MEMORANDUM

To: The Honorable Harris B. McDowell, Co-chair
The Honorable Melanie George Smith, Co-chair
Joint Finance Committee Members

From: Sarah G. Fishman, Esq., on behalf of the following organizations:

Disabilities Law Program
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens
State Council for Persons with Disabilities

Date: February 21, 2013

Re: Division of Substance Abuse and Mental Health FY 14 Budget

Good morning. My name is Sarah Fishman and I am a Staff Attorney with the Disabilities Law Program ("DLP") of Community Legal Aid Society, Inc. I am presenting these remarks on behalf of four (4) organizations: the Disabilities Law Program, the Developmental Disabilities Council, the Governor's Advisory Council for Exceptional Citizens, and the State Council for Persons with Disabilities. I am addressing two (2) components of the DSAMH budget, i.e., the need to expand capacity in community housing and the need to expand community housing supportive services.

U.S. DOJ Settlement Agreement

Delaware has a continuing obligation to meet the terms of the Settlement Agreement with the United States Department of Justice. The Settlement Agreements sets out specific deadlines by which the State must achieve concrete levels of community-based services for individuals with mental illness. By the end of FY14, the Agreement requires the Delaware to have implanted, among other requirements, housing vouchers or subsidies and bridge funding to a total of 550 individuals, an increase of 100 new individuals from the end of FY 2013.

Benefits of Supportive Housing

According to the Bazelon Center for Mental Health Law, supportive housing "leads to more housing stability, improvement in mental health symptoms, reduced hospitalization and increased satisfaction with quality of life, including for participants with significant impairments, when compared to other types of housing for people with mental disabilities."[1] The Bazelon Center emphasizes that consumer choice in where they live and how they receive supportive services in the community results in increased "by-in" from consumers and is a strong predictor of successful treatment.

[1] Bazelon Center for Mental Health Law, *Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities* (2010) (Attachment A).

Lack of Affordable Housing Options for Individuals with Mental Illness

The linchpin of providing community-based mental health services and ensuring compliance with the Settlement Agreement is having safe and affordable supportive housing options available for consumers. However, individuals with disabilities often lack the financial resources necessary to secure appropriate housing. A report published in April 2012 on the housing needs for people with disabilities in Delaware highlights that "an estimated 39% of people with disabilities have income below 200% of the poverty level," and they "make up about 19% of those in poverty in Delaware."[2] In 2013, an individual receiving SSI as his or her only source of income will received a monthly payment of $710.[3] In contrast, the fair market value of a 1-bedroom unit in Delaware is approximately $829.[4] Furthermore, in Delaware only 6.5% of rental units have a rent below $400 a month, and only 29% have a rent below $800 a month.[5]

The discrepancy between income and housing costs is particularly acute for individuals with mental illness. At the time the report on housing needs for individuals with disabilities was published in April 2012, DSAMH had identified "at least 882 individuals who could be considered in need of stable housing."[6] Moreover, 25% of consumer served by DSAMH reported that their primary source of income was SSI or SSDI.[7] Another 5% reported that their primary source of income was from another form of public benefits.[8] Therefore, increasing funding for housing assistance is crucial to achieving integrated care for individuals with mental illness.

Integrated Housing is more Cost-Effective than Institutional Care

Providing supportive integrated community-based housing is not only more effective for consumers in recovery, it is also cheaper and more cost-effective for the State than long-term institutionalization. The estimated annual cost for one person at the Delaware Psychiatric Center (DPC) is approximately $203,500, compared to an estimated $61,500 for the same individual to live and receive services in the

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[2] Excerpt from Delaware Housing Coalition, Housing Sub-Committee of the Governor's Commission on Community Based Alternatives for people with Disabilities'& State Council on Persons with Disabilities, *Community and Choice: Housing Needs for People with Disabilities in Delaware*, 12-14 (April 2012) (Attachment B). Full document available at http://www.destatehousing.com/FormsAndInformation/Publications/community_choice_full.pdf.

[3] U.S. Social Security Administration, *2013 Social Security Changes*, Washington, D.C. (2013). Available at http://www.ssa.gov/pressoffice/factsheets/colafacts2013.pdf.

[4] Delaware State Housing Authority, *Delaware Housing Fact Sheet* (January 2013). Available at http://www.destatehousing.com/FormsAndInformation/datastatmedia/ds_delaware_fs.pdf.

[5] Delaware Housing Coalition, *supra* note 2, Table: Percent of Occupied Rental Units by Rent, at 12.

[6] Delaware Housing Coalition, *supra* note 2 at 26- 30 (Attachment C).

[7] Delaware Housing Coalition, *supra* note 2 at 26-30.

[8] Delaware Housing Coalition, *supra* note 2 at 26-30.

community.[9] This means that for the same dollars, the State could provide housing and services to 3+ people the community, for the same cost of serving one person at DPC. According to DSAMH estimates, there are approximately 30 individuals currently at DPC who are ready and appropriate for discharge, but remain at the hospital due to a lack community housing. Providing funding specifically to assist individuals transition to community placements will reduce the artificially inflated DPC census and result in overall savings to the State.

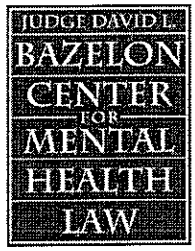
Recommendation

We support and recommend the DSAMH funding request included in the Governor's Recommended Budget to transition patients at DPC to living in the community. Providing funding to DSAMH for community placements and community-based services is absolutely critical to Delaware's success in meeting the requirements of the Settlement Agreement and in providing support and services to individuals in the most integrated setting, as required by the Americans with Disabilities Act and the Supreme Court decision in *Olmstead*.

Thank you for your consideration.

[9] Delaware Housing Coalition, *supra* note 2 at 42-43 (Attachment D).

ATTACHMENT "A"



SUPPORTIVE HOUSING:
The Most Effective and Integrated Housing for People with Mental Disabilities[1]

Introduction

People with mental disabilities can successfully live in the community like everyone else, as envisioned by the Americans with Disabilities Act. Supportive housing makes this possible. Supportive housing gives them their own apartment or home while making available a wide variety of services to support recovery, engagement in community life and successful tenancy.

A growing body of evidence confirms that supportive housing works for people with mental disabilities, including those with the most severe impairments. Indeed, these individuals may benefit the most from supportive housing. Supportive housing gets much higher marks than less integrated alternatives; research confirms that people with disabilities vastly prefer living in their own apartment or home instead of in group homes or buildings housing primarily people with disabilities. Moreover, supportive housing is less costly than other forms of government-financed housing for people with disabilities. Studies have shown that it leads to more housing stability, improvement in mental health symptoms, reduced hospitalization and increased satisfaction with quality of life, including for participants with significant impairments, when compared to other types of housing for people with mental disabilities.[2] Supportive housing has been endorsed by the federal government, including the U.S. Department of Housing and Urban Development,[3] the Surgeon General,[4] the U.S. Department of Health and Human Services[5] and the National Council on Disability.[6]

The Basic Principles of Supportive Housing

Three basic principles guide supportive housing.[7] First, supportive housing gives participants immediate, permanent housing in their own apartments or homes. Unlike most other housing for people with disabilities, there is no limit on how long the person can stay in the residence, and temporary absences do not lead to disenrollment. Treatment compliance or sobriety is not a requirement for receiving or remaining in housing.[8] Supportive housing participants have the same rights and responsibilities as any other tenant. They may lose their unit, for

example, for disruptive behavior or drug use. Supportive housing staff, however, try to avoid this situation by providing supports and the accommodations necessary to help ensure successful tenancy.

Supportive housing provides housing first, allowing participants the opportunity to focus on recovery next. Adequate, stable housing is a prerequisite for improved functioning for people with mental disabilities and a powerful motivator for people to seek and sustain treatment.[9] Studies find that providing immediate, permanent housing leads to more long-term housing stability when compared to housing conditioned on treatment.[10]

Second, individuals in supportive housing have access to a comprehensive array of services and supports, from crisis mental health services to cooking tutors.[11] Services are provided as needed to ensure successful tenancy and to support the person's recovery and engagement in community life. Services and supports are provided in the home and other natural settings, allowing individuals to learn and practice skills in the actual environment where they will be using them.[12] Services are available whenever people need them, including after working hours and on weekends when necessary. Service providers are highly flexible and supports are highly individualized. A creative "whatever it takes" approach is pursued. No "program" attendance is required and services are increased, tapered or discontinued as decided by the individual in consultation with the provider. As a result, individuals "buy in" to the treatment plan—the most important predictor of plan success.[13]

Available services and supports include mental health and substance abuse treatment and independent living services, including help in learning how to maintain a home and manage money as well as training in the social skills necessary to get along with others in the community. Medication management, crisis intervention and case management are also available. Peer-support services are especially effective in securing good results.[14] For individuals who are unable to do certain tasks, such as cooking and cleaning on their own, personal care and/or home-care services are provided until no longer needed.

Assertive Community Treatment (ACT) teams serve the clients with the greatest challenges, including individuals with serious mental illnesses who have co-existing problems such as homelessness, substance abuse or involvement with the judicial system.[15] ACT teams are interdisciplinary and mobile, typically including a social worker, psychiatrist, substance abuse counselor, nurse, vocational counselor and housing specialist. They develop individualized treatment plans with their clients and provide services around-the-clock in consumers' homes and in the community. Among the services ACT teams may provide are: case management, initial and ongoing assessment, psychiatric services, rehabilitation services, employment and housing assistance, family support and education, substance abuse services, and other supports critical to an individual's ability to live successfully in the community. ACT teams have

been widely recognized as one of the most effective ways to provide services to individuals with mental illnesses. They can be covered by Medicaid.[16]

Third, supportive housing facilitates full integration into the community. Individuals are encouraged to integrate into the community through employment, volunteer work and social activities. People are encouraged to participate in neighborhood activities or become members of community organizations of their choosing. Vocational training, training in managing symptoms in the workplace and conflict-management skills are available to those ready to seek employment. Research has shown that employment can be critical to recovery; it helps individuals with mental disabilities live autonomously, build meaningful personal relationships, become integrated into society, improve self-esteem and learn to control symptoms.[17] Moreover, unlike the case with traditional disability housing, supportive housing participants do not live and interact only with other mental health clients; nor are they in an identifiable mental health program.[18]

Supportive Housing Works

Supportive housing is effective for various reasons. First, housing is a key aspect of well-being and recovery.[19] People with mental disabilities cannot be expected to succeed without a safe, secure home, particularly if they are struggling to recover from a mental illness.[20] Moreover, stable housing can act as a motivator for people to seek services and supports and to engage in and sustain treatment.[21]

Second, supportive housing is built around individuals' preferences and strengths. Client-driven planning provides an opportunity for individuals to gain control over their lives and determine their own path of recovery. Supportive housing participants are involved in the process of choosing their housing unit, rather than unilaterally being placed in a residence.[22] The services offered are highly flexible and individualized to meet the participant's needs and preferences, rather than defined by a "program." Research shows that greater choice of residence not only correlates positively with consumer satisfaction but also is a significant predictor of housing stability.[23] It also establishes that consumer choice and buy-in to service plans is a great predictor of success. A "good" plan that is not accepted by a consumer is not likely to work.[24]

Supportive housing takes advantage of the clear preferences of people with mental disabilities about how they want to live. Studies show that consumers prefer living in their own homes, either alone or with one or two roommates, rather than in congregate settings with many other people with mental disabilities, particularly when they receive supports to help them engage socially in their own communities.[25] "They want to be able to choose, among other things, the type of housing in which they live, the neighborhood, with whom they live (if they choose not to live alone), what and when to eat, whether or not to

participate in mental health services (and, if they want services, to choose the ones they want) and how to schedule their days."[26]

Hence, it is no surprise that study after study has found that supportive housing programs work for people with mental disabilities, even those who are hardest to house, such as chronically homeless individuals with mental illnesses.[27] Research has shown that providing immediate, permanent housing leads to more long-term housing stability when compared to traditional housing programs.[28] Other positive outcomes for supportive housing participants include reduced hospitalization, decreased involvement with the criminal justice system, participants' greater satisfaction with their quality of life and improvement in mental health symptoms.[29]

Supportive Housing Reduces Costs

Supportive housing is less costly than other forms of government-financed housing for people with disabilities. Even for clients with the greatest challenges, quality supportive housing, including necessary community treatment and support services, compares favorably with the cost of traditional mental health housing and services.[30] Supportive housing also costs far less than other places where people with mental disabilities end up: The cost of serving a person in supportive housing is half the cost of a shelter, a quarter the cost of being in prison and a tenth the cost of a state psychiatric hospital bed.[31] Moreover, most of the cost of supportive housing can be funded through existing programs, including Medicaid and federal housing and rental assistance programs.[32]

Supportive housing reduces costs in several ways. It saves money by utilizing apartments or houses available for rent on the market. Unlike other housing for people with disabilities, such as group homes or buildings designated exclusively for people with disabilities, supportive housing does not require investment for new construction or purchase and rehabilitation. Moreover, supportive housing's use of scattered-site rental units avoids the delay and expense of fighting neighborhood opposition to the siting of permanent housing for people with disabilities, as often occurs.[33] In addition, supportive housing saves money by reducing participants' use of expensive resources, such as day programs, shelters, inpatient psychiatric hospitals, public hospitals, and prisons and jails, which can cost tens of thousands of dollars per person in a year.[34]

Implications

Supportive housing should be the primary housing option available though mental disability service systems. In most communities, this will require a substantial shift, including replacing existing congregate settings with scattered-site supportive housing. Public officials and stakeholders should work to ensure that housing, when provided as a service, has the following characteristics:

- Housing units are scattered-site or scattered in a single building.
- A wide array of flexible, individualized services and supports is available to ensure successful tenancy and support participants' recovery and engagement in community life.
- Services are delinked from housing. Participants are not required to use services or supports to receive or keep their housing.
- Participants have a say in choosing their housing unit, any roommates (if they choose not to live alone) and which services and supports (if any) they want to use.
- Participants have the same rights and responsibilities as all other tenants. They should be given any accommodations necessary to help ensure successful tenancy.

To achieve this end, mental health systems must play an active role, both by contracting with supportive housing providers and helping them secure rental subsidies and by declining to finance or support the expansion of congregate housing, including through building purchases.

Conclusion

Supportive housing is what people with disabilities want. It is the most integrated type of housing and helps people with mental disabilities be a successful part of the community—an opportunity to which they are entitled under the Americans with Disabilities Act. Supportive housing programs are the most clinically and cost-effective and offer the most integrated housing available for people with mental disabilities. Public officials and stakeholders should push for supportive housing and turn into reality the desire of people with mental disabilities to live in the community like everyone else.

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[1] This paper was developed by the Bazelon Center for Mental Health Law under a grant to the University of Pennsylvania from the Department of Education, NIDRR grant number H133B080029 (Salzer, PI). However, the contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government.

[2] See Rogers, Sally, et al., *Systematic Review of Supported Housing Literature 1993-2008*, The Center for Psychiatric Rehabilitation, 2009.

[3] U.S Dept. of Housing and Urban Dev. Office of Policy Dev. and Research. *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*. July 2007: 102-03. Available at http://www.huduser.org/publications/homeless/hsgfirst.html.

[4] U.S. Surgeon General. *Mental Health: A Report of the Surgeon General*. 1999: chapter 4. Available at http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec6.html#human_services.

[5] U.S. Dept. of Health and Human Services. Substance Abuse and Mental Health Services Admin. *Transforming Housing for People with Psychiatric Disabilities: Report. 2006.*

[6] National Council on Disability. *Inclusive Livable Communities for People with Psychiatric Disabilities*, 17 Mar. 2008: 17-26. Available at http://www.ncd.gov/newsroom/publications/index.htm.

[7] There is not consensus about the name for this service – some people use the term "supportive" housing while others call it "supported" housing. Fidelity to the basic principles set out in this paper – not the terminology – is what is important. In many communities, much of the housing that is called "supportive" or "supported" does not follow these basic principles.

[8] The strict admission criteria and program rules of traditional mental health housing often deny housing to those most in need. Pathways to Housing, Inc. "Providing Housing First and Recovery Services for Homeless Adults with Severe Mental Illness." *Psychiatric Services*, 56.10 (2005): 1303.

[9] Tsemberis, Sam, Leyla Gulcur, & Maria Nakae. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis." *American Journal of Public Health*, 94:4 (2004): 655.

[10] Tsemberis, Sam & Ronda F. Eisenberg. "Pathways to Housing: Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities." *Psychiatric Services* 51:4 (2000): 487; Burt, Martha R. & Jacquelyn Anderson. "AB2034 Program Experiences in Housing Homeless People with Serious Mental Illness." *Corp. for Supportive Housing*. (2005): 3. Available at http://www.csh.org/index.cfm/?fuseaction=Page.viewPage&pageID=3621.

[11] In some communities, existing "supportive" or "supported" housing is of uneven quality because the full array of necessary services and supports is not available.

[12] Tsemberis. supra note 10, at 488.

[13] Id. Nelson, Geoffrey, John Lord, & Joana Ochocka. *Shifting the Paradigm in Community Mental Health: Toward Empowerment and Community*. Univ. of Toronto Press. 2001.

[14] Surgeon General, supra note 4.

[15] Some supportive housing providers have their own dedicated ACT teams, while other individuals in supportive housing receive ACT services through the mental health system.

[16] U.S. Dept. of Health and Human Services. *Medicaid Support of Evidence-Based Practices in Mental Health Programs.* (2005): 6-7. Available at http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS030888&intNumPerPage=2000.

[17] "Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities." Briefing Document for the National Governors Association, Center for Best Practice (NGA) Webcast Transforming State Mental Health Systems: Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities. 31 July 2007. Rogers, S.E., et al. "A Benefit-Cost Analysis of a Supported Employment Model for Person with Psychiatric Disabilities." *Evaluation and Program Planning* (1995). Bond, G.R., et al. "Implementing Supported Employment as an Evidence-Based Practice." *Psychiatric Services*, Mar. (2001).

[18] National Council on Disability, supra note 6, at 23.

[19] Id.

[20] Id.

[21] Tsemberis, supra note 9, at 655.

[22] The federal government has recognized the importance of consumer choice in housing and the role of housing in promoting recovery. U.S. Substance Abuse and Mental Health Services Administration. *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders*. Rockville, MD: SAMHSA, 2003. Available at http://mentalhealth.samhsa.gov/publications/allpubs/sma04-3870/Chapter6.asp#C6TocEvidence.

[23] Srebnik, Debra et al. "Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness." 31 *Community Mental Health J.* 31(1995): 139.

[24] Tsemberis. supra note 9, at 651. Nelson, supra note 13, at 160.

[25] Yeich, Susan et al. "The Case for a "Supported Housing" Approach: A Study of Consumer Housing and Support Preferences" *Psychosocial Rehabilitation J.* 18.2 (1994): 75-77. Tanzman, Beth. "An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services." *Hosp. & Community Psychiatry* 44 (1993): 450-55. National Council on Disability, supra note 6, at 21.

[26] National Council on Disability, supra note 6, at 22-23. This paper is not intended to imply that all people with mental disabilities prefer supportive housing. Some do not. Individuals with disabilities should have choices, like everyone else, about their living options.

[27] Id. at 654-55. U.S Dept. of Housing and Urban Dev., supra note 3, at 80-104.

[28] Tsemberis. supra note 9, at 654-55.

[29] U.S Dept. of Housing and Urban Dev., supra note 3, at 82-84. Culhane, Dennis P. Culhane, Stephen Metraux, & Trevor Hadley. "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative" *Housing Policy Debate* 13.1 (2002): 137-38. Available at: http://works.bepress.com/metraux/16. National Council on Disability, supra note 6, at 23. U.S. Dept. of Health and Human Services, supra note 5, at 25.

[30] Based on a survey of costs in several states.

[31] Houghton, Ted, *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*, (May 2001) 6-7. Available at http://www.csh.org/index.cfm/?fuseaction=Page.viewPage&pageID=3251.

[32] These include the Section 8, Section 811, Home, Shelter Plus Care, and Hope VI programs. See www.nationalhomeless.org/publications/facts/**Federal**.pdf

[33] Id. at 4. U.S. Dept. of Justice. "Department Sues Florida County for Refusing to Allow the Operation of Six Homes for Individuals with Mental Illness and a History of Substance Abuse." *Disability Rights Online News* Aug. 2006. Available at http://www.ada.gov/newsltr0806.htm. U.S. Dept. of Justice. "Department Intervenes to Secure Site for Adults with Mental Illness." *Disability Rights Online News* Feb. 2006. Available at http://www.ada.gov/newsltr0206.htm.

[34] *See* Culhane, supra note, at 135-41.

increase about 16% from 2000 to 2040, the population over 60 will increase 150%.

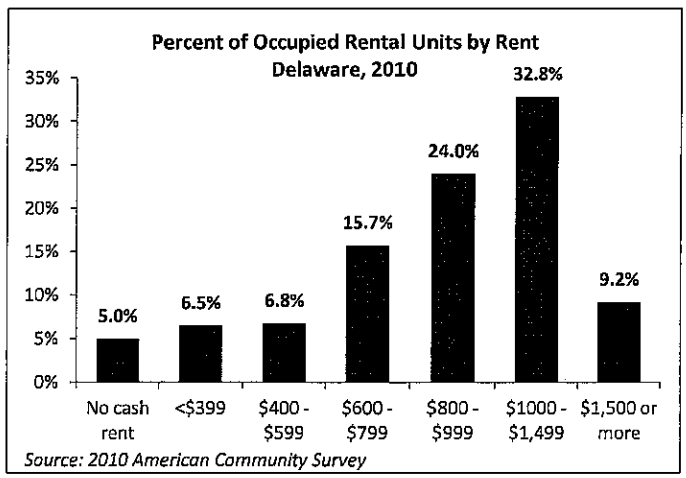
To create a general estimate of how this might affect disability prevalence in Delaware, we applied the 2009 rates of disability prevalence by detailed age group and sex reported by the American Community Survey in Delaware to the Delaware Population Consortium's 2010 Population Projection Series. The 2009 rate was held constant across the projections. Using this method, individuals with any disability are projected to increase from 13.1% of the population in 2010 to 16.8% of the population in 2040.

POVERTY AND HOUSING NEEDS AMONG PEOPLE WITH DISABILITIES

AFFORDABILITY CHALLENGES FOR ALL HOUSEHOLDS

The recent recession and persistently high unemployment hit lowest income households earliest and hardest, in an environment where the largest employment growth was already among lower-wage jobs in lower-wage industry sectors. The foreclosure crisis has also put upward pressure on rents as millions of households, with battered credit, lost savings and often unemployed, return to renting in a housing market that had added little multifamily rental stock through the homeownership boom years. Decreases in home prices are of little help to the most vulnerable households.

According to the 2010 American Community Survey, only 10% of rental units in Delaware had rents below $500, while over 40% have rents over $1,000 – the percentage of units renting for less than $500 dropped by more than half from 2000 to 2010 and the percentage renting for more than $1,000 quadrupled.



Fair market rents for a 2 bedroom apartment in Delaware range from $750 in Sussex County to $1,077 in New Castle: nowhere in the state can an individual earning minimum wage afford even an efficiency (0 bedroom) apartment. The gap between what an extremely low-income household can afford and the 2-bedroom fair market rent ranges from $286 in Sussex County to $474 in New Castle. The National Low Income Housing Coalition (NLIHC) estimates that 54% of renters in Delaware cannot afford the fair market rent on a 2 bedroom apartment.[9]

An estimated 42% of Delaware's renter households have income below 50% of median (very low income).[10] Of these 36,150 households, 75% (27,130) are cost burdened and 48% are severely cost-burdened. Among the state's poorest households, those with extremely low incomes (<30% of median), 62% (12,845 of 20,570) of renter households are severely cost-burdened. These households are the state's most vulnerable, most precariously housed and at risk of homelessness.

HUD's *Worst Case Needs* report shows a surge in worst case needs from 2007-2009; in this same time period, there was no increase in housing assistance in proportion to the surge in very low-income renters. Households are

considered to have worst case needs when they have very low incomes (below 50% of median), do not have housing assistance, and are either severely cost burdened or living in severely inadequate housing. In 2009 7.10 million households had worst case needs by this definition: 41.4% of very low income renter households.[11] Only 25% of very low income renter households reported having housing assistance.

For those without housing assistance, options are scarce due to a declining stock of affordable rental housing, the long-term loss of federally assisted housing, substandard housing conditions, and "mismatch" of renters to units. Nationally, higher income households occupy about 42% of the units that are affordable to extremely low-income renters, and 36% of units affordable to households from 30-50% AMI. Only 32 units of adequate, affordable rental housing are available every 100 extremely low income renters.[12] In Delaware, only about 12% of vacant for-rent units are affordable to extremely low income households. Worsening this situation, the country's stock of subsidized rental housing has declined steadily in recent years: since 1995, approximately 360,000 project-based Section 8 units have been lost, with another 10,000 – 15,000 lost every year, and annually, about 10,000 public housing units are lost to either demolition or sale.

In Delaware, as in the nation, there is a general scarcity of housing assistance for the most vulnerable households. Statewide, approximately 13,600 households are on public housing and Housing Choice Voucher waiting lists, mostly households with extremely low incomes.[13] As of 12/31/11, there were a combined 8,170 households on waiting lists at project-based Section 8 sites in Delaware (privately owned, federally subsidized sites), and over 3,000 households on waiting lists for Low income Housing Tax Credit (LIHTC) sites.[14]

INCOME AND POVERTY RATES

Earnings and household income are both lower for persons with disabilities, both at the national level and in Delaware. The 2008 Current Population Survey (CPS) showed an estimated household income of $32,000 for persons with disabilities, compared to $63,500 for those with no disability.[15] Looking only at earnings, the 2008-2010 ACS estimated that persons with a disability in Delaware had median annual earnings of $20,331, compared to $31,991 for persons with no disability. Nationally, persons with no disability had median earnings of $30,263 compared to $19,970 for those with a disability.

Table 6: Median Household Income, Civilian Noninstitutionalized Population, Delaware, 2008

	With a work limitation		Without a work limitation	
	Estimate	95% Margin of Error	Estimate	95% Margin of Error
Delaware	$32,000	± $7,264	$63,500	± $3,522
United States	$32,500	± $667	$60,200	± $393
Source: Current Population Survey, calculated by the Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics				

Likewise, persons with disabilities are much more likely to live in poverty. In Delaware, 16.7% of all individuals with a disability were estimated to have poverty level income, compared to 10.5% for those with no disability.[16] However, this split is even greater for working-age people with disabilities (18-64): the poverty rate for this group is 19.7%, compared to 8.9% for working-age individuals with no disability. This is likely a low estimate, as the ACS does not include the population in group quarters or institutions; those with disabilities in institutions, especially the non-elderly, likely also have poverty-level income.

Table 7: Poverty Rates and Median Earnings by Disability, Delaware, 2008-2010

	With a Disability	With no Disability
Median earnings	$20,331	$31,991
Percent in poverty (<100% of poverty threshold)*	16.7%	10.5%
Percent in poverty or near-poverty (<200% of poverty threshold)	39.4%	24.9%
**Poverty thresholds used in the ACS are those set by the Census Bureau by household size and presence of children. For a one-person household under 65, the 2009 poverty threshold was $11,161. Source: U.S. Census Bureau, 2008-2010 American Community Survey*		

Poverty is even more widespread among people with severe disabilities. Those with a severe disability are far more likely to be in poverty: 27% of people 25 – 64 years old with a severe disability had poverty-level income compared to 12.0% of those with a non-severe disability and 9.1% of those with no disability.[17] In 2005, 41.5% of people 25 - 64with a severe disability had monthly household income below $2,000, compared to 20.4% of those with a nonsevere disability and 13.7% of those with no disability.

Poverty-level income itself is an inadequate measure of material hardship and need, as the level is so low: the federal poverty threshold for one person in 2009 was $11,161 (those under 65; for those over 65, $10,289)[18]. A family or person may have double that income and still face serious housing and other needs. Nationally, 36% of individuals with a disability are estimated to have income below 200% of the federal poverty level, making up 18% of persons with income below 200% of the poverty level.[19]

In Delaware, 18,434 people were estimated to have income below 100% of the federal poverty level and a disability in 2008-2010. When we expand our view of poverty to include households with income from 100-200% of the poverty level (for one person under 65, 100% in 2009 was $11,161; 200% was $22,322), the disparity between people with disabilities and those with no disabilities is even more stark. In Delaware, an estimated 39% of people with disabilities had income below 200% of the federal poverty level, compared to 25% of people with no disabilities. People with disabilities make up about 19% of those in poverty in Delaware.

Table 8: Percent of Population with a Disability by Poverty, Delaware, 2008-2010

	Population	With a Disability	Percent
Below 100% of Poverty Threshold* (2009: $11,161)	97,812	18,434	18.8%
Below 200% of Poverty Threshold (2009: $22,322)	230,789	43,442	18.8%
Over 200% of Poverty Threshold	631,594	66,937	10.6%
**Poverty thresholds used in the ACS are those set by the Census Bureau by household size and presence of children. For a one-person household under 65, the 2009 poverty threshold was $11,161. Source: U.S. Census Bureau, 2008 - 2010 American Community Survey Universe: Civilian noninstitutionalized population for whom poverty status was determined.*			

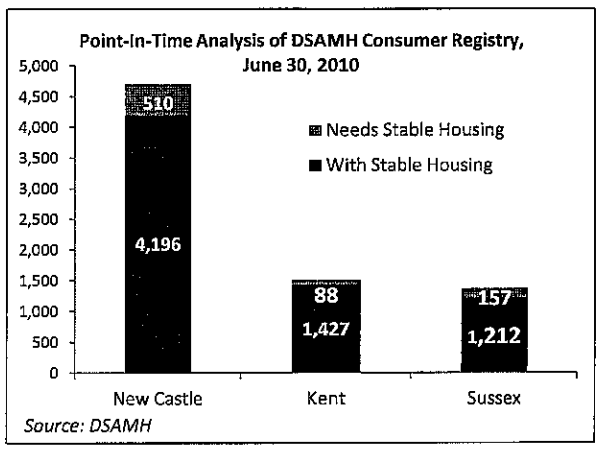
Among those who are homeless, about 35% of whom have a disability, incomes are often so low as to be practically negligible. The 2011 Delaware Point-in-Time study showed that 43% of individuals surveyed who were homeless had no income whatsoever, and 25% had income of less than $500 a month[20]. Many of these individuals count state General Assistance (approximately $90 a month) as their only income. 68% of individuals surveyed thus had income below $500 a month.

As with other populations, transportation and integration into community activities – work or day programs, or other activities, and adequate transportation to participate - are vital to avoid isolation and ensure a high quality of life in the community.

SUBSTANCE ABUSE AND MENTAL HEALTH

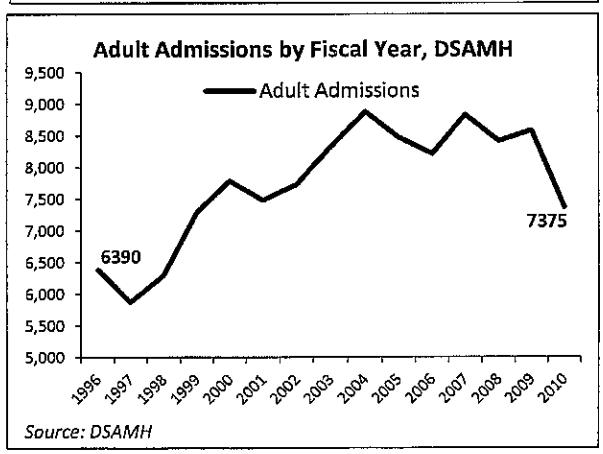
The American Community Survey data do not offer any specificity beyond the broad category "cognitive difficulty", which is not specific to mental health disorders. Many other national health or disability surveys similarly group intellectual or developmental disabilities with mental health disorders, so there is also a lack of national estimates to apply. Detailed information on the prevalence and extent of substance abuse and mental health issues at the local level is largely limited to local sources. In 2010, the Social Security Administration reported 1,292 SSDI recipients in Delaware in the diagnostic category "Mood disorders" and 832 in the category "Schizophrenic and other psychotic disorders".[37]

In FY 2010, DHSS' Division for Substance Abuse and Mental Health (DSAMH) served 13,995 clients (unduplicated within categories, clients may have used more than one service) with inpatient, community mental health, and substance abuse treatment.[38] Total DSAMH substance abuse adult admissions have climbed steadily over the 2000s, from 6,390 in FY 2003 to 8,590 in FY 2009, although dropping again to 7,375 in FY 2010.[39] DSAMH's substance abuse treatment caseload has also increased progressively: 3,950 as of June 30, 2010, up from 2,690 at the end of FY 2003.[40] As of June 30, 2010, the caseload in Delaware's community mental health system was 4,896.[41]



A point-in-time analysis of DSAMH's consumer registry on June 30, 2010 shows an active caseload of 8,402 statewide, 56% in New Castle County, 18% in Kent, 16% in Sussex, and 10% with county unknown. Some key findings include:

- By age, 94% (7,896) were between 18 and 64, 1% (64) under 18 and 5% (442) over 65.
- 276 (3% of total) were identified as veterans.
- 34% were employed full or part-time, 21% unemployed and seeking work, 19% unemployed and not seeking employment, and 15% (1,222) identified as disabled or unable to work.
- For primary source of income, 2,511 (30%) listed Social Security (238), SSI (855), SSDI (1,211), VA-Disability (26), General Assistance (155) or AFDC/TANF (26) as their primary source of income.



- 25% (2,066) of the total caseload in this point-in-time analysis relied on SSI or SSDI as their primary source of income; as noted earlier, both of these sources are not likely to provide enough to afford even the most basic, minimal housing anywhere in Delaware.
- While annual income information was only available for about 75% of clients, 54% of the total clients (4,557) had extremely low incomes – below 30% of the Area Median Income for their county of residence. An additional 9% (767) had very low income: below 50% of AMI.

The DSAMH point-in-time analysis also identified at least 882 individuals who could be considered in need of stable housing: those with a residential arrangement listed as a nursing home, corrections facility, other institution, other, homeless, or unknown. 251, or 3% of the total point-in-time caseload, were identified as homeless. 362 of the 882 had residential arrangement listed as unknown, it is likely that many of these were Front Door clients about whom little information was collected. Removing these 362 with unknown residential arrangement leaves 520 people in need of stable housing: residential arrangement of an institution, jail, or none/homeless. In addition, it is impossible to know how many individuals with more stable residential arrangements are not actually in stable housing: a private residence may be doubled up with a family member or living with a friend, adult foster care, or a boarding house.

Table 22: DSAMH Consumer Registry by Residential Arrangement, June 30, 2010 Point-in-Time Analysis

	Number	Percent
Private residence – unsupervised	6,557	78.0%
Private residence – supervised	376	4.5%
Adult foster care	65	0.8%
Boarding house	26	0.3%
Group setting/unsupervised	58	0.7%
Group setting/supervised	438	5.2%
Nursing home/ICF/SNF	3	0.0%
Corrections facility/jail	198	2.4%
Other Institution	15	0.2%
Other	53	0.6%
None/homeless	251	3.0%
Unknown	362	4.3%
Source: Division of Substance Abuse and Mental Health		

Of those identified as needing stable housing, 46% had mental health needs, 35% substance abuse, and 13% co-occurring mental health and substance abuse. The remaining 6% did not have information or were gambling addiction clients. This is fairly consistent with the overall caseload, 41% mental health, 44% substance abuse, 12% co-occurring mental health and substance abuse, and 3-4% either gambling or unknown. Clients with extensive unknown information may be walk-in community treatment center clients where the period of contact is brief and thus extensive case information is not collected.

While several fields of DSAMH's intake and annual assessment forms are housing-related, unfortunately these are often apparently not filled in. Still, the cases in which there is information offer interesting insight. 8% of the total caseload for which the question was answered (5,279) indicated that they had been homeless within the past 30 days and 6% within the past 12 months (this separate question had fewer responses, 1,897). Among those in the "Needs Stable Housing" pool, on these same questions, 41% of those with information (439 total) indicated that

they had been homeless within 30 days and 12% (91 total) within the past 12 months. Of the total caseload with responses to the question "How many places has the client lived in the past 90 days?" (1,877), 9.5% had 2 or more residential arrangements in the past 90 days. Of those for whom annual income information was available (284), 74% of those needing stable housing had income below 30% of the county Area Median Income.

Table 23: Individuals with Substance Abuse or Mental Health Conditions Identified as in Need of Stable Housing, DSAMH Point-in-Time Analysis, June 30, 2010

		Number
Needs stable housing		882
County	Kent	88
	New Castle	510
	Sussex	157
	Unknown	127
Income	<30% of AMI	209
	30 – 50% of AMI	8
	>50% of AMI	67
	Unknown	598
Modality	Mental health	406
	Substance abuse	306
	Co-occurring	116
Age	<18	47
	18 – 64	789
	65 or over	46
Homeless history	Homeless w/in 30 days	180
Veteran status	Veterans	30
Primary source of income	Social Security	11
	SSI/SSDI	94
	General Assistance	26
	Family/friends	39
	None	272
Note: Subheadings may not add up to total due to lack of data for some clients.		
Source: Division of Substance Abuse and Mental Health		

While the use of these data is hindered by the large number of "unknown" fields, the estimate of approximately 500 people with mental illness or substance abuse disorders in immediate need of affordable housing is our best possible estimate from a direct source at the moment covering the entire population. Working to narrow this to people with severe and persistent mental illness, we can look at discharge data from the Delaware Psychiatric Center (DPC) and information on chronic homelessness. In calendar year 2010, 344 people were discharged from DPC, an estimated 7% to homeless status (shelter or transitional housing, half of those discharged to transitional housing were estimated to be transitioning to homeless status). In FY 2010, 648 unduplicated clients were served at DPC: assuming 7% of clients in a given year would be homeless without housing support, 45 people would have needed housing assistance in FY 2010. Combining these with rough estimates based on the 2011 Point-in-Time Study, approximately 200 people with severe mental illness may need housing assistance over the course of a year, and there is likely duplication across these estimates and across years. As of June, 2011, two of the larger nonprofit service providers also had total waiting lists of 184 individuals (Connections: 112, NAMI-DE: 72).

Table 24: Estimates of Housing Need for Persons with Substance Abuse and Mental Illness, Delaware

Source/Population	Calculation	Estimate
DPC discharges	648 in FY 2010 Estimated 7% to homeless status	45
Chronically homeless with mental illness (HPC Point-in-Time Study)	6,584 homeless over course of a year 25% with mental illness (1,646) 9.5% chronically homeless (119, annual estimate 625) 29% of chronically homeless self-report mental illness (35, annual estimate 181)	181 chronically homeless with mental illness
Homeless with mental illness (HPC Point-in-Time Study)	6,584 homeless over course of a year 25% with mental illness (1,646)	1,646 homeless with mental illness over the course of a year
DSAMH point-in-time analysis	Consumers with residential arrangement of none/homeless, incarcerated, institution, or unknown (882 total) as of 6/30/2010. 362 "unknown" are likely to be short-term clients about whom little information is collected. This leaves 520 in need of stable housing as of the point-in-time, 251 immediately homeless.	520 in need of housing 251 homeless

As part of its settlement agreement with the Department of Justice, DSAMH has assembled data from the Homeless Management Information System (HMIS, now Community Management Information System), Delaware Criminal Justice Information System (DELJIS), and the Division of Medicaid and Medical Assistance to identify individuals with severe and persistent mental illness (SPMI) who are in the target population identified in the agreement. Early efforts in this area have resulted in the identification of approximately 5,000 Delawareans who meet the agreement's priority criteria:

- People who are currently at Delaware Psychiatric Center, including those on forensic status for whom the relevant court approves community placement;
- People who have been discharged from the Delaware Psychiatric Center within the last two years and who meet any of the criteria below:
- People who are, or have been, admitted to private institutions for mental disease (IMDs) in the last two years;
- People with SPMI who have had an emergency room visit in the last year, due to mental illness or substance abuse;
- People with SPMI who have been arrested, incarcerated, or had other encounters with the criminal justice system in the last year due to conduct related to their serious mental illness; or
- People with SPMI who have been homeless for one full year or have had four or more episodes of homelessness in the last three years.

Nineteen group homes with 156 beds for persons with mental illness are listed as licensed by the Division of Long-term Care Facilities Resident Protection. DSAMH reports a capacity of 161 beds in group homes and 171 in supervised apartments with 24-hour supervision. The inventory assembled for this report shows 170 units in group homes, 677 units of permanent supportive housing in a variety of forms (vouchers, scattered sites, supervised or staffed apartments, shared apartments), and 232 beds in residential treatment programs.

Table 25: Inventory of Assisted Beds for People with Substance Abuse/Mental Illness, Delaware, 2011

	Kent	New Castle	Sussex	Blank or Statewide	Total
Group home	62	75	33	0	170
Permanent supportive housing	29	306	51	60	446
Vouchers, permanent supportive housing	30	58	20	123	231
Residential treatment program	10	151	46	25	232
Total	**131**	**590**	**150**	**208**	**1079**

While not traditional permanent supportive housing, the Oxford House movement has also grown in Delaware. There are 35 of these peer-supported, self-run houses for people in recovery in Delaware. As these homes do not receive any supportive services and are self-run, they are not reflected in the above inventory.

As part of a 2011 settlement with the U.S. Department of Justice regarding providing services in the most integrated settings appropriate to consumers' needs, DSAMH must develop the capacity to serve 650 individuals with community placements by 2016. 150 of these placements were grandfathered in through units already available; 500 must be added. In addition, to prevent unnecessary institutionalization by the provision of community-based services, the settlement calls for the development of expanded peer support services; a statewide crisis system composed of mobile crisis teams, crisis walk-in centers, stabilization services, a 24-hour hotline and crisis apartments as an alternative to institutionalization; expanded supported housing and supported employment programs.

Delaware's mental health and substance abuse care systems have a well-developed network of group home and supervised apartments. As in the area of intellectual and developmental disabilities, these congregate settings have been advanced as priority housing options and alternatives to institutional care. However, these settings may not always be the least restrictive setting, and there is increased attention on developing tenant-based rental assistance programs to allow individuals to live independently in the community with supportive services. DSAMH's Eligibility and Enrollment Unit (EEU) works closely with providers to move clients to a lower level of care when it is appropriate; however, a lack of housing assistance may be a serious barrier to such transitions if tenant-based rental assistance or other subsidized units are not available. In the focus group held for consumers of substance abuse and mental health services, the lack of housing options and narrow focus on congregate situations was raised as a concern. While many appreciated the supports available in group situations, these settings can also raise numerous challenges, and consumers felt there was little opportunity to live independently and not enough of a "step" between congregate situations and full independence. At the same time, congregate or clustered settings offer critical peer support, and can help serve as a transition, especially when many people also report feelings of isolation and fear about being in the community.

Aging and Disability Resource Center (ADRC) initiative, DHSS implemented a diversion program to provide community support to individuals who have been referred for long-term care. Through January 2012, 162 of 192 (84%) clients referred for admission to public long-term care facilities had been connected to community-based services and assisted to remain in the community. Admissions have been reduced from 10.2 per month to 3.8 per month as of the last quarter of 2011.

THE COST OF CARE

Analysis conducted during the development of the new Delaware State Rental Assistance Program (SRAP), which was funded in FY 2012 with $1.5 million for the creation of approximately 150 vouchers for supportive housing for persons with disabilities, mirrors national findings that integrated supportive housing is typically much less expensive than institutional care. Housing an individual in a state-run long-term care facilities costs an estimated $157,300; estimated community costs for housing and supportive services are $46,400. Even in a private long-term care facility, if an individual is covered by Medicaid, state and federal costs are an estimated $96,900. Facilities like the Delaware Psychiatric Center are especially expensive; estimated annual costs for one person are $203,500, compared to approximately $61,500 for housing and services in the community.

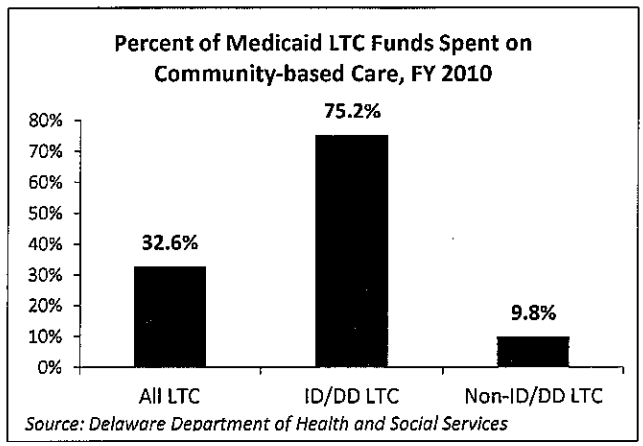


Table 36: Estimated Institutional and Community Cost Estimates, Delaware, 2010

	Institutional Costs	Community Costs
Long-term Care Facilities (Public)	$157,300	$46,400
Long-term Care Facilities (Private)	$96,900	$46,400
Delaware Psychiatric Center	$203,500	$61,500
Source: Delaware Department of Health and Social Services, 2010		

In general, the cost of serving a Medicaid consumer in their home or community is much less than the average cost of nursing home-based care (although community-based care for some individuals, depending on their support needs, can exceed the cost of institutionalization). The typical estimate is that a person who is able to be served in their home can average less than half the costs of institutional care. One study indicated a 63% reduction in per person spending for a nursing facility waiver program compared to institutionalization.[52] Expressed other ways, for the annual cost of one nursing home stay, two to three people can be served in their home or community.

A survey conducted in December 2008 of 1,000 Delaware residents age 35 and older found the following opinions and concerns:

- 42% thought it likely that either they or their family member will need LTC services in the next five years.
- 50% are not very or not at all confident in their ability to afford the annual $81,000 cost of a nursing home in Delaware.

- 51% of respondents with incomes less than $50,000 a year say they plan on relying on government programs to pay for their LTC.[53]

In December 2009, the percentage of all nursing facility residents for which Medicaid was the primary payor was just under 57%, representing about 2,421 Medicaid residents.[54] The 2,421 Medicaid nursing facility residents translates into a 1.8% prevalence rate of institutionalization among Delaware's elderly age 65 and older.

Assuming a constant rate of institutionalization, by year 2030, the number of nursing home residents paid by the DMMA will increase to 4,626. On an annualized cost basis, this translates into well over $150 million more in new Medicaid-funded nursing home stays or a combined total of over $320 million spent on nursing homes per year. This also assumes the annual cost of nursing home services remains static at $70,000; it may be more realistic to assume the cost of care will gradually increase over time and, thus, push institutional spending to even higher levels.

As the need for supportive services and care increases, the cost savings of transitioning to a model that prioritizes community care can be reinvested in expanding community services and serving more individuals. This transition does not always result in immediate or visible cost savings, as reducing census in long-term care facilities means that revenues from Medicaid that supported those beds are also reduced; it may also take substantial reductions before facilities, facility costs, and staff may be reduced. The greatest advantage is in the avoidance of future costs: building a community-based system of care that prioritizes remaining in the community will help avoid further expansion of institutional settings and the higher costs associated with institutional care.

MONEY FOLLOWS THE PERSON INITIATIVE

The Money Follows the Person demonstration grant program was created in 2005 to assist states in rebalancing their long-term care systems and help Medicaid enrollees who have lived in long-term care institutions for at least three months transition from institutions to community based care. Community residences are defined as homes, apartments, and small group homes with four or fewer unrelated individuals. 43 states and the District of Columbia are now participating. Delaware's MFP program began in 2008. Since then (as of 12/31/11), 60 individuals have transitioned from institutions to the community. The lack of affordable housing has been a major barrier to transitions, frequently the only barrier, and demand for the program is high. In calendar year 2011 through 6/8/11, Delaware's MFP program had 63 new referrals and 58 people waiting to be discharged and in the pipeline to transition – waiting on housing. An additional 81 referrals had been assessed and reviewed by the nurse and transition care team, and these individuals will also all likely be in need of housing. Nationally, while older adults living in nursing facilities made up the majority of those eligible for MFP in 2007 (75%), the largest group of MFP participants through June 2010 has been people with physical disabilities under age 65 who had lived in nursing homes.[55]

By the end of 2010, almost 12,000 people had transitioned from institutions to the community through MFP nationally.[56] With the Affordable Care Act health care reform initiative, Money Follows the Person was extended an additional five years through 2016. To date, national evaluation suggests that post-transition outcomes in the MFP program are positive. Two 2011 reports from Mathematica Policy Research using data on outcomes for MFP participants in 25 states who transitioned before March 2010 show that: