Addressing Serious Mental Illness and Homelessness

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Utah Mental Health Commissioner
Assistant Director, Substance Use and Mental Health

Utah Department of Health & Human Services

Utah's state of the State

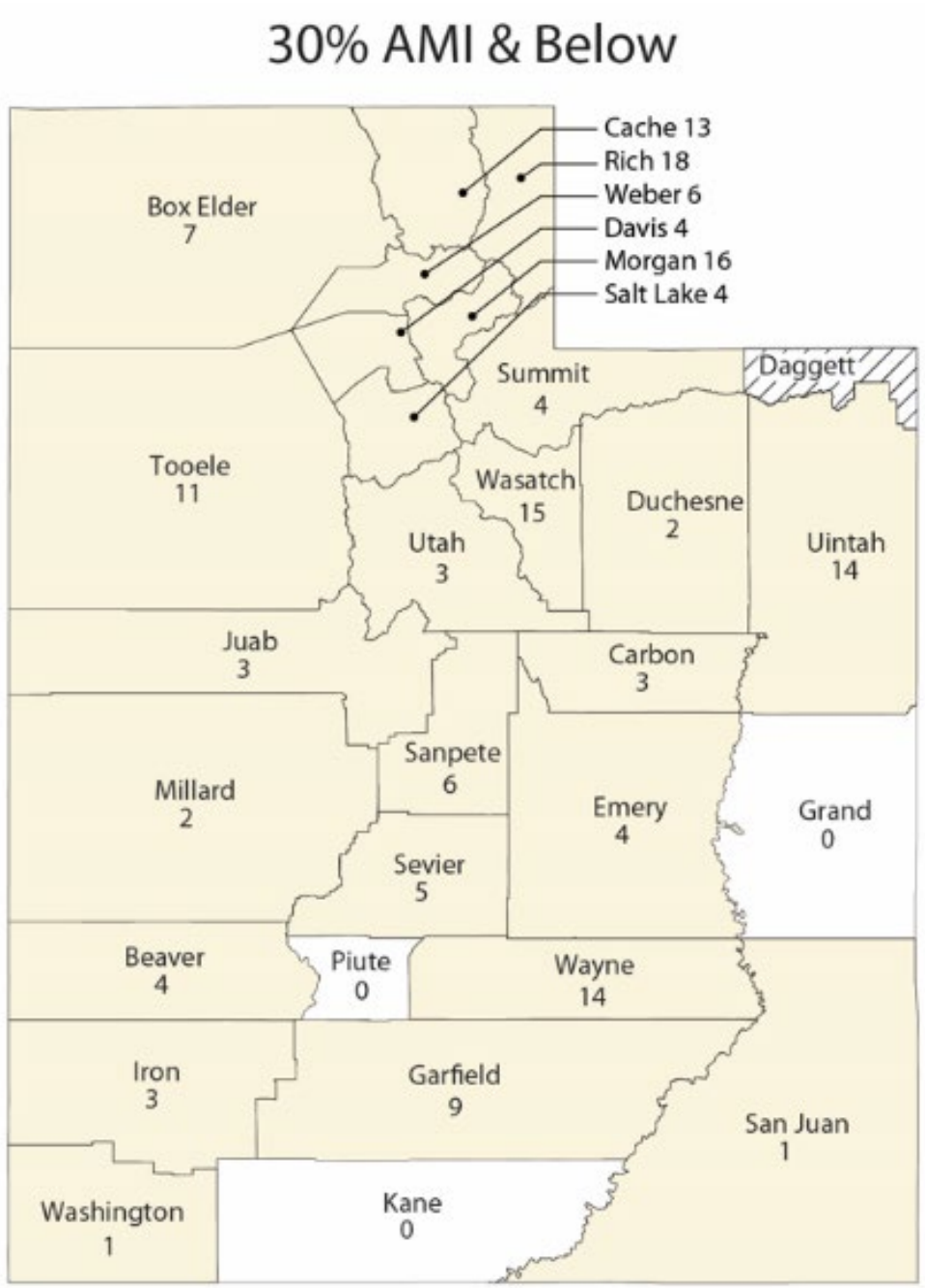
- 3,869 homeless households
- 2,906 without children
- 1,378 severely mentally ill
- 839 chronic substance misuse
- 906 chronically homeless
- 647 transition-age youth (5,984 TAY at risk) in SLCo

Housing in Utah

Multiprong issue:

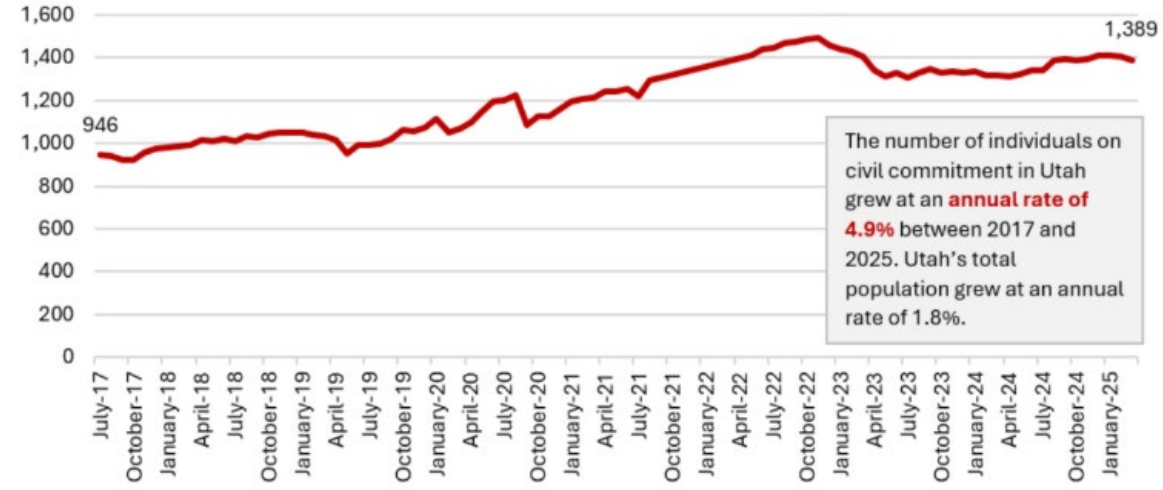
- Systems
- Life events
- Lack of affordable/ deeply affordable housing

Entry level workforce can't afford housing



Increasing Number of Individuals on Civil Commitment

Figure 1: Total Number of Individuals on Civil Commitment, 2017-2025

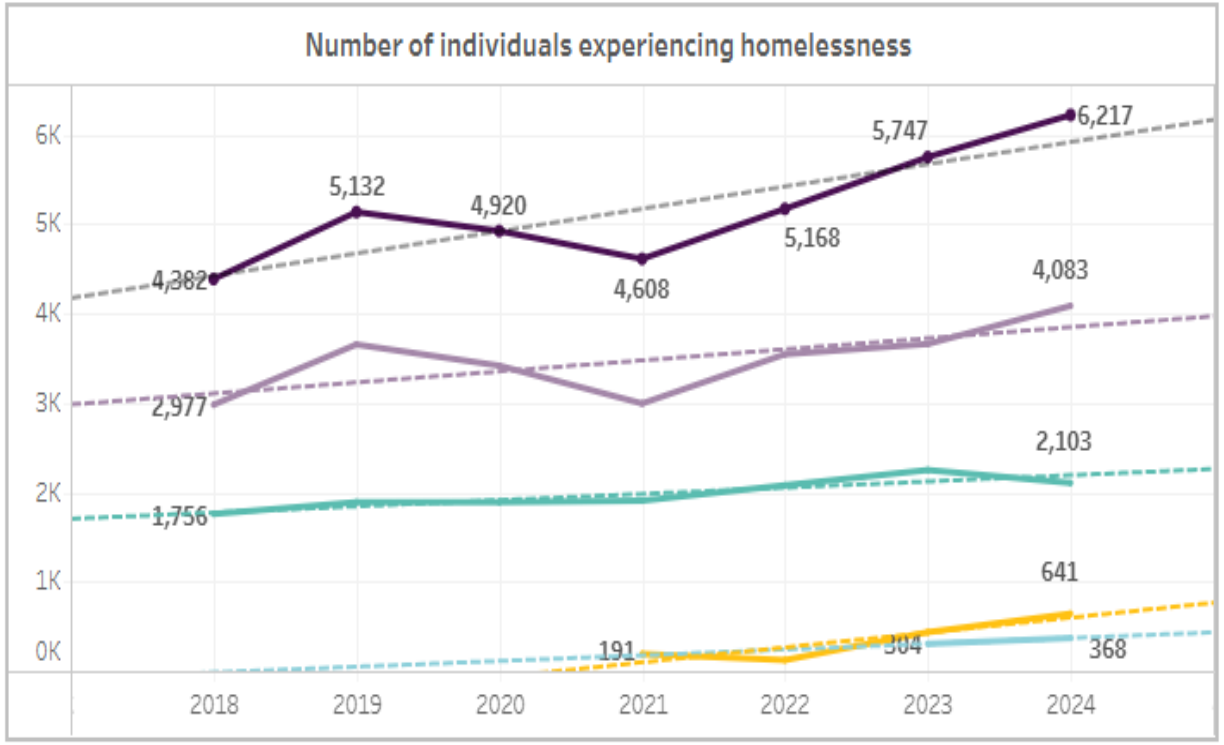


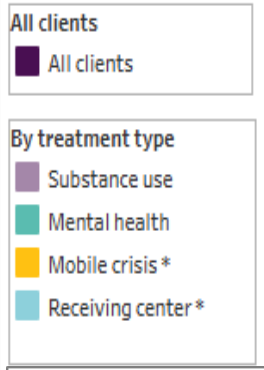
Utah's new homeless board is warned of major mental health bed shortage

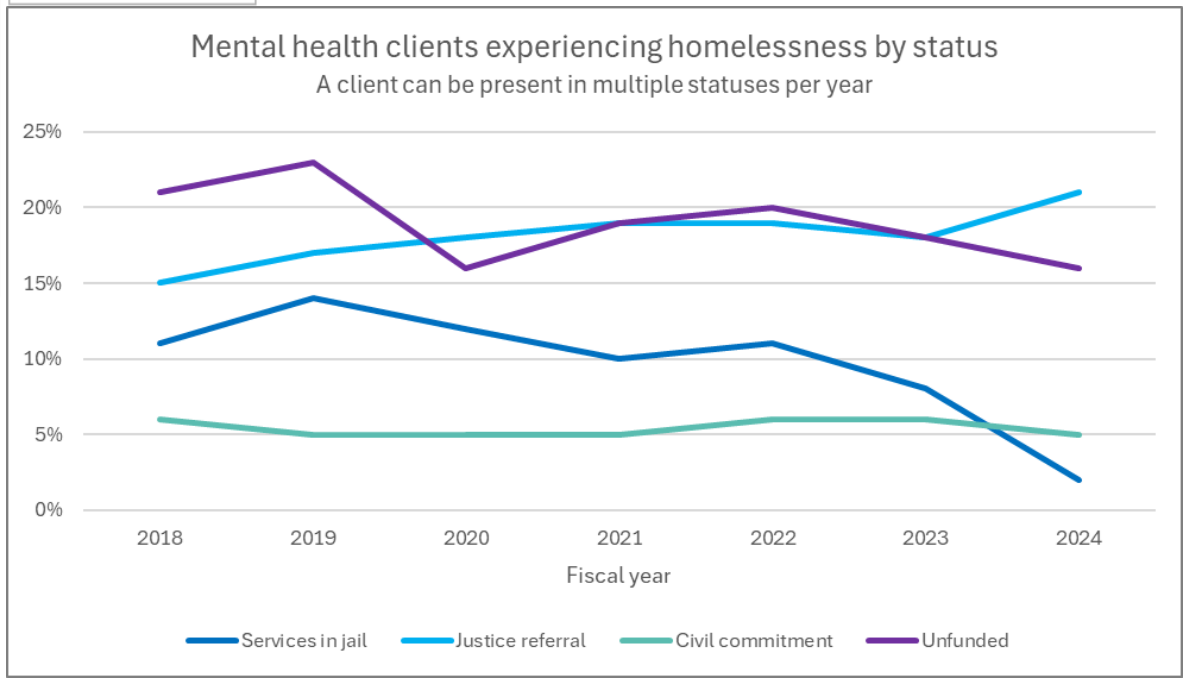
In its first meeting, newly revamped governing body issues nearly $31 million in grants to homeless providers – while signaling it wants to increase oversight to ensure safety in shelters, root out drugs

BY: **KATIE MCKELLAR** - MAY 17, 2024 4:33 PM

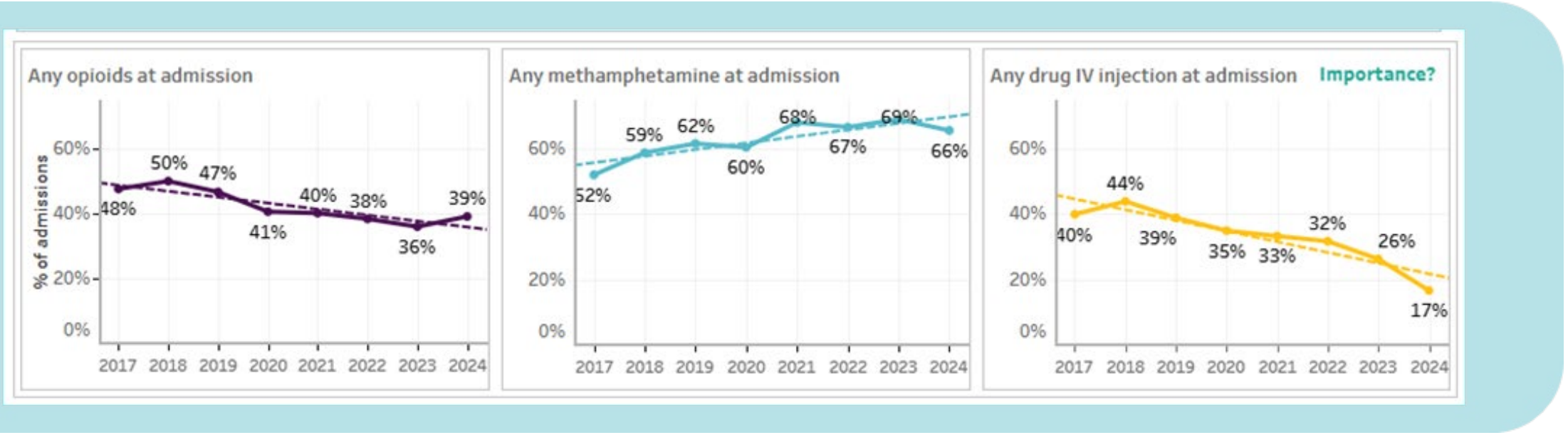
Homelessness and Mental Health (sumh.utah.gov/data-portal-home)







Homelessness and SUD (sumh.utah.gov/data-portal-home)

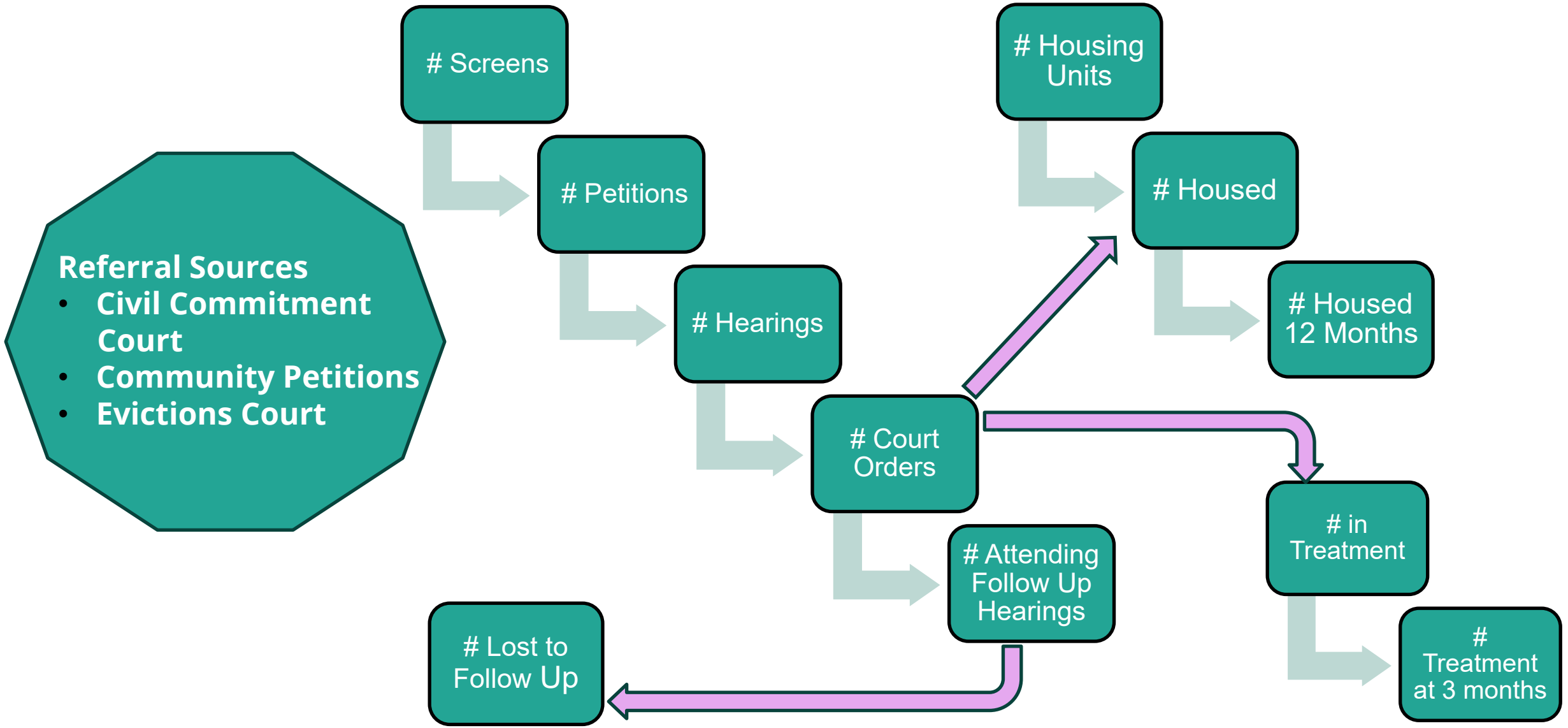


2024 HB 421 H.O.M.E. Court

Healing Opportunities to Mentally Excel

- Salt Lake County – Supported by state general funds
- Civil court process
  - High acuity individuals with SMI
  - Not on civil commitment
  - Ongoing housing issues
- LMHA develops 40 housing units and increases ACT capacity

HOME Court Pilot Flow

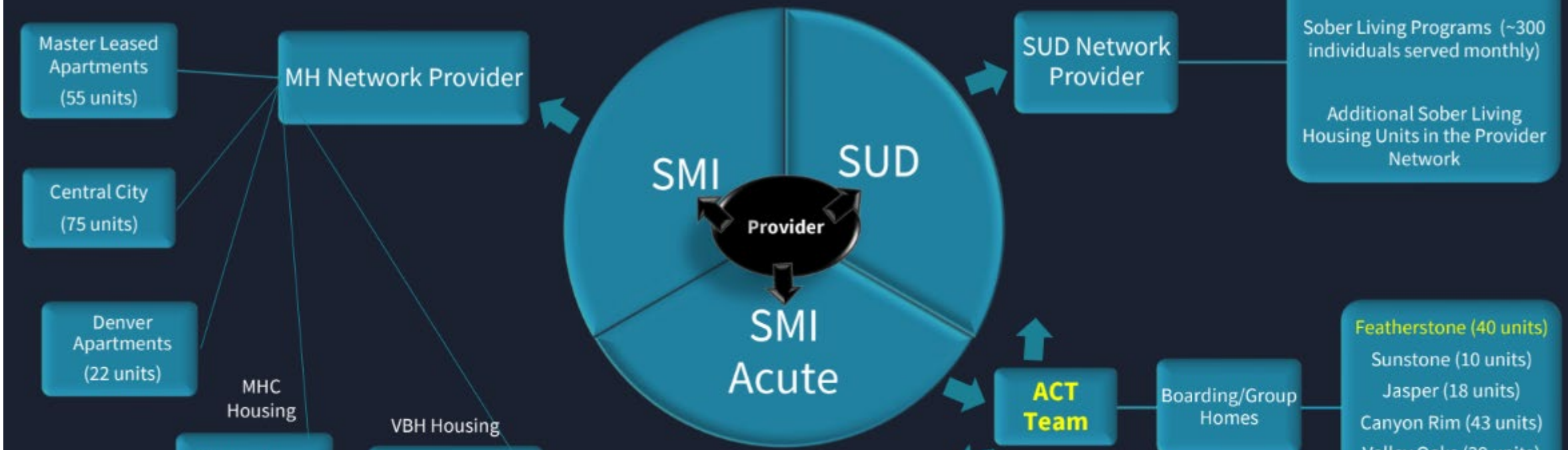


Housing

Additional Community Programs

- Palmer Court
- Sunrise Metro
- Pamela's Place
- Grace Mary Manor
- Kelly Benson
- Section 8 Housing
- VA Housing
- HOPWA
- Refugee Support Housing
- Housing Choice Voucher
- Family Reunification Program
- Others

DBHS Supported Housing



An ACT Team Expansion and Featherstone Renovations

~$700K HOME Court Funding and ~$1.6M - $1.7M additional funding through SL Co BHS

Familiar Faces, Homeless Outreach Court (Kayak Court)

“Transformative, centralized campus”

Other Projects

- **One local mental health authority provides almost all housing and Code Blue shelter**
- **Closed schools = permanent supportive housing apartments**

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New York State's Approach to Helping Unsheltered Individuals

Ann Marie T. Sullivan, M.D.
Commissioner

JULY 28, 2025

Policy Influences and Considerations

Data estimates on unsheltered homelessness can vary (the following information was collected by the U.S. Department of Housing and Urban Development (HUD) and the New York State Office of Temporary and Disability Assistance (OTDA))

- New Yorkers are homeless at a rate of 8 per 1,000 individuals for an estimated total of 158,000 with 140,000 of those individuals living in New York City
- 5,600 individuals are unsheltered in NYS – The Homeless Outreach Population Estimate (HOPE) count in New York City estimated 4,140 in 2024
- Estimated at least 1,000 individuals with Serious Mental Illness (SMI)

Recognizing the challenges experienced by individuals

- Cognitive impairment
- Co-morbid medical conditions
- Difficulty with daily living and social skills

Addressing public perceptions

- Homelessness
- Mental illness

Stigma

Respecting individual's rights and self-determination

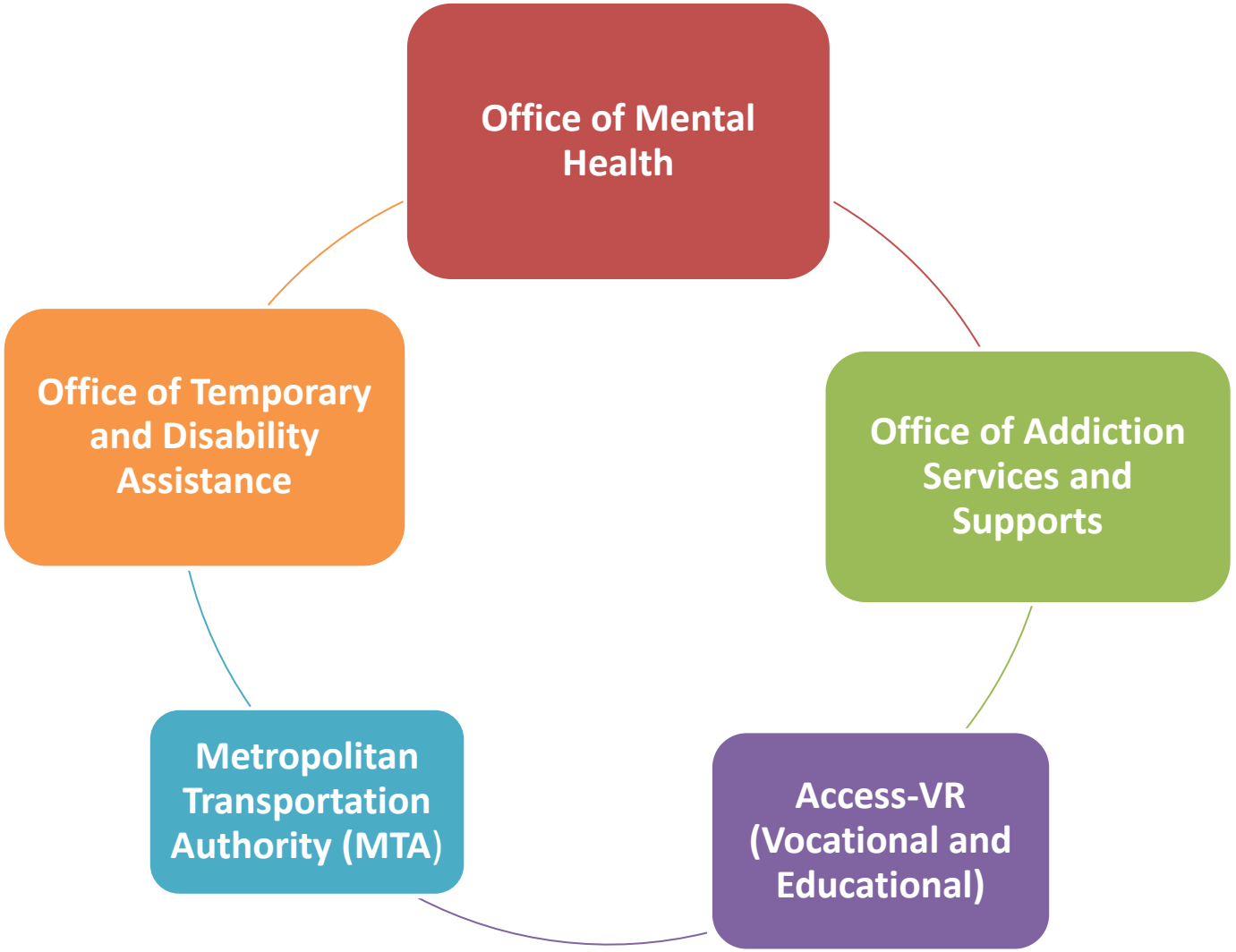
Engagement & Access to Housing: SOS and THU

Meeting individuals where they are and remaining connected through the transitions

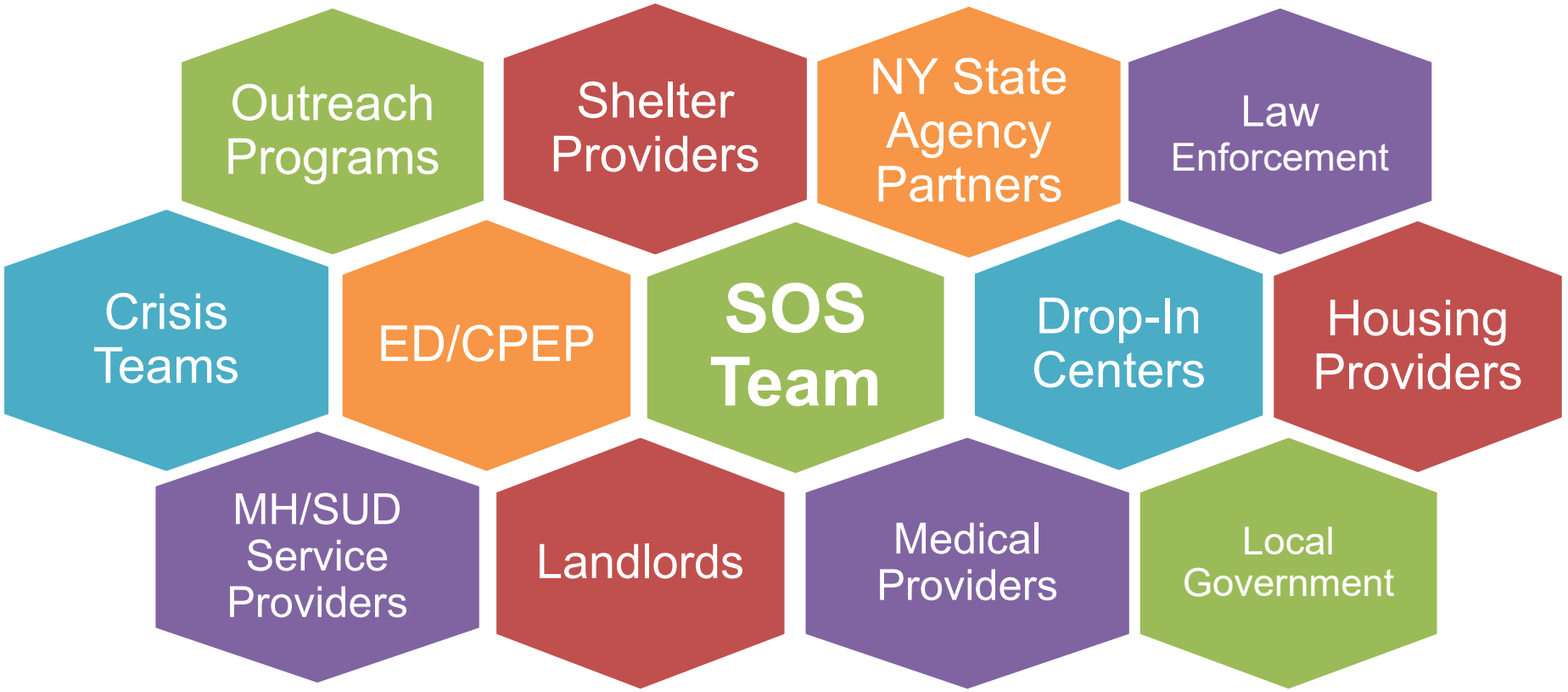
Safe Options Support (SOS): Multidisciplinary community team, including peer supports, using Critical Time Intervention (CTI) model to engage and support individuals who are unsheltered to transition into permanent housing

Transition to Home Inpatient Units (THU) at Manhattan PC: Provides treatment and support to individuals who were chronically unsheltered to find stability and achieve permanent housing

New York State Agency Partners



Community Collaboration



Safe Options Support Teams

Safe Options Support Implementation & Expansion

- Multidisciplinary teams using Critical Time Intervention approach to provide intensive outreach, engagement, and care coordination services to unhoused individuals until stably housing (approximately 12 months).
- Each team has 9-12 members when fully staffed. Teams are composed of licensed clinicians, care managers, and peer specialists. NYC Teams also include a registered nurse. (Most teams now have a psychiatric practitioner providing services to members one day a week)
- Since the Safe Option Support (SOS) program was created in 2022, **18 teams have been developed in New York City**
  - Specialty teams include 3 overnight outreach teams and 1 Older Adult and Medically Fragile Consult Team
  - There are 2 Young Adult teams in development
  - A Targeted Response SOS team launched in the Times Square Area in August 2024
- Safe Options Support Teams launched in **Rest of State at the end of 2023** where there are currently 11 teams operational in Upstate New York

SOS Differs From Traditional Homeless Outreach

Focused:

Individualized and focuses on a small number of service areas that place member at risk. Focus areas are identified based on the history and needs. Focus areas of work may change during the different phases of the intervention.

Quick Access and Response:

Participants are able to reach the services they need when they need them, and in ways that are psychologically, culturally, financially, linguistically, and physically suitable.

Relationship-Based:

Services organized around relationships, in which contacts with the service system are characterized by familiarity, personalization, and warmth. Communication occurs between member and service providers, and among the various service providers involved with a specific member's care.

Flexible:

Frequency, duration and type of engagement adjusted based on the needs in all phases. Members can determine intensity keeping them involved and satisfied with type of service. Service delivery is not regimented so members set the pace of their progress.

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Services Offered Through SOS Outreach

- The menu of services that can be provided during outreach is limited only by imagination and resources. Some potential services commonly offered include:

Engagement

- Initiating conversation
- Offering a sandwich, coffee, or water
- Offering a blanket, socks, shoes, hats, gloves, or other clothes
- Offering hygiene articles, sunscreen, first aid items

Information & Referral

- Offering information about available services in the community
- Linking to shelter or other housing options or transition placement
- Refer to sites that offer food, clothing, shower, laundry, or other basic needs

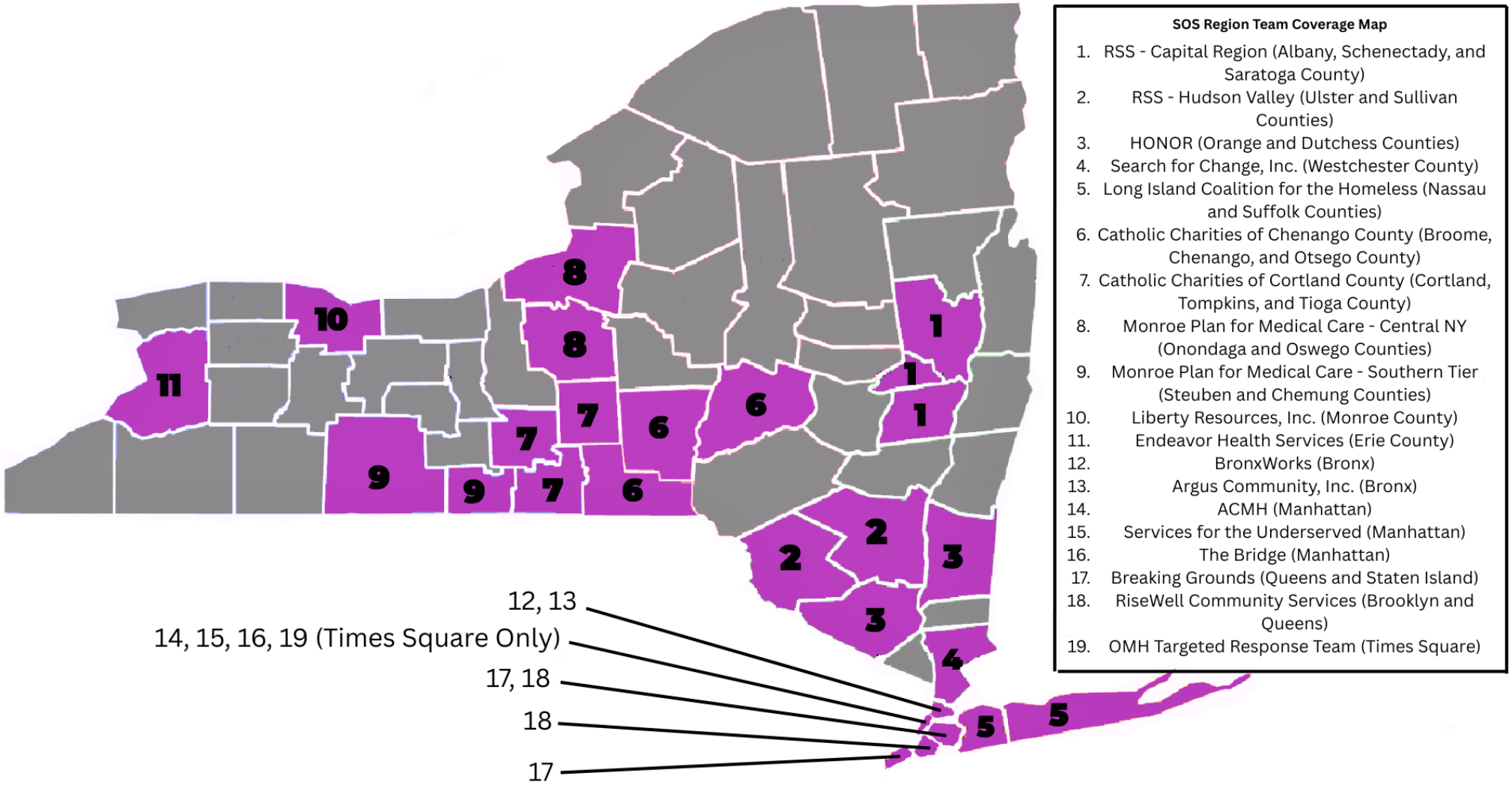
Direct Services

- Connecting with Dept of Social Services
- Obtaining IDs and applying for entitlements
- Case management
- Crisis intervention including links to emergency or hospital care
- Advocacy and assistance navigating the systems of care

Safe Options Support (SOS) Teams Financing

- SOS program does not currently bill Medicaid (fully State-aid funded); providers receive funding for staffing, operational costs, and wrap-around dollars.
- Fiscal model allows for greater flexibility by programs to best meet the needs of each region.
- Wrap-around dollars can help meet immediate needs and support community inclusion post-housing placement.

Safe Options Support Teams Map



SOS Region Team Coverage Map

1. RSS - Capital Region (Albany, Schenectady, and Saratoga County)
2. RSS - Hudson Valley (Ulster and Sullivan Counties)
3. HONOR (Orange and Dutchess Counties)
4. Search for Change, Inc. (Westchester County)
5. Long Island Coalition for the Homeless (Nassau and Suffolk Counties)
6. Catholic Charities of Chenango County (Broome, Chenango, and Otsego County)
7. Catholic Charities of Cortland County (Cortland, Tompkins, and Tioga County)
8. Monroe Plan for Medical Care - Central NY (Onondaga and Oswego Counties)
9. Monroe Plan for Medical Care - Southern Tier (Steuben and Chemung Counties)
10. Liberty Resources, Inc. (Monroe County)
11. Endeavor Health Services (Erie County)
12. BronxWorks (Bronx)
13. Argus Community, Inc. (Bronx)
14. ACMH (Manhattan)
15. Services for the Underserved (Manhattan)
16. The Bridge (Manhattan)
17. Breaking Grounds (Queens and Staten Island)
18. RiseWell Community Services (Brooklyn and Queens)
19. OMH Targeted Response Team (Times Square)

NYC SOS Teams Outcome Data

In New York City, teams have accomplished:

- 65,437 Outreach Encounters
- 3,212 Total Bed Placements (Includes placements to Respite programs, Shelter, Safe Haven Bed, or a DHS Welcome Center)
- 2,640 Enrollments into the SOS Program
- 101,642 Enrolled Contacts
- **773 Permanent Housing Placements in OMH Licensed and Unlicensed Housing (Includes Community Residence, Apartment Treatment, Family Care, Supportive Housing, Independent Housing, and Skilled Nursing Facility)**

***Data updated as of 6/27/25**

Rest of State SOS Teams Outcome Data

Data from the Upstate Teams:

- 25,422 Outreach Encounters
- 736 Enrollments into the SOS Program
- 514 Currently enrolled into the SOS Program
- 56 Currently enrolled members who are unsheltered
- 26,929 Enrolled Contacts
- **416 Permanent Housing Placements in OMH Licensed and Unlicensed Housing (May include Community Residence, Apartment Treatment, Family Care, Supportive Housing, Independent Housing, and Skilled Nursing Facility)**

***Data updated as of 6/20/25**

Housing Eligibility & Enrollment

- 300 Scattered Site Supportive Housing Units awarded in NYC and 225 units awarded in rest of state for street homeless individuals referred from SOS or Assertive Community Treatment (ACT).
- Expedited referral, low barrier admission process. Providers lease units in advance to facilitate rapid placement.
- 1:15 staff to recipient ratio; housing staff visit recipient 4 times per month via face-to-face contacts and home visits - may decrease over time.
- Residents of supportive housing pay 30% of their income towards rent and reasonable utilities.

Housing Data & Outcomes

- Between October 2023 – May 2025, approximately 270 people have been admitted into low barrier supportive housing units.

- Of those 270 SOS members admitted, 260 remain stably housed today.

Securing a Home and Building Skills to Thrive in the Community: One Member's Story

- Joe is a 51-year-old man from Out-of-State. He has two daughters still residing in that other state with whom he maintains contact. He has experienced homelessness for over 20 years in his native city prior to his relocation to NYC.
- Joe continued to experience street homelessness in Times Square upon his arrival to NYC. In the fall of 2024, the Targeted Response Team (TRT SOS team) encountered him while canvassing Times Square. Through consistent outreach and engagement, Joe started accepting support from the team with a goal to secure housing.
- In the winter of 2024, TRT was able to successfully help Joe move into permanent housing. Since being housed, he has continued to work on his recovery with the support and encouragement of the team and remains connected to a behavioral health provider where he receives treatment. He has developed positive relationships with neighbors and peers and reports enjoying this connection to others in his new community.
- Joe was connected to Fountain House, where he was able to gain employment, further deepening his reintegration in the community. He reports that gainful employment gives him purpose. He continues to demonstrate motivation to remain housed and improve his overall quality of life.

Transition to Home Inpatient Service

Transitions to Home Unit (THU)

- 50-bed inpatient unit at Manhattan Psychiatric Center which opened in November 2022
- Accepts referrals from emergency departments and comprehensive psychiatric emergency programs (CPEPs) – both voluntary and involuntary admissions

Referral Criteria:

- Street-homeless or unstably shelter domiciled with severe mental illness
- Psychiatrically appropriate for inpatient-level psychiatric car
- Medically appropriate for care at a standalone psychiatric hospital

Active Treatment on the Transitions to Home Unit (THU)

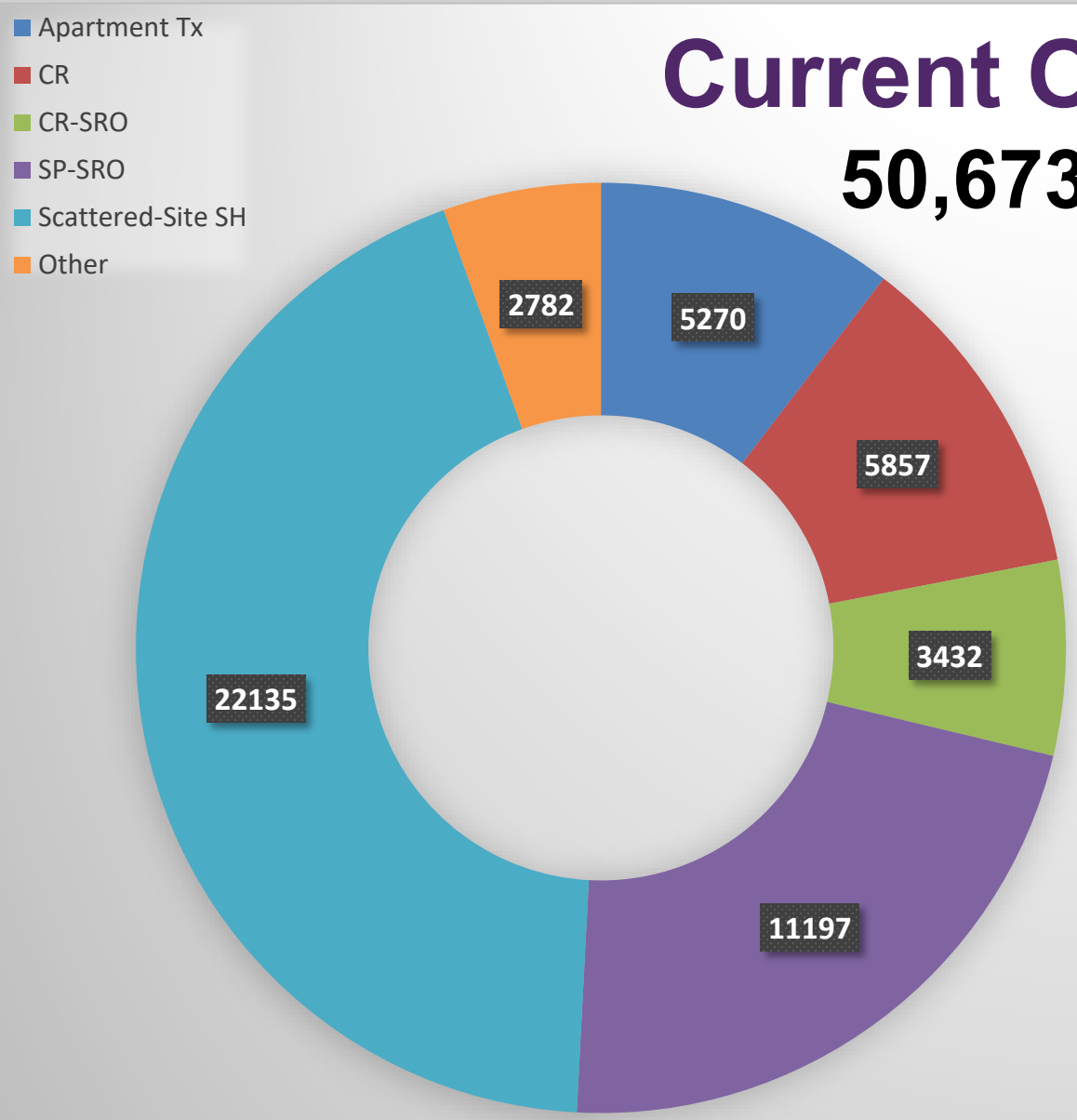
Informative assessments provide the basis for provision of individualized treatment that meets individuals where they are at and helps them strive toward where they want to be

- Aspirations
- Motivation
- Functional Skills
- Cognition
- Trauma
- Suicide Attempts
- Violence
- Substance Misuse
- Medical needs

Valuing the Individual's Aspirations

THU Requests	Our Responses
Independence	Value the individual's right to actively participate in their future planning
Housing	Identify housing opportunities that provide adequate supports
Employment	Provide opportunities to give back and gain rewards
Education	Provide opportunities to learn, grow, and achieve successes
Community	Provide opportunities to make, grow, and maintain connections with others

New York State's Investment in Housing



Current OMH Housing Units in NYS

50,673 operational units of housing

- Apartment Treatment: 5,270
- Community Residence (CR): 5,857
- CR-SRO: 3,432
- SP-SRO: 11,197
- Scattered-Site SH: 22,135
- Other: 2,782

OMH projects 891 more beds to open in FY26, with 6,240 beds in the pipeline total over the next 5 years.

Transition to Home Units - Outcomes

- Majority of clients - in addition to serious mental illness - have significant substance use and serious chronic medical conditions that need intensive follow up over time
- 60% remain in permanent housing
- 66% remain connected to teams and services even if they leave housing

Questions?

Office of Mental Health