

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston

Tenisha Smith Breland¹, Gbolahan Solomon Osho²

¹Barbara Jordan Policy Research and Survey Center Texas Southern University

²Prairie View A& M University

ABSTRACT: The intersection of severe mental illness and housing instability increasingly shapes homelessness in the Houston metropolitan area. While the region has achieved measurable reductions in overall homelessness over the past decade, individuals living with untreated or inadequately managed behavioral health conditions remain disproportionately represented among the unsheltered population. This paper examines the cyclical relationship between mental illness and homelessness in Harris, Fort Bend, and Montgomery counties, highlighting systemic fragmentation between housing services, psychiatric care, and crisis response systems. Drawing on local data and national research, the analysis identifies gaps in supportive housing capacity, timely access to behavioral health treatment, and cross-system coordination. The paper evaluates policy options, including expanding permanent supportive housing, integrating multidisciplinary care teams, enhancing community-based mental health services, and implementing diversion strategies within the criminal justice system. It recommends a unified “Housing as Healthcare” framework that aligns public health investment, Medicaid financing mechanisms, and preventive mental health strategies to create a sustainable continuum of care. By institutionalizing integrated governance and stable funding, Houston can disrupt the cycle linking serious mental illness to chronic homelessness and advance a model in which homelessness becomes rare, brief, and non-recurring.

KEYWORDS: homelessness, severe mental illness, supportive housing, behavioral health integration, Medicaid policy, Houston metropolitan area

EXECUTIVE BRIEF

Mental health challenges considerably contribute to homelessness in the Houston metropolitan area. Many individuals face housing instability due to untreated or inadequately managed serious mental illnesses (SMI) and co-occurring behavioral health conditions, while homelessness frequently exacerbates these issues. Local data indicate that people experiencing homelessness in Houston/Harris County are disproportionately impacted by SMI, highlighting the importance of integrated strategies that address both behavioral health and housing insecurity.

My policy recommendation is that Houston should develop a coordinated investment strategy to expand rapid-access psychiatric services, increase supportive housing capacity, and enhance cross-system case management. Implementing a unified funding and governance framework that connects healthcare providers, housing agencies, and crisis response systems would help address the cyclical relationship between untreated mental illness and homelessness.

I. INTRODUCTION

Homelessness in the Houston metropolitan area, encompassing Harris, Fort Bend, and Montgomery counties, remains one of the region’s most complex public policy challenges. While Houston has been nationally recognized for its coordinated response model and measurable reductions in overall homelessness since 2011, the composition of the unhoused population has shifted in ways that demand renewed attention. In particular, severe mental illness (SMI) and co-occurring behavioral health disorders have become increasingly visible drivers of prolonged and unsheltered homelessness. The intersection of psychiatric vulnerability, housing instability, and fragmented service delivery has produced a cycle that is difficult to interrupt without deliberate and coordinated intervention. The 2025 Point-in-Time Count indicated that 56% of unsheltered individuals reported a diagnosed mental health condition, with 74% of those individuals stating that it substantially limited their ability to work or live independently (Ochoa, 2025). While the region has made progress in reducing overall homelessness since 2011, it is currently experiencing increases in unsheltered populations, reductions in specialized funding, and greater complexity in service provision (Arrieta & Gonzalez, 2024). This brief outlines the local factors connecting mental health challenges to homelessness, identifies key gaps within the system, and offers policy recommendations tailored to regional needs.

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

Recent local data underscore the scope of the problem. The Coalition for the Homeless of Houston/Harris County's annual Point-in-Time (PIT) Count continues to document disproportionately high rates of mental health conditions among individuals experiencing unsheltered homelessness (Coalition for the Homeless of Houston/Harris County, 2025; Daramola & Osho, 2017). A substantial share of respondents report a diagnosed mental health condition, and many indicate that their symptoms significantly limit their ability to secure employment, maintain stable housing, or navigate public systems independently. While PIT data rely on self-reporting and likely understate the full prevalence of untreated illness, the trend is consistent with national findings that severe mental illness is markedly overrepresented within homeless populations (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

Houston's experience mirrors broader structural patterns but also reflects distinctive local pressures. The metropolitan area's rapid population growth, rising housing costs in specific corridors, and the ongoing strain on public behavioral health infrastructure have intensified service gaps. Although the region has benefited from strong collaboration among local governments, nonprofit providers, and federal housing programs, recent fluctuations in funding streams and workforce shortages in mental health services have constrained capacity (Osho et al., 2020). Community mental health centers often operate with long waitlists, limited psychiatric appointment availability, and insufficient crisis stabilization beds, leaving many individuals without timely access to treatment (Texas Health and Human Services Commission, 2024; Daramola, A., & Osho, 2017). For individuals already living on the streets or cycling through shelters, these delays can translate into repeated emergency department visits, incarceration, or prolonged unsheltered homelessness (Osho et al., 2006; Ononugbo et al., 2006).

The relationship between homelessness and mental illness is bidirectional and mutually reinforcing. Untreated psychiatric conditions, including schizophrenia spectrum disorders, bipolar disorder, major depressive disorder, and severe post-traumatic stress disorder, can impair executive functioning, social relationships, and occupational stability, increasing vulnerability to housing loss. Conversely, the stressors associated with homelessness, sleep deprivation, exposure to violence, victimization, social isolation, and limited access to medication can worsen existing symptoms and trigger new episodes of mental health crises (Gilmore, Osho & Heads, 2013). This dynamic creates what policy scholars often describe as a "service trap," in which individuals repeatedly encounter fragmented systems that address symptoms episodically rather than stabilizing the underlying drivers of vulnerability (Culhane et al., 2019). Houston has made notable progress through its coordinated entry system and emphasis on Housing First principles. By prioritizing permanent supportive housing placements and improving interagency data sharing, the region significantly reduced chronic homelessness over the past decade (Coalition for the Homeless of Houston/Harris County, 2024). However, the recent rise in unsheltered homelessness suggests that housing production alone is insufficient when not paired with scalable behavioral health interventions. Permanent supportive housing programs require ongoing case management, psychiatric access, and wraparound services to sustain housing retention for residents living with serious mental illness. When these supports are limited, housing placements may be delayed, and individuals with acute psychiatric needs may remain in crisis on the streets (Osho, Ochonogor, & Ojumu, 2024).

Moreover, crisis response systems in Houston, like those in many large metropolitan areas, are stretched thin. Law enforcement officers, emergency medical personnel, and hospital emergency departments often serve as default responders to behavioral health emergencies (Woods & Osho, 2013). While crisis intervention training (CIT) programs and mobile crisis outreach teams have expanded in Texas, coverage remains uneven, and coordination between housing providers and mental health responders is not always seamless (Texas Judicial Commission on Mental Health, 2023). This fragmentation can lead to repeated short-term stabilization without long-term housing or treatment continuity. Another structural barrier lies in financing and governance. Behavioral health services are funded through a patchwork of Medicaid reimbursements, state block grants, county appropriations, philanthropic investments, and federal housing funds. These streams are often siloed, governed by distinct eligibility criteria and reporting requirements. Housing agencies may lack the clinical resources to address psychiatric crises, while healthcare providers may not have direct pathways to secure permanent housing placements for patients experiencing homelessness (Espinosa et al., 2008). Without an integrated funding and accountability framework, system actors are incentivized to address their portion of the problem rather than the whole.

Addressing mental health-related homelessness in Houston, therefore, requires more than incremental program expansion. It calls for a coordinated investment strategy that aligns psychiatric services, supportive housing development, and cross-system case management under a unified governance structure. Rapid-access psychiatric care, particularly low-barrier outpatient services and medication management, can prevent deterioration before individuals become chronically unsheltered (Belshaw et al., 2009). Expanding permanent supportive housing capacity ensures that individuals with serious mental illness have stable environments conducive to recovery. Strengthening cross-system case management can bridge hospitals, crisis response teams, housing providers, and community mental health centers, reducing duplication and closing service gaps.

This policy brief examines the specific ways in which untreated or inadequately managed serious mental illness contributes to homelessness in Houston's tri-county region (Johnson & Osho, 2026). It analyzes system-level gaps in psychiatric access, supportive

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

housing capacity, and governance coordination. Finally, it proposes a unified investment and oversight framework designed to disrupt the cyclical relationship between behavioral health instability and housing loss. By aligning healthcare and housing strategies, Houston can move beyond crisis management toward sustained stabilization and recovery for some of its most vulnerable residents.

II. PROBLEM STATEMENT

Despite Houston's nationally recognized progress in reducing overall homelessness during the past decade, a persistent subgroup of residents remains caught in long-term housing instability driven largely by untreated or poorly managed serious mental illness (SMI). Individuals living with conditions such as schizophrenia spectrum disorders, bipolar disorder, severe depression, and trauma-related disorders are disproportionately represented among those who remain unsheltered for extended periods. Local service providers consistently report that behavioral health needs, rather than the simple absence of shelter beds, are the primary barrier preventing many people from exiting homelessness (Coalition for the Homeless of Houston/Harris County, 2025). For many individuals, mental illness is not merely a consequence of homelessness but a precipitating factor. Symptoms including paranoia, cognitive impairment, mood instability, and impaired decision-making frequently interfere with employment retention, family relationships, and lease compliance. Without timely treatment, individuals may lose housing, disengage from support networks, and struggle to navigate application processes for assistance programs. National research shows that severe mental illness significantly increases the likelihood of becoming chronically homeless and decreases the probability of successfully maintaining housing without ongoing support (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Houston's outreach teams observe similar patterns: individuals with untreated psychiatric conditions often cycle repeatedly through short-term shelters, emergency rooms, and jail bookings rather than stabilizing in permanent housing.

Homelessness, in turn, worsens psychiatric vulnerability. Living outdoors or in unstable environments exposes individuals to sleep deprivation, victimization, extreme weather, and inconsistent medication access (Adams et al, 2022). These conditions intensify psychiatric symptoms and frequently lead to crisis episodes requiring emergency intervention. Hospitals and law enforcement agencies, therefore, function as de facto mental health providers, yet they are not designed to deliver sustained treatment or housing placement. The result is a revolving-door pattern in which individuals receive short-term stabilization but quickly return to homelessness once discharged (Texas Judicial Commission on Mental Health, 2023). A central driver of this cycle is fragmentation between housing and behavioral health systems. Housing programs often require stability and documentation that individuals in acute psychiatric distress cannot provide. At the same time, clinical providers may stabilize a patient medically but lack the authority or resources to secure housing. Funding streams reinforce this separation. Behavioral health services rely heavily on Medicaid reimbursement and state allocations, whereas housing programs depend on federal housing grants and local subsidies, each with different eligibility rules and timelines (Texas Health and Human Services Commission, 2024). Because these systems operate independently, individuals must navigate multiple agencies during periods of cognitive impairment, creating practical barriers to continuity of care.

Access to timely psychiatric care is also limited. Community mental health clinics frequently operate at capacity, and appointments for psychiatric evaluation or medication management can take weeks to obtain. During that waiting period, outreach workers may lose contact with clients, and symptoms may escalate to crisis levels. Without rapid-response care options, the system responds reactively rather than preventively, intervening only after a person's condition deteriorates enough to require emergency services. The absence of low-barrier treatment pathways, therefore, prolongs homelessness and increases public costs associated with emergency healthcare and incarceration (Culhane et al., 2019; Ononugbo et al., 2010). Supportive housing capacity presents an additional constraint. Permanent supportive housing has demonstrated strong effectiveness in stabilizing individuals with serious mental illness when paired with consistent case management and clinical care. However, the availability of such units in Houston remains insufficient relative to demand, particularly for individuals requiring intensive behavioral health support. When housing placements are delayed or disconnected from treatment services, individuals often disengage or relapse into crisis before stabilization can occur.

Thus, these conditions reveal a structural problem rather than a programmatic gap. The region's current approach addresses mental health treatment, housing placement, and crisis response through parallel systems that intersect only during emergencies. Without coordinated governance, shared accountability, and aligned investment priorities, individuals with serious mental illness continue to move between street homelessness, hospitals, and temporary shelters without achieving recovery or stability. Breaking this cycle requires an integrated strategy that simultaneously expands rapid psychiatric access, supportive housing availability, and cross-system case management within a unified framework capable of treating housing and mental health as inseparable components of the same public policy challenge (Adams et al., 2008)

III. POLICY OPTIONS

Houston’s homelessness response system has demonstrated that coordinated planning can significantly reduce overall homelessness; however, residents living with serious mental illness (SMI) continue to experience long-term instability because existing programs often operate in parallel rather than in concert. Addressing the behavioral health dimension of homelessness, therefore, requires policies that do more than add beds or expand clinics independently. The following options represent different but complementary approaches the region could pursue. Each option varies in cost, implementation complexity, and expected time to impact, but all are grounded in research demonstrating the importance of pairing housing stability with behavioral health treatment (SAMHSA, 2023; Culhane et al., 2019).

Option 1: Expand Permanent Supportive Housing

Permanent supportive housing (PSH) combines stable housing with voluntary services such as psychiatric care, substance use counseling, and life-skills support. Houston has already implemented Housing First principles within its coordinated entry system, yet demand continues to exceed supply for individuals requiring high-intensity behavioral health support. Expanding PSH capacity would target those repeatedly cycling through hospitals, shelters, and jail bookings due to untreated mental illness.

Under this option, the city and county would increase capital investment in PSH development while strengthening long-term service funding through partnerships with healthcare systems and Medicaid billing. Evidence from multiple metropolitan areas shows that supportive housing stabilizes residents with SMI and reduces emergency service utilization, often offsetting public expenditures in healthcare and criminal justice systems (National Alliance to End Homelessness, 2022).

Expand Supportive Housing Programs

Amplify the deployment of "Housing First" models, which provide permanent residential solutions alongside voluntary supportive services. Empirical evidence indicates these interventions significantly decrease chronic homelessness and enhance mental health outcomes.

Table 1. Permanent Supportive Housing Expansion: Core Components and Expected Outcomes

Policy Element	Description	Expected Impact
Housing production	Increase PSH units through public-private partnerships and low-income housing tax credits.	Reduces chronic homelessness
Service funding	Link housing residents to ongoing behavioral health treatment	Improves psychiatric stability
Data coordination	Use shared data tracking between housing and health agencies	Enhances retention rates

Option 2: Integrate Mental Health and Housing Services

Many individuals experiencing homelessness must navigate multiple agencies—housing intake offices, behavioral health clinics, and crisis responders while actively experiencing symptoms that impair decision-making (Ojumu et al, 2025). A coordinated care model would establish multidisciplinary teams comprising clinicians, case managers, peer specialists, and housing navigators, who would work under a shared care plan. This option emphasizes system integration rather than program expansion alone. Medicaid waivers and managed care partnerships could fund housing-related supports such as tenancy assistance, transportation, and medication monitoring. Studies of integrated care models show improved treatment adherence and reduced hospital readmissions among people with serious mental illness (Texas Health and Human Services Commission, 2024).

Table 2. Integrated Behavioral Health and Housing Care Coordination Model

Service Component	Current Situation	Proposed Change
Case management	Fragmented across agencies	Single care team per client
Medical follow-up	Episodic, crisis-driven	Continuous treatment coordination
Housing placement	Separate referral pathways	Direct placement through care teams

Establish multidisciplinary teams comprising case managers, mental health clinicians, and housing navigators to facilitate coordinated care. Promote the adoption of Medicaid waivers that finance housing-related support mechanisms.

Option 3: Enhance Accessibility to Community Mental Health Services

Even when individuals are willing to accept treatment, timely psychiatric care remains challenging to obtain. Appointment delays and transportation barriers often lead to disengagement before treatment begins. Expanding Certified Community Behavioral Health Clinics (CCBHCs), telepsychiatry services, and mobile outreach units would create low-barrier entry points into care.

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

CCBHC models provide 24-hour crisis response and same-day evaluation, reducing reliance on emergency departments and law enforcement intervention (SAMHSA, 2023). Mobile teams, particularly those embedded within outreach programs, can reach individuals reluctant to enter traditional clinics and maintain continuity after housing placement (Williams & Osho, 2010).

Table 3. Community Mental Health Access Strategies and Target Populations

Intervention	Primary Function	Target Population
CCBHC crisis services	Immediate psychiatric evaluation	Individuals in acute crisis
Telepsychiatry	Remote follow-up and medication management	Individuals with transportation barriers
Mobile outreach teams	Field-based engagement and treatment	Unsheltered populations

Allocate resources toward Certified Community Behavioral Health Clinics (CCBHCs) to provide continuous, 24/7 crisis intervention. Broaden telepsychiatry offerings and deploy mobile outreach units specifically targeting unhoused and marginalized populations.

Option 4: Decriminalize Mental Illness

Law enforcement officers frequently encounter individuals whose behavior stems from psychiatric distress rather than criminal intent. Without diversion options, these encounters often lead to incarceration, where treatment continuity is limited, and housing instability worsens upon release. Expanding diversion pathways, such as mental health courts, crisis intervention teams (CITs), and pre-arrest referral programs, can redirect individuals toward treatment rather than detention. Research indicates that diversion programs reduce recidivism and improve treatment participation when paired with community services (Texas Judicial Commission on Mental Health, 2023; Osho & Grant, 2011). This option would require coordination between courts, hospitals, and behavioral health providers to ensure treatment availability following diversion.

Table 4. Criminal Justice Diversion Pathways for Individuals with Mental Illness

Justice System Interaction	Traditional Outcome	Diversion Outcome
Crisis call	Arrest or emergency detention	Clinical assessment and referral
Minor offenses	Jail booking	Mental health court supervision
Repeat encounters	Recurring incarceration	Stabilization through treatment

Comparative Assessment

Implement diversion strategies redirecting individuals with mental health conditions from detention facilities to appropriate treatment settings via specialized mental health courts and diversion programs. Fund crisis intervention teams that integrate clinicians with law enforcement agencies to facilitate de-escalation and treatment. The following table summarizes the strengths and limitations of each option.

Table 5. Comparative Assessment of Major Policy Options

Policy Option	Advantages	Challenges
Expand Supportive Housing	Long-term stability; reduces public system costs	Requires capital investment and development time
Integrate Services	Improves coordination and retention	Administrative complexity and workforce needs
Expand Mental Health Access	Prevents crisis escalation	Ongoing operational funding required
Diversion Programs	Reduces incarceration and recidivism	Dependent on treatment capacity

IV. POLICY DIRECTION

Each option addresses a different point in the cycle linking mental illness and homelessness: housing stabilizes, treatment prevents deterioration, coordination sustains recovery, and diversion reduces harmful system entry. Implemented independently, they produce incremental improvements. Implemented together, they create a continuous pathway from crisis to stability. For Houston, the most effective approach would combine these strategies under a shared governance and funding framework so that housing, healthcare, and crisis response function as components of one system rather than separate interventions. Aligning investment across these areas would allow the region to move beyond managing episodes of homelessness toward preventing recurrence among residents living with serious mental illness. Here are some pros and cons for each policy option:

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

Table 6. Advantages and Implementation Challenges Across Proposed Policy Strategies

Policy Suggestion			Pros	Cons
Expand	Supportive	Housing Programs	• Proven to reduce chronic homelessness and improve stability. • Strong evidence base linking Housing First to better mental health outcomes. • Cost-effective over time by reducing emergency service use.	• Requires substantial upfront investment in housing units and services. • Limited availability of affordable housing stock. • Some communities may resist permanent supportive housing developments.
Integrate Mental Health and Housing Support Services			• Improves care coordination and reduces service fragmentation. • Multidisciplinary teams can address complex needs more efficiently. • Medicaid waivers can create sustainable funding streams for nontraditional services.	• Implementation requires cross-agency alignment and administrative capacity. • Medicaid waivers can take years to design and approve. • Workforce shortages (clinicians, case managers) may limit scalability.
Enhance	Accessibility	to Community Mental Health Services	• CCBHCs offer comprehensive, 24/7 crisis care that reduces reliance on emergency departments and jails. • Telepsychiatry and mobile units increase reach to unhoused individuals who face transportation barriers. • Expands preventive and early-intervention capacity.	• Requires ongoing state and federal investment to maintain clinic certification and staffing. • Technology and broadband gaps may limit telepsychiatry effectiveness. • Mobile outreach programs can be resource-intensive to operate.
Decriminalize Mental Illness			• Reduces incarceration of individuals with behavioral health conditions. • Mental health courts and diversion programs lower recidivism and increase treatment engagement. • Crisis intervention teams improve safety and reduce use-of-force incidents.	• Requires extensive training for law enforcement and judicial personnel. • Diversion programs depend on the availability of treatment beds and community services. • Cultural resistance may arise within traditional criminal justice settings.

Implementing a unified and coordinated investment strategy that expands rapid-response psychiatric services, enhances supportive housing options, and strengthens cross-system case management will provide Houston with the integrated services necessary to address the cycle between serious mental illness and homelessness.

V. RECOMMENDATIONS

Houston’s homelessness challenge cannot be resolved through housing expansion or clinical reform alone. The evidence suggests that severe mental illness and housing instability must be treated as interdependent public health concerns rather than parallel social service issues (SAMHSA, 2023; Knox, Adams, & Osho, 2017). To interrupt the cycle linking psychiatric vulnerability and chronic homelessness, policymakers should adopt a coordinated strategy grounded in prevention, treatment access, and long-term stabilization (Arungwa & Osho, 2024). The following recommendations outline a practical and fiscally grounded pathway forward. To mitigate homelessness attributable to mental health conditions, policymakers should:

1. Adopt a “Housing as Healthcare” Framework

Implement a "Housing as Healthcare" paradigm, emphasizing the deployment of permanent supportive housing as a critical component of public health intervention (Adams et al, 2007). Partner with hospital systems to co-fund supportive housing placements, given the cost savings associated with reduced emergency room utilization. Pursue state-level funding via the Texas Department of Housing and Community Affairs (TDHCA) to support the development or rehabilitation of supportive housing units. A growing body of research demonstrates that stable housing functions as a health intervention, particularly for individuals living with serious mental illness (National Alliance to End Homelessness, 2022; Osho & Williams, 2013). Without consistent shelter, medication adherence, treatment engagement, and symptom stabilization become significantly more difficult. Houston should formally adopt a “Housing as Healthcare” framework that positions permanent supportive housing (PSH) as a core component of its behavioral health infrastructure rather than solely as a housing policy initiative.

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

Under this framework, public health agencies, hospital systems, and housing authorities would align funding and performance metrics. Hospitals in the Houston region absorb substantial uncompensated costs associated with repeated emergency room visits by individuals experiencing homelessness and psychiatric crises. Research indicates that supportive housing placements can significantly reduce avoidable emergency department utilization and inpatient admissions (Culhane et al., 2019; Amadi & Osho, 2025).

Action Steps:

Co-Funding Agreements with Hospitals: Develop cost-sharing partnerships between major healthcare systems and local housing agencies. Hospitals could invest community benefit dollars into supportive housing placements for high-utilizer patients, recognizing downstream cost savings.

State Housing Investment: Pursue competitive funding through the Texas Department of Housing and Community Affairs (TDHCA) to expand or rehabilitate supportive housing units specifically designated for individuals with serious mental illness.

Table 7. Housing as Healthcare Implementation Framework and Responsible Stakeholders

Recommendation Component	Lead Stakeholders	Expected Outcome
Hospital–Housing Partnerships	Hospital systems, Harris County Public Health	Reduced ER utilization and inpatient admissions
TDHCA Funding Applications	City of Houston, County Housing Authorities	Increased PSH supply
Data Sharing Agreements	Housing & Health Agencies	Improved targeting of high-risk individuals

2. Expand Medicaid Coverage for Housing-Related Supports

Expand Medicaid coverage to encompass housing-related supports and intensive case management services. Seek federal approval for a Medicaid 1115 waiver amendment to fund housing transition services, tenancy supports, and intensive case management for individuals with serious mental illness. While Medicaid traditionally does not pay for housing itself, federal policy has increasingly allowed states to fund housing-related support services that help individuals transition into and maintain stable housing. These services include tenancy support, housing navigation, and intensive case management for individuals with complex behavioral health needs (Texas Health and Human Services Commission, 2024). Houston policymakers, in coordination with the State of Texas, should pursue a Medicaid 1115 waiver amendment to expand reimbursement for housing transition services and sustained tenancy support for individuals with serious mental illness. Such reforms would create a sustainable financing stream for services that are currently grant-dependent and inconsistent across providers.

Action Steps:

1115 Waiver Amendment: Collaborate with state leadership to request federal approval for expanded Medicaid funding covering housing transition assistance, landlord mediation, and intensive case management. **Managed Care Alignment:** Engage Medicaid managed care organizations to incentivize investment in supportive housing services for high-cost beneficiaries experiencing homelessness.

Table 8. Medicaid Housing-Related Support Expansion and Anticipated Outcomes

Medicaid Reform Element	Policy Mechanism	Impact on Homelessness
Housing Transition Services	1115 Waiver Amendment	Faster movement from street/shelter to housing
Tenancy Support Services	Medicaid Reimbursement	Increased housing retention rates
Intensive Case Management	Managed Care Incentives	Reduced psychiatric crises

Expanding Medicaid-funded housing supports would strengthen continuity of care while reducing reliance on episodic emergency interventions (Adams & Osho, 2008).

3. Invest in Prevention and Early Intervention

Allocate resources toward preventive care initiatives, including early intervention programs and mental health services within educational settings (Bentley & Osho, 2004). Direct state mental health block grant funding toward early intervention strategies, such as school-based behavioral health services and youth crisis programs. Apply for federal grants, such as SAMHSA’s Children’s Mental Health Initiative or Project AWARE, to support the enhancement of school- and community-based prevention services (Reeves & Osho, 2010). Long-term reductions in homelessness require upstream investment. Many adults experiencing chronic homelessness report that untreated behavioral health conditions began in adolescence or early adulthood. Early identification and school-based mental health services can significantly reduce long-term instability (SAMHSA, 2023).

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

Houston-area policymakers should allocate a portion of state mental health block grant funding toward preventive services, including school-based behavioral health programs, youth crisis stabilization initiatives, and early psychosis intervention programs. By addressing psychiatric symptoms before they escalate into school dropout, family conflict, or justice involvement, the region can reduce future homelessness risk (Moore & Osho, 2017).

Action Steps:

State Block Grant Allocation: Direct mental health block grant funds toward expanding behavioral health clinicians within public schools and youth-focused crisis programs (Osho & Raphael, 2008).

Federal Grant Applications: Pursue competitive grants such as SAMHSA’s Children’s Mental Health Initiative or Project AWARE to strengthen early intervention infrastructure.

Table 9. Prevention and Early Intervention Strategies to Reduce Future Homelessness Risk

Prevention Strategy	Target Population	Long-Term Benefit
School-Based Behavioral Health	K–12 Students	Early detection of psychiatric conditions
Youth Crisis Programs	Adolescents in crisis	Reduced justice system entry
Early Psychosis Intervention	Young adults	Improved long-term stability

Prevention investments do not yield immediate visible reductions in unsheltered counts, but over time, they address the root conditions that contribute to chronic homelessness.

Integrated Implementation Approach: Individually, these recommendations address distinct system gaps: housing supply, service financing, and early prevention. Together, they form a continuum of care spanning crisis response, stabilization, and long-term prevention. A unified governance structure potentially housed within a cross-agency task force should oversee implementation to ensure that funding streams are aligned and that performance metrics are shared across housing, healthcare, and justice systems. By treating housing stability as an extension of healthcare, expanding Medicaid-funded support services, and investing in preventive behavioral health infrastructure, Houston can move beyond crisis management toward a sustained public health solution that reduces homelessness linked to severe mental illness while strengthening community well-being (Adams & Osho, 2007).

VI. CONCLUSION

Homelessness in the Houston metropolitan region cannot be understood solely as a housing shortage nor solely as a healthcare gap. For a substantial portion of the population living unsheltered, severe mental illness both contributes to housing loss and worsens as a consequence of life without a stable shelter. Psychiatric symptoms interfere with employment, relationships, and the ability to navigate assistance programs, while the instability of homelessness intensifies stress, trauma exposure, and treatment disruption. The result is a reinforcing cycle in which individuals rotate among shelters, hospitals, and the justice system without achieving lasting stability (SAMHSA, 2023). Breaking this pattern requires policy responses that treat housing stability and behavioral health treatment as inseparable components of the same public responsibility.

Houston already offers important examples demonstrating that progress is possible when systems operate together rather than independently. Collaborative initiatives such as Healthcare for the Homeless services, programs administered through the Harris Center for Mental Health and IDD, and multidisciplinary outreach teams affiliated with academic medical partners have shown measurable reductions in emergency utilization and improvements in housing retention for high-need populations (Texas Health and Human Services Commission, 2024). These programs succeed not because they provide housing alone or treatment alone, but because they combine both while maintaining consistent engagement with individuals who might otherwise remain disconnected from care. Their results suggest that the central challenge facing the region is not the absence of effective models, but the limited scale and uneven coordination of those models (Vairez et al, 2017).

Moving forward, the policy direction is clear. Permanent supportive housing must be expanded so individuals living with serious mental illness have environments that support recovery rather than undermine it. Behavioral health services must be accessible quickly enough to prevent crises rather than respond after deterioration occurs. Outreach must prioritize individuals least able to seek services independently, including those experiencing long-term unsheltered homelessness. At the same time, preventive investments, particularly youth behavioral health supports, are necessary to reduce future inflows into homelessness. Evidence consistently shows that when these elements are implemented together, communities experience fewer hospitalizations, fewer jail encounters, and higher housing stability rates (Culhane et al., 2019; Osho et al., 2016). Equally important is sustained coordination. Housing agencies, healthcare providers, crisis responders, and courts often share the same clients but operate under different funding rules and accountability structures. Without shared governance and aligned financing, individuals remain responsible for navigating fragmented systems during periods of impaired functioning. Institutionalizing cross-system collaboration, supported by stable funding streams and shared outcome measures, would allow Houston to transition from managing episodes of homelessness to preventing recurrence.

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

Houston has already demonstrated that coordinated action can reduce homelessness at scale. The next phase requires strengthening that approach by integrating behavioral health treatment more deeply into housing policy and expanding proven programs to meet current demand. Acting now through targeted investment, structured collaboration, and long-term planning would help ensure that homelessness becomes rare, brief, and non-recurring rather than cyclical (Adams & Osho, 2006). In doing so, the region would not only improve public safety and fiscal efficiency but also affirm a broader commitment: that residents facing mental illness and housing instability are not temporary problems to be managed, but neighbors whose stability contributes to the health of the entire community.

REFERENCES

- 1) Adams, M. O., Osho, G. S., & Bonner, F. C. (2007). Immigration and Healthcare Systems in the United States: Policy and Administrative Implications. *European Journal of Social Sciences*, 5(1), 1–10.
- 2) Adams, M. O., & Osho, G. S. (2008). Migration, Immigration and the Politics of Livable Space: Immigration and Local Housing Issues in the United States. *RES. J. INT'L STUD.*, 8, 5-9.
- 3) Adams, M. O., Osho, G. S., & Hadnott, C. D. (2008). The Consequences And Public Policy Implications Of Welfare Reform: A Cost-Benefit Analysis Of The Welfare Reform Policy. *Journal of Business & Economics Research*, 6(4), 53.
- 4) Adams, M. O., & Osho, G. S. (2006). Drugs Company Profits In The United States: Are They Excessive? Evidence From Public Administration Perspectives—*Journal of Business & Economics Research (JBER)*, 4(2).
- 5) Adams, M. O., Johnson, L. A., & Osho, G. S. (2022). Public Opinions of Black Democrats in Texas: An Empirical Investigation. *Journal of Public Administration and Governance*, 12(4), 3546–3546.
- 6) Amadi, V., & Osho, G. S. (2025). Causal Effects of Low Income on Obesity: Business and Health Insights From a National Survey and Machine Learning Analysis With Applied Econometrics Technique. *The Journal of Applied Business and Economics*, 27(4), 302–312.
- 7) Arungwa, S., & Osho, G. S. (2024). Policy implications and cost of prevention of juvenile delinquency: A willingness survey of college-educated adults for Communities That Care. *Journal of Sociological Research*, 15(1), 32–54.
- 8) Adams, M., & Osho, G. (2007). The effects of performance assessment and communication systems (PACS) on Social Security Administration's production. *International Bulletin of Business Administration*, 1(2), 6–10.
- 9) Arrieta, V., & González, E. (2024, May 31). Houston's homeless population reports more mental illness than the national average. *Community Impact*. <https://communityimpact.com/houston/bay-area/nonprofit/2024/05/31/houston-homeless-population-reporting-more-mental-illness-than-national-average/>
- 10) Belshaw, H. S., Rodriguez, J., & Osho, G. S. (2009). Does color matter in Houston, Texas? An empirical analysis of the impact of race on homicides. *Contemporary Issues in Criminology and the Social Sciences*, 3(4), 21–47.
- 11) Bentley, B. T., & Osho, G. S. (2004). The Efficacy of Remedial Education Program on Houston's At Risk Youth. *Journal of College Teaching & Learning*, 1(12), 65–70.
- 12) Coalition for the Homeless of Houston/Harris County. (2024). Houston area homelessness trends and coordinated response outcomes. <https://www.cfthhouston.org>
- 13) Coalition for the Homeless of Houston/Harris County. (2025). 2025 Point-in-Time count results highlight shifts in homelessness across Houston. <https://www.cfthhouston.org/2025-pit-results>
- 14) Culhane, D. P., Metraux, S., Byrne, T., Stino, M., & Bainbridge, J. (2019). The age structure of contemporary homelessness: Evidence and implications for public policy. *Analyses of Social Issues and Public Policy*, 19(1), 141–167. <https://doi.org/10.1111/asap.12190>
- 15) Daramola, A., & Osho, G. S. (2017). The relevance of the social control theory in explaining crime among African Americans. *Journal of Sociological Research*, 8(1), 204-223.
- 16) Daramola, A., & Osho, G. S. (2017). Race, Ethnic Drug Use, and Delinquency in Public Schools among High School 12th Graders. *Journal of Social Science Studies*, 4(2), 29–41.
- 17) Espinosa, E. M., Belshaw, S. H., & Osho, G. S. (2008). Justice by gender: Understanding the role of gender in disposition decisions involving out-of-home placement for juvenile offenders. *American Journal of Criminal Justice*, 33(2), 267–281.
- 18) Gilmore, A. D., Osho, G. S., & Heads, A. B. (2013). Stress, anxiety, depression, and psychological responses among African Americans: Empirical investigation and coping strategies. *American Journal of Health Sciences—Third Quarter*, 4(3).
- 19) Johnson, T., & Osho, G. S. (2026). Illiteracy and mental disorders in Texas prisons: A policy framework for accountability and recidivism reduction. *International Journal of Judicial Law*, 5(3), 48–57.
- 20) Knox, R., Adams, M. O., Arungwa, S., & Osho, G. S. (2020). A Practical Guide for Policy Analysis on Affirmative Action Policy. *Journal of Public Administration and Governance*, 10(3), 112-121

Healing the City: Housing as Healthcare—A Coordinated Mental Health and Housing Policy Framework to Reduce Homelessness in Houston¹

- 21) Knox, R., Adams, M. O., & Osho, G. S. (2017). History and Relevance of Patronage, the Civil Service Reform, and the Pendleton Act: The Rationale for Congressional Intervention. *J. Pub. Admin. & Gov.*, 7, 55.
- 22) National Alliance to End Homelessness. (2022). Permanent supportive housing: Evaluating the evidence for improving health and housing stability. <https://endhomelessness.org>
- 23) Moore, A. N., & Osho, G. S. (2017). An assessment of adolescent pregnancy and social risk factors: Evidence from agencies and organizations in the juvenile justice system. *International Journal of Social Work*, 4(2), 1–14.
- 24) Ochoa. F. (2025). Press Release: CFTH's 2025 Point-in-Time Count Results Highlight Shifts in Homelessness Across Houston. Coalition for the Homeless of Houston/Harris County
- 25) Ojumu, O., Amadi, V., & Osho, G. S. (2025). Quantitative Modeling of the Critical Impact of Socioeconomic Status on Body Mass Index Using Double Machine Learning. *Global Journal of Health Science*, 17(6).
- 26) Ononugbo, V. I., Akpan, A. I., & Osho, G. S. (2010). An empirical analysis and assessment of housing needs for the low-income people of Enugu metropolitan areas of Nigeria: Evidence from statistical housing model approach. *European Journal of Social Sciences*, 13(2), 243–270.
- 27) Ononugbo, V. I., Akpan, A., Osho, G. S., & Kritsonis, W. A. (2010). Housing needs for the low-income people of Enugu metropolitan areas of Nigeria: Policy issues and challenges. *International journal of management, business and administration*, 13(1), 1–40.
- 28) Osho, G. S., & Raphael, J. J. (2008). Are The Home Prices Really Affected By The Quality Of The Public Schools: A Policy Analytical Perspective?. *Journal of Business & Economics Research*, 6(1).
- 29) Osho, G. S., Ochonogor, K. N., & Ojumu, M. (2024). Optimizing supply chain management with data analytics for data-driven decisions: Insights and lessons from Radienz Living. *International Journal of Technical & Scientific Research Engineering*, 7(3), 1–7.
- 30) Osho, G. S., Adams, M., Coleman, Q., & Uwakonye, M. (2020). 2020 Stimulus Coronavirus Aid, Relief and Economic Security Act: Comparative Analysis of President Roosevelt's New Deal Programs and President Obama's American Recovery and Reinvestment Act of. *Journal of Social and Development Sciences (ISSN 2221-1152)*, 11(1), 19–26.
- 31) Osho, G., Adams, O. M., Jones, R. N., & Onwudiwe, D. I. (2006). An empirical analysis of the Federal Emergency Management Agency. *International Bulletin of Business Administration*, 1(1), 127–135.
- 32) Osho, S. G., & Grant, M. (2011). Substance use of repeat juvenile offenders: an empirical investigation. *European Journal of Social Sciences*, 19(4), 492–498.
- 33) Osho, G. S., Joseph, J., Scott, J., & Adams, M. (2016). An investigation of juvenile gang membership and psychopathic behavior: Evidence from multilinear analysis. *International Journal of Social Work*, 3(2), 29–48.
- 34) Osho, G. S., & Williams, F. (2013). An investigation of offender and victim relationships in a sample of juvenile homicides in California. *Journal of Sociological Research*, 4(1), 185–194. <https://doi.org/10.5296/jsr.v4i1.3005>
- 35) Reeves, T. C., & Osho, G. S. (2010, March). THE SATISFACTION OF COMMUNITY COLLEGE STUDENTS REGARDING DISTANCE EDUCATION VERSUS TRADITIONAL EDUCATION. In *National Forum of Applied Educational Research Journal (Vol. 23, No. 3)*.
- 36) Substance Abuse and Mental Health Services Administration. (2023). Behavioral health services for people experiencing homelessness: Evidence-based practices resource guide. U.S. Department of Health and Human Services. <https://www.samhsa.gov>
- 37) Texas Health and Human Services Commission. (2024). Texas behavioral health system performance and access report. <https://www.hhs.texas.gov>
- 38) Texas Judicial Commission on Mental Health. (2023). Diversion and treatment best practices for justice-involved individuals with mental illness. <https://www.txcourts.gov>
- 39) UTHHealth Houston. (2025). Homeless Outpatient Mental Health Expansion Services (HOMES) program. <https://med.uth.edu/psychiatry/uthealth-houston-homeless-outpatient-mental-health-expansion-services-uthealth-houston-homes/>
- 40) Williams, F., & Osho, G. S. (2010). Are We Losing the War on Drugs? The Relationship between Drug and Juvenile Delinquency? Evidence from a Statistical Perspective. *European Journal of Social Sciences*, 13(3).
- 41) Woods, D. A., & Osho, G. S. (2013). Is the United States juvenile justice system working: an empirical investigation from the life course approach. *J. Public Admin. Governance*, 3, 142–152.
- 42) Vairez Jr, M. R., Hermond, D. S., Gomez Jr, F. C., & Osho, G. S. (2017). Factors that contribute to the disparity in academic achievement of students from southern Belize. *Caribbean Quarterly*, 63(1), 83–108.