

Senate Memorial 44 Working Group

Recommendations

November 2015

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Introduction

The MOST prominent cause of homelessness in America is poverty and New Mexico (NM) has the second highest poverty rate in the nation (DeNavas-Walt and Proctor 2014). Further, housing instability disproportionately impacts people with disabilities, including people with mental illness or substance use disorders, and they often have the lowest incomes. The percent of New Mexicans with disabilities experiencing poverty (31.2%) is higher than the percentage of adults with disabilities experiencing poverty nationwide (28.4%; Erickson, Lee, von Schrader. 2014). Many of the most vulnerable New Mexicans struggle to access safe, affordable housing, suggesting the strong need for housing stabilization supports and additional affordable units. The priority is to ensure that individuals and families not only secure housing, but maintain permanent housing. People who experience homelessness in NM include: families with children; people who are working at low-wage jobs; people with mental health and substance use disorders, migrant workers; runaway teens; victims of domestic violence, formerly incarcerated people and veterans. This includes representation from both our culturally diverse population, in terms of race/ethnicity and our large geographic area, thus, enhancing access to both housing and supportive services is critical.

Senate Memorial 44 (SM 44) seeks to address local or regional systems change efforts to serve people experiencing homelessness. Specifically, in response to SM 44, the Senate Memorial 44 Working Group was convened to discuss expansion and scale-up efforts to increase the number of communities and settings using the targeted Recommended Practice(s) within the State so that more individuals and families experiencing homelessness are able to access and retain

THE “CULTURE OF POVERTY”: INCOME DISPARITY AND PUBLIC POLICY

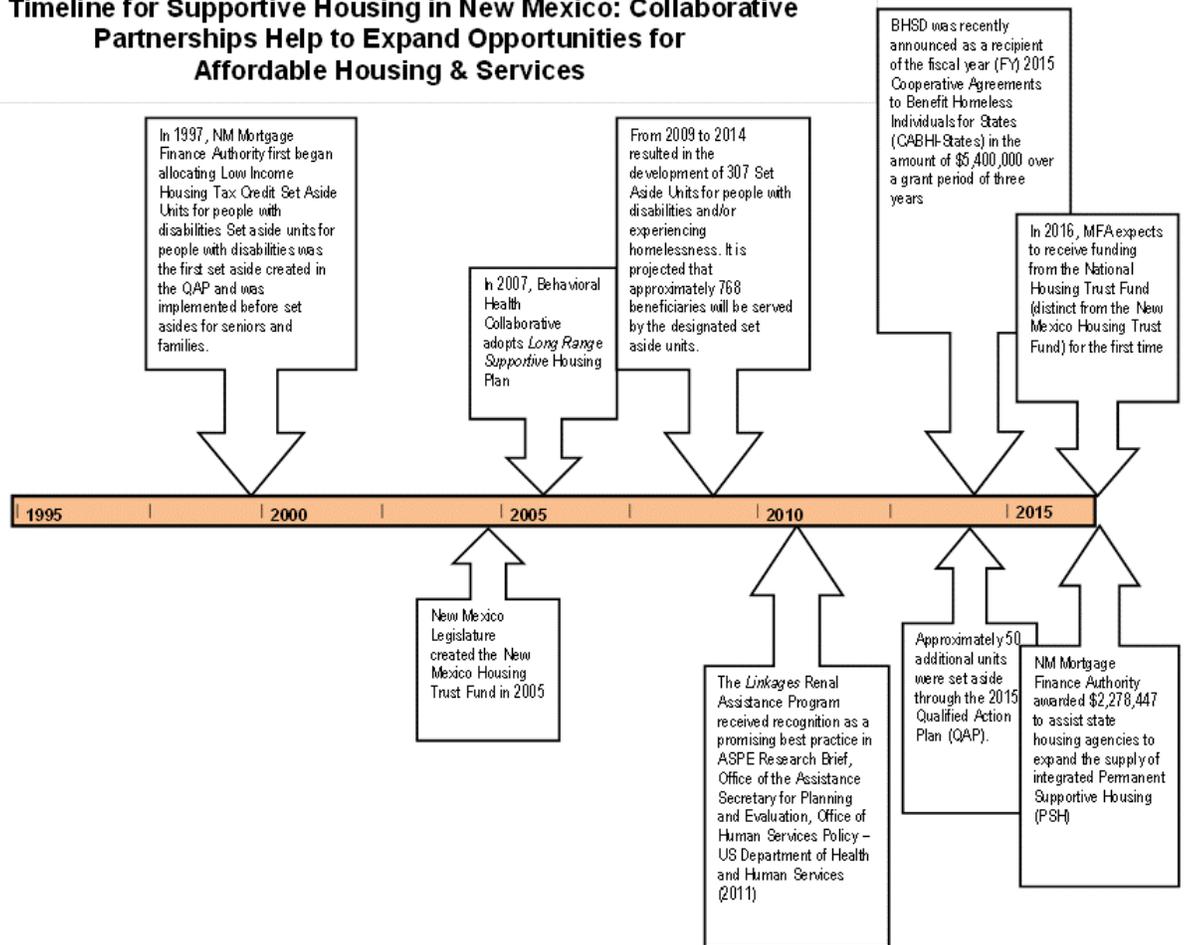
In social services, poverty is not seen as being caused by low wages or lack of jobs, but by wrong choices, bad attitudes, and faulty lifestyles. (The Other America, Michael Harrington; Frazier, The New Yorker, 2013)

So we design social programs to cure, not poverty, but the “culture of poverty.” (Barbara Ehrenreich, truthout.org)

safe, affordable, community-based, supportive housing. Such housing would also include enhanced access to services and drug or alcohol treatment.

Senator Sander Rue sponsored SM 44 in 2015. Senator Sander Rue also sponsored Senate Joint Memorial 4 (SJM 4) in 2015. Task Force members have included a discussion of strategies that may relate to the work of SM 44 participants. SJM 4 asks participants to determine alternative responses to include both housing and clinical service options for defendants with serious mental illness who are in custody awaiting trial. In addition, Senator Gerald Ortiz y Pino sponsored a Senate Bill in 2015 seeking an appropriation to scale-up supportive housing across the State. , Representative Tomás Salazar introduced a House Bill in 2015 seeking an appropriation for permanent supportive housing services and rapid rehousing services for homeless people. Their collective interest and support of such work recognizes the powerful effects of safe housing and two prominent consequences of supportive housing as a health intervention: (1) improved health outcomes; and (2) cost reductions. Related memorials were passed in 2008 and 2010.

A Timeline for Supportive Housing in New Mexico: Collaborative Partnerships Help to Expand Opportunities for Affordable Housing & Services



Quick Glossary of Terms

<p>Supportive housing – refers to a housing program that offers residents a range of psychosocial support services designed to promote wellness, recovery and resiliency, and minimize the harms associated with mental health and/or substance use disorders.</p>	<p>Housing First – the philosophy and practice of ensuring that safe housing is the number one priority for homeless people irrespective of any status that would exclude them from housing such as active substance use or legal status as a formerly incarcerated person.</p>
<p>Wrap around services – comprehensive support and community referrals designed to provide a continuum of care and maximize physical and behavioral health outcomes.</p>	<p>Rapid re-housing – the practice of minimizing the amount of time individuals and families are homeless in order to prevent the harms associated with any period of homelessness.</p>

Key Findings

RECOMMENDATIONS	
1. Reinvigorate and commit a State Leadership Team to the issue of homelessness through the existing Housing Leadership Group	Enhance and sustain a team of cross-agency state leaders and agency representatives responsible for planning, coordination and oversight of implementing Permanent Supportive Housing and other Recommended Practices statewide.
2. Broad access to training and technical assistance	Select and develop subject matter experts (in-state) who are responsible for delivering training and providing assistance through mentorship and coaching to ensure high-fidelity implementation of the evidence-based practice Permanent Supportive Housing with special attention toward new implementation sites.
3. New implementation sites/demonstration sites and existing implementation sites	Build and sustain support for programs across existing network where there is significant unmet need and bring new resources to increase access to evidence-based practices in other communities (i.e., rural, frontier and tribal) that have yet to receive services.
4. Data and evaluation systems	Commit to data-based decision-making and agree to methods for data collection, measures and evaluation procedures.
5. Explore and select innovative financing models	
6. Increase community investments in Permanent Supportive Housing units	Build statewide capacity through the prioritization and funding of subsidized community-based housing accessed by a Tenant-based Voucher or a Project-based Voucher.
7. Dedicate additional resources to rapid rehousing/move-in assistance and eviction prevention efforts	Financial assistance and services that are flexible and readily available to prevent individuals and families from becoming homeless and help those who are experiencing homelessness to be quickly re-house and stabilized.
8. Flexible funding streams and payment mechanisms under Medicaid	Compensate providers for supportive housing-related activities and services. Permanent supportive housing is a model – not a program. Therefore, there is not a single federal or state Permanent Supportive Housing funding stream. Different funding mechanisms, (or braiding of various funding streams), are required to accomplish the three components of the model. <i>It is critical that service dollars not be used to pay for housing and housing dollars not be used to pay for services in order to attain the maximum benefit from both resources.</i>
9. Expand coverage for non-Medicaid supportive housing-related services	
10. Provide and enhance opportunities for Supported Employment	

Understanding Homelessness in New Mexico

NM is the most ethnically diverse state in the continental U.S, and is home to 23 sovereign Tribes, Pueblos and Nations. NM has the highest proportion of Native Americans (10.4%) in the country, and is a majority minority state, with close to half of the citizens being Hispanic (47.3%). Almost 40% of New Mexicans are White, 2.5% are Black, and 1.6% of the population is Asian. Spanish (28% statewide compared to 12% nationally) and several native languages (5%) are spoken in many homes. NM is also geographically diverse with large rural and frontier areas. It is the 5th largest state in the nation, with over 121,000 square miles and a small population that is just over 2 million. Approximately 50% of the population is female, and 74% is 18 or over (US Census Bureau, 2015).

NM ranks among the lowest in the country in per capita income (\$43,820 vs. \$51,914 nationwide), with more than 35% of the population being recipients of Medicaid (CMMS. 2015). These expenditures account for more than 25% of the State budget (NASBO, 2014). Poverty rates are higher than the national average with 20.4% of New Mexicans living below the poverty level compared to 15.4% nationally (US Census Bureau, 2015). NM also has a lower percent of high school graduates (83.6% vs. 86% nationally; US Census Bureau, 2015). Access to health insurance is related to poverty and NM ranks fifth lowest for uninsured residents, with 18.6% lacking health insurance compared to 14.5% of the nation (Smith et al., 2014). Literacy is also an issue, with 46% of the adult population functionally illiterate (NM Coalition for Literacy, 2015). Thus, poverty, geographic isolation, and other social determinants of health are prevalent in NM and all contribute to homelessness.

People Experiencing Homelessness in NM Include:

Individuals with long histories of homelessness (poverty)

People with complex clinical needs: mental health, substance use disorders, and chronic health problems

Persons with a history of trauma

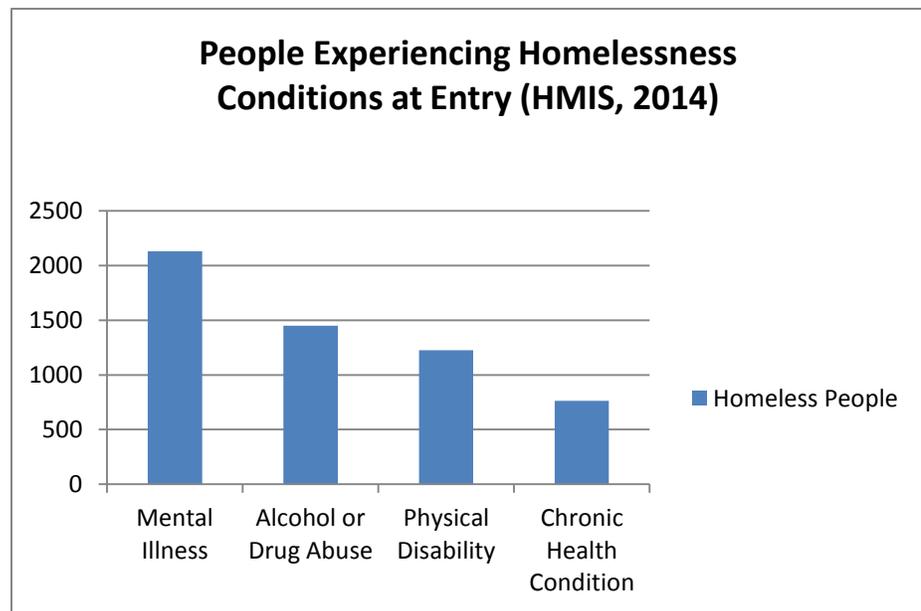
Frequent users of acute care systems

Families

People who experience homelessness in NM include families with children, people who are working at low-wage jobs, people living with mental illness, those with substance use problems, migrant workers, runaway teens, victims of domestic violence, formerly incarcerated people and veterans. Simply, New Mexicans experiencing homelessness are a diverse group of people with a variety of factors contributing to their homelessness.

An estimated 51,705 adults in NM have a serious mental illness (SMI) representing 6.6% of low-income adults' statewide (McGee et al., 2008). Over 84% of New Mexicans with serious mental illness are over age 16, and more than 30,000 live in poverty (TAC, 2007). Substance abuse is one of NM's leading causes of death and NM consistently ranks among the worst

in the nation for mortality associated with drugs and alcohol. The devastation caused by co-occurring substance use and mental health disorders is associated with domestic violence, incarceration,



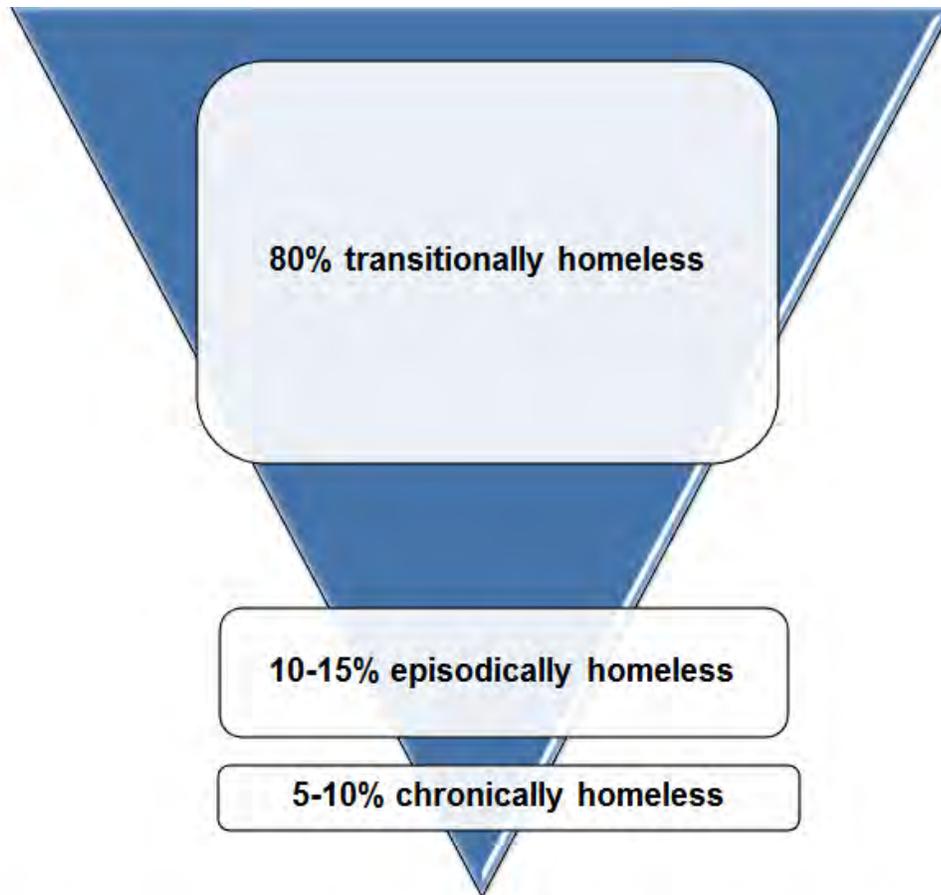
poverty, homelessness, neuropsychological impairment, infectious diseases, and significant medical problems (Compton et al., 2007). Of the total population, twelve percent of New Mexicans are veterans and it is estimated that approximately 23% of male homeless adults are veterans (NM, Department of Veteran Services, 2013; National Coalition for the Homeless, 2009).

Homelessness is caused by poverty and a lack of affordable housing. Homelessness has grown dramatically since the 1970's primarily due to the steady decrease in public benefits for people living in poverty including welfare payments and public housing. In part because

of the decrease in spending for public housing, there has been a steady decline in affordable housing. NM continues to struggle to address the housing needs of its most vulnerable residents, especially individuals and families experiencing chronic homelessness. There continues to be a lack of affordable housing stock for the lowest income people with disabilities or any other extremely low income household. In addition to limited access to affordable housing, there has been a significant increase in Extremely Low Income (ELI) households. The lack of affordability also impacts individuals who may be at-risk of homelessness and others who may be precariously housed in unsafe or otherwise unsuitable housing arrangements.

The New Mexico Coalition to End Homelessness (NMCEH) estimates there are at least 17,000 people in NM experiencing homelessness over the course of a given year. Further, based on the 2015 Point in Time (PIT) Count conducted by the NMCEH, on one night in Albuquerque, 1287 people experienced homelessness. In addition, NMCEH determined that 8,419 individuals experiencing homelessness received help in 2014 from a program in New Mexico that reports data to the Homeless Management Information System (HMIS).

Homelessness in New Mexico is different in some ways from homelessness in other parts of the United States. One difference is that in urban areas homeless people who are not in shelters sleep in cars, abandoned buildings, and empty lots. In New Mexico homeless people use all of these places but they also camp out in the wide open spaces. This use of open space means that homeless people are somewhat less visible in New Mexico than in a more urban state. In Southern New Mexico many of the homeless are immigrants and migrant workers. In northwestern New Mexico known as 'Indian Country', many of the homeless are Native Americans (New Mexico Coalition to End Homelessness, <http://www.nmceh.org/pages/homelessness.html>).



SAMHSA. *Housing First for People Experiencing Serious Mental Illness and Co-occurring Disorders*, PowerPoint Presentation (July 2015)

Supportive Housing

Supportive housing programs in New Mexico serve people with:

- Serious Mental Illness;
- Substance use disorder (i.e., individuals in treatment and demonstrated recovery);
- Developmental disability
- Physical, sensory, or cognitive disability
- Disability caused by chronic illness
- Age-related disability (i.e., frail elderly, or, young adults with other special needs, or,
- Households/ individuals who are homeless

Supportive housing is a cross-population, cross-agency initiative.

Defining Supportive Housing

Supportive housing is a combination of affordable housing and supportive services designed to help vulnerable individuals and families use stable housing as a platform for health, recovery and personal growth. It focuses on balancing three distinct components of the model — housing, supportive services, and property and housing management. These three components can be viewed as a “three-legged stool,” in which each part must bear equal weight to have a balanced project. Supportive housing, however, should not be isolated from the larger community. A project’s relationship to the community adds a vital fourth leg, turning the stool into a community table at which supportive housing providers must have a seat.

Quality supportive housing projects are as diverse as the communities in which they are located. Despite these differences, all supportive housing:

- Targets households whose heads of household are experiencing homelessness, at risk of homelessness, or are inappropriately staying in an institution. They may be facing multiple barriers to employment and housing stability, including mental illness, substance use, and/or other disabling or chronic health conditions.

- Is affordable, meaning the household ideally pays no more than 30% of its income toward rent.
- Provides households with a lease or sublease identical to non-supportive housing — with no limits on length of tenancy, as long as lease terms and conditions are met.
- Proactively engages members of the household in a flexible and comprehensive array of supportive services, without requiring participation in services as a condition of ongoing tenancy.
- Effectively coordinates with key partners to address issues resulting from substance use, mental health and other crises, with a focus on fostering housing stability.
- Supports residents in connecting with community-based resources and activities, interacting with diverse individuals including those without disabilities, and building strong social support networks.

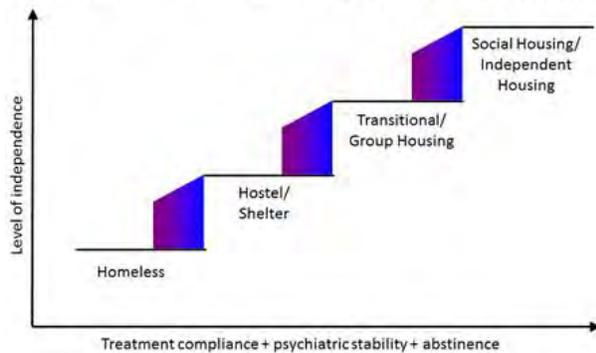
The above section is reproduced from the Corporation for Supportive Housing (CSH) publication, *Dimension of Quality Supportive Housing*. The full document is posted the CSH website, csh.org. For additional resources and materials related to the CSH *Dimensions of Quality Supportive Housing* please visit csh.org/quality.

Principles and Practices of Housing First

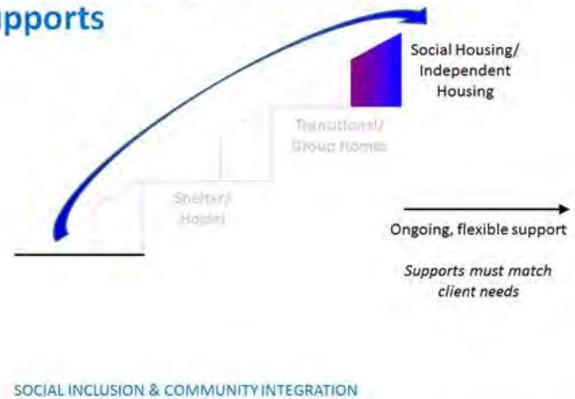
1. Choice in housing and services
2. Separation of housing and support services
3. Service array (services match needs)
4. Recovery orientation
5. Program structure

Also see "Housing First Task Force Report" (2008)

Housing First was created to offer an alternative to traditional services approach



Immediate and Direct Access + Supports



SAMHSA. *Housing First For People Experiencing Serious Mental Illness and Co-occurring Disorders*, PowerPoint Presentation (July 2015)

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is further defined in the section below. Detail for this section is taken from an Evidence-Based Practice (EBP) KIT on Permanent Supportive Housing that is available from the Substance Abuse and Mental Health Services Administration (SAMHSA). The KIT provides tools to support the implementation of Permanent Supportive Housing for people with mental illness. The Kit also contains a summary of research evidence. In addition, language for this section was added directly from the United States Interagency Council on Homelessness Solutions Database (USICH, http://usich.gov/usich_resources/solutions/explore/permanent_supportive_housing).

Permanent supportive housing is safe, affordable, community-based housing that provides residents with the rights of tenancy and links to voluntary and flexible supports and services for people with disabilities who are experiencing homelessness. Permanent supportive housing is a proven, effective means of reintegrating chronically homeless and other highly vulnerable homeless families and individuals with psychiatric disabilities or chronic health challenges into the community. This is accomplished by addressing their basic needs for housing and providing ongoing support.

Permanent Supportive Housing (PSH or “supportive housing”) is for people who need long-term housing assistance with supportive services in order to stay housed. Individuals and families living in supportive housing often have long histories of homelessness and face persistent obstacles to maintaining housing, such as a serious mental illness, a substance use disorder, or a chronic medical problem. Many supportive housing residents face more than one of these serious conditions.

Supportive housing links safe, affordable, community-based housing with flexible, voluntary support services designed to help the individual or family stay housed and live a more productive life in the community. It looks and functions much like any other brand of housing. People living in supportive housing have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. The difference is that they can access, at their option, services designed to address their individual needs and preferences. These services may include the help of a case manager or counselor, help in building independent living and tenancy skills, assistance with integrating into the community, and connections to community-based health care, treatment, and employment services.

Permanent supportive housing programs allow people with one or more serious disabling condition to stabilize their housing and address underlying issues that often have gone untreated for many years. The combination of housing and supportive services creates a synergy that allows residents to take steps toward recovery and independence.

The “permanent” in “permanent supportive housing” means the length of stay is up to the individual or family. There is no time limitation, and residents may live in their homes as long as they meet the basic obligations of tenancy. While participation in services is encouraged, it is not a condition of living in the housing. Housing affordability is ensured either through a rent subsidy or by setting rents at affordable levels.

There is no single model for supportive housing’s design. The provision of supportive housing may involve the renovation or construction of new housing, set-asides of

apartments within privately-owned buildings, or leasing of individual apartments dispersed throughout an area. There are three primary forms of supportive housing:

- Single-site housing, in which the residents receiving support services live in units in the same building or a group of buildings, with the support services provided either on site or off site.
- Scattered-site housing, in which residents live in independent apartments throughout the community, in either private or agency-owned housing; depending on the program, staff, can deliver some support services through home visits, or all services may be provided at other locations in the community.
- Mixed housing, in which residents live in developments that contain a mixture of supportive housing residents and other residents not part of the supportive housing program.

Supportive housing emerged as an intervention to prevent and end homelessness in the 1980s. Since that time, use of the model has expanded nationwide. As its use has grown, national organizations and the Substance Abuse and Mental Health Services Administration (SAMHSA) have drawn from practice and research to identify several core elements of permanent supportive housing:

Housing

1. Tenant choice. Supportive housing staff helps residents or potential residents define their housing needs and preferences. Residents choose whether or not to participate in services and cannot be evicted from their housing for rejecting them. In scattered-site supportive housing, residents choose where they want to live, and receive help finding an apartment that best meets their needs.
2. Access. The housing is available to people who are experiencing homelessness or are precariously housed and who have multiple barriers to housing stability and employment. These barriers may include little or no income, poor or no credit histories, prior evictions, disabilities, histories of criminal justice involvement, and past

or current substance use. In scattered-site housing, staff may facilitate access by proactively developing positive relationships with landlords, advocating on behalf of prospective residents, and offering landlord incentives such as reimbursement for excessive damages or court costs should the tenancy be unsuccessful.

3. Quality. The housing is similar to what is available to other households at fair-market rents in the community. It has a home-like, residential appearance (on both the interior and exterior), and its scale, appearance, design, and quality are consistent with (or exceed) neighborhood and community standards. The housing units provide adequate living space for essential daily activities such as cooking, eating, and sleeping. Ideally each unit has a private bathroom and kitchen. The housing includes appropriate safety features and meets standards for quality established by applicable codes and regulations.
4. Integration. Adults with disabilities have a right to receive housing and supportive services in the most integrated settings that are available. There are several ways that integration can be achieved, including scattered-site or mixed-housing models in which supportive housing residents live in buildings that include neighbors who do not have disabilities, as well as site-based supportive housing that is located in neighborhoods that provide access to an array of community services and resources used by people with and without disabilities. Integration reduces stigma and offers residents opportunities to interact with a broad spectrum of neighbors.
5. Rights of tenancy. Supportive housing residents have a lease in their name and control over their living space, meaning that each resident has a key to his or her own apartment or room and the resident can come and go at any time and control who can visit. In some cases, a service agency may hold a lease with residents holding a sublease, and in other cases the agency itself might own the property. Regardless of the arrangement, resident leases or subleases confer full rights of tenancy, including limitations on landlords' entry into the property and the right to challenge eviction in landlord-tenant court. Residents can remain in their homes as long as the basic requirements of tenancy are met—paying the rent, not interfering

with other residents' use of their homes, not causing property damage, etc. House rules, if any, are similar to those found in other housing.

6. **Affordability.** Supportive housing residents ideally pay no more than 30 percent of their income toward rent and basic utilities and rarely pay more than 50 percent. The remainder of the rent is covered either by tenant-based rental assistance, which residents can use in housing of their choice, or project-based rental assistance or an operating subsidy, which is linked to a specific location.
7. **Coordination between housing and services.** Property managers and support service staff stay in regular communication and coordinate their efforts to help prevent evictions and to ensure residents facing eviction have access to necessary services and supports.
8. **Delineated roles.** The supportive housing model distinguishes between housing and services. Even if some services are provided on site, there is a functional separation, with the housing elements (rent collection, property maintenance, enforcement of responsibilities of tenancy) carried out by different staff than those providing services (case management, mental health treatment, wraparound services).

Services

1. **Resident choice.** Supportive housing residents have choices in the support services that they receive. Rather than a limited menu of services for a particular location, supportive housing is intended to help residents define their needs and preferences, and then to develop an individual plan of support that reflects those. As their needs change over time, residents can receive more intensive or less intensive support services without losing their homes; the services come and go rather than the residents.
2. **Housing focus.** To help residents achieve residential stability, the service team focuses on increasing residents' ability to choose, obtain, and keep housing. It focuses on helping residents meet their lease obligations, including paying rent,

maintaining a safe and healthy living environment, allowing others the peaceful enjoyment of their homes, and complying with the terms and conditions of the lease.

3. Assertive outreach and engagement. Some residents are reluctant to accept help, suspicious of promised benefits, and feel hopeless about their future. The service team uses a variety of outreach and engagement techniques that bring severely disenfranchised people into helping relationships. The most effective approaches include an attitude of respectful persistence, meeting the person's real and immediate needs, and helping the person address difficulties one step at a time.
4. Case management. Skilled and flexible case managers most often serve as the bridge between residents and the supports that help them achieve stability and long-term tenancy. Case managers first build trust, then help residents select and obtain the supports that will work best for them. Ideally, caseloads are no more than 15 residents to each case manager.
5. Recovery supports. The service team works with residents to promote long-term stability, recovery, and a sense of self-efficacy as contributing community members. The services they provide directly or arrange for on behalf of residents fall under three broad categories:
 - Mainstream supports, including income supports and entitlements from public benefits programs, health care from hospitals and clinics, and employment help from vocational agencies.
 - Specialized supports that help residents succeed in accomplishing their goals, such as life skills training, budgeting, medication management, and behavioral health treatment.
 - Natural supports, including connections with peers, family, community, and faith communities.

A growing number of supportive housing providers recognize the importance of integrating formerly homeless people as members of their service teams. The advantages of peer support include increased empathy and understanding based on shared experiences,

offering supportive housing residents a living model of recovery, and helping organizations to be consumer-focused.

Many supportive housing providers use evidence-based practices in the delivery of services to residents. The most frequently used include:

- Housing First, in which housing is offered with no preconditions;
- Motivational Interviewing, which enables the provider to take the resident's readiness to change into account and to reinforce the resident's intrinsic motivation for change;
- Integrated Treatment for Co-occurring Disorders, which provides and integrates treatment for both substance use and mental health issues;
- Assertive Community Treatment, which uses a team approach to meet participants' diverse needs;
- Illness Management and Recovery, which enables residents to manage their own symptoms; and
- Supported Employment, which helps residents take advantage of appropriate opportunities for mainstream employment.

Perhaps the most important aspect of the supportive housing service approach is that the service team goes the extra mile to help residents succeed. Instead of putting the burden of success solely on the person being served, service teams adopt a partnership attitude and are willing to step outside the boundaries of conventional services.

Outcomes/Results

A range of research efforts reinforce evidence that permanent supportive housing is an effective approach for meeting the needs of people experiencing homelessness with disabilities and chronic health conditions (SAMHSA, 2010; Tsemberis Eisenberg, 2000; Rog et al., 2014; Culhane et al., 2001; O'Hara, 2003; Rosenheck et al., 2003). Research also indicates this combination of long-term housing and wraparound services leads to improved residential stability and reduction in psychiatric symptoms (Rog et al., 2014). A more recent study underscores the relationship between Permanent Supportive Housing and chronic

homelessness at the community level (Culhane, D. P., Thomas Byrne, Jamison D. Fargo, Ann Elizabeth Montgomery and Ellen Munley, 2014). The study uses longitudinal data collected by the US Department of Housing and Urban Development (HUD), specifically the analysis uses estimates of homelessness by Continuums of Care (CoCs) from point-in-time counts (PIT) and measures of community investment in Permanent Supportive Housing determined by the number of Permanent Supportive Housing units designated specifically for individuals and families experiencing homelessness. This measure is obtained from HUD's Housing Inventory Chart (HIC). The researchers were able to demonstrate through the use of community-level data that "communities that add relatively more Permanent Supportive Housing units show steeper declines in chronic homelessness over time."

Benefit –Cost Analysis

Studies have also found that supportive housing is associated with significant reductions in costs for emergency room visits, hospitalizations, shelters, sobering centers, jails, and other public services used by people experiencing homelessness. Information on anticipated savings for New Mexico has been drawn from a comprehensive cost benefit analysis that was prepared for the Albuquerque Heading Home Initiative (City of Albuquerque Heading Home Initiative Cost Study Report Phase 1, 2013). The study measured cost of services before and after housing was secured for chronically homeless persons in Albuquerque. The findings indicated that supportive housing is cost effective, or at least cost neutral, for specific populations. Some specific findings are shared in brief below:

Considering all of the cost types, the one year post-Heading Home costs were 31.6% less than the one year pre-Heading Home program costs. This amounted to an average savings of \$12,831.68 per study group member.

For example, after being housed, emergency room visits for study group members declined by 36.2%. Accordingly, emergency room costs declined from \$208,439.74 to \$181,272.62, a demonstrated decrease of approximately \$27,167.12.

New Mexico may anticipate savings using the average savings from the Albuquerque study of \$12,831.68 for study group members as a working assumption for Permanent Supportive Housing as a potential health intervention for people experiencing homelessness.

Related Profiles

Evidence-Based Practice: Permanent Supportive Housing

Evidence-Based Practice: Assertive Community Treatment

Evidence-Based Practice: Motivational Interviewing

Evidence-Based Practice: Integrated Treatment for Co-Occurring Disorders

Promising Practice: Vulnerability Index

Harm Reduction Philosophy: Housing First

Model Program: Albuquerque Continuum of Care, Albuquerque (NM)

Model Program: Albuquerque Heading Home, Albuquerque (NM)

Model Program: Almost Home, St. Martin's Hospitality Center, Albuquerque (NM)

Model Program: Balance of State Continuum of Care, Statewide (NM)

Model Program: Healthy Homes, The Life Link Inc., Santa Fe (NM)

Model Program: *Linkages* Rental Assistance Program, Grant, Santa Fe, Bernalillo, Dona Ana, Chaves, San Juan, Lea, Taos (NM)

Model Program: Local Lead Agency (LLA) Low Income Housing Tax Credit (LIHTC) Set Aside Units for people with disabilities and/or experiencing homelessness (formerly the Special Needs Program), Bernalillo, Chavez, Curry, Doña Ana, Edy, Lea, Los Alamos, Luna, McKinley, Sandoval, San Miguel, San Juan, Socorro, Santa Fe, Taos, Valencia, Zuni (NM)

Model Program: Section 811 Project Rental Assistance (Tied to eligible LLA LIHTC Set Aside Units)

Model Program: Rental Assistance Program, MFA administers the State of New Mexico homeless funds and federal resources under the Emergency Solutions Grants and Behavioral Health Services Division administers state resources for Move-in Assistance and Eviction Prevention.

Model Program: Veterans Affairs supportive Housing (VASH), Statewide (NM)

Problem Statement

Senate Memorial 44 Working Group met to promote the quality of life result where:

Individuals and families experiencing homelessness are able to access and retain safe, affordable, community-based, supportive housing, in addition to services and treatment.

NM continues to struggle to address the housing needs of its most vulnerable residents, especially individuals and families experiencing chronic homelessness. Supportive housing in New Mexico has been reliant on federal resources for early implementation and expansion. However, federal funding streams are not enough. There continues to be a lack of affordable housing stock and barriers to coverage of some housing-related activities and services for the lowest income people with disabilities or any other extremely low income household.

Frequent use of costly systems like acute care and criminal justice by highly vulnerable residents comes at a great cost to both society and the individual. In contrast, by offering ***the right service, at the right place and at the right time***, NM could reduce costs and improve health outcomes for people experiencing homelessness.

Gap Analysis/Housing Inventory

The New Mexico Coalition to End Homelessness (NMCEH) estimates the number of supportive housing placements needed through an assessment of need and inventory of available units across the State. The goal over time is to use data to understand the need for supportive housing and related best practices to determine how to target resources to New Mexicans experiencing homelessness, individuals and families at-risk of homelessness, and to meet the needs of other vulnerable residents who may be precariously housed. To present the level of need across the State, the NMCEH uses data from its own survey of existing supportive housing resources produced for HUD's Housing Inventory Chart, the New Mexico Behavioral Health Collaborative Long Range Supportive Housing Plan (2007), and study of the need for permanent supportive housing units. It also estimates population

and poverty rates for New Mexico counties from the U.S. Census. The chart showing the statewide breakdown of numbers can be found in the Appendix. However the counties with the highest need are shown in the Table below.

Need for Supportive Housing by County (2015)				
County	2014 Census Population	Poverty Rate	Total # of Homeless People Counted on 1/26/15*	Estimated Total Need for Supportive Housing
Dona Ana County	213,676	27	333	534
Sandoval County	137,608	17.7	35	344
Valencia County	75,817	23.4	20	190
Chaves County	65,878	21.2	28	165
McKinley County	74,098	40.3	108	185
Otero County	65,082	21.3	14	163
Lea County	69,999	14.8	12	175
Bernalillo County	675,551	18.7	1378	1689
San Juan County	123,785	22.7	207	309
Eddy County	56,395	15.1	86	141
Rio Arriba County	39,777	24.8	2	99

State and local decision-makers should consider basic needs assessments and invest in regular comprehensive analyses of the supportive housing need statewide to inform resource allocation decisions. The State should also determine processes for data collection, availability and reporting on cross-population, and cross agency investments in supportive housing. These efforts should be person-centered so that there is not a singular focus on

"chronic homeless" to qualify an individual or family for assistance. Senate Memorial 44 Working Group members were able to describe cases where screening for eligibility using strict definitions of homelessness has had the effect of "screening out" highly vulnerable persons including, but not limited to, the following examples: individuals with serious mental illness who are precariously housed in unregulated boarding homes, youth who "couch surf," and individuals from various cultural backgrounds who "double-up" with family members, but remain at imminent risk for becoming homeless as continued tenancy is contingent upon the hospitality of the primary leaseholder or owner.

In addition, based on the above gap analysis and discussion by Senate Memorial 44 Working Group participants, an effort to allocate new resources for scale-up or expansion should consider new implementers in additional communities as well as building and sustaining support for programs that have achieved full implementation as demonstration sites or early adopters. Continuing to use scarce new resources to meet the unmet demand in the same communities limits access to evidence-based practices in other communities that have yet to receive services.

RECOMMENDATION

Ongoing Comprehensive Analysis of Need for Supportive Housing

State and local decision-makers should consider basic needs assessments and invest in regular comprehensive analyses of the supportive housing need statewide to inform resource allocation decisions.

Senate Memorial 44 Working Group participants realized that a comprehensive financial analysis for use of supportive housing as a key strategy for ending homelessness while needed was outside the scope of practice for participants. As such, complete financial modeling for community-level investments in supportive housing is needed to better understand and plan for expansion and scale-up efforts (See more details about program and financial modeling at: <http://www.csh.org/csh-solutions/community-work/local-planning/program-and-financial-modeling/#sthash.QzkIdZNW.dpuf>). However, basic information about costs associated with existing programs is shared throughout the report.

RECOMMENDATION

Complete Program And Financial Modeling For Supportive Housing Across Communities In New Mexico Is Required

Program and financial modeling should be an important part of the next phase of planning for State and local decision-makers as they consider community-level investments in supportive housing.

Recommendations

Long-term planning and commitment to permanent supportive housing as a health intervention is needed to address the significant gap in supply of available permanent supportive housing units and the demand for placements. This report, in addition to widely available and published material, can be used as a guide for implementing widespread use of evidence-based practices to improve health outcomes and reduce costs. Overall system improvement requires prioritization and funding to increase capacity, access and financing for housing, health care and services. As stakeholders consider support of new and existing initiatives, they must think more broadly, rigorously, and over a longer timeframe about Medicaid and non-Medicaid funded preventive health care initiatives designed to reduce long-term costs. The initiatives selected should exemplify a shift in expenditures that may help to:

- Understand what changes could affect the lives of our most vulnerable residents;
- Promote information and resource sharing across disciplines and organizations; and
- Prepare and plan to more effectively operate in the future.

Variation in capacity and access across the State may require additional resources, and guidance and coordination for systems-change efforts to succeed. The report for Senate Memorial 44 is largely reflective of input from stakeholders from the larger metropolitan areas of Santa Fe, Albuquerque and Las Cruces. However, the Senate Memorial 44 Working Group included in their discussions considerations for how guidance or new resources could be used by regions within the State and by rural, frontier and tribal communities.

System Recommendations

In the context of New Mexico's competitiveness as a state in rural US regions, system-level recommendations that address models for service are challenged by the implications of low population density (i.e., lower federal funding, a small tax base leads, increasing costs of providing physical infrastructure and support services, etc.). Federal funding is lower in rural regions, particularly for community resource programs such as housing, infrastructure and business (2004. Competitiveness in Rural Regions: Learning and Research Agenda, Institute for Strategy and Competitiveness, Harvard Business School). To overcome such barriers to upfront investments in housing and prevention and to replicate proven programs and practices throughout the State, Senate Memorial 44 Working Group participants identified a number of strategies meaningful to system-change efforts.

RECOMMENDATIONS

1. Reinvigorate and commit a State Leadership Team to the issue of homelessness through the existing Housing Leadership Group

Enhance and sustain a team of cross-agency state leaders and agency representatives responsible for planning, coordination and oversight of implementing Permanent Supportive Housing and other Recommended Practices statewide.

2. Broad access to training and technical assistance

Select and develop subject matter experts (in-state) who are responsible for delivering training and providing assistance through mentorship and coaching to ensure high-fidelity implementation of the evidence-based practice Permanent Supportive Housing with special attention toward new implementation sites.

3. New implementation sites/demonstration sites and existing implementation sites

Build and sustain support for programs across existing network where there is significant unmet need and bring new resources to increase access to evidence-based practices in other communities (i.e., rural, frontier and tribal) that have yet to receive services.

4. Data and evaluation systems

Commit to data-based decision-making and agree to methods for data collection, measures and evaluation procedures.

5. Explore and select innovative financing models

Discussion

In brief, the broad strategies for systems-change efforts are shared again below, with some additional insights offered by Senate Memorial 44 Working Group participants:

Reinvigorate and commit a State Leadership Team to the issue of homelessness through the existing Housing Leadership

Enhance and sustain a team of cross-agency state leaders and agency representatives responsible for planning, coordination and oversight of implementing Permanent Supportive Housing and other Recommended Practices statewide. The team should arrange for funding, policy initiatives, evaluation and data to inform decision-making, training, site selection, education and outreach

Broad access to training and technical assistance

Select and develop subject matter experts (in-state) who are responsible for delivering training and providing assistance through mentorship and coaching to ensure high-fidelity implementation of the evidence-based practice Permanent Supportive Housing with special attention toward new implementation sites

New implementation sites/demonstration sites and existing implementation sites

Identify new implementation sites and existing implementation sites that were early adopters and have reached program-wide high fidelity implementation to serve as demonstration sites. In addition to sustaining support for programs by bringing new resources, to increase access to evidence-based practices in other communities that have yet to receive services, the state leadership team should seek to fill gaps in the continuum of available services with special considerations for service delivery in rural, frontier and tribal communities

Data and evaluation systems

Commit to data-based decision-making and agree to methods for data collections, measures and evaluation procedures. Include measures that indicate how personnel at implementation sites are accurately providing evidence-based practices. In addition, beyond a simple count of permanent supportive housing units as a measure of progress, include procedures to measure quality of life.

- Increase access to screening, brief intervention, and brief treatment of substance abuse and mental health disorders in various settings to include primary care, behavioral health and homeless service provider agencies.
- Coordinated Assessment, a common assessment tool to determine what types of housing and support would best help a homeless individual or family obtain housing, and the Homeless Management Information System, an online centralized database designed to collect client-level information on the characteristics and services needs of people experiencing homelessness, are promising practices that are showing positive outcomes but require more evidence to support generalizable conclusions about statewide application.
- Care Coordination was identified as a potential aligning strategy to promote timely access to appropriate services and care. Formal partnerships and contracts are being established to ensure ease of access between provider agencies and Senate Memorial 44 Working Group participants suggested that homeless providers be considered as eligible providers for inclusion in managed care organization networks.

Explore innovative financing models

Incentivize performance-based financial strategies, like Pay for Success and others, to reward positive consumer outcomes, increased collaborations, risk sharing and integration of housing, health care and services

Pay For Success

Pay-for-success contracts, also referred to as “social impact bonds,” are an innovative approach to improving outcomes and reducing costs for contracted government services. Pay-for-success contracts are contracts in which a substantial portion of the payment is conditioned on the achievement of specific outcomes based on defined performance targets. Unlike typical pay-for-performance contracts, pay-for-success contracts often ask contracted parties to raise upfront capital and only reimburse such upfront capital expenses if an independent evaluator determines that performance targets have been achieved. If outcomes are achieved, the initial investors are reimbursed for the entire cost of the program plus risk premium payments. Ideally, these payments are made when government and/or societal savings are realized due to the program’s effectiveness. Programs in which potential governmental savings are larger than the cost of the program are strong candidates for the social impact bond model.

Since the initiation of the first pay-for-success program in Peterborough, England in 2010, eight Pay for Success transactions have closed in the United States to date with dozens more currently at various stages of development.

Pay for Success and Supportive Housing

Supportive housing is a combination of affordable housing and supportive services designed to help vulnerable individuals and families use stable housing as a platform for health, recovery and personal growth. Supportive housing can be any type of affordable and independent housing that meets the needs of residents and is integrated within a neighborhood or community. The services available in supportive housing are flexible and voluntary.

Supportive housing is a solution that more efficiently uses limited resources and improves outcomes, particularly for populations that are most costly to the system due to their frequent or high use of crisis systems of care or long or repeated stays in institutional settings. In dozens of studies across the country over the last 20 years, (SAMHSA, 2010; Tsemberis Eisenberg, 2000; Rog et al., 2014; Culhane et al., 2001; O’Hara, 2003; Rosenheck et

al., 2003) permanent supportive housing has been repeatedly proven to be an effective intervention that improves housing stability, reduces the use of expensive crisis care, and improves outcomes even for the most vulnerable individuals with complex needs. Despite this strong evidence, lack of upfront funding has made investing in supportive housing at scale a challenge for many states. Social impact investment provides the upfront capital needed to create supportive housing, ensures that government pays only for what works, and results in long-term cost savings and improved outcomes for vulnerable persons.

Supportive housing and Pay for Success can also serve as a catalyst or be complementary to broader health and housing related efforts particularly given housing's important role as a social determinant of health. According to Corporation for Supportive Housing (CSH), "Access to safe, quality, affordable housing - and the supports necessary to maintain that housing - constitute one of the most basic and powerful social determinants of health. In particular, for individuals and families trapped in a cycle of crisis and housing instability due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions, housing can entirely dictate their health and health trajectory. For these populations, housing is a necessary precursor of health." Pay for Success efforts focused on supportive housing present a significant opportunity to optimize the role that Medicaid, managed care organizations and state and local housing partners can play in ensuring that vulnerable individuals have access to the housing and supports needed for them to achieve housing stability and improved health outcomes.

Pay for Success contracts can be a valuable tool for catalyzing more comprehensive changes in the housing and healthcare system. These projects can complement current efforts to expand supportive housing by filling gaps in funding for operations, leading to the expansion of Medicaid reimbursable services, and helping vouchers go further.

For example, Massachusetts' Pay for Success project leveraged existing housing resources at the State level to develop a housing intervention that could be sustainable in the long term. The Pay for Success project itself paid for outcomes per person housed, but the resources the State put in place to begin the project expanded the availability of services in the

system as a whole. The State converted some of its shelter funding to supportive housing funding and also contracted with MCOs to allow payments for supportive housing services under a case rate. Pay for Success was a mechanism for changing the way the State invested in supportive housing.

As another example, Santa Clara County, in California, has created a Pay for Success transaction focused on providing supportive housing to 150-200 chronically homeless persons who are also frequent users of the County's emergency rooms, acute mental health facilities, and jail. Services in this initiative will be provided using the Assertive Community Treatment (ACT) model and funded through both the State's Medi-Cal program and the Pay for Success contract.

New Mexico Human Services Department (HSD) Behavioral Health Services Division (BHSD) is one of six sub-grantees selected through the 2014 Social Innovation Fund Pay for Success (PFS) award from the Corporation for National and Community Service. Accordingly, the State of New Mexico is part of a cohort of state governments interested in the use of the Pay for Success model to provide persons residing in institutional settings with the opportunity to transition to community-based supportive housing. The project team meets regularly to identify the target population for Permanent Supportive Housing placements as the health intervention and has started financial modeling. New Mexico Human Services Department (HSD) Behavioral Health Services Division (BHSD) sent two representatives to a Cohort Convening held in Cambridge, Massachusetts, and the first of a series of sessions to bring together the three states investigating the application of Pay for Success.

Planners and policymakers for the City of Albuquerque and Bernalillo County are also meeting to discuss use of the Pay for Success model. Core agency representatives are meeting to identify what policy area to address, analyze all relevant data systems, identify promising programs and determine a clearly defined target population for selected interventions.

Capacity, Access and Financing for Affordable Housing

To restate one of the core issues to be addressed, NM continues to struggle to address the housing needs of its most vulnerable residents, especially individuals and families experiencing chronic homelessness. Supportive housing in New Mexico has been reliant on federal resources for early implementation and expansion. However, federal funding streams are not enough. There continues to be a lack of safe, affordable housing stock accessible to the lowest income people experiencing homelessness, people with disabilities or any other extremely low income household.

RECOMMENDATIONS

6. Increase community investments in Permanent Supportive Housing units

Build statewide capacity through the prioritization and funding of subsidized community-based housing accessed by a Tenant-based Voucher or a Project-based Voucher.

7. Dedicate additional resources to rapid rehousing/move-in assistance and eviction prevention efforts

Financial assistance and services that are flexible and readily available to prevent individuals and families from becoming homeless and help those who are experiencing homelessness to be quickly re-house and stabilized.

Discussion

The housing strategies considered by Senate Memorial 44 Working Group participants promote efforts to access existing units of rental housing and to develop additional permanent supportive housing units. A hallmark of the current permanent supportive housing programs in New Mexico has been a steadfast commitment to creating integrated permanent supportive housing. In fact, much of the permanent supportive housing initiatives across the State have opted to create integrated permanent supportive housing through either tenant-based or project-based/development strategies as an alternative to the development of single purpose supportive housing (i.e. 100% of the units in the project are dedicated as supportive housing). In 2007-2008, the New Mexico Behavioral Health Collaborative started to design, implement and support sustainment of permanent supportive housing initiatives for adults and transition age youth with serious mental health and substance use issues. Permanent supportive housing initiatives are public-private

partnerships that have resulted in a significant increase in the number of permanent housing units linked with supportive services made available for homeless individuals with mental illness and youth transitioning out of New Mexico's juvenile justice and foster care systems.

Existing supportive housing initiatives in New Mexico are based on the Housing First philosophy which is designed to provide immediate, independent, permanent housing and individualized supportive services, such as mental health services, medical care, and other supportive services. Consistent with the principles of harm reduction, Housing First recognizes the necessity for each individual to receive personalized treatment. A main feature differentiating the Housing First approach from that of others is its lack of pre-conditions. The Housing First philosophy does not require that an individual be sober or enrolled in a treatment program.

New Mexico's permanent supportive housing initiatives are collaborative efforts that include the New Mexico Mortgage Finance Authority (MFA), the two homeless Continuums of Care (CoCs), homeless provider agencies, public housing authorities, property owners/developers, mental health and substance use treatment providers, federally qualified health centers, and a number of state agencies who are part of the Behavioral Health Collaborative including the State's mental health authority, Behavioral Health Services Division (BHSD), Adult and Long-term Services Department (ALTSD) and the Child and Family Services Department (CYFD).

Subsidized community-based housing accessed by a tenant-based voucher (i.e., Linkages Rental Assistance Program)

Human Services Department and MFA initiated *Linkages* in 2007-2008 to provide state-funded, tenant-based vouchers for homeless adults diagnosed with serious mental illness and/or co-occurring substance use issues. The program began operations in three counties, Bernalillo, Santa Fe and Grant. Local public housing authorities and core service agencies partnered to provide the housing vouchers and support services respectively. *Linkages* is an

essential component of New Mexico's permanent supportive housing programs in that the number of units created under the LIHTC program, in combination with public housing authorities voucher and unit preferences for persons with disabilities, are insufficient to meet demand. Senate Memorial 44 participants also identified that in general, across the network of public housing authorities, there are not voucher or unit preferences for people experiencing homelessness.

In 2014, *Linkages* received an additional \$450,000 appropriation from the State of New Mexico legislature that was used to expand the program to serve target populations in three additional counties: Chaves, Dona Ana and San Juan. During the last legislative session, a general fund appropriation was made to the Behavioral Health Services Division in the contractual services category that included \$650,000 for transitional and supportive housing programs. State-funded Permanent Supportive Housing programs that were positively affected by the additional funding include the Linkages Rental Assistance Program and Local Lead Agency (LLA) Low Income Housing Tax Credit (LIHTC) Set Aside Units for people with disabilities and/or experiencing homelessness (formerly the Special Needs Program).

- Linkages Rental Assistance Program, the subsidized community-based housing accessed by a tenant-based voucher, is provided in 5 service areas (i.e., Grant, Santa Fe, Bernalillo, Dona Ana, Chaves) and expanded to 3 new communities in FY 16 (i.e., San Juan, Lea, Taos).
- In addition to an increase in the number vouchers available in communities, housing administrators received an increase in their administrative fee to be more commensurate with the requirements associated with voucher distribution.

As a tenant-based voucher, *Linkages* relies primarily on a network of private landlords that work closely with the public housing authorities. Originally, *Linkages* was designed to "graduate" households into Section 8 housing, but closed or extremely long wait lists, coupled with an insufficient number of permanent supportive housing units in public housing authority or Low Income Housing Tax Credit property inventories, has meant that *Linkages* residents remain in the program much longer than expected. The current backlog

in Section 8 vouchers and public housing authority units means expanding *Linkages* is the only way to provide real and meaningful leverage for qualified residents to access quality rental housing. Between October 2014 and present, the average tenant-based voucher in the *Linkages* Rental Assistance Program cost about \$530 with an average utility payment of \$59, for a total cost per resident of \$589 per month. In addition, housing administrative agencies receive a fee of \$100 per voucher. Enrollment at its highest point during this time period, reached 133 individuals, positively affecting approximately 346 households.

Existing Capital Resources for Supportive Housing

Local Lead Agency (LLA) Low Income Housing Tax Credit (LIHTC) Set Aside Units for people with disabilities and/or experiencing homelessness (also known as the Special Needs Program)

New Mexico Mortgage Finance Authority (MFA) is New Mexico's allocating agency for Federal Low Income Housing Tax Credits (LIHTC) pursuant to Section 42 of the Internal Revenue Service Code and monitors a portfolio of 334 properties and more than 16,000 units for the LIHTC program. New Mexico's Local Lead Agency (LLA) Low Income Housing Tax Credit Set Aside Units for people with disabilities and/or experiencing homelessness (also known as the Special Needs Program) is a core component of the Qualified Action Plan (QAP) and was implemented in 1997 when MFA first began allocating LIHTCs. Set aside units for people with disabilities was the first set aside created in the QAP and was implemented before set asides for seniors and families. In 1997, the set aside included a limited definition of eligible households and provided bonus points for a 25 percent set aside of units. In 1998, the set aside was amended to require a social service plan and the definition of qualifying individuals and families was expanded to include homeless households and households meeting HUD's definition. In 2009, as a result of a collaboration with the Human Service Department's Behavioral Health Division, the eligibility criteria was expanded further to its current form and included a requirement to coordinate with the Local Lead Agencies (LLAs) for applicant screening and a referral mechanism to property managers was added. Today, the network of Local Lead Agencies exists across 17 counties

throughout New Mexico and serves as the access point for approximately 40 LIHTC properties comprising nearly 350 LIHTC units. Finally, in 2010, a five percent set aside option was implemented, and the 20 percent set aside was revised to require that 10 percent of units be income targeted for households earning 30 percent Area Median Income (AMI) or less.

The current definition to qualify households for set aside units in this category in the QAP is households in which an individual or household member is in need of supportive services, tenancy supports and housing, and has a substantial, long-term disability, which includes any of the following: (1) Serious Mental Illness; (2) Addictive Disorder (i.e., individuals in treatment and demonstrated recovery from substance use disorder); (3) Developmental Disability (e.g., intellectual disability, autism, or other disability acquired before the age of 22); (4) Physical, sensory, or cognitive disability occurring after the age of 22; 5) Disability caused by effects of chronic illness (e.g., people with HIV/AIDS who are no longer able to work); (6) Age-related Disability (e.g., frail elderly, or, young adults with other special needs who have been in the foster care or juvenile services system); or 7) households/individuals who are homeless.

The above set aside is one of the core programs in New Mexico's Permanent Supportive Housing (PSH) initiatives in that it is the primary mechanism for creating additional units. All affordable rental projects in New Mexico are heavily incentivized to set aside units because LIHTCs are the greatest source of equity and primary source of funding for affordable rental projects. Very few affordable rental projects are built in New Mexico without LIHTCs and the process has become so competitive most developers commit to the set aside that serves people with disabilities and/or experiencing homelessness. Because all other Mortgage Finance Authority (MFA) multifamily funding sources are typically packaged with LIHTCs, the QAP institutionalizes this particular set aside across MFA multifamily programs.

New Mexico Housing Trust Fund

The New Mexico Legislature created the New Mexico Housing Trust Fund in 2005, with an initial appropriation of \$10 million and \$8.7 in subsequent appropriations through the present date. Because appropriations have not been made annually and because amounts fluctuate greatly, MFA currently operates the New Mexico Housing Trust Fund as a revolving loan fund. This ensures that all appropriations made by the State come back to the fund and are reinvested in new projects. Many New Mexico Housing Trust Fund awards made by MFA are part of larger financing packages for a single project; for example, a Housing Trust Fund loan will often be paired with an award for LIHTCs. For this reason, the New Mexico Housing Trust Fund is often used to help finance set aside units under the LLA LIHTC Set Aside Units for people with disabilities and/or experiencing homelessness.

Over time, it has been suggested that MFA use a portion of the New Mexico Housing Trust Fund for grants, rather than loans, and that specific populations or housing programs be targeted. Without a permanent and recurring source of funding for sustainment of the resource, however, MFA has been reluctant to make grants or special commitments with Housing Trust Fund resources.

In 2016, MFA expects to receive funding from the National Housing Trust Fund (distinct from the New Mexico Housing Trust Fund) for the first time. New Mexico's allocation, which MFA will administer, is estimated at \$3 million annually. While the National Housing Trust Fund can be used in conjunction with the LIHTC program like the New Mexico Housing Trust Fund, as a capital grant, the funding is intended to support deep affordability in rental housing target very low and extremely low income households. In these respects, it will be better suited to households experiencing homelessness than the New Mexico Housing Trust Fund. MFA is currently working on an allocation plan to align the National Housing Trust Fund with LIHTC, the QAP, and other sources of subsidy, such as Section 811 Project Rental Assistance (PRA), discussed below. It will likely take a year of experience with the National Housing Trust Fund and Section 811 PRA for MFA to determine how well these new resources are addressing the unmet need for households experiencing homelessness and

whether additional changes to the above set aside or the New Mexico Housing Trust Fund might be needed.

Project Based Rental Assistance

The greatest challenge with the LLA set aside is that Internal Revenue Service (IRS) regulations for the LIHTC program require developers to rent units to households with incomes at or below 60-50 percent Area Median Income (AMI). Rents are then charged according to HUD's rent limits for these households. While developers can set income and rent limits below 50 and 60 percent AMI, such low rents can be problematic for the financial feasibility of the project. Because qualified households typically have incomes at or below 20 percent AMI, well below 50-60 percent AMI (most have fixed incomes that are dependent on social security, disability payments or supplemental security income), the rent limits for 50-60 percent AMI LIHTC units are typically out of reach. Households experiencing homelessness are even more difficult to house in LIHTC properties because they initially have no income at all and may have co-occurring disabilities which prevent or limit their future ability to pay rent.

As mentioned above, in 2010, MFA revised its 20 percent SN set aside to require that 10 percent of units be income targeted for 30 percent AMI households. While this has helped eligible households access LIHTC units, there are only a small number of units in this category and there are still many extremely low income households for which 30 percent AMI rents are out of reach. Additional subsidy—found in the form of project-based rental assistance or operating subsidy tied to LIHTC set aside units—is needed to cover the gap between LIHTC property rents and the income of a qualified extremely low income household. Some LIHTC projects receive project-based rental assistance through HUD's Section 8 Program to subsidize rents so that they conform to no more than thirty percent of the resident's household income. HUD commits the subsidy for the assisted units for a contractually determined period, typically an initial 15 year contract subject to annual appropriations with an option to renew the contract.

MFA is currently rolling out a new rental assistance program to address this need. A HUD Section 811 Project Rental Assistance grant for close to \$2.3 million over a five-year period will provide rental assistance for approximately 95 households. The assistance will cover the gap between rent and income in LIHTC projects for persons who are homeless, at risk of homelessness or at risk of institutionalization and meet the criteria for Serious Mental Illness (SMI). Rental assistance is also available for young adults between ages of 18 and 21 with serious mental illness who have been emancipated from foster care or are transitioning from the juvenile justice system.

The State of New Mexico has discussed the potential for using state funds for additional project-based rental assistance. Because state project based rental assistance would be used in conjunction with the LIHTC program to address the challenges associated with mismatched rents and extremely low income households, several months of planning are needed to align existing and new resources to determine if additional or strengthened incentives are needed in the QAP. Furthermore, the feasibility of the state providing project-based rental assistance needs to be explored. While it is badly needed, project-based rental assistance is relatively expensive to provide, requires a commitment over many years and is subject to fluctuation in rental markets. As an example of the scale of funding needed, MFA's Section 811 PRA grant estimates approximately \$24,000 in rental assistance per household over a five-year period.

Additional Resources for Move-in Assistance and Eviction Prevention/Matching Funds for Rapid Re-Housing

Language for this section was added directly from the United States Interagency Council on Homelessness Solutions Database (USICH, http://usich.gov/usich_resources/solutions/explore/permanent_supportive_housing).

Rapid Re-Housing and Homeless Prevention

Rapid re-housing is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered

without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid re-housing program are below. While a rapid re-housing program must have all three core components available, it is not required that a single entity provide all three services nor is required that a household utilize them all.

Housing Identification

- Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness.
- Address potential barriers to landlord participation such as concern about short term nature of rental assistance and resident qualifications.
- Assist households to find and secure appropriate rental housing.

Rent and Move-In Assistance (Financial)

- Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow individuals and families to move immediately out of homelessness and to stabilize in permanent housing.

Rapid Re-housing Case Management and Services

- Help individuals and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources.
- Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues).
- Help individuals and families negotiate manageable and appropriate lease agreements with landlords.
- Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing.
- Monitor participants' housing stability and be available to resolve crises (at a minimum) during the time rapid re-housing assistance is provided.

- Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/ appropriate) so that they can sustain rent payments independently when rental assistance ends.
- Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.

Currently, the New Mexico Mortgage Finance Authority administers the State of New Mexico homeless funds and federal resources under the Emergency Solutions Grants for Rental Assistance Program, and Behavioral Health Services Division administers state resources for Move-in Assistance and Eviction Prevention.

Capacity, Access and Financing for Health Care & Services

"The Right Services" to Reduce Homelessness

System transformation is needed to achieve enhanced services for individuals transitioning out of homelessness or institutional settings. Specifically, the Centers for Medicare and Medicaid Services (CMS) recently released an Informational Bulletin that describes housing related activities and services as loosely organized into three main areas:

- 1) Individual Housing Transition Services - services that support an individual's ability to prepare for and transition to housing;
- 2) Individual Housing & Tenancy Sustaining Services - services that support the individual in being a successful resident in his/her housing arrangement and thus able to sustain tenancy; and
- 3) State-level Housing Related Collaborative Activities - services that support collaborative efforts across public agencies and the private sector that assist a state in identifying and securing housing options for individuals with disabilities, older adults needing LTSS, and those experiencing chronic homelessness (CMCS, 2015).

The Bulletin clearly articulates that states have a number of options under Medicaid and demonstration programs to cover housing-related services and activities that promote community integration for individuals needing long term services and supports, particularly individuals transitioning from institutions. Section 1115 demonstrations include housing-related services consistent with the statutory authorities described in the CMS bulletin. For example, states can use the 1115 waiver authority to provide Medicaid reimbursement for services to individuals already in the community, by helping the individual to problem solve, advocate with landlords, access community resources to assist with back rent, and assist individuals to complete forms for subsidized housing. For people leaving institutions, states can provide Medicaid reimbursement for assistance with locating housing, completing forms for subsidies, moving, and household set ups. Federal resource maximization for services will allow the State to redeploy critical scarce resources to help fill gaps in financing for housing placements.

RECOMMENDATIONS
<p>8. Flexible funding streams and payment mechanisms under Medicaid</p> <p>Compensate providers for supportive housing-related activities and services. Permanent supportive housing is a model – not a program. Therefore, there is not a single federal or state Permanent Supportive Housing funding stream. Different funding mechanisms, (or braiding of various funding streams), are required to accomplish the three components of the model. <i>It is critical that service dollars not be used to pay for housing and housing dollars not be used to pay for services in order to attain the maximum benefit from both resources.</i></p>
<p>9. Expand coverage for non-Medicaid supportive housing-related services</p>
<p>10. Provide and enhance opportunities for Supported Employment</p>

Discussion

The NM Human Services Department (HSD) Medical Assistance Division (MAD) began transitioning in 2013 to a new Medicaid 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS) called Centennial Care. NM consolidated all waivers under a single Section 1115(a) of the Social Security Act waiver authority to carve-in behavioral health with physical health and long-term services and contracted with four managed care

organizations (MCOs) for the delivery of all covered services under Centennial Care (CC), a capitated risk-bearing agreement. A key feature of CC is the provision of care coordination with a single point of contact for all members with moderate to high health care needs. CC serves most Medicaid recipients and the Medicaid expansion population, which includes people experiencing homelessness. The goal of CC is to educate recipients to become more savvy health care consumers, promote more integrated care, provide proper care coordination services for the most at-risk members, involve individuals in their own wellness, and pay providers for outcomes.. NM believes that this up-front investment in “seeding” medical and health homes, and investing in health literacy will result in a healthier population and a reduction in spiraling health care costs.

Stakeholders and state planners are discussing innovative strategies for supportive housing-based services from the viewpoint of Medicaid and are raising considerations for use of Medicaid resources to provide supportive housing-based services to improve health outcomes and reduce costs. Under the terms of a Federal Medicaid Section 1115 waiver, the first objective is to ascertain financing mechanisms for services that supportive housing residents need to achieve housing stability that may already fit well under the high level of flexibility of the 1115 waiver. Service providers currently leverage Medicaid resources for supportive housing primarily through the Comprehensive Community Support Services (CCSS) platform. New Mexico is in the second year of a five-year demonstration project intended to promote more integrated care and to properly coordinate care for the most at-risk members. Members with behavioral health needs have access to services that could support housing stability. Comprehensive Community Support Services provide a comprehensive and intensive approach as needed, with flexibility in the time and location of service delivery. CCSS is very similar to Critical Time Intervention, an evidence-based practice that provides support to people during and after transition from homelessness. Modification of CCSS or creation of Critical Time Intervention (CTI) as a value-added Medicaid approach are optional strategies under the 1115 waiver that may help serve people with complex needs experiencing homelessness. Medicaid has been charged with controlling costs, however, initial investments in Critical Time Intervention (CTI) or a modified

CCSS approach will likely result in long-term cost savings from a reduction in costly acute care and expensive health care services, continued homelessness and possible incarceration. In general, Senate Memorial 44 Working Group Participants supported the review and identification of essential services in supportive housing for inclusion in an existing benefits package or an enhanced benefits package(s) to include housing stabilization supports.

In addition, Senate Memorial 44 Working Group participants suggested the need to identify ways to increase Medicaid enrollment by individuals experiencing homelessness and assist NM Human Services Department Medical Assistance Division (MAD) in streamlining the Medicaid eligibility process for people experiencing homelessness. Participants supported the following initiatives or strategies:

- Support considerations by MAD for expanding eligible providers who can employ and bill for Certified Peer Specialists (CPS) from Core Service Agencies only to other behavioral health providers, Community Mental Health Centers and nontraditional provider –types who serve people experiencing homelessness.
- Explore presumptive eligibility for individuals who are chronically homeless.
 - Expand locations that have Medicaid presumptive eligibility "determiners" to include housing providers, soup kitchens, etc. (i.e., places where homeless persons congregate). Create opportunities for full Medicaid enrollment at these same locations.

Senate Memorial 44 Working Group participants supported the need to increase provider enrollment in Medicaid to expand Medicaid billing entities/services/service providers to ensure that as appropriate, providers can bill for services through capacity building and recognition of provider qualifications. This may also be achieved through linking and coordination among providers of services linked with permanent supportive housing programs and managed care organizations (MCOs). Service providers serving people experiencing homelessness often have limited experience contracting with MCOs and most MCOs have limited experience serving people experiencing homelessness who may have

complex health problems, limited ability to care for themselves, and difficulty obtaining or becoming engaged with health care and treatment services.

Senate Memorial 44 Working Group participants identified the potential opportunity to redistribute funding toward additional housing placements and/or non-Medicaid covered housing related activities or services as Medicaid enrolled service providers maximize their use of Medicaid and other federal resources. The Table shared below is offered as an example of one such service provider’s transition away from state funding for care management to coverage through Medicaid reimbursement. In this example, the shift in use of state resources as compared to federal resources through Medicaid is seen between Year 2014 and Year 2015.

	STATE	MEDICAID
FY2012	\$349,516.56	\$ 549,965.57
FY2013	\$330,806.29	\$ 580,351.78
FY2014	\$448,731.90	\$ 578,579.94
FY2015	\$263,224.74	\$ 950,780.50

The general trend that may have positive implications for supportive housing providers is one where a strong emphasis is placed on maximizing federal resources for services that will then allow the State to redeploy critical scarce resources to help fill gaps in financing for housing placements.

Through future technical assistance opportunities, New Mexico may leverage the expertise of national technical assistance providers to help NM with a Crosswalk. A Crosswalk is a state-specific reference document that illustrates what services provided in supportive housing are eligible for Medicaid reimbursement. - See more at:

<http://www.csh.org/resources/csh-medicaid-crosswalk-connecticut/#sthash.7vC7hTqk.dpuf>

Some additional strategies discussed by Senate Memorial 44 Working Group participants included:

- Increase awareness about existence of (and increase use of) navigators and SAMHSA's SSI/SSDI Outreach, Access, and Recovery (SOAR) workers; use both types of supports to help train homeless agency staff on enrollment assistance for health care.
- Educate health care providers on adequately documenting disability
- Allow Managed Care Organizations to advocate for their members around Medicaid re-certification, especially in interactions with Human Services Department's Income Support Division
- Develop protocol to streamline recertification for people experiencing homelessness so as not to lose continuity of care

Furthermore, through the integrated health care model adopted by NM, a number of opportunities may prove effective in meeting the needs of highly vulnerable New Mexicans experiencing homelessness. Presently, several state departments are collaborating to implement a variety of integrative strategies to include NM Certified Community Behavioral Health Clinics (CCBHCs), Carelink Health Homes, care coordination, innovations by MCOs (i.e., value-added) and the State Innovation Model. Coverage for supportive housing -related activities and other services related to social determinants of health and interventions should be identified under these examples. Other payment methodologies are being proposed to also enhance collaborations among provider types. Specifically, one such method is prospective payment. Prospective payments are intended to motivate providers to deliver care more effectively, efficiently and without over utilization of services (as opposed to fee for service payments which tend to drive overutilization of services). There are two examples that may be applied to future operations: payments for social services through Managed Care Organization contracting and global/total cost of care budgets. With Managed Care Organizations that are at risk for the total patient spending, they can use waiver authority (Medicaid 1115 waiver) to provide beneficiaries with care coordination, transportation, and other services via payments to providers. However, there are particulars related to the non-medical services, rate setting and medical loss regulations that must be considered and addressed in this example. Arizona is one example that contracts with one

of its MCOs, Care1st, to pay an area agency on aging a case rate for social services. The other example is a total cost of care/global payment for all services and all patients to cover upfront costs and provide cost-reduction incentives, enabling providers to make investments necessary to improve quality and cost of care for highest cost patients. The funding sources are typically direct state funding and health plan pass-through dollars. There are two examples of this type of payment model - Hennepin Health Plan (MN) and Montefiore Health System, Health and Hospitals Corporation (NY). Both Hennepin Health and Maimonides Medical Center are partnering with community agencies outside of traditional medical providers to develop reinvestment plans, whereby savings generated through coordinated care management of high-cost populations are allocated to community-development efforts. These funds can be used more flexibly toward the expansion of affordable housing and vocational training which are expected to increase the likelihood that additional health care savings will be generated.

A prospective payment model can allow for more flexibility with reinvestment of dollars for housing supports, services and "non-clinical" interventions. However, there are a few considerations and challenges with this model, including the need for financial reserves. This type of approach is often not feasible for small organizations and it requires a certain level of provider financial sophistication. In addition, establishing targeted metrics is important to ensure quality and monitoring.

In fiscal year 16 (FY 16), supportive housing program staffs and stakeholders identified activities that relate to the desired outcomes and other recommended practices identified by SM 44 Working Group participants that are successfully and effectively carried out by Peer Recovery Support Specialists/Community Health Worker. Peer Recovery Support Specialists (aka CPSS and/or CPSW) serve an important role in supportive housing. A major infrastructure success of NM's initial SAMHSA-funded T-SIG grant was the development of the Certified Peer Support Specialist/Support Worker Program (CPSS/CPSW), and employment of peers in behavioral health settings. Currently, Certified Peer Support Specialists/Support Workers provide support services using the Comprehensive Community

Support Services model, a rehabilitation services program offering assistance in recovery/resiliency planning; interpersonal, community and functional skill development; and linkages to natural supports. In 2010, this curriculum was augmented to include eight modules for training providers to effectively use Certified Peer Support Specialists/Support Workers to help individuals obtain and maintain stable housing. Through Healthy Homes, Mental Health Transformation Grant, NM developed an advanced supportive housing curriculum resulting in a cadre of Certified Peer Support Specialists/Support Workers with expertise in housing laws and regulations, landlord/tenant relationships, tenants' rights, advocacy for consumers in court, and strategies for accessing and maintaining housing. This transformed the role of Certified Peer Support Specialists/Support Workers by ensuring they have significant skills to work within and outside behavioral health settings. Duties include providing assistance in the development of interpersonal, community coping and functional skills; ensuring interagency collaboration and case management, providing screening for underlying medical conditions, promoting linkages to natural supports; assisting in the development of the individual's recovery/resiliency plan; providing support in crisis situations and necessary follow-up to determine if services have adequately addressed needs. All Certified Peer Support Specialists/Support Workers are individuals who have "lived experience," have completed training on the peer support model, have been certified through the Behavioral Health Services Division Office of Peer Recovery and State Office of Consumer Affairs; and are currently in recovery from Substance Use Disorders, Serious Mental Illnesses, or Co-occurring Disorders. These staff can assist others by drawing on their own experiences to promote wellness and recovery.

Senate Memorial 44 Working Group participants discussed the need for Supported Employment as a widely available service for people experiencing homelessness. Supported Employment incorporates on the job supports into the integrated work setting with ongoing support services for individuals in need of intensive supported employment services to perform work and achieve a successful employment outcome. Senate Memorial 44 Working Group participants identified the potential for coverage as a non-Medicaid service and shared basic details about existing service requirements and utilization guidelines.

Conclusion

Senate Memorial 44 Working Group participants met over several months to discuss supportive housing and related resources within the State. Participants were all interested in promoting the quality of life result where: *individuals and families experiencing homelessness are able to access and retain safe, affordable, community-based, supportive housing, in addition to services and treatment.* Further, some stakeholders were interested in meeting the needs of residents who may be precariously housed in unregulated boarding homes, exiting institutional settings or even other persons at-risk of homelessness. Overall, Permanent Supportive Housing was selected based on experience, including numerous successful pilots and relevant data as an important health intervention to meet the needs of some of the most vulnerable New Mexicans – **Permanent Supportive Housing has proven outcomes and is cost effective.** People experiencing homelessness can be served at the community-level by additional investments in housing, treatment and prevention. System-level changes in reimbursement, capital funding, organizational capacity and workforce development to increase access to private, subsidized rental housing placements in which a resident holds a lease and is linked with supportive services will set forth Permanent Supportive Housing as a long-lasting service solution to end homelessness in New Mexico.

Personal & Provider Stories

“I first came into contact with St. Martin’s Outreach team at the West Side Winter shelter. I did not at first qualify for any specific services until I was referred to be evaluated for mental health issues. Being diagnosed helped to open doors that would normally be closed to me. This qualified me for a special program called Linkages; I was able to access supportive housing through Bernalillo County Housing.

I am now off the streets and am able to live in safety and peace. Now that I have a normal life, I now feel confident enough to take the next step toward self-sufficiency. I now attend Brookline College.” – Wanda, *Linkages* resident

Wanda became known to us [St. Martin’s Hospitality Center staffs] from a woman, Christine that worked at the Rescue Mission. The first thing Christine asked was, “you have to help

this woman - she is my friend." Christine explained that she has known Wanda for several years and stated that it was heart breaking to see Wanda year after year at the Rescue Mission and winter shelter. When we met Wanda, she informed us that she already knew that she would not qualify for any programs that assist in housing people. Wanda had a negative outlook on the programs that were out there to help people.

Wanda was very discouraged but would regularly check in with the Outreach Team from St. Martin's. Wanda would update staff on her health and share where she was staying.

When the *Linkages* program became available through St. Martin's, we immediately knew Wanda was a perfect candidate for the program. At first, when given the news that there was a housing opportunity available to her, Wanda did not believe it. We worked with Wanda to get the necessary documents that she needed, she had her housing orientation for the *Linkages* voucher and had a place picked out within that same week.

Wanda is now living in an apartment and attending groups at St. Martin's. She checks in regularly with her Community Support Workers. Wanda has even enrolled at Brookline College where she hopes to become a medical assistant. Wanda has flourished with having the stability and opportunity to be housed. Wanda's goal is to become totally independent.

Harold

I [St. Martin Hospitality Center staff] met Harold in May of 2006. The police knew him as Linus (Peanuts) because of all the blankets he carried around with him. He must have had a least 5 blankets, a duffel back and no telling how many layers of clothes on. He looked dirty. His clothes were stained and he always appeared to have some type of dirt or mud on his face and hands.

At first Harold wouldn't talk to us on outreach encounters. He would just stare. We'd offer him water and snacks and he would appear to simply ignore us. Over the course of the next 2 months, we tried all kinds of different strategies to get him to at least talk to us. We tried to make contact with him at least three times a week. Slowly but surely he began to respond. At 4 months, he agreed to have lunch with us and at 6 months, he agreed to stay

in a motel room and try on a different set of clothes. After a nice stay in a motel room and hot shower, we were certain he wouldn't want to leave. But after about a week, he told us he wanted to go back home – to Concrete Park. So we took him back. For the next couple weeks we told him we had an apartment available and that it was his if he wanted it. And for the next couple weeks he regressed back to pretending to ignore us.

Then, one day he approached us on an outreach encounter. He asked us if the apartment offer still stood. We showed him the apartment and he agreed to take it. Over the next year, things weren't easy for Harold. On two occasions he disappeared and we found him hanging out at Concrete Park. He also ended up in jail as well after having a psychotic episode that resulted in dispute with police. Then, after 2 years of working with staff, he finally agreed to take medication. At 3 years, he obtained income benefits and Permanent Supportive Housing. And after 7 years, he is still a client in the Comprehensive Recovery Treatment program, and still housed.

I learned that he'd been diagnosed with schizophrenia in his early 30s, that he had a Bachelor's degree in physics and a master degree in chemistry from the University of Utah. I learned that he wanted to go back to school after he started taking classes again at UNM. I also learned that recovery for some people is a long process and in some cases a lifelong process. I learned that even some of the most seemingly hopeless cases can show improvement; that people don't get better on my time table; and that working with these types of clients is really hard work.

Harold continues to study these areas and takes online courses from time to time. Many times during home visits, he is reading chemistry books to "keep his brain sharp". Recently, Harold has started to interact with staff more directly, asking how their day is going and responding with meaning rather than one or two words answers. Harold has a very friendly and respectful demeanor, and maintains his appearance very well. His long hair is combed back into a neat ponytail and his clothes are clean. Scott takes the initiative to maintain himself and his home and understands that he is lucky to have a roof over his head, and thanks St. Martin's for their continued help and support.

Appendices

Gap Analysis/Housing Inventory

Calculating the Need for Permanent Supportive Housing (by County) (2015)

County	2014 Census Population	Poverty Rate	Total # of Homeless People Counted on 1/26/15*	Estimated Total Need for Supportive Housing	Total # of TH + PSH + RRH Beds (2015 HIC Count)	Relative Priority
Dona Ana County	213,676	27	333	534	312	H
Sandoval County	137,608	17.7	35	344	140	H
Valencia County	75,817	23.4	20	190	15	H
Chaves County	65,878	21.2	28	165	0	H
McKinley County	74,098	40.3	108	185	94	H
Otero County	65,082	21.3	14	163	0	H
Lea County	69,999	14.8	12	175	0	H
Bernalillo County	675,551	18.7	1,378	1,689	1,918	H
San Juan County	123,785	22.7	207	309	204	H
Eddy County	56,395	15.1	86	141	10	H
Rio Arriba County	39,777	24.8	2	99	0	H
Cibola County	27,349	32.2	2	68	0	M
Luna County	24,673	31.2	15	62	0	M
San Miguel County	28,239	35.9	7	71	26	M
Taos County	33,084	26.2	21	83	14	M
Torrance County	15,611	27.8	0	39		M
Roosevelt County	19,536	24.6	0	49		M
Curry County	50,969	21.1	30	127	71	M
Sierra County	11,325	26.9	0	28		M
Grant County	29,096	22.4	8	73	34	M
Lincoln County	19,706	18.8	0	49		M
Quay County	8,501	25.8	0	21		M
Colfax County	12,680	20.1	0	32		L
Guadalupe County	4,468	25.8	0	11		L
Hidalgo County	4,560	25.7	0	11		L
Santa Fe + County	148,164	18.1	323	370	514	L
Socorro County	17,310	27.9	0	43	126	L
Mora County	4,592	23.8	0	11		L
Catron County	3,556	21.7	0	9		L
De Baca County	1,825	22	0	5		L
Union County	4,297	20.1	0	11		L
Los Alamos County	17,682	4	0	44		L
Harding County	683	15.2	0	2		L
New Mexico	2,085,572	21.4	2,629	5,214	3,478	

* Total number of homeless persons in ES, TH and unsheltered counted on January 26, 2015

** Need for supportive housing based on state study showing need for 5,000 beds, divided up by

Acronyms

Point In Time (PIT), Housing Inventory Count (HIC), Emergency Shelter (ES), Transitional Housing (TH), Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH)

Supportive Housing Forum for the Future

Project Design/Implementation and Administration	Housing Administrative Agencies (Public Housing Authorities, Property Managers/Developers/Owners)	Supportive Services Providers	Community
<p>Adequate Funding for Ongoing Operations</p> <p>Additional Funding (for Vouchers)</p> <p>Additional Funding (for Staff)</p> <p>Additional Funding (Training)</p> <p>Clearly-defined Roles and Responsibilities among Supportive Housing Partners</p> <p>Allocation of Staff Time for Administrative Duties/Staffing Shortages</p> <p>Increase Financial Resources for Move-In/Eviction Prevention</p> <p>Inter-agency Communication</p> <p>Burdensome Requirements (i.e., # of meetings)</p> <p>Commitment to Fund Providers for Home Visits - Policy Changes</p>	<p>Additional Housing Units</p> <p>Increase Opportunities to Network</p> <p>Understand Regulations</p> <p>Educate Property Managers about Supportive Housing projects</p> <p>Affordable Housing Stock</p> <p>Inter-agency Communication</p> <p>Applicants are Challenged in Meeting Criteria for Eligibility</p> <p>Capacity in Rural and Frontier Areas</p>	<p>Increase Client Self-sufficiency</p> <p>Adequate/Additional Support Services Providers</p> <p>Increase Opportunities to Network</p> <p>Recruitment of Licensed Providers</p> <p>Use of Peer Support Workers</p> <p>Inter-agency Communication</p> <p>Logistics of Contacting Homeless Clients</p> <p>Sustaining Commitment to Client</p> <p>Capacity in Rural and Frontier Areas</p> <p>Commitment to Fund Providers for Home Visits - Policy Changes</p>	<p>Increase Client Self-sufficiency</p> <p>Work with Local Governments to include Supportive Housing in Community Planning</p> <p>Advocate for Homelessness Cessation Projects</p> <p>Advocate for Transitional Housing (i.e., Group Homes)</p> <p>Educate Legislators about Social and Economic Issues related to Homelessness</p> <p>Connect to Current Research</p> <p>Provide information about Supportive Housing to Housing Associations, Provider Associations, Community Organizations, etc.</p> <p>Regulatory Changes</p> <p>Community Involvement in Solutions</p>

Source: Table Summarizing Key Discussion Points from Supportive Housing Forum for the Future, Meeting Held September, 18, 2014

Glossary of Terms

Housing First – the philosophy and practice of ensuring that safe housing is the number one priority for homeless people irrespective of any status that would exclude them from housing such as active substance use or legal status as a formerly incarcerated person.

Care coordination – the integrative approach to assisting in the navigation of comprehensive medical care and behavioral health services for a patient. One goal of care coordination is to educate the patient to engage in chronic disease self-management.

Case management – the overall coordination of health and social services for an individual including, but not limited to, medical care, behavioral health and substance use services, vocational training and employment readiness, community referrals, and advocacy.

Harm reduction – the theory and practice of “meeting people where they are” in their drug or alcohol use to reduce attendant negative consequences associated with substance using behaviors without mandating abstinence or treatment.

Wrap around services – comprehensive support and community referrals designed to provide a continuum of care and maximize physical and behavioral health outcomes.

Peer support specialists – paraprofessional role for people who have past personal experience with homelessness to provide peer services to assist in facilitating “recovery and resiliency” for people still experiencing challenges relative to their homelessness, disability, substance use and/or mental health disorder. Within appropriate professional boundaries peer support specialists use their experiences in recovery to help facilitate the process for others.

Recovery support specialists – paraprofessional role for people who have past personal experience with a substance use and/or mental health disorder to provide peer services to assist in facilitating “recovery and resiliency” for people still experiencing challenges from their own substance use and/or mental health disorder. Within appropriate professional

boundaries recovery support specialists use their experiences in recovery to help facilitate the process for others.

Trauma-informed care/services – According to the Substance Abuse and Mental Health Services Agency (SAMHSA), agencies that provide trauma-informed care and services, “realize the widespread impact of trauma and understand potential paths for recovery; recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; respond by fully integrating knowledge about trauma into policies, procedures, and practices; and seek to actively resist re-traumatization.

Supported employment – refers to on-the-job program that provides ongoing vocational and psychosocial support services to employed people living with disabilities.

Rapid re-housing – the practice of minimizing the amount of time individuals and families are homeless in order to prevent the harms associated with any period of homelessness.

Dually diagnosed – term used to describe people living with both a substance use and a mental health disorder.

Low threshold services – client-centered and easily accessed programs with minimal bureaucratic requirements for admission.

Reasonable accommodations – Provision of the American with Disabilities Act that requires housing to be accessible to people living with disabilities. Reasonable accommodations does not protect juvenile and adult sex offenders, people who are actively using illicit substances, or people with disabilities who are considered a “direct threat” to public safety.

Supportive housing – refers to a housing program that offers residents a range of psychosocial support services designed to promote wellness, recovery and resiliency, and minimize the harms associated with mental health and/or substance use disorders.

Behavioral health - refers to a state of mental/emotional health and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicidal ideation, and mental and

substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders and related problems, treatments and services for mental and substance use disorders, and recovery support.

Mental and substance use disorders -a phrase meant to be inclusive of mental disorders, serious mental illness, substance use disorders, and co-occurring substance use and mental disorders.

Permanent Housing - community-based housing without a designated length of stay (e.g., no limit on the length of stay). Housing is decent, affordable, and integrated in the community. It may include an apartment or single room occupancy in a building (congregate housing), rent-subsidized apartments, or houses in the open housing market (scattered housing), as well as designated units within privately owned buildings.

Permanent Supportive Housing - refers to housing that is considered permanent (rather than temporary or short-term) and offers residents a range of supportive services aimed at promoting recovery from mental and/or substance use disorders. There should not be any arbitrary limits for the length of stay for the resident as long as the resident complies with the lease requirements (consistent with local landlord-resident law).

Homeless - characterized under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, and defined by the December 5, 2011, Final Rule Defining Homeless (76 FR 75994), establishes four categories of homelessness. These categories are: (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution; (2) Individuals and families who will imminently lose their primary nighttime residence; (3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or (4) Individuals and families who

are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Chronic homelessness - characterized under the McKinney-Vento Homeless Assistance Act, as amended by S. 896 of the "Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 means, with respect to an individual or family, that the individual or family—(i) is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter; (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least 4 separate occasions in the last 3 years; and (iii) has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability, posttraumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions. In addition, a person who currently lives or resides in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital or other similar facility, and has resided there for fewer than 90 days shall be considered chronically homeless if such person met all of the requirements described above prior to entering that facility.

The terms "homeless" and "chronically homeless" also may include individuals who are "doubled-up"—a residential status that places individuals at imminent risk for becoming homeless—defined as sharing another person's dwelling on a temporary basis where continued tenancy is contingent upon the hospitality of the primary leaseholder or owner and can be rescinded at any time without notice.

Sources: SAMHSA, Corporation for Supportive Housing, New Mexico Behavioral Health Collaborative, U.S. Department of Housing and Urban Development

Full citations for source documents can be found in Works Consulted.

Senate Memorial 44 Working Group Participants

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Nelson Simpson, Presbyterian	Natalie Michelback, New Mexico Mortgage Finance Authority
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Senate Memorial 44 Working Group: Purpose & Objectives

Purpose: Senate Memorial 44 Working Group will convene to discuss expansion and scale-up efforts to increase the number of communities and settings using the targeted Recommended Practice(s) within the State so that more individuals and families experiencing homelessness are able to access and retain safe, affordable, community-based, supportive housing, in addition to services and treatment, by:

1. Planning and making recommendations for expanded infrastructure for new implementers
2. Planning and making recommendations for sustained support for programs that have achieved full implementation

Meeting Objectives:

1. Achieve stakeholder attendance with broad representation and conduct high quality meetings
2. Identify and discuss critical elements of Senate Memorial 44; present and collect relevant data to inform shared decision-making regarding recommendations
3. Develop a report that includes the objectives related to all the critical elements of Senate Memorial 44

SENATE MEMORIAL 44

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

Sander Rue

A MEMORIAL

REQUESTING THE HUMAN SERVICES DEPARTMENT, THE NEW MEXICO MORTGAGE FINANCE AUTHORITY AND OTHERS TO IDENTIFY STRATEGIES TO COORDINATE SUPPORTIVE HOUSING AND OTHER RESOURCES FOR THE HOMELESS AND TO IDENTIFY AND REPORT ON GAPS IN HOUSING AND SERVICES.

WHEREAS, people who experience homelessness in New Mexico include families with children, people who are working at low wage jobs, people suffering from mental illness, those with substance abuse problems, migrant workers, runaway teens, victims of domestic violence and veterans; and

WHEREAS, the New Mexico coalition to end homelessness estimates that there are at least seventeen thousand people in New Mexico who experience homelessness over the course of a year; and

WHEREAS, providing housing resources to people who are homeless is a vital and important goal; and

WHEREAS, a 2013 university of New Mexico study showed that providing supportive housing and services to medically vulnerable people experiencing homelessness resulted in a savings of over twelve thousand dollars (\$12,000) per year per person when compared to the costs to government and health care services used by the same people living outside or in shelters; and

WHEREAS, supportive housing programs throughout New Mexico have proven to be very effective at helping homeless individuals and families obtain and maintain permanent housing; And

WHEREAS, initiatives such as the New Mexico coordinated assessment work to ensure that people experiencing homelessness are directed to the most appropriate housing resource as quickly as possible using a common assessment tool, a community prioritization system and a centralized database; and

WHEREAS, initiatives such as Albuquerque heading home have shown that providing permanent supportive housing to medically vulnerable, chronically homeless people using the housing first model is cost-effective and has proven to help people exit homelessness permanently; and

WHEREAS, the New Mexico mortgage finance authority supports housing programs for the homeless throughout New Mexico and the development of new supportive housing through the federal low-income housing tax credit program; and

WHEREAS, the human services department's linkages program provides state-funded permanent, supportive housing based on the housing first model; and

WHEREAS, coordination of these various efforts would lead to a more strategic and effective response to homelessness in New Mexico; and

WHEREAS, Medicaid expansion has the potential to ensure that people experiencing homelessness have access to needed behavioral health and medical services;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the human services department, the New Mexico mortgage finance authority, the New Mexico coalition to end homelessness and Albuquerque heading home be requested to identify strategies to coordinate resources to more efficiently house people who are homeless; and

BE IT FURTHER RESOLVED that these entities identify a strategy for using Medicaid, linkages, the statewide coordinated assessment system, the Albuquerque heading home model, the low-income housing tax credit program and other successful supportive housing programs to most effectively address homelessness in New Mexico; and

BE IT FURTHER RESOLVED that these entities identify gaps in the availability of housing and services for people experiencing homelessness; and

BE IT FURTHER RESOLVED that these entities provide a report of the strategies identified and other findings to the legislative health and human services committee by November 1, 2015; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the secretary of human services, the executive director of the New Mexico mortgage finance authority, the executive director of the New Mexico coalition to end homelessness and the chief executive officer of Albuquerque heading home.

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10% of the population
uses 50% of system
resources

Or in the context of
Medicaid spending, the
top 5% of enrollees
account for more than
half of Medicaid
spending.

Julia Paradise, *Medicaid
Moving Forward*. (Kaiser
Family Foundation, March
2015)