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ADVANCING SOLUTIONS TO HOMELESSNESS

In Partnership with DHCS and CalMHSA

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Pathways to Housing 101: Navigating Access for Clients with Behavioral Health Needs

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Webinar Housekeeping

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Mute

We ask that attendees raise their hand to indicate they'd like to ask a question + come off mute

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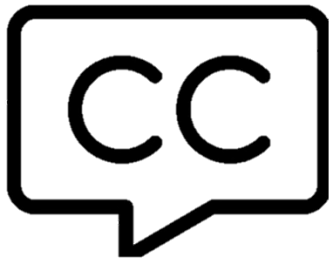
Captions are available (Click "Show Captions")



Questions

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Finding housing for clients with behavioral health needs is often confusing and frustrating. **Behavioral health staff must navigate a patchwork of systems, funding rules, and documentation requirements that rarely align**. These complex systems, while each serving important functions, can create navigation challenges that delay placements and require additional coordination to connect people to stable housing that supports recovery.

Today’s Agenda

System Partners + Key Steps for Collaboration

Understanding the Housing Continuum

Landlord Engagement

Q&A and Discussion

Webinar Goals

1. Build foundational knowledge of the housing continuum for individuals with behavioral health needs.
2. Increase participant (BHA leaders and staff) ability to navigate housing pathways, both within and outside the homelessness system
3. Support cross-sector coordination between behavioral health, housing, and homelessness partners.
4. Offer actionable strategies and tools to reduce barriers to housing access.

System Partners + Key Steps For Collaboration

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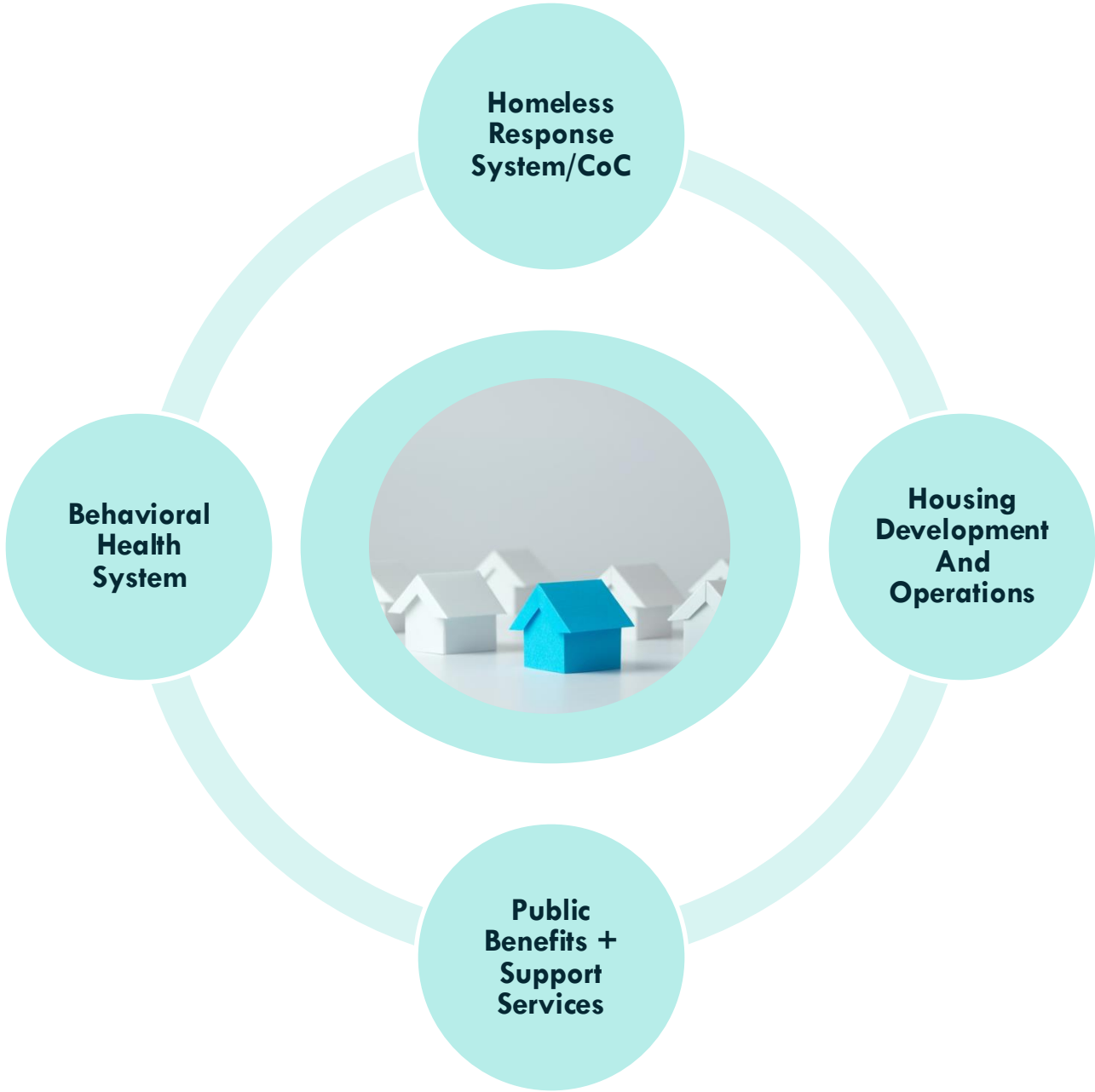
System Partners: The Big 4

To effectively connect clients to housing, behavioral health staff need to understand and engage with four key system players. These include the homeless response system (which includes the Continuum of Care (CoC)), housing development and operation, public benefits and support services,, and the Behavioral Health System—**all of which control critical pieces of the housing access puzzle.**



Who facilitates access to housing in my community? Homeless Response System

- **Continuum of Care (CoC):** A local or regional planning body that coordinates the community's response to homelessness through a broad group of stakeholders, with a designated **Lead Agency** responsible for managing housing programs, overseeing HMIS, and administering HUD funding.
    - **Coordinated Entry System (CES) Operators**: Match clients to available housing resources based on vulnerability and need.
- **Homeless Outreach Teams**: Identify and engage unsheltered individuals, often the first connection to housing services.
- **Emergency Shelter and Transitional Housing Providers**: Offer immediate shelter and can connect clients to permanent housing.
- **Permanent Housing Providers:** Offer Rapid Rehousing (time-limited assistance) and Permanent Supportive Housing (non time-limited assistance)

Who facilitates access to housing in my community?
Behavioral Health System

- **County Behavioral Health Departments**: Serves seriously mentally ill client that need support services as well as housing (e.g., Assertive Community Treatment (ACT), Full-Service Partnerships (FSPs), CARE Court).
- **Substance Use Treatment Providers**: May have access to housing subsidies (e.g., SUD housing pilots, CalAIM funding streams).
- **BHSA Program Leads:** Oversee housing intervention requirement under the BHSA and the new facilities funded through Prop 1, as well as the previously funded interim, bridge, and permanent housing connected to behavioral health care.

Who facilitates access to housing in my community?
Public Benefits and Support Services

- **Social Services Agencies (e.g., CalWORKs, General Assistance)**: May have housing assistance for eligible families or individuals.
- **Veterans Affairs (VA):** Administers housing access through medical centers, County VA officers, and funding streams (e.g., GDP, SSVF)
- **Adult and Aging Services / APS**: Often serve vulnerable older adults at risk of or experiencing homelessness with access to housing programs.
- **CalAIM Housing and Community Supports:** Through Medi-Cal managed care plans, provides housing navigation, tenancy supports, and short-term housing to Medi-Cal beneficiaries with behavioral health needs or who are experiencing homelessness. Beginning January 1, 2026, MCPs will be required to cover a 6 month transitional rent benefit for members meeting the BH population of focus and who have a housing support plan in place.

Who facilitates access to housing in my community?
Housing Development and Operations

- **Public Housing Authorities (PHAs)**: Administer Section 8/HCV, Emergency Housing Vouchers (EHVs), HUD-VASH and other subsidies. *Note: EHV funding expires in 2026, but PHAs will be positioned to hear about and apply for new funding streams that support similar housing interventions.*
- **Affordable Housing Developers and Operators**: Build and manage permanent supportive housing or other affordable units.
- **Property Managers and Landlords**: Gatekeepers for units—relationships and landlord incentives can improve access.
- **Local City or County Housing Departments**: Oversee funding streams (e.g., HOME, CDBG, state/local bonds) and typically fund tenant-based rental assistance through contractors rather than providing it directly. Some cities and counties also own or control inclusionary housing units that can provide affordable options.

Zoom Poll

How have you worked with the homeless response and the housing development systems that influence housing access?

What's the biggest barrier you face when helping clients access housing?

🤝 Partnering Across Systems: Where Can Behavioral Health Staff Start?

Partnering Across Systems: Where Behavioral Health Staff Can Start

1. Homeless Response System

Why it matters: This system manages Coordinated Entry (CE), outreach teams, emergency shelters, and housing programs like Rapid Re-Housing and Permanent Supportive Housing.

Ways to engage:

- Join your local **CoC meetings or workgroups** to stay in the loop on housing opportunities.
- **Build direct relationships** with CE operators and housing navigators to coordinate referrals.
- **Co-locate staff** or join case conferences with homeless service providers to share client updates and reduce duplication
- **Participate in "housing pipeline" groups** hosted by Homeless Coalitions or CoC Lead Agencies—these meetings discuss housing projects in development and offer opportunities to identify where the behavioral health system might partner.

Partnering Across Systems: Where Behavioral Health Staff Can Start

2. Public Benefits + Support Services

Why it matters: These partners control key programs (ex. Medi-Cal, CalWORKs) and documentation that open doors to housing

Ways to engage:

- **Build referral relationships with eligibility workers** at local social services agencies to streamline applications for Medi-Cal, SSI, CalWORKs, or GA.
- **Collaborate with CalAIM Community Supports leads** at Managed Care Plans to identify mutual clients and align housing support services.
- Build relationships with **legal aid** and public benefits advocates to help clients overcome documentation or benefits access issues.

Partnering Across Systems: Where Behavioral Health Staff Can Start

3. Housing Development + Operations

Why it matters: This includes the people who **own, build, and manage** affordable and supportive housing units.

Ways to engage:

- Partner with **property managers and developers** to support placements and prevent evictions.
- Work with **local housing departments** to stay updated on new units, rental subsidy programs, and application cycles (city or county-level).
- Connect clients to **landlord incentive programs** or **tenancy support services**—and help troubleshoot when housing stability is at risk.

🤝 Partnering Across Systems: Action Steps

Partnering Across Systems:
Action Steps

1. Identify Your Local Housing Contacts

- Find out who your local CoC Lead Agency is and who operates the Coordinated Entry System in your area.
- Locate your county or city housing department and subscribe to their updates or attend a public meeting.
- Ask your team: *Who do we already know in the housing system—and who do we need to meet?*

2. Build a Housing Resource Cheat Sheet

- Create or request a quick reference of:
  - Local housing programs and what they offer (RRH, PSH, etc.)
  - Contact info for CoC navigators or housing case managers
  - Rental subsidy programs tied to Medi-Cal or CalWORKs
- Share this with your team and update it quarterly.

Partnering Across Systems:
Action Steps

3. Initiate Strategic Partnership Conversations

- Contact key partners in the **homelessness system**, **housing department**, or **public benefits office** with a value proposition:

  "The BHSA has a new emphasis on housing with designated funding for housing support. We want to discuss best ways to maximize resources towards our shared goal of ending homelessness in our community and explore large-scale coordination to minimize service duplication."

4. Engage in Systems-Level Coordination

- Join CoC Board meetings, Coordinated Entry Committee meetings, or Homelessness Task Forces as a **contributing partner** rather than just an observer
- Come prepared to discuss how behavioral health resources can be integrated into existing housing strategies
- Focus on identifying policy and procedural changes that can streamline client pathways between behavioral health and housing services

Partnering Across Systems:
Action Steps

5. Map Your Client Touchpoints

- For one client you serve, **sketch out** who they're connected to: housing provider, PHA, benefits office, etc.
- Use this to see where coordination is working—and where it's breaking down.

6. Integrate Housing Partners into Your Planning Sessions

- Set aside time in team meetings to:
  - Share updates on housing referrals and client progress through housing systems
  - Problem-solve around clients experiencing barriers in the housing pipeline
  - **Invite housing navigators and social services partners as regular guests** to present on current housing opportunities, waitlist status, and eligibility requirements
- Use these meetings to identify which clients would benefit from multidisciplinary team coordination and initiate appropriate ROIs for housing-focused information sharing

Privacy Compliance When Coordinating Housing Services

- **For BH staff concerned about client privacy**: You can legally share case facts unrelated to diagnoses with housing partners when connecting clients to appropriate housing options:
  - **WIC 18999.8 (2017)**: Allows creation of multidisciplinary teams to share confidential information for coordinating housing and supportive services
  - **Formal releases of information (ROIs)** that specify which agencies can access client supportive services and housing needs information (communities often include housing partners as authorized agencies in their standard ROIs)
  - **Multidisciplinary team (MDT) structures** that ensure continuity of care while maintaining privacy compliance
- Focus information sharing on **housing and supportive service needs** rather than clinical diagnoses to maintain appropriate boundaries while enabling effective coordination

Case Study: Why Collaboration Matters

Meet Raymond:

Raymond is a 38-year-old man living with undiagnosed schizophrenia and a history of methamphetamine use. After losing housing during the pandemic, he's been cycling between a tent near the riverbed and short jail stays.

A behavioral health case manager encounters Raymond during a routine outreach visit and recognizes he needs both mental health support and housing assistance. She wants to make a referral to get him connected to housing and services, but experiences the following collaboration challenges:

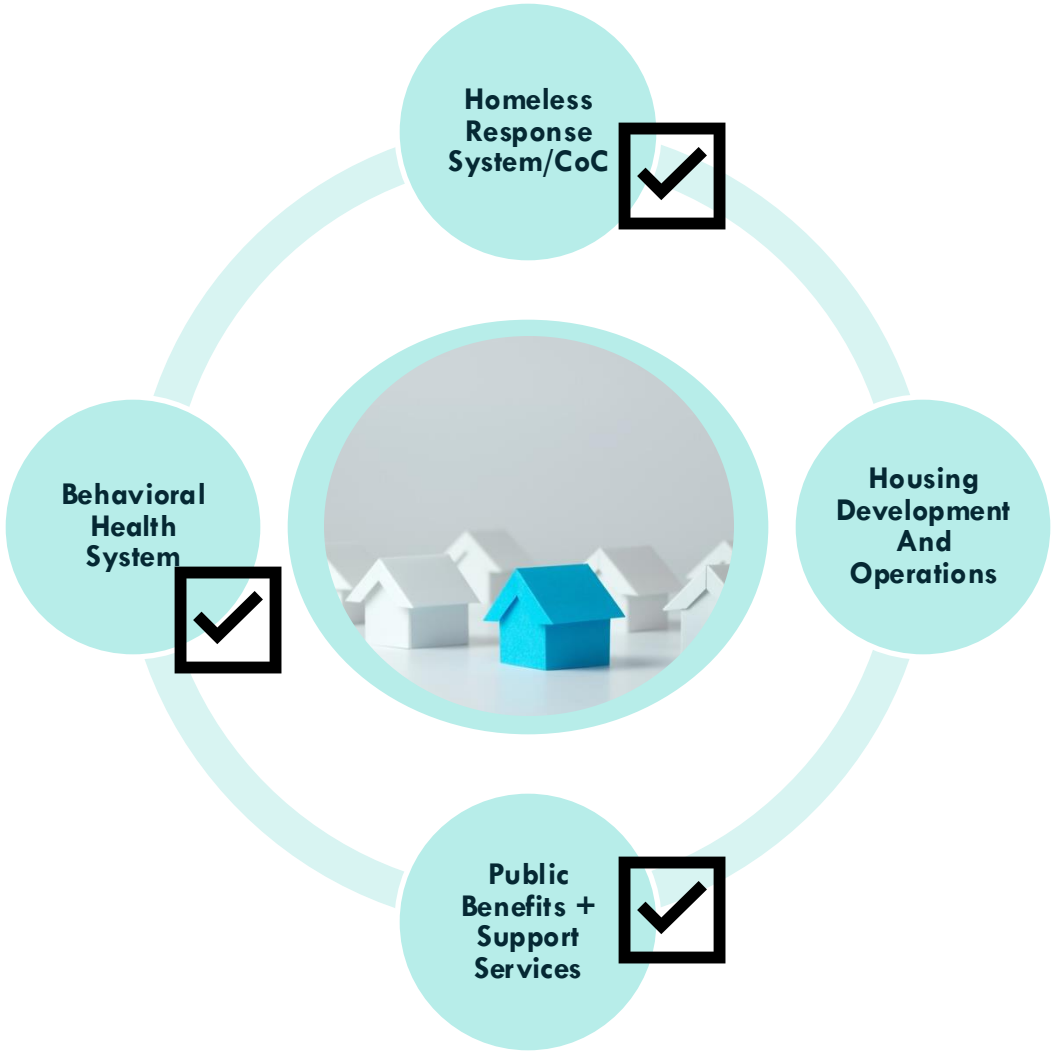
- **Coordinated Entry System:** The case manager could refer Raymond for a vulnerability assessment, but not having the correct point of contact on the local CES team causes delays
- **County homeless outreach team:** They specialize in obtaining IDs and enrolling clients in CES, but they're not automatically notified when behavioral health identifies someone who needs services.
- **CalAIM Housing Community Supports:** Could fund housing deposit, navigation, and housing sustaining supports, but the case manager is not sure how to connect with Managed Care Plan to assist with enrollment and services

Case Study: Why Collaboration Matters

The case manager begins reaching out:

- She persuades Raymond to be evaluated by behavioral health and gets him enrolled in a **Full Service Partnership (FSP)** program for ongoing mental health support and BH housing opportunities.
- She contacts a **CES assessor** to complete an in-person vulnerability assessment and helps Raymond gather the documentation needed for a government-issued ID. She connects with a **social services benefits worker** to expedite Raymond's documents.
- She identifies an opening in the county's **behavioral health bridge housing program** and coordinates his placement there.
- Working with the **CalAIM MCP housing liaison**, she develops a comprehensive **housing support plan** that identifies specific permanent housing options (including potential permanent supportive housing units coming online in 6 months) and outlines the pathway to get there. Only after this plan is approved can the MCP authorize 6 months of transitional rent supports.

Thanks to this cross-system coordination, Raymond moves into behavioral health bridge housing within three weeks and begins FSP services. His housing support plan provides the roadmap for transitioning to permanent housing, allowing CalAIM to fund the transitional supports needed to bridge the gap.



Understanding the Housing Continuum

Housing Continuum

- The **housing continuum** refers to the **range of housing interventions** available to people experiencing or at risk of homelessness.
- It includes options that range from **short-term emergency shelter** to **permanent supportive housing**, and everything in between.
- Each type of housing is funded, operated, and accessed through **different systems**—which is why **cross-system coordination is essential**.
- People do **not always move through the continuum in a straight line**—especially those with behavioral health needs who may cycle through hospitalizations, incarceration, or unstable placements.

Housing Intervention Types vs. Housing Subsidy Types

Housing Intervention Types

- Generally, these refer to the **form or structure of the housing program**—what kind of housing is provided and what services are paired with it.
- **Think of these as the "housing programs"** where clients physically stay and receive services.

Housing Subsidy Types

- These are **funding tools** that help cover the **cost of rent** in various housing settings. They make otherwise unaffordable units accessible to low-income tenants.
- **Think of these as the "payment mechanism"** that makes housing financially possible, either for the client or provider.

Key Difference:

A **housing intervention** is where someone lives + the services they receive.

A **housing subsidy** is how the rent is paid—and can often be **used across different intervention types.**

Homelessness and Housing Interventions

Intervention Type	Description	How to (typically) Access
Emergency Shelter	Immediate, short-term shelter	Street outreach, self-referral, and occasionally via CES or waitlist
Interim/Bridge Housing	Time-limited housing paired with services	CES or BH programs
Transitional Housing	Structured, residential program (typically limited to two years)	CES, referrals from BH/SUD programs, or population-specific system (DV, Youth, etc.)
Rapid Rehousing (RRH)	Short-term rental assistance + case management	CES or coordinated referral
Permanent Supportive Housing (PSH)	Non-time-limited housing with wraparound services	County/BH or CES
Affordable Housing	Low-cost housing without intensive supports	Waitlists, vouchers

Housing Subsidy Types

Subsidy Type	Administered By	Target Population	Portability/Limitations
Housing Choice Voucher (HCV)	Public Housing Authorities (PHAs)	Low-income households	Portable; long waitlists; income limits
Emergency Housing Voucher (EHV)	PHAs via CoC referral	People experiencing homelessness	Time-limited; CES referral; expiring
Veterans Affairs Supportive Housing (VASH)	HUD + VA partnership via PHAs	Veterans experiencing homelessness	Must be VA-eligible; SUD/MH services
Project-Based Vouchers (PBV)	PHAs in partnership with developers	Low-income renters in specific units	Tied to specific unit/property
Tenant-Based Rental Assistance (TBRA)	Local jurisdictions, ESG/HHAP funding	Flexible – varies by program	Time-limited; local discretion
Transitional Rent (Medi-Cal)	Managed Care Plans (MCPs)	Medi-Cal POF; experiencing or at risk of homelessness	Up to 6 months; MCP must authorize and have a Housing Support Plan in place

Why You Need to Understand Interventions *and* Subsidies

1. **You need both the place *and* the payment.**
   A great housing program doesn't help if your client can't afford it—and a voucher doesn't help if there's nowhere to use it.
2. **Housing types aren't one-size-fits-all.**
   Some are short-term, some require a diagnosis, others need a referral. Knowing the difference matters.
3. **You're the connector.**
   You know your clients best. Understanding the housing landscape helps you open the right doors.

Case Study: Why Knowledge Matters

Meet Anthony:

Anthony is a 32-year-old man living with severe depression and a history of substance use. He's been unsheltered for several months, cycling between couch surfing and sleeping in his car. He recently engaged with a behavioral health provider but has no income, ID, or Coordinated Entry assessment.

- His case manager knew about a **Sober Living Environment (SLE)** operated by a local SUD provider that accepts direct referrals from behavioral health teams. That solved the **intervention** side: a stable, service-rich place to stay with built-in recovery supports. However, the program only covered a portion of the rent, and SSI alone wouldn't be sufficient to cover the full cost.

- To address the funding gap, the case manager helped Anthony apply for **General Assistance (GA)** and worked with the **county behavioral health agency to access BHSA housing funds** for rent subsidy and deposit. They also enrolled him in **Medi-Cal** and connected him to **SSI** through a SOAR worker. With Medi-Cal, Anthony could potentially access CalAIM Community Supports for housing services like Housing Transition Navigation, Housing Deposits, and Housing Tenancy and Sustaining Services. While this SLE placement may not be permanent, it provides Anthony with stability and recovery supports while working toward sustainable housing.

Landlord Engagement

Why Landlord Engagement Matters

- For many clients, especially those using tenant-based subsidies (e.g., Rapid Rehousing, Housing Choice Vouchers, CalAIM “Housing Trio” supports), **housing doesn’t exist until a landlord says yes**.
- Landlords are often navigating **risk**, **stigma**, and **complex systems**—just like your clients.
- Behavioral health providers can play a critical role in **bridging trust** and **offering support**.
- Think of landlords as partners – an extension of the the homeless response and the housing development systems

What Makes Landlords Say Yes?

Landlord Priorities:

- **Reliable rent payments** (subsidy + tenant portion)
- **Fast communication** if issues arise
- **Support with problem-solving** (noise, guests, late payments)
- **Assurance the tenant has services and support**

What helps:

- Clear points of contact, available 24/7
- Damage mitigation funds / signing bonuses
- Simple, fast application processes
- Stories of success!

How Behavioral Health Staff Can Support Landlord Engagement — Even If You're Not Leading It

1. **Be a stability partner:** Landlords are more likely to rent to high-needs tenants if they know **someone will be there to help if things go sideways**. That someone might be you.
2. **Communicate early and often -** Even if you're not the housing navigator, you might be the person landlords see most. Make sure the housing team has your number, and be responsive to any concerns they raise.
3. **Coordinate behind the scenes.**
   - Loop in the housing navigator or subsidy provider if a landlord concern pops up
   - Be available to help the housing team problem-solve
   - Help smooth transitions if a client is at risk of losing housing

Mapping the Housing Pathways:
What You Can Do Next

- Identify your **local housing system players** (CoC, housing department, MCP, landlord partners)
- Get familiar with **the housing interventions and subsidies** available in your community
- Attend a **CoC or other housing workgroup meeting**
- Ask your team: *Who do we know in housing—and who do we need to know?*
- Coordinate with your housing navigator or outreach lead on **landlord communication**
- Track BHSA Housing Interventions as they roll out in your county

Zoom Poll

What's one action you're most likely to take after today's session?

What's one thing from today's session that changed or clarified how you think about housing?

Q&A + Discussion