

Getting There:

*Helping People With Mental
Illnesses Access Transportation*



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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Contents

Executive Summary	1
Introduction	5
The 5 A’s: Current Barriers Facing Mental Health Consumers	7
Emerging Best Practices for Providing Transportation to Mental Health Consumers	19
Potential Sources of Funding for Transportation Initiatives	35
Recommendations for Developing Transportation Initiatives	41
List of Contributors	43
Resources	45
References	49

Executive Summary



A central goal of the President's New Freedom Initiative is the full participation of people with disabilities in all areas of society. Access to transportation is critical to achieve this goal. People with mental illnesses require reliable transportation to work, access services, shop, learn, worship, volunteer, and make and socialize with friends, as does everybody. However, too many mental health service consumers have unmet transportation needs due to significant barriers that exist in urban, suburban, and rural areas. These barriers can be described as the 5 A's (Adapted from the Beverly Foundation, 2004):

1. **Affordability.** In addition to their mental disability, many mental health consumers face the disabling effects of poverty. Those who rely on Supplemental Security Income (SSI) or other income supports often cannot afford to own a car or even to use public transportation regularly.
2. **Accessibility.** Public transit is becoming more accessible to people with physical disabilities, but many people with mental and other hidden disorders continue to have a difficult time using transit systems. Even specialized transportation programs present difficulties, such as advance scheduling requirements, that limit users' ability to get where they need to go and the freedom to do so as they choose.
3. **Applicability.** In many communities, programs abound for people with unmet transportation needs, but too often, mental health consumers are not eligible. Other programs, for which they are eligible, are available only for limited purposes.
4. **Availability.** Some communities offer few if any transportation solutions; many rural



communities have no public transit. In other communities, public transit schedules greatly limit when and where people can travel.

5. **Awareness.** Many mental health consumers do not know about the transportation opportunities that are available or how to use them.

While many needs remain unmet, transportation initiatives in certain communities and States have successfully addressed some of these barriers. Wider replication of these initiatives could help alleviate transportation problems elsewhere.

Some of these initiatives focus on improving people's ability to use public transit by making it more affordable or by addressing accessibility and awareness issues. Encouraging the use of public transit has many advantages: it is cost-effective, fosters independence, and encourages integration into the community. Examples of public transit initiatives include offering reduced fares, issuing transit passes, and training people to use transit independently. Of course, these initiatives work only in communities with public transit, and many communities either do not have public transit or have only limited transit services.

In areas not served by public transit, community transportation initiatives use a variety of methods to get people where they need to go. Some programs use their own vehicles; others rely on privately owned vehicles or taxis. Some employ consumers and some rely heavily on volunteer drivers. An innovative approach issues vouchers, reimbursed at a flat rate per mile, that allow people to arrange their own transportation.

Coordinating transportation resources is a new trend. Several States, including Florida and Oregon, have established systems that consolidate their transportation services to eliminate duplication and waste, and to get the most from limited resources. In February 2004, the President issued an Executive Order (No. 13330) requiring such coordination at the Federal level.

Since some communities already have many pieces of the puzzle in place, other communities and States can adopt these successful approaches. Additionally, Federal policy can have a major impact on transportation for mental health consumers by encouraging widespread access to public transit; by helping communities create solutions for serving older adults, people with disabilities, and families of low income; and by encouraging States to coordinate their human service transportation programs.





Introduction



The full integration of people with disabilities into our Nation's communities is a primary goal of the President's New Freedom Initiative. In 1999, the U.S. Supreme Court in *Olmstead v. L.C.* held that States should provide community-based services and supports to people with disabilities to enable them to live in the most integrated settings possible. However, for many, community integration is still a dream. Most communities nationwide are still struggling to develop the necessary services and supports. One of the greatest challenges is providing the transportation necessary for people with disabilities to participate in society.

Community integration for mental health consumers and other people with disabilities requires much more than a place to live and outpatient medical services. In *Olmstead*, the Court noted, "Confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." For community integration to occur, people with disabilities must have the opportunity to participate in these important activities. Transportation is the vital link to all of these activities. Therefore, transportation is at the very heart of community integration.

Unfortunately, for many people with disabilities—particularly mental health consumers—obtaining transportation is extremely difficult, although ongoing initiatives seek to improve access. As the President acknowledged in his February 2004 Executive Order (No. 13330), "A broad range of Federal program funding allows for the purchase or provision of transportation services and resources for persons who are transportation disadvantaged. Yet, in too many communities, these services and resources are fragmented, unused, or altogether unavailable."

“(Having) mobility is the only way you can fulfill your recovery. Everyone has the right to access (community-based services and supports), but to have access, you need mobility.”
—Consumer



Since 1999, the Consumer Affairs staff of the Center for Mental Health Services (CMHS) in the Substance Abuse and Mental Health Services Administration (SAMHSA) has held mental health consumer meetings in several Department of Health and Human Services (DHHS) regions to gain input and recommendations from consumers on how to improve publicly funded mental health services. Lack of adequate transportation that limits access to treatment, employment, and socialization is one of the most critical problems identified in the course of those meetings.

SAMHSA/CMHS developed this report in response to the findings, to delineate specific transportation barriers and to discuss ways to address or resolve them for mental health consumers. After existing literature was reviewed, consumers and administrators across the Nation were interviewed (see List of Contributors at the end of this report). The project team chose the key informants after preliminary research and consultations with representatives of both the Federal Transit Administration (FTA) and Easter Seals Project ACTION. Selections were based on the informants' familiarity with transportation issues in urban, suburban, and rural areas throughout the Nation. In addition, information was gathered from several programs identified as offering particularly innovative approaches to providing transportation to mental health consumers and other people considered to be "transportation disadvantaged."

The 5 A's: Current Barriers Facing Mental Health Consumers



The Federal, local, and State governments and transit authorities have attempted to address the transportation needs of people with disabilities by supporting public transit infrastructure and by developing specialized transportation. Dozens of Federal programs support transportation for people with disabilities; key examples are paratransit, Medicaid transportation, and the half-fare program.

Paratransit is a curb-to-curb service offered by public transportation to people whose disabilities make taking public transportation difficult. The Americans with Disabilities Act (ADA) mandates that transit authorities provide this alternative service. In addition, Federal Medicaid regulations require that States ensure that recipients have transportation to covered medical services, and States typically provide curb-to-curb service to Medicaid recipients for visits to the doctor and other medical services. Under the Transportation Equity Act, States that receive transportation block grant funding must offer half-fare prices on non-rush hour transit to eligible individuals. These individuals are older adults, Medicare recipients, and people whose disability interferes with their capacity to use public transportation.

Despite these programs, difficulties in meeting the transportation needs of people with disabilities remain. The President noted in his February 2004 Executive Order (No. 13330):

Transportation plays a critical role in providing access to employment, health care, education, and other community services and amenities. The importance of this role is underscored by the variety of transportation programs that have been created in conjunction with health and human services programs, and by the significant



Federal investment in accessible public transportation systems throughout the Nation. These transportation resources, however, often may be difficult for citizens to understand and access.

For mental health services consumers, the difficulties frequently are compounded because they often are ineligible for programs serving people with other types of disabilities. The transportation barriers that face mental health consumers fall into five categories that can be called the five A's: Affordability, Accessibility, Applicability, Availability, and Awareness (Adapted from the Beverly Foundation, 2004).

Barrier One: Affordability

For many people, cost is the primary barrier to getting from place to place. The cost of owning and operating an automobile, or even the cost of using public transit, can be prohibitive to people living in poverty. Without affordable transportation, the opportunity for full community integration may elude many mental health consumers.

People with disabilities, particularly mental health services consumers, are found in disproportionate numbers in the Nation's lowest-income groups, especially in the group relying on Supplemental Security Income (SSI) payments as their primary source of income. SSI is a need-based cash assistance program administered by the Federal Social Security Administration (SSA). For many mental health consumers, SSI provides a safety net, but recipients still live in poverty. In 2004, the monthly SSI benefit paid to individuals by SSA was \$564; the annual total of \$6,768 is well below the Federal poverty guideline of \$9,310. As disability advocacy groups have reported, "As a national average, SSI benefits in 2002 [\$6,540] were equal to only 18.8 percent of the one-person median household income" (O'Hara and Cooper, 2003). Although some States provide monthly cash supplements

to people receiving SSI, individuals receiving these supplements still live in poverty.

The staggering number of mental health consumers relying on SSI payments reveals the magnitude of the transportation affordability problem. According to 2002 SSA data, over 1.6 million people with mental disorders other than mental retardation received SSI payments. This figure is 34 percent of the nearly 4.8 million people under age 65 receiving SSI. No other category of disability constitutes as large a percentage.



Owning an automobile usually is not within the means of a person relying on SSI for income. According to the Bureau of Transportation Statistics, the average cost of owning and operating a car was over \$7,500 annually in 2002, the latest year for which statistics are available. This amount is more than the annual Federal SSI benefit. It is little wonder that fewer than 20 percent of SSI recipients with disabilities owned a vehicle in 1999.

Public transit and paratransit, although more affordable than owning an automobile, are not necessarily within the financial means of people with disabilities who have very low incomes or who rely on SSI. Even in major urban areas where transit costs tend to be lowest, the cost of monthly transit passes can represent a significant portion of monthly SSI benefits. Here are some examples of monthly transit pass costs: Chicago, \$75; Philadelphia, \$70; Milwaukee, \$56, based on weekly cost; Atlanta, \$53; and Dallas, \$40. In these cities, the cost of transit passes is equal to 7 to 13 percent of the Federal SSI benefit.

In rural areas, transit providers often charge higher fares to cover their costs, making it even more difficult for some to afford. Furthermore, paratransit providers are permitted to charge up to twice the cost of public transit. When they met with focus groups of people with disabilities in rural communities, representatives of the Association of Programs for Rural Independent Living (APRIL) found that “many consumers . . . were



forced to walk, bike, or miss work during extremely difficult travel conditions due to affordability issues” (APRIL, 2003).

Clearly, mental health services consumers need access to affordable transportation. A large proportion have limited incomes, so they are unable to pay for reliable transportation. These circumstances can have a direct impact on their participation in the work force and on their full integration into the community.

Barrier Two: Accessibility

The Americans with Disabilities Act (ADA) mandates accessibility to public transit. Public transit agencies have responded to ADA requirements by making buses and trains accessible to people who are blind, or who use wheelchairs or other mobility aids. However, “[t]he system is less responsive to hidden disabilities,” says consumer advocate Cliff Hymowitz, who lives in Suffolk County, New York. He hopes to make transit systems aware of some of the difficulties encountered by people with cognitive and mental disabilities. As an example, he cites the new transit ticket machines in the New York metropolitan area. Although the machines were designed to be accessible to people using wheelchairs, their operation confused too many people with hidden disabilities, including those with mental disorders,

“Other aspects of the public transit system can pose problems for people with cognitive or mental disabilities,” says Mr. Hymowitz. For example, the signs at bus stops providing route information might be difficult to interpret; all bus stops might not be marked with the same types of signs, making them difficult to recognize. “Most people don’t realize that a person with a hidden disability (might not be able) to venture out and find a bus stop,” he says. Other aspects of fixed-route transit, such as route maps that are difficult to understand, can further hinder people’s ability to navigate the transit system without assistance. Because the accessibility needs of mental health consumers have

not been documented in studies, transit agencies do not have the information they need to respond to these needs in a systematic way.



Federally mandated programs that provide curb-to-curb transportation for people with disabilities often are unreliable and inconvenient. Most curb-to-curb programs require 24-hour to 1-week advance scheduling and generally ask for a 30-minute window during which the rider is expected to be ready to travel. These requirements often limit the flexibility of the rider's lifestyle. In the words of one State transit planner, "I don't (always) know what I am doing a day from now, and to subject another segment of the population to this requirement is a little paternalistic." He and other transit planners, as well as disability advocates, think that if mainstream transit were more affordable, accessible, and widely available, much of this inconvenience could be eliminated.

The transit system has provided accommodations that may address the needs of people with disabilities, but not the needs of mental health consumers. Transit agencies have not documented the accessibility needs of these consumers, whose limitations are hidden and are not so well defined. Further, Federal programs are not always responsive to the needs of people with disabilities. Transit planners and disability advocates believe that making transit more affordable, accessible, and available could meet many of those needs.

Barrier Three: Applicability

Federal, State, and local governments have created many programs to address transportation affordability and accessibility for people with disabilities. Unfortunately, as one advocate observed, although the Federal Transit Administration (FTA) provides funding for older adults and people with disabilities, many communities offer varied transportation options for older adults but very limited options for younger people with disabilities. If transportation options for people with disabilities do



“Mental illness is the least likely reason for people to apply for paratransit. Most often, people (who have mental illnesses) are not eligible.”
—Metropolitan area transit authority official

exist, mental health consumers often cannot demonstrate that they meet eligibility requirements. These requirements, rather than being based on financial need, may be based on whether consumers can use public transit without assistance. Even some programs serving mental health consumers are not always available to help them for shopping, education, employment, social visits, and other activities central to integration into the fabric of the community. For example, people participating in vocational rehabilitation programs might have access to transportation for employment-related purposes, but not for social events, advocacy groups, or peer support.

Three major federally established programs implemented by local and regional transit authorities, in particular, present applicability barriers for mental health consumers. These are paratransit, the half-fare program, and Medicaid transportation.

Paratransit. Many mental health consumers considered disabled under the ADA or Social Security guidelines nonetheless are not considered eligible for paratransit programs. Under Federal law, a person with a disability qualifies for paratransit service if he or she “is unable, as the result of a physical or mental impairment (including a vision impairment), and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from [a] vehicle” such as a bus or train (49 C.F.R. §37.123).

Unfortunately, making eligibility determinations is complicated by a lack of clear standards to determine the ability of mental health consumers to ride transit without assistance. According to one transit official, no real assessment tool exists to determine whether someone is unable to use public transit as the result of a mental disability. Although many mental health consumers can ride transit unassisted and, therefore, do not meet the Federal standards for paratransit eligibility, the lack of clear standards increases the likelihood that some people fall through the cracks. People applying for paratransit often are given a “functional assessment” that measures

their ability to ride transit. Frequently, the Functional Assessment of Cognitive Transit Skills (FACTS), a test developed and validated for people with mental retardation, is used to measure the transportation abilities of mental health consumers. While FACTS might identify obstacles such as disorientation, confusion, or inability to navigate the system, it is less likely to identify problems associated with agoraphobia, anxiety, or panic attacks, which can impair a person's ability to use public transit.

The Half-Fare Program. Eligibility for the half-fare program is subject to difficulties similar to those found in the paratransit program. Many people considered “disabled” for other purposes, including many of those whose disability qualifies them for SSI payments, nevertheless are ineligible for half-fare on public transit. According to Federal law, half-fare is mandated for: individuals 65 and older, Medicare recipients, and “individuals who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are nonambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected” (49 C.F.R. § 609.23). This is a much narrower definition than the eligibility criteria for Medicaid and SSI.

Under Federal regulations, a person with a disability who receives Medicaid and SSI might not be eligible for the half-fare program, while a person with an identical disability who receives Medicare automatically qualifies. Further, a person who uses a wheelchair automatically qualifies regardless of his or her income, while a mental health consumer who struggles to subsist on SSI payments might not qualify. Some people have criticized what they perceive to be discrimination against people with certain disabilities, particularly mental disabilities.

Federal regulations do allow transit authorities to use a broader definition of disability, but many continue to



“I don’t see the reason why only ‘transportationally disabled’ people qualify for a Federal program. Every other definition of ‘person with a disability’ is inclusive, and we don’t tolerate discrimination among disabilities (in the services we provide).”
—Service provider



“Transportation providers in a lot of places go right by the house of someone who needs a ride, and (then) Medicaid sends a taxi 20 miles (to pick up that same person).”
—Advocate

use the narrow Federal definition. In these jurisdictions, many mental health consumers remain ineligible for half-fare discounts because they cannot demonstrate that their disability impairs their ability to use transit.

Medicaid Transportation. Many mental health consumers do qualify for at least one transportation program mandated by Federal regulations: Medicaid transportation. However, this program presents a different type of applicability limitation—the transportation is available only for limited purposes. To ensure that Medicaid recipients can access the medical services covered by the program, States provide transportation to and from services covered by Medicaid. Unlike paratransit and half-fare programs that are available for any and all purposes, the scope of Medicaid transportation is very limited. Advocates are quick to point out that Medicaid transportation is not available for many services critical to a person’s recovery, such as consumer-run drop-in centers and mental health services not covered by Medicaid. Similarly, Medicaid transportation is unavailable for many purposes necessary for community integration, such as getting to and from home, shopping, and social events.

The result of this patchwork of transportation programs is the inefficient use of existing limited resources available for transportation. One advocate blames conflicting funding rules: Transportation providers funded by a State department of transportation must charge Medicaid the actual cost of service, often higher than the discounted rates the provider normally charges. However, Medicaid rules prohibit charging more for Medicaid transportation than for other forms of transportation. The result, she says, is that State-funded transportation providers that offer discounted fares would have to charge everyone a higher rate to accept Medicaid clients, which they choose not to do. This leaves Medicaid clients no choice but to use providers that charge the higher rates reimbursed by Medicaid.

Difficulties such as these are common. A study conducted by the U.S. General Accounting Office

(GAO) in 2003 concluded that in many areas, Federally funded transportation services were “overlapping, fragmented, or confusing” (GAO, 2003).

Barrier Four: Availability

In many areas, public transit is not available at all; therefore, people who cannot afford their own vehicles have extremely limited transportation options. Mental health consumers, especially those relying on SSI or with limited income, are disproportionately unable to afford their own vehicles. According to the Association of Programs for Rural Independent Living (APRIL), the problem is especially severe in rural areas:

For 41 percent of rural residents, there’s NO public transportation available at all. Another 25 percent live in areas where public transportation is extremely inadequate, providing fewer than 25 trips per year for each household without a personal vehicle. Lack of transportation is one of the most frequently cited problems facing people with disabilities living in rural areas (APRIL, 1998).

Even in places served by public transit, transportation might not be available at the times needed, or to and from needed destinations. Betty Newell, board president of Community Association for Rural Transportation (CART) in Rockingham County, Virginia, notes, “People’s lives don’t stop and start at the county line and don’t start at 8:00 a.m.” In her semi-rural county, CART provides rides when and where people need them, but in most rural communities, transportation options are severely limited by both time and place.

Because of insufficient public transportation, many mental health consumers are unable to access needed services. This inability can have dire consequences, according to the National Association for Rural Mental Health (NARMH). An article in the group’s newsletter relates the story of one Vermont woman: “[B]ecause of her remote residence, she was too far for the day service



“If a person wants to attend a social event at night, he or she is probably out of luck. Even when advocacy groups meet at night, (many) people can’t get there.”
—Service provider in a rural area



program or for more than limited visits from a case worker. She returned again and again to the hospital and to community care homes, unable to become independent” (Donahue, 2000).

Barrier Five: Awareness

Even in communities with transportation options, many people miss out on the limited opportunities available to them because they don’t know the options or the fact that they are eligible for the services. Part of the problem is a lack of outreach to mental health consumers. An advocate for people with disabilities noted, “People with mental illnesses are the most underserved because they’re invisible (to many transportation providers).” Several providers of flexible transportation for people with disabilities noted that they received calls requesting rides that were readily available from other sources. For example, some people requested rides for dialysis, even though the rides could have been paid for by Medicaid. Others requested rides, despite being eligible for transportation for older adults.

People who train mental health consumers to use transit independently note that efforts to increase consumer awareness of transportation options are sometimes complicated by competing interests. For example, a treatment program that provides billable services can maintain attendance levels by transporting people using the program’s vans, instead of by encouraging consumers to learn to use transit independently. In other cases, consumers’ family members have expressed safety concerns about consumers’ use of public transit, fearing that they might get lost or become the victim of a crime. Travel trainers note that sometimes these concerns motivate people to steer consumers away from available travel training programs, so trainers often must be persistent in their efforts to recruit participants.

Even the best-run, most easily accessible transportation options available cannot help the mental health consumer who is unaware of them.

In short, these barriers to transportation are barriers to independence and community involvement for many, and they need to be addressed:



- **Affordability.** Keeping the cost of transportation within the means of consumers, even those who are living in poverty.
- **Accessibility.** Creating accommodations to be appropriate for mental health consumers.
- **Applicability.** Ensuring that hidden disabilities are recognized and addressed within both eligibility requirements and actual transportation services.
- **Availability.** Creating transportation options where none currently exist.
- **Awareness.** Ensuring that the information is in the hands of the people who most need it.

Although existing programs have a good start at providing greater freedom of movement and access to transportation for people with disabilities, the issues that specifically affect many mental health consumers remain. Identifying these issues is the first step to addressing them.



Emerging Best Practices for Providing Transportation to Mental Health Consumers



Despite the many transportation barriers facing mental health consumers nationwide, consumers in some communities have some or all of their transportation needs met through innovative programs. A number of these emerging best practices address the five barriers of affordability, accessibility, applicability, availability, and awareness.

This chapter describes initiatives that take advantage of existing transit opportunities. These programs may expand the transit system’s half-fare program, issue transit passes to Medicaid recipients, or provide travel training to people with disabilities. Next, other programs, such as consumer-run transportation, volunteer-augmented programs, and voucher programs, which focus on providing transportation in situations in which transit is unavailable, are profiled. Finally, State programs that have coordinated all publicly funded transportation resources to maximize efficiency are discussed. More information about the transportation programs profiled is available directly from the programs or through the national technical assistance centers listed in the Resources section at the end of this report.

Expanding Access to Public Transit

- **Expanded Half-Fare Programs**
- **Medicaid Transit Passes**
- **Travel Training**

Many local communities and States have worked hard to expand the use of public transit—such as buses, trains,



and subways—by people with disabilities. Often, health care and social service providers distribute transportation tokens that people can use to travel to medical or rehabilitation services. Other communities have enabled people with disabilities to use public transit for whatever reason they see fit. This approach encourages people with disabilities to seek and obtain employment, go shopping, attend school, participate in social activities, and attend support group meetings. Broad access to public transit helps people with disabilities become part of their communities, in the true spirit of the U.S. Supreme Court’s *Olmstead* decision, and the President’s New Freedom Initiative.

Programs that expand access to public transit have many advantages according to the Federal Transit Administration (FTA), part of the U.S. Department of Transportation. Public transit agencies benefit by increasing their revenues through increased ridership. In fact, allowing unrestricted access to public transit boosts ridership at non-peak hours—such as during evenings and weekends—when many seats are unused. Therefore, the transit agency benefits financially without having to increase capacity. Bolstering public transit in this way helps not only people with disabilities but also the community at large.

Agencies and government programs also save money when they enable people to use public transit instead of special vehicles. Expansion of public transit benefits people with disabilities by allowing them greater mobility and independence. People can ride when and where they want to, without the worry of making reservations in advance for rides that can be taken only for limited purposes. They can ride public transit alongside other members of the community, rather than being segregated by specialized transportation (FTA, 2004). Of course, the major shortcoming of these initiatives is that they demand the existence of public transit in a community.

Expanded Half-Fare Programs. Expanded half-fare programs, enacted by State law or by local or regional transit authorities, increase the availability of reduced

transit fares beyond that required by Federal law. Whenever a public transit authority receives Federal funds, it must offer a half-fare program for off-peak hours on trains, subways, and buses to qualified people with disabilities. Generally, an individual submits an application and verification of his or her disability, and receives a photo identification card. Under Federal qualifications, only people with a disability that interferes with the ability to ride transit unassisted and people receiving Medicare are eligible. Transit systems, however, are permitted to use a broader definition of disability for their half-fare programs. Some communities and States, recognizing that many more people with disabilities face great financial hardships, have expanded their half-fare programs. For example, anyone who receives services from the Massachusetts Department of Mental Health is eligible for a Transportation Access Pass that entitles the holder to reduced fares on all transit systems in the State.



“The issue (of transportation) resonates in people’s hearts very strongly.”
—Advocate

In New York State, mental health advocates argued for years to allow mental health consumers receiving SSI and Medicaid the same right to reduced fares as people receiving Social Security Disability Insurance (SSDI) and Medicare. People who qualify for SSDI and Medicare usually have had more work experience than SSI/Medicaid recipients, but advocates “didn’t think that a 2-year journey in a corporation should be more important than a 2-year journey on the street in determining who gets half-fare,” according to Fred Levine.

Mr. Levine is an attorney and consumer advocate who participated in the Half-Fare Fairness Coalition. This broad coalition of advocates gathered support throughout the State for the expansion of the half-fare program. The coalition succeeded in convincing the State legislature to enact the Half-Fare Fairness Law, which now specifically states:

Notwithstanding any other provision of law, the authority and any of its subsidiary corporations shall establish and implement a half-fare rate program for persons with serious



mental illness who are eligible to receive Supplemental Security Income benefits as defined pursuant to title sixteen of the Federal Social Security Act and section two hundred nine of the Social Services Law (New York State Public Authorities Law, Section 1205(8)).

The passage of the law, however, was not the end of the story. An effective half-fare program also requires a fair, straightforward application process and proactive outreach to educate consumers about the availability of the discount. According to Mr. Levine, the Metropolitan Transit Authority (MTA) needed extra time to implement the Half-Fare Fairness Law in the New York City metropolitan area. Initially, the application they designed placed extra requirements on mental health consumers—including discussion of an individual’s diagnosis—rather than simply verifying the individual’s disability status with the Social Security Administration. Ultimately, advocates went to court to ensure fair implementation of the law. An out-of-court settlement resulted in a revised application that did not require disclosure of a specific diagnosis. Additionally, MTA agreed to promote the availability of the discounts by sending 10 copies of a letter to each of more than 1,200 mental health programs. By the end of 2003, over 6,000 mental health consumers had received half-fare cards under the new standards. The coalition hopes to increase that number to 25,000.

In addition to expanding half-fare to include mental health consumers with financial need, simplifying the application process, and promoting the availability of the discounts, Levine suggests one more feature is needed to promote the utility of a half-fare program: Make it available for rush-hour commuting. Federal regulations do not require transit agencies to offer half-fare during peak hours or on express buses and trains. In the New York City metropolitan area, the system is not set up to differentiate between peak and non-peak fares; as a result, half-fare is available on regular transit vehicles 24 hours a day. However, advocates are still fighting to expand the half-fare program to express buses, which do not accept the half-fare card. Levine says that the half-

fare program has allowed many people with disabilities to get real jobs. Discouraging people with disabilities from using commuter routes is inconsistent with State and Federal efforts to increase employment opportunities for people with disabilities.



Medicaid Transit Passes. Like the half-fare program, Medicaid transit passes make transportation affordable for people with disabilities who are living in areas served by public transit. The passes enable people to obtain transportation for whatever purpose they desire. Each participant simply receives a monthly transit pass that allows him or her unlimited rides on public transit. Funding comes entirely from the State's Medicaid budget, and experience shows that States actually save money by initiating this type of program.

In fact, Medicaid transit pass programs originated with some innovative thinking by State Medicaid agencies. States are required to ensure that Medicaid recipients have transportation to services covered by Medicaid, which can include doctor and therapist visits, drug and alcohol programs, and psychiatric rehabilitation. Traditionally, this transportation has been provided either through special Medicaid transportation vans, by taxi, or by private shuttle service. The cost per trip is significant, and for people making several trips per month to doctors and other services, the costs mount quickly.

In Miami-Dade County, Florida, Medicaid administrators realized that the cost of providing two round trips per month was roughly the same as the cost of a monthly transit pass. A monthly transit pass enables a person capable of using public transit to travel not only to all needed services, but also to anywhere else he or she desires. Miami-Dade found it less expensive to provide this versatile transit pass than to provide even three round trips per month. The Medicaid agency, therefore, established a partnership with the local transit authority to provide transit passes for Medicaid recipients requiring frequent transportation for medical needs. People who sign up for the program receive a transit pass and no longer are eligible for door-to-door transportation for non-emergency services. The Medicaid agency



“Travel training provides the opportunity for independence for people who have been encouraged to become reliant [on forms of transportation with less flexibility].”
—Travel trainer

saves money on transportation, and the transit authority benefits from additional sales of monthly passes (Crain and Associates, 1998).

The Metro-Dade Transit Agency (MDTA) handles applications and distribution of passes; the Medicaid agency pays for the passes plus a monthly administrative fee. To keep information confidential, Medicaid codes instead of diagnoses are used in the application process. To save money and to reduce the number of lost or misdelivered passes, MDTA distributes a large majority of the passes through agencies providing services to Medicaid recipients. MDTA also takes an active role in recruiting agencies that serve Medicaid clients to participate in the program.

As an aid to Medicaid agencies and transit authorities interested in starting a Medicaid transit pass program, MDTA has produced a detailed set of materials explaining how to establish a similar program (Metro-Dade Transit Agency, 1997). Several other Medicaid agencies across the Nation also have established local and statewide Medicaid transit pass programs using available technical assistance. An FTA publication, *Medicaid Transit Passes: A Winning Solution for All*, is available online at <http://www.fta.dot.gov/CCAM/www/publications/medicaid.html>. It describes several programs that have saved millions of dollars each. Additional information about cost savings is available in a report by the Transit Cooperative Research Program, *Economic Benefits of Coordinating Human Service Transportation and Transit Services* (Burkhardt et al., 2003).

Travel Training. To increase the number of people with disabilities who use public transit, a number of local transit authorities and private organizations offer travel training programs that help people overcome any difficulties. Unlike half-fare and Medicaid transit pass programs, which address affordability issues, travel training programs focus on accessibility and raising awareness of public transit to foster greater independence. Using public transit, rather than demand-response services such as paratransit, gives people

greater flexibility to make trips because there is no advance scheduling requirement; it also saves money for both the rider and the transit system (Crain and Associates, 1998).

Although travel training programs traditionally have focused on helping people with physical disabilities or vision impairments, a number of programs now offer training to mental health consumers. Typically, travel trainers work either with individuals or with groups of people enrolled in a particular rehabilitation program. In addition to classroom-style workshops, travel training involves experiential learning, such as taking bus or train trips. Such programs help with skills that include finding the right bus stop, reading a schedule, calling in for information, recognizing landmarks for the purpose of disembarking, and transferring to other vehicles. Travel training programs can be conducted by the transit system or by a nonprofit organization under contract with the transit system.

Fremont, California, initiated a peer-to-peer model for travel training by hiring people with disabilities and older adults who used public transit as peer instructors. The peer instructors were able to discuss overcoming their own fears and, thus, helped diminish the stigma often felt by trainees (Crain and Associates, 1998). When a person with a disability establishes a relationship with a peer trainer who has overcome many of the same obstacles he or she faces, the trainee develops confidence that he or she also can overcome those obstacles. In the Fremont program, a full-time transit authority employee trained and supervised the peer trainers. In other locations, peer trainers have received stipends from the transit authorities to conduct trainings.

Another advantage of travel training is that it helps identify people who are not able to use transit independently, the qualification requirement for curb-to-curb paratransit service. People with mental disabilities often are not deemed eligible for paratransit because no reliable tool exists to evaluate the effect of a mental disability on the capacity to use transit. Yet, some people have disabilities that the transit system



“A person who we see today (for an office-based assessment) might be having a very good day, so we’re not really aware of the issues the person might be facing.”
—Travel trainer



cannot accommodate. For example, a person might suffer extreme anxiety when exposed to the crowds in rail stations. In the words of one travel trainer, “Travel training provides a safety net, because it allows extensive contact (and shows) how a person reacts in ‘real life.’” The prolonged contact of travel training can be more effective than a single in-person assessment because of the sometimes episodic nature of mental illnesses. Further, if travel training is not successful in helping a person ride public transit, trainers then can help the individual qualify for paratransit.

Providing Specialized Transportation

- **Consumer-Run Programs**
- **Volunteer-Augmented Programs**
- **Travel Vouchers**

Programs expanding access to public transit have many advantages in terms of flexibility and cost, but the transportation that they provide is only as good as the local transit system. In many parts of the country, especially in rural areas, public transit either does not exist or has limited hours or routes. Even in areas served by public transit, a transit system may not meet an individual’s needs or in some way may be inaccessible. For these reasons, many communities have created specialized transportation programs for people considered to be “transportation disadvantaged,” a category that generally includes people with disabilities, older adults, and people of limited income.

Many different specialized transportation programs exist. Some are limited to a certain group of people, for example, older adults or preschool children from families of low income. Some are available for just one purpose, such as attending a particular rehabilitation program. However, because everyone has transportation needs, many communities have found innovative ways—such as employing mental health consumers, recruiting volunteers, and issuing travel vouchers—to provide transportation to people who otherwise could not

afford it. In the words of Betty Newell, board president of CART in Rockingham County, Virginia, “Just because you’re old, disabled, or low-income, doesn’t mean you shouldn’t be able to get where you need to go.”



Consumer-Run Programs. Throughout the Nation, mental health consumers have started a wide variety of support programs, including self-help groups, drop-in centers, peer advocacy, employment supports, and crisis services. However, helping people obtain transportation to these services is a common problem. Such services generally are not covered by Medicaid, so Medicaid transportation is not available. Yet, many people find these peer-run services essential to the recovery process. In response to the lack of transportation, some groups have started peer-run transportation initiatives. Some provide transportation to peer-run services, while others have secured funding to employ consumers to transport other consumers whenever necessary.

The consumer-run program that perhaps best exemplifies the more inclusive approach to peer transportation is Peer Transportation Services (PTS), a project of the West Virginia Mental Health Consumers’ Association. Much of West Virginia is rural with no public transportation; some small urban areas have only limited public transportation. Often, the public transportation operates on a very limited schedule, leaving people who cannot afford a car with few transportation options. PTS operates in five service areas, each with a 50-mile radius, and according to PTS, its services are available to “all adult consumers of mental health services who have no other means of transportation.” PTS operates as a typical demand-response transportation service. Users are required to make reservations a week in advance (when possible), and a consumer employee of PTS will transport the person using one of the program’s vehicles.

PTS does not charge a co-payment for its services, which are available for a wide variety of purposes, such as grocery shopping, social outings, family events, and meetings of the mental health planning council. Many people use PTS to reach doctors’ offices



and community mental health centers, and to access nonclinical services they consider essential to recovery, such as drop-in centers, peer support groups, Wellness Recovery Action Plan (WRAP) classes, and 12-step groups. Typically, PTS does not provide transportation to Medicaid-covered services, but does provide medical transportation to people not covered by Medicaid.

PTS has played an instrumental role in community integration for many people. Several of the sites provide more than 1,000 rides per year to people who otherwise would have no transportation. PTS also arranges social outings, such as trips to yard sales or bowling nights. A growing number of rides are for job interviews and the first few weeks on a job, when meeting transportation costs is still difficult. PTS is exploring additional funding sources for this employment-related transportation. Currently, PTS receives reimbursement for its operating expenses from the State through Community Mental Health Services Block Grant funds administered by the Federal Substance Abuse and Mental Health Services Administration. These funds pay for gasoline and repairs, but PTS is not allowed to use the funds to purchase vehicles. Its vehicles have been donated. Although the program has been very successful, its wide service area makes gasoline costs significant. Because the program relies on donated vehicles that often are older models, repairs costs are also significant.

Volunteer-Augmented Programs. Some remarkable programs have made great strides in alleviating local transportation shortages by using differing combinations of paid staff and volunteers, program vehicles and personal vehicles. By using volunteers and personal vehicles, a nonprofit transportation program can provide rides to a broader group of people for a wider variety of purposes than a program that is funded for a specific type of transportation. The Community Association for Rural Transportation (CART) in Rockingham County, Virginia, is an excellent example of a program that seeks to provide rides to as many people as possible for whatever reasons they need rides. CART's motto is, "Getting people where they need to go." CART is a

nonprofit agency with an active board of directors and a large group of volunteer drivers.

In a semi-rural county with several large employers but limited public transportation, CART serves anyone who is 65 or older, anyone who has any type of disability, and anyone who has a family income below the Federal poverty level. CART operates as a combination service broker and transportation provider. Some rides are provided by a private taxi service subsidized by CART, and some rides are provided by CART volunteers using either their own vehicles or one of CART's vehicles. CART has a wheelchair accessible vehicle available for volunteers to use and provides thorough training in how to operate it. People can ride CART for any purpose they desire; thus, CART fills the gaps left by programs such as Medicaid transportation.

When someone first calls CART, a staff person completes an intake form that establishes whether the caller is eligible for CART's services, and equally important, whether the caller is eligible for rides from other services, such as Medicaid, the American Cancer Society, or paratransit. CART makes optimal use of its ability to offer rides by not providing rides that could be made available by other means. Of course, someone eligible for Medicaid transportation for medical purposes can use CART for nonmedical purposes. CART holds down costs by setting a weekly limit on nonmedical trips.

Once someone's eligibility for CART services is established, he or she may arrange a ride by calling the participating taxi company or the CART staff, who can arrange a ride through the taxi company or a volunteer driver. Riders make a co-payment of \$3, \$5, or \$10, depending on distance. One-day notice is required for local trips, and 3-day notice is required for trips to medical centers outside of the area. To ensure everyone's safety, CART screens its volunteers by checking driving and criminal records, and by requiring proof of auto insurance. CART provides excess liability insurance to its drivers, which helps to protect volunteers against awards above their own insurance coverage limits. CART also



“Getting someone to the beauty shop should be just as important as getting someone to a medical appointment.”

—Nonprofit agency president



“(A) problem arises when a customer needs a ride from one publicly funded service area to another, and the transportation provider is not permitted to cross an imaginary administrative or political boundary that has nothing to do with the customer’s transportation needs.”

—K. Freund, 1998

offers mileage reimbursement; however, most volunteers decline the reimbursement and instead deduct the mileage on their tax returns. Volunteers always are free to accept or decline a trip.

In addition to the use of volunteer drivers, another key to CART’s flexibility has been its diversified funding sources. Initially funded by a local Disability Services Board, CART has since received funding or vehicles from the county government, the Virginia Department of Rail and Public Transportation, retirement communities, the United Way, the State Department of Aging, the Virginia Health Care Foundation, and the local Area Healthcare Education Center. CART has also received a major grant from the Merck & Company Foundation.

In Portland, Maine, Independent Transportation Network (ITN) relies on volunteer drivers to provide transportation to older adults. To help older adults who can no longer drive maintain their mobility and still feel comfortable, ITN uses unmarked cars to make riders feel less conspicuous when using the service. ITN requires membership. Members pay monthly into a prepaid account, so mileage and pickup charges can just be deducted from their account. Riders receive discounts in exchange for booking rides in advance or sharing rides, but riders also have the flexibility of not having to plan ahead or share rides.

ITN also maintains flexibility through its selection of funding sources. It has chosen to forgo public funding, which its founder believes would result in rationing rides and limiting service areas.

ITN relies heavily on user fees as well as financial and vehicle donations. It also has adopted some innovative approaches, such as helping an older adult sell his or her car and applying the proceeds to a prepaid ITN account, and providing stickers good for ITN credit that merchants can give to customers in place of validated parking stickers.

For organizations interested in using volunteers to provide transportation, the Community Transportation

Association of America (CTAA) offers a detailed publication, *Volunteers in Transportation—Some Issues to Consider*, which is available online at http://web1.ctaa.org/webmodules/webarticles/articlefiles/rtap_volunteers.pdf.



Travel Vouchers. In rural areas throughout the Nation, communities have initiated travel voucher programs that differ from other programs discussed in this report in that they do not rely on specific forms of transportation. Rather, participants are free to arrange their own rides and to present a voucher that is reimbursed by the sponsoring agency to the ride provider. Rides can be provided by taxi services, public transportation, and even friends and family—all of whom are reimbursed by the agency issuing the voucher. Even a service agency that maintains vans for a particular purpose, such as transporting older adults to senior centers, can offer its vans for other uses that can be reimbursed through these vouchers. Although the sponsoring agency might offer a list of potential transportation providers, the program participant has the flexibility to seek other arrangements if he or she prefers.

The sponsoring agency issues travel vouchers with carbon duplicates to eligible participants who, in turn, present vouchers to the persons providing the rides. The person providing the ride then submits the voucher to the sponsoring agency for reimbursement, usually based on a fixed rate per mile.

Depending on their funding sources, sponsors of voucher programs have a great deal of flexibility in determining who is eligible to receive travel vouchers as well as the purposes for which the vouchers may be used. In Montana and South Dakota, for example, participants in a demonstration project were people with a wide range of disabilities who used vouchers for employment, medical, daily living (e.g., shopping), and social purposes (Bernier and Seekins, 1999).

In a pilot project being conducted by the Association of Programs for Rural Independent Living (APRIL) in 10 communities nationwide, vouchers are issued to people



with disabilities who must use them for employment-related purposes. Dennis Stombaugh of APRIL noted the impact the voucher program can have for mental health consumers. Of one program participant he said, “He only worked one-and-a-half hours on Saturday and one-and-a-half hours on Sunday, but the opportunity to be out in the community meant a lot to him.”

Voucher programs are very flexible because they allow participants to take advantage of whatever transportation opportunity is available. They also encourage social service agencies to use their vehicles to serve more people. The individual choice associated with vouchers makes them “compatible with an independent living philosophy that calls for maximizing individual control and community integration of people with disabilities” (Bernier and Seekins, 1999). Voucher programs also are eligible for Federal funding under FTA’s Capital Assistance Program for Elderly Persons and Persons with Disabilities (49 U.S.C. 5310, known as Section 5310) and Nonurbanized Area Formula Program (49 U.S.C. 5311, known as Section 5311) discussed in the next section.

For organizations interested in travel voucher programs, the Research and Training Center on Disability in Rural Communities offers a detailed publication, *Making Transportation Work for People with Disabilities in Rural America*, available online at <http://rtc.ruralinstitute.umd.edu/Trn/TrnManual.htm>. APRIL also is developing a toolkit to help interested entities start and run a voucher program.

Coordinating Transportation Resources

Traditionally, Federal funding for transportation for people with disabilities and other people considered to be “transportation disadvantaged” has been a confusing patchwork subject to conflicting regulations. These conflicting regulations have resulted in considerable waste, such as when several programs drive half-filled vans on similar routes because they each serve a different clientele.

The President issued Executive Order 13330 requiring coordination of Federal transportation programs to encourage programs to serve people more effectively. Noting that “Federally assisted community transportation services should be seamless, comprehensive, and accessible to those who rely on them for their lives and livelihoods,” the President established the Interagency Transportation Coordinating Council on Access and Mobility with representatives from the Departments of Transportation, Health and Human Services, Education, Labor, Veterans Affairs, Agriculture, Housing and Urban Development, Justice, and the Interior as well as the Social Security Administration. A central goal of the Council is to “promote interagency cooperation and the establishment of appropriate mechanisms to minimize duplication and overlap of Federal programs and services so that transportation disadvantaged persons have access to more transportation services” (Executive Order 13330, February 2004).



Some States already have taken the initiative to coordinate transportation services and, as a result, are able to provide more services at a lower cost. In Florida, the Commission for the Transportation Disadvantaged monitors transportation throughout the State for people who are unable to obtain transportation because of their age, disability, or income. Its authority covers transportation programs both for general purposes such as shopping and social visits, and for special purposes such as medical transportation—any program receiving State or Federal funding to provide transportation to “transportation disadvantaged” people. The Commission oversees a network of 49 Community Transportation Coordinators (CTCs), which can be government agencies, private businesses, private nonprofit agencies, or transit authorities. These CTCs contract with transportation providers and are responsible for spending money in a cost-effective way and for monitoring fraud. An individual who needs a ride contacts the local CTC, which, in turn, determines eligibility and arranges for the appropriate service. Funding for transportation comes from various programs, such as Medicaid, the State Department of Children and Families, and the State Department of Elderly Affairs.



For rides not covered by specific programs, funding might be available through the Transportation Disadvantaged Trust Fund, which receives money from the State's transportation budget, from license tag sales, and from sales of temporary disabled parking permits. However, funding limits prevent a great number of requests for rides from being met; in 2002, over one million requests went unfulfilled. Nonetheless, the program has been successful in maximizing transportation with the funding available, with an average trip cost of under \$6.

Extensive information about the Commission's methods is available directly from the Commission. In addition, the National Governor's Association has produced an in-depth report, *Improving Public Transportation Services through Effective Statewide Coordination*, which is available online at <http://www.nga.org/files/live/sites/NGA/files/pdf/011503IMPROVINGTRANS.pdf>

Potential Sources of Funding for Transportation Initiatives



Some of the programs described in this report have specific funding sources, such as Medicaid transit pass programs, which are funded through the State administrative budgets for Medicaid. Other programs, such as half-fare expansion programs, are funded through the operating budgets of local transit agencies. However, some programs described in this report are supported by a variety of sources, such as foundations, local businesses, and community members. This diversity in funding greatly increases their flexibility in providing transportation.

Some Federal programs that provide funding for transportation can be used to provide transportation for mental health consumers. A 2003 report by the General Accounting Office (GAO), *Transportation-Disadvantaged Populations*, lists 62 separate Federal programs, administered by various agencies, that provide transportation to people with disabilities, people of low income, and older adults. The report is available at <http://www.gao.gov> (use report number GAO-03-697 in the search window).

Much Federal funding is distributed to States, which, in turn, allocate the funds according to a local or State plan. For example, the FTA requires each State to designate an agency to handle Section 5310 funds for providing transportation to older adults and people with disabilities, and Section 5311 funds for developing transportation outside of major urban areas. Each major urban area must designate a Metropolitan Planning Organization (MPO) responsible for determining how



Federal transportation funds will be used. Transportation planning committees also can be found in rural counties and regions. Each State department of transportation is the starting point for learning about the Federal funding opportunities that are administered at the State or local level.

Understanding transportation funding sources is important for any organization seeking to provide transportation to mental health consumers or participating in planning infrastructure changes needed to expand access to transportation for mental health consumers.

Several national organizations can provide information about planning strategies and funding opportunities. These organizations also administer funding for pilot transportation projects. Among them are Easter Seals Project Action, the Community Transportation Association of America, and the National Rural Transit Assistance Program of the American Public Works Association. Contact information for each of these organizations is listed in the Resources section at the end of this report.

Federal Funding

Efforts are underway to coordinate Federal funding of transportation initiatives. Of the 62 Federal programs that the 2003 GAO report identified as sources of funding for people who are “transportation disadvantaged” (including people with disabilities), 16 regularly fund transportation. Two programs of particular interest to organizations interested in planning or seeking to provide transportation for mental health consumers are the Capital Assistance Program for Elderly Persons and Persons with Disabilities (Section 5310) and the Nonurbanized Area Formula Program (Section 5311). Each State designates an agency to administer these programs. (Ask the relevant State department of transportation for contact information.)

“Regardless of the size of a county, it will be getting Federal and State dollars for transportation for elderly people and people with disabilities. (The planning process is) a great avenue for getting consumers involved.”
—Service provider

The Federal SAMHSA Community Mental Health Services Block Grant, administered by State mental health authorities, also has provided funds for transportation initiatives in several States. All Federal funding sources for domestic programs are described in detail in the Catalog of Federal Domestic Assistance, available online at <http://cfda.gov>. It is the source of the following descriptions:



The Capital Assistance Program for Elderly Persons and Persons with Disabilities (Section 5310). The purpose of Section 5310 is “to provide financial assistance in meeting the transportation needs of elderly persons and persons with disabilities where public transportation services are unavailable [or] insufficient. . . . The Section 5310 program is designed to supplement the Federal Transit Administration’s other capital assistance programs by funding transportation projects for elderly persons and persons with disabilities in all areas—urbanized, small urban, and rural.”

Generally, Section 5310 funding is reserved for private nonprofit organizations. Government agencies can qualify if no nonprofit organizations are able to provide transportation in a particular area to older adults and people with disabilities. Organizations must apply for funding through the State agency designated by the Governor to administer the program. This agency will evaluate, select, and approve eligible applicants and will submit a program of projects to the FTA.

Nonurbanized Area Formula Program (Section 5311). The purpose of Section 5311 funding is “to improve, initiate, or continue public transportation service in nonurbanized areas by providing financial assistance for operating and administrative expenses and for the acquisition, construction, and improvement of facilities and equipment.” State agencies and local government bodies, nonprofit organizations, and public transportation providers in rural and small urban areas are eligible to apply for Section 5311 funds through the State agency designated by the Governor.



Job Access and Reverse Commute (JARC). The purpose of the JARC program is “to provide competitive grants to local governments, nonprofit organizations, and designated recipients of Federal transit funding to develop transportation services to connect welfare recipients and low-income persons to employment and support services. Job Access grants will be for capital projects, to finance operating costs of equipment, facilities, and associated support costs related to providing access to jobs.”

State and local government agencies, nonprofit agencies, and transit providers are eligible to apply for JARC funds. Organizations should submit their applications to the FTA Regional Office.

Community Mental Health Services Block Grants.

The purpose of Community Mental Health Services Block Grants is “to provide financial assistance to States and Territories to enable them to carry out the State’s Plan for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance. . . . Services under the plan will be provided only through appropriate, qualified community programs (which may include community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs).” Only State, Territorial, and Tribal governments receive block grant funding; however, nonprofit organizations can apply for funding through the State.

Other Funding Sources

Because providing transportation can be very expensive, many transportation initiatives have put together funding from multiple sources to meet their clients’ needs. Some transportation providers are able to charge other agencies for specific types of rides on a fee-for-service basis. For example, some community transportation providers have contracted to provide transportation for clients receiving vocational rehabilitation, and the vocational

rehabilitation agency, in turn, pays the transportation provider a fee for each ride provided.

Other programs have turned to the local community for support. Many transportation initiatives rely on donated vehicles, volunteer efforts, and cash donations from private individuals and businesses. Some programs have sought funding from local merchants and major employers by stressing the impact that transportation can have on their workforce development or sales. Often, transportation providers charge a co-payment for their services to help defray costs.

Many successful programs have received funding from United Way Agencies and private foundations. Membership in the United Way opens the way for raising funds from employees through payroll deductions, as well as for receiving technical expertise from the United Way. Foundations are likely to support community transportation in the areas in which they are located.





Recommendations for Developing Transportation Initiatives



Although mental health consumers nationwide face many barriers to obtaining transportation, some communities and States have developed initiatives to help overcome these barriers. Federal policy has great potential to improve transportation and, as a result, community integration, for many mental health consumers. The following recommendations by the author and contributors are made for Federal initiatives and for State and local efforts that rely on Federal funds:

- 1 . States inspired by the *Olmstead* decision or the New Freedom Initiative should make transportation a central part of any plan to help people with disabilities live in the community.
- 2 . Information gathered about the accessibility barriers faced by mental health consumers should be shared with transit providers so that they can better understand consumer needs and ensure appropriate transportation access.
- 3 . Projects receiving Section 5310 funding should include people with mental disabilities when they provide services to older adults and people with disabilities.
- 4 . An assessment tool appropriate for mental disabilities should be developed to aid in determining mental health consumer eligibility for paratransit.
- 5 . The half-fare statute or regulations should incorporate a more inclusive definition of disability so that all people with disabilities who also experience hardship qualify.



- 6 . The half-fare statute or regulations should extend reduced fares to rush hour and commuter vehicles, recognizing that many people with disabilities want to work but cannot, due to transportation costs.
- 7 . Materials should be developed for training travel trainers who want to help mental health consumers use public transit independently.
- 8 . State Medicaid agencies should receive technical assistance on implementing Medicaid transit passes, and should be encouraged to provide them whenever feasible.
- 9 . States should receive technical assistance on using Community Mental Health Services Block Grant funds to provide transportation through innovative programs such as consumer-run, volunteer-augmented, and voucher programs.
- 10 . States should follow the Federal lead in coordinating transportation resources to eliminate waste.
- 11 . Mental health consumers, family members, and advocates should receive technical assistance on becoming involved in transportation planning within Metropolitan Planning Organizations and other planning bodies.

List of Contributors



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Ken Thompson, Easter Seals Project ACTION, Washington, DC
Susan Milstrey Wells, Advocates for Human Potential, Inc., Delmar, NY



Resources



Federal, State, and City Resources

Federal Transit Administration
400 7th Street, SW
Washington, DC 20590
(202) 366-4020
<http://www.fta.dot.gov>

Florida Commission for the Transportation
Disadvantaged
605 Suwanee Street
Tallahassee, FL 32399
(850) 414-4100
<http://www.dot.state.fl.us/ctd>

Miami-Dade Transit
3300 N.W. 32nd Avenue
Miami, FL 33142
(305) 637-3754
<http://www.co.miami-dade.fl.us/transit>

Other Resources

Association of Programs for Rural Independent Living
5903 Powdermill Road
Kent, OH 44240
(330) 678-7648
<http://www.april-rural.org>

Community Transportation Association of America
1341 G Street, NW, 10th Floor
Washington, DC 20005
(800) 527-8279
<http://www.ctaa.org>

Consumer Organization and Networking Technical
Assistance Center (CONTAC)
910 Quarrier Street, Suite 414
Charleston, WV 25301
(888) 825-8324
<http://www.contac.org>



Peer-to-Peer Resource Center
Depression and Bipolar Support Alliance
730 North Franklin Street, Suite 501
Chicago, IL 60610
(800) 826-3632
<http://www.peersupport.org>

Easter Seals Project ACTION
700 Thirteenth Street, NW, Suite 200
Washington, DC 20005
(202) 347-3066
<http://www.projectaction.org>

NAMI Support, Technical Assistance, and Resource
Center (STAR)
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
(866) 229-6264
<http://www.nami.org>

National Governors Association
444 North Capitol Street, Suite 267
Washington, DC 20001
(202) 624-5300
<http://www.nga.org>

National Mental Health Association Consumer Supporter
Technical Assistance Center
P.O. Box 16810
Alexandria, VA, 22302
(800) 969-NMHA (6642)
<http://www.nmha.org>

National Mental Health Consumers' Self-Help
Clearinghouse
1211 Chestnut Street, 11th Floor
Philadelphia, PA 19107
(800) 553-4539
<http://www.mhselfhelp.org>



National Rural Transit Assistance Program
American Public Works Association
1401 K Street, NW, 11th Floor
Washington, DC 20005
(202) 408-9541
<http://www.nationalrtap.org>

**Note: This list of resources neither implies
endorsement nor is exhaustive.**



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