Report on the Housing Needs of Persons with Mental Illness

Prepared by Tennessee Housing Development Agency

Pursuant to SJR 279 and SJR 529

August 2000

This report can also be accessed on THDA's website:
http://www.state.tn.us/thda

The information contained in this report was compiled with the assistance of numerous individuals and organizations, including the following:

A.I.M., Inc
Foundations, Inc.
Healthcare for the Homeless
Housing Committee of the Tennessee Mental Health Planning Council
Kress and Associates
Lowenstein House
Members and Staff of the Tennessee Association of Mental Health Organizations
Memphis Veterans Administration Medical Center
Mental Health Cooperative, Inc.
Mental Health Planning Council
Mountain Home Veterans Administration Medical Center (Johnson City)
Nashville Veterans Administration Medical Center
National Alliance for the Mentally Ill - Tennessee
Park Center Housing
Pathways Behavioral Health Services
TennCare Partners Roundtable
Tennessee Christian Medical Center
Tennessee Coalition for the Homeless
Tennessee Commission on Aging
Tennessee Department of Children's Services
Tennessee Department of Correction
Tennessee Department of Health
Tennessee Department of Human Services
Tennessee Department of Mental Health/Mental Retardation
Tennessee Mental Health Consumers Association
Tennessee Mental Health Planning Council

NOTE: Effective July 1, 2000, the Tennessee Department of Mental Health and Mental Retardation (DMHMR) officially became the Tennessee Department of Mental Health and Developmental Disabilities (DMHDD). Because people are not yet familiar with this name and to avoid confusion about which agencies are being referred to, we have referred to the department in this document as DMHMR.

EXECUTIVE SUMMARY

By Senate Joint Resolution 279, the Tennessee Housing Development Agency (THDA) was directed to assess the housing needs of persons with mental illness in Tennessee and, along with designated advisors, develop a plan to improve the suitability, safety, and affordability of housing for these persons. Specifically, THDA was asked to assess the availability and affordability of suitable housing; evaluate any available funding sources; and identify relevant barriers to appropriate housing for persons with mental illness. We were directed to develop a plan, based on these findings, with recommendations for improvement of the housing conditions of these persons.

The framework of the study was first, to establish how many persons with serious and persistent mental illness have housing needs. The study set out to develop a more complete understanding of the variety and severity of housing needs among these persons, the factors contributing to those needs, any geographical differences in needs, and the barriers that operate to prevent meeting those needs.

The second major prong of the study concerned developing a better understanding of the housing resources that are currently available to persons with severe and persistent mental illness. Again, the study set out to determine what kinds of facilities are being used; what kinds of supervision and services are available at those facilities; what types of persons can and do live in these facilities; where the facilities are; and, how well the space in these facilities is being utilized.

THDA led two survey projects to acquire the information about both the needs of the people with severe and persistent mental illness and the housing available to them. THDA also collected data about other segments of the mentally ill population (such as inmates in penal institutions and the homeless) to form a more comprehensive view of the range of housing problems throughout the state. Based on the results of these surveys, and the other data collected, several important conclusions can be drawn, including the following:

- Approximately 15% of persons with severe and persistent mental illness receiving case management are housed inappropriately. These consumers are receiving services from the mental health delivery system; however, one can assume that this percentage might be considerably higher among those other segments not receiving services at all, such as homeless persons.
- In all areas of the state, and among every sub-group of the population surveyed, the primary barrier to appropriate housing was insufficient income to pay for monthly expenses.
- The type of housing most appropriate for the majority of the consumers surveyed is independent living units. A large portion of consumers described as living in inappropriate facilities are currently in independent living units, *and need to remain in independent living unit*s – but not the units they are currently in. Structural problems, personal safety issues, and inadequate finances were all listed as reasons why current independent living units were not appropriate.
- The needs of persons with dual diagnosis (MH/MR and MH/A&D) are different from the needs of the rest of the consumer population. Nearly one-third of persons in our survey

described as having inappropriate housing are dually-diagnosed. These persons are more likely to need housing in a more structured and highly supervised setting. However, only ten percent of licensed facilities that focus on a specific population segment responded that they concentrated on providing housing for dually-diagnosed consumers.

- Young adults (age 18-24) and women lack access to a considerable share of these licensed facilities.
- Smaller metropolitan areas, such as Jackson and Clarksville, do not contain a proportionate share of licensed facilities. Particularly in these areas, consumers frequently have to live further from their homes than is ideal.
- A large proportion of persons awaiting release from Regional Mental Health Institutes cannot be released because there are not enough spaces available in appropriate licensed facilities.

The report goes into considerable detail to explain these findings. Financial resources for affordable housing development are also described. A number of recommendations for action to address these findings appear at the end of the report.

THDA looks forward to working with the Department of Mental Health and Mental Retardation (now the Department of Mental Health and Developmental Disabilities), the General Assembly, and other vital players in helping to develop solutions to the problems described in this report.

INTRODUCTION

The importance of housing is common to all people in all cultures. For persons who suffer from mental illness, housing can be an especially problematic issue. For those with serious and persistent mental illness (SPMI), finding and retaining a place to live is exceedingly difficult. Serious mental illness commonly has a negative impact on the way one is treated and understood by society-at-large. The internal and external impact of serious and persistent mental illness devastates the lives of the persons with the illness and the lives of the families and friends. The loss to society of human potential represented by serious and persistent mental illness is incalculable.

There is currently consensus among consumers, family members, advocates, and mental health providers that housing is a key component of treatment and recovery for this population. Access to decent, affordable housing increases efficacy of various treatment modalities as well as significantly enhancing opportunities for recovery.

In May 1999, the Tennessee General Assembly passed Senate Joint Resolution 279[1] (included in Appendix 1) in response to the Tennessee Mental Health Planning Council's identification of the critical importance of housing for persons with mental illness. SJR 279 mandated the Tennessee Housing Development Agency (THDA) to:

- Assess the needs of mentally-ill Tennesseans for available and affordable housing which provides reasonable access to appropriate mental health services
- Assess the availability of funding from all sources
- Identify social, economic, and political barriers to suitable housing for mentally-ill persons
- Propose ways to reduce or eliminate the identified barriers
- Develop a comprehensive plan with specific recommendations to improve housing conditions for persons with mental illness.

THDA's efforts to complete the study were aided by a wide range of mental health professionals, advocates, and consumers, including the Tennessee Department of Mental Health and Mental Retardation, the Tennessee Association of Mental Health Organizations, and the Tennessee chapter of the National Alliance for the Mentally Ill. Two formal meetings were held,

[1] Senate Joint Resolution 529 revised the final study report date to no later than 8/1/00. SJR 529 is also included in Appendix 1.

in October 1999 and in June 2000. In addition, regular contacts were made and maintained with various members of these groups throughout the course of the study, which could not have been completed otherwise. (A complete listing of participants can be found at the front of the report.)

The following list of questions was used to guide the study:

- How many mentally ill Tennesseans have housing needs?
- Where are persons with mental illness with housing needs living currently?
- What are the current types of housing available to persons with mental illness?
- What type of housing and level of support services is most appropriate for those persons with mental illness who have housing needs?
- Do we have any extant housing resources that could be redirected toward serving this population?
- What are the significant factors that contributed to the current housing situation?
- How can we best provide for the housing needs of this population?

This report presents findings from THDA's study of the housing needs of persons with mental illness in Tennessee. The report is based on the premise that housing should not be a barrier to treatment and recovery for the mentally-ill citizens of the state and that persons with mental illness are entitled to a fair share of societal resources and support.

The main body of information presented in this report was collected as a result of two surveys performed by THDA. The surveys were designed to produce complementary data: the survey results would be compared and contrasted in order to illuminate the nature of the problem and, hopefully, the direction for solutions. Information was also gathered by analysis of existing data from various sources.

The report includes an overview of the current situation; a description of the population; analyses of data gathered during the course of the study; a description of the barriers to housing for persons with mental illness; and recommendations based upon the study findings.

PART 1. OVERVIEW OF THE CURRENT SITUATION

Tennessee's mentally ill population is served by a complex and diverse system of providers. The system includes the state's mental health institutions, community mental health centers, managed care entities, faith/service organizations, and private individuals. Both non-profit and for-profit entities are part of the structure of Tennessee's mental health system. This structural complexity is caused by several factors, including the policy of deinstitutionalization, changes in the mental health system, a growing imperative to control costs in an era of decreasing resources, and societal attitudes toward persons with mental illness. Not least among these factors was the implementation of the TennCare Partners Program, switching from the traditional Medicaid process to a managed care approach.

The policy of deinstitutionalization, which began to impact Tennessee in the late 1970s and early 1980s, was driven in large part by societal reaction to exposes of abysmal conditions within certain psychiatric hospitals and by advances in psychotropic medications, thereby allowing more people to function at higher independence levels. As a result of deinstitutionalization, large numbers of formerly institutionalized persons with mental illness were discharged from state psychiatric hospitals into the community. Many of these persons were chronically mentally ill, were accustomed to a very restrictive setting, and had few financial resources. Very few communities were prepared to address the needs of this newly-visible segment of society. The need for community-based services for these former long-term hospital residents produced two consequences relevant to the topic of this study.

The discharge of persons with mental illness into the community created a demand for housing. The private sector responded to this demand for housing in the form of supportive living facilities (SLF). SLFs, variously called boarding homes or board and care homes, are facilities, frequently private homes, in which persons with mental illness reside. The earliest SLFs were essentially a market response to demand; they were also the only community setting available to newly discharged persons with mental illness. The provision of this type housing was not an organized effort on a statewide basis, but rather an individual response to local demand. The ad hoc origins of SLF housing places these providers in a curious position relative to other mental health providers. Nevertheless, supportive living facilities (SLF) remain a major component of housing for persons with mental illness.

Another consequence of deinstitutionalization was the creation, via federal legislation, of community mental health centers mandated to serve persons with mental illness in community settings.[2] It is crucial to note that during the era of deinstitutionalization, housing was not understood to be a vital component of mental health services. This fact is primarily due to the dominant model of mental health practice of the time.[3] The traditional medical model of mental health services focused on the individual without reference to context or environment. Thus, recognition of housing as an important aspect of treatment of persons with mental illness was an idea whose time had not yet arrived.

For the past decade, however, the mental health field has been adapting to a new model of practice. The medical model has been superseded by the psychosocial perspective, which emphasizes the impact of context and environment upon the individual. Such a perspective fosters an awareness of the importance of housing stability to the provision of mental health services.

As previously mentioned, mental health services have also been influenced by the development of new pharmaceuticals. The impact of these new drugs has been profound, both in terms of the quality of life of persons with mental illness and in terms of the opportunities for recovery from severe and chronic mental illness. The concept that some severely and chronically mentally ill persons can and do recover has important, long-term ramifications for consumers, providers, and society-at-large. Nevertheless, some persons with serious and persistent mental illness will always need long-term supportive residential care in order to function outside the institution.

PART 2. EVALUATION OF HOUSING APPROPRIATENESS FOR PERSONS WITH MENTAL ILLNESS

It is widely known to caregivers that stable living conditions, with access to appropriate supportive services, contribute significantly to the continued well being of persons with psychiatric disability. Providing a safe and stable living environment and providing access to the

[2] The Mental Health Center Acts of 1963 and the Mental Health Systems Act of 1980.
[3] Models of practice are important because they influence how problems are defined and solutions designed; they determine which services are provided, how they are provided, how agency resources are allocated, what aspects of the client and his/her environment are valued and which are discounted.

necessary care and services, together, facilitate their stabilization, gradual recovery, and reintegration into the community. For this reason, evaluation of the housing needs of persons with chronic mental illness must include informed assessments of the appropriateness of their current residence in addressing their special needs. This assessment may also have to incorporate an array of common concerns pertaining to housing; namely quality, safety, affordability, and the like.

Data Availability

Given the recognized importance of stable housing in psychiatric recovery and rehabilitation, it might be assumed that residential histories of the consumers are routinely tracked within the mental health care system. Such tracking is essential in developing efficient and cost-effective methods to achieve patient recovery and rehabilitation within the community setting and in preventing the recurring and costly journey of chronic psychiatric patients through hospitals, jails and homelessness. However, our persistent inquiry left us with the impression that neither cross-sectional nor longitudinal evaluations of consumer housing experience were part of the mental health records in Tennessee. This sample survey was conducted as a modest attempt to evaluate current residential adequacy of the psychiatric clients of the Mental Health Service Providers in Tennessee. It is worth noting that this survey does not serve as a substitute for the routine tracking of housing and the development of effective housing strategies within a comprehensive system for psychiatric care.

Objectives of the Residential Adequacy Survey

The survey seeks to evaluate the residential care environment of the consumers at the time of the survey in order to answer the following questions:

- What type of residential-care environments do they live in now?
- How many are inappropriately housed in each residential category?
- What prevents these consumers from choosing appropriate residential care and what needs to be done in order to eliminate these barriers?
- How are these housing problems tied to areas of residence, gender, age and other consumer demographics in ways that potentially limit their residential choices?

Answers to these questions will help quantify the housing problems among persons with mental illness and develop adequate housing strategies and programs within different areas of the state. The inventories of the licensed residential facilities obtained through the Licensed Facilities Survey and the estimates of housing need obtained from this survey, together, may give a sound basis for formulating housing program goals and strategies for persons with mental illness.

Survey Design

Mental Health Service Providers (MHSPs) play a pivotal role in the delivery of mental health services in Tennessee. They constitute a statewide network of mental health professionals who provide services to consumers at the local, grassroots level. The delivery of services is tailored to match individual needs of the consumers. Their primary role in the customization of services, and their regular contact with consumers, make the MHSP personnel a knowledgeable source of information and a logical choice for statewide data compilation.

Nineteen MHSPs took on the responsibility for data collection[4]. Since this undertaking was beyond the routine work of the MHSP field staff, the MHSPs were asked to choose the most suitable among them, those who have good knowledge of their clients' residential needs and the willingness to put in extra time to complete the survey. Each MHSP made this staff selection with the understanding that all cases assigned to these staff members were to be included in the survey and the total completed surveys should represent 15 percent of all consumers served at the time by the MHSP. We chose this approach deliberately to expedite the survey and maximize the data quality. Given the limitations of time and resources, and the diversity of MHSP data systems, random selection of clients at each site became less of an option.

The survey procedure has the following features:

- The survey covered clusters of clients who constituted the caseload of the staff chosen by the MHSPs to evaluate the residential adequacy.
- The sample ratios and the extent of departure of this selection process from random selection will be examined by comparing the demographics and clinical characteristics of the surveyed consumers to those of the entire MHSP caseload.

[4] Included in the group of 19 are 15 members of the Tennessee Association of Mental Health Organizations, three non-members and the Mental Health Co-op of Nashville. (A complete list can be found under Appendix 2.)

- The proposed selection ratio (15 percent) yields numbers within geographic areas and demographic groups that are large enough to provide reliable survey estimates, accurate enough for sizing the need-based housing program components within these subcategories.

Size and Representativeness of the Sample

MHSP Case Managers were the primary group who completed the survey questions and in doing so, evaluated the housing appropriateness of their psychiatric clients (A copy of the survey instrument can be found in Appendix 3, entitled Housing Survey). As a result, most of the survey responses (89%) pertain to clients who were receiving case management (CM). From the estimates provided by the participating MHSPs, altogether their client pool includes 36,400 who are eligible for case management. Of these, 23,928 were receiving case management at the time of the survey. About ten percent of the CM-eligible clients were included in the survey, although a 15 percent sample was expected. It is still a large enough sample (3,646 responses) to yield fairly reliable estimates for the study.

Since priority for CM services is primarily based on chronicity and severity of the illness, it seems safe to assume that most of these CM-eligible clients are SPMI. The numerical estimates of various categories of housing need provided in this study are reflective of the CM-eligible population in Tennessee. It is true that this population does not serve many SPMI who are homeless or who live in institutions. We have attempted, in a separate section of this report, to throw some light on the unique housing needs of these SPMI populations who are rarely served by the MHSPs in our survey. It is our belief that these two sets of estimates, in combination, provide a comprehensive quantitative assessment of the housing needs of persons with psychiatric disability in Tennessee. Those who have reliable estimates of the state SPMI population may also adjust these estimates accordingly using the multiplier which is the ratio of all SPMI to the clients eligible for case management represented in this study.

Children and elderly with psychiatric illnesses have residential care issues unique to their age groups. Children who are Seriously Emotionally Disturbed (SED) usually live with a parent or guardian or, in the absence of this option, are cared for under state supervision. Skilled Nursing and Assisted Living facilities for the elderly often provide long-term housing for those with

psychiatric illness. These two age groups are also underrepresented in this survey[5]. For these reasons, the evaluation focuses primarily on the housing adequacy of adults with SPMI, ages 18-64.

It is worth mentioning that the purpose of this survey was to obtain realistic estimates of the numbers of persons with mental illness who are inappropriately housed and their frequency distributions based on the appropriate housing they need and the barriers that they face in order to achieve these housing goals. These estimates pertain to the clients of the mental health delivery system who are eligible for case management services from the many Community Mental Health Centers or their equivalents providing continued case management services to the chronically mentally ill in Tennessee. (More specific information can be found in Appendix 4.) Estimates are derived by adjusting the sample data based on the size of the total CM-eligible population of these MHSPs and the varying ratios of sampling they have achieved.

Current Residential Distribution

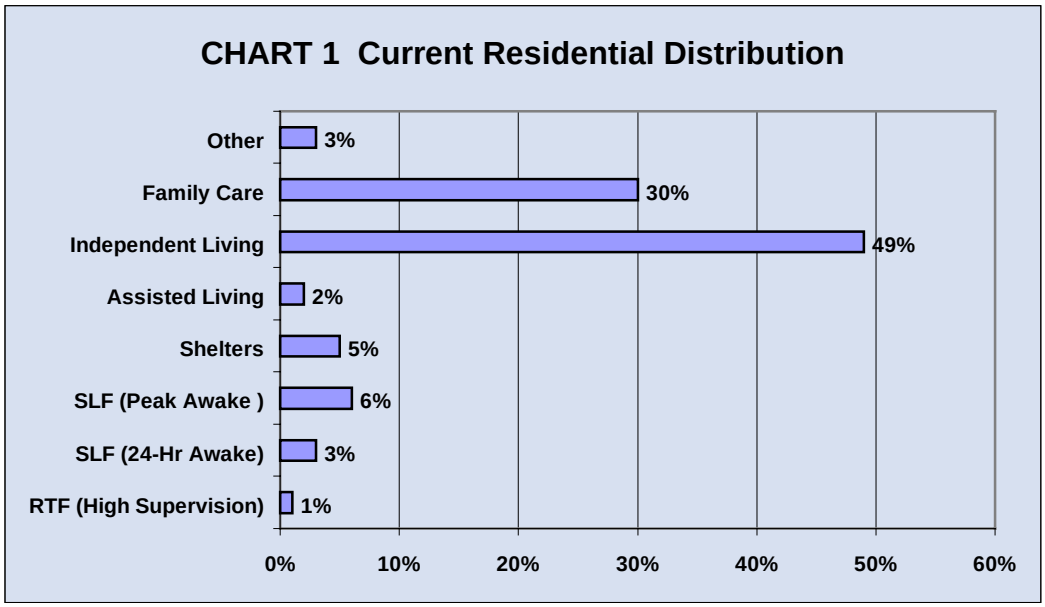
For the population surveyed, licensed facilities (Residential Treatment Facilities and Supportive Living Facilities) account for only nine percent of the current residential arrangements. On the other hand, independent living units (49%) and housing with family (30%) are the two residential options in which most of the surveyed clients currently live (see Chart 1). Those who live in transitional care facilities account for less than eight percent in our sample. The following assessments can be made based on this finding:

- In terms of the type of residences, the current residential pattern closely fits the consumer preferences expressed in numerous surveys across the nation. Persons with psychiatric disabilities prefer to live in private, non-institutional settings. Seventy-nine percent of the consumers in Tennessee do so. These individuals are able to live either alone or with friends, families, or other loved ones rather than with other consumers in a congregate living facility.
- Consumer surveys have previously shown that a small segment of them do prefer congregate living and are in need of continued support. Supported Living Facilities are the home for eight percent of the consumers. Following the discussion of this survey, we present the

[5]Based on Dept. of Health data from the Hospital Discharge Data System, THDA analysis of 1997 psychiatric discharges from hospitals (other than the five mental health institutes) across the state shows that 10 percent of those discharged were children and 22 percent were elderly. In our survey, these two groups consisted of 3 and 6 percents respectively. Similar comparisons also indicate that our sample has a slightly smaller proportion of men (37%) compared to 42 percent in the discharge data.

facilities survey which shows that these group homes tend to address the long-term residential need of those consumers who require 24-hour supervision and monitoring.

- The segment of consumers who live in temporary or transitional sectors of the residential spectrum is relatively small.



Whatever the housing scenario at the state level, those with psychiatric disability may be facing housing inadequacies of various kinds at the community level. The survey aimed to broaden this analysis in order to size these inadequacies and to understand the factors that negatively affect consumer access to appropriate living facilities.

Levels of Occurrence of Inappropriate Housing

In this survey, **housing was defined as appropriate if, and only if, it is safe (free from physical and emotional harm) and conducive to stabilization and recovery**. Among the surveyed clients, 15 percent were not living in units that met this criterion. In general, supportive living facilities (SLFs) have the lowest proportions of inappropriately housed, with peak-awake SLFs having less than four percent. Co-op/independent living facilities and havens/shelters, neither requiring state licensing, have proportions of inappropriately housed slightly below the state level, between 12 and 14 percents. Inappropriate housing is well above

the state level among current residents of Assisted Living facilities (21%) and Residential Treatment Centers (17%) and among those who live in a family environment (19%). In the survey, the incidence of inappropriate housing is relatively higher in the eastern grand division (20%) compared to 11 percent in the middle and 15 percent in the western portions of the state. Notable are the unusually high proportions in Jackson MSA (30%), in Tri-Cities MSA (33%), and in the non-MSA part of East Tennessee grand division (20%). Inappropriate housing among male clients exceeded females slightly by two percentage points.

Impediments to Appropriate Housing

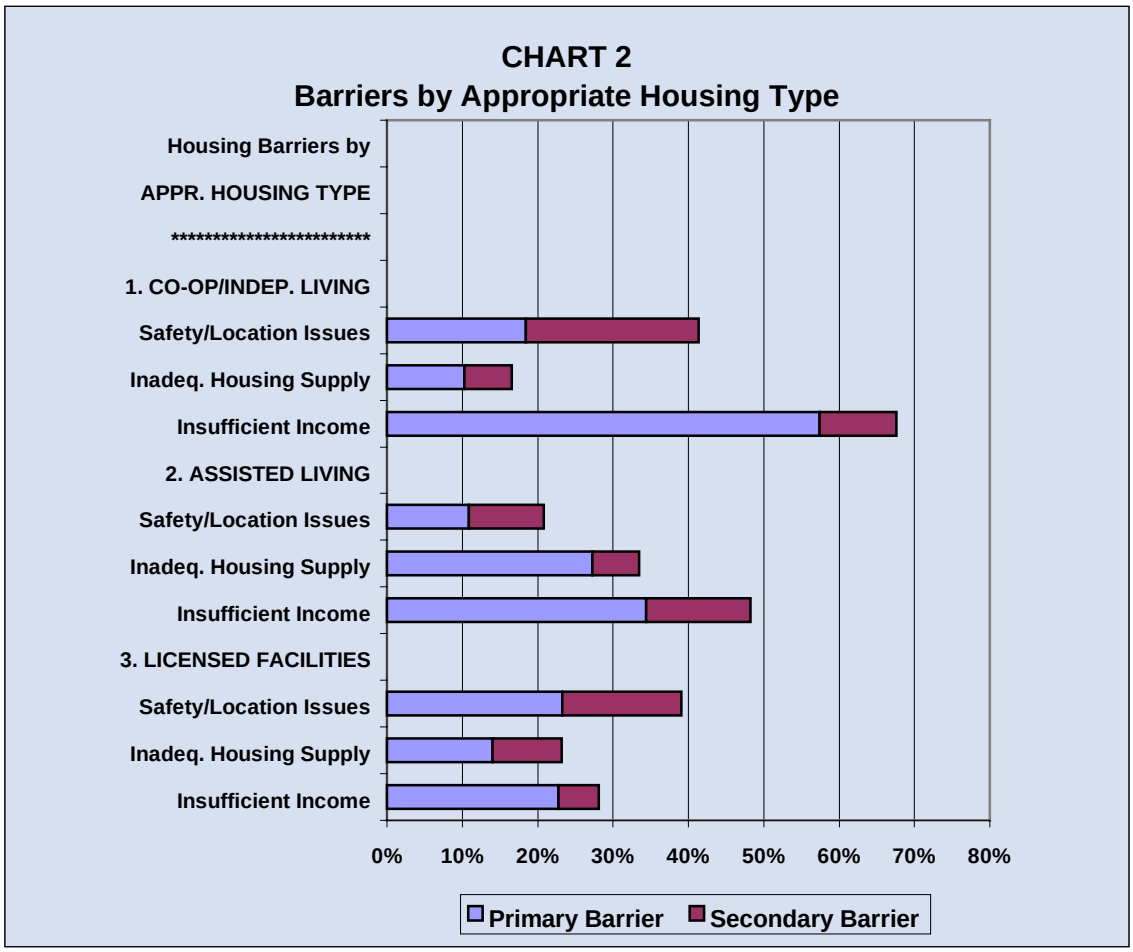
Barriers to appropriate housing were identified and ranked in the survey based on how crucial they have been in impeding the acquisition of appropriate residence by the consumers. Of these ranked barriers, we include the top two in this analysis. While appropriate housing units remained beyond the reach of many consumers (over 5,400 on the basis of our conservative estimation based on the sample data), this survey suggests a combination of reasons for their plight. First and foremost, many of these consumers (56%) lacked sufficient income to acquire the desirable residential units. Unavailability of appropriate units in the chosen community of their residence, the second major factor, caused many more (20%) to reside in inappropriate units. Thirdly, many consumers had to choose inappropriate housing, when units available in the categories most suitable to them lacked many essential features due to their location – an environment that assures emotional and physical safety (19%), sufficient proximity to their family (10%), or adequate transportation to necessary services (15%).

Barriers by Housing Type

Among the inappropriately housed, the housing units that would be most appropriate (but are currently unattainable) had the following distribution:

	Percent	Est. Number
Co-op/Independent Living Units	59%	3,078
Facilities requiring licensure (RTFs and SLFs)	28%	1,467
Transitional and Assisted-Living Facilities	8%	401
Other Housing Units	5%	265
TOTAL		5,211

Relative distributions of barriers that kept consumers from obtaining appropriate housing vary among these broad categories as shown in the chart below. Consumer surveys across the nation agree to the fact that independent living, the appropriate housing type for a vast majority of the inadequately housed in our survey, is also the most preferred housing choice of the consumers. Insufficient income is the major impediment in obtaining housing units in this category. It is also the primary barrier for those who failed to gain access to assisted living units, although they form a much smaller group. Inadequate supply of units and insufficient safety play the major role in the failure to choose Residential Treatment and Supportive Living Facilities by many clients who were considered most suitable for this category of residence. Location and safety considerations also have stood in the way of many clients in realizing their goal of appropriate housing in the co-op/independent living category.



Primary Barriers by Grand Division

The estimates provided below pertain to the surveyed population of consumers who were receiving case management services at the time of the survey. These were derived from sample figures adjusted for the relevant sample fraction in each participating MHSP.

ESTIMATED NUMBER OF CM-QUALIFIED CLIENTS WHO ARE INAPPROPRIATELY HOUSED

	GRAND DIVISION			
BARRIERS TO ADEQUATE HOUSING*	**East TN**	**Middle TN**	**West TN**	**TOTAL**
Insufficient Income	1,274	795	940	3,009
Inadequate Supply	444	369	267	1,080
Transportation	459	138	197	794
Distance from Family	215	114	204	533
Safety	515	191	328	1,034

* Includes primary and secondary barriers listed

Insufficient income remains the major obstacle in obtaining adequate housing for the MHSP psychiatric clients in all three grand divisions. Inadequate supply of housing units is also a significant factor for the failures of many to gain appropriate housing in East and Middle Tennessee. Unsuitable locations and unsafe environment were also significant factors that kept many clients from making appropriate residential choices, especially in the East and West grand divisions of Tennessee.

Dual Diagnoses and Inappropriate Housing

Consumers who are also diagnosed with Substance Abuse or Mental Retardation account for a third of the inappropriately housed in the surveyed population. Estimates of their numbers by Grand Division are as follows:

ESTIMATED NUMBER OF DUALLY DIAGNOSED CLIENTS WHO ARE INAPPROPRIATELY HOUSED

DUALLY- DIAGNOSED	GRAND DIVISION East TN	Middle TN	West TN
Alcohol/Drug Abuse	573	317	444
Mental Retardation	267	76	229
Combined Count*	828	388	662
All Inappropriately Housed	2,344	1,291	1,776
Percent who are Dually Diagnosed	35%	30%	37%

*Does not equal the sum because of small overlap in groups.

In order to provide appropriate housing, a much larger segment of the dually diagnosed need to be in facilities that provide closer supervision (see table below). A more detailed categorization of the suggested destinations and corresponding estimated counts are given in Appendix 3 on the Housing Needs Continuum.

APPROPRIATE HOUSING CATEGORY FOR THOSE CURRENTLY INAPPROPRIATELY HOUSED – DUALLY-DIAGNOSED VS. OTHERS

Consumer would be most appropriately Housed in:	Dually Diagnosed #	%	Others #	%	Totals
Licensed Facilities (RTFs and SLFs)	692	37%	774	22%	1,466
Transitional/Assisted Living	57	3%	343	10%	400
Co-op/Independent Living	978	52%	2,100	59%	3,078
Other (Includes Shelters)	151	8%	315	9%	466
Total Number Inadequately Housed	1,878	100%	3,532	100%	5,410

As reflected below, transportation, safety, and proximity to family are concerns that more often impede the appropriate choice of housing for the dually diagnosed mentally ill.

BARRIERS TO APPROPRIATE HOUSING DUALLY-DIAGNOSED VS. OTHERS

Barriers* to Appropriate Housing Were:	**Dually Diagnosed** #	%	**Others** #	%	**Totals**
Insufficient Income	930	50%	2,079	59%	3,009
Inadequate Supply of Units	279	15%	802	23%	1,081
Physical/Emotional Safety	277	15%	517	15%	794
Proximity to Family	221	12%	312	9%	533
Transportation	462	25%	572	16%	1,034

*Includes primary and secondary barriers listed

Group homes and other congregate facilities with varying levels of supervision, monitoring, and support would have been the appropriate housing for one-third of the clients identified as "inappropriately housed" in the survey. Inadequate supply of housing units in this category was recognized as a significant barrier that kept many of them from getting a housing unit of this type. For this reason, it is pertinent to examine the current stock and occupancy of units in this category across Tennessee. In order to conduct this evaluation, another survey was sent to providers of housing for persons with psychiatric disability.

PART 3. LICENSED FACILITIES INVENTORY SURVEY

Among the various residential options for the seriously and persistently mentally ill adult, Tennessee requires licensing only for residential treatment facilities (RTFs) and supportive living facilities (SLFs). A brief questionnaire was mailed directly to these licensed facilities listed by MHMR. In addition, the Community Mental Health Centers were asked to route the survey to other facilities (which may not be licensed) to which they often refer their psychiatric clients. Bear in mind that the non-licensed respondents represented in the survey form a very small portion of all such facilities that may be housing persons with mental illness across the state. In contrast, the survey did include all licensed facilities, which were its primary focus. Housing options for emotionally disturbed children were not part of this survey either.

Estimated Number of Residential Units in License-Requiring Facilities

The survey respondents consist of 166 facilities (with total capacity of 1,826 residential units) of the type that require state licensing. Not responding to the survey were 63 in the list of licensed facilities (with total capacity of 661 units). These add up to 229 facilities with a total capacity of 2,487 residential units. The results reported in the survey are based on 72.4 percent of all licensed facilities and 73.4 percent of all licensed facility units. (A copy of the survey instrument can be found at Appendix 5.)

Providers and Facility Type

The breakdown of these reported cases by facility type and provider type is given below. It is evident from this data that supportive living facilities, often private individual undertakings, claim the major share of this inventory. It is understood that some facilities licensed as RTFs may not truly operate as RTFs. We reported facilities as they were reported to us.

	PROVIDER TYPE							
	Private Individuals		CMHC		Other Organizations		TOTAL	
FACILITY TYPE	**#**	**Units**	**#**	**Units**	**#**	**Units**	**#**	**Units**
Residential Treatment Facility	1	8	6	53	4	165	11	226
SLF (24-hr Awake Staff)	37	446	15	135	12	127	64	708
SLF (24-hr Peak-Awake Staff)	66	618	11	106	14	168	91	892
TOTAL	104	1,072	32	294	30	460	166	1,826

Gender- and Age-Based Restrictions

Although our survey found that the majority of units are available to either gender, a significant percentage of units are restricted to certain groups. Chart 3 depicts age and gender restrictions that limit access to some of the facilities. While the elderly (ages 65 plus) lack access to 50 percent of the RTF residential units, other facilities that focus on the elderly may fill this void.

Forty-three percent of the SLFs with peak-awake staff do not take young mentally ill adults (ages 18-24). This finding is quite significant to young adults with psychiatric disabilities, as they approach their time to leave parental protection or state custodial care in search of relative independence.

Women lack access to a significant portion (42 to 47 percent) of the SLF units. Given that women outnumber men in many demographic profiles of populations diagnosed with mental illness, this potential deficit in SLF units is worth serious consideration.

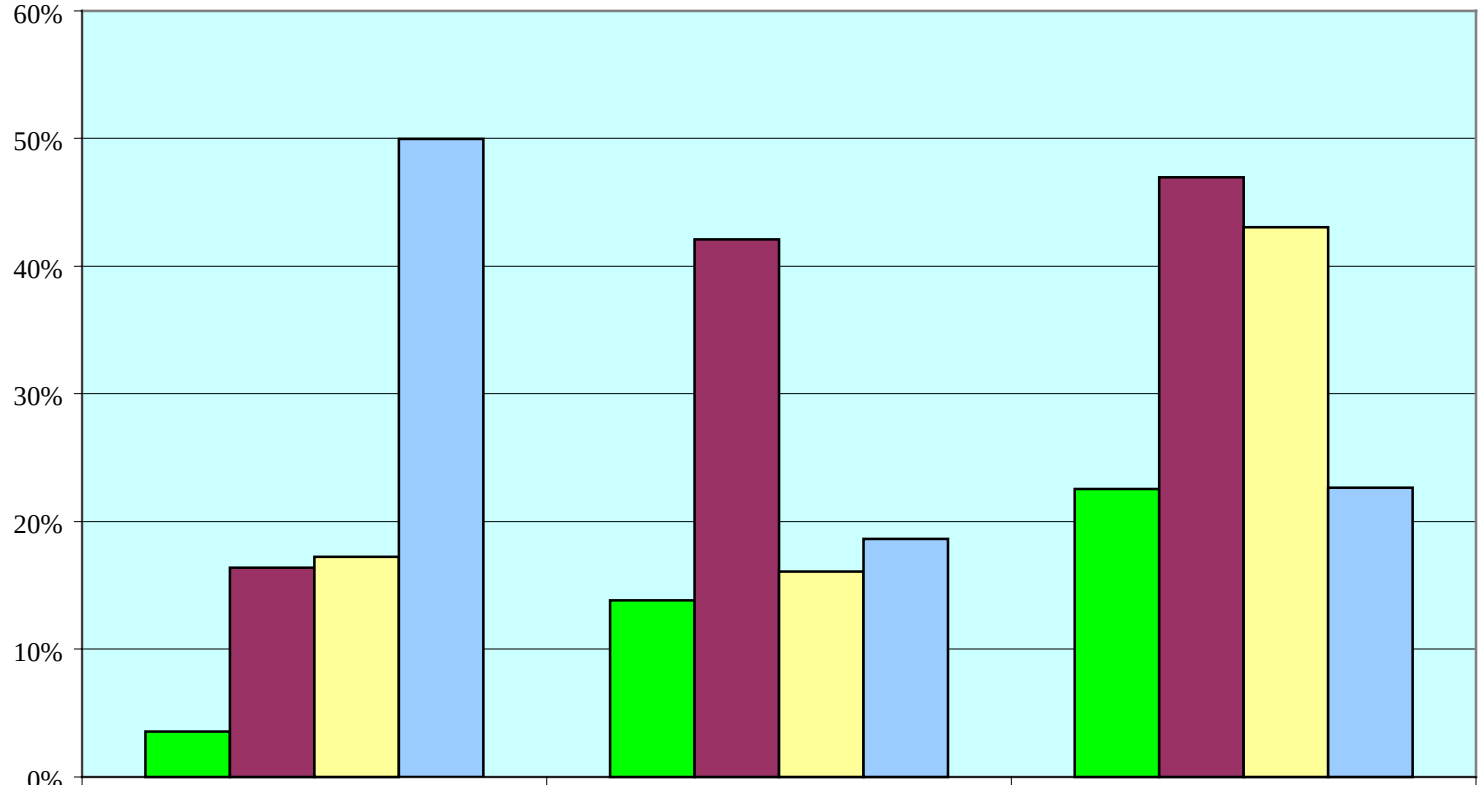
Geographic Distribution of RTF and SLF Residential Units

Distributions of licensed residential units for persons with mental illness among the three Grand Divisions and among the metropolitan areas within them are provided in Chart 4 and

Chart 5. The Middle Tennessee region is relatively plentiful with respect to peak awake SLFs, but has the fewest RTFs. While West Tennessee significantly outnumbers its regional counterparts in RTF units, its peak-awake SLF unit counts are the lowest.

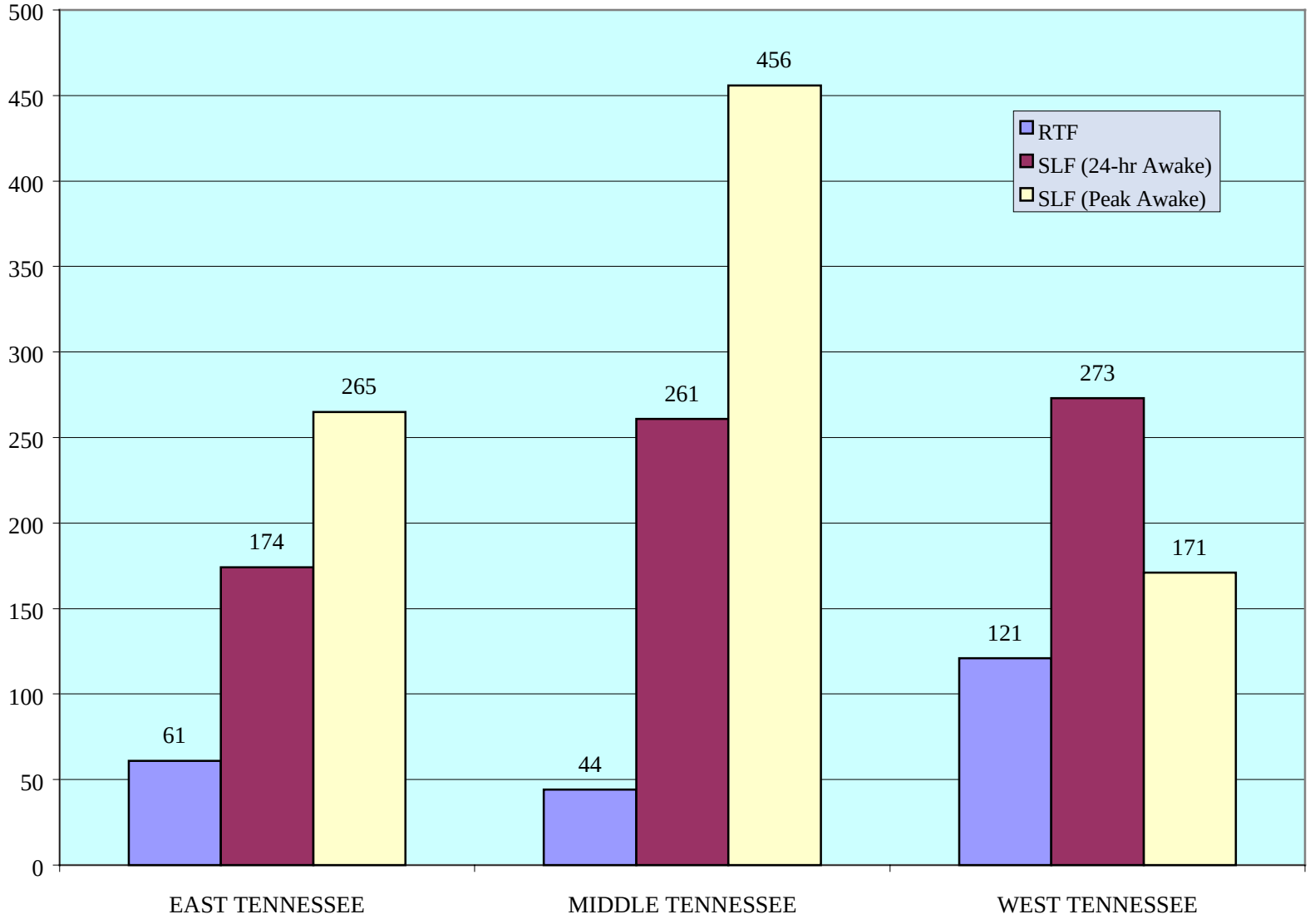
Relative shortages in licensed residential facilities (both RTFs and SLFs) for SPMI are also evident in three MSAs -- Jackson, Clarksville, and Tri-Cities. Non-metropolitan counties in the East Tennessee region, as a whole, also depict a similar shortage.

CHART 3 Units not Available to Specified Demographic Groups



	Residential Treatment Facility	SLF (24-hr Awake Staff)	SLF (24-hr Peak-Awake Staff)
Men	4%	14%	23%
Women	16%	42%	47%
Youth 18-24	17%	16%	43%
Elderly	50%	19%	23%

CHART 4 License-Requiring Units by Facility Type and Grand Division



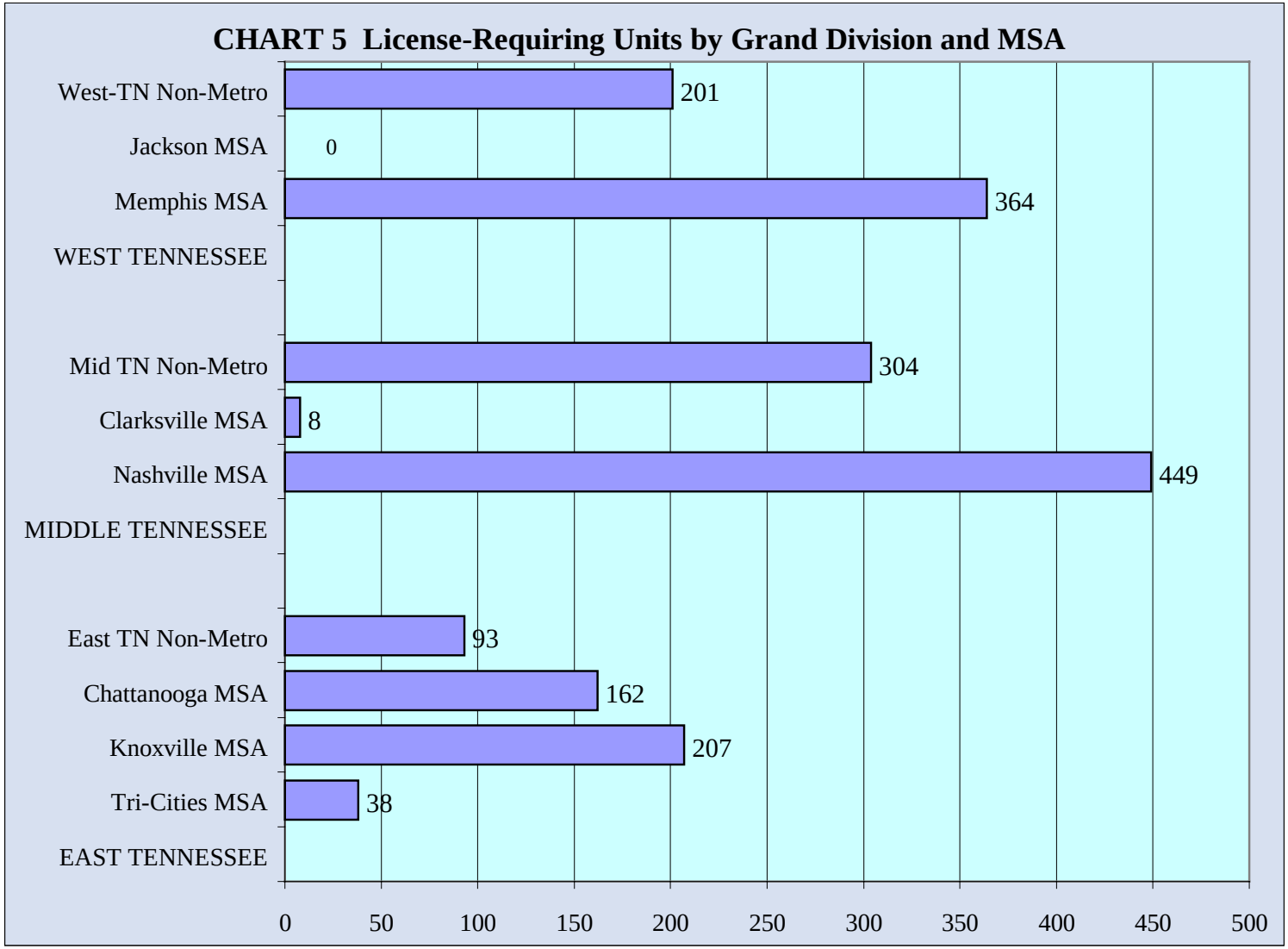


CHART 5 License-Requiring Units by Grand Division and MSA
West-TN Non-Metro
201
Jackson MSA
0
Memphis MSA
364
WEST TENNESSEE
Mid TN Non-Metro
304
Clarksville MSA
8
Nashville MSA
449
MIDDLE TENNESSEE
East TN Non-Metro
93
Chattanooga MSA
162
Knoxville MSA
207
Tri-Cities MSA
38
EAST TENNESSEE
0
50
100
150
200
250
300
350
400
450
500

Vacancy and Length of Stay

Vacant units are much more prevalent in the Residential Treatment Facilities (see Chart 6) compared to SLFs. In West Tennessee, almost half of the units were vacant at the time of this survey. A disproportionately large inventory of units in this category may account for this high vacancy rate. However, short stays and the resultant high turnover, along with difficulties in locating relevant occupants such as the homeless, also might have contributed to this high vacancy rate in West Tennessee. In contrast to the RTF units, SLFs provide much more stable living. Long-term residence (staying over one year) is the norm for SLFs. The Peak Awake SLF units are most congenial to longer duration of stay. Relative housing stability provided by SLF units is highest in West Tennessee and lowest in East Tennessee. (See Chart 7)

Up to this point, the study has focused on the segment of the mentally ill population who is being served by community-based housing and services. There are other important segments of the mentally ill population, though – consumers being released from various institutional settings or who may not be accessing the system for providing services at all.

CHART 6 Percent of Units Vacant at the Time of the Survey

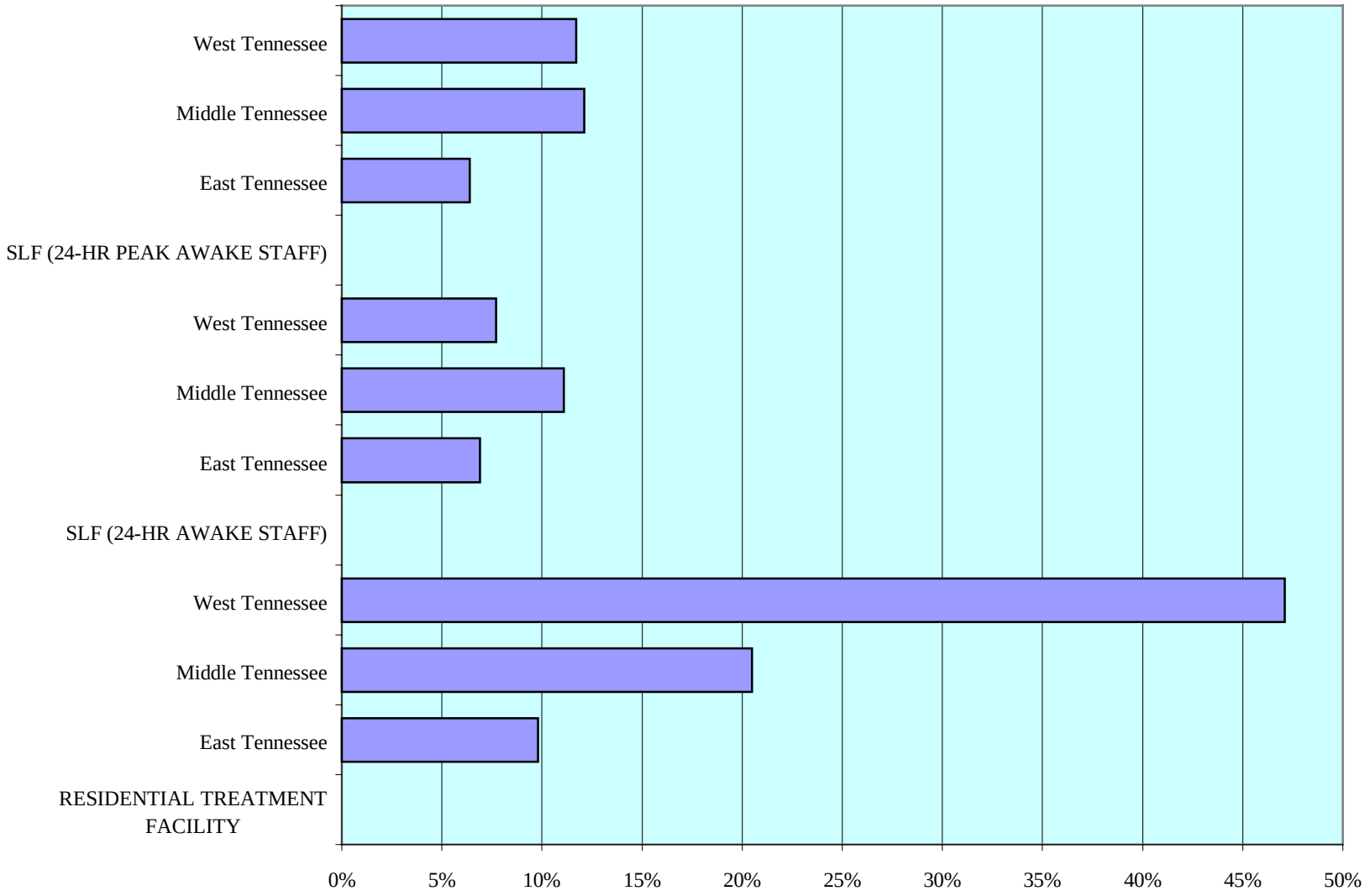
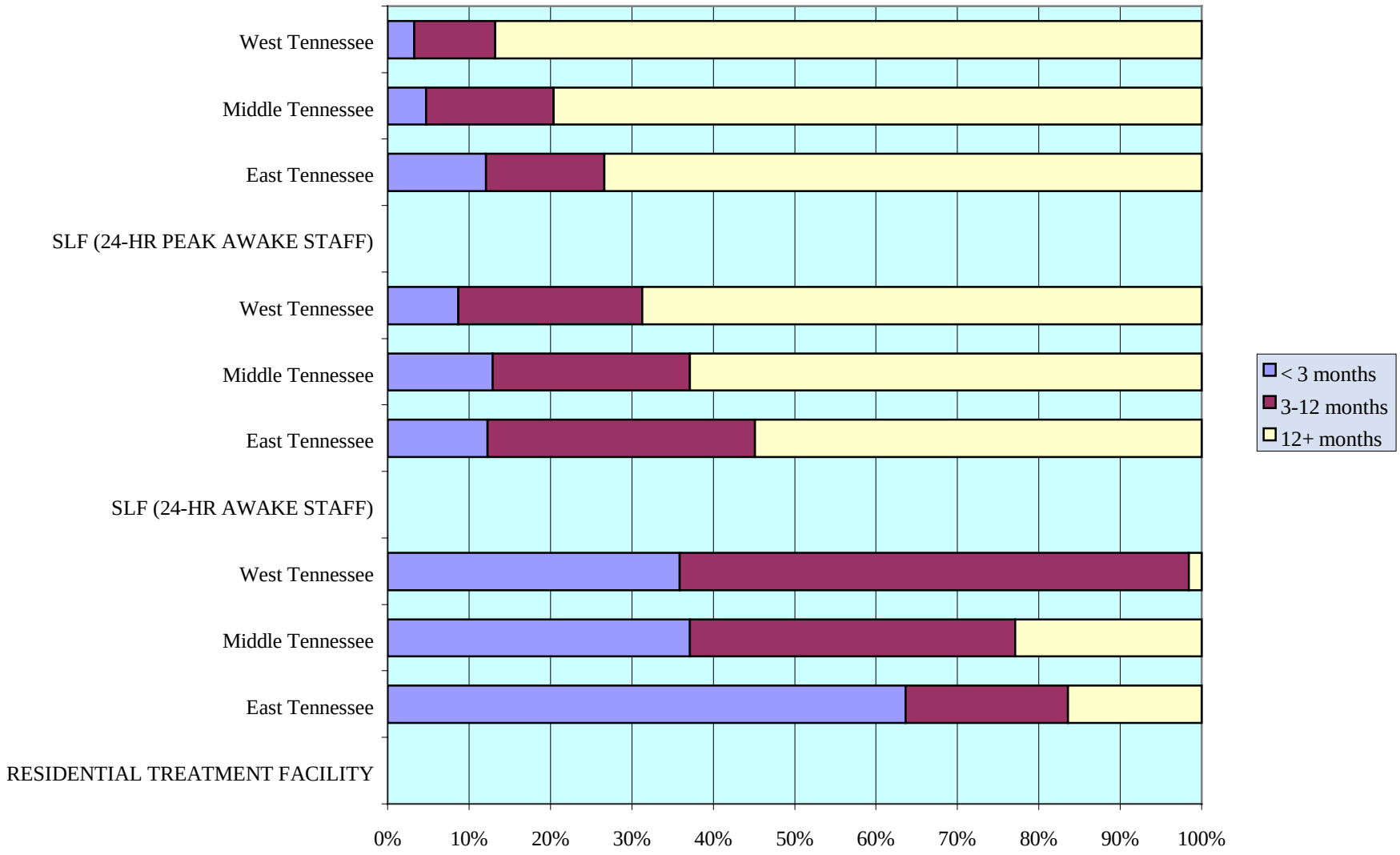


CHART 7 Duration of Stay



PART 4. SPECIAL POPULATIONS – GROUPS LEAVING VARIOUS INSTITUTIONAL SETTINGS, ETC.

One of the most difficult-to-house segments of the mentally ill population is that segment coming out of incarceration. These individuals face both the difficulties and resistance which confront almost all persons with mental illness looking for housing, and also the added resistance and special considerations confronting other offenders searching for a place to live. As with any segment of society, the offender population has a wide range of characteristics and special needs. Many are incarcerated for very minor, non-directed acts at variance with the law. These would include misdemeanor offenses such as public intoxication, criminal trespassing, and general vagrancy. The housing needs of this group of people are likely to be different from the needs of individuals who have been released from the state prison after serving a sentence of several years. Indeed, the needs among even these, more serious, offenders can vary quite dramatically.

This section tries to make some general estimates of the size of this population, broken down by possible housing needs. This effort will be limited by several factors, including an absence of significant and uniformly collected data on mentally ill inmates in county jails and their various housing needs. While there is more information available on the history of mental illness of those inmates in the state correction system, we are still limited in our ability to assess the most appropriate kind of housing for these people. Nevertheless, we have tried to make some estimates.

The Jail Population

In terms of numbers, there are many more persons with mental illness serving some period of time in county jails than in state prisons. The time these people spend in jail ranges from a single night to almost a year or even more. It is not uncommon for some to rotate in and out of jail on a quickly recurring basis. If housed properly (e.g., in a facility that would have services for their mental illness available), it is believed that a substantial portion of this group would not have future encounters with the criminal justice system. There is also a portion of this group who has served time for a more substantial infraction of the law, and whose needs may more closely resemble those of some offenders being released from prison.

In doing this analysis, we have relied on the information contained in *A Survey of County Jails in Tennessee, A Descriptive Study To Quantify The Number of Persons In Jails Who Have A Mental Illness Or Have Substance Abuse Problems* by the TennCare Partners Roundtable, October 1998. Several issues emerged from this study. First, of the county jails responding to the survey, only about two-thirds stated that they had a procedure to link persons with mental illness jail population to local mental health services after release from jail. In order to minimize the quickly recurring recidivism among many of these inmates, this would seem to be a critical link in the "continuum of care".

Another critical finding was that two-thirds of respondents felt that the number of mentally ill inmates had increased in the prior 12-month period. This seems to further illustrate the importance of having a placement system available to assist the individuals upon their release.

This study, and the recently released report *Mental Health & Criminal Justice in Tennessee (Criminal Justice Task Force Report, TDMHMR and TN Mental Health Planning Council, June 2000)*, estimate that approximately 3,500 inmates of the county jail system may have a diagnosis of mental illness. Those with a mental illness accounted for nearly 20% of total jail inmates in Tennessee, most of which were pre-trial detainees. The survey did not attempt to elicit the type of diagnosis or severity of illness of these individuals, nor what kind of housing would be most appropriate for them upon their release.

The Prison Population

The Tennessee Department of Correction (DOC) has a little bit more information on its inmates' mental health problems. DOC keeps data on the primary mental health diagnosis of its inmates. For purposes of this study, DOC gave THDA data on the inmates with a diagnosis of mental illness who had a release eligibility date during each of the next three years (Year 2000-2002), their diagnosis code(s) and their current level of supervision. From this information, we calculated an approximate number of released offenders with serious mental illness that would need "free world" housing in an average year. In making these calculations, we made the following assumptions:

- All the inmates would not be considered SPMI (the focus of our study), so a portion of them were excluded from consideration, based on their DSM code.

- If an inmate's diagnosis is DSM Code 290-302, we considered that to be his primary diagnosis.
- Although we cannot tell from the data whether their current supervision level in prison is related more to the type of crime they committed or to any mental illness or behavioral problems while incarcerated, we assumed that this could be an indicator of the level of supervision they would need upon their initial release.

From our analysis of the numbers, we would estimate that approximately 75-80 seriously mentally ill offenders are released from the state prison system in an average year. This number consists of 1-2 females and 5-10 males housed under close supervision in prison. These individuals would most likely need to be housed in a relatively more restrictive setting, at least in the initial period following their release. In addition, this annual figure includes 5-10 women and 10-15 men in minimal supervision before their release. These individuals are most likely to be in need of more independent living quarters. Finally, 50-55 individuals (fewer than 10 of whom are women) who are housed in moderate supervision conditions prior to their release. This group, of course, comprises the majority of the total and consists of the broadest range of needs and appropriate housing. Based on the numbers we used, these estimates seem to be fairly stable for the relevant years.

The Homeless Population

Persons with mental illness who are homeless represent the most desperate need for housing among persons with mental illness. Homelessness and mental illness pose serious challenges to survival. In combination, they act as both cause and effect of each other. Homeless persons with mental illness are among the most disadvantaged members of society.

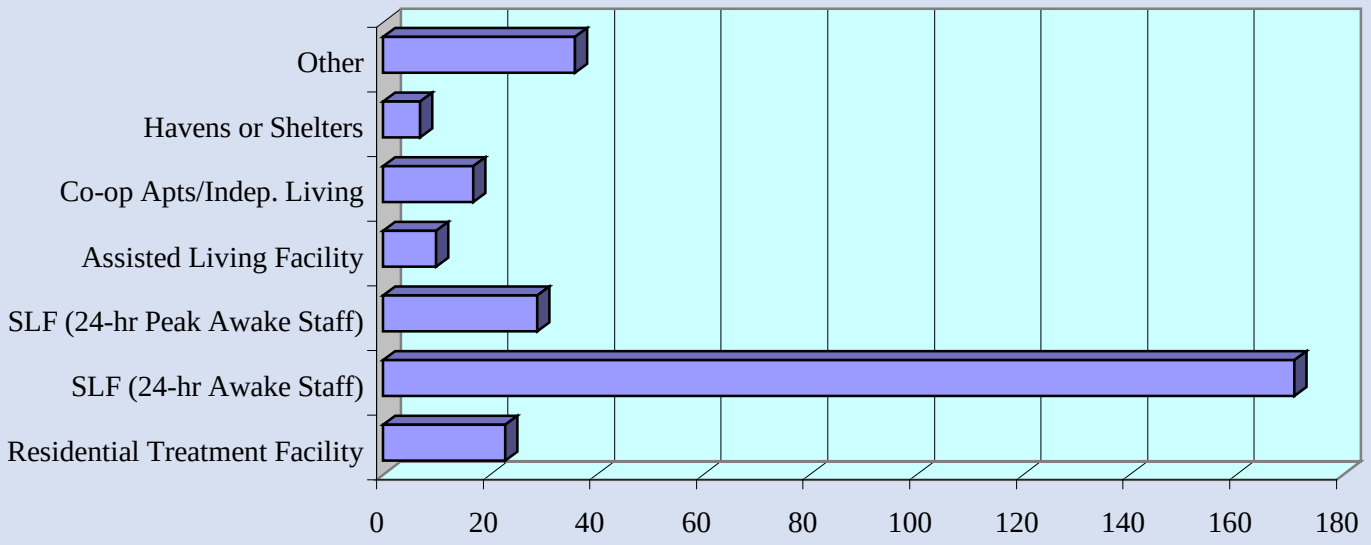
Enumeration of homeless persons is problematic, due in part to the complex nature of homelessness. The homeless population includes single adults, families, and children/youth with no family affiliations. Homelessness can be chronic or episodic. Patterns of service utilization vary across the population; some segments of the population reportedly do not access the service system at all. Consequently, the process of counting the number of homeless persons is a matter of estimates, with considerable variation in the resultant figures. Figures as disparate as 6,566 and 10,000-14,000 have been estimated as the number of homeless persons in Tennessee. Estimates of the prevalence of serious mental illness among homeless persons also vary

considerably, ranging from 45%-14%. Studies funded in the 1980s by the National Institutes of Mental Health reported a 20%-25% rate of serious, chronic mental illness for single homeless adults. In January 2000, the National Council on Disability reported that approximately 1/3 of homeless individuals has serious mental illness. Homeless specialists in Tennessee commonly quoted 30-40% as the rate of serious mental illness in the homeless population. An experienced provider in West Tennessee indicated that 30%-40% of single homeless adults and 5%-10% of homeless adults in families suffer from serious mental illness.

The Hospitalized Population

THDA received data in January 2000 from DMHMR on the number of patients awaiting discharge from Regional Mental Health Institutes. These consumers were ready to be released, as soon as appropriate housing could be found. It is quite striking how predominant the need for SLF (24 hr. awake staff) units is, again indicating a probable unmet need.

CHART 8 Number Awaiting Discharge to Non-Familial Settings from Regional Mental Health Institutes at the Time of the Survey



Young Adults in DCS Custody

Another group of consumers are those who have been in state custody as juveniles, but who have reached the age of 18 without a suitable place to move to. These individuals are kept in Department of Children's Services (DCS) custody for humanitarian reasons. Again, there is a lack of information on the housing needs of this group, but DCS data indicate that in October 1998, there were 127 dually diagnosed (MH/MR) older teenagers – aged 16-18 – in their custody, and 13 individuals over age 19. DCS officials expressed great concern about the growing size of this population. Their data did suggest that 53% of their dually diagnosed population would require either residential or supported living when released from their custody to adult housing.

The needs of all segments of the mentally ill population need to be kept in mind when developing policies and funding priorities. It may be that by addressing the needs of the dually diagnosed in the community (as expressed by our survey of mental health service providers) we may also help to meet the needs of some of the young adults in state custody and/or those awaiting release from the hospital. Similarly, the need for independent living units, also expressed in the survey of MHSPs, may help to address the needs of the homeless and/or released inmate population.

PART 5. FINANCIAL RESOURCES AVAILABLE FOR HOUSING PERSONS WITH MENTAL ILLNESS

Federal funding offers the largest funding sources, most widely available. Possible funding agencies include the U.S. Department of Housing and Urban Development, the Federal Home Loan Bank, and the U.S. Department of Agriculture's Rural Housing Service. Also, Fannie Mae, a federal government sponsored enterprise (GSE), has affordable housing funds available.

There are not many sources of state-level funding for housing. In past years, THDA has administered the HOUSE program, which provided for acquisition, rehabilitation, and new development of low-income housing. In particular, THDA always set aside a portion of HOUSE funds to be used for special needs populations. This program has been suspended for the

foreseeable future; however, organizations should remain aware that THDA might develop special programs in the future as alternatives.

There are also private funding sources, large and small, national and regional. These include things such as the Community Foundation of Middle Tennessee and the Public Welfare Foundation.

The most successful projects typically have a variety of funding streams, used in tandem to fund various aspects of the project. One of the biggest hurdles in smaller entities accessing these funds is the lack of technical knowledge about the various funding sources, the grant application process, and the ability to pull together all the necessary information about the proposal. Many times, consultants are hired to provide technical assistance. THDA contracts with the Development Districts in Tennessee which provide for technical assistance to communities who want to apply for grant funds, such as HOME or CDBG.

Below is a listing of various funding sources, a brief description of each, and a place to get more information. Also included are brief descriptions of a few Tennessee projects using these funding sources.

HUD FUNDS

HOME Program – provides grants to state (through THDA) and directly to larger local governments for development or rehabilitation of affordable housing for rent or homeownership. THDA awards grants to local governments and non-profit organizations as well as to community housing development organizations (CHDO's) to operate local housing programs serving low-income persons. Most funds are awarded to benefit the very low-income population (below 50% of area median). There is a local match requirement, which THDA has provided for its grantees in the past.

For more information, contact Jane Boles, Director of Community Programs, THDA, (615) 741-9653. Also, there is information at http://www.thda.state.tn.us**.**

Community Development Block Grant Program – provides grants to state (through the Department of Economic and Community Development) and directly to larger local governments for revitalizing neighborhoods, expanding affordable housing and economic

opportunities. States make awards exclusively to local governments that conduct community development activities. Seventy percent of funds must be awarded to activities that benefit low and moderate-income persons**.**

For more information, contact Mike McGuire, Grants Program Director, Department of Economic and Community Development, (615) 741-6201.

Supportive Housing Program – provides grants to develop supportive housing services that will enable homeless people to live as independently as possible. HUD awards funds as a competitive grant on an annual basis. Eligible applicants include government entities (including PHA's), private nonprofit organizations, and community mental health associations that are public nonprofits**.** Beneficiaries must be homeless**.** The program can fund permanent housing for homeless people who are disabled. A local match is required**.**

For more information, contact Jean Whaley, HUD Office of Special Needs Assistance Programs, Community Planning and Development, 451 7th St., S.W., Washington, D.C. 20410, (202) 708-0614, ext. 4473.

Shelter Plus Care – provides rental assistance to support housing for homeless people with disabilities. Accompanying supportive services must be funded by other sources and must be at least equal in value to HUD's rental assistance. Eligible applicants are state and local governments and public housing agencies.

For more information, contact Allison Manning, HUD Office of Special Needs Assistance Programs, Community Planning and Development, 451 7th St., S.W., Washington, D.C. 20410, (202) 708-0614, ext. 4497.

Section 811 Housing – this program provides grants to nonprofit organizations for rental housing development with supportive services for very low-income persons with disabilities. Grants provide interest-free capital advances and also project rental assistance. This program can be used to assist those with chronic mental illness. Each project must have a supportive services plan. Eligible applicants include certain nonprofit organizations and public housing authorities.

Resident Opportunities and Self-Sufficiency – the purpose of this program is to link public housing residents to supportive services. Grants are made to PHA's and non-profits that administer programs benefiting public housing residents. There is a 25% local match required, which can be in-kind. Supportive services must be provided for a minimum of two years following completion of renovation work. At least 25% of the resident population must be elderly/disabled. There is a three-year grant term. Two or more PHA's may join together to share a service coordinator grant.

For more information on these two programs, contact the HUD Office of Public and Assisted Housing Delivery, (202) 708-0477.

Other Federal Funding Sources

Federal Home Loan Bank – The Affordable Housing Program is a subsidy program designed to finance housing for very low, low, and moderate income families (80% or below of area median income). FHLB funds must be accessed by member banks that then make them available in the community. The Affordable Housing Program can be used for owner-occupied or rental housing. It can be used for the direct costs of housing development. Funds are made available in two competitive offerings with submittal deadlines of March 1 and August 1. Special needs housing has a priority for scoring, as does rural housing.

For more information contact your local member bank. A list of these banks is available at http://www.fhlbcin.com/cgi-bin/fhlb_members_listings.pl?state=Tennessee**.** Or contact Carol Mount Peterson, Director of Housing and Community Investment, Federal Home Loan Bank of Cincinnati, (513) 852-7615.

U.S. Department of Agriculture, Rural Housing Service – Section 521 Rural Rental Assistance. This program provides rent subsidies to ensure that elderly, disabled or low-income residents of complexes financed by RHS are able to afford rent. These subsidies are available to renters of Section 515 Program properties (see below).

The RHS also offers programs to help in the development of new affordable rental housing in rural areas. The Direct Loan program (Section 515) provides direct loans to developers with interest rates subsidized as low as 1%. Funds can be used for new construction or rehabilitation

of existing properties. Most renters must be very low income or disabled. Those living in substandard housing are given first priority for tenancy. A Notice of Funds Availability (NOFA) should be published about November 1 with details about applying. There is also the Guaranteed Loan Program (Section 538), in which RHS guarantees up to 90% of a loan from a private lender for development of rental housing for very low-income residents.

For more information on these programs, contact the State of Tennessee USDA Rural Development State Office at (615) 783-1300.

Fannie Mae – Fannie Mae has a new office located in Middle Tennessee and has committed to providing funds for affordable housing development. Fannie Mae will make grants to community-based organizations addressing affordable housing issues. A new initiative called *HomeChoice* can assist homebuyers with disabilities or people who have family members with disabilities living with them. Low downpayments and flexible underwriting are features of this program. The *Community Living* initiative provides financing for small residential group home facilities. Loans may be made to individuals, for-profit or nonprofit corporations, or government agencies. Fannie Mae has also made a commitment to develop multi-family housing**.**

For more information contact Ralph Perry, Director, Fannie Mae Tennessee Partnership Office, 214 Second Avenue, North, Suite 205, Nashville, TN 37201.

The Emergency Food and Shelter Program – is a public-private cooperative effort providing federal funds to local areas for food and shelter for the homeless. Several groups we talked to had used this funding source to supplement other funds to provide housing for homeless mentally ill. Certain counties have amount setaside for their use. Funds can be used to build a homeless shelter or to pay one month's rent or utility bill.

For more information, contact the program's staff at (703) 706-9660.

Private Foundations

There are many private foundations, both local and national, that could be potential funding sources for housing projects for persons with mental illness. Typically, though, these foundations are much more limited in their funds availability and are trying to serve a wide

variety of needs with different funding priorities. These foundations are too numerous to give a listing in this report, but Internet research yields information on a number of them. Many foundations seek to fund projects that will serve as models of new, innovative methods of serving people, thereby allowing their dollars to reach beyond the scope of the immediate project. A couple of foundations of note include:

The Public Welfare Foundation – This foundation is dedicated to supporting organizations that provide services to disadvantaged populations and work for lasting improvements in the delivery of services that meet human needs. Their average grant is about $40,000. They fund projects throughout the year, but can only fund about 15% of requests. They have a Health Initiative, which includes the importance of mental health issues. They have helped to fund ($25,000) the development of affordable housing for the mentally disabled in the District of Columbia. They can be contacted at (202) 965-1800; www.publicwelfare.org.

The Community Foundation of Middle Tennessee – This foundation encourages grant requests in the fields of health and housing and community development and is most interested in providing long-term solutions. Grantees must be non-profit organizations. Grants are usually small (under $5,000). For more information, visit their website at fdtninfo@cfmt.org**.** Similar organizations exist in other parts of the state (e.g., The Community Foundation of Greater Chattanooga, Inc., the East Tennessee Foundation).

The Plough Foundation – This foundation serves the people of Shelby County and makes grants to tax-exempt organizations. It has made substantial contributions to improve living facilities for persons with mental illness in the Memphis Area. Current areas of special interest of the foundation include families in crisis and the homeless population. There are four funding cycles during the year. For more information, call Barbara Jacobs, Program Director, (901) 761-9180.

A few examples of how these funding sources have been used in Tennessee to benefit persons with mental illness are:

Renewal House of Nashville was established in 1997 and provides services and housing to women with addictions in a venue that allows the women to have their children with them on-site. Eighty percent (80%) of the agency's clients are MH/AD; 92% are homeless. Housing units consist of 18 one-bedroom apartments and 18 two-bedroom apartments.

Renewal House's funding is derived from a blend of public and private funding streams. Public funding streams include several HUD programs, administered in Davidson County by Metropolitan Development and Housing Agency (MDHA). Funding components include the Supportive Housing Program (operational expenses and support staff), the Shelter Plus Care program (tenant based rental assistance), the Emergency Shelter Grant Program, and FEMA's Emergency Food and Shelter program, used primarily for building repair and renovation. THDA's HOUSE program provided funding for building acquisition. The Tennessee Department of Human Services provides funding under the Families First and Vocational Rehabilitation programs; Nashville Career Advancement Center provides Welfare-to-Work funds. The Tennessee Departments of Health and Mental Health/Mental Retardation also contribute to the agency's funding stream.

Private sources of funding include the United Way and other federated funds, private foundations, corporate foundations, civic organizations, faith-based groups, and individual donors.

Friends for Life Corporation in Memphis established in 1994 provides housing and services for homeless HIV positive persons in a 21-bed facility. Eighty-five percent (85%) of their clients are seriously and persistently mentally ill. Friends for Life provides Transitional Housing and Shelter Plus Care housing. HUD's Supportive Housing program contributes to the agency's operating funds; the agency matches the HUD funds with supportive services such as case management, transportation, and training in daily living skills. Shelter Plus Care funds provide rental assistance for the agency's clients. Private foundation funds and City of Memphis funds also contribute to agency funding. The agency recently submitted a grant application to HUD's Housing Opportunities for Persons With AIDS (HOPWA) program – administered by the state Department of Human Services - and is investigating additional sources of funding.

Housing Development Corporation of Clinch Valley has a project underway which will provide 11 one-bedroom apartments for persons with mental illness in LaFollette, TN. Ridgeview Mental Health will offer mental health services to the residents. The project, which is slated to open about January 2001, is funded by a combination of a Federal Home Loan Bank Affordable Housing Program loan (see below), a 1999 HOME grant from THDA, a Neighborhood Reinvestment Corporation Grant, and a municipal bond issued through the health education board.

Foundations Associates is a Nashville not-for-profit, established in 1995 that provides an "integrated continuum of care treatment model for the dual diagnosed". They provide a range of services including Crisis Stabilization, Intensive Residential Living, Step-Up Housing, and rehabilitation services. Foundations receives funding from numerous sources, including SAMHSA – Centers for Substance Abuse Treatment and Prevention. A block grant from DMHMR helps provide funds for deposit expenses. For funding the residential facilities themselves, Foundations receives subsidies from the Mental Health Cooperative. They have also received grants from MDHA and private benefactors. For more information, their website is www.dualdiagnosis.org or call (615) 256-9002.

PART 6. CONCLUSIONS AND RECOMMENDATIONS

Need for Centralized Database

In the process of collecting data for this report and learning about the housing available for persons with mental illness in this state, we were struck by how fragmented the information is and by the lack of availability of hard data on system functioning. We found information on segments of the population from a variety of sources. In most cases, these sources of data were not collected in a manner that enabled us to "connect them" to data from other segments of the system, thereby developing a comprehensive database on the people served and what their housing needs are.

There was also inadequate information on housing that is currently available. In performing our survey on housing facilities, we used the Department of Mental Health and Mental

Retardation's list of licensed facilities. However, a large portion of living facilities (especially those with lower supervision levels) is owned privately and not subject to licensure. Consequently, they are not included on this list. We tried to reach these other housing providers through the survey, but many were missed. There is no comprehensive listing of housing providers (i.e., including the non-licensed facilities) for those with mental illness, resulting in yet another information gap.

Because of these information gaps, we undertook the collection of data from two separate surveys. These surveys provided important information to help inform management decisions. However, these data will become stale quickly, especially as the system changes. Procedures need to be put in place to continue to collect data on the population served, their housing situation and needs, and on housing that is available to this population. Such data collection efforts will be critical in making informed management decisions to serve this population in the future. Inter-agency discussions on how to enable information sharing on this population should be beneficial to all segments and service providers. The agencies that provided us with data include the Departments of Mental Health and Mental Retardation, Health, Children's Services, and Correction. In addition, it would be especially important to include the Department of Finance and Administration, to access the TennCare Partners database whose system should provide a great deal of important information.

Need for Independent Living Units and Cost Subsidy

Our survey results demonstrated other areas of concentrated needs, suggesting possible funding priorities. Our consumer survey found that, among those consumers currently with inappropriate housing, the greatest portion is currently in independent living units. When asked where the most appropriate housing for the consumer would be, the answer was most often that they needed to be in independent living, thus suggesting that their current housing was inappropriate, either because its cost was prohibitive or its quality was inadequate. Similarly, the second largest group of respondents who were inappropriately housed was currently in a family care environment. The most common response concerning where these individuals needed to be was also independent living units. This suggests a real need for additional independent living units for this population. Furthermore, when we looked at the barriers that were listed for these

two groups of people, the primary barrier was insufficient income for monthly expenses. The second highest barrier was insufficient income for deposits. These findings suggest further that any additional independent living units should have some sort of subsidy to minimize expenses – either through rent subsidies or through construction cost subsidies. We would recommend that both types of cost containment measures be explored. (It is worthwhile to note here that, in addition to minimizing the cost of the housing, another means for increasing affordability is to increase the income of the consumer population through job training and career development efforts.)

Need for Housing for the Dually Diagnosed Population

Another significant finding of our surveys is the need for additional housing for the dually diagnosed population, both mental illness and mental retardation (MH/MR) and mental illness coupled with drug and/or alcohol dependence (MH/A&D). Both of our surveys indicate a need for housing for this population segment. Our survey of housing providers asked whether the provider focused on serving any particular segment of the mentally ill population. Less than 10% of units in "focused" facilities serve the needs of the dually diagnosed. In our survey of consumers, over one-third of consumers who are inappropriately housed are also dually diagnosed. Taken together, these two findings suggest a mismatch in resources and that more facilities need to be providing the special services needed by this segment of the population. In our survey, there are about twice as many of these consumers who were MH/A&D than there were MH/MR. Not included in these figures, however, are the young adults still in the custody of the Department of Children's Services because of a lack of an appropriate place to be released to. This group of persons is, largely, in the MH/MR group.

A similar analysis of this population's current housing and their most appropriate housing indicates that the biggest group of dually diagnosed consumers who are inappropriately housed are currently in family care, with those currently in independent living following closely behind. A much larger portion of respondents for this group said the most appropriate housing for them was in SLF's or RTF's (37% vs. 22% of the overall mentally ill population). Still, over half the responses indicated these consumers needed to be in independent living units. Further investigation should perhaps be done to find out exactly what kinds of independent living

facilities can best meet the needs of this segment of the mentally ill population. Nonetheless, it seems pretty clear that resources need to be devoted to developing housing for this needy population.

Need to Tap All Available Funding Resources

As we pointed out in the section of this report on funding, various funding sources are available to help ease the housing problems of persons with mental illness. However, in order to take maximum advantage of the funding sources that are available, the technical knowledge and capacity to develop a proposal, package all the financing "pieces" and properly apply for the funds needs to be developed. For some programs, there are setasides for many counties in Tennessee that are never applied for because of a lack of resources and know-how. Therefore, we recommend that a means for providing smaller communities and not-for-profits with technical assistance be explored by the Department of Mental Health and Mental Retardation. One idea may be to try to enter into technical assistance contracts with officials (such as development district housing officers or others) who will be compensated by DMHMR for providing assistance with grant packaging and application. It is quite clear that the problem is not only a lack of available funds, but also a failure to access what is available.

Summary of Recommendations

- Establish an interagency working group to find ways to improve data sharing and some degree of uniform data collection procedures.
- Develop ongoing data collection procedures, which may include obtaining access to existing data systems, or making slight modifications to existing data systems, for the purpose of informing management decisions and obtaining a better understanding of the population in question and their needs. To the greatest extent possible, such data collection procedures should be a product of normal workflow and not an additional burden on people who work in this system.
- Availability of funding for rent subsidies (such as Section 8 disability vouchers, or programs such as the STRAP program for the developmentally disabled) should be pursued. We understand that DMHMR has already initiated efforts such as these.

- Existing housing programs such as HOME and the Low Income Housing Tax Credit Program, both administered by THDA, might consider using setaside funds (or setting aside funding) to help subsidize construction of independent living units to be used exclusively for persons with mental illness. Before making any setasides of Tax Credits, issues having to do with long-term compliance should be fully explored. Obtaining such setasides should be pursued not only through state programs (THDA) but also through local participating jurisdictions, such as the City of Memphis, the City of Nashville/Davidson County, etc.
- Establish a task force to discuss how best to use any setasides, in conjunction with other available funding, to develop permanent housing that will guarantee access to needed services. In making funding recommendations, this task force should also define what constitutes a successful project and develop some performance measures to evaluate a particular project's success.
- Special housing for the dually diagnosed needs to be developed. Perhaps some portion of funding from the above programs could be specified for use by persons with dual diagnoses. This appears to be especially critical in the West Tennessee grand division. Supportive services funding for this population could and should be pursued along with the housing development funding.
- Additional technical assistance should be provided to smaller communities and non-profits to help them access funds that are available, perhaps through some sort of technical assistance contracts with DMHMR.

DMHMR has recently established an Office of Housing Planning and Development which has taken steps to address some of these issues. More specific information on their initiatives is contained in the department's response to this study (in the Appendix). THDA was glad to have served as the primary agent behind the completion of this report, and again acknowledges the help we received from many people throughout the state. THDA looks forward to continuing to work to help improve the housing available to the many persons with mental illness in Tennessee.

Appendices

Appendix I

State of Tennessee

SENATE JOINT RESOLUTION NO. 279

By Rochelle, Burchett, Dixon

A RESOLUTION Relative to assessing the housing needs of persons with mental illness in Tennessee, development of a comprehensive plan to address those needs, and making specific recommendations to improve housing opportunities for such persons.

WHEREAS, It is in the best interests of this state that persons with mental illness have suitable, safe, and affordable housing, consistent with and supportive of their efforts to remain stable and productive citizens of Tennessee; and

WHEREAS, Such housing is needed in all areas of the state, both urban and rural; and

WHEREAS, The Tennessee Mental Health Planning Council has identified housing for persons with mental illness as one of the most critical needs within the state-supported system of care; and

WHEREAS, It is important that this state explore every opportunity obtaining federal assistance to expand the inventory of suitable, safe, and affordable housing for Tennessee's mentally ill; and

WHEREAS, There is a critical need to initiate a comprehensive planning effort involving mental health professionals and stakeholders, and state policymakers; and

WHEREAS, Such an effort should identify the comprehensive housing needs of persons with mental illness, should determine how those needs can best be addressed, should ensure that all available government and private funds are identified and capitalized upon, and should present recommendations for an approach to effectively coordinate resources leading to better access to suitable, safe, and affordable housing for the mentally ill; now, therefore,

BE IT RESOLVED BY THE SENATE OF THE ONE HUNDRED FIRST GENERAL ASSEMBLY OF THE STATE OF TENNESSEE, THE HOUSE OF REPRESENTATIVES CONCURRING, That the Tennessee Housing Development Agency (THDA), with its mission to be the lead state agency in the promotion of safe and affordable housing, should convene and direct a study and planning effort to assess and improve the suitability, safety, and affordability of housing for persons with mental illness in Tennessee.

BE IT FURTHER RESOLVED, That the study and planning include representatives of each of the following:

(1) Department of Mental Health and Mental Retardation;

(2) Department of Finance and Administration;

(3) Tennessee Mental Health Consumers Association;

(4) Tennessee Association of Mental Health Organizations;

(5) National Alliance for the Mentally Ill – Tennessee Chapter;

(6) Mental Health Association of Tennessee;

(7) Each behavioral health organization providing services under TennCare; and

(8) Such other organizations and individuals considered necessary or helpful by THDA.

BE IT FURTHER RESOLVED, That the administrative head of each such agency or organization shall identify to THDA a representative to participate on or before June 1, 1999, and that THDA should convene the first meeting of the participants on or before July 1, 1999.

BE IT FURTHER RESOLVED, That in organizing and conducting the study, THDA shall consider and incorporate the work of other organizations which have focused on the housing needs of persons with mental illness.

BE IT FURTHER RESOLVED, That the study shall assess the housing needs of the mentally ill, focusing particularly on the availability and affordability of suitable housing that in turn will provide reasonable access to appropriate mental health services.

BE IT FURTHER RESOLVED, That the study shall assess the availability of funding from all sources, governmental and private, which may assist in making housing more affordable to persons with mental illness.

BE IT FURTHER RESOLVED, That the study shall identify social, economic, and political barriers to suitable, safe, and affordable housing for persons with mental illness, and should propose ways to reduce or eliminate these barriers.

BE IT FURTHER RESOLVED, That, based on the findings and conclusions of the study, the participants shall develop a comprehensive plan with specific recommendations which would improve the housing conditions of persons with mental illness.

BE IT FURTHER RESOLVED, That the results of the study, the comprehensive plan, and specific recommendations shall be reported to the Governor, the Department of Mental Health and Mental Retardation, the Department of Finance and Administration, and to the General Assembly.

BE IT FURTHER RESOLVED, That a status report be provided to each of these parties no later than February 1, 2000.

SENATE JOINT RESOLUTION NO. 279

ADOPTED: May 26, 1999

JOHN S. WILDER
SPEAKER OF THE SENATE

JIMMY NAFEH, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 15th day of June 1999

DON SUNDQUIST, *GOVERNOR*

State of Tennessee

SENATE JOINT RESOLUTION NO. 529

By Rochelle, Dixon

A RESOLUTION Relative to extending the reporting date for a study assessing the housing needs of persons with mental illness in Tennessee as required by Senate Joint Resolution No. 279 of 1999.

WHEREAS, The Tennessee Housing Development Agency (THDA) was directed by Senate Joint Resolution No. 279 of 1999 to conduct a study of the housing needs of persons with mental illness; and

WHEREAS, In organizing and conducting the study, the THDA is considering and incorporating the work of other organizations which have focused on the housing needs of persons with mental illness; and

WHEREAS, The study will assess the housing needs of the mentally ill, focusing particularly on the availability and affordability of suitable housing that, in turn, will provide reasonable access to appropriate mental health services; and

WHEREAS, The study will assess the availability of funding from all sources, governmental and private, which might assist in making housing more affordable to persons with mental illness; and

WHEREAS, The study is attempting to identify social, economic, and political barriers to suitable, safe and affordable housing for persons with mental illness, and to propose ways to reduce or eliminate these barriers; and

WHEREAS, Based on the findings and conclusions of the study, the participants will attempt to develop a comprehensive plan with specific recommendations to improve the housing conditions of persons with mental illness; and

WHEREAS, The results of the study, the comprehensive plan, and specific recommendations were to be reported to the Governor, the Department of Mental Health and Mental Retardation, the Department of Finance and Administration, and to the General Assembly, with a status report due February 1, 2000; and

WHEREAS, The comprehensiveness of the study, the lack of accessible relevant data, and the need to collect data from multiple sources has made it impossible to meet all of the objectives of the study within the initial time allocated; now, therefore,

BE IT RESOLVED BY THE SENATE OF THE ONE HUNDRED FIRST GENERAL ASSEMBLY OF THE STATE OF TENNESSEE, THE HOUSE OF REPRESENTATIVES CONCURRING, That the Tennessee Housing Development Agency shall have until August 1, 2000, to present the results of the study required by Senate Joint Resolution No. 279 of 1999.

BE IT FURTHER RESOLVED, That the THDA shall provide the results of the study to the Governor, the Commissioner of Mental Health and Mental Retardation, the Commissioner of Finance and Administration, and to the Chairmen of the Senate General Welfare, Health and Human Resources Committee, the Senate Finance, Ways and Means Committee, the House Health and Human Resources Committee, and the House Finance, Ways and Means Committee.

SENATE JOINT RESOLUTION NO. 529

ADOPTED: June 7, 2000

JOHN S. WILDER
SPEAKER OF THE SENATE

JIMMY NAFEH, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 19th day of June 2000

DON SUNDQUIST, *GOVERNOR*

Appendix II

Mental Health Service Providers (MHSP) Survey Participants

Organization	Grand Division	Surveys Received
A.I.M., Inc.	East	Yes
Carey Counseling Center	West	Yes
Case Management, Inc.	West	Yes
Centerstone Community Mental Health Centers	Middle	Yes
Cherokee Health Systems	East	Yes
Fortwood Center	East	Yes
Frayser Family Counseling	West	Yes
Frontier Health	East	Yes
Helen Ross McNabb Center	East	Yes
Kress and Associates	East	Yes
Mental Health Cooperative, Inc.	Middle	Yes
Midtown Mental Health Center	West	Yes
Pathways Behavioral Health Services	West	Yes
Peninsula Behavioral Health	East	Yes
Professional Counseling Services	West	Yes
Quinco Community Mental Health Center	West	Yes
Ridgeview Psychiatric Hospital and Center	East	Yes
Southeast Mental Health Center	West	Yes
Volunteer Behavioral Health Care System	East & Middle	Yes
Whitehaven-Southwest Mental Health Center	West	Yes

Housing Survey

Appendix III

Agency Contact Name: _____
Phone: _____
Chart #: _____

I. Demographics

_____ Age _____ Sex _____ County of current residence

II. Clinical Indicators

Currently is the consumer:

A. Receiving case management Y/N
B. Medication compliant N/A Y/N
C. SPMI/SED Y/N
D. In a treatment program Y/N
E. A veteran Y/N
F. A criminal offender or defendant Y/N
G. Physically disabled If yes, please indicate:
  1. Hearing impaired Y/N **2.** Vision impaired Y/N **3.** Wheelchair bound Y/N
  4. Other: _____
H. Dually diagnosed: if Yes, indicate diagnosis
  1. MH/MR Y/N **2.** MH/A&D Y/N
  3. Other: _____

III. Housing Experience:

A. For purposes of this survey, please use the following definitions:

1. ***Appropriate housing*** *is housing which is safe and conducive to stabilization and recovery. Safe in this context is defined as free from harm and danger, both physically and emotionally.*
2. *A* ***homeless person*** *is: An individual who (1) lacks a fixed, regular, and adequate nighttime residence and (2) has a primary nighttime residence that is (a) a supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill), (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.*

B. Current type of housing: (select from attached Housing Continuum) _____
Length of stay at current housing _____ 0 - 3 months _____ 6 - 12 months
_____ 3 - 6 months _____ over 12 months

C. Is the current housing the most appropriate housing for this consumer at this time? Y/N
If Yes, go to end of survey. If No, indicate primary reason:
1. Never should have been here in the first place Y/N **3.** Improved functioning Y/N
2. Environmental or structural change in current residence Y/N **4.** Declined functioning Y/N
5. Other: _____ Y/N

D. Is the consumer currently homeless? Y/N
If No, go to question **E**. If Yes:
1. Duration of current homelessness _____ 0 - 3 months _____ 6 - 12 months
_____ 3 - 6 months _____ over 12 months
2. Causes for homelessness. Check all that apply:
  a. Loss of job Y/N **d.** Change in symptomology Y/N
  b. Insufficient income Y/N **e.** Had no housing to begin with Y/N
  c. Consequence of inpatient treatment Y/N **f.** Relationship problems Y/N
  g. Program design (for example, completion of 3 month residential A&D treatment program) Y/N
  h. Other: _____ Y/N

E. Other than currently, has he/she been homeless at any time during the past year? Y/N
If No, go to question **F**. If Yes:

1. How many times _____
2. Duration of homelessness in months (sum of past year) _____
3. Causes for homelessness. Check all that apply:

a.	Loss of job	Y/N	**d.**	Change in symptomology	Y/N
b.	Insufficient income	Y/N	**e.**	Had no housing to begin with	Y/N
c.	Consequence of inpatient treatment	Y/N	**f.**	Relationship problems	Y/N
g.	Program design (for example, completion of 3 month residential A&D treatment program)				Y/N
h.	Other: _____				Y/N

F. Select the most appropriate type of housing for this consumer (from attached Housing Continuum). ____

G. Barriers to placement in most appropriate housing: Select up to three.
Rate selected barriers in terms of importance, with 1 being the primary barrier.

		Rating
1.	Insufficient income for monthly expenses	_____
2.	Insufficient income for deposits	_____
3.	Transportation	_____
4.	Physical safety issues	_____
5.	Emotional safety issues	_____
6.	Presence of dependent children	_____
7.	Presence of pets	_____
8.	Distance from primary social support (family, etc..)	_____
9.	Physical disability	_____
10.	Medical needs	_____
11.	Lack of adequate housing supply	_____
12.	Access to mental health services	_____
13.	Other: _____	

H. If access to the most appropriate type of housing for this consumer requires relocation to another county, indicate which county: _____
Why? _____

Comments:

_____
_____
_____
_____
_____
_____

Completed by: _____ _____
NAME TITLE (Case worker, therapist, other)

Was consumer present? Y/N
If consumer was present, please note any differences in opinion or preference:

_____
_____
_____
_____

Housing Needs Continuum

Type	Description	Resident Characteristics
A (Residential Trt. Facility)	24 hr supervision; restricted egress treatment primarily in/at facility	SPMI/ SED Dual diagnosis: MH/MR or MH/A&D
B (Supportive Living)	24 hr awake staff; monitored egress egress with supervision treatment primarily offsite	SPMI/ SED Dual diagnosis: MH/MR or MH/A&D
C (Supportive Living)	24 hr awake staff; monitored egress treatment provided primarily offsite	medically fragile SPMI and/or geriatric SPMI
D (Halfway House)	24 hr awake staff; monitored egress treatment off and onsite	SPMI Dual diagnosis: MH/MR or MH/A&D
E (Supportive Living)	24 hr peak hour awake staff monitored egress treatment primarily offsite	medically fragile SPMI and/or geriatric SPMI
F (Supportive Living)	24 hr peak hour awake staff monitored egress treatment primarily offsite	SPMI Dual diagnosis: MH/MR or MH/A&D
G (Assisted Living)	minimal supervision (10-20 hrs/wk) no monitoring treatment offsite	SPMI Dual diagnosis: MH/MR or MH/A&D
H (Transitional Housing)	minimal supervision (10-20 hrs/wk) no monitoring treatment offsite	SPMI Dual diagnosis: MH/MR or MH/A&D
I (Subsidized Furnished Independent Living)	no supervision no monitoring treatment offsite	SPMI Dual diagnosis: MH/MR or MH/A&D
J (Co-op Apartments)	no supervision no monitoring treatment offsite	SPMI Dual diagnosis: MH/MR or MH/A&D
K (Independent Living)	minimal supervision no monitoring treatment offsite	SPMI Dual diagnosis: MH/MR or MH/A&D
L (Independent Living)	no supervision no monitoring treatment offsite	SPMI Dual diagnosis: MH/MR or MH/A&D
M (Havens or Shelters)	full or part time supervision no monitoring treatment provided offsite	homeless SPMI or Dual diagnosis: MH/MR or MH/A&D
N (Family Care)	With parents, spouse, significant other, children	SPMI Dual diagnosis: MH/MR or MH/A&D
O (Other) ***example***: *shelter for battered women*	**Please describe** *full or part time supervision* *no monitoring*	**Please describe** *SPMI in crisis*

Note
Supervision refers to the intensity of staffing levels and supportive services
Monitoring refers to the extent to which the resident can come and go at will

The continuum was developed by members of the Tennessee Association of Mental Health Organizations (TAMHO) and modified for use with the Housing Needs Survey.

MHSP CLIENTS ELIGIBLE FOR CASE MANAGEMENT AND ESTIMATES OF THE PROPORTION INAPPROPRIATELY HOUSED

MHSPs by GRAND DIVISION	% Housed Inappropriately (survey estimates)	CURRENTLY RECEIVING CASE MANAGEMENT		ALL QUALIFIED FOR CASE MANAGEMENT	
		All	Inappropriately Housed (est)	All	Inappropriately Housed (est)
EAST TENNESSEE					
Cherokee Health Systems	18.8%	472	89	472	89
Fortwood Centers	10.6%	961	102	1,700	180
Frontier Health*	28.1%	2,266	636	4,160	1,167
Kress	9.1%	90	8	90	8
Peninsula BH*	7.3%	1,147	83	2,106	153
Ridgeview*	13.4%	459	62	843	113
Volunteer Behavior Health	26.8%	1,122	301	2,367	634
TOTAL		**6,517**	**1,281**	**11,738**	**2,344**
MIDDLE TENNESSEE					
Centerstone CMHCs*	12.1%	2,613	317	4,797	581
MH Co-op	8.1%	3,600	291	3,600	291
Volunteer Behavior Health	13.1%	1,515	199	3,194	419
TOTAL		**7,728**	**807**	**11,591**	**1,291**
WEST TENNESSEE					
Carey Counseling Center	12.7%	901	114	1,153	146
Case Management Inc.	5.1%	2,000	103	2,000	103
Frayser Family Counseling	33.1%	1,080	358	1,728	572
Midtown	12.5%	361	45	361	45
Pathways**	25.7%	2,304	592	2,304	592
Professional Counseling	10.1%	1,184	120	1,993	202
Quinco CMHC	2.3%	175	4	175	4
Southeast MHC	4.7%	734	35	1,600	75
Whitehaven-Southwest	2.0%	944	19	1,760	36
TOTAL		**9,683**	**1,390**	**13,074**	**1,775**
STATE-WIDE TOTAL		**23,928**	**3,478**	**36,403**	**5,410**

* These MHSPs did not report the number of their clients who are qualified for case management, although they did report less than 16 percent of their total consumers under current case management. For these centers, we assumed that the number qualified for CM is 1.8 times the number currently under CM, a ratio estimated from the pooled data of the reporting centers.

** Pathways also did not report the number of clients qualified for CM; however, since they reported over 54 percent of their total consumers were receiving CM, we made the assumption that all their CM-Qualified clients are receiving CM currently.

ESTIMATED NUMBER OF INAPPROPRIATELY HOUSED BY APPROPRIATE HOUSING TYPE

APPROPRIATE HOUSING*	Estimated # of Inappropriately Housed		
	A/D or MR	Other	All
Residential Trt. Facility	83	106	189
Supportive Living - B	85	46	131
Supportive Living - C	39	36	75
Halfway House	143	40	184
Supportive Living - E	25	197	222
Supportive Living - F	167	173	340
Assisted Living	176	373	549
Transitional Housing	32	147	179
Subsidized Furnished Independent Living	173	427	601
Co-op Apartments	88	73	161
Independent Living - K	237	620	857
Independent Living - L	479	979	1,459
Havens or Shelters	15	6	21
Family Care	20	182	202
Other	37	5	42

*Refer to Housing Needs Continuum for more explanation.

Housing Inventory Survey

Date of Inventory: _____

Name of Housing Provider:			
Facility Name:			
Address:		Tel. No.	
		Fax No.	
County:		Email:	

I. Source of Referrals: (Please supply us with a specific name, contact person, address, and phone number, if possible, as we may use this information in further research. List in descending order, with the most common source of referrals as number 1.)

1. _____
2. _____
3. _____
4. _____

II. Do you require that your residents:

a. have case management Y/N
b. be medication compliant Y/N
c. be seriously & persistently mentally ill Y/N
d. be in a treatment program Y/N
e. other (please specify) _____

III. Do you receive Level I vouchers? Y/N **Do you receive Level II vouchers?** Y/N

IV. Do you focus on a particular segment of the mentally ill population? Y/N

If yes, please indicate which segment:

Homeless _____
Veterans _____
Criminal Offenders/Defendants _____
Directly from the hospital _____
Other (please specify): _____

V. Inventory: (refer to Attachment for "Type" definition. A blank area, Type N, has been provided for your use, should your situation not fit within the definitions of Types A through M):

Facility Type	Number of Beds for Either Gender		Number of Beds Reserved for Men		Number of Beds Reserved for Women		Age Range of Residents
	Total	Open	Total	Open	Total	Open	

VI. Consumer length of stay: (enter the number of residents under the appropriate date range. Calculate from the date of the inventory):

	0 - 3 months	3 - 6 months	6 - 12 months	over 12 months
Number of Residents				

VII. Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VIII. Inventory completed by: _____ (please print)

Telephone if different from above: _____

Please return this survey by December 10, 1999 to Tennessee Housing Development Agency.

By mail: 404 James Robertson Parkway, Suite 1114
Nashville, TN 37243-0900
Attn: Anne Kenny

or

By fax: (615) 741-9621
Attn: Anne Kenny

Thank you for your time and assistance.

Housing Continuum

Type	Description	Resident Characteristics
A (Residential Trt. Facility)	24 hr supervision restricted egress treatment primarily in/at facility	SPMI (CRG 1 or 2) SED (TPG 2) Dual diagnosis: MH/MR or MH/A&D
B (Supported Living)	24 hr awake staff monitored egress egress with supervision treatment primarily offsite	SPMI (CRG 1 or 2) SED (TPG 2)
C (Supported Living)	24 hr awake staff monitored egress egress with supervision treatment primarily offsite	Dual diagnosis: MH/MR or MH/A&D
D (Supported Living)	24 hr awake staff monitored egress treatment provided primarily offsite	medically fragile SPMI and/or geriatric SPMI
E (Halfway House)	24 hr awake staff monitored egress treatment off and onsite	SPMI/SED Dual diagnosis: MH/MR or MH/A&D
F (Supported Living)	24 hr <u>peak hour</u> awake staff monitored egress treatment primarily offsite	medically fragile SPMI and/or geriatric SPMI
G (Supported Living)	24 hr <u>peak hour</u> awake staff monitored egress treatment primarily offsite	SPMI/SED Dual diagnosis: MH/MR or MH/A&D
H (Assisted Living)	minimal supervision (10-20 hrs/wk) no monitoring treatment offsite	SPMI/SED
I (Subsidized Furnished Independent Living)	no supervision no monitoring treatment offsite	SPMI/SED
J (Co-op Apartments)	no supervision no monitoring treatment offsite	SPMI/SED
K (Independent Living)	minimal supervision no monitoring treatment offsite	SPMI/SED
L (Independent Living)	no supervision no monitoring treatment offsite	SPMI/SED
M (Havens or Shelters)	full or part time supervision no monitoring treatment provided offsite	homeless SPMI/SED
N Other (please specify) *example: boarding home*	please describe as above *24hr peak awake staff* *monitored egress*	please indicate resident characteristics *elderly SPMI (DoH license)*

Note
<u>Supervision</u> refers to the intensity of staffing levels and supportive services
<u>Monitoring</u> refers to the extent to which the resident can come and go at will

The continuum was developed by members of the Tennessee Association of Mental Health Organizations (TAMHO) and modified for use with the Housing Inventory Survey.

Appendix VI

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
CORDELL HULL BUILDING, THIRD FLOOR
425 FIFTH AVENUE, NORTH
NASHVILLE, TENNESSEE 37243

DON SUNDQUIST
GOVERNOR

ELISABETH RUKEYSER
COMMISSIONER

July 23, 2000

Ms. Lorrie Shearon
THDA
Parkway Towers, 11th floor
404 James Robertson Pkwy., Suite 1114
Nashville, TN 37243

Dear Lorrie:

I am writing you these formal comments, concerning the Housing Needs of the Mentally Ill Study, in addition to those written comments discussed earlier with Jane and you at THDA.

As an advisory committee member, I would first like to commend you and the staff at THDA for a job well done given the information that was returned to you by those mental health agencies across Tennessee. However, as discussed earlier, my "on the job knowledge" of our state's housing needs leads me to conclude that the following items should be taken into account concerning this report:

-The apparent lack of information concerning persons with mental illness from the West Tennessee portion of our state, namely those in Memphis, could potentially skew the findings of this report.

-The lack of completed surveys representing persons with mental illness currently residing on the streets, in shelters, jails, prisons, and institutions could sway the findings towards those persons with mental illness who are higher functioning and not account for the housing needs of persons with mental illness who are dealing with more obstacles and not as high functioning. Essentially, then leading the report to address only the housing needs of the higher functioning, rather than the total population of persons with mental illness and in effect not addressing the needs of persons with mental illness who would require higher levels of support within the community to live in independent housing.

-Notation of the fact that the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD), through the Office of Housing Planning

and Development, has already taken steps to improve data sharing and comprehensive data collection by requesting that housing status be a part of all TennCare Partners information systems.

-Notation of the fact that the TDMHDD, through the Office of Housing Planning and Development has instituted a housing plan and procedure to increase and expand permanent housing for persons with mental illnesses throughout the state. (Please see attached Creating Homes Initiative).

-Notation of the fact that in our state we are currently underutilizing free housing technical assistance offered through HUD to address the housing needs of persons with mental illness.

In closing, I am truly grateful for the time spent and the consideration given to the housing needs of Tennesseans with mental illness. As discussed, the housing needs for persons with mental illness is a stated top priority of our Department and our Commissioner (Please see attached letter). I look forward to working with you in the years to come to expand housing for persons in our community diagnosed with mental illness. Together with our local community partners, through intention, strategy, and commitment, we can make a difference!

Sincerely,

Marie Williams

Marie Williams, LCSW
Director of Housing Planning and Development

Creating Homes Initiative (CHI)

A Tennessee Department of Mental Health and Developmental Disabilities strategic plan to partner with communities to create housing options for people with mental illness effectively and strategically in Tennessee

Presented To:
Elisabeth Rukeyser
Commissioner, TDMHDD

Proposed By:
Marie Williams
Director, Housing Planning and Development
May 17, 2000

Creating Homes Initiative

Background:

Everyday across Tennessee, in cities and towns, we see the impact of insufficient housing and support services for those diagnosed with a mental illness. Specifically, we watch as those with mental illness go through our systems of help—hospitals, mental health centers, homeless shelters, faith-based and social service agencies. Growing numbers of people enter this system daily looking for hope, help, healing and home. Unfortunately, all too often, there is no safe or affordable place to call home. We see the examples of this phenomenon everywhere—jails, hospitals and shelters all report increases in those persons who have a mental illness, cycling and re-cycling through their networks. We hear the frustration in the voices of persons with mental illness, case workers, BHO representatives and family members about the low availability and questionable conditions of the housing where those they care about are placed. Home is what I've been asked to focus on...however, it has become quite clear that home cannot truly exist for persons with mental illness without an increase in adequate housing, enhancements of current community housing options, coupled with coordinated and effective community services support.

The lack of safe, decent, quality, permanent and affordable housing options for people with mental illness is a major problem in Tennessee. This statement is made evident by the following facts:

-People with mental illness receiving SSI benefits ($494 average monthly income) are among the lowest income households in the country.

-There is not a single housing market in the United States where a person with SSI benefits can afford to rent a modest efficiency apartment.

-In Tennessee, the average cost of a one-bedroom apartment is 60% of the SSI monthly income.

-Despite a period of robust economic expansion, the affordable housing stock in Tennessee continues to shrink.

-Rents are rising at twice the rate of general inflation.

-For every 100 households at or below 30% of median income, nationally, there were only 36 units both affordable and available for rent.

-1 in 5 persons in our criminal justice system are diagnosed with a mental illness.

-Current estimates state that over 180 persons in our Regional Mental Health Institutes could be discharged if they had the appropriate supported community housing placement.

(Information obtained form *Priced Out in 1998, The Widening Gap: New Findings on Housing Affordability, Criminal Justice Task Force Report,* and *Tennessee Housing Development Agency SJR 279 Housing Report.*)

It is clear that unnecessary stays in hospital beds and regional mental health institutes, due to the lack of supportive community housing options, which range from $304.00 (Lakeshore) to $408.00 (Memphis), and could be more effectively and efficiently provided through our community if developed and coordinated. In addition to the lack of housing options for people with mental illness, Tennessee's local communities have yet to fully capitalize on available housing funds and opportunities. To create an effective and sustaining positive change in this situation I am proposing the following initiative----Creating Homes Initiative (CHI).

CHI, a significant new initiative, will be facilitated by the Tennessee Department of Mental Health and Developmental Disabilities, Office of Housing Planning and Development. The first objective of this initiative is to partner with local communities to establish local CHI time-limited, action-oriented task forces to develop and maintain affordable housing options for people with mental illness. The following pages outline the vision, mission, goal and action steps.

Creating Homes Initiative
(CHI)

Vision

To create and expand affordable, safe, permanent and quality housing options in local communities for people with mental illness in Tennessee.

Mission

To assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable and permanent housing options for people with mental illness.

Goal

To create *2005* new and improved housing options for Tennesseans with a mental illness by the year *2005*.

Slogan

2005 by 2005

Action Steps

1.) Establish and facilitate new CHI task forces, in local communities, across the state, to include representatives from the following key agencies:

Tennessee Department of Mental Health and Developmental Disabilities (Adult Services & Housing Planning and Development)
Fannie Mae
Homebuilders Association
United Way
Mental Health Centers and Mental Health Social Service Agencies
NAMI
Housing Authority
Statewide and Regional Planning Councils
Habitat for Humanity
Department of Housing and Urban Development
Housing and Community Development
Association of Realtors
Office of Economic and Community Development
Inner City Development Corporation
Local Government
Foundations
Business Community
Tennessee Housing Development Agency
Tennessee Association of Mental Health Organizations
TennCare Partners
Behavioral Health Organization
Faithbased Community
Tennessee Mental Health Consumer Association
Local Banks
Landlords
Supportive Living and Group Home Operators
Housing Counselors
Federal Home Loan Bank
Federal Reserve Bank
Mental Health Associations
Architects & Builders
Other Interested Community Persons

2.) Conduct local permanent housing assessments outlining current housing options, gaps and quality indicators. (Utilize local Consolidated Plan, SJR 279 Study, Continuum of Care, and DMHDD Statewide Housing Survey.)

3.) Develop and maintain a local housing resource mechanism based on local housing assessment information. (Vanderbilt University, DMHDD, and HUD website)

4.) Create and execute a local strategy to expand the menu of needed permanent housing and supportive services options (Single Room Occupancy Units, One Bedroom Apartments, Congregate Housing, Homeownership, Subsidized Housing, Permanent Supportive Housing, etc.) for persons with mental illness, based on the needs determined through the community housing assessment.

5.) Create a local strategy to maintain, enhance and upgrade current housing options for persons with mental illness based on information gathered.

To provide leadership for this initiative, TDMHDD, Office of Housing Planning and Development will:

- facilitate the local CHI task force meetings;
- aggressively seek out and collaborate with potential funding entities to leverage and funnel housing funds to local communities;
- identify and recommend financing strategies and grants that will provide support for the development of permanent housing options;
- collaborate with the local CHI task force to increase the availability of and access to housing;
- coordinate with other public agencies and the private sector to stimulate the preservation, development, and enhancement of housing options;

- direct new resources and develop plans, as funds become available, to increase housing options; and

- uphold the quality of the current housing utilized for those persons diagnosed with a mental illness.

Phase 1: Targeted Communities:

- CHI Chattanooga
- CHI Memphis
- CHI Nashville
- CHI Jackson

Phase 2: Targeted Communities:

- CHI Knoxville
- CHI Clarksville
- CHI Johnson City

Proposed Initiative Start Date:

- August, 2000 to be announced at the TN/KY Housing Institute.

We can change the current housing situation for people with mental illness in Tennessee---through intention, strategy, collaboration and community we can do 2005 by 2005!

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
CORDELL HULL BUILDING, THIRD FLOOR
425 FIFTH AVENUE, NORTH
NASHVILLE, TENNESSEE 37243

DON SUNDQUIST
GOVERNOR

ELISABETH RUKEYSER
COMMISSIONER

March 23, 2000

Dear Friends and Colleagues:

Since being named Commissioner I have taken a special interest in the housing needs of those persons diagnosed with mental illness across the state. I have listened to those of you in the community who have stated that affordable, quality, and safe housing was of the highest priority. To that end, I have created a new office of Housing Planning and Development that will be directly under the office of the Commissioner. I have named Marie Williams as the Director of this new office. Her primary mission will be to work with local community social service providers, nonprofit, government, foundation, mental health and housing agencies to develop and expand housing and community service alternatives in a strategic and effective manner.

Ms. Williams, a licensed clinical social worker, joins the Department with extensive experience in working with mentally ill and dually diagnosed persons. She served as Director of Residential Treatment Programs at Catholic Charities and as a Supervisor at Midtown Mental Health Center in Memphis. She comes to us from the United States Department of Housing and Urban Development where she coordinated and initiated key policy and community housing efforts as a Community Builder Fellow. Her experience in working with consumers of mental health services and expertise in community development uniquely qualifies her for this position.

In addition, Ms. Williams will work in tandem with Dennis Wenner, Director of Adult Services, and the Adult Services Section of the Division of Mental Health Services. The Division will continue to work with the current agencies that have a contract for housing services with the Division, as well as the Housing Committee of the Statewide Planning Council.

In closing, I am extremely excited about this new addition to the Department and the possibilities that this opens for those persons with housing and coordinated service needs in our communities. If you would like any further information regarding housing planning and development in your community, please feel free to contact Marie Williams at (615) 253-3049.

Sincerely,

Elisabeth Rukeyser

Elisabeth Rukeyser
Commissioner

ER: mw

NAMI Tennessee

Bristol
Chattanooga
Clarksville
Coffee County
Columbia
Cookeville
Covington
Dickson
Dyersburg
Greene County
Hamblen County
Jackson
Johnson City
Knoxville
Lawrenceburg
Loudon County
Martin
Maryville
McMinn Bradley
Memphis
Memphis S.W.
Monroe County
Nashville
Oak Ridge
Paris
Plateau
Rhea County
Roane County
Rutherford County
Savannah
Sevier County
Sumner County
Warren County

Memo to: Lorraine C. Shearon, Director of Research, Planning & Technical Services
Tennessee Housing Development Agency

From: Gene Pool, President, NAMI Tennessee

Re: Housing Needs of the Mentally Ill Study

Date: July 25, 2000

NAMI Tennessee is a grassroots organization of families of persons with severe and persistent mental illnesses (SPMI). We were glad to serve on this committee in order to bring attention to the dire needs of persons diagnosed with SPMI who do not have adequate, safe and affordable housing.

We concur with the report's notation that "It is crucial to note that during the era of deinstitutionalization, housing was not understood to be a vital component of mental health services. Some of them will always need long-term supportive residential care in order to function outside the institution. Providing a safe and stable living environment and providing access to the necessary care and services together, facilitate their stabilization, gradual recovery and hopefully, reintegration into the community."

NAMI Tennessee appreciates the efforts of THDA in conducting this study. We further acknowledge the collaborative efforts of many others, including persons representing TDMH/DD and provider agencies.

In responding to the report, it is the opinion of NAMI Tennessee that the graphic displays included in the report are enlightening; however, in some cases they are incomplete and therefore are misleading. We offer the following comments in this regard:

LIMITED DATA:

* We agree with the statement in the conclusions of the report "...we were struck by how fragmented information was and by the lack of availability of hard data on system functioning."

* We firmly believe that participation in the survey should be mandatory for all provider agencies, and that the collection and reporting of the data should not be optional.

5410 Homberg Drive, Suite 4, Knoxville, TN 37919 (423) 602-7900, Fax: (423) 602-7809
Affiliated with the National Alliance for the Mentally Ill, Partially funded by TN Dept. MH/MR

* Data collection on housing for this population should be coordinated with the TennCare Bureau, who has plans to establish an overall data collection system for the entire TennCare population.

* Data collection was only on a limited sample of providers and was conducted by hand-picked case managers. It did not include large numbers of SPMI who do not have case management. (Note: While the information collected is useful, more indepth sampling, in our opinion, is necessary for the study to have credibility.) We are concerned that meaningful data collection on the current housing situation for the SPMI is an option for Providers and is not mandatory. The TennCare Steering Committee made strong recommendations to the Administration that data collection be required, be uniform, and that certain essential data be made public. This recommendation certainly applies to housing for SPMI.

* The numbers of SPMI needing housing is far greater than identified in this report.

* It must be recognized that the scientific data published on a national basis documents that there are many more SPMI people who need housing, and that it is not limited to those only in institutes or to the homeless population.

* Any long-range plan to solve the overall housing problem must recognize the validity of this national data.

LACK OF SAFE, AFFORDABLE HOUSING:

* There is currently insufficient safe, affordable housing for the numbers of SPMI people in need.

* Many of the SPMI are living in substandard housing and cannot afford anything better.

* Any plan being considered must recognize the severe limitation of funds made available to SPMI, who usually only receive Medicaid financial assistance, which is below poverty level for this population.

- The Chair of NAMI Tennessee's Housing Committee expressed concern that this report does not address the vast majority of SPMIs who do not have a case manager, or those who, because of a shortage of Supportive Living Facilities (SLF) live in Homes for the Elderly that are licensed by the Tennessee Department of Health. Nor does it address the frail SLF system, which,

because of lack of a supplement, must meet its residents' needs on less than $550 per month per resident.

- Many areas of Tennessee have little or no SLFs. As an example, Jackson, population over 55,000 and Madison County population of 85,000, do not have any SLFs.

- There are many SPMI from across the state who must be housed miles from their friends and family, increasing stress for both consumer and family.

The report provides additional data on some of the housing needs of some of the SPMI population in Tennessee as well as identification of both funding sources and approaches to take in correcting identified problems. However, the report fails to meet the standard of "comprehensive" embodied in SJR 279 or the "availability of funding from all sources, governmental and private, which might assist in making housing more affordable to persons with mental illness" as in the extending SJR 529.

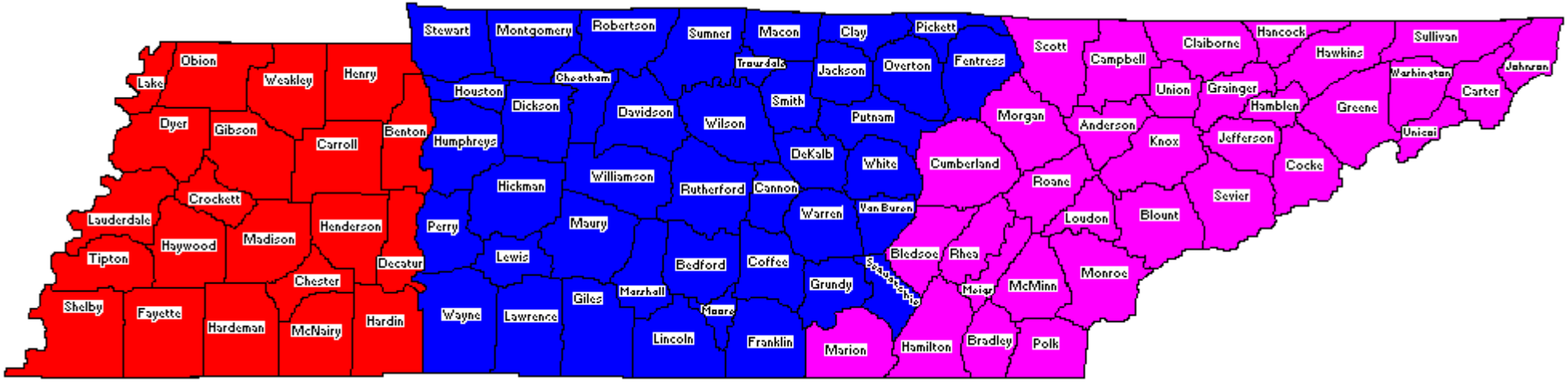
SUMMARY:

In summary, NAMI Tennessee restates the importance of this Study, extends appreciation to THDA for their efforts, and observes that this survey is long overdue. It clearly points out the need for increased, safe, affordable housing for SPMI. It is our hope that this Report will be reviewed by appropriate Departments and the Legislature, and that follow up action will be taken on the recommendations of this Report.

We request that those agencies charged with oversight of the housing resources insure that those funds that are available be utilized fully for the benefit of the SPMI population.

We request that the final Report be made available to the Mental Health Planning Council, to advocacy organizations, and to the public at large.

Appendix VII



THREE GRAND DIVISIONS OF TENNESSEE

WESTERN DIVISION/21 COUNTIES

BENTON
CARROLL
CHESTER
CROCKETT
DECATUR
DYER
FAYETTE
GIBSON
HARDEMAN
HARDIN
HAYWOOD
HENDERSON
HENRY
LAKE
LAUDERDALE
MCNAIRY
MADISON
OBION
SHELBY
TIPTON
WEAKLEY

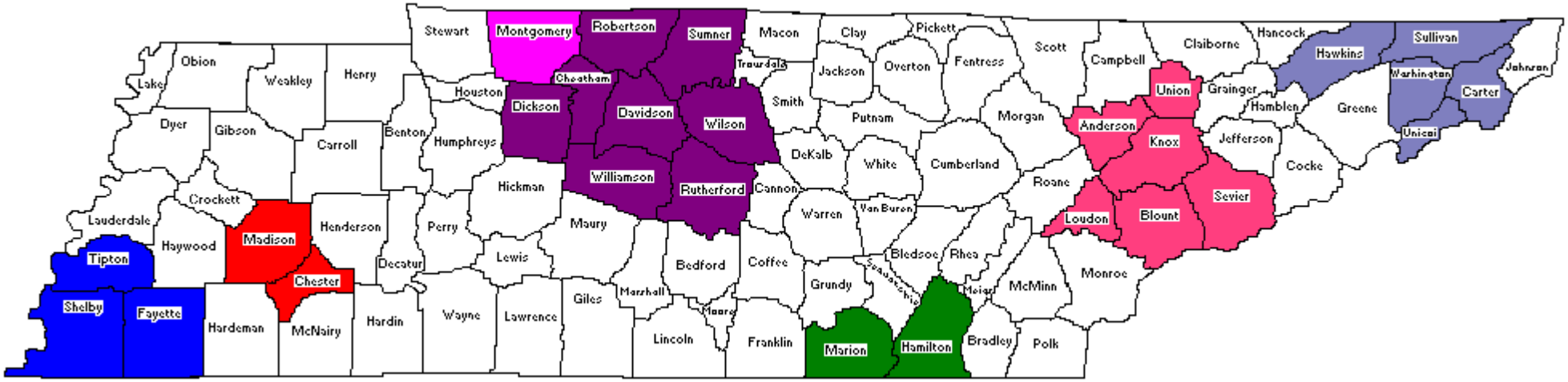
MIDDLE DIVISION/41 COUNTIES

BEDFORD
CANNON
CHEATHAM
CLAY
COFFEE
DAVIDSON
DEKALB
DICKSON
FENTRESS
FRANKLIN
GILES
GRUNDY
HICKMAN
HOUSTON
HUMPHREYS
JACKSON
LAWRENCE
LEWIS
LINCOLN
MACON
MARSHALL
MAURY
MONTGOMERY
MOORE
OVERTON
PERRY
PICKETT
PUTNAM
ROBERTSON
RUTHERFORD
SEQUATCHIE
SMITH
STEWART
SUMNER
TROUSDALE
VAN BUREN
WARREN
WAYNE
WHITE
WILLIAMSON
WILSON

EASTERN DIVISION/33 COUNTIES

ANDERSON
BLEDSOE
BLOUNT
BRADLEY
CAMPBELL
CARTER
CLAIBORNE
COCKE
CUMBERLAND
GRAINGER
GREENE
HAMBLEN
HAMILTON
HANCOCK
HAWKINS
JEFFERSON
JOHNSON
KNOX
LOUDON
MCMINN
MARION
MEIGS
MONROE
MORGAN
POLK
RHEA
ROANE
SCOTT
SEVIER
SULLIVAN
UNICOI
UNION
WASHINGTON

Appendix VIII



MSA METROPOLITAN AREAS OF TENNESSEE

MSA:	Chattanooga, TN-GA	HAMILTON, MARION
MSA:	Clarksville-Hopkinsville, TN-KY	MONTGOMERY
MSA:	Jackson, TN	MADISON. CHESTER
MSA:	Tri-Cities, TN-VA	CARTER, HAWKINS, SULLIVAN, UNICOI, WASHINGTON
MSA:	Knoxville, TN	ANDERSON, BLOUNT, KNOX, LOUDON, SEVIER, UNION
MSA:	Memphis, TN	FAYETTE, SHELBY, TIPTON
MSA:	Nashville, TN	CHEATHAM, DAVIDSON, DICKSON, ROBERTSON, RUTHERFORD, SUMNER, WILLIAMSON, WILSON