Housing for People With Mental Illness: Update of a Report to the President's New Freedom Commission

Ann O'Hara

A significant barrier to participation in community life for people with serious mental illness is the lack of decent, safe, affordable, and integrated housing of their choice linked with supportive services. The nation's affordable housing and mental health systems have historically failed to address consumers' housing needs and choices. The lack of housing has resulted in disproportionately high rates of homelessness and chronic homelessness. The author summarizes these issues, which were examined by the Subcommittee on Housing and Homelessness of the President's New Freedom Commission, and discusses the subcommittee's recommendations to end chronic homelessness among people with mental illness, expand access to affordable housing resources for consumers, and promote evidence-based practices. There has been uneven progress nationwide in ameliorating the widespread and multidimensional housing and homelessness problems that were exposed in the subcommittee's paper. The permanent supportive housing model, including "housing first" approaches, has proven effective in preventing and ending homelessness among consumers, but efforts to expand the supply are hampered by significant reductions in federal funds for housing. State and local mental health systems are also struggling to reconfigure service system resources to better address housing and homelessness issues. Apparent reductions in chronic homelessness will be short-lived unless affordable housing policies and mental health services are reoriented to both prevent and end homelessness for people with mental illness. *Psychiatric Services* 58:907–913, 2007

In 2004 a seminal background paper was published by a team of national experts in the housing and mental health field who served together on the Subcommittee on Housing and Homelessness of the President's New Freedom Commission on Mental Health (1). The Commission's intent was to enable persons with serious mental illness to live, work, learn, and participate fully in the community. The subcommittee's paper was an analysis of the interplay of unmet housing needs with these goals and an agenda for how to initiate change in this arena.

The Commission's final report, *Achieving the Promise: Transforming Mental Health Care in America* (2), identified adequate and affordable housing in the community as essential for consumers to participate fully in their communities. Recognizing that traditional reform measures were not enough, the Commission recommended fundamentally transforming how mental health care is delivered in America, including access to integrated community-based permanent housing. Since the report's publication, there has been uneven progress nationwide in ameliorating the widespread and multidimensional housing and homeless problems that were exposed in the subcommittee's paper.

This article serves as an update to the subcommittee's paper three years after it was issued. It recasts, in an abbreviated format, the paper's problem issues and policy options and reports on progress related to its key recommendations. This article begins with a summary of the affordable housing and homelessness issues presented in the first paper, all of which continue to interfere with the stability and integration of persons with mental illness into our wider society. It restates policy options and program innovations that were recommended to federal, state, and local governments by the subcommittee and provides an update on the status of key federal housing programs. The achievements of several state and local mental health systems that are focused on affordable housing as a core component of mental health transformation activities are also described.

Defining the problem

Housing is more than a basic need. The lack of decent, safe, affordable, and integrated housing is a significant barrier to participation in community life for people with serious mental illnesses (3). Today, many such individuals do not have decent, safe, and affordable permanent housing that meets their preferences and needs. Historically, housing for people with mental illnesses has been in segregated, congregate residential

Ms. O'Hara is associate director, Technical Assistance Collaborative, Inc., 535 Boylston St., Suite 1301, Boston, MA 02116 (e-mail: aohara@tacinc.org).

treatment settings, such as group homes (4). Yet studies have shown that people with mental illnesses prefer to live in less restrictive, independent housing that is integrated in the community (5–7). Consumer preference or choice has also been found to be an important predictor of housing success (8,9). Success in housing also requires access to services and supports that reinforce consumers' dignity, independence, and ability to live in the community.

The lack of affordable housing and accompanying support services often causes people with serious mental illnesses to cycle between jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in large, segregated facilities or substandard housing (10). Research demonstrates that people with serious mental illnesses also make up a large percentage of those who are repeatedly homeless or who are homeless for long periods of time (11–13). Many more face the constant stress of losing their housing or living in dangerous and unsafe housing conditions. People with co-occurring mental illnesses and substance use disorders are in particular need. They make up a significant percentage of people who are homeless and chronically homeless (11). Such individuals are also likely to have acute and chronic physical health problems; exacerbated, ongoing psychiatric symptoms; excessive alcohol and drug use; and a higher likelihood of victimization and incarceration (14).

Analysis of problem issues

Understanding and addressing the housing and homelessness issues that confront people with serious mental illnesses requires analyzing the following key issues.

Housing affordability gap

People with serious mental illnesses often have pronounced difficulties in affording housing (2). They share the same housing affordability problems experienced by all very-low-income Americans who, according to federal guidelines, should pay no more than 30% of income for housing. Households that include persons with disabilities are more likely to have housing problems because they are twice as likely to have incomes below federal poverty guidelines (15). In 2004 five million households in the bottom income quartile were headed by a nonelderly disabled person, and in 2.6 million of these households housing cost burdens were severe or residents lived in crowded conditions (16).

The widening gap between rents and Supplemental Security Income (SSI) payments means that the lowest-income people with serious mental illness are completely priced out of the rental housing market. In 2006, on the basis of data from the U.S. Department of Housing and Urban Development (HUD) regarding the national average for rental units, a person with a mental illness relying on SSI would have needed to pay 113% of his or her monthly income to rent a modest one-bedroom apartment (17). The federal government deems that a very-low-income household paying more than 50% of monthly income for housing is "seriously rent burdened" and has "worst case" housing needs (10). In recent years, the relative value of SSI payments has continued to decline and in 2006 was equivalent to only 18.2% of the median national income (17). An overall decline in the number of affordable housing units being produced has further exacerbated these severe housing affordability problems (18).

Mental illness and homelessness

In addition to poverty and the lack of affordable housing options for people with extremely low incomes, individual risk factors, such as disabling health and behavioral health issues increase a person's vulnerability to homelessness. People with serious mental illnesses are particularly vulnerable and are overrepresented among the homeless population (19). According to a study by the Urban Institute, as many as 46% of people who are homeless have a mental illness (11). Furthermore, this same research indicates that 31% of individuals using homeless services report a combination of mental health and substance use problems within the previous year (11). The symptoms of serious mental illness and co-occurring substance use may contribute to an individual's risk of becoming homeless, just as they may be caused or worsened by homelessness. The fragmentation of mental health systems, a lack of resources, and the continuation of traditional models of service delivery have also contributed to the vulnerability of this population and the volume of acute cases that lead to homelessness (4).

As a result, people with serious mental illnesses often have greater difficulty exiting homelessness on their own and are more vulnerable to experiencing chronic homelessness, defined as being continuously homeless for a year or more or having had at least four episodes of homelessness in the past three years (20). Experts believe that between 150,000 and 200,000 people with disabling conditions such as mental illness are chronically homeless (21).

Editor's Note: This article is the fifth in a series of articles addressing the goals that were established by the President's New Freedom Commission on Mental Health. The commission called for the transformation of the mental health system so that all Americans have access to high-quality services that promote recovery and opportunities to pursue a meaningful life in the community. The series is supported by a contract with the Substance Abuse and Mental Health Services Administration (SAMHSA). Jeffrey A. Buck, Ph.D., and Anita Everett, M.D., developed the project, and Dr. Buck and Kenneth S. Thompson, M.D., are overseeing it for SAMHSA. The series will feature 15 articles on topics such as employment, housing, and leadership, which will be solicited by the journal's editor and peer reviewed. Also planned are case studies from each of the states that received a SAMHSA-funded State Incentive Mental Health Transformation Grant.

Inadequate response from the affordable housing system

The State of the Nation's Housing 2006, published by the Joint Center for Housing Studies of Harvard University (16), noted the housing challenges faced by people with extremely low incomes who have disabilities and the lack of response from the federal government. Federal "elderly only" housing policies enacted in the 1990s prevent people with mental illness and people with other disabilities under age 62 from accessing many federally subsidized rental properties (22). Programs that can help people with mental illness obtain affordable housing, including the Section 8 Housing Choice Voucher program and the Section 811 Supportive Housing for Persons With Disabilities program, have experienced a decline in federal support in recent years (16,23,24). With the notable exception of funding targeted specifically to people who are chronically homeless, recent federal housing policy has focused on homeownership opportunities for households above 30% of median income rather than on increasing the availability of affordable rental housing for the lowest-income Americans (25).

Where housing opportunities exist, major barriers prevent people with serious mental illnesses from obtaining more access to housing intended to benefit people with the lowest incomes. For one, affordable housing programs are extremely complex, highly competitive, and difficult to access. In addition, during the 1990s the federal government devolved decision making for most housing programs to state and local housing officials, state housing finance agencies, and public housing agencies, which often do not understand or prioritize the needs of people with mental illnesses (26).

Inadequate response from the mental health system

Affordable housing and the community support services that consumers need to access and retain housing are often overlooked priorities for state and local mental health systems. This is evidenced by most systems' conventional categorical funding streams, bureaucratic program requirements, administrative approaches to resource allocation and management, and staff skills that are not geared toward rigorously supporting consumers in normal housing (27). Underlying this problem is the perception shared by many mental health systems that housing and housing stability are not their responsibility. Also at work is a preference of mainstream payers, who cover mental health services, for traditional office-based care rather than "in vivo" models of service. Such traditional approaches do not provide the flexibility and mobility necessary to support and sustain consumers in community-based permanent housing.

In addition, traditional case managers must deal with large caseloads, leaving them insufficient time to provide the more intensive support typically needed by persons with serious mental illnesses, such as found in the assertive community treatment approach (28). In general, mental health systems have been unresponsive to the needs of their constituents who are homeless (29). Categorical or "silo" funding streams, which are widespread in mental health systems, also make it difficult to serve the multiple needs of people who are homeless and have serious mental illnesses. These difficulties are amplified for persons with mental illness who are chronically homeless and must navigate a fragmented service system with gaps in the social services safety net (20).

Consumer choice and housing approaches

In addition to affordability, effective housing solutions for persons with mental illness should also reflect the housing choices of consumers themselves. Consistently, research demonstrates that this preference is for an innovative and independent form of housing known as supported housing, or more recently as permanent supportive housing (5,22). The term supported housing (30) was initially used to describe an alternative to residential treatment models that required consumers to progress from more to less restrictive living situations as they were deemed housing "ready." Permanent supportive housing, the term now more commonly used, offers affordable rental housing chosen by the consumer linked with voluntary community-based supports and specifically does not make housing conditional on participation in a supportive services program (22,31). Extensive consumer preference studies show a desire to live in one's own house or apartment, a disregard for segregated settings, and greater housing and neighborhood satisfaction with the permanent supportive housing model (5,32).

Permanent supportive housing is more effective at engaging and housing hard-to-serve people with mental illness than are residential treatment programs that use housing as leverage for treatment compliance (33). Permanent supportive housing has also been shown to be a cost-effective solution to homelessness (12). Research on a specific type of permanent supportive housing called "housing first" provides strong evidence for the impact of consumer choice on positive outcomes for people with mental illnesses. Clients of Pathways to Housing, a choice-based housing first program in New York City for homeless people with co-occurring serious mental illness and substance use disorders, demonstrated an 88% retention rate in housing over five years compared with 40% for those housed in residential treatment settings (14). Further, individuals in the Pathways program, which does not require mental health treatment or sobriety, reported greater perceived choice and achieved stable housing without compromising mental health or substance abuse symptoms (9,34). Research by Pathways staff has also demonstrated the effectiveness of engaging consumers in substance abuse treatment by using a harm-reduction approach that tailors intervention to an individual's stage of recovery (9). Converting traditional congregate residential facilities and office-based service approaches to the permanent supportive housing model preferred by consumers and making low-demand programs available for those who need them is central to the challenge of transforming the mental health system nationwide.

Progress in housing and system transformation strategies

The Housing and Homelessness Subcommittee made a number of recommendations on housing and homelessness issues that are key to effective mental health system transformation. Their recommendations sought to end chronic homelessness among people with mental illness, expand access to affordable housing resources for consumers, and promote evidence-based practices, including the use of Medicaid financing mechanisms, for people with mental illness who are homeless or at risk of homelessness.

Strategies to prevent and end chronic homelessness

In 2002 the Bush Administration announced its policy objective to end chronic homelessness in ten years. In the midst of the subcommittee's work in 2003, HUD, the U.S. Department of Health and Human Services (HHS), and the U.S. Department of Veterans Affairs (VA) in partnership with the U.S. Interagency Council on Homelessness initiated the first of three federal interagency permanent supportive housing initiatives targeted to chronically homeless people (35). The subcommittee strongly endorsed the President's commitment to end chronic homelessness and recommended that this coordinated interagency approach—linked with appropriate incentives in federal "mainstream" housing and support services programs—could create a framework for the federal government's efforts to address the housing and support services needs of people with serious mental illness.

To support and advance the goal of ending chronic homelessness among people with serious mental illness, the subcommittee recommended that HUD—in partnership with HHS and VA—develop and implement a comprehensive plan designed to facilitate access to 150,000 units of permanent supportive housing for chronically homeless individuals over the next ten years. They called for the plan to include specific cost-effective approaches, strategies, and action steps to be implemented at the federal, state, and local levels.

Five years into the federal commitment to end chronic homelessness, progress to expand permanent supportive housing for chronically homeless people is evident. In addition to the federal interagency initiatives, HUD appropriations legislation since 2002 has included new McKinney-Vento Homeless Assistance funds to develop between 5,000 and 10,000 new units of permanent supportive housing for chronically homeless people (36). Policy incentives have also been adopted to redirect existing permanent supportive housing units to people with disabilities who have been homeless for long periods of time (37). At the state and local levels, communities are creating plans to end chronic homelessness that focus on improving outreach activities, discharge planning, and housing and community supports for people with mental illness and others who experience chronic homelessness (38). Private philanthropic organizations and national homeless advocacy groups are actively promoting this agenda and providing financial support for these initiatives (39).

Strategies to expand access to affordable housing

The Housing and Homelessness Subcommittee recognized that to end homelessness among people with mental illness, federal housing policy must also respond to the needs of consumers at risk of homelessness. Toward that end, the subcommittee's report included several recommendations designed to improve mental health consumers' access to government-funded affordable housing opportunities. These recommendations recognized the importance of federal housing policies in facilitating access to a complex array of federal housing programs administered through a myriad of state and local public and private housing agencies and providers. In particular, the subcommittee noted the important role that HUD could play through structured partnerships with HHS and other federal agencies and by providing guidance and technical assistance to state and local housing officials and public housing agencies. Unlike the sustained federal effort to create new housing opportunities for chronically homeless people, there has been very little response from the federal government to address the housing problems of the lowest-income consumers before they become homeless.

Housing experts agree that federal housing funds—including so-called "mainstream" housing programs as well as housing programs targeted to people with disabilities—are essential to close the housing affordability gap that affects people with mental illness with the lowest incomes. Flexible capital funding through programs such as the Low Income Housing Tax Credit and the HOME Investment Partnerships programs are core components of affordable rental housing strategies in local communities. However, for units in these types of properties to be affordable for consumers with extremely low incomes, permanent rent subsidies provided through programs such as the Housing Choice Voucher program and the Section 811 Supportive Housing for Persons With Disabilities program are also essential.

During the past five years federal support for the rent subsidy programs needed by people with serious mental illness has declined significantly. In 2002 a successful policy initiated in 1997, which provided approximately 50,000 new Housing Choice Vouchers for people with disabilities, was eliminated (24). From 2003 to 2006 Congress and HUD created fiscal policies that contributed to the loss of more than 150,000 existing Housing Choice Vouchers and also weakened efforts to rejuvenate and preserve the nation's supply of housing for the lowest-income households (23). During this same period, HUD also repeatedly proposed legislation that would have redirected existing voucher funds to households above 30% of median income (25).

The Section 811 Supportive Housing for Persons With Disabilities program has also been adversely affected by recent federal housing policy (16). Section 811 is the only federal housing program dedicated to expanding the supply of affordable and accessible supportive housing for people with serious and long-term disabilities. Recognizing the value and symbolism of this program, the subcom-

mittee report called for reforms and improvements in Section 811, but none have been enacted. During the past four years the number of new rental units for people with disabilities produced through the Section 811 program has declined by more than 25% (40).

As new federal housing resources for the lowest-income households have steadily declined, more state and local mental health authorities have elected to create policies and housing approaches that rely on mental health system resources to expand affordable and permanent supportive housing opportunities for consumers. During recent years the State of California has reduced hospitalizations, incarceration, and homelessness and achieved substantial cost savings through the development of permanent supportive housing. These outcomes prompted the passage of Proposition 63 and an unprecedented state commitment to finance the creation of 13,000 new units of permanent supportive housing over the next ten years (41). Over the past decade state mental health–funded "bridge" subsidy programs have helped link thousands of consumers to Housing Choice Vouchers in Ohio, Connecticut, Oregon, and Hawaii. Given the recent cutbacks in the voucher program, the effectiveness of these bridge subsidies to link consumers to Housing Choice Vouchers may now be in question.

At the local level, counties and municipalities are also increasingly tapping discretionary mental health funds, such as savings from managed care, to leverage scarce government housing dollars. In 2004 and 2005 Arlington County, Virginia, and Allegheny County, Pennsylvania, both successfully implemented housing strategies for people with serious mental illness on the basis of this leveraging principle. Although these noteworthy state and local efforts have certainly helped some consumers obtain affordable housing, they are not sufficient to fill the gap created by declining federal support for housing programs that assist the lowest-income households.

The subcommittee's report emphasized that housing funding alone could not solve consumers' housing problems. Their recommendations reinforced the complexity of the housing issue for people with mental illness by calling for the creation of public-private partnerships between developers, landlords, housing agencies, and the mental health system. These types of partnerships were first modeled through the Robert Wood Johnson Foundation's Program on Chronic Mental Illness, which demonstrated the importance of housing planning and the important role of nonprofit housing corporations in mental health housing policy (42). Today, mental health nonprofit housing development corporations in numerous states own and manage thousands of units of permanent housing permanently set aside for consumers. However, the scarcity of new housing funding from programs such as Section 811 may reduce the number of new units that these development corporations could otherwise produce each year.

Mental health systems that have made significant progress on affordable housing issues do so by strengthening linkages with the affordable housing system (22). Strategies to implement this approach typically include dedicating one or more full-time staff members to work exclusively on housing and homeless issues. These mental health system staff must have the expertise to facilitate partnerships with housing agencies, track housing program and policy changes, obtain the scarce housing resources that are available, and provide training and technical assistance on housing issues. Today, Tennessee stands out as a strong example of this practice in action. The state has hired seven regional housing facilitators who have been instrumental in creating well over 2,000 units of affordable housing for persons with mental illness since 2002. Other state mental health authorities that have successfully used this model include Connecticut, Kentucky, Massachusetts, Ohio, and Oregon.

Strategies to promote evidence-based practices

Mental health care programs and practitioners often rely on clinical and service delivery practices that, although widely accepted in the field, are not evidence based (43). The subcommittee recommended that HHS establish funding policies to ensure that initiatives related to evidence-based practices and the integration of federal and state funding resources are tailored to people with mental illnesses who are homeless or at risk of homelessness. Evidence-based practices that are known to be effective in assisting people with mental illnesses who are homeless (or at risk of homelessness) to gain and sustain independent living in the community include assertive community treatment, integrated services for people with co-occurring substance use disorders and mental illnesses, supported employment, and illness self-management.

Financing and implementation of evidence-based practices have been adopted as a core principle and objective of the Substance Abuse and Mental Health Services Administration (SAMHSA) mental health system transformation effort. Implementation of these practices poses a significant challenge for state and local systems electing to reconfigure mainstream resources. At the service delivery level, a lack of knowledge of evidenced-based practices, readiness issues, fiscal disincentives, and inadequate support for the change process can often derail potentially successful systems change activities (43).

The subcommittee also recommended that HHS and its Centers for Medicare and Medicaid Services (CMS) improve and expand the ways in which Medicaid funding is used to maximum effect in serving people who are homeless, at risk of homelessness, or moving from homelessness to permanent supportive housing. Existing Medicaid statutes and regulations support some flexibility and ability to implement community-based services of importance to people with mental illnesses who are homeless or at risk of homelessness. However, best-practice services are optional as opposed to mandatory in state Medicaid plans, and thus states vary widely in how these service approaches are implemented. The subcommittee recommended that CMS exercise strong national leadership to

engender the inclusion of best-practice services into state Medicaid plans and service requirements.

CMS has acted on these recommendations through its policy guidance to state Medicaid directors, through a set of system change grants to states designed to reduce institutional care and increase integrated community service provision, and through active participation in HHS's mental health transformation agenda. However, it should be noted that Medicaid resources are being restricted and curtailed at both the state and federal levels at the same time that efforts are being made to expand Medicaid coverage for best-practice services targeted to people with serious mental illness. Stringent eligibility requirements for Medicaid and difficulties navigating the SSI application process can restrict access to services, particularly for homeless people with serious mental illnesses (4).

Housing as a key factor in transformation planning

To ensure that housing and other essential resources are available to consumers and families in a transformed mental health system, the commission called on states to develop comprehensive mental health plans to outline responsibility for coordinating and integrating programs. Through the accountability envisioned in the planning process, the commission postulated that states would have the flexibility to combine federal, state, and local resources in creative, innovative, and more efficient ways, overcoming the bureaucratic boundaries between the health care, housing, employment support, and criminal justice systems (2). The background paper of the Subcommittee on Housing and Homelessness made note of a similar vision articulated in policies that apply to federally mandated housing planning activities (that is, the Consolidated Plan, the Public Housing Agency Plan, the Continuum of Care Plan, and the Qualified Allocation Plan) required of state and local government housing agencies as a condition of receiving federal affordable housing funding.

In 2005 SAMHSA awarded Mental Health Transformation State Incentive Grants (MHT-SIGs) to seven states to advance the vision and goals of the Commission's final report. These grants are intended to support an array of infrastructure and service delivery improvement activities to help grantees build a solid foundation for delivering and sustaining effective mental health and related services. It is too early in the MHT-SIG planning process to determine whether state mental health systems will build the housing capacity necessary to successfully leverage interagency partnerships and the limited resources that are available from state and local housing systems and this planning process. It is clear, however, that these collaborations are essential for a transformed system.

Conclusions

Preliminary results achieved in several major cities suggest that federal policies targeted to end chronic homelessness are working. Denver, Philadelphia, and Portland, Oregon, all report significant reductions in street homelessness achieved through aggressive permanent supportive housing strategies and outreach strategies (21). Although progress toward this goal is encouraging, it may be short lived if the housing resources—and community-based supportive services—are not in place to prevent consumers from becoming homeless.

As *The State of the Nation's Housing 2006* makes clear, housing affordability problems are intensifying across the nation, particularly for households with the lowest incomes. For people with mental illness those acute problems are further exacerbated by stigma and housing discrimination. The report realistically concludes that "prospects for a turnaround are bleak" and notes that after nearly 20 years of increases in federal housing assistance, growth ground to a halt in the second half of the 1990s. Successful efforts to transform mental health system service approaches—including increased support for the implementation of evidence-based practices—will be compromised if these policies remain in place and consumers are unable to obtain decent and affordable places to live that are well integrated in neighborhoods and communities.

It is important for mental health systems, including consumers and family members, to join with other groups working to reorient affordable housing policy to focus on the needs of households with extremely low incomes. Collectively, these efforts must create the political will to support increased funding for the Housing Choice Voucher program as well as programs such as Section 811 and McKinney-Vento Homeless Assistance resources that focus exclusively on the needs of people with disabilities who are homeless or most at risk of homelessness. A new National Housing Trust Fund could also provide incentives for the creation of new rental housing affordable to people with disabilities whose income is below 30% of the median. The National Low Income Housing Coalition is leading the effort to create this new resource, including policies that would prioritize the needs of extremely low-income households (44).

In addition to the federal government, state and local governments can also play an important role in housing policy for people with mental illness. The success achieved by mental health advocates in California demonstrates that elected officials and voters can be convinced to support housing and supportive services policies that directly benefit people with mental illness. The key to success at all levels is to ensure that government housing officials are educated about the housing and supportive services barriers that exist today for people with mental illness and about the eventual—and higher—cost to the taxpayer if nothing is done to address this critical need.

Acknowledgments and disclosures

The author reports no competing interests.

References

1. Subcommittee on Housing and Homelessness: Background Paper. Rockville, Md, US Department of Health and Human Services, New Freedom Commission on Mental Health, 2004

2. Achieving the Promise: Transforming Mental Health Care in America. Pub no SMA-03-3832. Rockville, Md, US Department of

Health and Human Services, New Freedom Commission on Mental Health, 2003

3. US Department of Health and Human Services: Cooperative Agreements to Evaluate Housing Approaches for Persons With Serious Mental Illness: Guidance for Applicants. Rockville, Md, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1997

4. Blueprint for Change: Ending Chronic Homelessness for Persons With Serious Mental Illnesses and Co-occurring Substance Use Disorders. Rockville, Md, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2003

5. Tanzman B: An overview of surveys of mental health consumers' preferences for housing and support services. Hospital and Community Psychiatry 44:450–455, 1993

6. Yeich S, Mowbray C, Bybee D, et al: The case for a "supported housing" approach: a study of consumer housing and support preferences. Psychosocial Rehabilitation Journal 18(2):75-86, 1994

7. Fakhoury W, Murray A, Shepherd G, et al: Research in supported housing. Social Psychology and Psychology Epidemiology 37:301–315, 2002

8. Srebnik D, Livingston J, Gordon L, et al: Housing choice and community success for individuals with serious and persistent mental illness. Community Mental Health Journal 31:139–152, 1995

9. Tsemberis S, Gulcur L, Nakae M: Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health 94:651–656, 2004

10. A Report on Worst Case Housing Needs in 1999: New Opportunity Amid Continuing Challenges. Executive Summary. Washington, DC, US Department of Housing and Urban Development, Office of Policy Development and Research, 2001

11. Burt M: What Will It Take to End Homelessness? Washington, DC, Urban Institute Press, 2001

12. Culhane, DP, Metraux, S, Hadley, T: Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. Housing Policy Debate 13:107–163, 2002

13. Levy C: State panel seeks changes in homes for mentally ill. New York Times, Sept 24, 2002, p A1

14. Tsemberis S, Eisenberg R: Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities. Psychiatric Services 51: 487–493, 2000

15. American Community Survey. Washington, DC, US Census Bureau, 2005. Available at http://factfinder.census.gov

16. The State of the Nation's Housing 2006. Cambridge, Mass, Joint Center for Housing Studies of Harvard University, 2006

17. Priced Out in 2006. Boston, Technical Assistance Collaborative, Inc, 2007

18. Meeting Our Nation's Housing Challenges: Report of the Bipartisan Millennial Housing Commission. Washington, DC, US Government Printing Office, 2002

19. Rosenheck R, Bassuk E, Salomon A: Special populations of homeless Americans, in Practical Lessons: The 1998 National Symposium on Homelessness Research. Edited by Fosburg L, Dennis D. Washington, DC, US Department of Housing and Urban Development and US Department of Health and Human Services, 1999

20. Ending Chronic Homelessness: Strategies for Action. Report From the Secretary's Work Group on Ending Chronic Homelessness. Washington, DC, US Department of Health and Human Services, 2003

21. Chronic Homelessness Issue Brief. Washington, DC, National Alliance to End Homelessness, 2006

22. Technical Assistance Collaborative, Inc: Permanent Supportive Housing: A Proven Solution to Homelessness. Opening Doors, issue 20, Jan 2003. Available at www.tacinc.org/pubs/odpubs.htm#20

23. Center on Budget and Policy Priorities: The Effects of the Federal Budget Squeeze on Low-Income Housing Assistance. Washington, DC, Center on Budget and Policy Priorities, 2007

24. Priced Out in 2004. Boston, Technical Assistance Collaborative, Inc, 2005

25. Newly Proposed Housing Legislation Would Leave Public Housing Agencies Vulnerable to Substantial Funding Cuts and Shifting HUD Mandates. Washington, DC, Center on Budget and Policy Priorities, 2005

26. Technical Assistance Collaborative and the Consortium for Citizens With Disabilities Housing Task Force: Affordable Housing in Your Community: What You Need to Know! What You Need to Do! Opening Doors, issue 8, Sept 1999. Available at www.tacinc.org/pubs/odpubs.htm#20

27. Carling P: Housing, community support, and homelessness: emerging policy in mental health systems. New England Journal of Public Policy 8:281–295, 1992

28. Morse G: A review of case management for people who are homeless: implications for practice, policy, and research, in Practical Lessons: The 1998 National Symposium on Homelessness Research. Edited by Fosburg L, Dennis D. Washington, DC, US Department of Housing and Urban Development and US Department of Health and Human Services, 1999

29. Holes in the Safety Net: Mainstream Systems and Homelessness. San Mateo, Calif, Charles and Helen Schwab Foundation, 2003

30. Carling P: Housing and supports for persons with mental illness: emerging approaches to research and practice. Hospital and Community Psychiatry 44:439–449, 1993

31. Strategic Framework for Ending Long-Term Homelessness. New York, Corporation for Supportive Housing, 2002

32. Newman S: Housing attributes and serious mental illness: implications for research and practice. Psychiatric Services 52:1309–1317, 2001

33. Allen M: Waking Rip van Winkle: Why developments in the last 20 years should teach the mental health system not to use housing as a tool of coercion. Behavioral Sciences and the Law 21:503–521, 2003

34. Greenwood R, Schaefer-McDaniel N, Winkel G, et al: Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. American Journal of Community Psychology 36:223–238, 2005

35. US Departments of Housing and Urban Development, Health and Human Services, and Veterans Affairs: Notice of Funding Availability (NOFA) for the Collaborative Initiative to Help End Chronic Homelessness. Federal Register 68:4018–4046, 2003

36. HUD's Homeless Assistance Programs. Washington, DC, National Alliance to End Homelessness, 2006

37. FY 2006 Super NOFA: Continuum of Care Homeless Assistance Programs. Washington, DC, US Department of Housing and Urban Development, 2006

38. The Ten Year Plan to End Homelessness. Washington, DC, National Alliance to End Homelessness, 2005

39. Partnership to End Long Term Homelessness: Nine Partners Join Together to Galvanize a National Effort to End Long-Term Homelessness, Millions of Dollars Dedicated to Promote Awareness and Build Supportive Housing, New Data From Nine Cities Shows Supportive Housing is Cost-Effective Alternative to Chronic Homelessness, 2006. Available at www.endlongtermhomelessness.org

40. FY 2006 Notice of Funding Availability: Section 811 Supportive Housing Program for Persons With Disabilities. Washington, DC, US Department of Housing and Urban Development, 2006

41. The Importance of State Investment in Permanent Supportive Housing. New York, Corporation for Supportive Housing, 2004

42. Cohen M, Somers S: Supported housing: insights from the Robert Wood Johnson Foundation Program on Chronic Mental Illness. Psychosocial Rehabilitation Journal 13(4):43–50, 1990

43. Hyde P, Falls K, Morris J, et al: Turning Knowledge Into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices. Boston, Technical Assistance Collaborative and the American College of Mental Health Administration, 2003

44. Housing Trust Funds Grow Nationwide. Washington, DC, National Low Income Housing Coalition, 2007 Available at www.nlihc.org