiencing housing instability. The waiver includes

Figure 2. Title V Key Partners to Strengthen Housing Support Services for Vulnerable Families
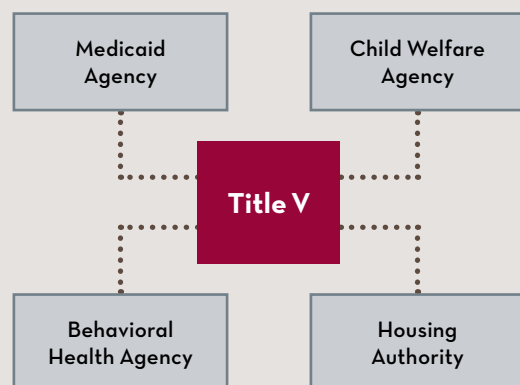
Figure 3. *North Carolina Healthy Opportunities Pilots Eligibility Criteria and Services*

Health Risk Factors	Social Risk Factors	Pilot Services
- Adults with two or more chronic conditions or repeated emergency room use or hospital admissions - High-risk pregnant women - High-risk infants and children or infants and children with one or more chronic conditions	- Homelessness and housing insecurity - Food insecurity - Transportation insecurity - At risk of witnessing or experiencing interpersonal violence	- Tenancy support; housing quality and safety; legal referrals; security deposit and first month rent; short-term post-hospitalization housing assistance - Food support and meal delivery - Non-emergency health-related transportation - Interpersonal violence-related transportation, legal referrals and parent-child supports

Source: KFF analysis of CMS, Special Terms and Conditions #11W00313/4, North Caroline Medicaid Reform Demonstration, Attachment G: Enhanced Case Management and Other Services Pilot Program Eligibility and Services (approved Nov. 1, 2019–Oct. 31, 2024, amended April 25, 2019) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

a Healthy Opportunities Pilot program. All health plans must screen enrollee's nonmedical needs and offer referrals to community resources using a statewide resource and referral tool. The Healthy Opportunities Pilot program also offers enhanced, targeted case management and support services to enrollees that meet specific risk factors *(as shown in figure 3)*, including high-risk pregnant women. Eligible enrollees receive case management and short-term financial assistance to secure housing.[50] This program is a promising innovation to meet the needs of vulnerable populations. Title V programs should assess their partnership with their state Medicaid agency and identify opportunities to support and advocate for similar program models.

Child Welfare and Housing Partnerships

Supported by the Corporation for Supportive Housing and the Robert Wood Johnson Foundation, Keeping Families Together targets families at risk for homelessness that are involved in the child welfare system. Families that meet the criteria of both homelessness and child welfare involvement receive permanent, supportive housing and team-based case management, connection to resources, and treatment for mental illness and/or SUD.[15] Indicators of family need for services include extremely low income, history of child welfare involvement, history of homelessness or housing instability, being a young adult primary caregiver (ages 18–25), and history of mental illness or SUD. After the initial pilot proved successful—90 percent of families still had housing and 100 percent of children returned to their families from foster care—the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) funded the project for $25 million, allowing five sites to each receive $5 million in grants to implement a demonstration project and evaluation.

Although full results are forthcoming, families who received supportive housing are significantly more likely to remain stably housed than those who received child welfare services alone.[51]

Keeping Families Together brings child welfare, housing and homelessness, and behavioral health agencies together to support vulnerable families. Title V can participate in the program by partnering to provide health care, home visiting, and other MCH services to this population. Creating a system of support allows families to experience a single, comprehensive program that meets their needs. The philosophy behind addressing the parents' mental illness and/or SUD as part of a unified service approach is that child welfare outcomes improve when parents have what they need to care for their children.[15] The core components of Keeping Families Together include supportive housing, targeted recruitment, multisystem collaboration, clinical consultation, and evaluation. Although this program is designed for the child welfare system, the program components may be replicated by Title V programs.

Massachusetts Title V and Department of Housing and Community Development Partnership

Massachusetts' Title V program developed a service targeted to families transitioning from homelessness that offers connections to SUD and mental health services. FOR Families (Follow-up, Outreach and Referral) is a home visiting program managed jointly by Massachusetts Department of Public Health and the Department of Housing and Community Development that helps families transition from homelessness to stable permanent housing. A team of public health and social service professionals provides services to families in shelters across the state.

Home visitors assess family needs and coordinate services with primary care and substance use treatment providers. The program collaborates with housing assistance programs, the Department of Children and Families, the Department of Transitional Assistance, and the Department of Mental Health to coordinate services for families. During fiscal year 2018, the FOR Families program worked with 206 families.[52]

Strategies for Title V MCH Programs

In light of the vast evidence of the negative effects of homelessness on MCH populations, Title V programs should consider policies and strategies that increase housing stability and promote the health of young children, adolescents, women, and mothers. MCH programs could adopt the following strategies to address the intersection of homelessness, mental illness, and SUD:

- Promote screening for housing instability at health care settings that serve women and children in the state, which includes prenatal and pediatric clinics and drug treatment centers

- Connect women with positive screens to housing services

- Partner with the state housing authority to offer targeted services to MCH populations experiencing homelessness

- Collaborate with the state child welfare agency to target at-risk families with support services, housing assistance, and connections to health care

- Equip home visitors with tools and resources for working with families experiencing homelessness, mental illness, and/or SUD

- Contract with community health centers to support case managers or community health workers to conduct outreach to families experiencing homelessness and connect them to services

- Ensure the state's Title V program is up to date on state and local housing resources and represent MCH populations' needs by joining the state's Interagency Council on Homelessness

Conclusion

Homelessness, mental illness, and substance use are intertwined and require public health intervention. Existing partnerships that help populations affected by housing insecurity and behavioral health disorders are models for Title V programs to replicate. With the high prevalence of family homelessness, and the far-reaching implications of homelessness for youth and families, the impetus for Title V involvement is heightened. Title V programs are well suited to collaborate with housing agencies, Medicaid, and other partners to address this multifaceted challenge and ensure that vulnerable families and children receive the services they need. ■

Visit amchp.org for more information.

Resources

Clinical Resources

- American Academy of Family Physicians:
  Care for the Homeless Overview

- Health Care for the Homeless Clinicians' Network:
  Adapting Your Practice: Recommendations for the Care of Homeless Patients with Opioid Use Disorder

- Substance Abuse and Mental Health Services Administration:
  Treatment Improvement Protocol 55: Behavioral Health Services for People Who Are Homeless

Partnership Resources

- Corporation for Supportive Housing and the Robert Wood Johnson Foundation:
  Keeping Families Together Matters: An Introduction to Creating Supportive Housing for Child Welfare-Involved Families

- Medicaid Innovation Accelerator Program:
  State Medicaid-Housing Agency Partnerships Toolkit

Policy Resources

- Institute for Children, Poverty, and Homelessness:
  Ideas for Action: Policies that Support Homeless Families

- National Alliance to End Homelessness:
  State of Homelessness and Key Policy Areas

- National Law Center on Homelessness and Poverty:
  2019 State Index on Youth Homelessness

Acknowledgments

Funding

About AMCHP

The Association of Maternal & Child Health Programs is a national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth, and families, including those with special health care needs. AMCHP's members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, and other public health leaders who work with and support state maternal and child health programs.

End Notes

[1]U.S. Department of Housing and Urban Development (HUD). (2019). *HUD 2019 Continuum of Care homeless assistance programs, homeless populations and subpopulations.* Retrieved from: https://files.hudex-change.info/reports/published/CoC_PopSub_NatlTerrDC_2019.pdf

[2]Association for Community Affiliated Plans. (2017, November 16). *Bridging the health and housing gap: Transitioning Medicaid recipients from institutions to the community in the context of housing shortages and affordability.* Retrieved from: http://www.communityplans.net/wp-content/uploads/2017/11/ACAP-Bridging-the-Health-and-Housing-Gap.pdf

[3]Sullivan, J. (2019, February 21). *Better state budget, policy decisions can improve health. Center on Budget and Policy Priorities.* Retrieved from: https://www.cbpp.org/research/state-budget-and-tax/better-state-budget-policy-decisions-can-improve-health

[4]National Health Care for the Homeless Council. (2018, May). *Suicide and homelessness: Data trends in suicide and mental health among homeless populations.* Retrieved from: https://nhchc.org/wp-content/uploads/2019/08/suicide-fact-sheet.pdf

[5]Pfefferle, S. G., Karon, S. S., & Wyant, B. (2019, June 24). *Choice matters: Housing models that may promote recovery for individuals and families facing opioid use disorder, Office of the Assistant Secretary for Planning and Evaluation.* Retrieved from: https://aspe.hhs.gov/basic-report/choice-matters-housing-models-may-promote-recovery-individuals-and-families-facing-opioid-use-disorder

[6]American Public Health Association (2017, November 07). *Housing and homelessness as a public health issue.* Retrieved from: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2018/01/18/housing-and-homelessness-as-a-public-health-issue

[7]Koh, K. A., Racine, M., Gaeta, J. M., Goldie, J., Martin, D. P., Bock, B., Takach, M., O'Connell, J. J., & Song, Z. (2020, February). Health care spending and use among people experiencing unstable housing in the era of accountable care organizations. *Health Affairs, 39(2).* Retrieved from: https://doi.org/10.1377/hlthaff.2019.00687

[8]Health Care for the Homeless Clinicians' Network. (2014, March). Adapting your practice: Recommendations for the care of homeless patients with opioid use disorders. Retrieved from: https://nhchc.org/wp-content/uploads/2019/08/hch-opioid-use-disorders_adapting-your-practice-final-to-post.pdf

[9]Office of Disease Prevention and Health Promotion (2020, March 9). Housing Instability, Healthy People 2020. Retrieved from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability

[10]AcademyHealth. (2016, July). *What housing-related services and supports improve health outcomes among chronically homeless individuals? Rapid Evidence Review.* Retrieved from: https://www.academyhealth.org/sites/default/files/Updated.Homelessness%20and%20Housing%20Rapid%20Evidence%20Review%20FINAL.pdf

[11]Cutts, D. B., Coleman, S., Black, M., Chilton, M., Cook, J. T., Cuba, S., & Frank, D. (2015). Homelessness during pregnancy: A unique, time-dependent risk factor of birth outcomes. *Maternal and Child Health Journal,* 19(6), 1276–1283.

[12]Cutts, D.B., Bovell-Ammon, A., Ettinger de Cuba, S., Shaefer, M., Huang, C., Casey, P. H., Coleman, S., Sandel, M., & Frank, D. (2018). Homelessness during infancy: Associations with infant and maternal health and hardship outcomes. *Cityscape: A Journal of Policy Development and Research*, 20(2), 119–132.

[13]Cutts, D. B., Meyers, A. F., Black, M. M., Casey, P. H., Chilton, M., Cook, J. T., Geppert, J. Ettinger de Cuba, S., Heeren, T., Coleman, S., Rose-Jacobs, R., & Frank, D. A. (2011, August). U.S. housing insecurity and the health of very young children. *American Journal of Public Health,* 101(8), 1508–1514.

[14]Brain & Behavior Research Foundation. (2018, November 19). *Homelessness and mental Illness: A challenge to our society.* Retrieved from: https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-our-society

[15]Corporation for Support Housing. (2012). *Keeping Families Together matters: An introduction to creating supportive housing for child welfare-involved families.* Retrieved from: https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2012/07/KFT-Guidebook-120711.pdf

[16]Maness, D. L., & Khan, M. (2014, April 15). Care of the homeless: An overview. *American Family Physician,* 89(8), 634–40.

[17]Substance Abuse and Mental Health Services Administration. (2019, March 29). *Housing and shelter.* Retrieved from: https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/housing-shelter

[18]Miller, B.F., Counts, N., Estus, E., & Moses, C. (2020, January). *Healing the nation: Advancing mental health and addiction policy.* Well Being Trust. Retrieved from: https://wellbeingtrust.org/wp-content/uploads/2020/01/WBT_Healing-the-Nation-digital.pdf

[19]Substance Abuse and Mental Health Services Administration. (2013). *Behavioral health services for people who are homeless.* Treatment Improvement Protocol (TIP) Series 55. HHS Publication No. (SMA) 13-4734.

[20]Dohler, E., Bailey, P., Rice, D., & Katch, H. (2016, May 31). *Supportive housing helps vulnerable people live and thrive in the community,* Center on Budget and Policy Priorities. Retrieved from: https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community.

[21]National Alliance to End Homelessness. *Health and homelessness.* Retrieved from: https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/

[22]National Alliance to End Homelessness. (2020, January). *Children and families.* Retrieved from: https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/children-and-families/

[23]National Institute of Mental Health. (2019, February). *Mental illness.* Retrieved from: https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154785

[24]Centers for Disease Control and Prevention. (2018, January 26). *Mental health.* Retrieved from: https://www.cdc.gov/mentalhealth/index.htm

[25]Corporation for Supportive Housing, National Council for Behavioral Health. (2014). *Substance use and housing National Leadership Forum convening report.* Retrieved from: https://www.thenationalcouncil.org/wp-content/uploads/2015/09/SUHLF-Convening-Report_FINAL.pdf

[26]Substance Abuse and Mental Health Services Administration. (2019, May 17). *Recovery and recovery support.* Retrieved from: https://www.samhsa.gov/find-help/recovery

[27]U.S. Department of Health and Human Services. Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health.* Retrieved from: https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

[28]Substance Abuse and Mental Health Services Administration. (2019, January 30). *Behavioral health treatments and services.* Retrieved from: https://www.samhsa.gov/find-help/treatment

[29] National Institute on Drug Abuse. (2018, January 17). *Principles of drug addiction treatment: A research-based guide (third edition).* Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition

[30] National Coalition for the Homeless. (2017, June). *Substance abuse and homelessness.* Retrieved from: https://nationalhomeless.org/wp-content/uploads/2017/06/Substance-Abuse-and-Homelessness.pdf

[31] Kertesz, S. G., Horton, N. J., Friedmann, P. D., Saitz, R., & Samet, J. H. (2003, April). Slowing the revolving door: Stabilization programs reduce homeless persons' substance use after detoxification. *Journal of Substance Abuse Treatment, 24*(3), 197–207.

[32] National Alliance on Mental Illness. (2020). *Psychosocial treatments.* Retrieved from: https://www.nami.org/learn-more/treatment/psychosocial-treatments

[33] Nelson, G., Aubry, T., & Lafrance, A. (2007, August). A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry, 77*(3), 350–361.

[34] National Alliance to End Homelessness. (2016, April 5). *Opioid abuse and homelessness.* Retrieved from: https://endhomelessness.org/resource/opioid-abuse-and-homelessness/

[35] Center for Evidence-based Solutions to Homelessness (2019, January). *Homelessness prevention: A review of the literature.* Retrieved from: http://www.evidenceonhomelessness.com/wp-content/uploads/2019/02/Homelessness_Prevention_Literature_Synthesis.pdf

[36] Bachhuber, M. A., Roberts, C. B., Metraux, S., & Montgomery, A. E. (2015, November 01). Screening for homelessness among individuals initiating medication-assisted treatment for opioid use disorder in the Veterans Health Administration. *Journal of Opioid Management, 11*(6), 459–462.

[37] The American Academy of Pediatrics. (2016, March). *Poverty and child health in the United States.* Retrieved from: https://pediatrics.aappublications.org/content/early/2016/03/07/peds.2016-0339/tab-article-info

[38] United States Interagency Council on Homelessness. (2017, February). *Strategies to address the intersection of the opioid crisis and homelessness.* Retrieved from: https://www.usich.gov/resources/uploads/asset_library/Strategies_to_Address_Opioid_Crisis.pdf

[39] United States Interagency Council on Homelessness. (2018, August 15). *Supportive housing.* Retrieved from: https://www.usich.gov/solutions/housing/supportive-housing

[40] National Council for Behavioral Health. (2018, May 3). *Building recovery: State policy guide for supporting recovery housing.* Retrieved from: https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18_Recovery-Housing-Toolit_5.3.2018.pdf

[41] Substance Abuse and Mental Health Services Administration. (2019, August 2). *Affordable housing models and recovery.* Retrieved from: https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/affording-housing-models-recovery

[42] U.S. Department of Housing and Urban Development. (2015, December). *Recovery housing policy brief.* Retrieved from: https://files.hudex-change.info/resources/documents/Recovery-Housing-Policy-Brief.pdf

[43] Housing First Europe Hub. (2020). *The history of Housing First.* Retrieved from: https://housingfirsteurope.eu/guide/what-is-housing-first/history-housing-first/

[44] Institute for Research, Education, and Training in Addiction. (2016, January 21). *Addressing substance use in a clinic for homeless people.* Retrieved from: https://ireta.org/resources/addressing-substance-use-in-a-clinic-for-homeless-people/

[45] Padgett, D. K., Stanhope, V., Henwood, B. F., & Stefancic, A. (2011, April). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with Treatment First programs. *Community Mental Health Journal, 47*(2), 227–232.

[46] National Alliance to End Homelessness. (2016, April 20). *Housing First.* Retrieved from: https://endhomelessness.org/resource/housing-first/

[47] United States Interagency Council on Homelessness. (2014, November). *The Affordable Care Act's role in preventing and ending homelessness.* Retrieved from: https://www.usich.gov/resources/uploads/asset_library/ACA_Homelessness_Fact_Sheet.pdf

[48] Center on Budget and Policy Priorities. (2018, January 19). Medicaid works for people with substance use disorders. Retrieved from: https://www.cbpp.org/research/health/medicaid-works-for-people-with-substance-use-disorders

[49] Musumeci, M., & Garfield, R. (2017, June 29). Medicaid's role in financing behavioral health services for low-income individuals. Retrieved from: https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/

[50] Hinton, E., Artiga, S., Musumeci, M. B., & Rudowitz, R. (2019, May 15). A first look at North Carolina's Section 1115 Medicaid waiver's Healthy Opportunities pilots. Retrieved from: https://www.kff.org/report-section/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots-issue-brief/

[51] Michael, J. (2018). A home amid crisis: Keeping the Families Together program model. *Children's Voices, 27(1).* https://www.cwla.org/a-home-amid-crisis-the-keeping-families-together-program-model/

[52] Massachusetts' Maternal and Child Health Services Title V Block Grant. (2020). Retrieved from: https://mchb.tvisdata.hrsa.gov/uploadedfiles/StateSubmittedFiles/2020/MA/MA_TitleV_PrintVersion_FY20.pdf