



National Association of State Mental Health  
Program Directors (NASMHPD)

NASMHPD Policy Brief

Affordable Housing:  
The Role of the Public Behavioral  
Health System

October 2011

## **Executive Summary**

For people with serious mental illness, having a home of one's own is an important element of self-determination, full community integration, and a pathway to recovery. The National Association of State Mental Health Program Directors (NASMHPD) and State Mental Health Authorities (SMHAs) housing vision and goal is to ensure that people served by the public behavioral health system have access to decent, safe and permanent affordable housing of their choice, linked with the full range of high quality services they may need to support successful tenancies.

### **Key Housing Issues**

People with serious mental illness are disproportionately poor and cannot afford even modestly priced rental housing without government housing assistance. Unfortunately, federal housing subsidies are extremely scarce, and housing waiting lists can be 5-10 years long. And, while Congress has reliably provided new housing funding to reduce chronic homelessness among people with mental illness, NASMHPD members are confronting enormous housing challenges and barriers. These include litigation resulting from the U.S. Supreme Court's *Olmstead* decision that may require the creation of 20,000 or more units of Permanent Supportive Housing (PSH).

Despite these housing challenges, NASMHPD and its members continue to establish successful partnerships at the federal, state and local level to expand affordable housing and PSH opportunities and choices for consumers, such as securing appropriations of new U.S. Department of Housing and Urban Development (HUD) Housing Choice Vouchers targeted to people with disabilities, initiating Housing First programs, and creating effective State and local Public Housing Agency partnerships. SMHAs have also created innovative mental health-funded housing strategies that have significantly leveraged affordable housing resources, such as temporary "bridge" rental subsidy programs that can assist consumers while they wait for a permanent HUD subsidy.

### **Permanent Supportive Housing (PSH)**

The PSH model is an evidenced-based housing approach defined in SAMHSA's Evidenced-Based Practice Toolkit as integrated, community-based, permanent and affordable and that is safe and secure with a lease in the tenant's name. PSH tenants receive individually tailored, flexible, and voluntary services that are accessible when needed to ensure successful tenancies. Research on PSH – including the Housing First model of PSH – has demonstrated positive impacts in terms of improved quality of life, housing stability, as well as health and behavioral health outcomes. Studies of the effectiveness of PSH have shown reductions in time spent homeless and housing retention rates of 75-85 percent for some of the most severely disabled tenants with mental illness. PSH works in urban, suburban, and rural areas and numerous studies have also illustrated the cost-effectiveness and improved mental health and substance abuse outcomes associated with PSH and Housing First for high need households.

## **Factors Relevant to NASMHPD Housing Policy**

Aligning federal housing policy with the Patient Protection and Affordable Care Act (ACA), improved federal and state interagency housing collaborations, new HUD polices to expand PSH, and the potential for more efficient SMHA housing and services resource alignment are all important factors relevant to NASMHPD housing policy. HUD and HHS are now partnering on several PSH initiatives including developing models of Medicaid financing for PSH-related supportive services. During the next few years, NASMHPD expects that the correlation between cost-effective, community-based care and PSH will be demonstrated through several new federal PSH opportunities including:

Groundbreaking legislation reforming HUD's Section 811 program which creates opportunities for new state level PSH partnerships;

Improved HUD policy to preserve 70,000 Housing Choice Vouchers which could help address chronic homelessness and help people with disabilities move out of restrictive, segregated settings;

Improved HUD fair housing and PSH policies which should help reduce barriers to housing (i.e. criminal record, poor housing history, etc.) and offer more opportunities for SMHAs to establish sustainable partnerships between State and local Public Housing Agencies;

Medicaid expansion through the ACA which will support re-balancing from facility-based care to integrated community based settings such as PSH.

## **NASMHPD Housing Policies and Action Steps Related to Federal Entities**

To capitalize on these developments in federal policy and expand evidenced-based housing opportunities for SMHA consumers, NASMHPD adopts the following policies and action steps related to federal entities:

HUD Appropriations: As an active member of the Consortium for Citizens with Disabilities Housing Task Force (CCD), NASMHPD and its members will continue to advocate for increased appropriations for key HUD programs targeted to expand permanent housing assistance to the most vulnerable people with mental illness and other disabilities who are homeless, institutionalized, or at-risk of these conditions;

HUD and HHS Implementation of Section 811 Reforms: NASMHPD urges HUD and HHS to adopt policies that support the development of robust Section 811 partnerships between State Housing Agencies and State Health and Human Service/Medicaid agencies: such partnerships can support SMHAs housing goals and promote an expansion of PSH for people with mental illness who are living in restrictive settings or who are chronically homeless. These policies include effective outreach, referral and service linkages and Medicaid and state appropriated service financing models for PSH;

HUD Policies: To expand access to HUD resources for the lowest income people with mental illness, NASMHPD will continue to support CCD's advocacy to increase access to Housing Choice Vouchers through local PHAs, including greater utilization of Housing Choice Vouchers and public housing units to create new PSH opportunities. NASMHPD also calls on HUD to create more uniform PSH policies and resolve barriers with its housing programs to promote and foster the development of PSH through existing HUD resources;

Olmstead: NASMHPD urges HUD, HHS, and the U.S. Department of Justice (DOJ) to collaborate on the development of federal policies to promote and incentivize the targeting of federal housing assistance programs for *Olmstead* settlement agreements and for people with mental illness living unnecessarily in institutional settings. Strong federal leadership on this issue is needed to help SMHAs preserve scarce public mental health system funding for supportive services;

Substance Abuse and Mental Health Services Administration: NASMHPD calls on the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to use its homeless and housing initiatives as well as its Block Grant and discretionary funding to: (1) support SMHA activities related to expanding PSH at the community level; and (2) assist SMHAs with housing infrastructure and housing capacity/competency issues;

SAMHSA/Centers for Medicare and Medicaid Services (CMS): NASMHPD urges SAMHSA and CMS to jointly develop and disseminate Medicaid-related "best practice" PSH policy and implementation guidance and models to assist SMHAs to expand the use of Medicaid for PSH services and supports.

# NASMHPD Policy Brief

## Affordable Housing: The Role of the Public Behavioral Health System

### **Part I. Background**

#### **Importance and Key Facts**

A decent, safe and affordable place to live is essential for anyone to achieve full participation in community life. For people with serious mental illness, having a home of one's own, and choosing that home – the neighborhood, the type of housing, and who (if anyone) it is shared with – is also an important element of self-determination, full community integration, and a pathway to recovery.

*To promote independence and support recovery, the goal of the National Association of State Mental Health Program Directors (NASMHPD) is to promote housing policies and programs to ensure that people served by the public behavioral health system are able to make informed choices among safe and permanent affordable housing options that are linked with high quality services and are available in the most integrated setting in the community.*

The affordable housing challenges which NASMHPD and SMHAs continue to confront to achieve this vision and goal include the following:

Poverty: People with serious mental illness are disproportionately poor and cannot afford even modestly priced rental housing without housing assistance. The bi-annual housing affordability study, *Priced Out in 2010*, just released by the Technical Assistance Collaborative (TAC) confirms that in 2010, people who relied on Supplemental Security Income (SSI) payments have incomes equal to only 18 percent of median income – more than 20 percent below the federal poverty level. In 2010, more than 2 million people with mental illness were receiving federal SSI payments and tens of thousands of chronically homeless people with mental illness were potentially eligible for SSI.

Housing Costs: The *Priced Out in 2010* study found that people with the most significant and long term disabilities continue to be completely priced out of the nation's rental housing market. Nationally in 2010, people receiving federal SSI payments would have needed to pay 112 percent of their entire monthly income in order to rent a one bedroom apartment priced at the HUD Fair Market Rent.<sup>1</sup> Lower priced studio/efficiency units were almost as high – at 99 percent of SSI. Federal housing affordability guidelines provide that extremely low income households should pay no more than 30 percent of their income for housing costs, which is

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<sup>1</sup> HUD Fair Market Rents are used to administer HUD's Housing Choice Voucher program, and generally are consistent with rents between the 40th and 50th percentile of the rental housing market.

approximately \$200 for an SSI recipient. With national average one bedroom rents above \$787, people with SSI level incomes must have access to a permanent rental subsidy in order to obtain decent, safe and affordable housing of their choice in the community.

Worst Case Housing Needs: For the first time ever, a U.S. Department of Housing and Urban Development (HUD) report to Congress<sup>2</sup> has confirmed that non-elderly adults with disabilities are more likely than those without disabilities to have very low incomes and to experience worst case housing needs – meaning that they pay more than one-half of their income for rent and/or have other serious housing problems, such as living in inadequate or overcrowded housing. Between 2007 and 2009, there was a 13 percent increase in worst case needs households that included non-elderly adults with disabilities. HUD further acknowledges that its Worst Case Needs reports may seriously understate the extent of worst case needs of people with disabilities.

Scarcity of Federal Rental Subsidies: NASMHPD members have struggled with the extreme scarcity of permanent rental assistance for more than 30 years. Like other extremely low income households, people with mental illness with incomes at or below the SSI-level should be assisted through federal housing assistance programs.<sup>3</sup> Very few states provide state funding for low income housing assistance. Unfortunately, federal rental subsidies are not an entitlement, and less than one-third of eligible households currently receive assistance. Currently, only 4.6 million HUD permanent rental subsidies are funded annually by Congress<sup>4</sup> – and these are renewal subsidies already in use by households. According to *The State of the Nation's Housing 2011* report just released by Harvard University's Joint Center on Housing Studies, the number of HUD-assisted renters grew each year in the 1970s by 228,000 households annually, as compared to 121,000 households in the 1990s and just 74,000 households in the 2000s. Because of the demolition or sale of HUD public and assisted housing, since the early 1990s the 'net' supply of permanent housing subsidies for the lowest income households has increased by only 13 percent.<sup>5</sup> As a result of these significant reductions in the growth of federal housing programs, waiting lists for rent subsidies in some communities can be 5-10 years long.

The Effect of Categorical Homeless Housing Programs: The housing eligibility silos, created when a vulnerable person with mental illness sleeps (on the streets or in a homeless facility vs. an institution), are a major barrier for SMHAs seeking to develop comprehensive PSH strategies to assist both groups. During most of the past decade, the federal government's primary housing policy focus with respect to people with disabilities was to end chronic homelessness. During the past eight years, between 4,000 and 5,000 new homeless rental subsidies were appropriated

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<sup>2</sup> 2009 Worst Case Housing Needs of People with Disabilities. U.S. Department of Housing and Urban Development. March 24, 2011.

<sup>3</sup> Very few states provide state funding for housing assistance for the lowest income households. Among the few states that do are Massachusetts, Connecticut, North Carolina, Washington State and Illinois. However, budget deficits in these states have reduced state appropriations for these programs during recent years.

<sup>4</sup> TAC estimates that as many as 500,000 of these subsidies are targeted primarily for elderly households aged 62 and older, while only 100,000 are targeted primarily for non-elderly people with disabilities. The remaining 4 million are available on an equal basis to elderly households, non-elderly households with disabilities, as well as non-elderly, non-disabled households

<sup>5</sup> In 1993, HUD's Recent Research Results estimated that HUD was funding approximately 4.3 million permanent rental subsidies, which at that time included public housing, HUD Assisted Housing and Section 8 Certificates and

Vouchers.

annually by Congress for people who are chronically homeless<sup>6</sup> – an important and sustained effort which has reduced the chronic homeless population by as much as 30 percent. Despite this success, these policies created an untenable situation for SMHAs struggling to reduce chronic homelessness, while also assisting people living unnecessarily in restrictive institutional settings to move to housing in the community.

*Olmstead*: NASMHPD's members confront enormous housing challenges posed by the U.S. Supreme Court's *Olmstead* decision. The lack of access to decent, safe, affordable and integrated community-based housing for the most vulnerable people with disabilities is fundamental to *Olmstead*. Currently, four SMHAs (New York, New Jersey, Georgia and Illinois) have *Olmstead* settlement agreements requiring an estimated 20,000 new units of Permanent Supportive Housing (PSH) and other *Olmstead*-related activities are pending in states. State and local housing agencies are not parties to these lawsuits and have not been required to provide any housing resources as a condition of these settlements. Nor has Congress appropriated housing funding to address the *Olmstead* housing issue, as it has to help end chronic homelessness. Without federal housing assistance targeted to people with disabilities leaving restrictive settings, the vast majority of the funding for the housing component of these settlements will continue to be paid for by declining SMHA budgets.

Successful Housing Partnerships: On a more positive note, 28 percent of all Housing Choice Vouchers appropriated by Congress (approximately 560,000 of 2 million vouchers currently leased) are assisting non-elderly households with disabilities<sup>7</sup> – more than double the number assisted in mid-1990s. This data is just one indicator of the substantial progress made by NASMHPD and other national disability housing advocates to: (1) influence Congress to appropriate more Housing Choice Vouchers targeted to people with disabilities; and (2) improve access to existing HUD-subsidized housing resources at the state and local level. In FY2008 and FY2009, national disability advocates were successful in obtaining 5,300 new Housing Choice Vouchers from Congress for people with disabilities, adding to the supply of more than 65,000 Housing Choice Vouchers previously appropriated by Congress for exclusive use by non-elderly people with disabilities. At the local level, an increasing number of Housing First initiatives have been using Housing Choice Vouchers provided through Public Housing Agency (PHA) partnerships. SMHAs have also initiated state-wide housing strategies that have significantly leveraged affordable housing resources through relatively small investments of SMHA funding, such as paying for temporary 'bridge' rental subsidies until assistance from HUD's programs is available.

During the foreseeable future, there will be both challenges as well as opportunities for NASMHPD and its members within federal, state and local affordable housing policy. Nonetheless, NASMHPD's members have demonstrated that it is possible to establish successful housing partnerships at the state and local level to expand the Permanent Supportive Housing

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<sup>6</sup> Defined as being continually homeless for 12 months or more, or having four or more episodes of homelessness over the past three years.

<sup>7</sup> HUD Resident Characteristics Report, May 31, 2011. Federal fair housing laws prohibit PHAs administering the Housing Choice Voucher program from asking questions about the nature or extent of a person's disability. For this reason, HUD does not collect data on the number of Housing Choice Vouchers being used by people with mental



illness.

(PSH) approach in local communities, including during years when new HUD funding is in short supply.

## **Part II. Housing Approaches and Models**

### **PSH -- The Evidenced-Based Housing Approach**

SAMHSA's Evidenced-Based Practice Toolkit on PSH defines the key elements of the PSH model:

- Integrated, community-based permanent housing that is safe and secure;
- Housing that is affordable with tenants paying no more than 30 percent of their income toward rent and utilities;
- Leases that are consistent with local landlord-tenant law and held by the tenants without limits on length of stay as long as the tenant complies with lease requirements;
- Individually tailored and flexible supportive services that are voluntary, accessible where the tenant lives, available 24 hours a day/7 days a week, and are not a condition of on-going tenancy; and
- On-going collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

Next year will be the 25<sup>th</sup> anniversary of the Robert Wood Johnson Foundation (RWJF) Demonstration program on Chronic Mental Illness – the PSH initiative which began a fundamental alteration of the housing paradigm within public mental health. At the time of the RWJF Demonstration, most mental health systems rejected the idea that people with the most serious mental illnesses could live successfully in PSH. Now PSH is almost universally acknowledged today as one of the most effective approaches embraced and is effective in urban, suburban, and rural areas.

### **PSH – The Evidence**

In addition to promoting greater community integration, choice and satisfaction, research on PSH has demonstrated positive impacts in terms of improved quality of life, housing stability, and health and behavioral outcomes. Studies of the effectiveness of PSH have shown reductions in time spent homeless and housing retention rates of 75-85 percent for some of the most severely disabled tenants with mental illness

The Housing First PSH approach – pioneered by Pathways to Housing in the late 1990s and now listed on SAMHSA's National Registry of Evidenced-Based Programs and Practices –has successfully demonstrated that even people with the most severe mental illnesses and active substance use disorders can live successfully in apartments of their own when provided with comprehensive, appropriate, and voluntary services.

Numerous studies have also illustrated the cost-effectiveness of PSH. The Cannon Kip Community House and Lyric Hotel study of service utilization for homeless individuals with mental illness and substance use disorders in San Francisco found a 56 percent reduction in

emergency room visits and a 45 percent reduction in inpatient stays after living in PSH. Findings from a cost-benefit analysis of Denver's Housing First Collaborative saw reductions in use of emergency room and inpatient care by 34 percent and 80 percent respectively, with an estimate total cost savings of \$31,545 per individual. The State of California's substantial investment in PSH for people with mental illness who are homeless or at-risk of homelessness (e.g. returning from jails or prisons) also resulted in substantial cost savings to local jurisdictions in terms of reduced homelessness, emergency room usage, hospitalizations, and incarceration.

PSH and Housing First models have also demonstrated improved mental health and substance abuse outcomes for high-need households as well as improved outcomes for multiple chronic health conditions including HIV-AIDS. The Minnesota Supportive Housing and Managed Care Pilot, which provided supportive housing to more than 500 adults and families with long histories of homelessness and complex needs, resulted in improvements in mental health outcomes as well as decreases in alcohol and drug use among these households.

### **The Influence of *Olmstead* Litigation on PSH Models**

During the past few years, State *Olmstead* settlement agreements have begun to challenge the appropriateness of the 'single purpose' PSH project model (e.g., projects with most or all of the units reserved for people with disabilities). Just as the group home model was considered a significant improvement over institutions in the late 1970s and early 1980s, single purpose PSH projects were also considered a significant advance in mental health system housing policy in the 1990s because tenants had leases and services were voluntary. Although certain HUD programs permit single purpose PSH projects (i.e., McKinney-Vento homeless programs, the Project-Based Voucher program, etc.), many are becoming more opposed to segregated/disability-specific PSH projects because they replicate the segregation of people with mental illness associated with adult care homes and other mental health facilities.

The success of large scale scattered-site, cross-disability PSH housing approaches in several states has demonstrated the efficacy of less stigmatizing PSH models, and has led to a new federal strategy for expanding integrated PSH recently enacted by Congress through reforms to HUD's Section 811 Supportive Housing for Persons with Disabilities program. Moving forward, this is an extremely important issue for NASHMPD members. Just as some service providers remain heavily invested in large congregate residential real estate, many non-profit PSH providers are heavily invested in single purpose PSH projects with grant-funded on-site services that may be difficult to align with the future of Medicaid. In a significant development, HHS recently proposed rules on the Centers for Medicare and Medicaid Services (CMS) 1915(c) waiver programs to include a new policy, which would prohibit referrals to certain disability-specific settings for waiver recipients transitioning to community-based housing.<sup>8</sup> CMS's increased emphasis on integrated housing models is also relevant to SMHAs involved in CMS's Money Follows the Person Demonstration program, as well as SMHAs seeking to maximize Medicaid financed services for people living in PSH.

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<sup>8</sup> CMS Notice of Proposed Rule Making, Federal Register, April 15, 2011

## **Part III. Federal PSH Environmental Scan**

### **Relevant Federal Agency Strategic Plans and PSH Collaborations**

The alignment of federal housing policy with the Patient Protection and Affordable Care Act (ACA), improved federal and state interagency housing collaborations, new HUD polices to expand PSH, and the potential for SMHA housing and services resource rebalancing are all important housing environmental factors relevant to NASMHPD housing policy. Although federal interagency collaborations alone will not automatically produce more affordable housing resources for people with mental illness in public mental health systems, they are creating the context and environment for innovation and systems change related to PSH that can be leveraged at the state and local level. The PSH related federal agency planning and interagency collaborations most relevant to NASMHPD members include:

HUD's Strategic Plan for 2010-2015 commits HUD to partner with federal, state and local organizations to deploy evidenced-based and promising interventions, such as PSH and the Housing First model, homeless prevention, and rapid re-housing to prevent and end homelessness. HUD's plan notes that "if individuals and families that are currently cycling through expensive institutions can be targeted for appropriate housing and services, there can be significant cost savings." HUD Secretary Shaun Donovan believes that the future of HUD rests partly on the effective use of HUD's programs as a 'platform' to achieve other important social policy objectives. Secretary Donovan also has more than 15 years of direct experience with the PSH approach, and is working extremely hard to realign HUD's programs to support a national expansion of PSH.

HUD and HHS have created a new partnership that includes a Community Living Partnership linked with the CMS Money Follows the Person Demonstration program and HUD/HHS efforts to model Medicaid-financed services for PSH tenants.<sup>9</sup> To inaugurate the Community Living partnership, HUD re-programmed approximately 1,000 new Housing Choice Vouchers to assist people with disabilities transition from restrictive settings into the community. Although these vouchers only scratch the surface of PSH needs in the states, lessons learned from this initiative should help NASMHPD members more effectively engage and collaborate with PHAs to set aside Housing Choice Vouchers for Olmstead-related activities.

In 2010, the U.S. Interagency Council on Homelessness (ICH) published *Opening Doors: The Federal Plan to Prevent and End Homelessness*, a road map for joint action by the 19-member ICH and its state and local partners. Federal agencies are working to improve coordination and targeting of existing resources – including SAMHSA block grant resources and Medicaid – to help prevent and end homelessness. While the current federal budget situation has limited the ability of federal agencies to commit new resources to support the ICH plan's implementation, a substantial effort is underway to

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<sup>9</sup> Unfortunately, the Housing Choice Vouchers which would have 'anchored' the HUD-HHS PSH Medicaid

initiative were not funded by Congress in the final negotiations on the FY2011 budget.

help states and localities 're-tool' homeless and mainstream programs to support the goals of *Opening Doors*.

SAMHSA's strategic plan, *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014* calls for a coordinated and consistent approach to preventing and ending homelessness and improved access to housing assistance programs and supportive services for people with mental illness and substance use disorders. Important SAMHSA action steps in housing include (1) working with HUD to develop policy guidance and directives that support increased access to mainstream housing programs; (2) distribution of SAMHSA's Permanent Supportive Housing Toolkit; and (3) disseminating information to behavioral health providers on effective financing strategies for creating and providing linkages to permanent housing and supportive behavioral health services.

The Veterans Administration (VA) strategic plan has identified ending veterans' homelessness as one of 13 strategic initiatives, and both SAMHSA and the VA intend their initiatives to dovetail with the ICH Federal Plan. Congress has also appropriated substantial new funding for housing, case management and supportive services funding for veterans, including new community-based approaches that could involve behavioral health non-profits with experience in the PSH approach.

Improved collaboration across federal agencies is essential to expanding PSH but it will take resources to produce PSH units and PSH services. Despite the increased pressure to reduce federal discretionary spending, PSH is generally recognized by both parties as a cost-effective model that helps to address the high cost associated with homelessness. As a result, homeless programs have been exempt from the budget cuts that have affected other HUD programs. Unfortunately, it is less well-understood by Congress that PSH is also essential to control the spiraling cost of institutional care for people with disabilities, which is affecting both federal Medicaid and Medicare budgets, as well as state budgets. During the next few years, NASMHPD expects that the correlation between cost-effective, community-based care and PSH will be demonstrated through new federal PSH resource and policy opportunities discussed below.

## **HUD Programs and Policies**

### *HUD's New Section 811 Program*

On January 4, 2011, President Obama signed into law the Frank Melville Supportive Housing Investment Act, which will modernize and reinvigorate HUD's outdated and moribund Section 811 Supportive Housing for Persons with Disabilities program. Section 811 is one of only two HUD supportive housing programs for non-elderly people with disabilities, and is therefore symbolic to the future of the PSH approach. This groundbreaking legislation creates two new integrated PSH housing models, including one that will be implemented at the state level through a formal PSH Agreement between the State Housing Finance Agency (HFA) and the State Health and Human Services/Medicaid agency (State HHS). This agreement, which must be completed in order to apply for Section 811 funding, must specify: (1) the target populations to be assisted through the program; (2) methods of outreach and referral to ensure prospective

tenants are referred to integrated PSH units in affordable housing developments in a timely manner; and (3) commitments of Medicaid and state-appropriated supportive services to ensure successful tenancies.

The Section 811 PSH units to be created under this Agreement will be integrated within new State Housing Agency affordable housing developments funded with mainstream federal housing programs, such as the federal Low Income Housing Tax Credit program, HUD's HOME program, and state bonds. To ensure community integration policies consistent with the Americans with Disabilities Act, no more than 25 percent of the units in any property can be set aside for people with disabilities. Both non-profit and for-profit housing developers are eligible to create these integrated PSH set-asides. And, because the new Section 811 program leverages other affordable housing programs, it is possible that 3,000-4,000 new units can be created annually, as compared to the 800-900 units that have been funded during recent years.

The Melville Act is the first federal housing program to formally incorporate state Medicaid policy in the planning and implementation of PSH and anticipates the full implementation of the Patient Protection and Affordable Care Act. It offers NASMHPD members an important opportunity to ensure that PSH programs target the highest need, highest cost people with mental illness for PSH units. Once in place, the PSH Agreement's policies can be used to create PSH partnerships that extend beyond the implementation of the Section 811 program to other state and local PSH activities with the State HFA and/or local PHAs.

#### *Targeting HUD Housing Choice Vouchers and Other HUD Resources to Expand PSH*

Through its membership in the Consortium for Citizens with Disabilities Housing Task Force, NASMHPD and other national disability housing advocates have embarked on an ambitious advocacy strategy with HUD to re-direct existing Housing Choice Vouchers, as well as other mainstream HUD programs, for PSH. This effort began by inserting specific provisions in the Section 811 Melville Act to re-direct 70,000 Housing Choice Vouchers to address chronic homelessness and help people with disabilities move out of restrictive, segregated settings. Other HUD programs that can be prioritized for PSH include new units of federal public housing being created through innovative PHA financing strategies, and rental housing opportunities funded through HUD's HOME program.

#### *HUD's PSH-Related Policies*

Currently, HUD has a myriad of confusing regulations and guidelines that deter the creation of PSH through mainstream HUD programs. These well-intended policies, originated after the passage of the ADA as a means to ensure that people with specific disabilities – particularly mental illness – were not steered or otherwise directed solely to housing settings that were stigmatizing and segregated. For example, these policies correctly prohibit a public housing agency from setting aside a public housing building solely for occupancy by people with mental illness. Unfortunately, these policies have also prevented Public Housing Agencies and other HUD grantees from targeting housing subsidies to people who are receiving disability-specific supportive services, such as Medicaid 1915 (c) waivers or Assertive Community Treatment (ACT) services. NASMHPD, through the CCD Housing Task Force, has also engaged in a



dialogue with HUD regarding the need to modernize these policies to reflect the implementation of scattered site housing strategies, such as Housing First and the new Section 811 program, and to urge changes to these policies that would assist SMHAs with the implementation of *Olmstead* settlement agreements in order to maximize HUD resources for housing.

### *HUD's Fair Housing Policies*

For more than 20 years, HUD has also had fair housing regulations that require HUD grantees to "affirmatively further fair housing opportunities" for groups likely to experience discrimination, including people with disabilities. Until recently, these regulations had little actual affect on state and local housing strategies, but successful litigation has prompted HUD to increase enforcement and initiate new regulatory reforms. Stronger enforcement means that people with mental illness will have more opportunity to overcome screening criteria that some housing agencies use to deny access to HUD resources.

HUD also has published guidance on how PHAs and other HUD housing providers should grant reasonable accommodation requests made by people with disabilities to make HUD's programs more accessible. For example, people with disabilities using a Housing Choice Voucher are permitted to rent from relatives (which is otherwise prohibited) because HUD recognizes that people with disabilities unfortunately may experience discrimination when attempting to rent housing. Unfortunately, HUD's guidance on these issues is not published in one document, but in many HUD Notices that PHAs may not read carefully and/or may not understand. Better access and training on these HUD policies targeted to PHA staff would undoubtedly help improve access by people with mental illness to HUD assisted housing resources.

### **PSH Services and the Patient Protection and Affordable Care Act (ACA)**

National Health Reform under the ACA and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act provides many opportunities to improve access to behavioral health and physical health services and to link best practice mainstream community services for people with mental illness living in PSH. The movement of currently uninsured people into either Medicaid or health insurance exchanges will eliminate some barriers to obtaining necessary community services and supports, while at the same time creating powerful incentives to use non-categorical state and federal funds (including SAMHSA Block Grants) only for services that cannot be included in Medicaid, Medicare or commercial insurance.

The Medicaid expansion population under the ACA will include many people with mental and substance use disorders. Eventually, the federal match requirements for these newly enrolled individuals will increase, with the consequence that non-federal dollars currently used to serve these individuals will be viewed as an attractive source of match. In addition, some of the providers and staff delivering services with these funds are unlikely to meet Medicaid requirements for reimbursement, or the services they deliver will not be included in either the benchmark plans or State Medicaid Plans and waivers. Finally, some traditional mental health providers will have to undergo clinical and technology changes to meet requirements for participation in Health Homes and Accountable Care Organizations. All of these eventualities have consequences for NASMHPD's members to assure that the mental health delivery system

can effectively link affordable permanent housing resources with mainstream community services and supports related to sustaining tenancy and community integration in PSH.

The ACA includes several provisions that reinforce the shift from facility-based care to integrated community settings, such as PSH. These include the new 1915(i) Home and Community Based Services provisions, Long Term Care Rebalancing, Community First, and the expansion of Money Follows the Person. CMS is also developing incentives for Medicare to shift costs from inpatient and intensive long term care to community-based modalities. Several Medicare-Medicaid dual eligible projects have already been funded for this purpose. These initiatives present substantial opportunities for SMHAs to use mainstream Medicaid funds to finance flexible and individualized community services for people with mental illness who are institutionalized or at risk of placement in restrictive settings. As noted above, CMS is also defining 'community living' in a manner that is consistent with SAMHSA's PSH toolkit, and will influence the housing settings in which Medicaid participants may receive services.

## **Part IV. Recommended Policies and Action Steps for Federal Entities and NASMHPD Members**

### **HUD Appropriation Recommendations**

As an active member of the Consortium for Citizens with Disabilities Housing Task Force (CCD), NASMHPD and its members will continue to advocate for increased appropriations for key HUD programs targeted to expand permanent housing assistance to the most vulnerable people with mental illness and other disabilities who are homeless, institutionalized, or at-risk of these conditions. These appropriation priorities include:

- \$300 million annually for the reformed Section 811 program, as authorized by Congress in the Melville Act;

- Full funding to renew all existing Housing Choice Vouchers administered by PHAs;

- \$2.4 billion for HUD HEARTH (formerly McKinney-Vento) homeless appropriations;

- Prioritizing new and existing Housing Choice Vouchers targeted to non-elderly people with disabilities moving from restrictive settings to PSH; and

- \$1 billion in appropriations for the National Housing Trust Fund.

### **HUD and HHS Section 811 Recommendations**

NASMHPD and its members are working to ensure full and effective implementation of the important Section 811 reforms authorized by the Melville Act.

At the federal level, NASMHPD will review and comment on the Section 811 Proposed Rule expected to be published in the summer of 2011. During the regulatory process, NASMHPD will urge HUD and HHS to adopt the following policies:

Allocate 50 percent or more of Section 811 funds to the new PRA option reserved for State Housing Finance Agencies;

Ensure that the structure and contents of the Section 811 Agreement between the State Housing Finance Agency and the State Health and Human Services/Medicaid Agency facilitate the housing goals of SMHAs and promote an expansion of PSH for people with mental illness who are living in restrictive settings and chronically homeless;

Adopt new HUD Section 811 outreach and referral policies consistent with the PSH policies and practices of SMHAs;

Adopt service linkage policies consistent with SMHA Medicaid and state appropriated service financing models; and

Ensure the active and sustained involvement of SAMHSA and CMS in the implementation of new Section 811 housing strategies, particularly those that involve State PSH Agreements between State HFAs and State HHS/Medicaid Agencies.

At the state level, NASMHPD will work closely with its members to support the development of new or expanded partnerships with State HFAs, including their full participation with State HFAs in the first competitive funding round for Section 811 expected during early 2012. These activities will include the preparation and dissemination of Section 811 materials, webinars and other distance-learning techniques covering the Section 811 regulatory process and the release of the Section 811 HUD Notice of Funding Availability. States should also be aware of and involved in the full range of State HFA and State and local PHA activities, including the conversion/revitalization of HUD public and assisted housing units/buildings to mixed income communities as opportunities to encourage PSH and the full integration of consumers into the community.

### **HUD Housing Choice Vouchers and Federal Public Housing Recommendations**

As a member of the CCD Housing Task Force, NASMHPD will continue to advocate for increased access by people with mental illness to HUD Housing Choice Vouchers. NASMHPD urges HUD to issue guidance that will ensure that PHAs properly administer more than 70,000 Housing Choice Vouchers, which are required to be provided only to non-elderly households with disabilities. NASMHPD also calls on HUD to incentivize PHAs using these vouchers for the creation of PSH opportunities for people with disabilities leaving restrictive settings, and to prioritize them to create supportive housing units called for in Olmstead settlement agreements. HUD should also make available training, technical assistance, and case studies in order to assist

PHAs to expand PSH through the Housing Choice Voucher program and in revitalized federal

public housing units. NASMHPD will also reach out to the two national PHA trade organizations (e.g., National Association of Housing and Redevelopment Officials and the Council of Large Public Housing Agencies) to explore strategies that could facilitate partnerships between SMHAs and their members.

### **HUD PSH-Related Policy Recommendations**

In concert with CCD, NASMHPD calls on HUD to create more uniform policies within its rental housing programs to promote and foster the development of PSH through existing HUD resources managed at the state and local level. NASMHPD also urges SAMHSA to engage HUD on this issue, and press for an effective and early resolution to HUD PSH policy barriers. NASMHPD understands that HUD has begun an internal process to review its fair housing policies to identify PSH barriers that have prevented successful partnerships between housing agencies, SMHAs and their service provider networks. However, time is of the essence, given the housing pressures confronting SMHAs. For example, last year, a PHA in Pennsylvania was required to obtain a HUD waiver (a very lengthy and time consuming process) in order to include a set-aside of units for people with serious mental illness at-risk of institutionalization in a revitalized mixed-income federal public housing property. Re-aligning existing HUD resources to expand the creation of PSH – such as was done in Pennsylvania – is an effective strategy which could be replicated by SMHAs in every state as soon as appropriate HUD guidance is available to the field. We also call on HUD to review the range of discretionary and exclusionary policies that have been adopted by some PHAs and to engage in a dialogue with them as to the research-based validity and usefulness of such added restrictions. Many of these policies disproportionately impact access to subsidized housing resources for persons with a mental illness disability compared to other groups, and their application adversely impacts the expansion of and is directly counter to PSH.

### ***Olmstead*-Related Recommendations**

NASMHPD calls on HUD, SAMHSA, HHS's Office of Civil Rights, and DOJ to initiate discussions to collectively develop new federal policies which would promote and incentivize the targeting of federal housing assistance programs for *Olmstead* settlement agreements.<sup>10</sup> These policies are essential because it is federal action which is holding SMHAs accountable for providing housing assistance to low income individuals who should be assisted through low income housing programs. NASMHPD believes that people with mental illness currently residing in restrictive settings, such as nursing homes and public institutions, are extremely disadvantaged in terms of applying for federal housing assistance. In addition, some state and local governments resist using programs that are available, such as HUD's HOME tenant-based rental assistance program, to help people transition from institutional settings to the community. NASMHPD believes that stronger federal leadership on this issue can greatly assist SMHAs that are now being required to redirect scarce public mental health system resources needed for services to pay for affordable housing in the community.

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<sup>10</sup> An excellent example of how federal resource can be targeted to implement *Olmstead*-related settlements is the Alabama Wyatt Case. The State of Alabama set aside between 33 percent and 50 percent of its federal Low Income Housing Tax Credits and HOME funds to create community-based permanent housing opportunities linked with

Housing Choice Vouchers set aside by local PHAs.

## **SAMHSA Recommendations**

NASMHPD calls on SAMHSA to use its specialized portfolio of homeless and housing initiatives, as well as its Block Grant and discretionary grant funding for mental health and substance abuse treatment systems to (1) contribute to the expansion PSH at the community level; (2) support PSH infrastructure development to access and coordinate affordable housing resources; (3) increase the housing competence of all SMHAs; and (4) enhance the capacity of local systems and providers to provide flexible and person-centered services for PSH tenants. NASMHPD also recommends that SAMHSA permit Mental Health Block Grant administrative funds be allowed for certain key SMHA housing related functions. These could include supporting the cost of SMHA senior housing staff assigned to develop and manage partnerships with state and local housing agencies, manage SMHA participation in the State HFA-HHS/Medicaid Agreement required for the new Section 811 PRA program, and managing training and technical assistance activities to increase the housing competency/practice skills of mental health system providers.

## **SAMHSA/CMS Recommendations**

NASMHPD calls for SAMHSA and CMS to jointly develop and disseminate Medicaid-related 'best practice' PSH policy and implementation guidance that will facilitate SMHA PSH initiatives. Such guidance should include: models for referral and management arrangements; services and housing pathways; service definitions; provider qualifications; staff credentialing standards and approaches; contracts between Medicaid and non-Medicaid providers for the purpose of obtaining reimbursement for PSH-related services; performance quality standards; inclusion of peer specialists and coaches on PSH teams, and cost models for conversion from residential services to mobile community supports, including specific examples from local jurisdictions. NASMHPD will support SAMHSA and CMS efforts by advocating for acceptable policy and PSH financing frameworks at the federal level; engaging and motivating SMHAs in PSH implementation; and transmitting implementation expertise and guidance to the SMHAs and related constituencies. Implementation guidance will emphasize the formation of effective housing partnerships; effective service modalities and practice approaches designed to assist people with mental illness to get and keep housing; and working with State Medicaid officials on benefit design, clinical criteria, service definitions and provider qualifications to maximize service linkage opportunities.

To maximize the HUD/HHS Community Living Partnership, which is linked with the CMS Money Follows the Person (MFP) Demonstration program and HUD/HHS efforts to model Medicaid-financed services for PSH tenants, NASMHPD calls on CMS to make MFP more flexible for the mental health population.

## **Conclusion**

NASMHPD is very proud of the efforts and accomplishments made by its members in creating thousands of housing opportunities for the people they serve and helping to reduce the number of

people living on the streets or in substandard housing. Despite a significant expansion of PSH and Housing First approaches across the nation during recent years, SMHAs continue to confront enormous challenges assisting consumers to obtain affordable housing of their choice, linked with appropriate community-based services and supports. Federal policies and programs directly influence and provide financial support for most state and local affordable housing and PSH activity that benefits people with mental illness, including SMHA-initiated housing partnerships and collaborations. Federal housing and services resources such as the Housing Choice Voucher program, HUD's reformed Section 811 program, and Medicaid are also critical to the future of building a system to promote independence and support recovery to ensure that people served by the public behavioral health system have access to decent, safe and permanent affordable housing of their choice, linked with the full range of high quality services they may need to support and empower themselves into recovery .

NASMHPD strongly supports the recent federal interagency PSH collaborations which have been created to help end chronic homelessness and expand the creation of PSH. The outcomes from these federal activities will help NASMHPD's members to create and better sustain successful state and community-level partnerships linking affordable housing resources with mainstream community services and supports to achieve full community integration for consumers. NASMHPD will continue to actively engage HUD, HHS, and other federal entities on these important housing-related issues, and continue to advocate for the specific federal housing policies and programs that best support these SMHA housing goals.