

Chapter 10: Housing

The purpose of this chapter is to describe housing services for people with serious mental illness and/or substance abuse problems, including existing resources, particular strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Existing Resources

As part of their current housing services, ODMHSAS offers Community Living Programs for mental health clients (see Exhibit 10.1). In FY 2005, 1,970 mental health clients were served by these programs, with the majority living in Residential Care facilities. Currently, Residential Care facilities operate as permanent housing for many clients.

Service Type	Number of Clients
Residential Care	1,559
Transitional Supported Living	244
Permanent Supported Housing	167
Total	1,970

Specialized housing options for people with mental illness are located in both urban and rural settings, and are funded through ODMHSAS, Housing and Urban Development (HUD), public housing authorities, and private sources. Housing models include transitional living programs, permanent housing (supervised, supported and independent), and several short-term subsidy programs, as described above and below, that help people access and maintain permanent housing. Tribal housing authorities are another source of housing available to ODMHSAS clients who are tribal members.

The map in Exhibit 10.2 indicates specialized housing options are available throughout the Central and Eastern parts of the state but there is limited availability in the Western part.

To provide for and encourage the development of group homes for individuals in recovery from alcohol or illicit drug addiction, ODMHSAS participates in the operation of a revolving loan fund. Federal substance abuse block grant funds were used to establish and maintain \$100,000 in a revolving loan fund. Loan applicants must complete a one page document which establishes the loan amount and sets the amount of monthly payments. By signing the loan document, the applicants agree to repay the loan along with a 6 percent interest on the loan. Applicants must comply with the following requirements:

1. At least six people, all intending to be group home residents, must sign the loan contract;
2. The home must agree to operate as an Oxford House;
3. The home must be run on a democratic basis;
4. The home must be financially self-supporting and pay its bills on time; and,
5. The home must immediately expel any member who uses drugs or alcohol or fails to pay his or her fair share of expenses.

ODMHSAS Substance Abuse Services program staff monitor the Oxford Houses to ensure contract requirements are followed

B. Strengths

In some areas of the state, organizations and collaborations have developed innovative approaches to housing that can serve as models for other communities. In Tulsa, the Mental Health Association (MHA) has implemented a continuum of 13 specialty housing programs to meet the needs of people with mental illness for safe and affordable housing. These include two Safe Haven programs, with a “low-demand, high expectation,” *Housing First* model for chronically homeless, street-habituated adults (including those with a dual diagnosis), regardless of whether they have an income or are actively in treatment. The MHA also offers transitional group living, permanent supported housing, long-term independent living options, and the Metropolitan Apartment Program, which offers long-term supportive scattered-site apartments for formerly homeless individuals. They have a model program for home ownership with Habitat for Humanity Tulsa called the “Partnership for Open Doors,” providing mental health consumers the opportunities to achieve “the American dream” of home ownership. Using federal Housing and Urban Development (HUD) funds, State mental health block grant funds, and by completing a successful capital campaign, the MHA in Tulsa has been able to develop a range of housing properties which they own debt-free. These models are responsive to the needs of consumers at different points on their recovery journeys, while promoting stigma-free reintegration into the community with the necessary wrap-around services for a high quality of life.

The City of Norman Housing Authority was instrumental in putting together a public/ private coalition (including mental health providers, other human service agencies, and private developers) that is successfully working to increase the range of transitional and permanent housing in their community. There are new housing options available through a growing Supported Housing program run by Thunderbird Clubhouse; Transition House in Norman is unique, because it not only provides transitional housing,

but continues to offer support services to former residents after they locate permanent housing.

Members of the Governor's Inter-Agency Council on Homelessness noted that cities and towns need to be given the resources to solve housing problems locally, and that, in most communities, there have not been concerted efforts to address these complex problems. The success of communities such as Tulsa and Norman are models that other communities can learn from and build on.

In recent years, ODMHSAS has developed several new approaches to housing and the prevention of homelessness for the people it serves. Currently, each of these models is available in selected areas of the state. The HOPE Program supports Tenant Based Rental Assistance projects to assist very low income persons with mental illness in rural Oklahoma. This transitional assistance, which is available for up to 24 months, is provided through contracts with seven designated CMHCs, serving a total of 17 counties. The goal is to provide supportive services and to assist participants in accessing other community resources (e.g., Section 8, SSI, employment) to get and maintain housing.

Another pioneering model is the Family Self-Sufficiency Program, a time-limited housing program for families of children with serious emotional disturbances who are homeless, at risk of losing housing, or in crisis. The program helps families create a stable home environment, reduce out-of-home placement, increase school attendance, and reduce or mitigate contacts with law enforcement. The program incorporates elements of a system of care for families, including blended funding, wraparound services, collaboration with other service providers, and strengths-based, family-directed plans and services.

Discharge Planning Housing Subsidy Funds assist very low-income adults with mental illness or co-occurring mental illness and substance abuse disorders who are being discharged from psychiatric inpatient care, released from the Department of Corrections, or who are aging out of the foster care system. These tenant-based subsidy funds serve a bridging function so that people are not discharged to homelessness, giving people time to get jobs, and apply for public housing or other services that will help them maintain stable housing. The subsidies are available for 9-12 months and can be used for housing costs such as rent, utilities, rent deposits and utility deposits.

In several communities, strong and effective housing development partnerships have been formed among local housing authorities, provider agencies, public health collaboratives, private developers, and other parties. These partnerships have been able to leverage private and public funds to develop creative housing options for people served by ODMHSAS. In areas of the state where this has not happened, participants frequently expressed a need for assistance from ODMHSAS with the mechanics of creating and sustaining partnerships, identifying funding opportunities, and writing successful grants.

The Governor's Interagency Council on Homelessness (GICH) was created in 2004 and is chaired by an ODMHSAS staff member. The group consists of 25 members with representatives from the Governor's Office, Legislature, state agencies and individuals from the homeless community, and its mission is to promote collaborations among stakeholders and develop and implement strategies to improve access to services, mainstream resources, and develop affordable, permanent housing (Henry, 2004). Among the innovative projects initiated by the GICH is SOAR Training (SSI/SSDI Outreach, Access and Recovery), providing case managers and other staff with an in-depth, step-by-

step explanation of the SSI/SSDI application and disability determination process, as well as strategies for working with homeless persons with serious mental illness and co-occurring disorders; only a fraction of this population currently receives the benefits to which they are entitled.

C. Needs and Existing Barriers Policies

An acute shortage of stable, affordable permanent housing for people with mental health diagnoses and a lack of sufficient sober living options for people recovering from substance abuse problems were perceived as major barriers to system transformation and to improved quality of life for clients. Focus group participants from a wide range of backgrounds across every area of the state noted that access to decent housing is a core issue that must be addressed if people are to have a foundation for recovery and community integration.

There was a wide-spread perception among participants that housing is not a priority for the state, and that it lacks a comprehensive, coordinated action plan to ensure that resources are available to meet the housing needs of the people it serves. ODMHSAS participates in the Governor's Inter-agency Council on Homelessness and the Oklahoma Olmstead Strategic Planning Committee¹. Some interviewees noted a need to develop a strategy to coordinate work across these two interagency workgroups to best meet the needs of its clients.

There are no current estimates of the number of homeless adults living in Oklahoma who have a mental illness or need substance abuse treatment. A survey conducted in Oklahoma City in 2005 found that approximately 1,500 (0.3%) of the city residents were homeless at that time. Of the adults surveyed, 31 percent reported having a mental illness and 29 percent reported having a substance abuse problem.¹

As clients enter, make their transition through, and exit programs funded by ODMHSAS, residential information is gathered. An evaluation of client discharge records from FY 2005 revealed that 12 percent of adult mental health clients were homeless during some part of their treatment episode, and 15 percent of adult substance abuse treatment clients were homeless (see Exhibit 10.3). On average, eight percent of both mental health clients and substance abuse treatment clients were chronically homeless, continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. The overall trend for homelessness among mental health clients has been fairly stable since FY 2001; however for substance abuse treatment clients there was a five percent increase from FY 2004 to FY 2005. It is not

¹ The Oklahoma Olmstead Strategic Planning Committee is an inter-agency group charged by the Governor and the Legislature with the development and implementation of a plan to ensure that all Oklahomans with disabilities have access to the resources and supports to live successfully in the integrated community settings of their choice. This charge grows out of the Supreme Court's decision in the case of *Olmstead vs. L.C.*, 527 U.S. 581 (1999), requiring states to prevent the unnecessary institutionalization of people with disabilities and to provide services in the most integrated settings.

clear whether these changes are due to an increase in the homeless population, an increase in substance abuse among persons who are homeless, or improved outreach efforts.

Exhibit 10.3. Homeless Status for Clients, Age 18 or Older , who Received ODMHSAS-funded Services						
Fiscal Year	Mental Health Treatment			Substance Abuse Treatment		
	Percent Homeless	Number Homeless	Total Served	Percent Homeless	Number Homeless	Total Served
2001	10%	1,779	18,610	9%	1,037	12,170
2002	11%	2,110	19,134	9%	1,162	12,967
2003	12%	2,078	17,252	9%	1,224	13,110
2004	11%	2,006	17,880	10%	1,363	13,593
2005	12%	2,313	18,510	15%	2,150	14,469

Exhibit 10.4 presents movement in the type of residential situation from admission to outpatient programs to discharge for ODMHSAS adult mental health clients during Fiscal Year 2005. Most clients were living in a private residence at the time of admission and 97% of those remained in a private residence at discharge. Of the three percent whose residential situation changed, most moved to more restrictive settings (112 to residential care homes, 33 to nursing homes, and 102 to institutional settings) and 155 became homeless (100 to community shelter and 55 on the street). Movement to more restrictive settings should be avoided where possible. Movement to homelessness is clearly a major problem.

Of persons who were in more restrictive settings, the clear tendency was for them to remain in the same residential situation. The percentages showing no changes range from 84% (residential care) and 83% (nursing homes) to 55% (institutional setting). Movement from these facilities was primarily to private residences; however 21 individuals were discharged to a homeless situation. This lack of change in residential situation may be due to a failure of providers updating client records at discharge.

Among persons who were homeless upon admission, there was also a strong tendency for them to remain homeless, either in a community shelter, 66% or 310 persons, or on the street, 47% or 144 persons. Of those whose residential situation improved, most (227) went to private residences. Additional alternatives need to be available to ensure that more of these homeless people do not remain homeless

Exhibit 10.4. Change in Residential Situation Among Adults ,Age 18 and Older, who Received ODMHSAS-funded Mental Health Services and Discharged in FY 2005*																
Residential Situation at Discharge																
Residential Situation at Admission	Total	Private Residence		Supported Living		Residential Care Home		Nursing Home		Institutional Setting		Community Shelter		On the Street		
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Private Residence	13,218	12,769	97%	47	0%	112	1%	33	0%	102	1%	100	1%	55	0%	
Supported Living	283	72	25%	189	67%	4	1%	1	0%	5	2%	11	4%	1	0%	

Residential Care Home	634	71	11%	4	1%	532	84%	13	2%	9	1%	4	1%	1	0%
Nursing Home	12	0	0%	0	0%	0	0%	10	83%	0	0%	1	8%	1	8%
Institutional Setting	99	35	35%	1	1%	7	7%	0	0%	54	55%	1	1%	1	1%
Community Shelter	472	113	24%	20	4%	10	2%	0	0%	4	1%	310	66%	15	3%
On the Street	306	114	37%	7	2%	9	3%	0	0%	6	2%	26	8%	144	47%
Total	15,024	13,174	88%	268	2%	674	4%	57	0%	180	1%	453	3%	218	1%

* Includes only OMDHSAS Mental Health Clients served at a CMHC with at least 30 days between their admission and discharge. Clients under the custody of DOC and those whose services were limited to inpatient and/or Community-Based Structured Crisis Care were removed.

Exhibit 10.5 presents similar residential information for adult ODMHSAS substance abuse treatment clients during Fiscal Year 2005. As with mental health clients, most substance abuse treatment clients were living in a private residence at the time of admission and remained in a private residence at discharge. Of those whose residential situation changed, 39 became homeless. Also similar to mental health clients, substance abuse treatment clients living in more restricted settings remained in these settings at discharge. Only five of these clients became homeless. The tendency for homeless clients to remain homeless also continued, with 49% or 82 persons remaining in community shelters, and 53% or 157 persons remaining on the street.

Exhibit 10.5. Change in Residential Situation Among Adults ,Age 18 and Older, who Received ODMHSAS-funded Substance Abuse Services and Discharged in FY 2005*															
Residential Situation at Admission	Total	Residential Situation at Discharge													
		Private Residence		Supported Living		Residential Care Home		Nursing Home		Institutional Setting		Community Shelter		On the Street	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%
Private Residence	6,774	6,559	97%	42	1%	44	1%	1	0%	89	1%	13	0%	26	0%
Supported Living	44	17	39%	25	57%	1	2%	0	0%	0	0%	1	2%	0	0%
Residential Care Home	236	15	6%	1	0%	215	91%	0	0%	3	1%	1	0%	1	0%
Nursing Home	1	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Institutional Setting	110	36	33%	0	0%	3	3%	0	0%	69	63%	0	0%	2	2%
Community Shelter	168	52	31%	10	6%	16	10%	0	0%	2	1%	82	49%	6	4%
On the Street	298	91	31%	44	15%	0	0%	0	0%	2	1%	4	1%	157	53%
Total	7,631	6,771	89%	122	2%	279	4%	1	0%	165	2%	101	1%	192	3%

* Includes only ODMHSAS Substance Abuse Treatment clients with at least 30 days between their admission and discharge. Clients under the custody of DOC and those whose services were given at a detox-only facility are removed from the sample. Dependents of Substance Abuse Treatment clients were also removed.

The lack of a comprehensive approach to housing is not unique to ODMHSAS; the Olmstead Committee's Housing Subcommittee Position Paper (Oklahoma Olmstead Strategic Planning Committee, 2005) identified this as a major cross-agency issue affecting all people with disabilities. The policy barriers identified in that position paper are strikingly similar to those raised by focus group participants and personal interviews, and point to the fact that there are also policy barriers at the federal level. Among the policy barriers identified by the Housing Subcommittee are the following:

- Individual choice and community integration is limited because of over-reliance on segregated congregate housing.
- The lack of safe, accessible, affordable, and integrated housing makes it difficult for people with disabilities to leave institutions and to maintain residency in their community of choice.
- The process of finding and securing subsidized housing is unnecessarily complex.
- The proposed decrease in federal appropriations for housing initiatives will severely limit the intent of the President's "New Freedom Initiatives."

Other state-level housing policy issues raised by focus group participants included the lack of a state housing trust fund that could be used to leverage other public and private development funds for low-income housing, and a wide-spread opinion that development of Supported Housing should be a major new policy initiative for ODMHSAS. Consumers across the state felt that the Department's policy of funding housing through Community Mental Health Centers (CMHCs) should be changed, because it gives service providers too much control over individuals' daily lives. This was summed up by consumers in one focus group: "The transitional housing is run by the CMHC; you get kicked out if you're not on meds, don't show up for an appointment, or act in a way they think is inappropriate." People living in Residential Care facilities stated that they are required to attend daily programs at specific CMHCs in order to keep their housing. A provider put it this way: "We are still trying to figure out how to get the system to think about wellness instead of illness. It's important that treatment compliance no longer be a barrier to accessing housing... People need to have choices without getting kicked out of housing."

Some participants noted that Griffin Memorial Hospital often discharges people to shelters or the street, and said there should be an ODMHSAS policy forbidding this practice. However, consumer choice is certainly an important factor and it is understood that inpatient treatment settings are not intended to serve as housing once treatment objectives are achieved. Other groups noted that many mental health clients are inappropriately placed in nursing homes for lack of housing options, and that this policy runs counter to the mandates of *Olmstead*, which states that people must be served in the most integrated setting.

In addition to these over-arching policy barriers, respondents identified policies that effect specific sub-groups of people with mental health and/or substance abuse issues. It was reported that it is extremely difficult to find housing programs that will accept people who have both developmental and psychiatric disabilities, people with fetal

alcohol syndrome, and people with traumatic brain injury, and that there are no policies in place at the state level to ensure access to housing for these individuals. It was also noted that people with mental illness who have trouble living in congregate settings have very limited housing options because of a shortage of independent housing with supports.

Another sub-group for which there are major policy barriers to housing is people with criminal justice system involvement, particularly those with felony convictions and drug convictions. Depending on the nature of their convictions, these individuals are barred from public housing, including HUD-funded housing, for at least three years after release; some are barred for life. Mental health and substance abuse service providers, clients, and professionals within the criminal justice system all raised this issue: "People with criminal backgrounds are barred from many types of housing, even some shelters. People can't get what they need because of their legal status." Some criminal justice professionals stated that various sub-groups of people with criminal justice histories and mental health or substance abuse problems "have no options except to live under bridges." There are currently no policies within ODMHSAS or the various criminal justice agencies to ensure that people with mental health and/or substance abuse issues who are released from prison have a stable place to live.

Practices/Services

All focus groups of people receiving mental health and/or substance abuse services, and most groups made up of service providers, named access to decent housing as one of the most critical needs of people in the system. There was broad agreement that people cannot make good use of other services if they do not have stable housing, yet it was clear that many people receiving services are homeless, precariously housed, or in undesirable living situations.

The focus groups identified issues related to the following practices and services that interfere with people's ability to access housing:

- Serious shortages of safe, affordable housing in most areas of the state, both in the private real estate market and in publicly funded housing. In many areas of the state, consumers reported that private landlords do not want mental health or substance abuse clients as tenants, or do not accept federal or state housing vouchers.
- Cut-backs in federal housing funds in recent years resulted in the loss of over 1,000 existing Section 8 subsidy vouchers in the state, adding to already long waiting lists for subsidized housing programs. People also noted that the application process is complicated and that it is easy to lose subsidies if one has problems with paperwork or keeping appointments.
- Financial issues create major barriers to housing:
 - Many people have no income; it can take two years or longer to qualify for Social Security benefits. People in this situation say they sleep on friends' couches, move between family members, or have periods of homelessness in the interim.
 - Most clients have little savings, and cannot afford utility deposits, rent deposits, or the basics needed to set up a household.
- The scarcity of Supported Housing programs, public housing, and affordable private housing in the state, combined with the lack of public transportation in both urban and rural areas, has resulted in large numbers of people living in

congregate care facilities from which they have no transportation other than to mental health programs. This keeps people virtually institutionalized and unable to participate in their communities. People in these facilities often pay all but \$25 of their SSI check for room and board, leaving them destitute, unable to purchase clothes, personal care products, and other necessities.

- In some areas, transitional housing programs are unable to accept new residents because there is no permanent housing to which current residents are able to move.

Workforce Development Issues

Clients, service providers and housing experts around the state felt that housing assistance should be a core service offered by all mental health and substance abuse service providers, but acknowledged that few programs have staff with the requisite skills and experience. Participants identified a need for training and mentoring on this topic to ensure that all clients have access to services that will help them secure and maintain decent housing.

Organization/Collaboration

As noted above under Strengths, there are a few communities in which partnerships have been formed among local housing authorities, provider agencies, public health collaboratives, private developers, and other parties. However, most areas of Oklahoma have yet to see these developments. These partnerships should provide a model for other communities. In addition, the Tennessee Department of Mental Health has created a very successful program that provides regional housing specialists to assist communities in this process. Replication of this program in Oklahoma would pay for itself many times over if communities were able to leverage outside housing funds.

Data

Providers and staff of several state agencies noted that there is a lack of data on housing and homelessness in the state. For example, no one tracks who gets and loses housing subsidies, or how many homeless people there are in the state. Some state agencies do not attempt to count homelessness among the people they serve. It was also noted that multiple funding streams and redundant paperwork makes it difficult to collect accurate data, and that this keeps the state from being able to exploit certain funding opportunities.

Even programs that focus on homelessness have data problems. The Homelessness Management Information System (HMIS), a federal initiative, does not count everyone, and does not produce sufficient management reports. Participants pointed out that all state agencies use different data systems with different person identifiers, which means there is no easy way to aggregate data, and data that should be captured once has to be entered and re-entered. This issue has been discussed by the Governor's Inter-agency Council on Homelessness, which would like to be part of the state's interagency JOIN data project, to help address the need for full and accurate data about housing and homelessness.

References:

Henry, B. (2004). Executive Order 2004-10. Oklahoma City, OK. Retrieved August, 2006 from <http://www.sos.state.ok.us/documents/Executive/419.pdf>.

Oklahoma Olmstead Strategic Planning Committee, 2005 Subcommittee goals and action steps. Retrieved July, 2006 from <http://www.csctulsa.org/images/OLMSTEAD%20SUBCOMMITTEE%20ASSIGNMENTS%20FY05.doc>,