Supported Housing Among People with Serious Mental Illness: A Needs Assessment

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Public Health Council
of the Upper Valley

Supported Housing Among People with Serious Mental Illness: A Needs Assessment

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In partnership with and for the benefit of:
Upper Valley Housing First
Public Health Council of the Upper Valley

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Executive Summary

In Spring 2026, the Public Health Council of the Upper Valley (PHC) and the Upper Valley Housing First Working Group partnered with a team from the Dartmouth Center for Social Impact's Social Impact Nonprofit Consulting program. The following document explores details of the internship and a summary of literature exploring the value of supportive housing for people with serious mental illness, particularly in the Upper Valley.

Purpose of Project

This project aimed to complete a needs assessment for supportive housing for people with serious mental illness in the Upper Valley. We aimed to address the following questions:

1. What is serious mental illness, and how does it complicate access to housing?
2. What is supportive housing, and what is the history of housing for people with serious mental illness?
3. What are the social, physical, and economic implications of supportive housing for people with serious mental illness?
4. What is the state of serious mental illness in the Upper Valley, and what resources currently exist?
5. What are unique barriers to implementing supportive housing in the Upper Valley?

To complete the assessment, we worked under the guidance of Alice Ely, MPH, PHC Executive Director, and members of the Supportive Housing Committee of Upper Valley Housing First.

Methodology

A variety of resources were employed when searching for literature. The majority of citations are formal academic papers, and other sources include articles from the Mental Health Association and National Alliance on Mental Illness. Information specific to the Upper Valley was found through local government services, medical care providers, and interviews.

Conclusions

The evidence reviewed throughout this report demonstrates a strong need to address the impact of serious mental illness on housing instability in the Upper Valley through supportive housing. Studies show that supportive housing improves health, social wellbeing, and long-term housing stability while reducing reliance on emergency departments, shelters, and other public systems. Given the Upper Valley's housing shortages, workforce challenges, transportation barriers, and fragmented mental health services, supportive housing represents an opportunity to strengthen both individual wellbeing and overall community resilience.

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Introduction to Serious Mental Illness

Definitions of Serious Mental Illness (SMI)

Serious mental illness (SMI) lacks a single, universally accepted definition in the United States. Nonetheless, several federal agencies have developed definitions that are widely applied in policy and research contexts. The Substance Abuse and Mental Health Services Administration (SAMHSA), for instance, asserts that SMI is defined by "someone over 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that substantially interferes with a person's life or ability to function" (Substance Abuse and Mental Health Services Administration, 2024). Comparably, the National Institute of Mental Health (NIHM) classifies SMI as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities" (National Institute of Mental Health, 2024). Both agencies notably define SMI by its impact on functioning rather than as a distinct diagnostic category. Drawing upon this functional definition, SAMHSA estimates that in 2023, approximately 14.6 million American adults, or 5.7% of the population, experienced SMI in the past year (SAMHSA, 2024).

Importantly, SMI is not defined in the DSM-5, the American Psychiatric Association's guide for classifying mental health conditions, again underscoring the functional nature of the term. As a result, there is significant variation in how SMI is defined across policy contexts in the United States. A study conducted by researchers at Columbia and Adelphi Universities found that, between October 2020 and May 2021, 46 of 56 states, territories, and the District of Columbia had formal policy definitions of SMI, and that 82.6% of these definitions included functional impairment or disability criteria (Gonzales et al., 2022).

This variation is also reflected in the Upper Valley. In Vermont, state statute defines "mental illness" broadly as "a substantial disorder of thought, mood perception, orientation, or memory, any of which grossly impairs judgement, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but shall not include intellectual disability" (State of Vermont, 2025). By contrast, New Hampshire's administrative code defines SMI as requiring both a diagnosis (or provisional diagnosis) of mental illness and a resulting severe functional impairment (New Hampshire Department of Health and Human Services, n.d.). The Treatment Advocacy Center, an influential nonprofit focused on SMI policy, argues that the lack of a standardized definition limits the reliability of research, clinical services, and public policy (Treatment Advocacy Center, 2023).

Relationship Between SMI and Housing

The United States Department of Housing and Urban Development (HUD) does not primarily use the term SMI in determining eligibility for its housing programs. Instead, the agency relies on the concept of a "disabling condition," defined as a condition that is "expected to be of long continued and indefinite duration and substantially impair the client's ability to live independently" (U.S. Department of Housing and Urban Development, 2024). Within this framework, mental health conditions are considered disabling when they meet these functional, rather than diagnostic, criteria.

The relationship between mental health and housing is highly significant. HUD reports that approximately 39% of homeless individuals experience some form of mental health condition and that an estimated 20-25% meet the criteria for SMI (HUD, 2024). Ultimately, SMI extends beyond a simple diagnosis. It is redefined across different institutions but is generally understood in terms of how mental health conditions affect a person's ability to function in daily life.

Supportive Housing

Historical Context and Variations

Housing First policies prioritize immediate access to housing without requiring medical treatment or sobriety as preconditions ("Supportive housing," n.d.). In the context of mental illness and otherwise, these policies are intuitive but highly debated– while it is simple to recognize that someone with housing is more likely to experience the stability required to treat a serious mental illness, the stigma surrounding mental illness can make it difficult for governments and rental owners to see the value of integrating people with SMI into their community. Housing is an important first step to creating stability for people with SMI. Housing has proven to be so important that it has become enshrined as a human right in the International Convention on Human Rights, and this is directly tied to the role of housing in identity and community (Farkas & Coe, 2019). Contrary to psychological evidence, false claims and oversimplified evidence have led much of the general public to view people with SMI as dangerous, further complicating the issue of incorporation into the community (DeAngelis, 2022).

In the absence of government-sponsored SH, the quality of life of people with SMI is largely determined by income, and government financial support remains insufficient. Individuals with SMI are more represented among what the US Department of Housing and Urban Development terms "severe-case needs" (Newman & Goldman, 2008). As Newman & Goldman (2008) so eloquently summarize the issue, the general public and governments alike must ask themselves

one question: should the principle of everyone being treated the same be prioritized over the principle of housing as a human right?

Considering lasting debate, this paper seeks to examine the benefits of SH for people with SMI and conduct a needs assessment for the Upper Valley, demonstrating how such programs improve conditions for both people with SMI and the general public. The National Alliance on Mental Illness explains that there are many forms of housing for people with mental illness, including supervised group housing, SH, rental housing, and home ownership. A good housing match is one that prioritizes affordability, the right balance of independence and support, and meets an individual's physical limitations.

This paper specifically considers the utility of SH, described by Herrell & Straw (2002) as consisting of four minimal components:

1) The individual has a lease in his or her own name
2) Housing is integrated into the community
3) Housing is affordable (i.e. no more than 40% of adjusted gross income)
4) Services offered are not a condition for tenancy.

Notably, these conditions prioritize tenant autonomy, independence, and financial comfort, and these noble values can be explained as a response to the institutionalization movement.

When deinstitutionalization began in the 1950s, there were no social safety nets left to catch the patients who fell through the cracks. Patients went from living in hypersurveilled, oppressive conditions of institutionalization to a world that lacked mental health, financial, or housing support, and the number of these patients who were incarcerated increased. This inverse relationship between the number of patients in asylums and prisons is termed the Penrose hypothesis (Roth, 2021).

By the 1970s, there was a linear continuum of care developed for people with SMI– a patient would progress from a hospital to a halfway house, and finally would enter supervised apartments (Farkas & Coe, 2019). However, over time, these halfway homes became "smaller versions of highly supervised, regulated…residential environments [that] trapped residents in…trans-institutionalization" (Cometa et al., 1979). In the meanwhile, asylums– which had begun as a refuge for people with SMI– shifted purpose to "reducing perceived community risk through intensive supervision (Farkas & Coe, 2019).

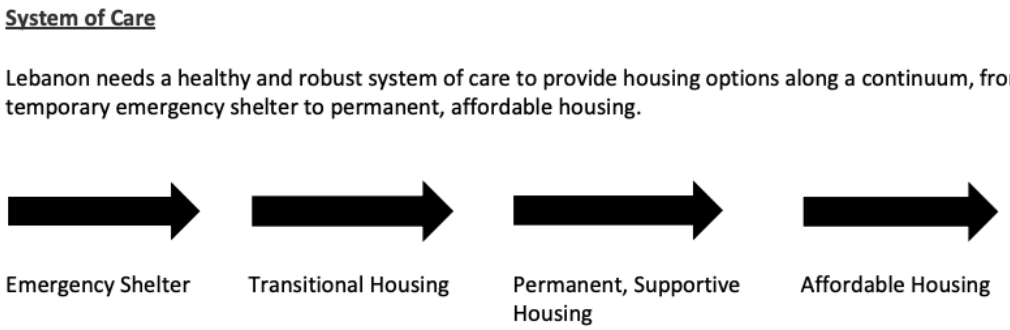

Figure 1: System of Care continuum from Emergency Shelter to Affordable Housing (Housing First Upper Valley, 2023)

Today, Figure 1 illustrates the range of housing options that should exist within a healthy system of care, from emergency shelter and transitional housing to permanent supportive and affordable independent housing. Rather than representing a single linear pathway, these housing models serve different populations and needs depending on individual circumstances. Together, they represent the framework that Lebanon and other Upper Valley communities can aim to establish for their unhoused populations.

In many ways, the shift towards prioritization of SH reflects a desire to stop the oversurveillance of people with SMI, focusing instead on uplifting and supporting these populations. We characterize effective support as consisting of social, physical, and economic improvements to quality of life. Given the historical context, this conversation must be approached with nuanced, evidence-based approaches focused on the experiences of tenants.

Social Implications

SH has significant implications for social outcomes of populations with SMI, including perceptions of autonomy and connectedness with other community members. We define autonomy as the right to personal freedom and self-governance ascribed by the simple fact of being human. We propose that autonomy is multidimensional and encapsulates physical autonomy (control over one's body and physical movement), emotional autonomy (the ability to safely express and process emotions), and relational autonomy (choice over who one engages in relationships with).

> **Autonomy, and particularly relational autonomy, are particularly crucial to people experiencing SMI.**

Following interviews with policy makers, administrators, and frontline providers, Henwood et al. (2014) reports that SH shifts housing systems to focus on client choice and client-driven decision-making rather than prescriptive care. This enhances physical autonomy through the lens of health. Friendships with togetherness and depth were considered relevant to both emotional and relational autonomy. Tjornstrand et al. (2020) reports that proximity to other residents created friendship and togetherness, and patients felt that staff were safe to confide in. Notably, enforced togetherness was negatively received due to the possibility of proximity to residents that were feared, and as a result, the ability to decline participation was important to residents. These findings indicate that the prioritization of relational autonomy in an SH setting improves the associated social outcomes.

Riha (2016) substantiates this further, explaining that despite the quality of housing, people with SMI cited relationships with the housing staff and other residents as having a substantial impact on quality of life. Satisfaction was also impacted by the surrounding community.

Conversely, a 2010 literature review reports that while SH represents an improvement in autonomy from custodial housing, both models still limit resident autonomy and control (Nelson, 2010). We propose that lingering limitations in autonomy reflect historical trends of institutionalization and the sequestering of people with SMI from the broader public.

Thus, our research suggests that in order to maximize the emotional health improvements under SH, models must emphasize autonomous socialization with other tenants and prioritize hiring well-trained staff capable of providing emotional support. Provided that these conditions are met, it is likely that SH improves the socialization, relational autonomy, and emotional autonomy experienced by people with SMI.

Physical Health Implications

SH has profound potential to improve physical health outcomes for populations with SMI, affecting both individual well-being and broader public health systems. We define physical health as not merely the absence of disease, but as a multifaceted concept encompassing proper physiological functioning, balanced lifestyle choices, and access to supportive medical care. These dimensions are often neglected in populations with SMI, and we underscore that physical and mental health outcomes are deeply intertwined. Accordingly, the extent to which SH improves physical health depends on its ability to address these dimensions in a comprehensive and individualized manner.

In a review of how SH affects vulnerable populations, Dohler et al. (2016) highlight why SH is more effective than affordable housing alone in improving physical health outcomes. While a lack of stable housing can significantly worsen health, the absence of supportive services can prevent individuals from maintaining their health even after being housed. Access to services such as dietary support and medication management shifts reliance away from emergency care and toward outpatient services, in part by preventing the exacerbation of chronic health conditions. Aubry et al. (2015) reinforce these findings in their review of the literature on Housing First for homeless individuals with SMI. They similarly report that HF can promote reduced use of emergency services and hospitalizations, but emphasize that these improvements depend on tailored, individual-targeted support.

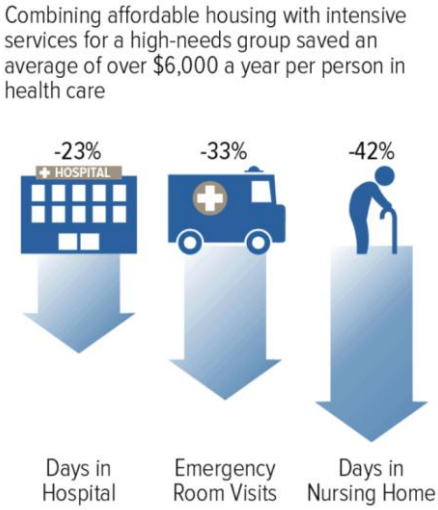

Figure 2: Reductions in healthcare utilization associated with supportive housing (Center on Budget and Policy Priorities, 2012)

The economic impact of these health improvements is substantial. As illustrated in Figure 2, supportive housing, combining affordable housing with intensive services, can reduce hospital days by 23%, emergency room visits by 33%, and nursing home days by 42% for high-needs populations. These reductions represent an average savings of over $6,000 per person annually in health care costs alone. However, this policy is complicated by the unique needs of the specific communities being served.

Reflecting on this limitation, Stefancic et al. (2013) argue that although SH has the potential to address physical health needs, its effectiveness in practice is more complex. One of the greatest challenges lies not merely in providing care, but in enabling individuals with medical conditions to manage their health and navigate healthcare systems, especially if they have had limited experience engaging with formal care.

Ultimately, these findings indicate that SH models are most effective in improving physical health outcomes when they combine individualized care with support that enables individuals to adopt and sustain that care. The literature suggests that access to housing and health services is foundational but insufficient alone. Physical health improvements depend on individuals' ability to engage with and consistently utilize these resources, stressing the central role of the "supportive" component within SH models.

Stability and Economic Value

The absence of SH imposes significant costs on both individuals with SMI and the communities in which they live. SH not only benefits those being housed by providing security, but also translates that increased stability into broader economic benefits. We define stability as a long-term condition in which individuals maintain safe, permanent housing without the threat of disruption. We propose that stability generates economic value, a multidimensional concept ranging from individual financial security to public expenditure savings. Thus, housing stability and economic value are mutually reinforcing, as the extent to which SH creates economic value depends on its ability to produce sustained stability.

Aubry et al. (2015) provide evidence for this relationship, demonstrating that HF dramatically improves housing stability among individuals with SMI. In a two-year study of adults with SMI and a history of homelessness, HF participants spent 73% of their time in stable housing compared to 32% among treatment-as-usual participants, highlighting the impact of immediate permanent housing on stability. Pathways Vermont, a nonprofit organization with a Permanent Supportive Housing program, further substantiates this relationship through program data (Stefancic et al., 2013). Over the past eight years, the organization reports an average housing retention rate of 85% and estimates that the daily cost of enrollment is approximately $57, significantly lower than the $97.47 daily cost of homelessness. These benefits extend beyond the populations directly served. Pathways Vermont also describes how increased housing stability helps break the institutional circuit between crisis services, state institutions, and the streets, a cycle that undermines individual well-being and generates high costs for public resources (Stefancic et al., 2013). A second economic consequence related to people with SMI is the cost of incarceration. A 2016 report estimated that approximately 20% of inmates in jails and 15% of inmates in state prisons are now estimated to have a serious mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009). This is likely reflective of periods in which people with SMI are symptomatic and untreated or due to self-medication with illegal substances.

The effectiveness of SH in producing long-term stability is partially contingent on the availability of affordable housing, which is a widespread structural issue across communities in the United

States. For instance, in the 1980s, New York City alone lost over 100,000 low-cost housing units due to processes such as gentrification and urban renewal (Farkas & Coe, 2019). This illustrates that structural factors can influence not only whether housing is obtained, but also whether it provides sustained stability and economic value over time. This is not just a historical phenomenon– the US Chamber of Commerce writes that there is currently a shortage of over 4.7 million homes, fueled by an ever-widening gap between supply and demand. This has created substantial impact, including skyrocketing prices and reduced workforce mobility (Hoover & Lucy, 2026).

Therefore, maximizing the economic benefits of SH at both individual and community levels is contingent on its capacity to produce long-term stability. SH models are most effective when they prioritize permanent housing without preconditions, as such security establishes the stability necessary to generate economic value.

The Role of Case Management

Case management (CM) services assist patients or clients in developing a plan that concurrently addresses healthcare and psychosocial needs. The primary goal of CM is to streamline the challenges associated with a disjointed healthcare system that is not well-tailored to high-risk populations (Giardano & De Jesus, 2023).

For people with SMI that lack supportive family members or financial resources, CM is crucial in accessing stable housing, obtaining employment, and gaining consistent access to healthcare services. As a result, case managers can be instrumental in helping people with SMI access SH, and CM may be embedded within SH to enhance the transition to independent living.

CM exists in a wide range, including standard case management (SCM), intensive case management (ICM), assertive community treatment (ACT), and critical time intervention (CTI). Previous research demonstrates that SCM is particularly effective in obtaining housing stability and that CTI is promising for people with substance use disorders or people with mental illness (de Vet et al., 2013). Thus, if CM models are considered for incorporation into a proposed SH model, these sub-types should be prioritized.

Examining the Upper Valley

SMI in the Upper Valley

The Upper Valley consists of four counties, two each from Vermont and New Hampshire. Orange and Windsor counties are located in Vermont and Grafton and Sullivan Counties are across the river in New Hampshire. Due to the bi-state nature of the region, it is challenging to find data specific to the area. Most data is for just Vermont or just New Hampshire, and often is for the entire state, not just one county. There are also unique challenges for implementing programs within the Upper Valley as there are two different state governments that need to be involved.

Serious mental illness is a major factor influencing ongoing housing crises in the United States, with one in five adults experiencing any mental illness and one in seventeen with a severe condition (National Institute of Mental Health, 2024). SMI is a major risk factor for housing instability due to difficulties maintaining employment and discrimination.

SMI seriously impacts people's ability to find adequate housing: 76% of homeless individuals nationwide have a current mental disorder, and around 30% experience SMI (Gutwinski et al., 2021).

In New Hampshire, 66,000 adults (National Alliance on Mental Illness, 2025) have an SMI, and 1 in 4 of the over 2,000 people experiencing homelessness in NH have an SMI. In Vermont, 35,000 adults have a SMI, and 1 in 5 of the over 3,000 people experiencing homelessness have an SMI (NAMI, 2025). A large proportion of individuals in both states experiencing homelessness also experience SMI.

In the Upper Valley, Orange County, VT experienced the second highest rate of clients served per 1,000 age-specific population of adults treated for SMI out of all Vermont counties with a rate of 4.8. Out of all Vermont adults experiencing SMI, 236 received housing services with an average of 254 housing service days per client. For the condition of clients upon termination of services for adults with SMI, 48% were improved and 43% were unchanged (Vermont Department of Mental Health, 2025).

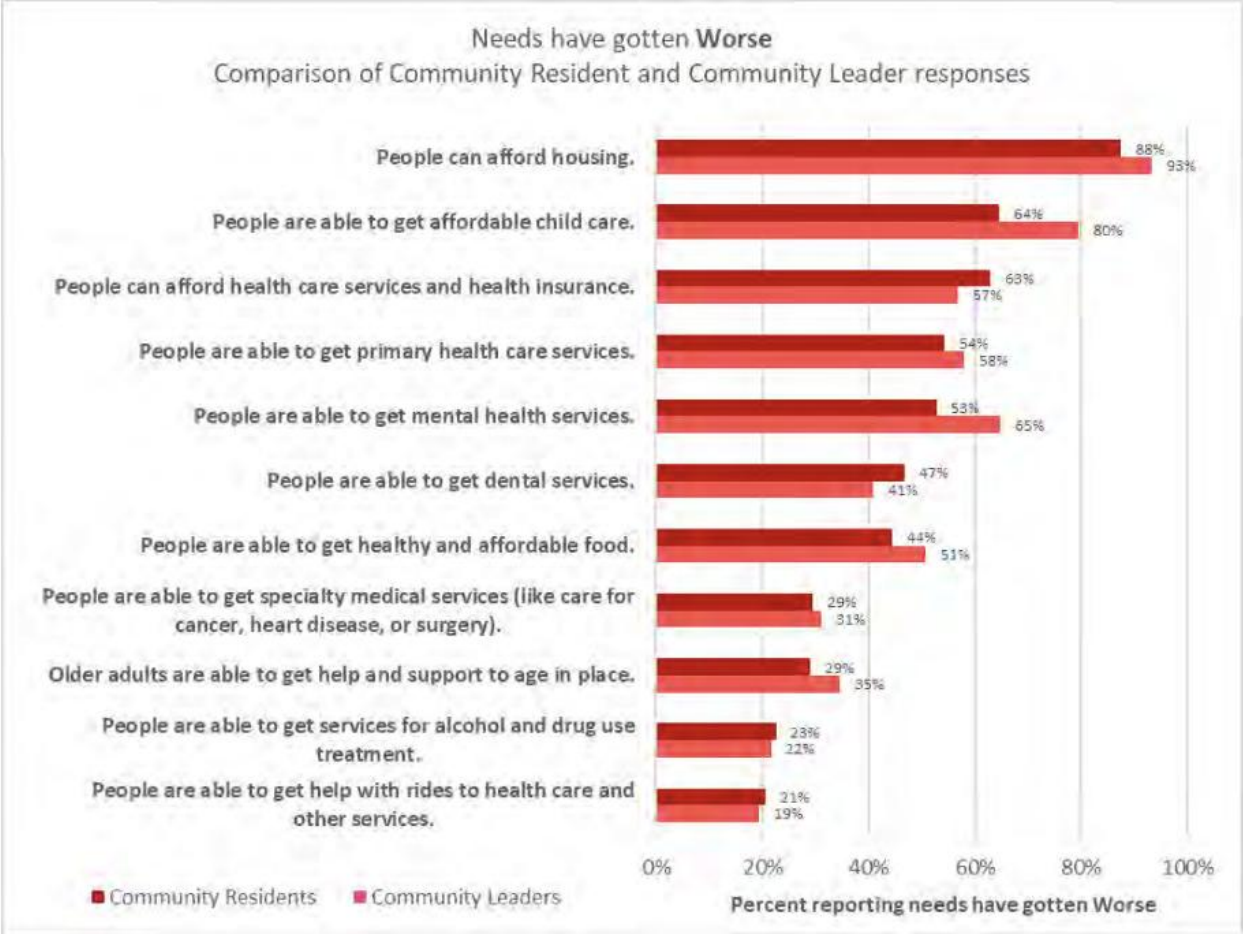

Figure 3: Community perspectives on worsening needs in housing affordability and mental health access (DHMC Community Health Needs Assessment, 2025)

Community perceptions within the Upper Valley reflect the structural pressures. A 2025 Dartmouth-Hitchcock Medical Center community health needs assessment found that both housing affordability and mental health access were consistently identified as worsening regional concerns (Figure 3). According to the report, 88% of respondents stated that housing affordability had worsened over the past several years, while 35% reported difficulty accessing mental health care services (Dartmouth-Hitchcock Medical Center, 2025). More broadly, 75% of respondents experienced difficulty accessing at least one form of health care. Community leaders similarly identified affordable, safe housing (79%) and mental health-informed emergency response systems (51%) as leading priorities for regional investment (Figure 4). Together, these findings suggest that housing instability and inadequate mental health infrastructure are increasingly understood not as separate issues, but as interconnected dimensions of regional vulnerability.

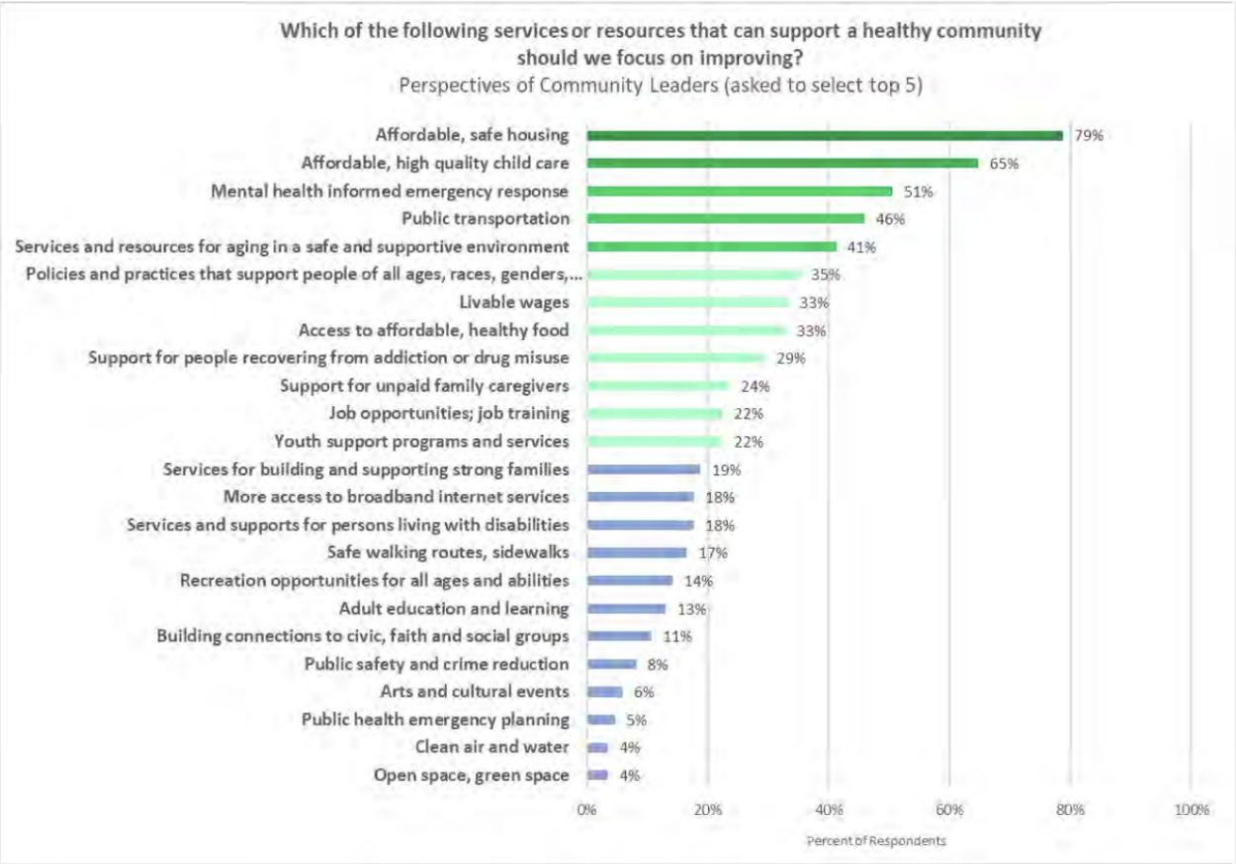

Figure 4: Leadership priorities for supporting a healthy community (DHMC Community Health Needs Assessment, 2025)

The Upper Valley exhibits specific bottlenecks as a rural community, including long waiting lists at community mental health centers and barriers such as transportation, insurance gaps, and workforce shortages. Together, these gaps in treatment access and housing availability create a cycle in which individuals with SMI are at significantly higher risk of housing instability and prolonged homelessness. Addressing the housing crisis, therefore, requires not only increasing affordable housing but also expanding mental health care capacity and continuity, particularly in underserved regions like the Upper Valley.

Existing Resources and Unique Barriers

Per New Hampshire state statute RSA 165, "whenever a person in any town is poor and unable to support [themself], [they] shall be relieved and maintained by the overseers of public welfare of such town, whether or not [they] have residence there" (Title XII: Public Safety and Welfare, 2023) In Lebanon, the Human Services Department serves as the local overseer of public welfare, serving as a primary contact for residents in need of shelter. Other New Hampshire

municipalities similarly designate an overseer of public welfare, while Vermont administers comparable services statewide through its Economic Services Division.

From Lebanon Human Services, which receives a disproportionate number of inquiries from unhoused individuals and families compared to neighboring NH communities, qualifying households receive temporary motel assistance in the absence of appropriate shelter availability. From there, individuals and families take the necessary steps to secure permanent housing, which may include securing income and applying for affordable housing. SMI complicates this otherwise straightforward process, with consequences for both the Department and the individuals it serves. Responsibility frequently shifts onto external actors such as family members and case workers, while behavioral symptoms can make people with SMI less competitive applicants in an already constrained rental market. In an interview with Lebanon Human Services Deputy Director, Rebecca Desilets, the limited number of landlords in lower Grafton County compounds this problem: individuals who lose housing due to behavioral symptoms may move through multiple landlords in rapid succession, depleting the small pool of willing housing providers and eventually exhausting their options for shelter. Limited income, reliance on Social Security benefits, and functional barriers to employment further complicate these circumstances.

Desilets notes that trends in motel assistance illustrate how dramatically the Department's role has expanded in recent years. Prior to the COVID-19 pandemic, motel assistance was relatively limited, accounting for an average of 6% of the Direct Assistance Budget between 2014 and 2019—and 8% in 2019 alone—reflecting the greater availability and affordability of rental housing in the Upper Valley during that period. The pandemic significantly shifted the housing landscape, prompting the establishment of the New Hampshire Emergency Rental Assistance Program (NH-ERAP), which supported the placement of individuals and families in motels between 2021 and April 2023. As NH-ERAP began to phase out in 2023, the Department assumed a central role in managing housing placement, with motel assistance rising to 63% of its Direct Assistance Budget in 2024 and 2025, and to 72% in Q1 2026. As Desilets explained, individuals with severe and persistent mental illness "tend to need motel assistance, rather than shelter due to the severity of the behavior," and are often assisted for longer periods because of additional barriers to securing stable housing.

A diagnosis of SMI is only one component of the challenges individuals face in securing stable, permanent housing; they also encounter a range of relational and logistical barriers. Many have extensive eviction histories and struggle to obtain positive landlord references due to behavioral symptoms associated with their conditions. These same symptoms can lead to involvement in the criminal justice system, adding another layer of housing instability. Compounding these issues, many individuals with SMI are unable to maintain employment and must rely on

Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Desilets notes that the Lebanon Department of Human Services, SSI provides up to $994 per month in New Hampshire, while median apartment rents approach $1,985—a gap of nearly $1,000 between maximum benefits and typical housing costs. (New Hampshire Housing, 2024) The Upper Valley's status as a highly desirable rental market further disadvantages these individuals: when landlords can select among multiple applicants, they tend to apply more rigorous screening criteria, and despite fair housing protections, applicants with SMI are even less likely to be selected.

Beyond these individual-level barriers, the Upper Valley's fragmented service system creates additional obstacles. The region contains a variety of agencies, each with different jurisdictions, funding sources, and areas of expertise. Because the presentation of mental illness varies widely across individuals, this fragmentation makes it difficult to provide consistent and effective support. Lebanon, for example, has a relatively high number of psychiatrists but a shortage of therapists, limiting the local continuum of care available. Moreover, nonprofit agencies operating without state funding are not contractually obligated to or are not licensed to provide certain services, and smaller shelters are often restricted by contract from managing medications for residents. Shelly Golden, the Grafton County Mental Health Court Coordinator, explains that transportation likewise varies across providers: while some, such as the Lakes Region Mental Health Center, operate dedicated van systems to transport clients to and from their facilities, comparable accommodations are not consistently available among Upper Valley providers, leaving transportation a significant barrier to accessing mental health care. Moreover, inconsistent transportation networks jeopardize the ability for probationary individuals to attend and receive credit for court-ordered therapy and support programs.

In addition to these systemic constraints, providers themselves face significant challenges. Staff working under psychologically demanding conditions may experience considerable physical and mental exhaustion, particularly when they lack adequate training. This strain is made worse by the fact that staff often feel unable to stop working with clients who display aggressive or controlling behaviors — because doing so could mean those clients lose their housing. Notably, when individuals with SMI have children, providers and case workers may extend additional flexibility to keep the family housed, given the heightened consequences of eviction for dependents. The West Central Behavioral Health six-bed program illustrates how, even when resources exist, they may be rendered ineffective by staffing limitations. Although the program was designed to provide transitional housing and case worker support while individuals sought more permanent arrangements, it never reached full capacity—operating with only two apartments before dissolving due to insufficient case worker capacity.

Rural settings introduce a distinct subset of challenges. Mental health in the context of housing requires deep trust with staff. Case in point, Rob Waters, a shelter administrator at the New Hampshire Bureau of Homeless Services, notes that individuals are often more willing to disclose substance use than mental health conditions, making close relationships with shelter staff crucial to identifying and addressing mental health needs. In rural areas, however, he notes that limited staffing and a shortage of credentialed professionals impede the development of these relationships, delaying diagnosis and appropriate care. Erik Becker, TCCAP's Housing Stability Director for Lancaster, New Hampshire, similarly noted that acute psychiatric care capacity remains limited even at major hospitals, including Dartmouth-Hitchcock Medical Center and facilities in Portsmouth, Franklin, and Concord.

Relocating rural individuals to shelters can also create a tradeoff, separating them from existing support systems such as family members and community organizations. Becker notes that this is particularly consequential for individuals with SMI under power of attorney, who cannot sign certain consent forms or access aid programs without guardian representation. More broadly, dependent individuals often rely on a parent, partner, or other companion to meet essential financial, legal, and medical obligations. When a caregiver dies, the dependent may be left without adequate support—an issue that is becoming increasingly common as New Hampshire's population continues to age.

While it remains true that there are a variety of mental health resources, the 'weakest links' in the chain of recovery processes are coordination problems: physical accessibility, access to trusted staff members, and few landlords willing or able to address this shortage of housing. In the next section, we discuss some of the stakeholders found in the recovery gaps; we will further contextualize these broad challenges in recovery by introducing the fuller ecosystem of agents who might assist or interact with individuals with SMI.

Stakeholder Analysis

Dartmouth-Hitchcock Medical Center Emergency Department

The lack of alternative care and case management for people with SMI results in overburdening of emergency departments that are already stretched thin. Adults in rural geographies often have difficulty accessing outpatient care, and this results in increased reliance on ED care (Gettel et al). We propose that by establishing secure, supported housing for people with SMI, the pressure on the DHMC Emergency Department is likely to decrease.

There are two likely reasons for SMI-related overburdening of EDs– 1) frequent visits as a result of health concerns, and 2) inability to discharge SMI patients.

Across the United States, the CDC reports 18% of mental-illness-related emergency department (ED) visits result from bipolar disorder and schizophrenia alone, both of which fall under the umbrella of SMI. Moreover, social support is crucial for the maintained physical and mental health of people with SMI, and this support is often limited. It is no surprise, then, that psychiatric patients who visit EDs are more likely than their non-psychiatric counterparts to visit the ED again within 30 days (Madsen et al). We suggest that by producing a safe home environment where staff support is readily available, patients with SMI may be more likely to seek psychiatric support elsewhere. In the above sections, the crucial relationships built in supportive housing are described at length, and these relationships and routines are crucial for the success of patients with SMI. Moreover, when the SH combines individualized care with emotional support that empowers individuals to adopt and sustain care, SH has the potential to improve physical health. Thus, under an SH model, it is possible that ED visits of people with SMI will decrease.

Discharge of SMI patients is complicated. Hospitals are legally required to release patients in their care into a safe environment (Capouellez), but when it comes to patients struggling with SMI, this can be difficult to guarantee. Transition to outpatient care, including case management or scheduling of psychiatric appointments, is often fragmented and disorganized. SH models often include staff members equipped with knowledge of case management, and most importantly, the SH provides a safe place for a patient to recover from an ED environment. In a world with widespread SH accessibility, providers are more comfortable releasing patients into experienced staff members' care, and outpatient care needs are fulfilled by the robust SH support system.

Furthermore, a report from the American College of Emergency Physicians describes that psychiatric patients often experience worsened symptoms as a result of the loud, hectic environment of the emergency room, and providers describe feeling inexperienced with psychiatric care. When a provider who does not feel comfortable is paired with a patient that is getting worse because of the environment they are in, symptom improvement and discharge become very unlikely. Keeping patients with SMI out of the ED helps patients and providers alike.

Law Enforcement

Law enforcement is a critical component of understanding the homeless crisis: They are involved in responding to encampments, welfare checks, overdose and mental health calls, and coordination with shelters and outreach workers. Police agencies often support housing

initiatives because stable housing can reduce repeat emergency calls, jail cycling, public disorder complaints, and emergency room use. Insufficient shelter and housing increases pressure on emergency responders and law enforcement because unsheltered people are more likely to experience crises outdoors (Upper Valley Haven, 2023). A strong case study on law-enforcement and community collaboration: Lebanon established a formal "Task Force on Homelessness" in 2016, which included the police chief, city officials, service providers, and nonprofits. The group focused on encampments, liability, property use, and connecting people to services, but has since fulfilled its task and disbanded. However, the challenge is far from over. During the summer of 2023, Lebanon officials reported more than 36 unhoused individuals identified locally.

Community Members

The reduced impact on both Dartmouth-Hitchcock Medical Center Emergency Department and local law enforcement directly ties into benefits for general community members due to reduced public costs. Housing first initiatives have been shown to outweigh their costs. The median cost of implementing these programs is roughly $16, 479 per person per year while the median benefit was about $18,247 per person per year, with some variation depending on the location and study (Jacob et Al, 2022). Across all US studies, the median benefit-to-cost ratio was 1.8:1 (Jacob et Al, 2022).

After implementing a housing first program, the city of Charlotte, NC saved $2.4 million over the course of a year. Savings were primarily in the categories detailed over. Tenants spent 1,050 fewer nights in jail, 292 fewer days in the hospital, and had 648 fewer emergency room visits (Charlotte Urban Institute, 2020). Similar findings were reported in other locations that implemented housing first initiatives.

Serious mental illness comes at a large economic cost. One Indiana study found that untreated mental illness led to $4.2 billion in annual societal costs, with $3.3 billion in indirect costs, $708.5 million in direct healthcare costs, and $185.4 million in non-healthcare costs (Taylor et al., 2023). These costs also include the criminal justice system, as mentioned above. One survey found that 10% of law enforcement budgets and 21% of officer time is spent addressing individuals with severe mental illness. Furthermore, a disproportionate number of individuals in the criminal justice system experience serious mental illness (Bausch et al., 2021); in a country where the average cost to incarcerate one person is $33,000, with a much higher number of $57,615 in Vermont (Vera, 2025), this means that serious mental illness significantly impacts taxpayers in ways that an investment in housing first could address.

Housing first initiatives improve housing stability in communities. In an analysis of 26 studies, housing first programs were shown to be vastly more effective in community stability over treatment first programs. Housing first programs decreased homelessness by 88% and improved housing stability by 41% (Peng et al., 2020). Furthermore, 79% of individuals in housing first programs remained stably housed at the end of 6 months as opposed to 27% of the control group (Tsemberis et al., 2004). Keeping people stably housed improves community security.

Furthermore, it is estimated that nationally, 80% of people with serious mental illness are unemployed (Bausch et al., 2021). Lack of housing offers significant barriers to employment: no address to register for a bank account or receive paychecks, difficulty with internet access to search for jobs, transportation challenges, and challenges receiving mail and therefore tax documents or identification management; all of which would be made easier with housing first support. The impact of this is twofold; first, it is of course best for the individual living with serious mental illness's wellbeing to be able to work, gain financial independence, and experience autonomy. Second, it is best for the economic wellbeing of the community if each member is able to contribute to the economy, and it benefits taxpayers when these individuals are able to get the care they need in order to rely less on public resources. Allowing people with serious mental illness to gain the autonomy they need to contribute to their communities, economically and otherwise, benefits everyone.

Mental Health Treatment Programs

Inpatient Services:

Organization	Location	Services
Dartmouth Hitchcock Medical Center (DHMC)	Lebanon, NH	Adult inpatient psychiatry; adolescent inpatient psychiatry; psychiatric emergency evaluation; medication management; individual and group therapy; consultation-liaison psychiatry; electroconvulsive therapy; transcranial magnetic stimulation
White River Junction VA Medical Center	White River Junction, VT	Inpatient psychiatry; residential mental health treatment; residential substance use treatment; trauma-related treatment; psychiatric medication management for eligible veterans

Chris's Place Crisis Stabilization Program / Clara Martin Center	Randolph, VT	Short-term voluntary crisis stabilization; step-down support after hospitalization; alternative to inpatient hospitalization when clinically appropriate

Outpatient Services:

Organization	Location	Services
West Central Behavioral Health	Lebanon, Claremont, Newport / lower Grafton and Sullivan Counties	Outpatient therapy; psychiatric care; medication management; case management; continuing care; residential supports; emergency mental health services
Health Care and Rehabilitation Services (HCRS)	Windsor County, VT	Outpatient mental health treatment; psychiatric support; case management; substance use treatment; referrals; crisis intervention; support around employment, housing, health, and transportation barriers
Clara Martin Center	Orange County and surrounding Vermont communities	Outpatient behavioral health treatment; psychiatric services; case management; substance use treatment; supported employment; peer support; housing-related support; disability-benefit assistance
White River Junction VA Medical Center	White River Junction, VT	Outpatient psychiatry; medication management; therapy; substance use treatment; trauma-related treatment; care coordination for eligible veterans
Dartmouth Hitchcock Medical Center (DHMC)	Lebanon, NH	Outpatient psychiatry; specialty psychiatric treatment; medication management; therapy; electroconvulsive therapy; transcranial magnetic stimulation
Upper Valley Psychiatry	Hanover, NH	Outpatient psychiatry; medication management; psychotherapy; letters for accommodation

The Upper Valley relies on a combination of inpatient psychiatric care and outpatient community mental health services to support individuals with severe mental illness (SMI). While these systems provide essential psychiatric stabilization and treatment, they are not designed to address long-term housing instability. As a result, individuals with SMI who are unhoused often experience fragmented care, repeated emergency department utilization, and difficulty maintaining long-term treatment engagement.

Inpatient Mental Health Services

Inpatient psychiatric services in the Upper Valley are centered primarily at Dartmouth Hitchcock Medical Center (DHMC) in Lebanon, New Hampshire, which serves as the region's primary psychiatric stabilization and emergency psychiatric provider. Additional inpatient and residential behavioral health services are available through the White River Junction VA Medical Center for eligible veterans, while programs such as Chris's Place Crisis Stabilization Program provide short-term stabilization as an alternative or step-down option to hospitalization.

Although inpatient psychiatric care is essential for acute stabilization, hospitalization alone does not resolve the long-term challenges associated with homelessness and SMI. (Laliberté et al, 2019) found that individuals experiencing homelessness at psychiatric discharge had significantly higher rates of psychiatric readmission and emergency department utilization and were substantially less likely to receive outpatient psychiatric follow-up care. Additionally, involuntary commitments from New Hampshire are then sent to the NH hospital in Concord. This moves patients farther from their support systems. These findings are particularly relevant in the Upper Valley, where discharge planning is complicated by limited affordable housing, transportation barriers, workforce shortages, and fragmented coordination between agencies. Without stable housing, individuals may cycle repeatedly between hospitals, shelters, motels, and crisis systems without achieving sustained recovery.

Outpatient Mental Health Services

Most long-term mental health treatment in the Upper Valley occurs through outpatient and community-based systems. In New Hampshire, West Central Behavioral Health (WCBH) provides outpatient psychiatry, therapy, medication management, and case management services for individuals with severe and persistent mental illness. In Vermont, Health Care and Rehabilitation Services (HCRS) and the Clara Martin Center provide outpatient behavioral health treatment, psychiatric support, substance use treatment, and community-based support services throughout Windsor and Orange Counties.

Despite the availability of outpatient services, maintaining continuity of care remains difficult for unhoused individuals with SMI. (Henwood et al., 2014) found that rural mental health systems

frequently experience fragmented coordination, provider shortages, transportation barriers, and limited service capacity, all of which reduce long-term treatment engagement among individuals experiencing homelessness. These challenges are consistent with conditions identified in the Upper Valley, where stakeholders reported shortages of therapists and case managers, inconsistent transportation access, and long wait times for services.

Research on supportive housing and Housing First models suggests that stable housing may help address these gaps by improving continuity of care and reducing reliance on crisis systems. (Aubry et al, 2015) found that Housing First participants with SMI spent significantly more time in stable housing than individuals receiving treatment-as-usual services, while (Dohler et al, 2016) reported reductions in hospital utilization and emergency room visits among supportive housing participants. Findings from these scholars suggest that stable housing is a critical component of long-term recovery for individuals experiencing both homelessness and severe mental illness.

Conclusions

Ultimately, the evidence reviewed throughout this report demonstrates a strong need for addressing the impact of severe mental illness on housing instability in the Upper Valley through the strategy of supportive housing. Studies show that supportive housing improves physical health outcomes, social wellbeing, and long-term housing stability. Simultaneously, it reduces reliance on emergency departments, shelters, and other costly public systems. These results are especially relevant to the Upper Valley, where rising housing costs, limited rental availability, transportation barriers, workforce shortages, and fragmented mental health services create significant obstacles for individuals with severe mental illness. Interviews with local stakeholders further illuminated the strain on public systems created by the absence of stable housing systems and coordinated support. Ultimately, supportive housing should be understood not only as a housing intervention, but also as a broader public health and community stability strategy. By investing in supportive housing, the Upper Valley has an opportunity to reduce public costs and build a healthier and more resilient community for all residents.

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