INSPIRED LEADERS
SHAPING CITIES

POLICY BACKGROUND: HOMELESSNESS, MENTAL HEALTH AND SUBSTANCE USE

INTRODUCTION

Mental health and substance use issues are closely linked to homelessness, both as both causes and consequences. Research suggests that up to 45 percent of people experiencing homelessness have one or more mental health conditions.[1]

Communities with large numbers of unsheltered individuals find that mental health and substance use exacerbate the crisis – both for the unhoused and the community at large. Such individuals are often the most challenging to help find housing, and yet resources and funding to help such people are often insufficient, preventing long-term solutions.

As the National Coalition for the Homeless notes, "Homelessness can be caused by chronic health issues, and homelessness can cause chronic health issues. Poor health can rapidly escalate into employment problems, financial difficulties and housing issues. Homeless people experience increased exposure to the elements, disease, violence, unsanitary conditions, malnutrition, stress, and addictive substances – all of which increases the chance of requiring healthcare."[2]

A lack of access to affordable health care aggravates economic hardships (e.g., medical bills, missing work, etc.) that can force people out of their homes. Advocates note that these issues are particularly acute for disadvantaged and vulnerable populations, including people of color and LGBTQ+ communities. Meanwhile, a lack of healthcare providers and facilities in underserved communities adds to the challenges, particularly when there is a shortage or absence of qualified mental health care providers.

These issues have been compounded by the country's opioid and fentanyl crisis; substance use both causes – and arises from – homelessness. One formerly unhoused person in Denver reported that cold winters on the street fueled his addition: "All winter, you get high so you can run around all night because you can't sleep because it's too cold. It's a horrible life."[3]

Factors that Exacerbate the Crisis

Urban place management organizations (UPMOs) report that addressing the confluence of homelessness with mental health and substance use is hampered by several factors:

- *Lack of resources, including workforce shortages and the number of available beds.* Advocates for the homeless point out that the policy mechanism for addressing homelessness – locally-based groups of mainly nongovernmental entities known as Continuums of Care – wield great expertise and commitment, but "have very limited capacity, including staffing and funding, and little to no governing authority to design or implement policy solutions." [4]

  In addition, as the National Alliance to End Homelessness (NAEH) notes, "The homeless services, healthcare, mental health, and broader human services sectors are all facing a workforce crisis that has limited their ability to serve people with the greatest needs. Correcting this situation demands greater federal resources to support these essential workers and expanded pathways to boost employment in these sectors."[5] Recent actions by the Trump administration to cancel grants, reduce federal staff and reduce funding levels for non-defense discretionary programs may exacerbate that trend and place pressure on states and localities to pick up the slack.

- *Lack of coordination between groups and programs.* Efforts to reduce homelessness are hampered by a lack of coordination between public and private entities, as well as the wide range of federal, state, and local government (in addition to philanthropic) programs that have different scopes, timelines, funding eligibility and reporting requirements.

  As a study from the National Institutes of Health (NIH) notes, the issue of homelessness is by its nature complex, and therefore demands complex responses:

  > First, extensive heterogeneity exists in homeless populations and in the types of services needed to address housing instability. Individuals with severe mental illness, for example, may require ongoing intensive supports to avoid falling back into homelessness, whereas pregnant teens with few connections to supportive adults have a different set of needs. This variation requires considerable flexibility and tailoring of resources to promote stability. A related implication concerns variation in the timing and patterns of homelessness. Some households experience single episodes of homelessness, while chronic homelessness refers to instability for more than two years . . . Homeless assistance typically requires the provision of multifaceted supports that adapt in response to shifting household demands and often includes unique combinations of residential and nonresidential supports. . . . The resulting

combinatorial complexity of housing interventions challenges sustained, systematic responses to homelessness.[6]

Experts argue that because addressing homelessness involves multiple social service and public policy areas, comprehensive solutions are by nature fragmented: "The diverse set of organizations and sectors needed to prevent and end homelessness often have distinct goals or service delivery models. For example, housing providers might focus on rental subsidies, social services agencies might focus on benefits like food assistance . . . and healthcare providers might focus on medical needs. But all of these supports can be necessary for someone to become stably housed."[7]

In other instances, a lack of coordination is due to structural issues within government itself, including competing political goals and agendas. In California, some have cited a lack of coordination and responsibility between state and local governments: "Overwhelmingly, unsightly encampments of homeless people are located within cities, but the social and medical services central to closing those camps are administered by counties, and in highly politicized urban areas, city and county officials tend to be rivals rather than partners.. . . the lack of local cooperation and coordination is a major impediment."[8]

- *Lack of support for formerly incarcerated individuals*. Research indicates that more than 10 percent of people entering or leaving incarceration are homeless in the preceding and/or subsequent months. As one organization observes, "parolees experience . . . a significantly high rate of mobility and that mental illness, drug and alcohol abuse, prior incarcerations, and prior experiences of homelessness were all predictive of residential instability."[9] Federal law generally prohibits Medicaid eligibility for incarcerated people, which advocates say worsens housing instability and other health challenges of formerly incarcerated people.[10]

- *Issues related to voluntary treatment versus involuntary*. One of the most difficult challenges that communities face is working with unhoused people who do not want to enter shelters or treatment programs. This issue came to a head in recent years via a series of court cases. *Martin v. Boise* and *Grants Pass v. Johnson* centered around whether city ordinances prohibiting sleeping in public outdoor spaces violated the Eighth Amendment's cruel and unusual punishment clause. In June 2024, the Supreme Court struck down lower court rulings, finding that city ordinances regulating camping on public property did not constitute cruel and unusual punishment.[11] The decision has led to a sharp increase in local ordinances across the country banning outdoor camping and sleeping, with more than 100 jurisdictions enacting such bans within six months of the ruling.[12]

- *Lack of reliable information.* The primary tool that localities use to collect and analyze data on homelessness is the HUD-administered Homelessness Management Information System (HMIS), which HUD describes as "a local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families at risk of and experiencing homelessness."[13] HMIS requires each Continuum of Care to identify an HMIS software vendor whose software complies with HUD's data collection, management, and reporting standards.

  Some observers have noted that HMIS makes it hard for communities to secure reliable data; one organization reports that "many communities struggle to effectively leverage HMIS data to drive reductions in homelessness. For example, a 2017 survey of 36 . . . communities . . . found that less than a third of respondents (29%) indicated their HMIS reported out all the information needed to end homelessness in their communities, while only 43% of respondents felt their HMIS collected all the information they needed." The organization cited challenges like incomplete data reporting, limited software functionality, costs, and a lack of technical expertise.[14]

Challenges for Downtowns

For urban centers, the intersection of homelessness with mental health and substance use creates a number of challenges that threaten the economic and social well-being of their communities. These include:

- *Public safety*. The mix of homelessness with mental health and substance abuse creates public safety challenges, although it is important to keep in mind that these challenges affect those that are unhoused as much if not more than those who live, work, and visit downtown.

- *Health.* For those who are unhoused, the risks of injury, disease and violence are ever-present. Living on the street is dangerous enough for someone without underlying mental health or substance use issues, but for those who face additional health problems while unhoused the risks of injury or death are even more acute.

- *Perceptions of downtown.* For the broader community, this issue impacts both the perception and reality of public safety. This in turn makes downtown less attractive places for housing, retail and other amenities, and diverts city and UPMO resources away from other needs.

- *Disagreements about approaches.* As the *Grants Pass* case showed, questions around addressing persistent homelessness evoke passionate debate between those that support efforts to clear encampments and those who strongly oppose any involuntary removal of unhoused individuals.

FEDERAL ROLE IN ADDRESSING HOMELESSNESS, MENTAL HEALTH AND SUBSTANCE USE

Although numerous programs across federal agencies exist to help states and localities address homelessness generally, the bulk of programs that focus on the health needs of the unhoused lie within the U.S. Department of Health and Human Services.

HHS Programs

Multiple HHS programs seek to address the intersection of homelessness and health care. (See table, below)

Medicaid *(https://www.medicaid.gov/)*	Jointly funded, federal-state health coverage program serving low-income families, children, pregnant women, adults without children, seniors and people living with disabilities.
Community Mental Health Services Block Grant *(https://www.samhsa.gov/grants/block-grants/mhbg)*	Provides funds and technical assistance states and territories for comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances.
Community Services Block Grant *(http://www.acf.hhs.gov/programs/ocs/programs/csbg)*	Funds community action agencies that provide services to reduce poverty, including around employment, education, housing assistance, nutrition, emergency services, health, and substance misuse needs.
Social Services Block Grant *(http://www.acf.hhs.gov/programs/ocs/programs/ssbg)*	Helps states deliver social services for children and adults, including employment, childcare, child welfare, adoptions, and youth services.
Health Care for the Homeless *(http://bphc.hrsa.gov/uds/datacenter.aspx?fd=ho&year=2013)*	Multi-disciplinary program that provides grants to nonprofits, and state/local governments to operate primary health care, substance use treatment, emergency care, and outreach services to help hard-to-reach homeless establish eligibility for entitlement programs and housing.
Community Health Center Program (*http://bphc.hrsa.gov/)*	Supports centers that help ensure access to primary care to underserved populations.
Projects for Assistance in Transition from Homelessness (PATH) *(https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path)*	Formula grant program that provides financial assistance to states to support programs for individuals who are at imminent risk of or experiencing homelessness who have a serious mental illness or co-occurring serious mental illness and substance use disorder.
Grants for the Benefit of Homeless Individuals *(https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/gbhi-program)*	Competitively awarded grant program to help communities expand treatment services for people experiencing homelessness who have substance use disorders or co-occurring mental and substance use disorders.
Treatment for Individuals Experiencing Homelessness *(https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/tieh-program)*	Competitively awarded grant program to help communities to expand access to treatment for people experiencing homelessness who have a serious mental illness or emotional disturbance (SED), or a co-occurring disorder, such as a substance use disorder.
SSI/SSDI Outreach, Access, and Recovery *(https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/soar)*	Increases access to Social Security disability benefits for eligible children and adults who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or co-occurring substance use disorder.

Justice and Mental Health Collaboration Program (https://jmhcp.org/)

Supported by the Justice Department's Bureau of Justice Assistance (BJA), the Justice and Mental Health Collaboration Program (JMHCP) works to connect criminal justice and health professionals with the goal of reducing criminal justice involvement for people with mental health conditions, or mental health and co-occurring substance use conditions, and connecting them to treatment and services. Grantees include states and territories, local governments, and federally recognized Indian tribes.

In 2021, BJA launched the Connect and Protect: Law Enforcement Behavioral Health grant program, which focuses on helping law enforcement and behavioral health agencies work together to improve crisis responses for people with mental health and substance use issues.

ORGANIZATIONS

A large number of non-profit organizations advocate on behalf of policies to reduce homelessness, including some that focus on its linkages to mental health and substance use issues.

- *National Alliance to End Homelessness (NAEH)* is "a nonpartisan, nonprofit organization whose sole purpose is to end homelessness in the United States." NAEH was founded in 1983 and is a national network of over 10,000 providers, public agencies, and private partners. (https://endhomelessness.org/)

- *The National Coalition for The Homeless* is "a national network of people who are currently experiencing or who have experienced homelessness, activists and advocates, community-based and faith-based service providers, and others committed to a single mission: To end and prevent homelessness while ensuring the immediate needs of those experiencing homelessness are met and their civil rights are respected and protected." (https://nationalhomeless.org/)

- *The National Health Care for the Homeless Council (NHCHC)* is "the premier national organization working at the nexus of homelessness and health care." Founded in 1986, their mission is to "build an equitable, high-quality health care system through training, research, and advocacy in the movement to end homelessness" by working with health care professionals, medical respite care providers, people with lived experience of homelessness, and advocates. (https://nhchc.org/)

- *Corporation for Supportive Housing (CSH)* is a national nonprofit intermediary and Community Development Financial Institution (CDFI) that works across more than 30 U.S. states and territories to provide supportive housing, which combines affordable housing with support services. (https://www.csh.org/)

POLICY SOLUTIONS

Experts have identified a number of policy approaches they believe can help address the intersection of homelessness and mental health/substance use.

Increasing health care access and quality

Advocates have argued that helping unhoused individuals with mental health and substance use issues can be improved "through policies that broaden the designations of who can provide healthcare services (including peer specialists and community health workers), expanding telehealth resources, and advancing street medicine and mobile health units."[15]

Increasing Medicaid funding is one policy objective that many advocates support, arguing that increasing benefits under Medicaid will actually reduce health care costs due to uncompensated emergency room care and criminal justice interventions.

Groups also argue that while efforts to increase access to health care is vital, just as important is improving the quality of care. As NAEH says, "by ensuring that healthcare policy is rooted in evidence-based and culturally appropriate practice, we improve the standard of care for people experiencing homelessness."[16] In addition, advocates support equity-centered trauma-informed care, which "builds a foundation of emotional safety, trust, and collaboration to help marginalized communities heal and thrive."[17]

Medicaid waivers

A number of advocates have espoused changes to Medicaid to make it easier for states and localities to use it for a range of services that address homelessness, mental health and substance use. Established in the 1960s as a federal-state cost-sharing program to provide health care to vulnerable populations, Medicaid was expanded in the 2010 Affordable Care Act (ACA, commonly known as Obamacare), which enables states to expand Medicaid eligibility to adults with incomes up to 133 percent of the federal poverty level.

Section 1115 of the Social Security Act gives HHS the ability to "approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations."[18]

HHS has allowed Medicaid 1115 waivers to fund some housing costs directly. Currently, more than one third of states have an 1115 waiver specifically targeting homelessness, with one in five states including provisions that cover direct housing costs (e.g., rent).[19] In addition, more than half of the nation's 100 largest health systems had homeless mitigation programs.[20]

In addition, so-called Medicaid 1115 Reentry Waivers enable states to cover services when someone is incarcerated, starting up to

90 days before release. Under the waivers, states must cover case management, medication assisted treatment and a 30-day supply of prescription medications at release.[21]

CARE Courts

California's Care Courts program is being watched closely by the rest of the country as a potential way to address these intersecting issues. According to the state, the "Community Assistance, Recovery and Empowerment (CARE)" system is "aimed at helping the thousands of Californians who are suffering from untreated mental health and substance use disorders leading to homelessness, incarceration or worse," arguing that it strikes a balance in getting care to those who need it without depriving people of their rights.[22]

The CARE Court program allows third parties like relatives, county and community-based social services, behavioral health providers, or first responders to petition the court to begin proceedings about people with mental health issues and/or substance use challenges. The petition must include either an affidavit from a licensed health care professional who examined them or tried to, or proof the person was recently detained under intensive treatment. The Court can order the individual to enter into a Care Plan for up to 24 months, which is managed by a care team in the community and may include supportive services, medication, and a housing plan (medication can be court-ordered, but not forcibly administered). Participants who do not successfully complete Care Plans may, under current law, be hospitalized or referred to conservatorship.[23]

Opponents of the CARE Courts argue that the legislation "creates a new pathway to conservatorship."[24]

According to data from the state superior court and county health officials, as of September 2024, at least 692 petitions had been filed across seven of the counties in the first cohort, excluding San Francisco. Of those petitions, about one in five have resulted in a voluntary CARE Agreement, six led to an involuntary CARE plan, and a little more than a third were dismissed by the court.[25]

Investing in more beds

In 2024, California voters narrowly passed Proposition 1, a ballot measure that authorizes $6.4 billion in bonds to pay for thousands of treatment beds and for more housing for the homeless, with the goal that this funding could help pay for the treatment plans put in place by CARE Court judges.[26]

CURRENT FEDERAL LEGISLATION

- H.R.2586, Reentry Act of 2025
  (Introduced by Rep. Paul Tonko (R-NY)
  H.R. 2586 would allow Medicaid payment of medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release.

- H.R.3320, Strengthening Medicaid for Serious Mental Illness Act
  (Introduced by Rep. Dan Goldman (D-NY)
  This bill would allow state Medicaid programs to cover intensive community-based services for adults with serious mental illnesses, including treatment services that are available 24/7, involve multidisciplinary care teams, and that are designed to improve outcomes for adults with mental illnesses who are at high risk of homelessness, psychiatric crisis, or hospitalization or who are involved in the criminal justice system.

- H.R. 577, Treatment and Homelessness Housing Integration Act
  (Introduced by Rep. Ken Calvert (R-CA)
  H.R. 577 would establish a HUD demonstration program to refer qualified participants within the Continuum of Care Program to Certified Community Behavioral Health Clinics for behavioral health, mental health, and substance use disorder treatment.

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[1] https://jmhcp.org/issue-areas/housing/

[2] https://nationalhomeless.org/health-care/

[3] https://denverrescuemission.org/homelessness-and-substance-abuse/

[4] https://read.dukeupress.edu/jhppl/article/50/3/469/392359/Medicaid-Waivers-to-Address-Homelessness-Political

[5] https://endhomelessness.org/ensuring-access-to-quality-healthcare-treatment-and-services/

[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC6445694/

[7] https://ternercenter.berkeley.edu/blog/webinar-building-stronger-homelessness-systems/

[8] https://calmatters.org/commentary/2024/09/homeless-programs-california-feuds-secrecy/

[9] https://www.voa.org/homelessness-and-prisoner-re-entry/?gad_source=1&gad_campaignid=20383360756&gbraid=0AAAAAD7cQmjJaEuC20gObVNmx-

tbTYlzf&gclid=CjwKCAjw9uPCBhATEiwABHN9K3jfZiWmAyZjwtqK6wSutS7cAe6-EQ2Yu_1yDXq87zAWQhN2_DM2FxoC4kwQAvD_BwE

[10] https://healthandreentryproject.org/wp-content/uploads/2025/05/Harp-MedicaidReentry-March2025.pdf

[11] IDA filed an amicus brief on the case in support of the town of Grants Pass (https://www.supremecourt.gov/DocketPDF/23/23-175/302130/20240304143056620_1_GRANTS%20PASS%20SUP%20CT%20Amicus%20brief%20FINAL.pdf)

[12] https://www.opb.org/article/2024/12/26/homeless-camping-ban-grants-pass/

[13] https://www.hudexchange.info/programs/hmis/

[14] https://community.solutions/research-posts/challenges-and-opportunities-for-establishing-quality-data-infrastructure/

[15] https://endhomelessness.org/ensuring-access-to-quality-healthcare-treatment-and-services/

[16] https://endhomelessness.org/ensuring-access-to-quality-healthcare-treatment-and-services/

[17] https://endhomelessness.org/creating-equitable-responses/

[18] https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations

[19] https://read.dukeupress.edu/jhppl/article/50/3/469/392359/Medicaid-Waivers-to-Address-Homelessness-Political

[20] https://news.cornell.edu/stories/2024/09/medicaid-could-bolster-or-reshape-us-homeless-policy

[21] https://healthandreentryproject.org/wp-content/uploads/2025/05/Harp-MedicaidReentry-March2025.pdf

[22] https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf

[23] https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf

[24] https://www.disabilityrightsca.org/latest-news/care-court-will-become-a-path-toward-institutionalization

[25] https://www.kqed.org/news/12007175/care-court-was-supposed-to-help-those-hardest-to-treat-heres-how-its-going

[26] https://www.nytimes.com/2024/03/20/us/california-prop-1-homelessness.html

ABOUT IDA

IDA is the premier organization for urban place professionals who are shaping and activating dynamic city center districts. Ourmembers are city builders and downtown champions who bring urban centers to life, bridging the gap between the public and private sectors. We represent an industry of more than 2,500 place management organizations, employing 100,000 people throughout North America and growing rapidly around the world. Founded in 1954, IDA is a resource center for ideas and innovative best practices in urban place management. For more information, visit downtown.org.

FOR MORE INFORMATION

Andrew Goldberg, Principal, Agora at andrew@agoragov.com or 202.321.1877

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