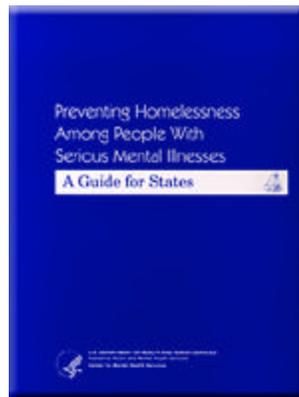


**National Resource Center  
on Homelessness and Mental Illness**



# **Preventing Homelessness Among People with Serious Mental Illnesses**

## **A Guide for States**



**Prepared by:**

Anne D. Lezak and Elizabeth Edgar

**Prepared for:**

National Resource Center on Homelessness and Mental Illness  
Policy Research Associates, Inc.  
Delmar, NY

**Published under contract 278-91-0016 by:**

Center for Mental Health Services  
Substance Abuse and Mental Health Services Administration  
U.S. Department of Health and Human Services  
Rockville, MD

**April 1996**

# Table of Contents

<b>Introduction.....</b>	<b>1</b>
• Using This Report .....	2
<b>A Model for Prevention.....</b>	<b>3</b>
• Reducing Risks and Increasing Protective Factors .....	3
<b>Risk Factors for Homelessness Among People With Serious Mental Illnesses .....</b>	<b>5</b>
• Individual Risk Factors .....	5
• Environmental Risk Factors.....	6
• The Current Response.....	10
<b>Identifying What Is Needed.....</b>	<b>13</b>
• Addressing Individual Risk and Protective Factors.....	13
• Addressing Environmental Risk and Protective Factors .....	14
• The Need for Further Research.....	25
<b>Developing Comprehensive Prevention Responses .....</b>	<b>26</b>
• Promoting "Housing as Housing" in Ohio .....	26
• Expanding Housing and Services in Oregon.....	28
• Developing a Community-Based System in Vermont .....	31
• Conclusion.....	34
<b>References .....</b>	<b>36</b>
<b>APPENDIX A: PATH State Contacts.....</b>	<b>39</b>

The opinions expressed herein are the views of the authors and do not necessarily reflect the opinions or policies of the Center for Mental Health Services or the U.S. Department of Health and Human Services.

# Introduction

The contemporary focus on homelessness began some 15 years ago. Throughout the 1980's, this expanding and highly visible social problem received increasing attention, with growing numbers of task forces, conferences, legislation, research studies, and services devoted to homeless people and their problems. The first response of well-meaning government, private, and voluntary agencies was to treat homelessness as a short-term crisis. Emergency shelters and nutrition programs sprang up across the Nation, but they did not stem the tide of homeless people, especially for those with serious mental illnesses.

In 1987, the Stewart B. McKinney Homeless Assistance Act provided the first significant Federal funding directed specifically to the needs of homeless people. As with other types of assistance, the McKinney Act initially funded primarily short-term help designed to tide people over until they could get back into the mainstream. McKinney funding provided important new resources to local programs for shelter, food, medical care, case management, and other services. But the number of people with serious mental illnesses entering or re-entering homelessness continued to eclipse those being helped into housing and stability.

In recent years, research and practice have helped providers identify how to better assist different groups of homeless people and have pointed to the need for long-term solutions. As a result, proportionally more funding, from the McKinney Act and other sources, has gone toward efforts designed to help homeless people, including those who have mental illnesses, to break the cycle of homelessness. Among the initiatives targeted to homeless people with serious mental illnesses are intensive outreach programs to engage disenfranchised people, dual diagnosis treatment programs to help individuals with co-occurring mental illnesses and substance use disorders, and supported housing arrangements to help people with serious mental illnesses obtain and retain permanent housing.

Increasing numbers of programs seek to identify the reasons that people with mental illnesses become homeless and to develop interventions that work to minimize the factors that contribute to homelessness. This emphasis on prevention is being echoed in efforts as modest as a program to assist long-term residents of a State hospital to reenter the community, and as large as the Federal emphasis on prevention articulated in two key reports: *Outcasts on Main Street*, the 1992 report of the Federal Task Force on Homelessness and Severe Mental Illness, and *Priority: Home! The Federal Plan to Break the Cycle of Homelessness*, published by the Interagency Council on the Homeless in 1994.

The Federal plan proposed a two-pronged approach to address homelessness -- expanding services to help those who have become homeless and addressing structural inadequacies in housing and social services to help prevent people from becoming homeless. Both the Federal plan and the Task Force report focus on helping States and communities develop comprehensive systems of care to help homeless people become reintegrated in their communities. Although the Federal Government can provide support and direction, much of the work of addressing homelessness occurs at the State and local level, both reports note.

## **Using This Report**

This report has three objectives: (1) to demonstrate the need for prevention-oriented approaches to end homelessness among people who have serious mental illnesses; (2) to make recommendations regarding State-level strategies to strengthen prevention efforts; and (3) to give examples of specific State-supported initiatives and local efforts that are helping people who have a serious mental illness avoid homelessness. Many of these State and local initiatives serve to expand the reach of Federal homelessness assistance programs.

To identify State-supported prevention initiatives, information was requested from each State mental health commissioner. Nearly one-half of the States responded. A number of the programs are statewide strategies, while some are being implemented at the local level. Taken together, the approaches comprise a rich resource of practical, workable ideas that are making a difference in stemming homelessness among people with mental illnesses.

The report is designed primarily for those involved in planning and administering mental health programs and services for homeless people. Among the specific examples, readers may find some innovative strategies that hold promise for their own States or localities.

The first section of the report presents a prevention model that serves as the organizational framework for succeeding sections. The second section describes risk factors that make people with serious mental illnesses particularly vulnerable to homelessness and examines the current response to homelessness among this population.

Next, initiatives needed to prevent homelessness among people with serious mental illnesses are described and illustrated with examples of actual program and funding strategies at the State and local levels. The final section describes several statewide, integrated prevention approaches. Appendix A contains a list of contact persons who can provide more information on homelessness prevention for persons with serious mental illnesses and the examples provided in this report.

# A Model for Prevention

A comprehensive discussion of how States can prevent homelessness among people with serious mental illnesses requires a conceptual framework to denote clearly what is meant by prevention and to present strategies in a systematic manner. A widely used approach that is readily applicable to this issue is the risk and protective factors model (Pransky, 1991).

## Reducing Risks and Increasing Protective Factors

Risk factors are those conditions, characteristics, or variables that make it more likely for a person to develop a particular disorder. For example, having an alcoholic parent increases the likelihood that an individual will have problems with alcohol dependence. Strategies to *reduce risks* focus on diminishing the presence of this risk factor, e.g., targeting interventions to parents who are problem drinkers.

The other half of this two-pronged prevention approach is to work to *increase protective factors*. Protective factors are characteristics or conditions that mitigate risk factors, minimizing the likelihood that a person will develop a particular problem or disorder even with risk factors present. The concept of protective factors follows from the observation, common across all disorders, that many people considered at high risk for a particular problem do not in fact develop that condition, whether it be schizophrenia, involvement in criminal activities, or heart disease.

Theorists began testing the hypothesis that certain individual factors and environmental factors (in the family, community, or society) actually "protect" people from developing a condition or disorder despite exposure to high levels of risk. Some of these factors, such as race or birth order, are not readily subject to influence by outside interventions. But others can be significantly strengthened through targeted prevention strategies. Research has indicated, for example, that involvement with a peer group that disapproves of substance abuse is a protective factor mitigating against future substance abuse problems on the part of adolescents.

According to the risk and protective factors theory, effectively preventing homelessness among people with mental illnesses means identifying the factors that place them at risk for homelessness and implementing strategies to reduce the risk factors and/or to enhance the factors that appear to protect people from homelessness (Mrazek and Haggerty, 1994). Studies over the past decade have provided important information on risk factors for homelessness among people with mental illnesses; the newer idea of protective factors is largely untested, although some inferences can be made from the literature.

The prevention efforts that States volunteered for inclusion in this paper do not necessarily derive from an analysis of the research or even a particular theoretical framework. In real life, prevention initiatives tend to reflect a mix of research findings, practitioner beliefs based on experience, and various political and economic factors.

However, the risk and protective factors model is a useful and instructive way to describe the factors contributing to homelessness and to understand efforts to combat homelessness among people with serious mental illnesses. This prevention framework gives funders and providers a basis from which to devise strategies that directly target the causes of homelessness, and to develop initiatives that strengthen individuals' abilities to avoid becoming homeless.

# **Risk Factors for Homelessness Among People With Serious Mental Illnesses**

Estimates have placed the number of homeless people at as many as 600,000 on any given night (Interagency Council on the Homeless, 1994; Burt and Cohen, 1989), with recent research indicating that as many as 7 million Americans may have experienced homelessness at least once in the latter half of the 1980's (Culhane et al., 1993; Link et al., 1995). Most studies report that about one-third of adults who are homeless have a serious mental illness, including schizophrenia, affective disorders, and schizoaffective disorders (Lehman and Cordray, 1993). However, it is important to note that only 5 percent of the estimated 4 million people who have a serious mental illness are homeless at any given point in time (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

Although it is rarely possible to point to a single cause of homelessness for any one person, a number of individual and environmental factors clearly increase the risk of homelessness for people with mental illnesses. Identifying these factors makes it possible to devise strategies that either reduce the risk of homelessness or enhance the protective factors that will mitigate against these risks.

## **INDIVIDUAL RISK FACTORS**

### **The Nature of Mental Illness**

The symptoms of serious mental illnesses increase vulnerability to homelessness. Depending on the disorder, people with a mental illness may experience periods of extreme paranoia, anxiety, depression, or active hallucinations and disruption of thought patterns. When symptoms occur, individuals may engage in behaviors that threaten their housing stability. They may disturb neighbors, miss rent or utility payments, or neglect their housekeeping to such an extent that they are evicted. If symptoms become severe enough to warrant hospitalization, rent may go unpaid, resulting in the loss of housing.

A distinct characteristic of mental illness is its unpredictability; symptoms may abate for awhile, only to return. For some people with a mental illness, stressful or unpredictable situations bring on a recurrence of symptoms. Those with serious mental illnesses may need help managing their everyday affairs and meeting the responsibilities of their various roles (e.g., tenant, employee, friend) — some just occasionally, and others for many months or years.

Many people with mental illnesses have difficulty developing and maintaining comfortable social relationships. This can lead to loneliness and isolation, as well as conflicts with family, employers, landlords, and neighbors. These conflicts can result in homelessness if appropriate treatment and services are not available.

## **Co-Occurring Mental Illnesses and Substance Use Disorders**

As many as one-half of all people who are homeless and have a serious mental illness also have a substance use disorder (Fischer and Breakey, 1991). People with both disorders tend to have significant functional limitations that make it difficult for them to maintain stability in the community.

The interaction of mental illness and substance abuse is complex and presents a challenge that few clinicians are prepared to meet. Common characteristics of people who have dual disorders include greater psychiatric symptomatology; denial of mental illness and substance abuse and refusal of treatment and medication; antisocial, aggressive, and sometimes violent behavior; combined drug and alcohol abuse and polydrug abuse; and high rates of suicidal behavior and ideation (National Resource Center on Homelessness and Mental Illness, 1990).

Few integrated treatment programs exist for people with co-occurring mental illnesses and substance use disorders, which means that even individuals motivated to get help may be unable to find it or face long waits. Self-help groups, shown to be especially effective in helping people curtail alcohol or drug use, may be reluctant to include people with mental illnesses.

Without treatment, those with both a serious mental illness and substance use disorder are likely to be poor tenants. Few housing providers, including private landlords, mental health agencies, and nonprofit developers, will rent to people with mental illnesses who are actively abusing substances. Individuals with dual disorders may also be unwelcome in structured, supervised residences, and many are unwilling to live by the rules and treatment requirements of some group living facilities. Their behaviors place them at high risk for eviction, arrest, and incarceration in jails or mental hospitals.

## **Exposure to Victimization**

Persons with serious mental illnesses who have been physically or sexually victimized at some point in their lives may be particularly vulnerable to homelessness, especially if the victimization was perpetrated by a family member. For example, research findings point to high prevalence rates of sexual abuse trauma in the lives of homeless women with serious mental illness. These factors complicate treatment planning and point to the need for program planners and clinicians to adapt interventions for trauma survivors (Harris, 1994).

## **ENVIRONMENTAL RISK FACTORS**

### **Mental Health System Factors**

**Inadequate discharge planning.** Research has identified support services during and immediately following hospitalization or incarceration as critical in preventing homelessness. Without efforts to ensure continued rent payments, prerelease programs to plan for a return to the community, and followup to help connect individuals to treatment and community supports, the risk of homelessness is especially high among people with mental illnesses who are leaving

institutions. Many individuals are released from hospitals or jails to tenuous community situations, with no single agency designated as responsible for helping them secure appropriate housing, treatment, and support services.

Research has shown that assertive community treatment (ACT) teams have been successful in negotiating and coordinating multiple service systems to assist clients in accessing basic services and supports (McGrew and Bond, 1995; Bond et al., 1991; and Dixon et al., 1995). Members of a multidisciplinary treatment team conduct regularly scheduled home and community visits based on individual needs, emphasizing attention to managing everyday problems and providing clients with support in learning skills for everyday living.

**Resource limitations.** Too often, funding and other resources for support services that would enable people with mental illnesses to maintain homes and manage in the community are not available. Where individual and group therapy and case management are available to people with serious mental illnesses, caseloads are usually high, enabling little more than medication management and infrequent client monitoring.

**Lack of integrated community-based treatment and support services.** Although much has been learned in the past decade about effective treatment interventions and preventing homelessness among people with serious mental illnesses, uncoordinated, fragmented service systems persist. One agency may view a homeless person with a serious mental illness as a shelter resident, another as a mental health client, and yet a third as a substance abuser. Most agencies do not recognize the client's full array of needs or address them in a coordinated and cohesive manner (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

In many instances, the burden of negotiating complex service systems rests with consumers who are frequently excluded from homeless programs because of their mental illnesses and from mental health programs because of their homelessness. Some consumers need long-term, intensive support to navigate the often fragmented bureaucracies that provide their benefits, to advocate for their service needs, and to assist them when problems arise. The intensity of services should be flexible, so that people can move to a lower or higher level of services as needed. Without intensive support, many people with serious mental illnesses are in danger of losing their housing when symptoms recur. In addition, services may be provided on a "one size fits all" basis, ignoring the heterogeneity of people with mental illnesses. Service systems need to identify and target groups with special needs and characteristics, such as mothers with young children, older people with long histories of institutionalization, and ethnic and cultural minorities.

**Lack of community-based crisis alternatives.** For many people with serious mental illnesses, hospitalization, often far from home, is the only option when they are in crisis. Crisis outreach teams and emergency residential services can enable people to stay in their own communities and maintain contact with their regular service providers and family members. Without such help, individuals experiencing acute psychiatric symptoms are at risk of being jailed or hospitalized, possibly resulting in the loss of their homes.

Even with supportive services, some people with mental illnesses experience residential instability for a time, either choosing to leave their housing on short notice, or through evictions. Immediate access to transitional or respite housing can help prevent individuals from ending up in emergency shelters or on the streets.

**Lack of attention to consumer preferences.** Until recently, mental health professionals presumed that most people with serious mental illnesses required supervised, treatment-oriented, group living arrangements to be successful in their communities. Current research, however, provides strong evidence that people with mental illnesses neither need nor want to live in such settings.

In consumer preference surveys, people with mental illnesses cited autonomy and privacy as the two most important qualities of housing, neither of which are easy to achieve in group living situations (Carling, 1993). The success of people with severe disabilities in independent housing depends on three central principles: (1) consumers choose their own housing; (2) they live in integrated, regular housing rather than in segregated, mental health programs; and (3) they receive the services and supports they need to maximize their success (Carling, Randolph, Blanch et al., 1987; Brown, Ridgway, Anthony et al., 1991).

Results of a recent Federal demonstration program administered by the Center for Mental Health Services (CMHS) indicate that residential stability is an attainable goal for most homeless people with serious mental illnesses when appropriate supportive services are available (Center for Mental Health Services, 1994). In Boston, one of five CMHS McKinney demonstration projects, 75 percent of project participants remained in community housing after 18 months. At 12 months, 60 percent of participants in the San Diego project lived in the same setting, and 86 percent had not been homeless the preceding 60 days.

Unfortunately, in most communities, supported housing is not available or is being offered only on a small-scale, demonstration basis. Often those individuals who have the most severe disabilities cannot manage the requirements of group living and end up without any home at all.

## **Structural Factors**

**Lack of affordable housing.** Individuals with mental illnesses often become homeless for the same reasons as other people with low incomes; primary among these individuals is the lack of affordable housing. The gentrification of cities in the past 20 years, combined with a sharp drop in new, low-cost housing construction in the past decade, has resulted in a severe shortage of affordable housing. When housing is affordable, it is often unsafe, in disrepair, or located far from services and public transportation.

Many people with serious mental illnesses qualify for Federal Section 8 certificates or vouchers. These vouchers provide a subsidy that requires people to pay only 30 percent of their income for rent and utilities. However, long waiting lists are the rule throughout the country, with many people having to wait years before they receive a subsidy. Other types of Federal housing that are available to people with low incomes generally rent for about twice what a person who receives Supplemental Security Income (SSI) can afford.

Public housing has been an important resource for people with mental illnesses for the past 30 years. However, this resource may become less available as a result of the Federal Housing and Community Development Act of 1992. This law permits public housing agencies (PHA's) to designate a project, a floor, or noncontiguous units for the exclusive use of either elderly people or people with disabilities. PHA's that intend to designate housing must submit an allocation plan to the U.S. Department of Housing and Urban Development (HUD) to show how the agency will maintain its efforts to assist nonelderly, disabled people.

The shortage of affordable housing for people with serious mental illnesses is also due, in part, to mental health agencies that have traditionally focused on offering clinical and case management services rather than housing, while the housing community has not been eager to develop housing for people with special needs. In an era of limited resources and increasing demand, many mental health and housing providers have begun to realize the importance of working together to address this problem (U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services, 1993).

To guide their efforts, HUD and the U.S. Department of Health and Human Services have developed a Blueprint for a Cooperative Agreement between Public Housing Agencies and Local Mental Health Authorities. This document outlines the respective roles and responsibilities of each agency in meeting the housing and service needs of homeless people with serious mental illnesses (U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development, 1994).

**Insufficient disability benefits.** Without special support, people who have a serious mental illness are often unable to work in the competitive marketplace, seriously hindering their ability to produce adequate incomes to meet their basic living needs (i.e., housing, food, clothing, medical expenses). Although most people with serious mental illnesses qualify for SSI, the SSI grant in 1994 was \$446 per month, or \$5,352 per year, meant to cover rent and all other expenses. Even with SSI supplements, provided by fewer than one-half the States, SSI recipients remain well below the Federal poverty level and in the lowest income bracket in the Nation.

A national study comparing SSI with housing costs in 1990 found that, on average, "66 percent of a monthly SSI check was required to pay rent for an efficiency apartment, and 80 percent was needed to rent a one-bedroom apartment." SSI represented only 23 percent of median income (McCabe, Edgar, Mancuso et al., 1993). This disparity between SSI income and the cost of renting an apartment means that many people with serious mental illnesses are virtually shut out of the housing market. Those individuals who do manage to find apartments generally have little money available for any unanticipated expenses. One high utility bill or a rise in the cost of medication may mean that they cannot pay their rent.

For SSI recipients who work, even minimal income may cause them to lose their benefits and, along with it, their eligibility for health insurance through Medicaid. Because they often work in part-time or entry-level jobs with little or no health insurance benefits, many people with mental illnesses forego paid employment to maintain their health care coverage. These factors point to the important need to expand incentives for persons with serious mental illnesses to obtain meaningful employment without jeopardizing their entitlements and to increase their access to

vocational training programs providing them with the skills and education needed to obtain higher paying jobs.

**Lack of coordination between mental health and substance abuse systems.** The apparent role of substance abuse, particularly drug abuse, in the loss of housing suggests that substance abuse treatment for persons with serious mental illnesses is critical (Center for Mental Health Services, 1994). However, a long tradition of separate mental health and substance abuse services has restricted the ability of existing agencies to provide adequate treatment for people who have co-occurring mental health and substance use disorders. Treating individuals in two separate systems not only places the burden of combined mental health and substance abuse treatment on the patient, but leads to mistrust and poor coordination between the two systems, as well as higher rates of treatment noncompliance.

Models for treatment that have emerged during the past decade emphasize the integration of mental health and substance abuse treatment. Integrated treatment programs involve the same clinician or teams of clinicians to treat both mental illness and substance abuse simultaneously. By integrating the knowledge, skills, and resources of both systems, treatment of co-occurring disorders can be significantly improved, which should also lead to a lower risk of homelessness (Drake et al., 1996).

### **Family/Community Factors**

**Stigma and discrimination.** Recent Federal legislation, notably the Fair Housing Amendments Act of 1988, prohibits discrimination in housing against people with disabilities. Nevertheless, resistance to community housing for mentally ill people is widespread, based in large part on negative stereotypes and unfounded fears (Robert Wood Johnson Foundation, 1990). These attitudes make it difficult for people with serious mental illnesses to find and maintain homes in their communities, obtain employment, participate in social activities, and be accepted by their neighbors and community.

**Poor family relationships.** People with mental illnesses who become homeless have less contact with their families and are more likely to have poor family relationships than those who are not homeless. Often relationships deteriorate over time, as parents or other relatives become exhausted and frustrated with the difficulties of helping a relative who may have recurring periods of disturbing or frightening behavior. Without the ongoing care and persistent advocacy that family members provide, many people with serious mental illnesses are at greater risk for homelessness.

## **THE CURRENT RESPONSE**

The Federal Government and nearly every State and locality have responded to the crisis of homelessness with a wide variety of initiatives. In most communities, a combination of public and private funding supports multiple services, including emergency shelters, outreach programs, drop-in centers, transitional housing, and health care. Most serve the general homeless

population, but some programs are specifically designed for people who are homeless and have mental illnesses.

A number of outreach programs have been effective in reaching homeless people with serious mental illnesses who are unable or unwilling to accept help from traditional mental health and social service agencies. Some programs offer a range of intensive services, often over a period of a year or more, to help reintegrate homeless people with mental illnesses into the community. In many cases, these efforts are literally saving people's lives.

However, the costs to run these programs are high, making them few and far between. While there certainly are success stories, the numbers of people in need far exceed the capacity of programs that provide the intensive outreach and case management needed. Most homeless people with mental illnesses receive minimal treatment and services and many cycle in and out of hospitals, jails, shelters, and life on the streets.

Across the five CMHS McKinney research demonstration projects, 78 percent of participants had a history of psychiatric hospitalization, and one-quarter had been hospitalized five or more times. Three-quarters of the participants had been homeless 1 year or longer, and 15 percent had experienced 10 or more years of homelessness. More than one-third of those interviewed had been homeless five or more times (Center for Mental Health Services, 1994).

To some extent, initiatives designed to help homeless people may inadvertently perpetuate homelessness. Many Federal- and State-funded programs aimed at ending homelessness, including some for people with serious mental illnesses, require that an individual be homeless to receive services, housing, or benefits. Thus, those who are teetering on the edge of homelessness cannot receive help until they have actually lost their homes and are sleeping in shelters or on the streets.

The loss of dignity and a sense of control over one's life that many homeless people experience may make it all the more difficult to escape homelessness (Culhane and Fried, 1988). In addition, the costs, time, and effort required to rehouse people with mental illnesses who have become homeless are far greater than the expense of measures to help people keep their homes.

Although not always termed prevention programs, efforts to address the problems that contribute to homelessness are on the increase. They range from efforts that are narrowly construed, such as short-term rental assistance to avert evictions, to full-scale, integrated efforts to fund the range of housing and services that people with serious mental illnesses need to achieve long-term stability. Some measures are aimed at a specific group of individuals, such as homeless people with mental illnesses being released from hospitals or jails, while other types of assistance may be available to any family or individual at risk of homelessness.

Prevention programs generally have the resources to serve only a small portion of those individuals at risk for homelessness. The development of comprehensive, integrated systems of care that would help stem the tide of homelessness are beyond the financial and human resources of all but a few locations. Still, many States and communities have initiated programs designed

to reduce the risks of homelessness for people with serious mental illnesses. A number of these initiatives are described in the following section.

# Identifying What Is Needed

Although providers cannot prevent the onset of serious mental illnesses and its attendant symptoms, they can help individuals with mental illnesses avoid homelessness. This section examines a number of strategies to reduce individual and environmental risks, where possible, and to increase the protective factors that mitigate against those risks. Specific examples culled from States and communities illustrate these efforts.

## ADDRESSING INDIVIDUAL RISK AND PROTECTIVE FACTORS

### Reducing Risks

**Treatment and supports for people with co-occurring mental illnesses and substance use disorders.** Treatment and supports for people with dual diagnoses have the potential both to reduce the risks associated with co-occurring conditions and to provide persons with mental health and substance use disorders the necessary skills to avoid homelessness.

*Providing substance abuse expertise on Assertive Community Treatment teams.*

*Illinois* has recently funded nine Assertive Community Treatment (ACT) teams that include staff who have expertise in substance abuse treatment. The ACT teams perform comprehensive assessments and refer people with co-occurring disorders to treatment programs, including detoxification, emergency residential treatment, outpatient substance abuse treatment, and residential rehabilitation. Services are designed to meet a range of needs and are delivered primarily in clients' homes and neighborhoods. (For more information on examples contained in this report, consult Appendix A for a list of State contact persons.)

*Assigning specialists in co-occurring disorders to psychiatric emergency rooms.*

*To enhance identification and appropriate referral of individuals with co-occurring disorders, the New York City Regional Office of the State Office of Mental Health stations specialists in dual diagnoses in the psychiatric emergency rooms of several city hospitals. The specialists evaluate individuals, make treatment recommendations, and link patients to community-based treatment resources.*

### Enhancing Protective Factors

**Support and training for community living.** Because the nature of mental illness makes it difficult for some people to meet the requirements of tenancy, manage their daily affairs, and develop friends and meaningful activities, support and training for community living can help consumers maintain stability despite sometimes debilitating symptoms. Assistance with the activities of daily living may include practical help such as guidance in money management, medication monitoring, housekeeping, and developing recreational and social interests. Mental health staff also can intervene in problems with landlords, housing managers, or neighbors.

This psychosocial rehabilitation approach to treatment requires specialized staff training and ongoing, regular involvement with consumers. It means a considerable shift in the allocation of resources away from the office to clients' homes and neighborhoods. Some States are funding staff-intensive services through the Medicaid Rehabilitative Services State option.

***Providing assertive community treatment.*** *In Rhode Island, mobile treatment teams serve people with serious mental illnesses judged most in need of intensive support, many of whom are at risk for homelessness. Team members, who include psychiatrists, nurses, employment counselors, case managers, and rehabilitation specialists, offer clients daily living skills training, assistance in developing positive social relationships, and help structuring free time. The staff-to-consumer ratio is no more than 1:10, and most services are delivered at individuals' homes or in the community. Funding for the mobile treatment teams comes from a mix of Medicaid dollars and State mental health funds.*

***Developing independent living skills.*** *In Berrien County, Michigan, the Supported Independence Program provides life skills training, support, and service linkages to 70 consumers per month, mostly in scattered-site apartments. The program's eight life skills consultants work directly with consumers on a one-to-one basis to help them develop the skills and resources they need for independent living. The local mental health center provides treatment, crisis intervention, and other support. Program participants are expected to work toward being employed and/or participate in a vocational/educational program, or volunteer at least 20 hours per week.*

***Mediating with landlords.*** *Case managers for the Network Project in Tampa, Florida, whose clients are people with mental illnesses who are homeless or at risk of homelessness, have found that the ability to mediate with landlords has prevented a number of evictions. Case managers meet with consumers and landlords to develop agreements, including arranging payment plans, offering emergency relief funds, and helping consumers with behavior management.*

## **ADDRESSING ENVIRONMENTAL RISK AND PROTECTIVE FACTORS**

### **Mental Health System Factors**

Mental health systems employ two primary strategies to reduce risk factors for homelessness among consumers. One strategy is enhancing discharge planning, which directly targets the periods of transition from institutions to the community. The other strategy is providing crisis services and temporary housing, which are aimed at reducing the increased vulnerability to homelessness during psychiatric emergencies and times of residential instability.

**Discharge planning.** Individuals who have mental illnesses are especially vulnerable during the period of transition from a hospital or jail to the community. Discharge planning is among the

most critical strategies that States can adopt to reduce the risk that these individuals will become homeless.

Discharge planning should begin well before an individual's scheduled release and should include visits to the community to locate housing and connect with necessary services. Followup is also important to ensure that individuals are receiving long-term support.

***Targeting long-term inpatients.** The Supported Housing and Supported employment Program in Weston, West Virginia, is a State-funded initiative to provide permanent housing and supports to former long-term patients of Weston State Hospital. Most clients are living in independent, supported housing or in supervised residences, and they report high levels of satisfaction with their current situations. The project coordinator attributes the program's success to extensive pre-discharge planning and client preparation for community living, a high level of staff support, a focus on client choice, opportunities for meaningful daytime activities, and extensive staff training.*

***Planning for deinstitutionalization.** As the 140 patients at a Regional Treatment Center (State hospital) in northeastern Minnesota are being released to the community on a gradual schedule, the State is encouraging development of comprehensive local efforts to help support these individuals in housing over the long term. A total of \$4.8 million in competitive funds has been dedicated to this effort over a 2-year period. Some of the local strategies being proposed are subsidized housing, personal care attendants, crisis services hospitalization, and team case management. Services will be provided by contracts with community mental health centers and other providers.*

***Preparing for release from jail.** The Network Project in Hillsborough County (Tampa), Florida, works with the local Public Defenders Office to reduce the number of people with mental illnesses released from jail who end up homeless. A Network Project case manager meets with the individual at the jail for screening and needs assessment and attempts to arrange for housing, treatment, and other resources prior to the individual's release. If needed, a case manager will meet the individual upon release and try to arrange temporary housing until more permanent arrangements can be made.*

**Crisis services and temporary housing.** Providers are increasingly recognizing the importance of being able to respond quickly to people in crisis, assist individuals onsite if needed, and provide short-term crisis facilities to avoid unnecessary hospitalizations. Although such efforts cannot eliminate residential instability for all people with serious mental illnesses, they help reduce the risk that those people who lose their housing will become homeless.

Ready access to short-term housing alternatives is an important adjunct to treatment and support services. In a recent survey of 26 consumer preference studies, help with crises and the ability to reach staff at any time were the two highest-rated staff supports. Many States are supporting some crisis resources, but statewide coverage is rare, and providing services in rural areas is especially problematic.

***Providing crisis teams and access to other supports.*** Each of North Dakota's regional human service centers has an Intervention Services Team consisting of a psychologist, social worker, and addiction counselor. The teams provide crisis assistance, onsite assessments, and linkage to services to stabilize individuals. Supervised crisis beds, medication monitoring, and case management services are also available. Hospitalization is seen as a last resort.

***Enhancing hospital psychiatric emergency services.*** The New York State Office of Mental Health funds a crisis intervention initiative called the Comprehensive Psychiatric Emergency Program. The program provides enhanced emergency services in specified psychiatric emergency departments that help prevent homelessness by maintaining people in their own homes or by locating transitional settings that can be used to avoid hospitalizations. Services include mobile crisis intervention, supervised emergency observation beds for up to 72 hours, dual diagnosis treatment, and access to crisis residential beds.

***Helping consumers secure appropriate crisis services.*** Hawaii's statewide consumer support organization, United Self-Help, has developed a simple, yet effective, homeless prevention strategy – the Emergency Health Information Card. The card provides information on whom to call – such as an individual's case manager or psychiatrist – when a person with mental illness is in jeopardy. Thus, the police or other party intervening in a crisis can make appropriate contacts, possibly averting arrest or institutionalization that may lead to homelessness.

***Providing short-term housing options to avoid homelessness.*** A 1992 Massachusetts study that investigated causes of homelessness among people with mental illnesses cited the need for "a bank of available housing, backed up by respite beds, to ensure rapid rehousing of those individuals who lose their housing placements" (Mulkern, Tessler et al., 1992). In response, the Department of Mental Health housing staff, while moving toward a supported housing model for permanent housing, has also put considerable effort and resources into subsidized transitional housing and respite placements.

## **Enhancing protective factors**

Strategies to enhance protective factors that mitigate against the risks of homelessness for people with serious mental illnesses focus on the development of systems of care that are appropriate, available, and responsive to the needs of those they are designed to serve. The characteristics of such a system include the following:

- Flexibility in services and funding that enable providers to offer individualized assistance;
- Comprehensive and integrated services that increase the range and accessibility of appropriate treatment, housing, and supports;

- Formal linkages between public housing and mental health agencies to support consumers in public housing and to increase access to public housing for people with mental illnesses;
- Residential options that respond to consumer preferences, thereby increasing the likelihood that people with serious mental illnesses will maintain long-term residency; and
- Treatment and services that are culturally relevant and sensitive.

**Flexibility in services and funding.** Flexible treatment and funding approaches that enable providers to individualize services and address the full complement of consumers' needs are instrumental in helping people avoid homelessness. These include protective strategies such as intensive case management programs that provide varying levels of assistance as clients' needs fluctuate and access to discretionary funds to pay for minor expenses that will help clients obtain or keep their housing. Treatment and service approaches that respond to the differing needs of specific groups of consumers, such as minorities, elderly people, and women with children, are also effective in attracting people with mental illnesses to services that will help them maintain community stability.

***Enhancing case management and providing discretionary funding for at-risk individuals.** In 1990, Alaska's Division of Mental Health and Developmental Disabilities began the Institutional Discharge Project, with Medicaid and State grant funding, to aid people with serious mental illnesses who are the highest users of the State hospital and jail facilities. New case managers have been added in Alaska's four largest communities to reduce the average staff-client ratio to 1:12, which is one-half the caseload in Alaska's community support programs. Project staff receive 6 weeks of training in psychosocial rehabilitation. Flexible service funds, which can be used for any expenses needed to keep clients in the community, have been increased tenfold to \$2,000.*

***Providing flexible funding for housing-related expenses.** As part of Missouri's Department of Mental Health Supported Housing Program, a flexible fund is provided to each agency contracted to provide support services to consumers in the program. The fund may be used to cover any housing-related costs, including deposits, utilities, furnishings, or emergencies.*

***Targeting specific groups of people at risk for homelessness.** Minnesota recently funded nine, 2-year Family Homeless Prevention and Assistance Program grants, providing rental assistance and coordinated support services to families who are at risk of homelessness. One grant was awarded to a community mental health center to help families with a parent who has a serious mental illness.*

Having consumers provide supported housing services. The Supported Housing Options Program (SHOP) in Virginia provides 31 people who have serious mental illnesses with permanent housing and support from a residential services team that includes 5 consumers.

Through a collaborative effort between the Fairfax-Falls Church Community Services Board and Pathway Homes, Inc., residents choose their own housing and receive individualized services. Consumer service team members are involved in all aspects of program development and operation. A supported housing fund assists program participants with rents, utilities, and security deposits.

**Comprehensive, integrated systems of care.** Enabling individuals to meet their housing, treatment, and service needs without having to deal with multiple providers and eligibility criteria can protect consumers from the common problem of "falling through the cracks." Integrating service systems can be accomplished in a number of ways, including co-location of multiple services, cooperative agreements among agencies, and development of common eligibility forms.

CMHS is currently funding demonstration grants to 18 localities in 9 States that are developing and evaluating local, integrated systems of care for homeless people with serious mental illnesses and co-occurring mental illnesses and substance use disorders. Many of the strategies being tested through these ACCESS (Access to Community Care and Effective Services and Supports) grants, such as offering multiple services in low-demand settings and creating multiagency provider coalitions, are appropriate strategies for preventing homelessness among people with mental illnesses.

***A multiagency, multidisciplinary approach.** The Bridgeport, Connecticut, ACCESS sites are testing a services integration approach that features the creation of a multiagency, multidisciplinary outreach team. Team members provide intensive engagement and assertive community treatment at two sites that also have drop-in centers for homeless people. At the systems level, a multiprovider task force will promote partnerships among participating agencies, identify barriers to service delivery for homeless people with serious mental illnesses, and develop strategies to address these barriers.*

***Co-location of services.** North Dakota has developed a system of Regional Human Service Centers providing a rich array of services that include mental health and substance abuse treatment, health care, vocational rehabilitation, and access to financial assistance, among others. The centers are co-located with county social service providers, offering ready access to a host of additional resources.*

***Developing an integrated system and a sense of community.** The Los Angeles Men's Place (LAMP) is a private agency in the skid row area of Los Angeles that provides housing and services for people with mental illnesses who are homeless or at risk of homelessness. LAMP programs, funded with a mix of public and private dollars, emphasize the principles of developing life-long support and building a sense of community. LAMP Village offers long-term housing within a structured community and access to LAMP's day program, employment training program, and other supports. Mental health treatment and case management are provided by the Skid Row Mental Health Clinic. LAMP employs clients in four small businesses and as residence staff.*

**Formal linkages between public housing and mental health agencies.** Because they generally control a good deal of subsidized low-income housing in their communities, PHA's are important players in strategies to prevent homelessness. As demographics change, many public housing developments designed primarily for elderly families have increasingly become home to younger people with mental illnesses. Whether individuals with a serious mental illness believe this is a reasonable housing option often depends on the efforts made by mental health agencies and PHA's to make this mixed-housing approach work.

Mental health agencies can support PHA's by preparing elderly residents of public housing for new, younger neighbors; offering information and referral to all residents; and providing 24-hour crisis intervention. They can also develop cooperative initiatives with PHA's that increase consumers' access to community housing, through Section 8 set-asides and other approaches, while providing support services for tenants (U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services, 1993). Such cooperation is particularly critical in light of the Housing and Community Development Act of 1992, which allows PHA's to designate housing for the exclusive use of either elderly people or disabled people.

*Placing service coordinators in public housing. Massachusetts is testing a six-site pilot project to place service coordinators in public housing for elderly families to mediate conflicts between residents, link tenants with services, and help prevent lease violations and evictions. The pilot project is a collaborative effort of seven State agencies, with funding for the coordinators provided by the Department of Mental Health, the Executive Office of Communities and Development, and the Housing Finance Agency. Also in Massachusetts, a 1993 directive from the State Commissioner of Mental Health instructs mental health area offices to establish formal linkages with housing agencies to assist people with serious mental illnesses.*

**Residential options that respond to consumer preferences.** A number of States are supporting local efforts to help individuals who have serious mental illnesses identify housing options, make realistic choices, and obtain the services they need to support them in their homes. Because a majority of consumers, if given a choice, opt for living alone or with a roommate in independent housing, many States are trying to expand consumer access to independent housing with supports.

*Separating housing and services. The Missouri Department of Mental Health (DMH) Supported Housing Program, which emphasizes consumer choice and flexible supports, provides temporary vouchers for people with serious mental illnesses who are on Section 8 waiting lists. A key feature is separation of housing and services, with leases negotiated between tenants and landlords. Program participants may continue to receive subsidies if they meet the conditions of tenancy, even if they refuse support services. The voucher is administered by local PHA's, and services are provided through contracts with local mental health agencies. A DMH housing team provides technical support.*

***Providing independent housing in the context of an integrated service community.***  
*LAMP Lodge is a permanent, independent housing program operated by LAMP in Los Angeles. LAMP Lodge provides 50 apartments located in a renovated building within several blocks of the businesses, day program, and other residences operated by LAMP. Residents may choose to accept any number of available support services or none at all, and may remain residents as long as they meet the terms of their leases. Many residents are employed at one of the four businesses operated by LAMP Village.*

**Providing culturally competent care.** Cultural differences can determine how individuals define their problems and how they express them, the treatment strategies they prefer, and from whom they seek help. Practitioners, too, perceive clients through their own cultural lenses unless they have become adept at seeing in other ways. To be effective with homeless people with mental illnesses, professionals must alter their practices and the service delivery system to become compatible with cultural expectations of care.

Culturally sensitive service provision includes (1) a language and culture match between providers and clients; (2) provision of the needed services in racial, ethnic, or other minority communities; (3) flexible hours and accommodation of walk-ins; (4) provision of Å or referral to Å services for social, economic, legal, and medical problems; (5) use of family members in the treatment process; and (6) use of Å or referral to Å clergy and/or traditional healers in the treatment process (Flaskerud, 1986).

### **Structural Risk and Protective Factors**

Among environmental factors contributing to homelessness, the structural factors of insufficient affordable housing and inadequate disability benefits are most amenable to risk reduction strategies. These strategies include efforts to increase affordable housing options; programs to help consumers afford housing, including State rent supplement programs and SSI supplement programs; and initiatives to minimize the consequences of loss of SSI income during hospitalization, such as rent continuation programs.

**Increasing affordable housing options.** Expanding access to low-cost housing can help reduce the risk that people with mental illnesses will become homeless. States and localities have directly funded affordable housing and have used a number of other approaches to encourage creation of housing for people with mental illnesses by private developers and PHA's.

State housing finance agencies, which often finance affordable housing through the sale of tax-exempt bonds, can be an important resource for organizations developing low-cost housing for people who have serious mental illnesses. State community affairs departments are another source of housing funds, with loans to private developers that require a certain percentage of housing developed to be reserved for low-income renters.

Some State mental health departments have capital program budgets that can be used to develop and acquire housing or to provide loans to private developers for creating housing for people with serious mental illnesses. One innovative approach that has proved effective is to create an

independent housing development entity that provides funding for housing on behalf of the mental health department.

***Offering equity loans to nonprofit groups.*** *The Massachusetts Legislature passed a \$30 million "capital pooling" housing development program that began in 1994. The State Department of Mental Health (DMH) intends to use it in part to fund permanent housing, with an emphasis on independent living units, for consumers who have no other residential alternatives. Equity loans covering as much as 30 percent of the total cost of approved construction or rehabilitation projects will be provided to eligible nonprofit groups developing housing for people with mental illnesses. DMH will also be able to enter into long-term leases with housing providers and will coordinate its efforts with Federal, other State, and local affordable housing financing programs.*

***Creating a nonprofit housing development corporation.*** *Thresholds, Inc., is a nonprofit housing development corporation designed to increase independent housing opportunities for people with serious mental illnesses in Rhode Island. Established in 1988 with a grant from the National Institute of Mental Health Community Support Program, the agency has funded more than 200 new units of supported, independent housing, with a focus on mobile services, community partnerships, and consumer choice. Thresholds funds both predevelopment and capital costs through State bond dollars targeted for housing development; in Fiscal Year 1994, \$1.9 million was available. Staff provide technical assistance to developers and to mental health and housing agencies.*

State and local mental health agencies are increasingly developing partnerships with public housing agencies and private, nonprofit developers to increase housing opportunities for people with serious mental illnesses. For example, a mental health agency may offer building managers assurances of timely rent payments, crisis intervention, and continuing support to clients in return for set-asides of a certain number of units for people with mental illnesses. Innovative partnerships have also been formed with private, for-profit developers, who can take advantage of Federal low-income housing tax credits.

***Funding a collaborative SRO project.*** *Greenup House in Covington, Kentucky, is a 19-unit, single-room-occupancy (SRO) development for people with serious mental illnesses who are homeless or at risk of homelessness. The project was financed through a unique collaborative effort. A private developer funded the building renovation through tax credits and a loan from a local bank. The local PHA assigned 19 project-based Section 8 certificates to make the units affordable to tenants. Residential aides who manage the building, staff the front desk, and do some medication monitoring are provided by the local community mental health center.*

The Federal Government plays a key role in financing low-income housing, including housing for people with disabilities. Although Federal housing programs have some limitations regarding flexibility and affordability for people with serious mental illnesses, they remain an important resource for increasing the supply of affordable housing for people with serious mental illnesses.

By combining two or more sources of Federal funding and/or State and local dollars, agencies have been able to create supported housing that is affordable to people on SSI.

*Using HUD foreclosed properties and HUD Section 811 grants. Through HUD's Single Family Property Disposition Program, some local providers in Virginia lease homes that HUD has acquired through foreclosure. Leases are for four renewable 1-year terms at \$1 per year, and houses must be used for homeless people during the lease period. With site control of the HUD homes, providers can more easily apply for HUD Section 811 grants, which cover costs to purchase and renovate housing for people with disabilities, as well as financing to subsidize rent and fund operating costs. As many as five three-bedroom homes can be developed under each Section 811 grant.*

**State rent supplement programs.** State rent supplements, usually modeled after the Federal Section 8 program, are one of the most straightforward, effective ways to enable people to afford housing and avoid homelessness. Like Section 8, State supplements generally require individuals to pay about one-third of their income for housing, with the balance covered by the supplement. State supplements are usually tenant-based, meaning that consumers can use them to pay rent in the private housing market. Often they are meant to be a temporary form of assistance, serving as a "bridge" while individuals are on lengthy Section 8 waiting lists.

*Interagency collaboration to provide rent subsidies. The Massachusetts Department of Mental Health funds a rental subsidy program for people with mental illnesses to enable them to rent housing at market rates. The program is administered by the State's Executive Office of Communities and Development, which contracts with local housing authorities to determine client eligibility, pay landlords, and perform inspections. In 1993-94, more than \$2.6 million was paid in rental subsidy assistance on behalf of 872 individuals. The program subsidizes a variety of housing types and provides both tenant and project-based assistance.*

*Providing rental subsidies to people on Section 8 waiting lists. In Minnesota, a \$1 million rental subsidy program called Bridges assists 250 individuals a year who have serious mental illnesses. The program, administered by the Minnesota Housing Finance Agency, provides a temporary, modified Section 8-type rental subsidy for individuals on a Section 8 waiting list. Priority is given to people who are homeless or at risk of becoming homeless.*

*Using Federal HOME funding to provide Section 8-type certificates. Delaware County, Pennsylvania, has allocated \$350,000 in Federal HOME funds to be administered by the Housing Authority in the same manner as Section 8 certificates. People with mental illnesses who are on the Section 8 waiting list can use the HOME rental assistance certificates to subsidize housing of their choice. When they receive their Section 8 subsidies, the HOME certificates can be used by other eligible applicants. The Office of Mental Health provides individualized support services to program participants.*

**State SSI supplement programs.** Like Section 8-type supplements, SSI supplement programs are meant to help people with mental illnesses and other disabilities who otherwise could not

afford to pay rent. Unfortunately, although nearly one-half of the States provide SSI supplements, few supplements are large enough to raise individuals' incomes to the point where they can compete for market-rate rents, even on the low end of the rental housing market. Thus, while the concept of State SSI supplements would appear to reduce the risk of homelessness due to insufficient income, the reality falls short of this goal.

***Providing SSI supplements in conjunction with rent subsidies.** Connecticut provides the second highest State SSI supplement in the Nation (after Alaska), bringing SSI to \$750 per month. However, it is still difficult for consumers to afford housing. Thus, the State also provides a "bridge rental subsidy" similar to Section 8 that is funded in a unique way – Department of Mental Health program funds unspent at the end of each fiscal year are automatically dedicated to the rental assistance fund.*

**Providing rent continuation during hospitalization.** A variation on rent supplements is temporary rental payments while people are hospitalized, because individuals who are institutionalized for more than a brief stay lose eligibility for SSI benefits. This strategy is highly effective in reducing the risk that a person will be evicted.

***Extending State housing vouchers to cover periods of hospitalization.** Missouri's Supported Housing Program includes a provision that State housing vouchers will be continued for as many as 90 days while an individual is in a more restrictive environment. To extend the subsidy beyond 90 days, the agency providing services must request an extension.*

***Designating a rental housing fund to avoid evictions during inpatient treatment.** The Minnesota legislature approved \$50,000 to pay for rental housing for 90 days when individuals with serious mental illnesses are in inpatient treatment. Although the amount of money is not large, it is sufficient to enable a number of people to pay rent and thus keep their housing until they return to the community.*

Developing housing expertise among mental health staff. Measures to develop housing expertise among mental health staff can help protect people with serious mental illnesses from becoming homeless despite housing and income shortages. Many mental health agencies are hiring housing specialists to cultivate relationships with low-income housing providers, affordable housing advocacy groups, PHA's, and private landlords to increase access to housing for clients of their agencies. In addition, housing specialists educate staff about the legal rights of people with disabilities, including fair housing legislation.

Even with a housing specialist on board, all mental health staff working in a case management or community support position should have some familiarity with existing housing options so they can help consumers make informed choices. They should also receive some training in tenant rights and responsibilities to help educate their clients.

***Hiring housing coordinators.** Rhode Island's eight community mental health centers have housing coordinators who receive State-sponsored training in housing issues. The housing coordinators are familiar with Federal, State, and local housing resources, are*

*knowledgeable about supported housing, and are able to help consumers obtain and maintain their housing. They ensure that housing issues are thoroughly addressed in client service plans and are active in housing organizations and issues in their communities.*

## **Family/Community Factors**

**Reducing the stigma of mental illness.** Initiatives aimed at reducing the stigma of mental illness are risk reduction strategies that increase opportunities for people with mental illnesses to live, work, and socialize in their communities. Public awareness campaigns, including information provided through the media, education of school children, and presentations by advocacy groups about the causes and symptoms of mental illnesses, can help reduce discrimination against people who have serious mental illnesses.

Perhaps the most effective way to reduce stigma is to ensure that people with mental illnesses have opportunities to live, work, study, and socialize alongside people who do not have mental disorders. When their neighbors and coworkers get to know people with mental illnesses as individuals, negative stereotypes tend to diminish.

***Reducing stigma through exposure to consumer staff members of supported housing programs.** The Center for Community Change Through Housing and Support surveyed 13 organizations about the impact of having consumers deliver services in supported housing programs. The organizations surveyed reported initial distrust of the consumer staff by others in their agencies. Survey results indicated that bias against mentally ill people was reduced when the consumer staff members performed their jobs well. In addition, consumers were effective in educating the broader community about mental illnesses and the ability of people with mental illnesses to work and make contributions despite their disabilities (Besio and Mahler, 1993).*

**Support for families of people with serious mental illnesses.** Helping families cope with the difficult aspects of living with and/or providing ongoing assistance to a person with mental illness can be an effective homeless prevention measure. If family members understand issues such as the cyclical nature of mental illnesses, possible side effects of medication, and what to do when symptoms flare, parents and others are often able to help their relatives maintain stability in the community. For those individuals who provide homes to their family members with serious mental illnesses, periods of respite give a much-needed break to this often stressful responsibility.

***Providing respite for families.** In Arizona, the Regional Behavioral Health Authorities, which provide or contract for treatment and services for people with serious mental illnesses, offer respite for families whose relatives with mental illnesses live with them. Space is provided at a supervised residential program or other settings for several days or as long as 2 weeks for individuals who cannot be left alone. Crisis stabilization beds are also available.*

*Education and support for families and significant others. Among the responsibilities of Mobile Treatment Teams in Rhode Island are several activities to assist families and other members of consumers' support networks. Treatment team members are expected to provide relatives with information about a consumer's mental illness and family members' roles in the therapeutic process, offer supportive counseling, and help resolve conflicts between consumers and relatives.*

## **THE NEED FOR FURTHER RESEARCH**

Recent research has helped delineate the causal or risk factors for homelessness among people who have serious mental illnesses. But our knowledge of how the various factors interact and why some people at apparent high risk do not become homeless is insufficient. Too often, program and funding decisions are made under the pressure of the need to respond immediately to a crisis and focus on perceived rather than actual homelessness prevention measures.

Although a great deal of anecdotal evidence is being gathered from current prevention initiatives, there is a need to dedicate more resources to gathering solid data. Controlled outcome studies, process evaluations, and surveys can all increase understanding of "what works best for whom." In particular, more information is needed on how to design and target risk reduction strategies effectively, and on the role of protective factors in minimizing the likelihood that people with mental illnesses will become homeless.

# Developing Comprehensive Prevention Responses

Because multiple factors contribute to homelessness among people with serious mental illnesses, prevention is most effective when carried out as a comprehensive, coordinated set of initiatives. To have a major impact on ending the entry of people with serious mental illnesses into homelessness, States need to promote a broad range of housing, treatment, and service initiatives that aim to reduce the risk factors that contribute to homelessness and to enhance protective factors that can mitigate these risks.

This section describes how three States: Ohio, Oregon, and Vermont, have put this holistic prevention approach into practice. Although not specifically designed in terms of reducing risks and increasing protective factors, these efforts are good examples of this overall prevention approach.

---

## Promoting "Housing as Housing" in Ohio

---

The State of Ohio has been a national leader in the movement to develop supported housing for people with disabilities, the result of a decade-long process of changes in policies, financing strategies, and attitudes. Beginning in 1986, the Ohio Department of Mental Health (DMH) began aggressively shifting resources from facility-based housing and services to independent housing with flexible, individualized supports.

In 1988, DMH issued what became a widely read position paper, the *Housing-as-Housing Discussion Paper* (Ohio Department of Mental Health, 1988), describing its commitment to the principles of independent housing, comprehensive community supports, and the value of consumer choice. The supported housing model is considered central to enabling people with serious mental illnesses to gain stability and acceptance in their communities.

### Initiatives Targeted to Individual Risk Factors

**Support and training for community living.** As independent housing opportunities have been developed, DMH has also recognized the need for individualized treatment and supports. The 1988 Housing-as-Housing paper stated that "supportive services must be available to people in their own homes to assist and sustain them in a natural environment." Increased funding has enabled significant expansion of intensive case management and individual rehabilitation services, which have been crucial to supporting individuals in their own homes. Extensive staff training and improved coordination of services with independent housing have contributed to the success of the supported housing approach.

## **Initiatives Targeted to Environmental Risk Factors**

**Comprehensive, integrated systems of care.** The community mental health boards in Ohio have responsibility for planning, purchasing, and coordinating local services. DMH has provided direction, training, and increased funding to enable them to provide a full complement of needed services; to provide ready access to all services through a single point of admission; and to develop approaches that are directly responsive to the expressed needs of consumers and their families. Grants from the Robert Wood Johnson (RWJ) Foundation Program on Chronic Mental Illness enhanced the ability of three recipient sites in Ohio (Columbus, Toledo, and Cincinnati) to implement responsive, coordinated systems of care.

**Residential options that respond to consumer preferences.** The driving force behind Ohio's supported housing movement is a belief in the importance of responding to consumer preferences. In a recent article, the DMH director and his coauthor underscore the importance that housing must be chosen by consumers and must be directly relevant to their wants and preferences (Hogan and Carling, 1992).

To help put these principles into practice, DMH has adopted policies and funding strategies that have expanded supported housing. Specifically, the department has (1) required community mental health boards to develop residential services and housing plans that emphasize consumer choice in housing and supportive services; (2) helped community mental health boards found housing development corporations that concentrate on integrated, scattered-site housing for consumers; and (3) provided ongoing guidance and training on ways to increase consumers' access to supported housing and help them be successful (Knisely and Fleming, 1993).

**Increasing affordable housing options.** After it made a commitment to encourage the development of supported housing, DMH took a number of steps to add to the availability of regular, scattered-site housing for people with mental illnesses. Among the most significant are the following:

*Establishing an office to lead housing development and financing efforts. An Office of Housing and Service Environments (which has since been divided into three offices) was created to be responsible for licensing and capital construction. Beginning in 1989, capital funds in the form of revenue bonds that had traditionally gone for development and renovation of hospitals, residential treatment facilities, and mental health centers began to be redirected to housing development. During 1991-92 alone, \$12.9 million in DMH funding was allocated for housing, residential construction, and rehabilitation (Knisely and Fleming, 1994).*

*Encouraging the formation of local, nonprofit housing development corporations. DMH has provided technical assistance to help a number of local community mental health boards create independent corporations run by housing professionals to develop housing for people with serious mental illnesses. In Franklin County (Columbus area), for example, the Community Housing Network owns and manages a growing number of properties and leases apartments directly to consumers. The corporation also*

*administers the DMH Housing Assistance Program (described below) for Franklin County (Knisely and Fleming, 1994.)*

***Creating new housing and supports.*** *In 1986, DMH applied for and received three of nine national RWJ grants for creation of local, comprehensive systems of care and housing for people with serious mental illnesses. These grants provided \$1 million in loans for housing development; 125 Section 8 grants per site provided by HUD; and resources and technical assistance to redesign administrative structures, services, and funding streams. In Ohio, the three communities used the RWJ funding largely to further develop the supported housing model.*

***Instituting an active technical assistance program.*** *The State initiated a technical assistance program to provide local communities with information about Federal and private resources for housing development and to help them pursue grants and demonstration funds. This effort has been successful in using DMH funding to leverage substantial Federal and foundation dollars.*

**State rent supplement program.** The DMH Housing Assistance Program (HAP) offers rent subsidies similar to Section 8 vouchers for people with mental illnesses who have very low incomes. The program gives priority to consumers who are being released from State hospitals, those who are at risk for homelessness, or those who are homeless. In addition to rental assistance, HAP provides flexible funding to cover deposits, furnishings, and other housing-related expenses, as needed.

### **Family/Community Factors**

**Reducing the stigma of mental illness.** With supported housing now well accepted throughout the State, DMH has set a goal of helping people with serious mental illnesses to attain a further level of community integration. A strength of the supported housing model is that it enables consumers to live in integrated, scattered-site housing that, because it is not identified as mental health housing, helps reduce stigma and increase community acceptance of people with mental illnesses. Efforts are being made to help consumers develop strengths and skills that enable them to integrate comfortably into community living and to be appreciated for what they can contribute.

---

## **Expanding Housing and Services in Oregon**

---

Faced with the twin problems of funding shortages and increasing need, the State of Oregon Office of Mental Health Services (OMHS) has taken a number of steps in recent years to develop comprehensive, individualized, and responsive local systems of care for people with serious mental illnesses. These steps include improving access to independent housing, expanding the number and variety of community-based services, and overcoming organizational barriers to move toward a more integrated system of care.

Oregon has made a concerted effort in recent years to help people with serious mental illnesses remain stable in the community and avoid homelessness by promoting innovative housing approaches, financing affordable housing, promoting interagency collaboration, and providing flexible treatment and supports. Some of these efforts, such as programs for consumers with extensive hospitalization histories, have directly targeted the risk factors for homelessness. Others are aimed at creating more opportunities for people with serious mental illnesses to succeed in community living, thus protecting them from homelessness. A number of specific initiatives are outlined below.

### **Initiatives Targeted to Individual Risk Factors**

**Treatment and supports for people with co-occurring disorders.** OMHS has recognized the need to develop specialized services and housing for individuals with co-occurring mental health and substance use disorders. A number of mental health centers and other providers have recently added clinical teams focused on individuals with dual disorders, and some drug-free housing options have been funded.

**Support and training for community living.** All people with serious mental illnesses in Oregon are eligible for case management services, which can range in intensity from a 1:5 case manager-to-client ratio to 1:60, depending on an individual's functional level and specific needs. To help support people with serious mental illnesses in the community, OMHS has expanded psychiatric rehabilitation and active outreach to those individuals not engaged in treatment and services.

Many providers have identified money management as key to helping consumers maintain independence. In response, some programs have added a money manager to assist clients, and several agencies have worked with banks to create special low-interest, no-fee accounts for consumers.

### **Initiatives Targeted to Environmental Risk Factors**

**Discharge planning.** The State has taken a leadership role in promoting development of permanent community options for many long-term patients with the most serious disabilities at State psychiatric hospitals. Key to the success of these models are substantial attention to discharge planning and the development of highly individualized treatment and support services designed to help people avoid repeated hospitalizations. The following two innovative approaches receive State mental health funding.

***"365" Proposals.** These programs are aimed at providing community-based residences and specialized services for high-need individuals who have been in a State hospital for 365 days or more. Providers are invited to submit an individualized discharge plan covering housing and a complete range of services and supports for each person they propose to serve in the community. In 1991, the first year of funding, 41 people were deinstitutionalized through this mechanism.*

***PASSAGES.** A new initiative similar to the "365" program, this effort is aimed at consumers who have been hospitalized for lengthy periods and who have not done well*

*upon discharge. PASSAGES provides grants to community-based providers for startup costs, staffing, and operating expenses to develop intensive, individualized plans for the transition to community living. The program emphasizes a smooth and gradual move for patients, including visits to the community prior to discharge to develop relationships with community-based providers. As of June 1994, 16 PASSAGES programs were serving more than 100 people with serious mental illnesses in both supported housing programs and staffed group residences.*

**Crisis services and temporary housing.** OMHS has funded several crisis/respice programs throughout the State that have been effective in preventing hospitalization and, thereby, reducing the risk of homelessness. These programs provide 24-hour supervision and crisis stabilization in nonhospital settings.

**Flexibility in services and funding.** Oregon has funded several programs aimed at responding to the needs and preferences of different groups of consumers. These innovative service approaches provide people who have had difficulty maintaining stability with intensive support in the community. They include the following:

*A consumer-operated, supported housing program. Consumers who serve as advocates and service coordinators help 30 people with histories of long hospital stays find housing and arrange for appropriate support services. A portion of the housing where clients of this program live has been developed and is operated by the consumer program.*

*Two "Psych-Voc" programs. Funded by both OMHS and the State Vocational Rehabilitation Division, these programs target long-term hospital patients who are interested in, and have an aptitude for, work. The Psych-Voc programs provide housing with intensive supports and vocational training along with supported employment.*

**Comprehensive, integrated systems of care.** Recognizing the importance of interagency collaboration to develop integrated systems of housing and services for people with serious mental illnesses, the Oregon Department of Human Services convened a State-level interagency task force that included OMHS. The group has encouraged collaborative efforts between housing agencies and service providers at the systems level, and has provided information and technical assistance to local groups developing housing and supportive services for people with serious mental illnesses.

**Formal linkages between public housing and mental health agencies.** OMHS has worked with the State housing agency and has encouraged mental health agencies to develop collaborative initiatives with their local PHA's. Several of these cooperative ventures have increased housing options for people with serious mental illnesses. In Yamhill County, for example, the PHA is developing 12 units that will support a mixed population of people with mental illnesses, drug and alcohol problems, and developmental disabilities.

**Increasing affordable housing options.** To help finance affordable housing, the OMHS Housing Fund was initiated in 1989 to provide grants for as much as \$35,000 for acquisition and

development and for as much as \$6,000 for renovation, for projects that house adults with serious mental illnesses. Priority is given to housing for people at high risk for psychiatric hospitalization or homelessness and to housing owned by public or nonprofit entities. As of July 1993, OMHS Housing Fund awards totaled \$1 million to help preserve or develop housing valued at \$13 million for approximately 400 people. An additional round of grants was awarded in June 1994.

**State rental assistance.** People with serious mental illnesses are eligible for two programs for low-income residents that provide temporary rental assistance.

***Preventing evictions.** The Oregon State Legislature created the Emergency Housing Account to prevent evictions of low-income residents and to support transitional housing for homeless people. The Oregon Housing and Community Services Department administers the account, which provides grants to community action agencies. Programs include emergency payment of mortgages, rents, or utilities to prevent homelessness, as well as supportive housing services for those who need them to remain housed. This is a generic program for which people with mental illnesses are eligible based on their low-income status.*

***Providing rental assistance.** Oregon requires rental property owners and managers to establish low-income housing accounts for security and other deposits. The accrued interest from deposits funds the Low Income Rental Housing Fund, administered by the Oregon Housing and Community Services Department through local partnerships with housing authorities and human services agencies. The agencies nominate applicants for grants, which can cover up to 6 months of rent, plus some moving costs. Those eligible include very low-income households at risk for losing their rental units due to involuntary hardship, or who are waiting for other rental assistance they have not yet received (e.g., people on the Section 8 waiting list).*

**Developing housing expertise among mental health staff.** The OMHS housing specialist leads a Housing Technical Assistance Work Group to which local mental health agencies involved in housing throughout the State are invited. The group, which meets every 2 months, provides ongoing training and updates on housing issues, including presentations by local groups that have developed housing for people with serious mental illnesses.

---

## Developing a Community-Based System in Vermont

---

The State of Vermont has developed a comprehensive, community-based support system with attention to case management, support for consumer-run initiatives, crisis resolution options, and access to a range of affordable housing. Vermont's Department of Mental Health (DMH) has actively encouraged a significant expansion of scattered-site, independent housing with supports, and consumer choice in housing is a priority.

Vermont's ability to build a system of community-based care has been greatly aided by the transfer of funds to community programs from Vermont's one State hospital. This was done with the help of a 3-year Robert Wood Johnson Foundation grant awarded in 1987 that was aimed at strengthening the community service system as the hospital census declined. Part of the money was used to develop programs to prevent individuals who were discharged from becoming homeless.

### **Initiatives Targeted to Individual Risk Factors**

**Treatment and supports for people with co-occurring disorders.** Vermont has recognized the need to treat people with dual disorders as a priority and is in the process of developing more capacity and expertise to do so within local mental health systems. Community mental health centers (CMHC's) generally provide treatment groups for individuals with co-occurring disorders, and staff work to find housing for those who are not yet engaged in treatment. Although housing options are limited for people who are actively abusing substances, Vermont takes the position that housing needs to be available for these individuals as long as they are able to meet the requirements of tenancy.

**Support and training for community living.** Vermont has developed a strong system of case management, with an emphasis on outreach, reduced caseloads, and the flexibility to provide varying intensities of service as needs change. Case managers help consumers develop the skills they need to live independently and provide the supports they require to maintain a home in the community. They also work with landlords and housing managers to help clients meet the requirements of tenancy. Several local catchment areas have developed effective assertive community treatment team models.

### **Initiatives Targeted to Environmental Risk Factors**

**Discharge planning.** Each CMHC has a staff liaison to the Vermont State Hospital who is responsible for ensuring close coordination between the agencies. A system of extensive, individualized discharge planning has been developed. If a client is hospitalized, CMHC staff work closely with the hospital to sustain continuity of care and to maintain the individual's housing during brief hospital stays. Good working relationships have also been developed with police, jails, and the courts. In Burlington, Vermont's largest city, the CMHC has a staff liaison to the local police department.

**Crisis services and temporary housing.** Crisis resolution options have been strengthened in Vermont with the help of extensive consumer and family involvement. The emphasis is on a flexible, mobile crisis team approach. Mental health centers have created new programs of in-home crisis care, with staff available to provide around-the-clock assistance in an individual's home. Crisis housing has been developed as another option to avoid hospitalization.

CMHC's are expected to continue to work with consumers who lose their housing. If an individual is evicted, which often occurs due to behaviors associated with substance abuse, case managers are expected to help clients learn from their experiences and find another suitable

housing placement. CMHC staff work with landlords to help maintain positive relationships with tenants who must be evicted.

**Flexibility in services and funding.** DMH has strengthened the ability of CMHC's to develop systems of care that respond to local conditions and needs. Although all CMHC's have received funding to strengthen case management services, each has also funded a number of other supports determined by local needs.

*Promoting consumer support. Consumer support efforts have become a key aspect of supported housing in Vermont. Apartment support groups, formed with the help of CMHC's, are active in many service areas; members turn to one another for problem solving, to avoid loneliness, and for regular support and celebrations of important events. Consumer-run groups are an important source of friendship and assistance.*

*Offering daytime activities. Meaningful daytime activities are seen as a key to community stability and consumer satisfaction. From the early 1980's, DMH has encouraged the development of clubhouses and other rehabilitation options. Supported employment opportunities are offered by all CMHC's.*

**Residential options that respond to consumer preferences.** DMH has a policy of supporting consumers in the housing they choose to the greatest extent possible. By promoting development of housing expertise in mental health centers, DMH has strengthened the ability of mental health providers to help people with mental illnesses locate a variety of independent housing options and make appropriate choices. At the same time, DMH has promoted expansion of a range of supportive services for clients to enable them to succeed in regular housing in the community.

**Increasing affordable housing options.** DMH has encouraged the creation of several nonprofit housing development corporations that have been successful in securing funding to develop new, independent housing options for people with serious mental illnesses. CMHC's have formed partnerships with the housing development corporations, including formal memoranda of understanding in some cases, to provide the services that assist people in independent housing.

**State rent supplement program.** A major resource in Vermont is the Housing Contingency Fund, which provides rent supplements to consumers while they are on Section 8 waiting lists. Partially supported with moneys shifted from the State hospital, the fund gives priority to housing developed by nonprofit developers and can only be used in regular housing that is available to the general public. It is available through CMHC's and CMHS-administered PATH (Projects for Assistance in Transition from Homelessness) programs.

In Vermont, PATH projects are located within a variety of organizations, including community action agencies, Health Care for the Homeless projects, and a consumer-run drop-in center. Making the Housing Contingency Fund available through these nontraditional providers has enabled the State to reach consumers at risk of homelessness who are not involved with mental health centers.

**Developing housing expertise among mental health staff.** Creating a strong housing coordinator role in each service area has been instrumental in enabling Vermont to move toward a supported housing model. Each CMHC has a housing coordinator, with all of them meeting at least quarterly with the DMH housing coordinator for training, technical assistance, and other support. Staff from State housing agencies, PHA's, nonprofit developers, Social Security offices, and others are invited to provide information, training, and opportunities for cross-systems collaboration.

Locally, CMHC housing coordinators serve as client advocates in housing issues and act as liaisons between and among case managers, PHA's, municipal housing offices, private landlords, and nonprofit housing developers. They ensure that eligible clients are on Section 8 waiting lists, help negotiate problems with tenancy, and are actively involved in local housing development issues.

Organizing a strong housing advocacy voice in State and local government has also expanded access to housing for people with serious mental illnesses. Mental health staff, consumers, and families, some of whom are associated with the Alliance for the Mentally Ill and Vermont Psychiatric Survivors, have become active participants in organizations such as the Vermont Affordable Housing Coalition and the Coalition for Disability Rights.

**Reducing the stigma of mental illness.** Part of the rationale for Vermont's endorsement of the supported housing model is its potential for reducing stigma. DMH policies address the goal of assisting consumers with living in regular housing in the community, rather than in segregated or group residences, where they will be readily identified as different from other community members. Supported employment programs that enable people with serious mental illnesses to have mainstream jobs are also viewed as helping to reduce discrimination.

---

## Conclusion

---

The case studies of homelessness prevention efforts in Ohio, Oregon, and Vermont highlighted in the previous section identify important strategies that can be, and have been, replicated in other States. One of the primary factors in the success of these efforts has been the willingness and commitment of key stakeholders to engage in strategic planning to maximize resources, despite uncertain fiscal and programmatic environments at all levels of government.

Ohio's actions to implement its "housing-as-housing" approach have made the State a national leader in the movement to develop supported housing for people with serious mental illnesses. In Oregon, the State has taken a number of steps to develop comprehensive, individualized systems of care for this population despite funding shortages. Vermont has used funds transferred from the State hospital to create a comprehensive, community-based support system for people with psychiatric disabilities.

The field has learned a great deal about the causes and consequences of homelessness for persons with serious mental illnesses during the past 15 years. One of the most important lessons is the pressing need to devote more attention and resources to the prevention of homelessness among this vulnerable population.

## References

- Besio, S., and Mahler, J. "Benefits and Challenges of Using Consumer Staff in Supported Housing Services." *Hospital and Community Psychiatry* 44:490-491, 1993.
- Bond, G.R., Witheridge, T.F., Dincin, J., and Wasmer, D. "Assertive Community Treatment: Correcting Some Misconceptions." *American Journal of Community Psychology* 19(1):41-51, 1991.
- Brown, M., Ridgway, P., Anthony, W. et al. "Comparison of Outcomes for Clients Seeking and Assigned to Supported Housing Services." *Hospital and Community Psychiatry* 42:1150-1153, 1991.
- Burt, M., and Cohen, B. *America's Homeless: Numbers, Characteristics, and the Programs that Serve Them*. Washington, DC: Urban Institute Press, 1989.
- Carling, P. "Housing and Supports for Persons with Mental Illness: Emerging Approaches to Research and Practice." *Hospital and Community Psychiatry* 44:439-449, 1993.
- Carling, P., Randolph, F., Blanch, A. et al. *Rehabilitation Research Review: Housing and Community Integration for People with Psychiatric Disabilities*. Washington, DC: National Rehabilitation Information Center, 1987.
- Center for Mental Health Services. *Making A Difference: Interim Status Report of the McKinney Demonstration Program for Homeless Adults with Serious Mental Illnesses*. Rockville, MD: Center for Mental Health Services, 1994.
- Culhane, D.P., Dejowski, E.F., Ibanex, J., Needham, E., and Macchia, I. *Public Shelter Admission Rates in Philadelphia and New York City: The Implications of Turnover for Sheltered Population Counts*. Washington, DC: Fannie Mae Office of Housing Research, 1993.
- Culhane, D., and Fried, M. "Paths in Homelessness: A View From the Street." In J. Friedrichs, ed. *Affordable Housing and the Homeless*. New York: Walter de Gruyter, 1988.
- Dennis, D., and Steadman, H. "The Criminal Justice System and Severely Mentally Ill Homeless Persons: An Overview." Unpublished paper prepared for the Federal Task Force on Homelessness and Severe Mental Illness, 1991.
- Dixon, L.B., Krauss, N., Kernan, E., Lehman, A.F., and DeForge, B.R. "Modifying the PACT Model for Homeless Persons with Severe Mental Illness." *Psychiatric Services* 46(7):696-701, 1995.

Drake, R.E., Mueser, K.T., Clark, R.E., and Wallach, M.A. "The Course, Treatment, and Outcome of Substance Disorder in Persons with Severe Mental Illness." *American Journal of Orthopsychiatry* 66(1):42-51, 1996.

Federal Task Force on Homelessness and Severe Mental Illness. *Outcasts on Main Street*. Washington, DC: Interagency Council on the Homeless, 1992.

Fischer, P. "Criminal Behavior and Victimization Among Homeless People." In Jahiel, R., ed. *Homelessness: A Prevention-Oriented Approach*. Baltimore, MD: The Johns Hopkins University Press, 1992.

Fischer, P., and Breakey, W. "The Epidemiology of Alcohol, Drug, and Mental Disorders Among Homeless Persons." **American Psychologist** 46(11):1115-1128, 1991.

Flaskerud, J.H. "The Effects of Culture-Compatible Intervention on the Utilization of Mental Health Services by Minority Clients." *Community Mental Health Journal* 22(2):127-141, 1986.

Harris, M. "Modifications in Service Delivery and Clinical Treatment for Women Diagnosed With Severe Mental Illness Who Are Also the Survivors of Sexual Abuse Trauma." *The Journal of Mental Health Administration* 21(4):397-405, 1994.

Hogan, M., and Carling, P. "Normal Housing: A Key Element of a Supported Housing Approach for People with Psychiatric Disabilities." *Community Mental Health Journal* 28(3):215-226, 1992.

Interagency Council on the Homeless. *Priority Home! The Federal Plan to End Homelessness*. Washington, DC: U.S. Department of Housing and Urban Development, 1994.

Knisely, M., and Fleming, M. "Implementing Supported Housing in State and Local Mental Health Systems." *Hospital and Community Psychiatry* 44:456-461, 1993.

Lehman, A.E., and Cordray, D.S. "Prevalence of Alcohol, Drug, and Mental Disorders Among the Homeless: One More Time." *Contemporary Drug Problems* 20(3):355-383, 1993.

Link, B., Phelan, J., Bresnahan, M., Stueve, A., Moore, R., and Susser, E. "Lifetime and Five-Year Prevalence of Homelessness in the United States: New Evidence on an Old Debate." *American Journal of Orthopsychiatry* 65(3):347-354, 1995.

Lipton, F., and Sabatini, A. "Constructing Support Systems for Chronic Mental Patients." In Lamb, H., ed. *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association*. Washington, DC: American Psychiatric Association, 1984.

McCabe, S, Edgar, E., Mancuso, L. et al. "A National Study of Housing Affordability for Recipients of Supplemental Security Income." *Hospital and Community Psychiatry*, 44:494-495, 1993.

McGrew, J.H., and Bond, G.R. "Critical Ingredients of Assertive Community Treatment: Judgments of the Experts." *Journal of Mental Health Administration* 22(2):113-125, 1995.

Mrazek, P., and Haggerty, R., eds. *Reducing Risks for Mental Disorders*. Washington, DC: National Academy Press, 1994.

National Resource Center on Homelessness and Mental Illness. *Working with Dually Diagnosed Homeless Persons*. Delmar, NY: National Resource Center on Homelessness and Mental Illness, 1990.

Ohio Department of Mental Health. *Housing-as-Housing Discussion Paper*. Columbus, OH: Ohio Department of Mental Health, 1988.

Pransky, J. *Prevention: The Critical Need*. Springfield, MO: Burrell Foundation, 1991.

Robert Wood Johnson Foundation. *Public Attitudes Toward People with Chronic Mental Illness*. Boston, MA: Robert Wood Johnson Foundation, 1990.

Segal, S., and Baumohl, J. "News and Views: The Community Living Room." *Social Casework*, 111-116, February 1985.

Technical Assistance Collaborative, Inc. *Creating Housing and Supports for People Who Have Serious Mental Illnesses*. Rockville, MD: Center for Mental Health Services, 1994.

Tessler, R., and Dennis, D. *A Synthesis of NIMH-Funded Research Concerning Persons Who Are Homeless and Mentally Ill*. Rockville, MD: National Institute of Mental Health, 1989.

U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development. *Blueprint for a Cooperative Agreement between Public Housing Agencies and Local Mental Health Authorities*. Rockville, MD: Center for Mental Health Services, 1994.

U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services. *Creating Community: Integrating Elderly and Severely Mentally Ill Persons in Public Housing*. Washington, DC: U.S. Department of Housing and Urban Development, 1993.

# **Appendix A**

## **Path State Contacts**

### **ALABAMA**

#### **Interim State Contact**

Molly Brooms, Director, Office of Community Programs  
Mental Illness Division  
Alabama Department of Mental Health & Mental Retardation  
100 North Union Street, Montgomery, AL 36130-1410  
Phone: (334) 242-3200 Fax: (334) 242-0796  
E-mail: mbrooms@mh.state.al.us

### **ALASKA**

#### **State Contact**

Gary Mandzik, M.S., Resource/Licensing Coordinator  
Division of Mental Health & Developmental Disabilities  
Alaska Department of Health & Social Services, Suite # 878  
3601 C Street, Anchorage, AK 99503  
Phone: (907) 269-3606 Fax: (907) 269-3623  
E-mail:gary\_mandzik@health.state.ak.us

### **AMERICAN SAMOA**

#### **State Contact**

Patolo N. Mageo, Acting Director, Department of Human and Social Services  
P.O. Box 997534, Pago Pago, American Samoa 96799  
Phone: 011 (684) 633-2609 Fax: 011 (684) 633-7449  
E-mail:dhss@samoatelco.com

#### **Alternate Contact**

Tanya White\*  
Grants Management and Evaluation Division  
Department of Human and Social Services  
P.O. Box 997534, Pago Pago, American Samoa 96799  
Phone: 011 (684) 633-2609 Fax: 011 (684) 633-7852  
E-mail:gmed@samoatelco.com

## **ARIZONA**

### **State Contact**

Michael Franczak, Ph.D., \* PATH Coordinator  
Arizona Department of Health Services  
2122 East Highland, Suite 100, Phoenix, AZ 85016  
Phone: (602) 381-8995 Fax: (602) 553-9042  
E-mail: mfrancz@hs.state.az.us

### **Alternate Contact**

Raymond Thomas, Manager  
Arizona Department of Health Services  
2122 East Highland, Suite 100, Phoenix, AZ 85016  
Phone: (602) 381-8995 Fax: (602) 553-9042  
E-mail: rthomas@hs.state.az.us

## **ARKANSAS**

### **State Contact**

Marilyn Hampton, Quality Assurance Coordinator  
Division of Mental Health Services  
Arkansas Department of Human Services  
4313 West Markham Street, Little Rock, AR 72205-4096  
Phone: (501) 686-9036 Fax: (501) 686-9182  
E-mail: marilyn.hampton@mail.state.ar.us

## **CALIFORNIA**

### **State Contact**

Linda Aaron-Cort,\* Mental Health Program Specialist  
California Department of Mental Health  
1600 9<sup>th</sup> Street, Room 130, Sacramento, CA 95814  
Phone: (916) 654-8643 Fax: (916) 653-5500  
E-mail: laaronco@dmhhq.state.ca.us

### **Alternate Contact**

Carol Goodman, Chief, Systems Planning, Development & Evaluation  
California Department of Mental Health  
1600 9<sup>th</sup> Street, Room 130, Sacramento, CA 95814  
Phone: (916) 654-6605 Fax: (916) 653-5500  
E-mail: cgoodman@dmhhq.state.ca.us

## **COLORADO**

### **State Contact**

Tom Machiorletti, Mental Health Program Specialist  
Mental Health Services  
Colorado Department of Human Services  
3824 West Princeton Circle, Denver, CO 80236  
Phone: (303) 866-7419 Fax: (303) 866-7428  
E-mail: tom.machiorletti@state.co.us

## **CONNECTICUT**

### **State Contact**

Madeline Napolitano, State Coordinator of Homeless Services  
Connecticut Department of Mental Health & Addiction Services  
410 Capitol Avenue, MS 14 HOU, Hartford, CT 06134-1431  
**Phone:** (860) 418-6910 **Fax:** (860) 418-6696  
E-mail: madeline.napolitano@po.state.ct.us

## **DELAWARE**

### **State Contact**

Elizabeth Dubravcic,\* Senior Planner  
Division of Alcoholism, Drug Abuse & Mental Health  
Delaware Department of Health & Social Services  
1901 North Dupont Highway, New Castle, DE 19720  
Phone: (302) 577-4465, ext. 22 Fax: (302) 577-4486  
E-mail: edubravcic@state.de.us

### **Alternate Contact**

Walter Mateja, Planner IV  
Division of Alcoholism, Drug Abuse & Mental Health  
Delaware Department of Health & Social Services  
1901 North Dupont Highway, New Castle, DE 19720  
Phone: (302) 577-4465, ext. 36 Fax: (302) 577-4486  
E-mail: wmateja@state.de.us

## **DISTRICT OF COLUMBIA**

### **State Contact**

Michele May, Homeless Services Coordinator  
District of Columbia Commission on Mental Health Services  
4301 Connecticut Avenue, N.W., Washington, DC 20008  
Phone: (202) 282-0297 Fax: (202) 282-0131

## **FLORIDA**

### **State Contact**

Vince Smith,\* Mental Health Program Office  
Florida Department of Children and Families  
1317 Winewood Boulevard, Building 6, Room 203, Tallahassee, FL 32399-0700  
Phone: (850) 413-0932 Fax: (850) 413-6887  
E-mail: vince\_smith@dcf.state.fl.us

### **Alternate Contact**

James Noble, Operations and Management Consultant II  
Mental Health Program Office  
Florida Department of Children and Families  
1317 Winewood Boulevard, Building 6, Room 207, Tallahassee, FL 32399-0700  
Phone: (850) 413-0930 Fax: (850) 413-6887  
E-mail: jim\_noble@dcf.state.fl.us

## **GEORGIA**

### **State Contact**

Charley Bliss, \* Mental Health Program Specialist  
Division of Mental Health, Mental Retardation, Substance Abuse  
Georgia Department of Human Resources  
Two Peachtree Street, NW, Room 23-100, Atlanta, GA 30030  
Phone: (404) 657-2141 Fax: (404) 657-2160  
E-mail: cbliss@dhr.state.ga.us

### **Alternate Contact**

Cherry Finn, Adult Mental Health Program Chief  
Division of Mental Health, Mental Retardation & Substance Abuse  
Georgia Department of Human Resources  
Two Peachtree Street, N.W., Room 23-212, Atlanta, GA 30303-3171  
Phone: (404) 657-6087 Fax: (404) 657-2160  
E-mail: chfinn@dhr.state.ga.us

## **GUAM**

### **State Contact**

Mamie C. Balajadia, Ed.D.,\* Clinical Administrator  
Guam Department of Mental Health & Substance Abuse  
790 Gov. Carlos G. Camacho Road, Tamuning, GU 96911  
Phone: (671) 647-5440 or 5315 (voice mail) Fax: (671) 649-6948  
E-mail: mamieb@mail.gov.gu

### **Alternate Contact**

Simeon M. Palomo, Planner III  
Guam Department of Mental Health & Substance Abuse  
790 Gov. Carlos G. Camacho Road, Tamuning, GU 96911  
Phone: (671) 647-5407 Fax: (671) 649-6948  
E-mail: smpalo@mail.gov.gu

## **HAWAII**

### **State Contact**

George Fujioka, M.P.H., Program Contract Coordinator  
Adult Mental Health Division  
Hawaii State Department of Health  
1250 Punchbowl Street, Room 256, Honolulu, HI 96813-2498  
Phone: (808) 586-4677 Fax: (808) 586-4745  
E-mail: ghfujiok@mail.health.state.hi.us

## **IDAHO**

### **State Contact**

Jerry Anderson, M.A., Mental Health Program Specialist  
Bureau of Mental Health & Substance Abuse  
Idaho Department of Health & Welfare  
450 West State Street, 5<sup>th</sup> Floor, Boise, ID 83720-0036  
Phone: (208) 334-5528 Fax: (208) 334-6699  
E-mail: anderso6@idhw.state.id.us

## **ILLINOIS**

### **State Contact**

Brenda Hampton, M.S.W., Manager, Metro South Network Office of Mental Health  
Illinois Department of Human Services  
Tinley Park Mental Health Center, 7400 West 183<sup>rd</sup> Street, Tinley Park, IL 60477-3695  
Phone: (708) 614-4002 Fax: (708) 614-4495  
E-mail: dhsmhmx@dhs.state.il.us

## INDIANA

### State Contact

Charles Boyle, Chief, Bureau for Adults with Mental Illness  
Indiana Department of Mental Health  
402 West Washington Street, Room W-353, Indianapolis, IN 46204-2739  
Phone: (317) 232-7805 Fax: (317) 233-3472  
E-mail: cboyle@fssa.state.in.us

## IOWA

### State Contact

James Chesnik, Housing Specialist  
Division of Mental Health & Developmental Disabilities  
Iowa Department of Human Services  
Hoover Building, 5<sup>th</sup> Floor, 1305 East Walnut Street, Des Moines, IA 50319-0114  
Phone: (515) 281-8472 Fax: (515) 281-8512  
E-mail: jchesni@dhs.state.ia.us

## KANSAS

### State Contact

Kimberly Reynolds,\* Housing Specialist  
Mental Health, Substance Abuse, Treatment & Recovery  
Kansas Department of Social & Rehabilitation Services  
Docking State Office Building, 5 North, 915 Southwest Harrison, Topeka, KS 66612-1570  
Phone: (785) 296- 3471 Fax: (785) 296-6142  
E-mail: kexr@srskansas.org

## KENTUCKY

### State Contact

Louis Kurtz, M.Ed.,\* Housing Coordinator  
Kentucky Division of Mental Health  
100 Fair Oaks Lane, 4W-C, Frankfort, KY 40621-0001  
Phone: (502) 564-4448, ext. 4508 Fax: (502) 564-9010  
E-mail: louis.kurtz@mail.state.ky.us

### Alternate Contact

Rose Blandford, Manager, Adult Branch  
Kentucky Division of Mental Health  
100 Fair Oaks Lane, 4W-C, Frankfort, KY 40621-0001  
Phone: (502) 564-4448, ext. 4500 Fax: (502) 564-9010  
E-mail: rose.blandford@mail.state.ky.us

## **LOUISIANA**

### **State Contact**

Jo Pine, Chief, Adult Service Development  
Louisiana Office of Mental Health  
P.O. Box 4049, Bin #12, Baton Rouge, LA 70821-4049  
Phone: (225) 342-0433 Fax: (225) 342-5066  
E-mail: [jpine@dhh.state.la.us](mailto:jpine@dhh.state.la.us)  
FedEx: 1201 Capital Access Road, Bin #12, Baton Rouge, LA 70802

## **MAINE**

### **State Contact**

Sheldon Wheeler, Housing Resource Development Manager  
DMHMRSAS, Commissioner's Office, State of Maine  
40 State House Station, Augusta, ME 04333-0040  
Phone: (207) 287-4226 Fax: (207) 287-4268  
E-mail: [sheldon.wheeler@state.me.us](mailto:sheldon.wheeler@state.me.us)  
FedEx: Marquardt Building, 2<sup>nd</sup> Fl, Commissioner's Office, AMHI Campus, Augusta, ME 04330

## **MARYLAND**

### **State Contact**

Marian V. Bland, M.S.W.,\* Director, Shelter Plus Care and PATH Programs  
Community Forensics Building, Division of Special Populations  
Maryland Department of Health & Mental Hygiene  
8450 Dorsey Run Road, P.O. Box 1000, Jessup, MD 20794-1000  
Phone: (410) 724-3237 Fax: (410) 724-3239  
E-mail: [blandm@dhhm.state.md.us](mailto:blandm@dhhm.state.md.us)

## **MARYLAND**

### **Alternate Contact**

Joan Gillece, Ph.D., Director, Division of Special Populations  
Community Forensics Building, Division of Special Populations  
Maryland Department of Health & Mental Hygiene  
8450 Dorsey Run Road, P.O. Box 1000, Jessup, MD 20794-1000  
Phone: (410) 724-3238 Fax: (410) 724-3239  
E-mail: [gillecej@dhhm.state.md.us](mailto:gillecej@dhhm.state.md.us)

## MASSACHUSETTS

### State Contact

Walter Jabzanka, Director of Community Systems  
Massachusetts Department of Mental Health  
25 Staniford Street, Boston, MA 02114  
Phone: (617) 626-8064 Fax: (617) 626-8077  
E-mail: walter.jabzanka@dmh.state.ma.us

## MICHIGAN

### State Contact

Monica Bellamy, M.S.W.,\* Housing Coordinator  
Community Living, Children & Families Administration  
Michigan Department of Community Health  
Plaza Building, Room #440, South Tower, 1200 6<sup>th</sup> Street, Detroit, MI 48826  
Phone: (313) 256-3065 Fax: (313) 256-2049  
E-mail: bellamy@state.mi.us

### Alternate Contact

Virginia Harmon, Deputy Director  
Community Living, Children & Families Administration  
Michigan Department of Community Health  
3423 North Martin Luther King Boulevard, Lansing, MI 48909  
Phone: (517) 335-9371 Fax: (517) 335-8560  
E-mail: harmon@state.mi.us

## MINNESOTA

### State Contact

David J. Schultz, M.A., Mental Health Program Consultant  
Mental Health Division  
Minnesota Department of Human Services  
444 Lafayette Road North, St. Paul, MN 55155-3828  
Phone: (651) 582-1820 Fax: (651) 582-1831  
E-mail: dave.j.schultz@state.mn.us  
FedEx: 2284 Highcrest Road, Roseville, MN 55113

## MISSISSIPPI

### State Contact

Matt Armstrong, Director, Division of Community Services  
Mississippi Department of Mental Health  
1101 Robert E. Lee Building, 239 North Lamar Street, Jackson, MS 39201  
Phone: (601) 359-1288 Fax: (601) 359-6295

### Alternate Contact

Albertstein Johnson,\* Program Planner/Evaluator  
Division of Community Services  
Mississippi Department of Mental Health  
1101 Robert E. Lee Building, 239 North Lamar Street, Jackson, MS 39201  
Phone: (601) 359-1288 Fax: (601) 359-6295

## MISSOURI

### State Contact

Karen Battjes, Program Coordinator  
Missouri Department of Mental Health  
P.O. Box 687, 1706 East Elm Street, Jefferson City, MO 65102  
Phone: (573) 751-7622 Fax: (573) 751-7815  
E-mail: mzbattk@mail.dmh.state.mo.us

## MONTANA

### State Contact

Rusty Redfield,\* Mental Health Officer  
Addictive and Mental Disorders Division  
Montana Department of Public Health & Human Services  
P.O. Box 202951, Room C118, Helena, MT 59620  
Phone: (406) 444-4924 Fax: (406) 444-4435  
E-mail: rredfield@state.mt.us  
FedEx: 1400 Broadway, Helena, MT 59620

### Alternate Contact

Dan Anderson, Administrator  
Addictive and Mental Disorders Division  
Montana Department of Public Health & Human Services  
P.O. Box 202951, Room C118, Helena, MT 59620  
Phone: (406) 444-3969 Fax: (406) 444-4435  
E-mail: danderson@state.mt.us  
FedEx: 1400 Broadway, Helena, MT 59620

## **NEBRASKA**

### **State Contact**

Rachel Mulcahy,\* Program Specialist  
Nebraska Department of Health & Human Services - West  
P.O. Box 94728, Lincoln, NE 68509  
Phone: (402) 479-5008 Fax: (402) 479-5162  
E-mail:rachel.mulcahy@hsss.state.ne.us  
FedEx: Folsom and West Prospector Place, Lincoln, NE 68509

### **Alternate Contact**

Linda Wittmuss, Manager, Managed Care Program  
Nebraska Department of Health & Human Services - West  
P.O. Box 94728, Lincoln, NE 68509  
Phone: (402) 479-5147 Fax: (402) 479-5162  
E-mail:linda.wittmuss@hsss.state.ne.us  
FedEx: Folsom and West Prospector Place, Lincoln, NE 68509

## **NEVADA**

### **State Contact**

Laura A. Valentine,\* Quality Assurance Specialist  
Nevada Division of Mental Health & Developmental Services  
505 East King Street, Room 602, Carson City, NV 89701-3790  
Phone: (775) 684-5979 Fax: (775) 684-5964  
E-mail:lvalentine@dhrmail.state.nv.us

### **Alternate Contact**

Kevin Crowe, Ed.D., Chief, Planning & Evaluation  
Nevada Division of Mental Health & Developmental Services  
505 East King Street, Room 602, Carson City, NV 89701-3790  
Phone: (775) 684-5984 Fax: (775) 684-5964  
E-mail:kcrowe@dhrmail.state.nv.us

## **NEW HAMPSHIRE**

### **State Contact**

JoAnn Maynard,\* Program Planning & Review Specialist  
Division of Behavioral Health  
New Hampshire Department of Health & Human Services  
105 Pleasant Street, Concord, NH 03301  
Phone: (603) 271-8388 Fax: (603) 271-5040  
E-mail:jmaynard@dhhs.state.nh.us

**Alternate Contact**

Lance E. DePlante, Administrator, Homeless & Housing Programs  
Division of Behavioral Health  
New Hampshire Department of Health & Human Services  
105 Pleasant Street, Concord, NH 03301  
Phone: (603) 271-5043 Fax: (603) 271-5139  
E-mail: ldeplant@dhhs.state.nh.us

**NEW JERSEY****State Contact**

Cathy Boland,\* Coordinator, Housing and Homeless Services  
Division of Mental Health Services  
New Jersey Department of Human Services  
Capital Center, 3<sup>rd</sup> Floor, P.O. Box 727, Trenton, NJ 08625  
Phone: (609) 777-0753 Fax: (609) 777-0835  
E-mail: cboland@dhs.state.nj.us  
FedEx: 50 East State Street, Trenton, NJ 08608

**Alternate Contact**

Alan G. Kaufman, Director, Division of Mental Health Services  
New Jersey Department of Human Services  
Capital Center, 3<sup>rd</sup> Floor, P.O. Box 727, Trenton, NJ 08625  
Phone: (609) 777-0702 Fax: (609) 777-0662  
E-mail: akaufman@dhs.state.nj.us  
FedEx: 50 East State Street, Trenton, NJ 08608

**NEW MEXICO****State Contact**

Marie DiBianco-Eik, M.S.W., PATH & Housing Coordinator  
New Mexico Department of Health  
Behavioral Health Services Division  
1190 St. Francis Drive, Room North 3150, Santa Fe, NM 87502  
Phone: (505) 827-1630 Fax: (505) 827-0097  
E-mail: mdibianc@health.state.nm.us

**Alternate Contact**

Lynn Marshall, MA, LPC,\* Coordinator, Housing and Homeless Services  
New Mexico Department of Health, Behavioral Health Services Division  
1190 St. Francis Drive, Room North 3152, Santa Fe, NM 87502  
Phone: (505) 827-0577 Fax: (505) 827-0097  
E-mail: lmarshall@doh.state.nm.us

## **NEW YORK**

### **State Contact**

Ann Marie LaVallo,\* Mental Health Program Specialist  
Housing Services Unit, New York State Office of Mental Health  
44 Holland Avenue, Albany, NY 12229  
Phone: (518) 474-5191 Fax: (518) 473-0066  
E-mail: coreaml@omh.state.ny.us

### **Alternate Contact**

Linsley Piper, Mental Health Program Specialist  
Housing Services Unit, New York State Office of Mental Health  
44 Holland Avenue, Albany, NY 12229  
Phone: (518) 474-5191 Fax: (518) 473-0066  
E-mail: cofalbp@omh.state.ny.us

## **NORTH CAROLINA**

### **State Contact**

Bonnie Morell, Dr.PH, Head of Community Initiatives Branch  
NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services  
3014 Mail Service Center, Raleigh, NC 27699-3014  
Phone: (919) 571-4980 Fax: (919) 571-4984  
E-mail: bonnie.morell@ncmail.net  
FedEx: 3509 Haworth Drive, Suite 105, Raleigh, NC 27609

### **Alternate Contact**

Debbie Webster,\* Community/PATH Program Coordinator  
NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services  
3014 Mail Service Center, Raleigh, NC 27699-3014  
Phone: (919) 571-4981 or Pager: (800) 420-3780 Fax: (919) 571-4984  
E-mail: debbie.webster@ncmail.net  
FedEx: 3509 Haworth Drive, Suite 105, Raleigh, NC 27609

## **NORTH DAKOTA**

### **State Contact**

Bonnie Selzler, Ph.D,\* Assistant Director, Mental Health Services  
Division of Mental Health & Substance Abuse Services  
North Dakota Department of Human Services  
600 South 2<sup>nd</sup> Street, Suite #1D, Bismarck, ND 58504-5729  
Phone: (701) 328-8941 Fax: (701) 328-8969 or (701) 328-8989  
E-mail: soselb@state.nd.us

**Alternate Contact**

Lauren J. Sauer, M.Ed, Coordinator of Planning  
Division of Mental Health & Substance Abuse Services  
North Dakota Department of Human Services  
600 South 2<sup>nd</sup> Street, Suite #1D, Bismarck, ND 58504-5729  
Phone: (701) 328-8733 Fax: (701) 328-8969 or (701) 328-8989  
E-mail:sosaul@state.nd.us

**NORTHERN MARIANA ISLANDS****State Contact**

Joseph Kevin P. Villagomez, Secretary of Health  
Department of Public Health  
Commonwealth of the Northern Mariana Islands Government  
P.O. Box 500409 CK, Lower Navy Hill, Saipan, MP 96950  
Phone: (670) 234-8950 Fax: (670) 234-8930  
E-mail:dphsec1@gtepacific.net

**Alternate Contact**

Josephine T. Sablan,\* Director, Community Guidance Center  
Department of Public Health  
P.O. Box 500409 CK, Lower Navy Hill, Saipan, MP 96950  
Phone: (670) 323-6560 or 6561 Fax: (670) 323-6580  
E-mail:health7@gtepacific.net

**OHIO****State Contact**

Nancy Nickerson, Manager, Community Development  
Office of System Development, Ohio Department of Mental Health  
30 East Broad Street, Suite 800, Columbus, OH 43266-0414  
Phone: (614) 466-0119 Fax: (614) 466-1571  
E-mail:nickersonn@mhmail.mh.state.oh.us

**OKLAHOMA****State Contact**

Connie L. Schlittler, LSW, MPA, Director, Consumer Support Services  
Oklahoma Department of Mental Health & Substance Abuse Services  
P.O. Box 53277, Oklahoma City, OK 73152-3277  
Phone: (405) 522-3863 Fax: (405) 522-3650  
E-mail:cschlittler@odmhsas.org  
FedEx: 1200 N.E. 13<sup>th</sup> Street, Oklahoma City, OK 73117

## **OREGON**

### **State Contact**

Jeanette Sander, Housing Specialist  
Oregon Mental Health & Developmental Disabilities Services Division  
P.O. Box 14250, 2575 Bittern Street, N.E., Salem, OR 97309-0740  
Phone: (503) 947-1045 Fax: (503) 373-7327  
E-mail:jeanette.sander@state.or.us

## **PENNSYLVANIA**

### **State Contact**

John F. Ames, \* Mental Health Program Specialist  
Pennsylvania Office of Mental Health & Substance Abuse Services  
P.O. Box 2675, Harrisburg State Hospital  
Beechmont Building #32, Room 205, Harrisburg, PA 17105  
Phone: (717) 705-9510 Fax: (717) 772-7964  
E-mail:joames@state.pa.us

### **Alternate Contact**

Robert L. Jones, Medical Assistance Program Specialist  
Pennsylvania Office of Mental Health & Substance Abuse Services  
P.O. Box 2675  
Harrisburg State Hospital, Beechmont Building #32, Room 206, Harrisburg, PA 17105  
Phone: (717) 772-7296 Fax: (717) 772-7964  
E-mail:roberjones@state.pa.us

## **PUERTO RICO**

### **State Contact**

Norman P. Cruz, PATH Program Director  
ASSMCA  
P.O. Box 21414, Barbarosa Avenue, Suite 414, San Juan, PR 00928-1414  
Phone: (787) 763-7575, ext. 2401 Fax: (787) 281-7762

### **Alternate Contact**

Gisela Velez Ramirez, \* PATH Program Director  
ASSMCA  
P.O. Box 21414, Barbarosa Avenue, Suite 414, San Juan, PR 00928-1414  
Phone: (787) 763-7575, ext. 2429 Fax: (787) 281-7762

## **RHODE ISLAND**

### **State Contact**

Arn Lisnoff,\* Administrator, Mental Health  
Division of Integrated Mental Health Services  
Rhode Island Department of Mental Health, Retardation & Hospitals  
Barry Hall, 14 Harrington Road, Cranston, RI 02920  
Phone: (401) 462-6037 Fax: (401) 462-1564  
E-mail: [alisnoff@mhrh.state.ri.us](mailto:alisnoff@mhrh.state.ri.us)

### **Alternate Contact**

Daniel J. McCarthy, Associate Director, Division of Integrated Mental Health Services  
Rhode Island Department of Mental Health, Retardation & Hospitals  
Barry Hall, 14 Harrington Road, Cranston, RI 02920  
Phone: (401) 462-6036 Fax: (401) 462-1564  
E-mail: [dmccarthy@mhrh.state.ri.us](mailto:dmccarthy@mhrh.state.ri.us)

## **SOUTH CAROLINA**

### **State Contact**

L. Michele Murff, Director, Housing and Homeless Programs  
South Carolina Department of Mental Health  
7901 Farrow Road, Columbia, SC 29203  
Phone: (803) 935-7262 Fax: (803) 935-6950  
E-mail: [lmm16@dirm.dmh.state.sc.us](mailto:lmm16@dirm.dmh.state.sc.us)

## **SOUTH DAKOTA**

### **State Contact**

Mary Reiss, PATH & Housing Coordinator, Division of Mental Health  
South Dakota Department of Human Services  
East Highway #34, c/o 500 East Capitol, Pierre, SD 57501-5070  
Phone: (605) 773-5991 Fax: (605) 773-7076  
E-mail: [mary.reiss@state.sd.us](mailto:mary.reiss@state.sd.us)

## **TENNESSEE**

### **State Contact**

Dennis Wenner, Director, Adult Services, Division of Mental Health Services  
Tennessee Department of Mental Health & Mental Retardation  
425 5<sup>th</sup> Avenue North, 3<sup>rd</sup> Floor, Nashville, TN 37243  
Phone: (615) 532-6732 Fax: (615) 532-6719  
E-mail: [dwenner@mail.state.tn.us](mailto:dwenner@mail.state.tn.us)

## TEXAS

### State Contact

Greg Gibson, M.A.H.S., Coordinator, Homeless Services  
Texas Department of Mental Health & Mental Retardation  
P.O. Box 12668, Capitol Station, Austin, TX 78711-2668  
Phone: (512) 206-4695 Fax: (512) 206-4784  
E-mail: greg.gibson@mhm.state.tx.us  
FedEx: 909 West 45<sup>th</sup> Street, Austin, TX 78711

## UTAH

### State Contact

Robert H. Snarr, State Mental Health, Housing & Case Management Coordinator  
Utah Division of Mental Health  
120 North 200 West, Salt Lake City, UT 84103  
Phone: (801) 538-4080 Fax: (801) 538-9892  
E-mail: rsnarr@hs.state.ut.us

## VERMONT

### State Contact

Brian M. Smith, Housing Program Administrator  
Vermont Department of Developmental & Mental Health Services  
103 South Main Street, Waterbury, VT 05671-1601  
Phone: (802) 241-2722 Fax: (802) 241-3052  
E-mail: bsmith@ddmhs.state.vt.us

## VIRGIN ISLANDS

### State Contact

Jaslene Williams,\* Virgin Islands Division of Mental Health  
Charles Harwood Hospital  
3500 Richmond, St. Croix, Virgin Islands 00820-4370  
Phone: (340) 773-1992 Fax: (340) 773-7900  
E-mail: mswillieatvicare@worldnet.att.net

### Alternate Contact

Janet Alexander, M.S.W., Unit Leader, Division of Mental Health  
Virgin Islands Department of Health  
Barbel Plaza South, 2<sup>nd</sup> Floor, St. Thomas, Virgin Islands 00802  
Phone: (340) 774-7700 Fax: (340) 774-4701

## **VIRGINIA**

### **State Contact**

Joel Ford, M.S.W.,\* Community Support Specialist  
Office of Mental Health  
Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services  
P.O. Box 1797, Richmond, VA 23218  
Phone: (804) 786-4407 Fax: (804) 786-0918  
E-mail: jford@dmhmrsas.state.va.us  
FedEx: 1212 Bank Street, 10<sup>th</sup> Floor, Richmond, VA 23219

### **Alternate Contact**

Michael Shank, M.S.W., Director, Community Support Services  
Office of Mental Health  
Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services  
P.O. Box 1797, Richmond, VA 23218  
Phone: (804) 371-2480 Fax: (804) 371-0091  
E-mail: mshank@dmhmrsas.state.va.us  
FedEx: 1212 Bank Street, 10<sup>th</sup> Floor, Richmond, VA 23219

## **WASHINGTON**

### **State Contact**

Steve Norsen, Mental Health Division  
Washington State Department of Social & Health Services  
P.O. Box 45320  
Mail Stop 5320, State Office Building 2, 14<sup>th</sup> & Jefferson, Olympia, WA 98504-5320  
Phone: (360) 902-0848 Fax: (360) 902-0809  
E-mail: NORSENS@dshs.wa.gov

## **WEST VIRGINIA**

### **State Contact**

Joan Jordan,\* Housing Program Specialist  
Bureau of Behavioral Health & Health Facilities, Office of Behavioral Health Services  
West Virginia Department of Health & Human Resources  
350 Capitol Street, Room 350, Charleston, WV 25301-3702  
Phone: (304) 558-3634 Fax: (304) 558-1008  
E-mail: joanjordan@wvdhhr.org

## WEST VIRGINIA

### **Alternate Contact**

Ted J. Johnson, Director, Office of Behavioral Health Services  
Bureau of Behavioral Health & Health Facilities  
Office of Behavioral Health Services  
West Virginia Department of Health & Human Resources  
350 Capitol Street, Room 350, Charleston, WV 25301-3702  
Phone: (304) 558-0627, ext. 8994 Fax: (304) 558-1008  
E-mail: tedjohnson@wvdhhr.org

## WISCONSIN

### **Temporary State Contact**

#### **For FY 2000 PATH Annual Report only:**

Jan Devore, Homeless Housing Coordinator  
Bureau of Community Mental Health  
Wisconsin Department of Health & Family Services  
1 West Wilson Street, Room 433, P.O. Box 7851, Madison, WI 53707-7851  
Phone: (608) 243-2418 Fax: (608) 267-7793  
E-mail: devorjk@dhfs.state.wi.us

### **Interim State Contact**

Chris Hendrickson, Director, Bureau of Community Mental Health  
Wisconsin Department of Health & Family Services  
1 West Wilson Street, Room 433, P.O. Box 7851, Madison, WI 53707-7851  
Phone: (608) 267-9282 Fax: (608) 267-7793  
E-mail: hendrch@dhfs.state.wi.us

## WYOMING

### **State Contact**

Carol Day, Mental Health Consultant  
Division of Behavioral Health  
Wyoming Department of Health  
6101 Yellowstone Road, Room 259B, Cheyenne, WY 82002  
Phone: (307) 777-7110 Fax: (307) 777-5580  
E-mail: cday@state.wy.us