



National  
Mental  
Health  
Association

# An Advocate's Guide to Expanding Housing Options for People Who Have Mental Illnesses





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*“One of the most critical things that we learned from consumers before we started developing housing in our community is that people who have mental illnesses don’t want housing, they want homes. Understanding this concept was key during our planning process.”*

— James Glenn, senior vice president of housing and community services, MHA of the Heartland (Mo.)

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*“It’s important that stakeholders in communities realize that housing, employment, and transportation are the three primary legs of the consumer support stool — each of these options need to be available for people who have mental illnesses in order for them to live successfully in the community.”*

—John Tote, executive director,  
MHA of North Carolina

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*“If an MHA wants to expand housing in the community, it must have a staff person that can dedicate all of their time to this type of a project. Executive directors cannot do it all by themselves.”*

— Mike Brose, executive director,  
MHA of Tulsa (Okla.)

## Introduction

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*There's no place like home. Home is where the heart is. Home sweet home.* For most Americans, these long-held adages represent reality. But for many people who have mental illnesses, these adages reveal only unfulfilled dreams.

The overwhelming majority of people who have mental illnesses are capable of living independently in their own homes.<sup>1</sup> Unfortunately, millions of people who have mental illnesses stand little chance of obtaining safe, decent and affordable housing.<sup>2</sup> Many factors contribute to this situation including low incomes, high rents, stigma and discrimination, and lack of accessible and appropriate support services. In fact, in the United States, approximately 60,000 people with mental health-related illnesses live in psychiatric institutions<sup>3</sup>; another 312,000 live in state correctional facilities<sup>4</sup>; and, as many as 175,000 are homeless on any given night.<sup>5</sup>

Moreover, research shows that an unstable living situation is a primary precipitant of psychiatric hospitalization, and a significant factor leading to extended lengths of hospital stays.<sup>6</sup> When successful community-based support programs—including housing programs—are in place, more people who have mental illnesses can live in their own homes or in community-based alternatives. Living at home or in another community-based alternative increases a person's self-confidence and quality-of-life, which in turn, aids in recovery. Living in the community is not stigmatizing, costs less to taxpayers, and allows people who have mental illnesses to be closer to their natural support systems, such as families and friends, which decreases their dependence on the overburdened mental health care service system.

The purpose of this manual is to:

- Help Mental Health Associations (MHAs) understand the dire need for affordable and safe housing.
- Help communities understand that people who have mental illnesses need a continuum of housing options.
- Work collaboratively with others in the community to address the current housing shortage.
- Implement housing and community support services that make stable housing a reality for people who have mental illnesses.

Although the nation's housing shortage is too large a problem for any one organization to tackle, organizations and advocates who are willing to work together have—and will continue to—improve the situation.

This document provides the basic information needed to begin discussions on various housing options and offers information about how to start a coalition to address housing needs. People who have mental illnesses need a wide variety of housing options and access to an array of support services to retain their housing.

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1. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. *Overcoming Barriers to Community Integration for People who have mental illnesses*. pp. 31. 2001.

2. Technical Assistance Collaborative and Consortium for Citizens with Disabilities Housing Task Force. *Going It Alone: The Struggle to Expand Housing Opportunities for People with Disabilities*. August 2000.

3. U.S. Department of Health and Human Services. "Overcoming barriers to Community Integration for People who have mental illnesses. Delmar, N.Y., 2001.

4. Department of Justice. "Mental Health Treatment in State Prisons." 2000.

5. Center for Mental Health Services. Homeless Programs Fact Sheet. <http://www.mentalhealth.org/cmhs/Homelessness/default.asp>

6. Mize, Timothy I.; Paolo-Calabrese, Michelle A.; Williams, Thelma J.; and Margolin, Helen K. "Managing the Landlord Role: How Can One Agency Provide Both Rehabilitation Services and Housing with Collaboration." *Psychiatric Rehabilitation Journal*. Vol.22, No. 2, Fall 1998. pp. 117-122.



## Section One **Obstacles and Barriers to Obtaining Housing**

There are several factors that contribute to and prohibit people who have mental illnesses from obtaining and retaining their housing. Unfortunately, more often than not, the factors have little to do with one's ability to live independently in the community and more to do with political and financial factors that make it difficult to secure or hold onto safe and decent housing.

### **Low Incomes**

Studies provide empirical evidence that the increased number of people who have mental illnesses living on the streets is not the result of "emptying" psychiatric institutions but is more likely caused by the inadequate housing available to people who have marginal income support, as well as the poor follow-up care provided to people leaving acute care hospitals after crisis episodes.<sup>7</sup> Minimum wage jobs and insufficient Social Security Income (SSI) benefits make it extremely difficult, if not impossible, to afford safe and decent housing.

In fact, an estimated 3.5 million people who have disabilities between the ages of 18 and 64 receive federal Supplemental Security Income (SSI) benefits. In 2000, these benefits were equal to a monthly income of \$512, or an annual income of \$6,144.<sup>8</sup> In contrast, an individual working full-time at the federal minimum wage earns a monthly income of \$917, or an annual income of \$11,000.<sup>9</sup>

The Department of Housing and Urban Development (HUD) considers housing to be affordable to a low-income family as long as the cost of the housing, including rent or mortgage payments plus basic utilities (minus telephone service), does not exceed 30 percent of the household income. HUD has termed this the Fair Market Rent (FMR) and it varies by location. Based on HUD's FMRs, people who receive SSI and earn minimum wage or just above minimum wage could afford the following monthly housing costs:

Annual Income	Affordable Monthly Housing Cost
\$6,000 (SSI) .....	\$150
\$11,000 (federal minimum wage) .....	\$275
\$15,000 .....	\$375
\$20,000 .....	\$500

(Technical Assistance Collaborative. Federal Housing Resource Guide available at [www.tacinc.org](http://www.tacinc.org). p. 1. July 2001.)

In 2000, there was not a single housing market in the country in which a person who has a disability and receives SSI benefits could afford to rent a modest efficiency or one-bedroom apartment based on HUD's definition of affordable housing.<sup>10</sup> On average, a person would have to spend over 98 percent of his or her SSI check to pay for a modest one-bedroom apartment. And even if these individuals were able to afford to rent apartments in their communities, they would have no additional money for food, clothing or other necessities.

In an effort to meet the needs of people with minimal incomes, the federal government has developed programs such as Section 8 rent subsidy vouchers, Shelter Plus Care and HOME. These programs are designed to make housing more affordable for low-income individuals and families and are described in more detail in Section Six.

7. Rothbard, Aileen B., Sc.D., et al. "Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A 3-year Follow-Up Study." *The American Journal of Psychiatry* 156:920-927, June 1999.

8. Technical Assistance Collaborative and Consortium for Citizens with Disabilities and Housing Task Force. *Priced Out in 2000: The Crisis Continues*. June 2001.

9. Technical Assistance Collaborative. *Federal Housing Resource Guide*. July 2001.

10. Technical Assistance Collaborative and Consortium for Citizens with Disabilities and Housing Task Force. *Priced Out in 2000: The Crisis Continues*.

To overcome the barrier of minimal incomes, there are several campaigns that MHAs can support and participate in. One such campaign is Universal Living Wage (ULW). ULW supports the premise that a person working 40 hours a week should be able to afford an efficiency apartment at FMR without spending more than 30 percent of one's gross monthly income on housing. The ULW will vary in accordance with each community's FMR (visit [www.universallivingwage.org](http://www.universallivingwage.org))

In addition, housing advocates are working to establish a National Housing Trust Fund to build and preserve 1.5 million units of rental housing over the next 10 years for the lowest income families. Although this fails to directly address the issue of minimal incomes, it does ensure low-income housing in the community and helps prevent homelessness (visit [www.nhtf.org](http://www.nhtf.org)).

### **Stigma and Discrimination**

People who have mental illnesses struggle not only with minimal incomes and high housing costs but also face daily stigma and discrimination. This prejudice often surfaces in communities where organizations are planning to build or renovate housing that is designated for people who have mental illnesses. Called NIMBYism, or the Not-In-My-Back-Yard mentality, this neighborhood reaction is often triggered by changes in communities that residents deem unpleasant or disruptive. Such neighborhood opposition can be aimed at a variety of issues such as the establishment of a community pool, plans to create a four-lane highway in a small town—or designating or constructing apartment buildings for people who have mental illnesses.

NIMBYism is prevalent in many communities. For example, in Purcellville, Va., residents appeared before the Board of Supervisors to request that it abandon a plan to establish a new group home for people who have mental illnesses. Some speakers complained that another group home in the community would raise public safety concerns; others expressed fear of the group home residents; and still others expressed concerns about potential decreases in area property values.<sup>11</sup>

Mental Health Associations implementing housing options in their communities can be faced with similar community resistance if they are inadequately prepared. The Mental Health Association in North Carolina (MHA-NC) has expanded housing options for people who have mental illnesses across the state. However, MHA-NC minimizes NIMBYism by meeting with community residents one-on-one, providing information about mental illnesses as necessary, and showing residents the success of other housing options they manage.

There are two primary myths that contribute to mental health-related stigma: (1) People who have mental illnesses are violent and (2) people who have mental illnesses do not recover.<sup>12</sup> In fact, researchers concluded in a May 1998 report indistinguishable violence rates between people who have mental illnesses and their “well” neighbors in the community.<sup>13</sup> Research also indicates that most people who were formerly considered long-stay psychiatric patients are able to live in residential settings while receiving community outpatient treatment and

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11. Morton, Margaret. “Purcellville Residents Push for Reversal of Group Home Purchase.” *Leesburg2day*. September 18, 2002. <http://www.leesburg2day.com>.

12. Rogers, Susan. *Fighting Stigma*. National Mental Health Consumers' Self-Help Clearinghouse.

13. Steadman, Henry J., Ph.D., et al. “Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhood.” *Archives of General Psychiatry* Vol. 55, May 1998.

intensive case management services at a reduced cost.<sup>14</sup> Stable housing, strong community supports, and effective treatment all contribute to recovery of people who have mental illness. The recently released report of the President's New Freedom Commission on Mental Health supports the notion that recovery should be the standard of care and not the exception.

Stigma and discrimination prevent people who have mental illnesses from obtaining jobs, securing housing and socializing in the community. This is not because people who have mental illnesses are unable to work, care for their homes or socialize; it is because prevailing myths and misperceptions about mental illness result in unfounded fear, mistrust and lost opportunities. Educating community members about mental health and mental illness is key to eliminating stigma and discrimination.

It is recommended that MHAs develop public education plans or campaigns before implementing housing programs to prepare for and preempt possible community resistance. Several anti-stigma campaigns offer materials and guidance for successful education activities. Two specific and useful resources are the National Stigma Clearinghouse (visit [community-2.webtv.net/stigmanet](http://community-2.webtv.net/stigmanet)) and the Resource Center to Address Discrimination and Stigma (visit [www.samhsa.gov/stigma](http://www.samhsa.gov/stigma)).

### **Zoning Laws**

Legal struggles with towns and local neighborhoods as well as restrictive zoning ordinances have also historically made locating community residences for people who have mental illnesses a difficult proposition.<sup>15</sup> For example, seven men in West Haven, Conn. were denied a request to establish a drug and alcohol recovery residence in a single-family neighborhood due to a zoning law that said no more than three unrelated people could occupy a house. Fortunately, in 1997, after an eight-day trial, a U.S. District Court Judge found the city had violated the federal Fair Housing Amendments Act (FHAA) and the Americans with Disabilities Act (ADA).<sup>16</sup>

Also in 1997, a U.S. District Court Judge "struck down" a 17-year-old section of state zoning law that allowed municipalities to place special zoning limits on state-licensed group homes, halfway houses and supervised apartments for seven to 15 people. This decision meant that thousands of adults with disabilities who were on waiting lists for homes would get them and hundreds of residents of two state institutions that were slated to close in the next year would be able to stay.<sup>17</sup>

Although zoning ordinances have been improved, there are still local zoning codes and ordinances that prevent people who have disabilities from having equal access to housing. In Indiana, for example, a zoning ordinance excludes a residential facility for people who have mental illnesses to be established within 3,000 feet of a similar residential facility.<sup>18</sup> While this may seem insignificant, it can be construed as denying equal rights to housing for people with disabilities.

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14. Rothbard, Aileen B., Sc.D., et al. "Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A 3-year Follow-Up Study." *The American Journal of Psychiatry* 156:920-927, June 1999.

15. Zipple, Anthony M. and Anzer, Thomas C. "Building Code Enforcement: New Obstacles in Siting Community Residences." *Psychosocial Rehabilitation Journal*. Vol. 18, No. 1, pp. 7-11. July 1994.

16. Scheffey, Thomas. "The House of Seven 'Does' Wins Big." *Connecticut Law Tribune*. January 18, 2002. [www.law.com](http://www.law.com).

17. Leusner, Donna. "Zoning to Exclude Disabled Eliminated." *The Star-Ledger*. New Jersey. January 6, 1997.

18. "Chapter 4. Residential Facilities for Developmentally Disabled Individuals and Mentally Ill Individuals." <http://www.in.gov/legislative/ic/code/title12/ar28/ch4.pdf>

The FHAA prohibits a broad range of practices that discriminate against people on the basis of race, color, religion, sex, national origin, familial status and disability. Although the act does not preempt local zoning laws, it does apply to municipalities and other local government entities, and prohibits them from making zoning or land use decisions or implementing land use policies that exclude or otherwise discriminate against protected people, including people who have disabilities.<sup>19</sup>

Advocates must become familiar with the FHAA and discriminatory zoning laws in their communities before they can change them. They must also learn the local process for changing such laws. With hard work, patience and understanding, these types of rules and regulations can be changed to benefit people who have mental illnesses.

### **Rental Market Discrimination**

The 1988 Fair Housing Amendment Act or FHAA prohibits discrimination in the sale or rental of housing on the basis of disability and has established guidelines that govern what questions a landlord can ask during the screening and application process for possible tenants.<sup>20</sup> Unfortunately, some landlords still ask questions and base decisions about tenancy that discriminate against potential residents. According to the National Fair Housing Alliance, 70 percent of all housing discrimination complaints are filed by African Americans, people with disabilities and families with children. In 2002, the percentage of complaints filed by African Americans dropped slightly, those filed by families with children remained level, and those filed by people with disabilities modestly increased.<sup>21</sup>

One of the best ways for people who have mental illnesses to protect themselves is to know what a landlord legally can and cannot ask, and on what basis a landlord can deny a potential renter's or owner's application. The following questions are legal as long as the landlord asks all potential renters and does not discriminate on the basis of race, color, religion, sex, disability, familial status or national origin:

- Can and will you pay rent on time?
- Will your tenancy be a threat to the health and safety of others?
- Will you obey the rules outlined in your rental agreement?
- Can you provide past rental references?
- Are you currently using illegal substances?

Questions that landlords cannot ask include:

- Do you have a disability, including a psychiatric disability?
- Do you have AIDS or HIV?
- Can I see your medical records?
- Can you live independently?
- Do you receive disability benefits?

This last bullet is a bit tricky because although landlords cannot ask outright if someone is receiving disability benefits, they do have the right to ask if one can pay rent on time and ask

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19. United States Department of Justice. "Joint Statement of the Department of Justice and the Department of Housing and Urban Development: Group Homes, Local Land Use, and The Fair Housing Act." [www.usdoj.gov/crt/housing/finals8\\_1](http://www.usdoj.gov/crt/housing/finals8_1).

20. Judge David L. Bazelon Center for Mental Health Law. Fair Housing Information Sheet #5: Disability Discrimination in the housing Application and Screening Process. [www.bazelon.org/fhinfosheet5](http://www.bazelon.org/fhinfosheet5).

21. National Fair Housing Alliance. 2003 Fair Housing Trends Report. [www.nationalfairhousing.org](http://www.nationalfairhousing.org). Retrieved May 2003.

for proof of income. How much a person wants and chooses to disclose is a decision that can only be made by the person wanting to rent the apartment. In some cases, a landlord may accept bank statements that detail the last three months of consistent deposits instead of requiring information about a person's employer or other sources of income. Knowledge of the law and creative disclosure methods are key to providing necessary information without disclosing details a person does not want to reveal.

Furthermore, the only two instances in which a landlord can ask questions about disabilities is when (1) the person is applying for housing that is designated for people with disabilities, or (2) the person is requesting a reasonable accommodation to modify a rule, policy or practice on the basis of on one's disability.<sup>22</sup>

Although landlords cannot refuse to rent to someone on the basis of one's disability, in most communities they can refuse to rent to someone who will be using a Section 8 Housing Choice Voucher to pay rent as long as they refuse to rent to everyone who relies on vouchers. Because courts have not recognized the correlation between disability and financial circumstances, the FHAA allows discrimination on the basis of financial criteria, including the use of Section 8 vouchers.<sup>23</sup>

In many cases, it is difficult to accuse landlords of discrimination because they do not openly admit to applicants that they are refusing to rent to them because they have disabilities. Landlords will often refrain from telling people who they do not want to rent to about apartment vacancies or lie about the rent amount to dissuade them from applying.<sup>24</sup> MHAs can play critical roles in increasing opportunities for people who have mental illnesses to rent apartments in the community by:

- Educating people who have mental illnesses about their rights as prospective tenants and the rights of landlords seeking tenants.
- Researching rental costs in the community and making that information available to people who have mental illnesses so that they are prepared when speaking with landlords.
- Establishing relationships with landlords to educate them about people who have mental illnesses, encouraging them to rent to people who have mental illnesses or use vouchers, and creating opportunities for them to contact MHAs to announce rental openings for people who have mental illnesses or vouchers.
- Developing or working with other organizations to develop a service that is similar to [www.socialserve.com](http://www.socialserve.com), an online tool that helps people find housing. Socialserve.com is a program of Non-Profit Industries (NPI) that is dedicated to developing easy-to-use Web applications that give agencies, municipalities and the general public access to tools and information that make it easier for them to find affordable housing. It also includes program information pertaining to the affordable housing options.<sup>25</sup> Specifically, this service enables landlords to post rental vacancies that accept people who use vouchers or have minimal incomes.

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22. Judge David L. Bazelon Center for Mental Health Law. *Fair Housing Information Sheet #5: Disability Discrimination in the Housing Application and Screening Process*. [www.bazelon.org/fhinfosheet5](http://www.bazelon.org/fhinfosheet5).

23. Judge David L. Bazelon Center for Mental Health Law. *Fair Housing Information Sheet #5: Disability Discrimination in the Housing Application and Screening Process*. [www.bazelon.org/fhinfosheet5](http://www.bazelon.org/fhinfosheet5).

24. Truhn, Melanie. "Housing Discrimination haunts Madison." *The Badger Herald*. April 22, 2003. [www.badgerherald.com](http://www.badgerherald.com).

25. [www.socialserve.com](http://www.socialserve.com). Accessed August 2003.

### **Home Sales Discrimination**

Landlords are not the only ones who discriminate when it comes to obtaining or retaining a home. Realtors and sellers also discriminate. In fact, in 2002, real estate sales discrimination was the second largest form of discrimination reported to private fair housing groups.<sup>26</sup> Agents and sellers discriminate in many ways. For example, real estate agents may show only homes located in predominantly minority neighborhoods to people who have minimal incomes even if there are homes within an affordable price range in a community that is more integrated in terms of race and income level. Or sellers may take their homes off the market to avoid selling to a person who would not “fit in” the neighborhood.

Although the FHAA prohibits these discriminatory practices, they still happen. Buyers, just like renters, must be aware of their rights. It's critical that home buyers select a trusted real estate agent, are familiar with local neighborhoods, and do not feel pressured to share personal medical information with real estate agents or sellers.

### **Lack of Support Services**

Housing is not just bricks and mortar. The cornerstone of a successful housing program is the philosophy upon which it is implemented. Fundamentally, the philosophy should embrace the notion that a variety of recovery-based support services must be available and accessible to people who have mental illnesses to assist them in achieving their life goals. This includes employment training opportunities; peer support services; supported education opportunities; daily living skills training; access to physical health, mental health and substance abuse services; and social events in the community. One provider does not need to supply all these services and supports in the community; however, these opportunities should be integrated in such a way that residents can easily access the services that best fit their needs.

In addition, the philosophy should embrace the reality that recovery is possible. Thus, residents should be respected. This includes respecting their personal belongings, their personal space and their homes. Without the support services and staff available to meet the needs of people who have mental illnesses in an appropriate time and manner, it can be extremely difficult for some people to live successfully in the community.

### **Co-occurring Mental Health and Substance Use Disorders**

People who have co-occurring mental health and substance use disorders, specifically those who are unwilling or unable to abstain from using illegal substances, can have a difficult time obtaining and retaining housing. As explained in the section above, landlords are legally entitled to ask potential tenants if they use illegal substances and can deny a person an apartment based on that information. In addition, the Department of Housing and Urban Development (HUD) has specific restrictions for HUD-funded housing regarding the use of substances. And, most group homes, supported housing settings and other federally funded housing options have abstinence policies in place that include the right to refuse access to or evict tenants who use any drugs or alcohol on the premises, or who enter the premises under the influence of a substance.

Advocates must work to expand affordable, safe and decent housing options for people who have mental illnesses. Knowing why housing is in such critical need can help advocates develop strategic plans to overcome obstacles and develop practical solutions.

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26. National Fair Housing Alliance. 2003 *Fair Housing Trends Report*. [www.nationalfairhousing.org](http://www.nationalfairhousing.org).

## Section Two Overview of Housing Options

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### **Housing: A Menu Approach**

A menu approach to housing offers people who have mental illnesses the ability to choose from a variety of housing options in many different locations in a community. Just like citizens who do not have disabilities, people who have mental illnesses should be able to choose:

- Where they live
- With whom they live, if anyone
- What type of housing they want
- What services and supports they need
- Where they receive those services and supports

Although communities and tenants can choose from a variety of housing options from transitional, supportive and supported housing models all share the ultimate goal of empowering people who have serious mental illnesses to live independent, integrated lives in their communities. Of course, everyone will approach this goal in a different way. The three housing models discussed below embrace NMHA's belief that housing options for people who have mental illnesses should help support their goal of living independently in the community.

### **Transitional Housing**

In general, transitional housing targets people who are expected to or who have had minimal success living independently in the community. The goal of transitional housing is to teach people the skills they need to live successfully in independent, long-term housing. People in transitional housing live in congregate settings in which all of the residents need intensive services and participate in various service options such as life skills training, psychiatric services, employment training, substance abuse services and social reintegration. Transitional housing often takes the form of a group home, which consists of housing occupied by unrelated people who usually share common areas such as kitchens, dining rooms and living rooms. Occupants may or may not have their own bedrooms or bathrooms.

Transitional housing offers time-limited housing, usually up to two years, and residents "transition" to different housing when they are either ready for less intensive services or in need of more intensive services than transitional housing programs can offer. Staff members are available onsite 24 hours a day, seven days a week, and develop structured daily schedules for the tenants, which may include meal times, educational opportunities, employment skills training and social activities. Although transitional housing works for some people who have mental illnesses, communities should consider the following aspects of transitional housing and their implications for people who have mental illnesses:

- Program participants may seek to "plateau" at a stage of recovery in an effort to remain in their current housing.
- Service providers may be tempted to transition participants to less intensive (and usually less expensive) services before they are fully prepared.
- Residents may feel as if they are never really part of a community.

Mental illnesses are episodic in nature and may require more or less intensive services over time. Therefore, a person may transition in and out of different programs. These frequent changes can make people feel that their living arrangements are also unstable and compromise their recovery.

### **Supportive Housing**

The Center for Health Care Strategies defines supportive housing as housing with site-based services.<sup>27</sup> Supportive housing usually offers eight to 25 individual rental apartments in one location that are available only to people who meet certain qualifications. For example, supportive housing may limit apartments only to people who are homeless and have a mental illness, or only to people with co-occurring mental health and substance use disorders.

Residents should have access to crisis support services 24 hours a day; however, these crisis services may not be available onsite. Unlike transitional housing, supportive housing is not time limited and participants can choose the services in which they participate and the intensity of those support services. In addition, supportive housing resembles the housing available in the larger community.

Supportive housing has become increasingly popular as individual rental units have become difficult to obtain due to high rents and tight rental markets. Although some research indicates that people who have mental illnesses place the highest value on privacy and autonomy and, therefore, generally prefer not to live with others,<sup>28</sup> some prefer supportive housing. People who need less intensive supports than in-patient care but more supports than complete independent living may feel comfortable in designated apartments, particularly if they are surrounded by a network of peer supporters.

Supportive housing is most successful for people who have been unable to successfully maintain stability in independent housing, support service programs or both. It is designed to prevent people from repeatedly becoming homeless, going into institutions, using high-cost services and getting caught in vicious revolving door cycles. A successful supportive housing program assists participants in improving their quality of life and effectively engaging in the community, so they can be productive members of society. Therefore, residents in supportive housing should have access to the same amenities in the community as other community residents use and enjoy. In essence, supportive housing supports the notion that “We’ll offer you the help you need to be a good tenant, and you can stay as long as you need.”<sup>29</sup>

### **Supported Housing**

Supported housing is defined as scattered-site housing that offers mobile supports that are usually provided in the person's home.<sup>30</sup> Scattered-site housing can be individual apartments, condominiums or single-family homes. Supported housing is, first and foremost, a conceptual and literal shift away from an exclusive reliance on residential treatment as the sole mode of service delivery.

Support services should take the form of a mobile team of support workers who deliver rehabilitative and support services in the location that is most helpful to the participant — typically, the person's own home.<sup>31</sup> Tenants who rent housing should have leases by which they must abide; however, the leases should in no way be attached to participation in services. As long as tenants abide by the terms of the lease agreement and choose to continue living there, the housing should be available to them without restrictions.

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27. Center for Health Care Strategies, Inc. “*Olmstead and Supportive Housing: A Vision for the Future.*” December 2001.

28. Mize, Timothy I. and Abbott, Susan C. “Supported Housing: A Brief Review of the Literature.” *Continuum*, Vol. 1, no. 2, Jossey-Bass Publishers, pp. 103-110. Summer 1996.

29. Proscio, Tony. *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness*. Corporation for Supported Housing, pp. 5. May 2000.

30. Center for Health Care Strategies, Inc. “*Olmstead and Supportive Housing: A Vision for the Future.*” December 2001.

According to experts, a true supported housing program is characterized by three principles: (1) people live as members of the community in integrated, stable housing — not in mental health programs; (2) people receive flexible services and supports required to maximize their opportunities for success over time; and (3) people exercise choice regarding both their housing and support services.<sup>32</sup>

The table on page 12 provides a side-by-side comparison of the three different types of housing. Be advised that the table highlights general differences. These are not steadfast rules and one may find exceptions to these generalizations.

### **Housing for People Who Have Co-Occurring Mental Health and Substance Use Disorders**

Assisting people who have co-occurring mental health and substance use disorders to obtain housing can be difficult, particularly if they do not want to abstain from drinking or using substances. Without appropriate supports and services, people who have co-occurring disorders become entangled in complicated revolving door cycles of homelessness, hospitalization and jail.

Gaining the trust of people who have co-occurring disorders is difficult, but it truly may be the only way to save their lives. Certain housing options can target this population and do not require tenants to abstain from using or abusing substances as long as they abide by the terms of their lease.

One type of housing aimed at people who have co-occurring disorders is *damp housing*, which is for people who want to live in a setting where substance use is limited. People are willing to live in this setting, but they are not willing to make an absolute commitment to being abstinent.<sup>33</sup> Damp housing, for example, can have policies in place that restrict people from using substances on the premises but do not turn people away or evict people from using substances offsite and returning to the housing drunk or high. The second type is *wet housing*, which is for people who do not want to make any commitment at all to be abstinent, and who, if they are not assisted, will be homeless.<sup>34</sup>

There is a great deal of controversy surrounding these two models. Some critics believe that such housing enables people to continue self-destructive, and sometimes illegal, behavior. On the other hand, proponents of the models point out that co-occurring and substance use disorders are illnesses, and consider housing to be a right for all people regardless of their situations. They believe that as a society we have a moral obligation to make sure they do not become or remain homeless. A true menu approach to housing would include all of the above options from which people who have mental illnesses and co-occurring disorders can choose.

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31. Mize, Timothy I. and Abbott, Susan C. "Supported Housing: A Brief Review of the Literature." *Continuum*, Vol. 1, no. 2, Jossey-Bass Publishers, pp. 103-110. Summer 1996.

32. Mize, Timothy I. and Abbott, Susan C. "Housing: A Brief Review of the Literature." *Continuum*, Vol. 1, no. 2, Jossey-Bass Publishers, pp. 103-110. Summer 1996.

33. Minkoff, Kenneth, M.D. *Professional Interview Series: Introducing Kenneth Minkoff, MD*. www.athealth.com. January 2001.

34. Minkoff, Kenneth, M.D. *Professional Interview Series: Introducing Kenneth Minkoff, MD*. www.athealth.com. January 2001.

## Characteristics of Various Housing Options

	Transitional Housing	Supportive Housing	Supported Housing
<b>Physical Appearance</b>	Looks like a large house.	Looks like a small apartment complex. Blends in with the neighborhood.	Housing is whatever is available in the community, be it an apartment, townhouse, condominium or house.
<b>Living Arrangement</b>	Congregate living arrangement in which people share living space such as a kitchen, dining room and family room. Residents may or may not have their own bedrooms and bathrooms.	Congregate living arrangement in which people with similar disabilities occupy the complex. Apartments may or may not be occupied by more than one person.	Integrated living situation where people live in in whatever housing is available in the community.
<b>Length of Stay</b>	Up to two years.	Unlimited.	Unlimited.
<b>Onsite Staff</b>	Yes. Most often 24 hours per day.	Yes. Most often on a part- or full-time basis.	No.
<b>Staff Responsibilities</b>	To ensure the safety of the residents, staff members provide life skills training, make sure meals are prepared for the residents, and, in some cases, keep track of medication intake.	Staff are available to answer any questions, address situations that may arise, offer support services the residents may need, coordinate linkage to community services, and make sure residents are stable.	N/A
<b>Food Service</b>	Breakfast and dinner often provided in a cafeteria-style setting.	Residents are responsible for their own meals.	Residents are responsible for their own meals.

## Section Three **Key Characteristics of Successful Housing Options**

Mental health experts have identified key characteristics of successful housing programs that offer the best support to people who have mental illnesses and are working toward living in the community. Some of the most common characteristics are:

- A focus on each person's goals and preferences.
- An individualized and flexible rehabilitation process.
- A strong emphasis on normal housing, work, and social networks to help people who have mental illnesses stay out of the hospital and become part of the community.<sup>35</sup>

### **NMHA's Key Elements of Successful Services**

Based on the experiences of successful service providers, NMHA has identified several key elements, or characteristics, that all programs targeting people who have mental illnesses, including housing programs, should encompass. The programs should be:

- **Recovery-Oriented:** Programs should recognize that mental illness can be successfully treated and that people who have mental illnesses are able to work, have relationships and lead fulfilling lives in the community.
- **State-of-the-Art:** Programs should provide high-quality services that incorporate the latest advances in treatment (including pharmacotherapy) and training that are evidence-based or at the cutting edge of the field.
- **Voluntary:** Consumers should be allowed to choose to participate in the program, and be given a range of options from which to make meaningful choices about expressed wishes and available services.
- **Empowering:** The service provider should create an environment that encourages individual decision-making, personal responsibility, and specific actions consumers can take to change their lives and their communities.
- **Holistic:** Programs should maximize a person's strengths and abilities, help manage their symptoms, and address aspirations, confidence, resources and opportunities.
- **Community-Integrated:** Treatment and services should be offered in the community so that people learn life skills in the environment in which they will use them.
- **Community-Supported:** The program should have the financial support and endorsement of a cross-section of stakeholders, and be offered in collaboration with service providers to be a part of a comprehensive mental health service delivery system.
- **Administratively Effective:** The program should be financially sound, have a system of accountability and responsibility, and have policies and procedures that ensure proper treatment of all people involved in the program (consumers, staff and volunteers).
- **Culturally Competent:** The program should be designed to effectively serve diverse populations that compose the local community.
- **Measurably Effective:** The program should evaluate its services to measure consumer success and satisfaction.

Key characteristics of successful housing programs de-emphasize traditional treatment models that focus on what is wrong with a person and seek to reduce symptoms, and instead emphasize psychiatric rehabilitation opportunities. Rehabilitation develops the person's

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35. Mize, Timothy I. and Abbott, Susan C. "Supported Housing: A Brief Review of the Literature." *Continuum*, Vol. 1, no. 2, Jossey-Bass Publishers, pp. 103-110. Summer 1996.

strengths and supports his or her recovery toward improved functioning and increased satisfaction in living.<sup>36</sup> This includes emphasizing natural supports in the community, such as peer-to-peer support, while also offering formal recovery-based supports, such as support groups.

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36. Mize, Timothy I. and Abbott, Susan C. "Supported Housing: A Brief Review of the Literature." *Continuum*, Vol. 1, no 2., Jossey-Bass Publishers, pp. 103-110. Summer 1996.

## Section Four **The Cost-Effectiveness of Housing Options**

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People who are unable to receive appropriate mental health services often use the most expensive public services such as emergency rooms, hospital psychiatric beds, detoxification services, residential treatment programs, and, in some cases, jail cells. This puts an unnecessary financial burden on local communities in the form of increased costs for physical healthcare, mental healthcare, substance abuse and correctional institutions.<sup>37</sup>

Studies have shown that supportive housing programs are far more cost-effective than relying on costly public services that provide inadequate or no services or supports. In New York City, for example, a state psychiatric hospital bed costs \$350 per day, a city hospital bed costs between \$600 and \$1600 per day, a state prison cell costs \$112 per day and a city shelter cot costs \$68 per day —while a home in a supportive housing program costs \$34 per day.<sup>38</sup>

The Corporation for Supportive Housing has examined studies conducted at supporting housing sites around the country.<sup>39</sup> These studies clearly demonstrate that supportive housing can:

- Decrease by 57 percent the number of inpatient days formerly homeless tenants spend in the hospital.
- Decrease by 58 percent formerly homeless tenants' emergency room visits.
- Increase the rate of employment among tenants.
- Decrease by more than 80 percent tenants' use of emergency de-tox services.
- Cut in half the rate of incarceration among formerly homeless tenants.
- Lower the homeless shelter population by as much as one-third, when the supportive housing units are produced at scale to match the shelter population.
- Improve neighborhood safety and beautification.
- Contribute to property value increases.

Expanding housing options for people who have mental illnesses can also result in economic stimulus. According to the National Low Income Housing Coalition, "Economic benefits from housing production and rehabilitation include increased jobs, growing wages, attracting additional funds, increased sales, and higher tax revenues, among others. Calculating these economic benefits has become one of the strongest arguments to make in advocating for the commitment of resources to affordable housing."<sup>40</sup>

The National Association of Home Builders has calculated the direct impact of residential construction on the economy, which is significant. The association found that construction of 1,000 single-family homes generates 2,448 full-time jobs in construction and construction-related industries; \$79.4 million in wages; and \$42.5 million in combined federal, state and local revenues and fees. Furthermore, the construction of 1,000 multifamily units generates 1,030 full-time jobs in construction and construction-related industries; \$33.5 million in wages; and \$17.8 million in combined federal, state and local tax revenues and fees.<sup>41</sup>

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37. Corporation for Supported Housing. *Why Supportive Housing?* [www.csh.org/advl](http://www.csh.org/advl)

38. <http://www.csh.org/ny>

39. Proscio, Tony. *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness*. Corporation for Supported Housing, pp. 15-19. May 2000.

40. National Low Income Housing Coalition. "Housing as an Economic Stimulus." *2002 Advocates' Guide to Housing and Community Development Policy*. [www.nlihc.org/advocates/housingstimulus](http://www.nlihc.org/advocates/housingstimulus).

41. National Association of Home Builders. *Housing's Direct Economic Impact*. [www.nahb.org/generic.aspx?sectionID=138&genericContentID=543](http://www.nahb.org/generic.aspx?sectionID=138&genericContentID=543).

That means that developing affordable housing employs members of the community while providing people with minimal incomes, including people who have mental illnesses, the opportunity to obtain and retain housing. This is a win-win situation for community members who want to eradicate the homeless situation, increase jobs in the community, and move people from costly institutional settings to more affordable community-based housing.

## Section Five **Expanding Housing in Communities**

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Through their expertise, established relationships and commitment, MHAs have the tools to ensure successful housing implementation and expansion. Given the many lessons learned by MHAs and other nonprofit advocacy organizations that have launched housing programs, no community should have to start from scratch.

Through its work on the Partners in CARE initiative, NMHA has identified model housing programs and worked with these programs to implement similar housing models in communities across the country. NMHA is eager and prepared to provide technical assistance to any MHA affiliates that are interested in designing their own programs or replicating a model program.

### **Gaining Support**

One important lesson learned is that it is critical to gain the support of a wide range of community stakeholders to successfully expand housing options for people who have mental illnesses. Stakeholders include those people or organizations who have an interest in expanding housing options for people who have mental illnesses and co-occurring disorders or who would be affected in some way by the implementation of a housing program. They are consumers, family members, advocates, service providers, neighborhood residents, business people, police, developers, funders, landlords, political leaders and policymakers. Stakeholders should be invited to get involved with the planning process from the beginning.

### **Forming a Coalition**

Developing a coalition involves determining how many people should be invited, who those people should be, what the mission of the group is, what outcomes are expected, how long it plans to exist, and how it will be supported. Coalitions range in size; however, a coalition with approximately 20 to 30 people is ideal. A coalition much larger than that can make it difficult to get everyone together for meetings and to make progress in a timely fashion. Conversely, a smaller coalition presents cumbersome workloads on coalition members, and there may not be participation from all those that should be involved.

Coalition stakeholders should offer expertise, influence and dedication to mental health issues, specifically for housing for people who have mental illnesses. It is essential to include people who have mental illnesses and access and participate in community services, and their family members, for their invaluable input. In addition, the coalition should reflect the diversity of the community including race, ethnicity, sexual orientation, age and income.

Consider these questions when determining who should be on the coalition:

- What types of expertise will the coalition need and who would best offer each type of expertise? (e.g., Who understands federal, state and local funding streams? Who has expertise in research and data analysis? Who knows various types of housing already offered in the community? Who is experienced in running public education campaigns and activities?)
- Who has the ability to make or influence important decisions in the community?
- What resources are needed and who can bring them to the coalition?
- From whom does the community need buy-in to make this process successful?
- Is there participation from people who have mental illnesses and their families?

The coalition members will have many roles, including:

- Actively participating in meetings by offering their expertise and suggestions.
- Volunteering to do tasks such as gathering facts and statistics.

- Completing tasks on time.
- Educating peers about community-based state-of-the-art services for people who have mental illnesses.
- Gaining support from other influential members of the community.

### **Inviting Stakeholders to the Table**

The manner in which people are invited to join the coalition will depend on how well the organizing agency knows each person. People members know can likely be contacted directly by phone or in person, while others may require a written appeal to participate. In any case, a letter of invitation is helpful for all prospective coalition members.

A letter of invitation should outline the purpose of the coalition, the rationale for participant selection, the roles participants can expect to play, and a date by which invitees can expect a call to discuss this opportunity. The letter should also include the date, time and location of the anticipated first meeting along with contact information. It should arrive four to six weeks in advance to give people time to include it in their schedules. Finally, the letter should make clear that the coalition belongs to all of the participants and avoid such references as “my coalition” or “my organization’s coalition.” Essentially, all members should feel equal in the coalition.

### **Reaching Community Consensus**

The coalition’s purpose is not only to agree that supported housing is important and worth expanding, but to determine funding sources, service providers, program design, targeted population and other design questions. For some coalitions, reaching consensus is difficult. A housing provider in the community may feel that a supportive housing program is not needed out of fear of competition over resources and clients. People in the community may not support the implementation of supportive housing in their neighborhoods due to NIMBYism. For the most part, these difficulties arise from a lack of knowledge about how many people actually need housing services and a lack of awareness that people who have mental illnesses can and do live successfully in communities.

Even if the coalition reaches consensus around expanding housing, it is less likely to become a reality if you lack the support of legislators. Lawmakers are often responsible for determining state mental health funding streams, Medicaid restrictions and licensing procedures. Educating them about community-based services, gaining their support for expanded housing options, and relentlessly advocating for funding are crucial pieces to ensuring success.

### **Designing a Housing Program**

There are many existing successful housing programs on which communities can model their own housing initiatives. Some are highlighted in the following section. Coalition members should consider the following questions when discussing program design:

#### Philosophy, Values and Mission

- How will the philosophies, values and mission of the model program be replicated to ensure that program staff and participants will adopt them? Some service models are based on a set of values, which then influence how the program operates. It is often not enough to replicate the service type or to figure out the financing—you need the vision and values to make it work.

- How will staff be trained to reflect the philosophy, values and mission of the program?

#### Program Overview

- What type of housing will be offered (e.g., scattered-site apartments, designated apartments, condos, townhouses, etc.)?
- Who will be the service provider? What support services will be offered?
- Who will be the landlord?
- Who will reside in the housing? Will there be eligibility criteria?
- Will the housing be available to people who are not willing to abstain from alcohol or other substances?
- What are the procedures for tenants who wish to rent housing? Vacate housing?
- What documentation will be required of people who would like to rent?
- What is the method of payment for receipt of services?
- What are the roles and expectations of all of the participants of the program (staff and consumers)?
- What licensing is needed for such a program? Who will be responsible for pursuing the licensing?
- How will consumer choice and empowerment be implemented and ensured?
- What role do consumers play in making decisions about agency programming and policies?
- What role do consumers play in making decisions regarding the services they receive?
- How will service planning be individualized, and how will this process be implemented?
- How will housing and services remain separate from each other?
- Will there be an advisory council for the housing program? If so, who will be on it?
- How will you ensure the safety of the program participants?
- How will you ensure the safety of staff?
- Will you have consumers as staff? If so, in what roles?
- What date is the program projected to be implemented?

#### Program Evaluation

- How will quality-of-care, and effectiveness and efficiency of services be measured?
- How often will services be evaluated?
- What evaluation tools will be used?
- How will the philosophy, values and vision of the housing program be maintained?
- How will the program participant's satisfaction with services and housing be evaluated?
- How will services or housing issues about which participants complain be improved or resolved?

#### Funding

- How will the housing program be funded initially?
- How will the housing be funded long term?
- Does the state's Medicaid system offer the rehab option? Will it pay for services provided through the supported housing program?

- Will HUD funds be accessed to build, renovate or offset rental costs?
- Are there private foundations or nonprofit organizations in the local community that may provide funding for supported housing programs?
- Are there companies in the local community that could donate supplies or resources that would help offset costs?

NMHA has a range of resources available that can assist coalitions as they discuss these key issues. For more information or to request publications, contact NMHA's Advocacy Resource Center at 800-969-NMHA (6642), 800-433-5959 (TTY) or visit [www.nmha.org/infoctr](http://www.nmha.org/infoctr).

## Section Six

### Successful Housing Programs

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Although some MHAs are just beginning to venture into this service arena, others have been designing and running housing programs for years. The housing experiences of an array of MHAs are detailed below.

#### **Mental Health Association in North Carolina (Raleigh, N.C.)**

The Mental Health Association in North Carolina (MHA-NC) has developed a successful statewide Residential Service Initiative for people who have severe and persistent mental illnesses. Since 1985, MHA-NC has developed more than 15,000 housing units for adults and children who have mental illnesses. These units come in the form of group homes, apartment complexes, single-family and duplex homes, and individual apartment units.

MHA-NC has successfully accessed funding streams, such as HUD 202/811, HOME, Shelter Plus Care, Supportive Housing Program, and its new Tax Credit Initiative. Although MHA-NC has encountered some community opposition, its innovative, grassroots efforts and unique designs that blend into community settings have enabled MHA-NC to develop a program that is accepted in the community.

MHA-NC provides property management oversight for all of its units while providing on-site residential services for 44 homes and apartments out of the 91 that it owns and coordinates. With this very strong base, MHA-NC plans to continue to develop programs to meet the needs of people who have serious, long-term mental illnesses, including those who have experienced homelessness, institutionalization and other setbacks.

Through its housing initiative, MHA-NC has brought together consumers, family members, community leaders, human service personnel and others to create a strong coalition and network of supporters. Most important, however, through the vision and foresight of advocates throughout the state, hundreds of individuals now have a place to call home—the MHA-NC Residential Service Initiative.

As result of the success of MHA-NC's residential services, the MHA has been able to expand in other specialty areas and now provides psychosocial services, including supported employment, peer support and supported education.

#### **Mental Health Association in Tulsa (Tulsa, Okla.)**

The Mental Health Association in Tulsa (MHAT) has six housing programs each of which provides homes to 131 people at capacity. Each program is unique and designed to meet the varying needs and circumstances of people at different points in their recovery.

Walker Hall is a highly structured 12-bed transitional living program. To participate in the program, people must be stable in their treatment program and willing to live in a group home setting. The program prepares people to move into more independent housing. Although residents can stay at Walker Hall for up to two years, the average length of stay is about seven months, at which time residents transition to more permanent housing. Walker Hall is staffed 24 hours a day, seven days a week, and is a licensed residential care facility. HUD provides 50 percent of the funding for this program and the other half is raised locally.

The MHAT's Baltimore Apartments is a 16-unit apartment complex offering efficiencies. Residents live completely independently in their apartments and can keep the apartment permanently. There is no staff available onsite, however, many residents request visits from the local mobile assertive community treatment (ACT) team.

The MHA's Safe Haven is 30-single room occupancy living situation located on the third floor of the downtown YMCA. Safe Haven specifically helps people who are homeless and operates as a "damp" facility. People can access Safe Haven's services without having to agree to mental health care or substance abuse treatment. However, through outreach and engagement, staff members work to get participants involved in services as soon as possible. Most people accept treatment services once they become comfortable in the program and begin to trust the staff. An outreach team, funded by HUD, serves as the gatekeepers for admittance. Immediate admittance is allowed for individuals whose goal is to obtain and retain housing. Safe Haven is staffed 24 hours a day, seven days a week, and funded through HUD and a state contract.

MHAT's Treepoint Apartments offers 19 one-bedroom units of permanent housing for people who are able to live successfully in the community fairly independently, but who still have some needs preventing them from living completely independent lives. Staff members are available onsite 24 hours a day, seven days a week, to respond to the residents' needs as appropriate. MHAT purchased the apartments through donations from local funders and receives funds from the Department of Mental Health for continued program operation.

Its Terrace View Apartments is a 42-unit apartment complex that has a seven-year Section 8 Project-Based Housing Assistance Payment (HAP) rent-controlled contract through HUD. Terrace View is restricted to low-income individuals who meet income eligibility guidelines regardless of whether they have a mental illness and who can live independently.

The MHAT's Metropolitan Apartment Program (MAP) is a supported housing program funded by HUD. MHAT leases 12 apartments throughout the city and subleases them to individuals who want to live independently in integrated community settings. MHAT staff members schedule regular home-based visits with the tenants to ensure they are not having problems maintaining their living arrangements. MHAT has found that landlords feel comfortable with this rental arrangement.

To track outcomes, MHAT keeps careful records of appropriate and inappropriate program vacancies. MHAT categorizes any move that is not planned as inappropriate. Appropriate moves are categorized as those that have been carefully planned; staff members continue to track these people as long as possible. People who return to homelessness, even years down the road, are considered failures for the housing program. At this time, MHAT's success rate using those criteria is 80 percent, which exceeds the organization's goal of 60 percent.

### **Mental Health Association of the Heartland (Kansas City, Kan. and Mo.)**

In September 2001, the Mental Health Association of the Heartland (MHAH) opened its first permanent supportive housing program in Kansas City, Mo., called Heartland Apartments. The program offers seven furnished one-bedroom apartments and one studio apartment for people who are homeless and have serious and persistent mental illnesses. With support from community stakeholders, MHAH purchased the property in December 2000 with HUD funding that was awarded under the Kansas City's Continuum of Care application.

MHAH works in collaboration with community organizations to ensure that residents have access to a variety of appropriate services. MHAH has established a set of basic support services that are available to all residents, which include:

1. TMC Behavioral Health Network, the local homeless outreach provider, provides referral and case management services.
2. The Missouri Department of Mental Health provides rent subsidy vouchers, which are attached to the units providing financial assistance to the residents.
3. MHAH provides a residential counselor who is available on-site 40 hours per week, most of which are non-traditional hours including evenings and weekends, depending on residents' needs. The residential counselor is responsible for providing general mental health counseling, education, information, referrals, linkage to community services and resources, and crisis prevention/intervention. The counselor is also involved in the local Continuum of Care, Homeless Services Coalition and other community action groups. Residents and neighbors have the residential counselor's cell and home phone numbers should there be an emergency when the counselor is offsite.
4. MHAH offers peer support services through a peer advocate to Heartland Apartment residents. Seventy-five percent of the funding to pay for the peer advocate and the residential counselor comes from HUD through the Continuum of Care grant.

MHAH has received a substantial amount of public recognition and press as a result of its pilot program's success. In fact, MHAH received a "Best Practices" award from HUD in May 2002 for the Heartland Housing Initiative, which directly stemmed from the success MHAH has had with Heartland Apartments.

MHAH is currently in the process expanding housing options in four more communities, either as housing owners or managers. One of these projects includes an 11-unit permanent supportive housing complex for people who are homeless and have a serious and persistent mental illness or substance use disorder or both, with preference given to veterans through the HUD SuperNOFA. In addition, MHAH provides housing opportunities through its involvement with the distribution-of-rent subsidy vouchers and Shelter Plus Care.

#### **Vinfen (Boston, Mass.)**

In addition to the incredible work of the affiliates, NMHA's Partners in Community Access to Recovery and Empowerment (CARE) program has identified Vinfen, a private, nonprofit human service organization, as a model housing program. Vinfen offers a continuum of residential services, ranging from independent living to highly supervised settings for children, adolescents and adults who have mental illnesses, developmental disabilities, HIV/AIDS, hearing impairments and other disabilities.

Established in 1977, Vinfen supports more than 200 sites in Massachusetts, from the New Hampshire border to Cape Cod, as well as in Connecticut. Whenever possible, Vinfen ensures that consumers have supported housing, which constitutes 40-45 percent of all Vinfen housing. Residential options are available for transition-age youth, single adults and families, and focus on maintaining a true home environment while building skills through supported activities such as shopping, household budgeting and cooking.

In addition to housing, Vinfen offers a range of support services, including:

- **Outpatient and Emergency Services:** Vinfen's licensed clinic in Cambridge, Mass. provides individual and group counseling as well as case consultation and psychiatric services. Consumers include adults, children, adolescents and families

challenged by emotional, developmental or behavioral conditions. Vinfen's clinicians work with public and private hospitals, community mental health centers and public schools throughout the Greater Boston area.

- **School-Based Services:** Vinfen supports children and adolescents whose emotional, developmental or behavioral challenges impair their ability to learn, grow and function in school. Services include onsite therapy for young people in need, as well as training for public elementary and middle-school teachers and administrators.
- **Day and Vocational Services:** Like people everywhere, Vinfen's consumers want and need opportunities to learn, work, grow and contribute to their communities. Vinfen offers a number of day and work services including adult day rehabilitation, arts-based rehabilitation, pre-vocational training and supported employment. Each program focuses on developing skills, self-esteem and confidence-the foundations of a successful life in the larger community.
- **Nursing Home Services:** Vinfen's Hancock Manor nursing home is a licensed skilled nursing facility for people whose age or physical or psychiatric conditions require high levels of clinical care.
- **Specialized Treatment Facilities:** Vinfen provides residential services for people who request assistance for specific needs such as HIV/AIDS, substance abuse, homelessness, etc.

## Section Seven

### Funding Sources

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Funding housing initiatives for people who have mental illnesses can be difficult, particularly during economic downturns. However, it is not impossible, and it is during these fiscally difficult times that people are in desperate need of affordable, safe and decent housing without being burdened with worrying about being evicted. Some possible funding opportunities include the following:

#### U.S. Department of Housing and Urban Development (HUD)

##### Shelter Plus Care (S+C)

Shelter Plus Care provides rental assistance combined with social service supports for people who are homeless and have a disability, particularly those people who have serious mental illnesses, chronic alcohol or drug problems, and HIV/AIDS or related diseases, and their families. Grants are available for up to five years and fund the following four types of housing assistance:

- Tenant-Based Rental Assistance that contracts directly with the tenants who qualify as low-income.
- Project-Based Rental Assistance that contracts directly with the building owner.
- Sponsor-Based Rental Assistance that contracts with a nonprofit organization.
- Single Room Occupancy (SRO)-Based Rental Assistance that contracts with a public housing authority.

S+C grants require that support services be offered in conjunction with the housing; however, the community must secure funding from sources other than S+C to fund the support services. In addition, these support services must be at least equal in value to the rental assistance provided by HUD through the S+C grant.

For more information, visit [www.hud.gov/offices/cpd/homeless/programs/splusc/index](http://www.hud.gov/offices/cpd/homeless/programs/splusc/index).

##### The Supportive Housing Program (SHP)

SHP provides supportive housing and support services to people who are homeless. SHP grants are available for up to three years, and funds can be used to create transitional housing, implement permanent supportive housing for people with disabilities, and provide support services that are not offered in conjunction with SHP-funded housing.

Some activities that can be funded through SHP include: acquisition, rehabilitation, construction or leasing of structures that can be used for supportive housing, operating costs of supportive housing and support services. Five percent of the grant pays for administration of the grant.

For more information, visit [www.hud.gov/offices/cpd/homeless/programs/shp/index](http://www.hud.gov/offices/cpd/homeless/programs/shp/index).

##### Section 811 Supportive Housing for Persons with Disabilities

Section 811 is designed to increase rental opportunities with support services to enable adults who are at least 18 years old who have disabilities and are very low-income to live independently in the community. The program provides interest-free capital advances to nonprofit organizations to construct or rehabilitate rental housing with support services for that population. The advance remains interest-free and need not be repaid as long as the housing remains available for very low-income persons with disabilities for a minimum of 40 years.

In addition, the program provides rental assistance for residents. Residents pay 30 percent of their adjusted gross income in rent, and Section 811 pays the difference between the monthly approved operating cost and the rent received from the tenant. (Please note: The companion to Section 811 is 202, which provides housing opportunities for older adults, including older adults who have mental illnesses.)

For more information, visit [www.hud.gov/nofa/supernofa/sprprt41](http://www.hud.gov/nofa/supernofa/sprprt41).

### **The Section 8 Moderate Rehabilitation Program for Single Room Occupancy (SRO) Dwellings for People Who Are Homeless**

The Section 8 SRO program provides rental assistance for the development of Single Room Occupancies for people who are homeless. Through periodic competitions, Section 8 funding is awarded to Public Housing Agencies (PHAs) and nonprofits for up to 10 years, which allows the project sponsor to find a long-term financial commitment for project development. Private, nonprofits are encouraged to contract with local PHAs to administer the subsidy.

For more information, visit [www.hud.gov/offices/cpd/homeless/programs/sro/index](http://www.hud.gov/offices/cpd/homeless/programs/sro/index).

### **Community Development Block Grant (CDBG) program**

CDBG is a block grant that is divided between states and local jurisdictions to ensure decent, affordable housing for all and to provide services to the people who most need it in our communities. This includes the creation of jobs and expanded business opportunities.

Grants are given for a period of one, two, or three years and no less than 70 percent of the CDBG funds must be used for activities that benefit low- and moderate-income people. All activities must meet one of the following national objectives for the program: they must benefit low- and moderate-income persons, prevent or eliminate slums or blight, or spur urgently needed community development because existing conditions pose a serious and immediate threat to the health or welfare of the community.

For more information, visit:

<http://www.hud.gov/offices/cpd/communitydevelopment/programs/cdbg.cfm>

### **Home Investment Partnership Program (HOME)**

HOME provides grants to states and localities to fund activities such as building, buying and rehabilitating affordable housing for rent or ownership, and provides direct rental assistance for low-income individuals and families. HOME is the largest federal block grant, allocating \$1 billion per year to state and local governments. It is designed exclusively to create affordable housing for low-income households.

HOME allows communities to design and implement housing options tailored to community needs; emphasizes partnerships among all levels of government and private sectors; and offers technical assistance activities. The HOME program requires grant recipients to match 25 cents of every dollar in program funds to mobilize community resources in support of affordable housing.

Eligibility for the HOME program varies with the nature of the funded activity. Assistance is based on the HUD-adjusted median family income for the specific localities. HUD develops the income limits. The lower income limit is set at 80 percent of the median income, and the very low-income limit is set at 50 percent of the median income.

For more information, visit [www.hud.gov/offices/cpd/affordablehousing/programs/home/index](http://www.hud.gov/offices/cpd/affordablehousing/programs/home/index).

### **HUD's Public Housing Program**

Public housing was established to provide decent, safe rental housing for eligible low-income families, older adults and people with disabilities. HUD administers federal aid to local housing agencies (HAs) that manage the housing for low-income residents at rents that they can afford. HUD furnishes technical and professional assistance in planning, developing and managing this housing.

Has determine public housing eligibility based on:

- Annual gross income
- Qualification as a family, an older adult or a person with a disability
- U.S. citizenship or eligible immigration status

For more information: visit [www.hud.gov/renting/phprog.cfm](http://www.hud.gov/renting/phprog.cfm).

### **HUD-VA Supported Housing Program (HUD-VASH)**

HUD-VASH is a supported housing program jointly sponsored by HUD and the Department of Veterans Affairs (VA). The goal is to provide permanent housing and ongoing treatment services to people who are homeless, who are veterans, and who have mental illnesses, substance use disorders or both.

HUD's Section 8 Voucher Program has designated 1,780 vouchers worth \$44.5 million for this harder-to-serve population. VA staff members at 35 sites provide outreach, clinical care and ongoing case management services. Rigorous evaluation of this program shows that this approach significantly reduces days of homelessness for veterans who have serious mental illness and substance use disorders.

For more information: visit [www.va.gov/homeless](http://www.va.gov/homeless) or contact the Homeless Veterans Programs Office at 202-273-5764 (phone), 800-829-4833 (TTY) or 202-273-5716 (fax); or 810 Vermont Ave. N.W., Washington, D.C. 20420

### **Section 8—Housing Choice Vouchers**

The Housing Choice Vouchers program is the federal government's major program that provides assistance to very low-income families, older adults and people with disabilities who seek to obtain decent, safe and sanitary housing in the private market. The participant is free to choose any housing that meets the program's requirements and is not limited to units located in subsidized housing projects.

PHAs receive federal funds from HUD to administer the Housing Choice Vouchers. Once a family has found suitable housing, the owner agrees to rent under the program, and the PHA approves the housing according to its health and safety standards, and the PHA pays the housing subsidy directly to the landlord. The family is responsible for covering the difference between the actual rent charged by the landlord and the subsidy. PHAs determine eligibility based on family income, assets and family composition.

For more information, visit [www.hud.gov/offices/pih/programs/hcv/index](http://www.hud.gov/offices/pih/programs/hcv/index).

### **Center for Mental Health Services (CMHS) Programs**

#### **Homeless Programs Branch**

The Homeless Programs Branch serves the treatment, support services and housing needs of people who are homeless and have mental illnesses. The branch administers programs to assist states and

localities in making services available such as mental health treatment, medical treatment, substance abuse treatment and legal assistance as part of transition efforts from homelessness.

For more information, visit [www.mentalhealth.org/publications/allpubs/KEN95-0015/default.asp](http://www.mentalhealth.org/publications/allpubs/KEN95-0015/default.asp).

### **PATH—Projects for Assistance in Transition from Homelessness**

PATH is a formula grant program administered by CMHS within the Substance Abuse and Mental Health Services Administration. PATH provides funding to states and territories that offer community-based services for people who are homeless or at risk of becoming homeless.

PATH funds can be used by providers to offer essential services such as outreach, screening and diagnostic treatment, community mental health services, case management, alcohol or drug treatment, habilitation or rehabilitation, supportive and supervisory services in residential settings, and referrals to other needed services. In addition, the funding may be used to fund limited housing assistance such as minor renovations and repairs to existing housing or one-time rental payments to prevent eviction.

For more information, visit [www.mentalhealth.org/cmhs/Homelessness/about.asp](http://www.mentalhealth.org/cmhs/Homelessness/about.asp).

### **Other Services**

#### **Fannie Mae**

Fannie Mae's public mission is to assist more families in achieving the American Dream of homeownership. Fannie Mae accomplishes this goal by providing financial products and services that make it possible for low-, moderate- and middle-income families to buy homes of their own. Since its establishment in 1968, Fannie Mae has helped more than 43 million families become homeowners.

For more information, visit [www.fanniemae.com](http://www.fanniemae.com).

#### **Habitat for Humanity**

Habitat for Humanity International is a nonprofit housing organization that works with other organizations and people in communities to build simple, decent and affordable homes for people in need of adequate shelter. Since 1976, Habitat has built more than 125,000 houses in more than 80 countries, including some 45,000 houses across the United States.

NMHA recently partnered with Habitat for Humanity and NAMI for a Partnership to Open Doors a collaborative national campaign. With the help of our affiliate networks, we were able to bring attention to the need for stable housing for families fighting mental illness, the discrimination that they often face, and their rights and needs to be embraced as valued members of our communities. Local affiliates can continue this partnership by working with Habitat for Humanity affiliates in their communities.

For more information, visit [www.habitat.org](http://www.habitat.org).

#### **Private Developers**

Private developers may be willing to work with you to design and build housing for people who have mental illnesses. Often, developers have access to funding streams that nonprofit organizations do not. Begin researching local developers and set up meetings to discuss the possibility of expanding housing options.

## Section Eight

### Action Starts Here

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With the need for safe, decent and affordable housing becoming more prominent in many, if not all, communities, it is critical that organizations work together to develop strategies to increase housing options for people who have mental illnesses and co-occurring disorders. Partnerships should be established and sustained among advocacy organizations, local businesses, housing developers, foundations and others in the community. Pooling resources, developing concrete strategies, and approaching political leaders and funders as a united front can define a coalition's success.

Designing the housing is as important as gaining support to implement and expand housing options. Involving people who have mental illnesses and their family members in the planning and design processes are critical steps toward developing housing in which tenants can feel safe from harm and eviction. Once implemented, the housing should be considered by all to be more than a building; it should be a home. Ensuring that tenants have a say in what happens to the housing, and that they have access to services and community life are essential to making a housing program a home.

This manual provides the basic information advocates need to begin developing coalitions, educating community members, and discussing the issue of appropriate housing options. This is the first step toward solving the housing shortage problem in communities across the country. NMHA staff members are available to provide technical assistance to MHAs that are interested in expanding housing in their communities. In addition, a list of resources providing a wide range of information follows. Coalitions should take advantage of these resources as they progress toward their goals.

#### NMHA Resources

NMHA Advocacy Resource Center  
2001 N. Beauregard Street, 12th floor  
Alexandria, VA 22311  
Phone: 800-969-NMHA (6642)  
TTY: 800-433-5959  
Fax: 703-684-5968  
Web site: [www.nmha.org/infectr](http://www.nmha.org/infectr)

#### NMHA Affiliate Resources

Mental Health Association of the Heartland  
739 Minnesota Avenue  
Kansas City, KS 66101  
Phone: 913-281-2221

Mental Health Association in North Carolina  
3490 Bland Road  
Raleigh, NC 27609  
Phone: 919-981-0740  
Web site: [www.mha-nc.org](http://www.mha-nc.org)

National Mental Health Association

Mental Health Association in Tulsa  
1870 South Boulder  
Tulsa, OK 74119  
Phone: 918-585-1213  
Web site: [www.mhat.org](http://www.mhat.org)

### **Additional Resources**

Consortium for Citizens with  
Disabilities Housing Task Force  
1331 H Street, NW, Suite 301  
Washington, D.C. 20005  
Phone: 202-783-2229  
E-mail: [Info@c-c-d.org](mailto:Info@c-c-d.org)  
Web site: [www.c-c-d.org](http://www.c-c-d.org)

Corporation for Supportive Housing  
Corporation for Supportive Housing  
50 Broadway, 17th Floor  
New York, N.Y. 10004  
E-mail: [information@csh.org](mailto:information@csh.org)  
Web site: [www.csh.org](http://www.csh.org)

National Association of Home Builders  
1201 15th Street NW  
Washington, D.C. 20005  
Phone: 800-368-5242  
Fax: 202-266-8559  
Web site: [www.nahb.org](http://www.nahb.org)

National Resource Center on  
Homelessness and Mental Illness  
Policy Research Associates, Inc.  
345 Delaware Avenue  
Delmar, N.Y. 12054  
Phone: 800-444-7415  
Fax: 518-439-7612  
Web site: [www.nrchmi.com](http://www.nrchmi.com)

Technical Assistance Collaborative, Inc.  
One Center Plaza, Suite 310  
Boston, MA 02108  
Phone: 617-742-5657  
E-mail: [info@tacinc.org](mailto:info@tacinc.org)  
Web site: [www.tacinc.org](http://www.tacinc.org)





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Alexandria, VA 22311  
800-969-NMHA (6642)  
[www.nmha.org](http://www.nmha.org)