NEW FREEDOM COMMISSION ON MENTAL HEALTH

Subcommittee on Housing and Homelessness:

BACKGROUND PAPER

June 2004

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The content of this publication reflects the views and opinions of the Subcommittee on Housing and Homelessness. Therefore, this paper is a product of the process that advised the full Commission and as such does not reflect the position of the President's New Freedom Commission on Mental Health or any agency of the United States Government.

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Preface

The President's New Freedom Commission on Mental Health appointed 15 subcommittees to assist in its review of the Nation's mental health service delivery system. The full Commission appointed a Chair for each subcommittee. Several other Commissioners served on each subcommittee, and selected national experts provided advice and support.

The experts prepared initial discussion papers that outlined key issues and presented preliminary policy options for consideration by the full subcommittee. The subcommittee reported to the full Commission only in summary form. On the basis of this summary, the full Commission reached consensus on the policy options that were ultimately accepted for inclusion in the Final Report, *Achieving the Promise: Transforming Mental Health Care in America*. Therefore, this paper is a product of the subcommittee only and does not necessarily reflect the position of the full Commission or any agency of the United States Government.

Contents

Defining the Issues

The ability to choose a home without discrimination, to live in a home without interference, to seek and be granted reasonable accommodations where they are necessary, and to find and acquire accessible housing are essential first steps for people with serious mental illnesses and other disabilities to live in the mainstream of our society.

The mission of the President's New Freedom Commission on Mental Health was to recommend improvements to enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. To live and participate in the community, one must have a place to live—a place to call home.

Housing

Housing is more than a basic need. Living in one's own home also brings new freedoms and responsibilities and marks the transition to adulthood in contemporary American culture. Finding and maintaining a home is a fundamental indicator of success in community life (Pitcoff, Schaffer, Dolbeare, & Crowley, 2002).

The lack of decent, safe, affordable, and integrated housing is one of the significant barriers to fully participating in community life for people with serious mental illnesses (DHHS, 1999). Today, many people with serious mental illnesses do not have decent, safe, and affordable housing that meets their preferences and needs. Consumers also want access to services and supports that reinforce their dignity, independence, and ability to live in the community.

Homelessness is the most visible manifestation of the housing and support service problems of people with mental illnesses.

The lack of affordable housing and accompanying support services often causes people with serious mental illnesses to cycle between jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in large, segregated facilities or substandard housing.

People with serious mental illnesses also make up a large percentage of those who are repeatedly homeless or who are homeless for long periods of time (Burt, 2001; Culhane, Metraux, & Hadley, 2002; Levy, 2002). People with mental illnesses who are precariously housed are at risk of becoming homeless and face the constant stress of losing their housing or living in dangerous and unsafe housing conditions.

Even when consumers access affordable housing, keeping that housing may be difficult. While some State and local mental health systems are learning the complexities of government-subsidized housing programs, often, too little attention is paid to providing the supportive services that can ensure long-term housing retention and community stability. This absence of ongoing supports has left many consumers with troubled tenant histories and higher rates of incarceration—both of which can lead to long-term ineligibility for Federal housing programs, such as Section 8 vouchers and public housing (Tsemberis & Eisenberg, 2000).

Homelessness

Homelessness is the most visible manifestation of the housing and support service problems of people with mental illnesses. People with mental illnesses and, in particular, people with co-occurring mental illnesses and substance use disorders, make up a significant percentage of people who are chronically homeless (i.e., they have been either continuously homeless for a year or more or have had at least four episodes of homelessness in the past three years).

People who are chronically homeless and have mental illnesses are likely to have acute and chronic physical health problems; exacerbated, ongoing psychiatric symptoms; excessive alcohol and drug use; and a higher likelihood of victimization and incarceration (Tsemberis, 2000**).**

To help people who are homeless and have mental illnesses as well as those at risk of homelessness access decent and affordable housing and supportive services, mental health systems must call on the leadership, commitment, resources, and efforts of all stakeholders in both the mental health and affordable housing systems.

Issues Description and Analysis

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

1. HOUSING AFFORDABILITY

People with severe mental illnesses—including those who receive Supplemental Security Income (SSI) benefits—often have serious difficulties affording housing (HHS, 1999; TAC, 2003).

2. CORRELATION BETWEEN MENTAL ILLNESSES AND HOMELESSNESS

There is a strong correlation between mental illnesses and homelessness. A recent study by the Urban Institute found that approximately 46% of people who are homeless have a mental illness (Burt, 2001).

3. INCREASED HOUSING DEMAND FROM THE OLMSTEAD DECISION

The U.S. Supreme Court *Olmstead* decision, which affirmed the integration mandates of the Americans with Disabilities Act (ADA) will likely increase the demand for integrated and affordable housing for people with serious mental illnesses (Allen, 2001).

4. STIGMA, DISCRIMINATION, AND NIMBY ATTITUDES

Stigma, housing discrimination, and "Not in My Back Yard" (NIMBY) attitudes are barriers to accessing integrated, community-based housing (National Council on Disability, 2001; HHS, 1999).

5. RESPONSE FROM THE AFFORDABLE HOUSING SYSTEM

Historically, the nation's affordable housing system has not been responsive to people with serious mental illnesses (U.S. DSSS General, 1999; TAC and CCD Housing Task Force, 2000).

6. RESPONSE FROM THE MENTAL HEALTH SYSTEM

Mental health systems vary in how successfully they have addressed consumers' housing needs, housing choices, and access to community-based supports to sustain tenure in housing (Emery, 2001).

In the remainder of this chapter we describe and analyze each of these six issues in detail.

ISSUE 1 Housing Affordability

Although some mental health consumers may have additional issues related to housing, they share the same housing affordability problems experienced by all low-income households in the United States.

The generally accepted standard of housing affordability for very low-income households is that total housing costs should not exceed 30% of monthly income. According to the Federal government, very low-income households paying more than 50% of their income for housing are "seriously rent burdened" and have "worst case" housing needs (HUD, 2001).

The U.S. Department of Housing and Urban Development (HUD) reports that as many as 1.4 million adults with disabilities who receive SSI have worst-case housing needs—approximately 25% of the total number of households with worst-case housing problems (HUD, 2001).

A new study by the Technical Assistance Collaborative (TAC) finds that people with serious mental illnesses and other disabilities relying solely on SSI benefits (currently $545

per month) have incomes equal to only 18% of median income and cannot afford decent housing in any of the 2,703 HUD-defined housing market areas of the United States (TAC, 2003). TAC found that in 2002, people with serious mental illnesses receiving SSI would need to pay, as a national average, 105% of their monthly SSI benefit to rent a modest one-bedroom apartment—clearly impossible (TAC, 2003).

The decline in the number of affordable housing units being produced has exacerbated affordability problems (Millennial Housing Commission, 2002). The Millennial Housing Commission appointed by Congress recently documented the growing mismatch between the number of extremely low-income renter households and the number of units available to them with acceptable quality and affordable rents. The Millennial Housing Commission noted that despite "persistent and growing need, it has been more than 20 years since an active Federal housing production program was designed to serve extremely low-income households."

ISSUE 2 Correlation Between Mental Illnesses and Homelessness

Homelessness in the United States endures as a significant problem despite Federal, State, and local initiatives. Approximately 637,000 adults in the U.S. are homeless on any given night, with 2.1 million people experiencing at least one episode of homelessness over the period of a year (Burt, Aron, Lee, & Valente, 2001).

Characteristically, people who cycle in and out of homelessness or are homeless for long periods of time tend to have disabling health and behavioral health problems. In *What Will It Take to End Homelessness?,* Burt (2001) states that 31% of individuals using homeless services reported a combination of mental health and substance-use problems within the previous year. An additional 15% reported mental health problems only. It is clear from this self-reported data that people with serious mental illnesses and substance-use disorders are particularly vulnerable to becoming homeless.

The symptoms resulting from serious mental illnesses also increase vulnerability to homelessness. Without appropriate services and supports, people with mental illnesses may exhibit behaviors that threaten housing stability, e.g., they may disturb neighbors, miss rent payments, and neglect their housekeeping—any of which may lead to eviction. They may also have difficulty with relationships, resulting in conflicts with landlords and neighbors. These conflicts can result in homelessness, unless appropriate services and supports are made available.

Fragmentation, a lack of resources, and the continuation of traditional models of service delivery have all contributed to the difficulties that mental health systems have meeting the multiple needs of mental health consumers who are homeless. These needs cross many service systems and include adequate food, clothing, income support, and physical health care. None of these services are effective unless safe, decent, affordable housing is also available and sustained.

ISSUE 3 Increased Housing Demand from the Olmstead Decision

On June 22, 1999, the Supreme Court of the United States issued its decision in *Olmstead v. LC*, a case brought by two women with mental illnesses who—despite their treatment team's decision that they were ready to live in the community—continued to be confined to a State psychiatric hospital in Georgia. The court described Georgia's action as "unjustified isolation" and determined that States may be violating Title II of the Americans With Disabilities Act (ADA) if they provided care to people with disabilities in institutional settings when they could be appropriately served in a community-based setting (Allen, 2001).

The *Olmstead* decision has been widely interpreted to apply to people with mental illnesses living in institutions or other restrictive

settings, as well as to people at risk of institutionalization. The Court was also clear that State discharge policies that result directly in homelessness could also violate the ADA. Given the broad scope of the decision, mental health authorities will undoubtedly face a greater demand for community-based housing and support services from people living in institutions, overly restrictive board and care homes, nursing homes, homeless shelters, and other settings (Allen, 2001).

ISSUE 4	Stigma, Discrimination, and NIMBY Attitudes

When discrimination and NIMBY ("Not in my backyard") attitudes intervene, they stigmatize, isolate, and remove free choice and the opportunity to live as part of the community of all Americans (National Council on Disability, 2001).

By the end of the 1980s, two sets of policies were enacted to provide the Federal government the necessary tools to combat housing discrimination: the Fair Housing Amendments Act of 1988 and HUD regulations enforcing Section 504 of the Rehabilitation Act of 1973. The latter policy, Section 504, required recipients of Federal funds (including State and local housing agencies receiving HUD funds) to ensure that their programs and activities were accessible to people with disabilities.

Despite the protections provided in these laws, housing discrimination is still a serious problem for people with disabilities and, in particular, for people with mental illnesses (Abt Associates, 2000). People with disabilities file 42% of the housing-discrimination complaints that HUD receives and were the largest single group of complainants in 1999 and 2000.

Despite this increasing demand for HUD action, HUD's fair-housing enforcement activities diminished during the 1990s. The average age of complaints at their closure was 497 days in FY 2000, nearly five times the 100-day period that Congress set as a benchmark. While HUD has developed important guidance and resources to support enforcement of Section 504, this information is not widely disseminated to individuals or entities affected by the law (National Council on Disability, 2001).

ISSUE 5	Response from the Affordable Housing System

Federal housing programs and policies are administered primarily—although not exclusively—through HUD. The Federal government also has:

- Rural housing programs administered by the U.S. Department of Agriculture,
- Federal Low Income Housing Tax Credits administered through the U.S. Department of the Treasury-IRS,
- Veterans Affairs mortgages for single family homes, and
- Loans and grants offered through the Federal Home Loan Bank.

Only a few States and localities put their own funds into housing for extremely-low income households.

Several major barriers prevent people with serious mental illnesses from obtaining more access to government housing programs. Affordable housing programs are extremely complex, highly competitive, and difficult to access. During the 1990s, the Federal government devolved decisionmaking for most housing programs to State and local housing officials, State Housing Finance Agencies, and Public Housing Agencies who may not understand or prioritize the needs of people with mental illnesses.

The flexibility within many Federal programs means that State and local officials can provide a range of homeownership and/or rental housing opportunities for households with incomes up to 80% of median income. People with incomes as low as SSI benefits cannot afford many of these options.

While some States and cities have created policies to assist people with the most severe disabilities, including mental illnesses, other jurisdictions need assistance in developing relevant and responsive policies.

Also, less Federally funded housing is available for people with mental illnesses and other disabilities. Since 1992, approximately 75,000 units of HUD public housing have been converted to "elderly only" housing, and more units are being converted every year.

Federal public housing reform legislation adopted in the late 1990s makes it more difficult for people with poor tenant histories, substance-use disorder problems, and criminal records to qualify for Section 8 vouchers and public housing units. Consumers who are fortunate enough to receive Section 8 vouchers sometimes cannot use the vouchers because:

1. The cost of available rental units may exceed voucher program guidelines, particularly in high-cost housing markets;
2. Private landlords may refuse to accept vouchers; and
3. Comprehensive housing search assistance may not be available to consumers.

Unfortunately, State and local mental health agencies sometimes find it difficult to establish effective partnerships with housing agencies.

ISSUE 6	Response from the Mental Health System

Housing and the services consumers need to access and retain housing are not always a high priority for State and local mental health systems. Conventional categorical funding streams, bureaucratic program requirements, administrative approaches to resource allocation and management, and even staff skills are often not geared toward rigorously supporting consumers in normal housing (Carling, 1992).

Persons who are chronically homeless must often navigate a fragmented service system, often leading to gaps in the social services safety net (HHS, 2003). Mainstream social services, including mental health systems, traditionally have not been responsive to the needs of persons who are homeless (Schwab Foundation, 2003).

Coverage gaps are a critical issue. Mainstream payers who cover mental health services typically prefer traditional office-based care. This approach does not provide the flexibility and mobility necessary to support and sustain consumers in their housing.

In addition, traditional case managers must deal with larger caseloads, leaving them less time to provide the more intensive support typically needed by persons with serious mental illnesses, such as found in the Assertive Community Treatment (ACT) case management approach (Morse, 1999).

Although Medicaid law permits States to cover a full array of comprehensive community-based services, many States have not used options, such as targeted case management and the rehabilitation option, to help with housing supports.

Categorical or "silo" funding streams make it difficult to serve the multiple needs of people who are homeless and have serious mental illnesses. Many have more than one diagnosis, requiring the coordination of many separate funding streams. Although some service providers have become quite creative at putting together coordinated funding sources, coordination doesn't solve the problem of funding inflexibility or duplication that exists across systems of care.

The mental health system is responsible for providing services to consumers who are homeless, as well as to those who are not. In practice, systems actually have duplicate support programs—one set of programs for consumers receiving mainstream mental health services and another specifically for consumers who are homeless.

The mainstream systems may have had some prior contact with some individuals who are homeless and have mental illnesses and may still be in contact through inpatient and emergency

room services. As consumers become chronically homeless, the mainstream service system often does not have the readiness, flexibility, or desire to stay involved. If consumers who are homeless are fortunate enough to obtain permanent housing, mainstream staff are often unprepared to deliver the services that are necessary for them to maintain stable housing.

Individuals who are homeless and have mental illnesses are eligible for a plethora of mainstream health, social services, and income-support programs that are available for all low-income people. However, they often face significant enrollment barriers, such as the lack of a fixed address. Although States have the authority to allow certain health care providers to "presumptively" enroll individuals who appear to be eligible in Medicaid (e.g., children and pregnant women), this authority has not crossed over into the adult mental health system.

Consumers who are homeless may wait six months or more to be eligible for Medicaid, and, in the meantime, they may be unable to access permanent supportive housing and/or some of the services provided in permanent supportive housing.

Finally, the mental health system has not been overly responsive to a client-centered approach to service delivery. Many mental health systems are based on a medical model and do not see housing as their responsibility.

The findings from a recent demonstration program of SAMHSA's Center for Mental Health Services clearly indicate that:

- Consumers prefer a housing-first approach that houses the individual or family immediately and involves aggressive outreach, placement in permanent housing, and the availability of appropriate support services; and
- Consumers are much more responsive to accepting treatment after they have housing in place (Rosenheck, Morrissey, & Lam, 1998; Shinn & Baumohl, 1999).

Innovations to Ensure Access to Affordable Housing with Supports

In this chapter we discuss consumer housing preferences and strategies for ensuring consumers access to affordable housing and supports.

Consumer Choice in Housing

Effective housing solutions must first reflect the housing choices of consumers. Extensive consumer preference studies consistently show that consumers prefer to live in their own house or apartment and to live alone or with a spouse or partner. They do not prefer to live in segregated settings with other mental health consumers (Tanzman, 1993).

Rather than living with staff, consumers strongly preferred outreach staff support that is available on call, and they emphasized the importance of rent subsidies, telephones, employment opportunities, and transportation for community living (Tanzman, 1993). This housing approach is sometimes referred to as "supportive housing" or "supported housing," primarily to distinguish it from the residential treatment model that dominated housing policies of mental health systems in the 1970s and 1980s and is still used in many systems today.[1]

Affordable Housing with Supports

About 15 years ago, housing policy for people with serious mental illnesses began a paradigm shift away from residential treatment to a more "normative" or "housing as housing" approach (Ridgeway & Zipple, 1990). In the supportive housing model, the consumer's housing needs are met the same way other low-income housing needs are addressed—through government affordable housing programs, such as public housing and Section 8 vouchers. The mental health system uses its resources to:

1. Facilitate links to affordable housing programs for consumers, and
2. Provide the services and supports necessary to maintain the housing once it is acquired.

Many mental health systems continue to fund residential treatment programs but have not used their funds to leverage supportive housing

[1] Within housing and mental health systems, the terms *supported housing* and *supportive housing* are sometimes used interchangeably. While little distinction in meaning may exist between the two, it is helpful to understand how each term originated. The term *supported* housing originated in mental health policy to describe normal housing that emphasized mental health consumer choice, rights of tenancy, housing quality and affordability, and voluntary and flexible support services that were functionally separated from but linked to the housing. To promote the most community integration possible, the ideal supported housing model was also based on a scattered-site approach. (U.S. Department of Health and Human Services, 1997). The term *supportive housing* usually refers to permanent supportive housing properties developed for people who are formerly homeless and have special needs (e.g., mental health conditions; substance-use disorder issues; chronic health conditions, including HIV/AIDS) or people most at-risk of homelessness, including Single Room Occupancy dwellings (SROs) or apartment complexes. These properties usually—but not always—have some type of voluntary/flexible services offered either on-or off-site. Because of the density of some supportive housing properties, some mental health professionals differentiated it from supported housing. However, because more permanent supportive housing is now being developed on a scattered-site basis, little, if any, distinction between the two terms may exist.

options There are many reasons for this, including:

- Difficulty unbundling the mental health-funded contracts that pay for both housing and services in residential treatment programs,
- Resistance from providers/operators of group homes or board and care facilities,
- Long waiting lists for Federally subsidized housing, and
- Lack of capacity to re-configure mental health system funding to better leverage government housing programs and expand the mobile and flexible supports that consumers need to live in homes of their own.

To ensure that consumers have access to affordable housing and supports, mental health systems need:

1. More access to government housing programs and successful partnerships with housing agencies at the State and local levels;
2. Stronger housing expertise within the mental health system;
3. Mental health system investment to leverage affordable housing resources;
4. Access to new permanent supportive housing (including new construction, acquisition, rehabilitation, leasing, and rental assistance) to address the needs of people with mental illnesses who are chronically homeless;
5. Rigorous enforcement of Federal fair-housing laws and effective anti-stigma campaigns to combat housing discrimination and NIMBY attitudes;
6. An expansion of Assertive Community Treatment (ACT) model service teams;
7. The creation of infrastructure at the State level to foster collaboration;
8. The use of Medicaid options at the State and local levels to cover supportive housing services; and
9. Technical assistance to orient services funding and implement these strategies.

In the remainder of this chapter we highlight innovative strategies for ensuring consumers access to affordable housing and supports.

Innovative Strategies

ROBERT WOOD JOHNSON FOUNDATION (RWJF)/HUD DEMONSTRATION PROGRAM ON CHRONIC MENTAL ILLNESS (1986–1992)

This nine-city demonstration program established local mental health authorities and required that each city create a separate nonprofit housing corporation to develop permanent housing. HUD gave the Public Housing Authority (PHA) in each city 125 Section 8 rent subsidies that were targeted to people with mental illnesses.

In total, more than 2,500 units of permanent supported housing were created, demonstrating the effectiveness of leveraging housing resources for people with mental illnesses through the affordable housing delivery system.

CENTER FOR MENTAL HEALTH SERVICES ACCESS TO COMMUNITY CARE AND EFFECTIVE SERVICES AND SUPPORTS (ACCESS) DEMONSTRATION PROGRAM (1993–1998)

This demonstration was funded by SAMHSA's Center for Mental Health Services (CMHS). It was designed to test the hypothesis that integrated systems (spanning several domains) will improve functioning, quality of life, and housing outcomes for people with serious mental illnesses who are homeless.

The five-year demonstration program provided funds to enhance services, particularly outreach and case management, for 18 sites in nine States. One community in each State, the experimental site, was given additional funds to support system-integration activities to enable creating formal working relationships across and between systems.

As an outcome of these programs and as a result of the innovative work of some State and local mental health authorities, an array of replicable best practices are available for State and local mental health authorities to use to expand affordable housing opportunities for people with mental illness.

Mental Health System/Housing System Partnerships Targeting HUD "Mainstream" Housing Resources

State and local mental health systems are learning to use HUD "mainstream" housing programs, including elderly/disabled public and assisted housing, Section 8, and the HOME program, to provide permanent housing for consumers.

Through the HUD-mandated Consolidated Plan and Public Housing Authorities Plan, mental health officials are engaging State and local housing officials and public housing authorities (PHAs) to make them aware of the housing needs of consumers and to suggest solutions. Several models of successful partnerships exist including:

- Memoranda of Understanding implemented between mental health agencies and PHAs to expand mental health services in public housing and to set aside units for key population groups, such as frail elders with mental illnesses (Cuyahoga and Lorain Counties in Ohio);
- Formal and informal agreements implementing tenant selection preferences or other facilitated access to Section 8 waiting lists for consumers (Anne Arundel County, Maryland; Honolulu, Hawaii; and Baltimore, Maryland); and
- State-level partnerships between housing and mental health system officials resulting in targeted resources for people with mental illness leaving institutions or other settings covered by the *Olmstead* decision (Massachusetts, Alabama, and Arkansas).

Along with fair housing laws, these partnerships also help to eliminate the stigma associated with mental illnesses by educating housing agencies about mental illnesses, consumer housing choices, and the services and supports that can assist consumers with housing issues.

Mental Health Authority Investment in Housing

Because of the fierce competition for limited affordable housing resources, mental health authorities have devised strategies to use their dollars to leverage housing funding. These strategies include:

1. Creating "bridge" rent subsidies to link consumers to Section 8 vouchers; and
2. Using mental health capital funds to leverage other Federal and State financing for housing development.

These strategies can leverage three to five times the funding invested and produce real systems change in local and State housing policies. Bridge subsidy programs in Ohio, Oregon, Connecticut, Hawaii, and several other States have resulted in access to thousands of new Section 8 subsidies for consumers.

Mental health system capital funding for housing (including re-investing land or funds from State psychiatric hospital disposition activities) has been combined with Federal capital financing (i.e., HOME and Community Development Block Grant capital, Low Income Housing Tax Credit equity, and Section 811 funding) in Maryland, Oregon, Ohio, and Rhode Island to produce thousands of affordable rental apartments for consumers.

Expanding Permanent Supportive Housing for Consumers Who Are Chronically Homeless

A variety of studies have found that permanent supportive housing is an effective solution to the problem of chronic homelessness among people with serious mental illnesses, including those with co-occurring substance abuse disorders (Corporation for Supportive Housing, 2002). It is also a very effective homelessness-prevention

strategy (Corporation for Supportive Housing, 2000; Tsemberis & Eisenberg, 2000).

Permanent supportive housing appears to be cost-effective when compared to the cost of homelessness. A University of Pennsylvania study that aggregated utilization data from mental health, corrections, Medicaid, and public institutions and shelters found that people who are homeless and have mental illnesses in New York City used an average of $40,449 of services per year; their subsequent residency in permanent supportive housing decreased service use by $16,282 (Culhane et al., 2001).

Based in part on this evidence of effectiveness, the President has announced a ten-year effort to end chronic homelessness.

The Millennial Housing Commission and national homeless advocacy groups have called for creating 150,000 units (through acquisition, rehabilitation, new construction, rental assistance, and leasing) of permanent supportive housing in the next ten years and are working to identify the capital, operating subsidy, and support services funding that will be needed (Millennial Housing Commission, 2002).

Several private philanthropic organizations are providing support for the public policy and capacity-building efforts needed to significantly expand the development of new permanent supportive housing.

Using Nonprofit Organizations to Expand Housing Opportunities for Consumers

Numerous localities across the country have replicated RWJF's model of using nonprofit housing corporations to expand affordable housing for consumers. These mission-driven organizations add valuable capacity within mental health systems to develop new permanent housing and administer both temporary "bridge" subsidies and HUD-funded permanent rent subsidies for people with mental illnesses. They typically partner with PHAs and State/local housing officials to obtain resources, although in some localities, they fill the gap created when the housing system does not respond.

Several mental health agencies have created a specific type of housing nonprofit called a Community Housing Development Organization (CHDO)—a designation which helps access funding from HUD's HOME program. CHDOs often include consumers, family members, and mental health system representation on their boards of directors.

Through long-term use restriction agreements, the housing developed is permanently made available for consumers, including some that may not qualify for other Federal housing programs, such as people with criminal backgrounds. If the properties are attractive and well managed (and they usually are), they also help change community NIMBY attitudes about people with mental illnesses.

Funding Housing Coordination Staff in Mental Health Authorities

The complexities within both the mental health system and housing system make it difficult for professionals in both systems to effectively communicate and partner with one another.

Some State and local mental health authorities have strengthened links between the two systems by dedicating one or more full-time staff members to work exclusively on housing and homelessness issues. This staff has the expertise to facilitate partnerships with housing agencies, track housing program and policy changes, identify new sources of housing funding, and provide training and technical assistance on housing issues.

Because key decisions about housing resources and policies are made at a very senior level, housing staff in mental health authorities should have policy-making responsibility and easy access to agency leadership. State mental health authorities with demonstrated leadership in this practice are Connecticut, Kentucky, Massachusetts, Ohio, and Oregon.

Support Services and Housing

Without housing, mental health services and support are not effective. However, for individuals with serious mental illnesses, the reverse is also true. That is, without services and support for individuals with severe mental illnesses, housing is often an unsuccessful experience.

Evidence suggests consumers are best served when flexible support services are available either on-site or off-site (U.S. Department of Health and Human Services, 1997). As defined in the CMHS Supported Housing Initiative, these services are:

1. Designed to maximize independence;
2. Flexible and responsive to individual needs;
3. Available as and when needed; and
4. Accessible where the individual lives.

Initial findings from the CMHS Supported Housing Initiative research (2002) show that housing with services, regardless of approach, has a dramatic effect on improving housing retention and stability and reducing homelessness. In fact, some people can successfully move directly from homelessness to independent housing with supports (Tsemberis & Eisenberg, 2000).

Intensive Multidisciplinary Case Management Teams

People with serious mental illness—and especially those who are homeless or at risk of homelessness—have complex needs and may require comprehensive, multidisciplinary services that are flexible and mobile. These services, often referred to as "wrap-around" services, are available 24 hours a day, seven days a week (24/7) and are based on consumers' changing needs rather than on a pre-set treatment plan.

One example of this approach, Assertive Community Treatment (ACT), is acknowledged to be highly successful, providing a full range of comprehensive, community-based services to people with serious mental illnesses and those with co-occurring substance use living in community housing (Phillips et al., 2001).

ACT team members cover most of the necessary service domains, are not office-based, have low caseloads (for example, a 10:1 client:staff ratio is recommended), and are available 24/7.

Since the teams often use mobile outreach, they are also well adapted to work with consumers who are homeless and who need housing assistance and have proved to be quite successful during the ACCESS Demonstration Program (Williams & Dennis, 2002).

Integrated Systems of Care

The findings of the ACCESS Demonstration Program articulated that an integrated system of care has a positive impact on housing stability. Undeniably, both research and practice in recent years have shown that services for people with serious mental illnesses and substance-use disorders who are homeless must be offered as part of a comprehensive and integrated system of care**.**

Partnerships across multiple systems (i.e., housing, employment, etc.) can increase residential and clinical stability and prevent homelessness (Davis, Johnson, & Mayberg, 2002; Rosenheck et al., 1998).

System integration requires creating a system of care that is seamless to the individuals it serves. The concept of "no wrong door" is the core of this system and allows consumers to enter anywhere in the service system, be assessed, and have access to the full complement of comprehensive services and supports they need (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

Opportunities and Policy Options

The Administration has made ending chronic homelessness within ten years a top objective. People who are chronically homeless—that is, unaccompanied persons who are homeless and have a disabling condition and who have either been continuously homeless for a year or more or have had at least four episodes of homelessness in the past three years—number between 100,000 to 200,000 (HHS, 2003). Experts have suggested that 150,000 additional units of permanent supportive housing will be needed to end chronic homelessness (Corporation for Supportive Housing, 2002; Millennial Housing Commission, 2002).

New Federal Policies to End Chronic Homelessness

HUD, the U.S. Department of Health and Human Services (HHS), and the Department of Veterans Affairs (VA) are actively working together with their Federal, State, and local partners to help people who are chronically homeless move from the streets to safe, permanent housing.

The Subcommittee on Housing and Homelessness strongly endorses the President's commitment as well as his plan to better coordinate Federal housing and services resources to help end the tragedy of chronic homelessness for people with serious mental illnesses and other disabilities in our country.

The President has directed HUD, HHS, and the VA—in partnership with the re-activated Federal Interagency Council on Homelessness—to lead this effort, beginning with a $35 million interagency joint initiative in 2003. This initiative represents a collaborative effort to provide funding for housing and services through a consolidated application.

Applicants must show how the funds they request will be part of a comprehensive, integrated community strategy to use funding sources, including mainstream support services resources, to assist persons who are chronically homeless to obtain housing and receive the range of services and other supports needed to promote and maintain greater self-sufficiency.

The Subcommittee believes that this coordinated interagency approach—when linked with appropriate incentives in Federal "mainstream" housing and support services programs administered at the State/local level—can create a framework for the Federal government's efforts to address the housing and related support service needs of people with serious mental illnesses.

Expanding Public/Private Partnerships

The Subcommittee believes that the public/private housing partnership model holds great promise as one strategy for achieving the permanent supportive housing commitment goals. To assist the most vulnerable people, this approach blends private-sector capital and housing development expertise with government and nonprofit housing and support service resources.

Successful public/private housing partnerships can be found across the country, including innovative projects developed on Federal government property using private-sector capital linked with Federal and State housing and supportive services programs. Two of these successful public/private partnerships include:

VANCOUVER, WASHINGTON

In Vancouver, Washington, land was made available through the VA Enhanced Use Leasing program to develop a 124-unit Single-Room Occupancy (SRO) that provides supportive housing to both veterans and non-veterans who are homeless, including people with mental illnesses.

HONOLULU, HAWAII

In Honolulu, 80 units of permanent supportive housing are being developed for people who are homeless and have mental illnesses on the former Naval Air Station at Barber's Point by U.S. Vets, a public/private partnership created to fill gaps in the continuum of care for veterans who are homeless.

Since 1992, thousands of new units of permanent supportive housing have been created through the work of the Corporation for Supportive Housing, a national nonprofit organization that works collaboratively with private, nonprofit, and government partners.

Over the next decade, more public/private partnerships will be needed to end chronic homelessness and assist people with serious mental illnesses who are at risk of homelessness.

Improved Federal interagency coordination and clearly targeted incentives within Federal programs are essential to attract private-sector investment and make available the housing, support services, and technical assistance resources needed in States and local communities.

To further the Administration's policy goals and to sustain successful efforts already under way in many communities, the Subcommittee offers the following eight policy options.

Policy Options

POLICY OPTION 1	**Facilitate Access to 150,000 Permanent Supportive Housing Units**

To support and advance the President's goal of ending chronic homelessness, the Subcommittee on Housing and Homelessness urges that HUD—in partnership with HHS and the VA—develop and implement a comprehensive plan designed to facilitate access to 150,000 units of permanent supportive housing **for chronically homeless individuals** over the next ten years. This includes developing specific cost-effective approaches, strategies, and action steps to be implemented at the Federal, State, and local levels.

Because of the complexities associated with chronic homelessness, the Federal government cannot end it by itself. However, the Subcommittee believes that the Federal government must provide the leadership and strategic framework for this effort, including developing a comprehensive plan for ending chronic homelessness.

The approaches, strategies, and actions steps included in this plan should provide:

1. An identification and analysis of the capital, subsidy, support service, and technical assistance resources needed to provide for 150,000 permanent supportive housing units;
2. An analysis and recommendations leveraging potential savings and "off-sets" from other public systems, such as health care for the homeless, shelters, and correctional facilities; and
3. Strategies for creating more public/private supportive housing partnerships that include government, nonprofit, and faith-based groups; PHAs; philanthropic organizations; and the private sector.

As the Nation's housing agency, HUD should take the lead in developing this comprehensive plan, beginning with a coordinated response across all HUD programs. HUD has already begun this process by developing an intra-departmental task force to examine barriers to mainstream housing resources for people who are homeless and organizations that work with them. Several initiatives were developed to ease access to mainstream housing programs for use by people who are homeless.

Furthermore, HUD is in the process of developing an action plan to end chronic homelessness. As part of the planning process, the Subcommittee proposes that HUD conduct comprehensive research of "gap-financing" for affordable and permanent supportive housing to

identify improvements to existing financing packages and develop new financial tools.

HUD strategies can then be integrated and coordinated with VA and HHS strategies to produce a realistic and achievable Federal plan to access 150,000 new permanent supportive housing units.

POLICY OPTION 2	**Facilitate Use of Mainstream Resources to Expand Housing Access**

To promote better targeting of HUD's mainstream resources for people with mental illnesses, including people who are homeless and people living in restrictive settings covered by the *Olmstead* decision, the Subcommittee proposes that HUD undertake a comprehensive initiative providing education, guidance, and technical assistance to State and local housing officials and PHAs on effective strategies to address these housing needs.

This policy option is designed to increase the use of mainstream resources to expand access to housing for people with serious mental illnesses, including people who are chronically homeless and people affected by the U.S. Supreme Court's *Olmstead* decision. Mainstream resources would include:

- A range of HUD programs, e.g.,
  - Community Development Block Grant,
  - HOME,
  - Section 8 Housing Choice Voucher program,
  - Emergency Shelter Grants,
  - Housing Opportunities for Persons with AIDS,
  - Federal Low Income Housing Tax Credit program, and
  - Federal Home Loan bank programs;
- Veterans Administration programs, and
- Resources from the private sector.

The technical assistance should:

1. Encourage Federal, State, local, and private investment in housing for people with serious mental illnesses;
2. Promote the participation of State and local mental health systems, consumers, and stakeholders in Federally mandated State and local housing planning activities;
3. Provide guidance on using flexible Federal housing funds;
4. Expand public/private partnerships;
5. Mitigate local resistance and overcome NIMBY responses to siting permanent supportive housing; and
6. Include specific monitoring and outcome measurement activities to determine its effectiveness.

This HUD initiative should conclude with a report to the President describing the effectiveness of this approach in promoting the use of flexible housing funding to increase housing opportunities for people with mental illnesses, including specific outcomes achieved and policy options for future action.

POLICY OPTION 3	**Reform and Improve the Section 811 Supportive Housing Program for Persons with Disabilities**

The Subcommittee on Housing and Homelessness proposes that HUD officials work in partnership with HHS, mental health housing advocates, and Congress to reform and improve the Section 811 Supportive Housing Program for Persons with Disabilities. Included in this effort should be a waiver granted by the HUD Secretary under the current Section 811 statute to award all new Section 811 tenant-based rental assistance subsidies to nonprofit disability organizations based on their administrative capacity as a mechanism to expand access to permanent supportive housing.

The Section 811 program is the only HUD program used exclusively to develop or lease permanent supportive housing for people with disabilities who are either homeless or at risk of homelessness. Reforming the program would help expand the production of new units by making it easier for nonprofits to leverage other housing funding, including private capital. New Section 811 legislation should authorize:

1. Permanent supportive housing for people with the most severe disabilities;
2. Housing production as its primary purpose, including construction, acquisition, rehabilitation, and rental assistance;
3. Nonprofit administration of all Section 811 funding based on their capacity to administer the program;
4. More flexible capital funding, as well as long-term subsidy funding; and
5. More flexible rental assistance activities.

Greater flexibility is needed in Section 811 capital funding to encourage more public/private partnerships and increase the ability of nonprofit groups to leverage Federal low-income housing tax credit equity, HOME funds, and State/local capital financing in Section 811 projects.

A more flexible rental assistance component would provide more rent subsidies to nonprofits developing or accessing permanent supportive housing on behalf of people with serious mental illnesses and other disabilities, including individuals with complex service needs that may prevent them from accessing public housing authority (PHA) programs.

Under the current Section 811 statute, through "the stroke of a pen," the HUD Secretary can permit qualified nonprofit housing organizations with administrative capacity to have exclusive access to an estimated 2,000 new Section 811 rent subsidies each year. Currently, nonprofits have limited opportunity to obtain permanent supportive housing rent subsidies directly from HUD.

Because the Section 811 program is critically important to the President's goal of ending chronic homelessness, the Subcommittee believes there is considerable advantage to implementing this policy change immediately rather than waiting for new Section 811 legislation to be enacted.

POLICY OPTION 4 — **Complete the Mental Health Action Plan**

The Subcommittee proposes that HUD, HHS, the VA, and the U.S. Department of Labor (DOL) complete the Mental Health Action Plan with the goal of creating and improving partnerships between housing and mental health systems at the State and local levels.

Appropriations language in the FY '99 HUD budget included Section 517:

> **Sec. 517. Mental Health Action Plan**
>
> The Secretary of Housing and Urban Development, in consultation with the Secretary of Health and Human Services, the Secretary of Labor, and appropriate State and local officials and representatives, shall—(1) develop an action plan and list of recommendations for the improvement of means of providing severe mental illness treatment to families and individuals receiving housing assistance under the United States Housing Act of 1937, including public housing residents, residents of multi-family housing assisted with project-based assistance under section 8 of such Act, and recipients of tenant-based assistance under such section; and (2) develop and disseminate a list of current practices among public housing agencies and owners of assisted housing that serve to benefit persons in need of mental health care.

The Subcommittee believes that the Mental Health Action Plan can be used as a policy tool to strengthen the efforts of HUD, HHS, VA, and DOL to promote better systems integration strategies on behalf of people with serious mental illnesses. Specific goals of a new effort should include:

1. Creating policy incentives within the (a) Community Mental Health Services, (b) Substance Abuse Prevention and Treatment, and (c) Community Development Block Grant programs to promote housing/services system integration activities at the State level;
2. Disseminating successful system integration strategies, including those identified in the ACCESS program; and
3. Identifying existing HUD, HHS, DOL, and VA resources and technical assistance that can be used to assist States in improving the integration of housing, mental health and substance abuse treatment, and employment policies and programs.

The Subcommittee suggests that HUD, HHS, and other relevant Federal agencies sponsor a series of policy academies for local mental health agencies and PHAs to develop strategies that could be used to implement the Mental Health Action Plan. Recent HUD/HHS policy academies and the ongoing HUD/HHS/VA collaboration to address chronic homelessness are both promising indicators that a viable Mental Health Action Plan can be developed.

POLICY OPTION 5 **Preserve and Sustain Subsidized Housing Resources**

To advance the Administration's goal of preventing homelessness among people with serious mental illnesses, the Subcommittee on Housing and Homelessness proposes that:

1. HUD and the Office of Management and Budget adopt policies to preserve and sustain subsidized housing resources already targeted to people with mental illnesses and other disabilities, including eligible McKinney/Vento projects, Section 811 subsidies, and Section 8 subsidies set-aside for those affected by "elderly only" housing policies; and
2. HUD take the necessary steps to ensure proper implementation of Federal "elderly only" designation policies by Federal public- and assisted-housing providers.

As part of Federal efforts to address and prevent homelessness, the Subcommittee believes that people with serious mental illnesses must continue to have access to the specially targeted HUD subsidies already created to address their housing problems. People with mental illnesses must also be able to access the Federally subsidized public- and assisted-housing units they continue to qualify for under existing Federal "elderly only" housing laws.

Because of their appropriations history and 3- to 5-year contracting mechanisms, existing HUD, McKinney/Vento, and Section 811 housing subsidies have less secure renewal funding than subsidies in the Section 8 voucher program.

The Subcommittee proposes that the Administration work with Congress to develop a more secure budget-neutral funding stream for renewals of McKinney/Vento and Section 811 subsidies. More secure renewal policies are needed so that permanent supportive housing developers will be able to attract other sources of sustainable public and private funding for their projects.

The Subcommittee recognizes that the number of Federally subsidized units in a local community in which non-elderly people with disabilities are eligible to live declines when owners have "elderly only" occupancy policies. Therefore, the Subcommittee suggests that HUD adopt policies which ensure that the estimated 50,000 Section 8 "designated housing" vouchers continue to be set aside by PHAs exclusively for people with disabilities.

The Subcommittee proposes that HUD and VA Supported Housing Program (HUD-VASH) rent subsidies provided by Congress for homeless veterans with mental illnesses and other disabilities also continue to be set aside by PHAs for this specific population. This approach will help to mitigate the long-term affects of designation and ensure that the vouchers provided by Congress to address the loss of housing for people with disabilities will continue

to be made available by PHAs as long as the housing remains designated.

The Subcommittee also urges that HUD promulgate regulations for the public- and assisted-housing programs covered under Title VI of the Housing and Community Development Act of 1992 to improve compliance with Federal "elderly only" housing designation laws and protect the rights of non-elderly people with disabilities according to these laws.

POLICY OPTION 6	**Develop and Implement an Integrated Strategy for Enforcing Disability Rights and Grantee Compliance with Fair Housing Obligations**

The Subcommittee proposes that HUD and the U.S. Department of Justice (DOJ) develop and implement an integrated strategy to coordinate enforcing disability rights and grantee compliance with fair housing obligations.

This effort should be led by HUD's Office of Fair Housing and Equal Opportunity (FHEO) and should include:

1. Short- and long-term strategies for improving interagency coordination and enforcement;
2. The development of mechanisms to coordinate the work of FHEO with other HUD program offices and DOJ;
3. Mechanisms to improve communication within HUD, between HUD and DOJ, and externally to consumers and HUD grantees; and
4. The development of a systematic plan to improve HUD's response to Section 504 complaints.

To improve Fair Housing education and assist HUD regional offices and State/local enforcement agencies, FHEO should also develop a system to identify and disseminate best practices on such topics as:

- Community outreach and education efforts,
- Intake and case processing,
- Investigative and compliance strategies, and
- Successful technical assistance initiatives, including those of private fair housing groups.

POLICY OPTION 7	**Promote Evidence-based Practices for People with Mental Illnesses who are Homeless or at Risk of Homelessness**

The Subcommittee proposes that HHS establish funding policies to ensure that initiatives related to evidence-based practices and the integration of Federal and State funding resources are tailored to people with mental illnesses who are homeless or at risk of homelessness.

Evidence-based practices that are known to be effective in assisting people with mental illnesses who are homeless (or at risk of homelessness) to gain and sustain independent living in the community include:

- Assertive community treatment,
- Integrated services for people with co-occurring substance use disorders and mental illnesses,
- Supportive employment, and
- Illness self-management.

HHS initiatives can be used to expand and replicate evidence-based practices and to create mechanisms for integrating and coordinating public mental health services with other Federal and State resources of importance to people with mental illnesses who are homeless.

The combination of financing evidence-based practices and Federal efforts to coordinate and integrate funding streams will result in service design, financing strategies, and incentives at the State and local levels that make mainstream resources more responsive and effective in meeting the needs and choices of people with mental illnesses who are homeless and at risk of

homelessness. These actions will also help these people to be successful in attaining permanent housing, employment, and community integration.

Examples of such cost-neutral strategies include:

- Establishing a direct policy and planning link at the State level between the Substance Abuse Mental Health Services Administration (SAMHSA) Community Mental Health Block Grant and the SAMHSA Projects for Assistance in the Transition from Homelessness (PATH) grant;
- Requiring States to specifically address how PATH and Mental Health Block Grant funds will be:
  - Coordinated to ensure that increased mainstream services linked with supportive housing are targeted to people with mental illness who are homeless,
  - Linked with other Federal and State supportive housing funding to leverage additional resources, and
  - Coordinated and integrated with other mainstream resources to enhance supportive housing development. HUD's Continuum of Care and Consolidated Plan processes are good examples of this type of planning mechanism;
- Refining HHS discretionary grant programs to include homeless and supportive housing strategies in larger science-to-services and evidence-based practice implementation and evaluation efforts;
- Requiring States to specifically address how they will allocate a portion of any discretionary grant funding to be dedicated to providing services in supportive housing and create incentives for grantees to establish partnerships with permanent supportive housing providers;
- Setting aside a portion of current SAMHSA/CMHS/Center for Substance Abuse Treatment (CSAT) discretionary grant authority to be used for specific State or local strategies to implement evidence-based practices specifically tailored to people with mental illnesses who are or who have been homeless and are in or moving towards supportive housing;
- Ensuring coordination and joint planning among Federal mainstream funding sources to reinforce State-level integration of resources and targeting of mainstream resources to supportive housing for people with mental illnesses who are homeless. These activities may include, but are not limited to, allowing expenses such as developing system collaboration infrastructure, hiring system integrators, flexible fund reserves, incentive funds, and developing strategic plans to build partnerships across systems; and
- Ensuring that all Federal efforts to increase the flexibility of Federal service funding and eligibility requirements are tailored to people with mental illnesses who are homeless and who are moving to supportive housing and employment in the community. Likewise, inform States about current Federal flexibility and service coordination opportunities involving persons with mental illnesses in these circumstances. Any new Federal waiver authority or new discretionary grant fund programs should include funding and evaluation activities related to new service delivery and/or financing approaches and incentives related to supportive housing for people with mental illnesses who are homeless or at risk of homelessness.

POLICY OPTION 8	**Employ Medicaid Financing Mechanisms that Effectively Serve People with Mental Illnesses who are Homeless or at Risk of Homelessness**

The Subcommittee proposes that HHS and its Centers for Medicare and Medicaid Services (CMS) improve and expand the ways in which Medicaid funding is used to maximum

effectiveness in serving people who are homeless, at risk of homelessness, or moving from homelessness to permanent supportive housing.

Existing Medicaid statute and regulations support some flexibility and ability to implement community-based services of importance to people with mental illnesses who are homeless or at risk of homelessness. However, several strategies could be implemented to:

- Increase the flexibility of current Medicaid financing;
- Increase the participation of State Medicaid programs in intergovernmental initiatives to reduce homelessness and expand permanent supportive housing; and
- Improve the access of people with mental illnesses who are homeless to Medicaid benefits.

These strategies include:

- Encouraging State Medicaid agencies to implement evidence-based or promising practices, such as assertive community treatment (ACT), supportive employment, integrated services for people with co-occurring mental illnesses and substance use disorders, and illness self-management services, that can be effective in assisting people with mental illnesses in their move from homelessness to permanent supportive housing;
- Requiring State Medicaid agencies to document in any State plan amendment or waiver request how the plan amendment or waiver could positively or negatively affect people with mental illnesses who are homeless; and how it will increase access to Medicaid benefits and/or support the implementation of new evidence-based or promising service models expected to assist people with mental illnesses who are homeless or at risk of homelessness;
- Encouraging CMS to issue guidance and provide technical assistance to State Medicaid agencies to ensure their participation in joint planning and implementation of integrated strategies to increase permanent supportive housing. Such activities should include providing information on Medicaid-qualifying services that have proven to be effective in meeting the needs and choices of people with mental illnesses who are homeless or at risk of homelessness; and providing information on joint Medicaid and other State agency strategies that have been successfully used in permanent supportive housing;
- Urging CMS to provide guidance to provider agencies that typically work with people with mental illnesses who are homeless or at risk of homelessness (e.g., Federally qualified health centers and health care for the homeless programs) to fully implement the mental health elements of the Medicaid Early, Periodic Screening Diagnosis and Treatment (EPSDT) program for youth who are homeless or at risk of homelessness;
- Advising CMS to encourage States to implement Medicaid presumptive eligibility guidelines for people with mental illnesses who are likely to be categorically and financially eligible once the eligibility and/or disability adjudication processes are completed. Presumptive eligibility should be encouraged for people with mental illnesses who are homeless or at risk of homelessness;
- Urging CMS to implement strategies that can assist homeless service providers and other non-traditional community service providers to become Medicaid providers and to bill Medicaid for services rendered. Such strategies include: developing streamlined Medicaid provider certification for providers who do not fit within Medicaid or State licensure or certification categories, establishing daily or monthly rates and corollary documentation requirements as opposed to brief service increments and encounter-by-encounter documentation, and providing for supervision rather than credentialing of paraprofessional and peer staff members; and

- Encouraging CMS and other HHS agencies to facilitate and support State efforts to use creative financing mechanisms and blended funding strategies to provide positive incentives and flexible approaches for delivering services to people with mental illnesses on a path from homelessness to permanent supportive housing. Such strategies could include milestone payments as opposed to fee-for-service payments; risk sharing arrangements, such as case rates and/or sub-capitation mechanisms; and blended funding models, such as global budgets with performance incentives.

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