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GRAY LAND

HOUSING FOR PEOPLE WITH SERIOUS MENTAL ILLNESS IN MARICOPA COUNTY



Housing Now:
An SMI Housing Initiative

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Housing for People with **Serious Mental Illness**

Jeff (not his real name) is a 56-year old man who was first diagnosed with schizophrenia when he was 22. In the ensuing 34 years, he has been confined to mental institutions, homeless on the streets, and lived in group homes, motels or in apartments by himself.

At one point he lived in Section Eight housing (a federal housing voucher program for low-income renters and homeowners) but lost it for violating the rules. After waiting seven years, he's back in a Section Eight apartment in North Central Phoenix, where he lives below someone who he says is "driving him mad" with "their constant loud walking."

"I'm overly sensitive to sound. But if I complain or ask to be moved, they'll kick me off the program."

"Housing is everything. If you don't have that, you don't have treatment at all."



Gray Land

Jeff is hardly unique. Many of the approximately 19,000 persons in Maricopa County's public behavioral health system who are diagnosed with a serious mental illness (SMI) grapple with housing issues on a regular basis, ranging from noisy neighbors and broken air conditioners to having no stable housing at all and being shuffled through a maze of often impenetrable programs, regulations and temporary arrangements that would tax the perseverance and skill of even those without a mental illness to successfully navigate.

Then there are the untold hundreds of people with serious mental illnesses and co-occurring disorders like drug and alcohol addiction who are not in the public behavioral health system and live in the shadow world of the streets, homeless shelters, nights at a friend's apartment or in jails and prisons. Some seek help and find it; others seek help and don't find it; still others refuse help and try to go it alone, with predictable consequences.

This is not a black and white world of neatly defined problems and solutions. It is a gray land of individual differences and complicated needs, competing priorities, legal disputes and mandates, funding and workforce shortfalls, and a labyrinth of public and private jurisdictions, agencies and providers that defies a deft description, let alone analysis.

"It's complicated beyond belief," says Ted Williams, CEO of the Arizona Behavioral Health Corporation (ABC), and a veteran of over 25 years in the system. "If anyone thinks they've got it figured out, they're delusional."

A Point of Departure

Whether one is delusional, of course, depends on one's starting definition of reality. In the world of housing and people with serious mental illness, there are multiple starting points and shades of gray. How we define the problem(s) frames the solution(s). Here, we are less concerned with "figuring out" the issue of lack of affordable and appropriate housing for the SMI population than we are with providing a critical framework for a discussion of the issue that might inform practice and policy decisions now and in the

Method

Gray Land is a collaborative inquiry between St. Luke's Health Initiatives (SLHI) and the Technical Assistance Collaborative (TAC) in Boston, a national not-for-profit consulting organization that works in the areas of affordable housing, mental health, substance abuse and human services, www.tacinc.org. We previously collaborated with TAC in our 1999 *Into the Light* study of Arizona's public behavioral health system. In addition to their work with other states, TAC consultants have considerable experience working with public and private organizations in Arizona's behavioral health and human services communities.

TAC's contributions to this report are a critical review of national issues and best practices with regard to permanent supportive housing for the SMI population, and a comparative analysis of Arizona practices and policies in Maricopa County, with recommendations for improvement. Carol Lockhart, Ph.D., a health policy researcher and frequent SLHI collaborator, worked with SLHI staff to conduct a critical review of the SMI housing situation in Maricopa County's public behavioral health sector. This consisted of an analysis of the relevant statistics, housing programs, and various legal, regulatory and economic issues; interviews with a broad range of experts and stakeholders, and feedback from a consumer focus group and individual consumer interviews. Excerpts from these interviews are found throughout the report and are de-identified where requested.

Finally, to underscore the *Gray Land* theme of this report, it is impossible to sharply delineate between housing issues faced by people with SMI, those with other disabilities or drug and alcohol addiction, and the chronic/temporary homeless population more generally. All face common issues and concerns. While this is not a study of homelessness and affordable housing per se in Maricopa County, we find ourselves reflecting on these broader issues to the degree that they illuminate the complexity of the pathways that persons who are seriously mentally ill must traverse if they are to succeed in finding stable, supportive and affordable housing on the path to recovery.

“Just lookin’
for a home,
he was lookin’
for a home.”

Lyrics from
“Boll Weevil”

future. We arrive at a conclusion on where housing for persons with serious mental illnesses and other co-occurring disorders ought to be headed in Maricopa County, but not without considering alternative views.

In that regard, this *Gray Land* issue brief is similar to previous SLHI Arizona Health Futures issue briefs and reports on behavioral health¹ and other topics where we provide a critical overview of the issue, compare and contrast the history and perspectives of multiple stakeholder groups, review the experience and practices of others in addressing the issue, and present recommendations for future policy and practice.

In all cases, this report is meant to be a point of departure, not a final destination.

“Homelessness is simultaneously a housing problem, an employment problem, a demographic problem, a problem of social disaffiliation, a mental health problem, a family violence problem, a problem created by the cutbacks in social welfare spending, a problem resulting from the decay of the traditional nuclear family, and a problem intimately connected to the recent increase in the number of persons living below the poverty level.”

James D. Wright, author, ‘Address Unknown’

FIGURE 1: Housing and the Seriously Mentally Ill:

Obstacles and Opportunities²



Why Housing?

More Than a Basic Need

For people with serious mental illness, housing is more than a basic need. The lack of decent, safe, affordable and integrated housing for consumers of publicly-funded mental health services is a significant barrier to participation in community life.

Lack of affordable housing and requisite support services often means that the lowest-income people with serious mental illness cycle between jails, institutions, homeless shelters and the streets. It's estimated that approximately 20-25 percent of the single adult homeless population has some form of severe and persistent mental illness;³ that figure can approach 70 percent when undiagnosed mental illness and substance abuse disorders are included. In worst case scenarios, persons with mental illnesses who are chronically homeless⁴ are also likely to have acute and chronic physical health problems; exacerbated and ongoing psychiatric symptoms, excessive alcohol and drug use, and a higher likelihood of victimization and incarceration.

In 2002, an estimated 1,200 mentally ill, disabled and chronically homeless persons virtually lived in Maricopa County's homeless system because they could not overcome barriers to housing and support services.⁵ This is compounded by the County's rapid growth rate of roughly a 100,000 net gain in new arrivals annually, with about 600,000 people moving in and another 500,000 moving out. Other parts of the country growing less rapidly have been able to reduce the number of homeless through aggressive efforts to develop new affordable housing and program supports. Even with these efforts in Maricopa County, it's a struggle to stay even in the percent of persons who are chronically homeless because of this growth.

Before we get to the situation in Maricopa County, we set the larger context.

Homeless and the Mentally Ill in Maricopa County: How Big a Problem is It?

TABLE 1: MAG Homeless Count, January 30, 2007⁶

Part 1: Homeless Population	SHELTERED		UNSHELTERED	TOTAL
	Emergency	Transitional		
1. Number of Households with Dependent Children:	320	544	20	884
1.a. Total Number of Persons in These Households (Adults and Children)	1,096	1,767	58	2,921
2. Number of Households without Dependent Children	1,679	1,053	2,795	5,527
2.a Total Number of Persons in These Households	1,679	1,053	2,795	5,527
Total Persons (Lines 1a and 2a)	2,775	2,820	2,853	8,448
Part 2: Homeless Subpopulations (Adults only, except g. below)	SHELTERED		UNSHELTERED	TOTAL
a. Chronically Homeless	407		1,082	1,489
b. Severely Mentally Ill	710		*	710
c. Chronic Substance Abuse	1,041		*	1,041
c. Veterans	368		*	368
e. Persons with HIV/AIDS	52		*	52
f. Victims of Domestic Violence	1,296		*	1,296
g. Unaccompanied Youth (Under 18)	69		*	69

“If you don’t have housing, you’re blued, screwed and tattooed.”

SMI consumer

Estimates on the number of homeless people in Maricopa County who have a serious mental illness or a mental illness and co-occurring disorder like substance abuse can vary widely. Some County officials place the number at anywhere from 1,200 to 1,700; others in the community referenced in a 2005 *Arizona Republic* series on the issue⁷ put the number at 3,000 to 4,500 – about 25 to 35 percent of the Valley’s 12,000 homeless. Another 1,100 people with SMI are estimated to be housed in Maricopa County jails at an annual cost of about \$20 million.

Table 1 presents Maricopa Association of Governments (MAG) street count and shelter data from the end of January 2007. This represents about 8,500 persons, but most officials believe another 3,000 – 5,000 homeless persons are unaccounted for. The number of persons classified as severely mentally ill – 710 – are those in emergency/transitional housing that have been diagnosed. A much greater number is projected in the homeless population that is undiagnosed, for reasons that we discuss later. A confounding factor in arriving at a coherent and defensible number of the homeless population who are seriously mentally ill is making a sharp distinction between severe mental illness and substance abuse, where one easily spills over into the other.

While people may arrive at different numbers, no one disagrees on the cost of being homeless and mentally ill. The same *Republic* article stated that the “annual cost of treating the Valley’s mentally ill homeless in emergency rooms, sheltering them and continually cycling them through the legal system averages \$30,000 to \$40,000 per person,” in contrast to housing them and providing supportive services for approximately \$15,000 – \$20,000 annually. Even if the costs are approximately equal,⁸ it clearly makes economic, medical and social sense to provide supportive housing instead of leaving people on the streets.



Those at Risk

The housing problems of people with serious mental illness are hardly limited to those who have become homeless. In fact, there are many more people with mental illness who are at *imminent risk* of homelessness. Often they languish in psychiatric hospitals and institutions because there is no permanent affordable housing available in the community. Others live in dangerously substandard housing or pay virtually all of their monthly income for housing, or both. People living in disability-specific congregate housing or segregated residential treatment settings can remain there for years simply because there is no decent, safe and affordable permanent housing available.

Disability, Poverty and Housing Affordability

To understand why it is so critical for public mental health systems to address the housing needs of the SMI population, it is important to analyze the relationship between disability, poverty and housing affordability:

- ❑ People with disabilities are disproportionately poor compared to people without disabilities. According to the 2000 Census, the poverty rate for people with disabilities is more than three times higher than the poverty rate for people without disabilities.
- ❑ Some 61 percent of families with a disabled household member receive Social Security benefits, needs-based Supplemental Security Income (SSI) or public assistance, compared to 17.8 percent of families where there is no person with a disability.⁹

- ❑ An analysis of recent American Community Survey (ACS) data done by Cornell University for the Technical Assistance Collaborative (TAC) indicates that households with disabilities with incomes at or below 30 percent of the federal poverty level are three times more likely than non-disabled households to be paying more than 50 percent of their income for rental housing costs.¹⁰
- ❑ According to the federal government, any very low-income household paying more than 50 percent of their income for rent is considered to have “worst case” housing needs.

Priced Out in Arizona

TAC’s biennial *Priced Out* study, which compares the income of individuals receiving SSI to local Fair Market Rents, is a more relevant analysis of the housing affordability problems of people with serious mental illnesses who rely on the federal SSI program for all their basic needs. Nationally, there are an estimated four million non-elderly adults who receive SSI because their disability prevents them from being employed. Mental health experts suggest that approximately 33 percent of these individuals have a serious mental illness – an estimated 1.33 million.

In 2005,¹¹ Arizona had 57,357 non-elderly adults who received federal SSI payments. Based on national prevalence data it is likely that 19,000+ of these people had a serious mental illness. The most recent *Priced Out* study – *Priced Out in 2006*,¹² published by TAC and the Consortium for Citizens with Disabilities Housing Task Force – indicates that people with serious mental illness who rely exclusively on SSI have significant housing affordability problems in all areas of Arizona (Table 2).

According to *Priced Out*, an individual participating in the SSI program in Arizona in 2006 had an income of \$603 per month, which was equal to 17.2 percent of Area Median Income (AMI) in the Phoenix/Mesa/Scottsdale Metropolitan Statistical Area (Phoenix MSA) and 18.8 percent of AMI statewide. In the Phoenix MSA, people receiving SSI needed to pay 107.5 percent of their monthly income – an impossibility – to rent a one-bedroom unit priced at the federal Housing and Urban Development (HUD) Fair Market Rent. Rents for modest studio/efficiency units priced at the HUD Fair Market Rent were equal to 91.7 percent of SSI.

Table 2 provides *Priced Out in 2006* statewide data as well as data for each of Arizona’s MSAs. *Priced Out* clearly illustrates that people with mental illness in Maricopa County and throughout Arizona who have SSI level incomes cannot obtain affordable rental housing without some type of ongoing financial assistance.

“Bad housing is better than no housing at all.”

Chic Arnold, lawyer for the plaintiff, Arnold v. Sarn

Nationally, there are an estimated four million non-elderly adults who receive SSI because their disability prevents them from being employed. Approximately 1.33 million have a serious mental illness.

TABLE 2: Priced Out in 2006:
Arizona Statewide and MSA Data

Metropolitan Statistical Area	SSI Monthly Payment	SSI as % Median Income	% SSI for Efficiency Apt.	% SSI for One-Bedroom	NLIHC Housing Wage
Flagstaff	\$603	19.1%	115.9%	137.8%	\$15.98
Phoenix/Mesa/Scottsdale	\$603	17.2%	91.7%	107.5%	\$12.46
Prescott	\$603	21.4%	94.7%	97.7%	\$11.33
Tucson	\$603	19.7%	83.4%	98.0%	\$11.37
Yuma	\$603	25.1%	81.8%	96.5%	\$11.19
Non-Metropolitan Areas	\$603	25.2%	76.8%	85.4%	\$9.91
State Average	\$603	18.8%	89.1%	103.7%	\$12.03

How Much Financial Assistance is Enough?

Clearly, low-income people with an SMI diagnosis require some type of subsidized housing and supportive services if they are to make progress on the road to recovery. But how much financial assistance is enough in an environment with a lack of affordable housing and continuously rising prices for rent and ownership?

Many subsidized housing programs, including HUD's Section 8 program, set the upper limit of the consumer's financial responsibility for housing at 30 percent of adjusted income: beyond that, the consumer is at risk of lacking sufficient resources for other necessities such as food and transportation, to say nothing of basic services and household items such as a telephone, silverware, dishes and furniture, recreational and educational activities, etc.

By way of illustration, HUD estimates the 2008 fair market rent in Maricopa County to be \$609/month for an efficiency apartment and \$715/month for a one-bedroom apartment.¹³ Assuming the consumer is on SSI (\$623/month in 2007), her responsibility would be around \$188/month, based on 30 percent of income. That leaves \$435/month left for food, transportation, a telephone and everything else.

Imagine what it would be like to live like this. Based on the feedback we received from the consumer focus group and individual consumers, lack of money for the basic necessities – even if they have subsidized housing – is a source of constant stress. In this environment, basic survival takes precedence over the process of recovery.

The inescapable conclusion: Benefit levels have not kept up with increases in the cost of rent and living, and do not provide persons with SMI and other disabilities with an allowance sufficient for the basic necessities of life.

Cultural, Legal and Regulatory Barriers

The social stigma associated with mental illness in the U.S. is endemic. Despite decades of advances in treatment and documented cases of millions of persons with mental illnesses who lead normal and productive lives, a majority of Americans continue to associate mental illness with violence and out of control behavior – the “Other” in the midst of their controlled and “safe” communities.

Historically, persons with serious mental illnesses have been housed in institutions and segregated, congregate residential communities, such as group homes.¹⁴ Even though studies have shown that persons with mental illnesses prefer to live in less restrictive, independent housing that is integrated in the community,¹⁵ many Americans prefer to shut them out – the “Not in My Back Yard” mentality associated with being in proximity of anyone or anything perceived to be “different.” Arizona behavioral health officials can give chapter and verse about citizens angry and upset about living in proximity of people perceived to be “dangerous to themselves and to others” in their neighborhood.

Zero Tolerance

Attitudes are slowly changing, but it's an uphill battle, especially in a shrill social climate of fear and loss of control stoked by anti-terrorism, drug abuse and violent crime. In this environment, the desire for safety and social control trumps individual freedom and choice.

As a result, many communities have a “zero tolerance” policy toward crime and drugs. In a “Crime Free” neighborhood, if you can't pass a background check or have a criminal record (in addition to credit checks and the ability to pay the first and last month's rent up front), you can't rent an apartment. It is not unusual for persons with mental illness who have co-occurring substance use disorders

**“You can tell by the way people look at you.
They don't trust you.
They think you must be dangerous.”**

SMI consumer

and minor run-ins with the law to find their housing options restricted by community covenants and rental restrictions. Some HUD programs – notably Federal Public Housing – have tenant screening policies that restrict access to housing for people with criminal histories or previous use of alcohol and other drugs. These policies limit the ability of some consumers to move into subsidized housing.

Legal, regulatory and cultural barriers restrict housing options for some and drive them into unsafe conditions, either on the streets or in unregulated facilities where unscrupulous landlords are more interested in taking their money than in investing in clean and livable facilities. Such conditions were, in fact, part of the genesis of the Arnold v. Sarn lawsuit in the 1980s. Conditions have dramatically improved since then, but for some consumers it remains a challenge to find affordable, supportive housing because of legal and regulatory barriers. This was a consistent and forceful theme in our consumer interviews.

Not a Priority Issue

In *Housing for People With Mental Illness: Update of a Report to the President’s New Freedom Commission*,¹⁶ Ann O’Hara, a TAC consultant and contributor to this report, documents the “inadequate response” to housing needs of persons with serious mental illnesses and other disabilities by the affordable housing system. Among her conclusions:

- ⊗ Federal “elderly only” housing policies prevent persons with mental illness and other disabilities under the age of 62 from accessing many federally subsidized rental properties.
- ⊗ Programs that can help SMI consumers access affordable housing, such as the Section 8 Housing Choice Voucher Program and Section 811 Supportive Housing for Persons With Disabilities, have experienced a decline in federal support in recent years.
- ⊗ With the exception of funding for people who are chronically homeless, recent federal housing policy has shifted to home ownership opportunities for households above 30 percent of median income rather than on affordable rental housing for very low income persons.
- ⊗ The feds have devolved decision making for most housing programs to the state and local level, where support can be sporadic, and where officials do not always “understand or prioritize the needs of people with mental illnesses.” Reductions in federal housing subsidies have left states and municipalities “holding the bag” for new housing production.

For all the rhetoric, the housing needs for persons with serious mental illnesses is not a high priority issue in Maricopa County. We will return to this point later.

“Utilities and other services are more expensive in the East Valley than they are in parts of Phoenix and the West Valley. I couldn’t afford to live there even if I wanted to.”

SMI consumer





Are persons with serious mental illness in the public behavioral health system able to find permanent supportive housing?

How does the system stack up against emerging best practices, what are the barriers to constructive change, and what strategies and initiatives can we employ to overcome them and move forward?

Not a Strength of Mental Health Systems

O'Hara goes on to make the case that "affordable housing and the community support services that consumers need to access and retain housing are often overlooked priorities for state and local mental health systems."¹⁷ Among her points:

- Conventional categorical funding streams, bureaucratic program requirements and traditional administrative approaches to resource allocation and program management are not always in sync with "rigorously supporting consumers in normal housing."
- Many who work in mental health systems do not always see housing as their responsibility – and not as their chief skill set.
- Mainstream payers are used to covering mental health services for "traditional office-based care rather than 'in vivo' models of service." This lacks the flexibility and mobility necessary to keep consumers in permanent supportive housing.
- Traditional case managers are overwhelmed with large case loads and don't always have the time to provide the more intensive support that might be needed occasionally to keep their clients in permanent community housing.
- Generally speaking, mental health systems haven't always been responsive to consumers who are homeless.
- Categorical or "silo" funding streams make it difficult to meet the needs of SMI persons who are also homeless.

Is this the situation in Maricopa County? Are persons with serious mental illness in the public behavioral health system able to find permanent supportive housing? How does the system stack up against emerging best practices, what are the barriers to constructive change, and what strategies and initiatives can we employ to overcome them and move forward?

Before we take up these questions, we provide a historical perspective on how we arrived in *Gray Land* and some of the distinctions people make in describing our convoluted housing system for persons with serious mental illness.

The *Historical* Context

Over the past 35 years, the understanding of what constitutes appropriate housing for people with serious mental illness has changed dramatically – but not easily. Two paradigm shifts in housing models during the past three decades – the permanent supportive housing model (PSH) and more recently the “*Housing First*” approach to permanent supportive housing – continue to challenge long-standing assumptions about the ability of people with the most serious mental illnesses to live successfully in the community with appropriate supports. The emergence of these approaches also introduced the goals/principles of housing choice and full community integration into the already complex discussion of “best practice” housing policies for people served by the public behavioral health system.

De-Institutionalization and the Housing Continuum

Until the 1970s, state mental health hospitals were the “housing of last resort” for people with serious mental illness who could not live independently without supports in the community. Ironically, during those days there were many more affordable housing units available in the rental housing marketplace for very low-income people than there are today. What was lacking was a network of community-based supports for people with the most severe disabilities who wished to live in the community rather than in institutional settings.

By the early 1980s, the de-institutionalization movement was in full force as most public mental health systems sought to create a residential “continuum” of housing and residential treatment programs that included “quarter-way houses,” “half-way houses,” semi-independent living programs, staffed-apartment programs, and other models that co-mingled the provision of housing with residential services programs mandated as a condition of living in the housing. People typically needed to be “ready” to move to the next step in this continuum and were thought to need some sort of “supervision” in order to live successfully in the community. A relapse or hospitalization, an increase in symptoms, or resistance to the degree of control exercised by the service provider could easily jeopardize an individual’s housing stability.

In the late 1980s – prompted by the Robert Wood Johnson Foundation’s Demonstration Program on Chronic Mental Illness – the *permanent supportive housing model* (PSH) began to emerge and challenge fundamental mental health systems housing assumptions, policies and practices. Simply stated, PSH is *permanent housing with voluntary services*. While the emergence of this model was significant, it did not necessarily challenge the concept of the residential “continuum.” In some cases, local systems strayed from PSH by defining it as the last step in the residential continuum to which people were expected (or entitled) to “graduate” after spending time in more restrictive housing settings.¹⁸

A Continuum of Care

This “continuum” approach in mental health residential policy was further reinforced by the federal Housing and Urban Development (HUD) policy introduced in 1996, which also promoted the concept of a Continuum of Care to assist homeless people, including homeless people with mental illness. For many years, HUD’s *Continuum of Care* policy was expressed as a “linear” approach that encompassed homeless outreach and emergency shelter programs, followed by transitional housing, and then permanent supportive housing. It was not until after



A DEFINITION OF PERMANENT SUPPORTIVE HOUSING

HOUSING THAT IS:

- Decent, safe and secure.
- Affordable to consumers who should pay no more than 30 percent of income for rent.
- Permanent, with continued occupancy as long as the consumer pays the rent and complies with the terms of the lease or applicable landlord/tenant laws.

LINKED WITH SUPPORTIVE SERVICES THAT ARE:

- Flexible and responsive to the needs of the individual.
- Available when needed by the consumer.
- Accessible where the tenant lives, if necessary.

2002 – when HUD adopted the goal of ending chronic homelessness in ten years – that HUD policy clearly acknowledged that the Continuum of Care was not necessarily a linear approach but rather a “system” of programs and services designed to address the comprehensive needs of all homeless people.

Researchers and practitioners focused on the permanent supportive housing model have now demonstrated that many people with the most serious mental illnesses – and other people with serious and long-term disabilities – can live successfully in homes of their own in the community, and that they do not need to move through a “linear continuum” in order to achieve that success. As behavioral health systems now seriously consider the implications of implementing the *Housing First* approach (see page 15), it is helpful to recall the skepticism and difficulty experienced by public mental health officials and not-for-profit service provider organizations in the recent past as they struggled to understand the principles and dimensions of the permanent supportive housing model, and how its implementation would affect future behavioral health systems development.

What is Permanent Supportive Housing (PSH)?

The term ‘permanent supportive housing’ is used to make a clear distinction between housing that is a person’s permanent home versus other supportive housing settings that provide both housing and supports but are either time limited or require mandatory participation in a services program as a condition of continued occupancy. Other terms – “housing as housing” and “supported housing” – have also frequently been used by behavioral health professionals to describe the permanent supportive housing model.

While there may still be some disagreement on the exact term that best describes the model, there is no disagreement on its basic features. PSH refers to integrated permanent housing (typically rental apartments) linked with flexible community-based services that are available to tenants when they need them but are not mandated as a condition of getting or keeping the housing. The PSH model is based on a philosophy that supports consumer choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible and available services that meet each consumer’s changing needs.



PSH Principles and Dimensions

Certain key principles/dimensions are required in order for any supportive housing unit to be classified as PSH. These requirements are derived from the fundamental idea that *people who live in PSH units should be considered tenants rather than “residents” of a program*. They are consistent with both research and best practices in the field and are outlined in Table 3.

TABLE 3: Required Permanent Supportive Housing Principles/Dimensions

PRINCIPLES/DIMENSIONS OF HOUSING	REQUIRED FOR PERMANENT SUPPORTIVE HOUSING PROGRAMS
Relationship of Housing to Services	Services are linked to the housing but are considered voluntary. Services are not mandated as a condition of residency in the housing.
Permanency, Tenure, and Applicability of Landlord/Tenant Laws	Housing is considered permanent. Landlord/tenant law governs operation of the housing. Tenants have leases or rental agreements.
Supportive Services	Mental health system agrees to directly provide, or to fund or otherwise facilitate the delivery of supportive services to tenants. <i>However</i> , participation in supportive services is entirely voluntary and is not made a condition of tenancy. Services may be delivered on-site or off-site.
Control of Dwelling/Privacy	Tenant controls access to the dwelling unit by others in accordance with applicable landlord/tenant law.

These PSH principles/dimensions are important because over the past 20 years many behavioral health systems – at least initially – provided housing programs that were categorized as PSH but did not incorporate all of the above dimensions. These created much confusion in the field and that confusion still exists today in many parts of the country. The most common problems associated with these “faux” PSH programs were that they mandated some services as a condition of tenancy, or did not provide residents the rights of tenancy under prevailing landlord/tenant laws.

Recognizing that confusion still exists today about the features of the permanent supportive housing model, the Substance Abuse and Mental Health Services Administration (SAMHSA) plans to publish a PSH Tool Kit in 2008 to assist state and local mental health systems to expand this evidence-based practice, including evaluating their existing supportive housing programs for consistency with the dimensions of the PSH model.

Emphasis on *Consumer Choice and Community Integration*

Extensive studies on the housing preferences of people with serious mental illness have consistently shown a desire to live in their own house or apartment that is fully integrated within the community.¹⁹ These studies strongly indicate a disregard by most consumers for housing that is concentrated/segregated by disability and demonstrate a clear preference for the scattered-site model, which reduces – rather than reinforces – the stigma and discrimination so often associated with mental illness.

Expanding integrated housing options in the community for people with mental illness (and other disabilities) is also aligned with the U.S. Supreme Court’s *Olmstead* decision, which articulates a vision of community housing options for people who are living unnecessarily in institutions or other restrictive settings. *Olmstead* was a seminal event in the evolving discussion in the late 1990s on what constituted “state of the art” disability housing policy because it affirmed the community integration mandates embedded within the Americans With Disabilities Act.

How Many Units is *Too Many*?

As of 2007, the debate concerning how many units targeted for people with mental illness (or for that matter, other disability sub-populations) is optimal on one property or in one building rages on.

Cities such as New York, Philadelphia, Fort Lauderdale, Portland, Baltimore, Hartford, and Columbus have continued some development of larger scale single purpose/population permanent supportive housing properties but are increasingly implementing scattered-site strategies. Permanent supportive housing advocates and stakeholders in Connecticut, Louisiana and other localities have adopted a 50/50 “mix” of permanent supportive housing units together with so-called “work-force housing” targeted to households at 50-60 percent of AMI.

At the same time, the single purpose supportive housing property approach is increasingly being challenged by consumers and other disability advocates who believe that behavioral health systems – and systems that serve people with other disabilities – must put more emphasis on expanding integrated and scattered-site permanent supportive housing approaches. They make their case based on the following arguments:

- The scattered-site model is more consistent with consumers’ stated housing preferences.
- The scattered-site model reduces the stigma and discrimination associated with mental illness.
- The Not In My Back Yard (NIMBY) response from abutters and neighborhood residents has stymied and/or significantly delayed the development of single purpose projects.
- The desire to de-concentrate poverty through the development of “mixed income” properties that serve a broad range of incomes.
- An increasing recognition by behavioral health systems housing professionals that they cannot “build” their way out of the serious housing crisis that affects people with mental illness, and must rely on mainstream housing production mechanisms.

Affordable housing policy makers and practitioners have long recognized that while the development of a permanent supply of rental housing that is affordable over the long term is a critically important activity, less complicated rental subsidy approaches are also essential for a locality or state to make any headway meeting affordable housing needs.

Today, HUD’s Housing Choice Voucher program has approximately 2 million rental subsidies and has grown by more than 30 percent in the past 12 years, while the public housing program has declined from a high of 1.4 million units to less than 1.2 million units in 2007.²⁰ The understanding that a scattered-site approach to poverty de-concentration actually works was one reason a politically divided Congress repeatedly defeated proposals from the Bush Administration to end the Section 8 Housing Choice Voucher program.

The Affordable Housing Game

It has also been important over the past 20 years that behavioral health systems got into the “affordable housing development game.” By creating affordable rental housing in the community for people with mental illness, the system sends an important message that people with mental illness can and should live in the community just like everybody else.

But what strategies should the system employ? More of the same? Or more integrated approaches that do not concentrate people with mental illness in one location, that honor consumers’ housing choices, and that truly promote community integration?

The answer to the question “How many units is too many?” is not a simple one. But it is clear to many national experts (including TAC consultants for this report) that behavioral health systems are moving – perhaps slowly but steadily – away from single population buildings. These policy developments are, in part, a direct response to consumers’ stated housing preferences. Many of them refuse to live in single purpose buildings, preferring to remain homeless in some cases rather than live in a stigmatizing housing setting that is obviously set aside for a specific disability sub-population (e.g., people with mental illness, people who are homeless).

The move towards more integrated permanent housing is also being driven – again in part – by the fact that some behavioral health systems do not want to be “stuck” with these single purpose properties down the road, when consumers may have more housing options to choose from and “vote with their feet.” This dynamic is becoming a problem with group homes for people with disabilities around the country as providers have begun to abandon older Section 202 and Section 811 group home properties with high concentrations of people with disabilities in favor of integrated permanent supportive housing models.²¹



Housing First

In 1992, Dr. Sam Tsemberis, a clinical psychologist in New York City’s mental health system, set about helping people with mental illness who had been homeless for long periods of time to move into their own homes – typically a one-bedroom apartment – thus effectively ending their homelessness. Dr. Tsemberis’s effort, which became the *Pathways to Housing Program*, included the offer (but not the requirement) of access to comprehensive mental health and substance abuse services if desired by the consumer moving into the apartment. The program had only two simple requirements: (1) tenants must pay 30 percent of their adjusted income towards the rent, and (2) tenants must allow the Pathways staff to visit them at their apartment twice a month.

The extraordinary success of the Pathways to Housing Program – 88 percent of program participants remained housed in the community – has prompted the second paradigm shift in mental health housing policy: *People with serious mental illness and co-occurring substance abuse disorders do not need to be “housing ready” in order to be successful in housing.* Rather, the Pathways program relies on the principles of housing choice and housing integration to successfully engage chronically homeless people and offer them the option of moving into their own decent, safe and affordable apartment. This has become known as the *Housing First* model.

Key Features of the *Housing First* Approach

There are several key features of the *Housing First* approach to permanent supportive housing:

- 🔑 The direct or nearly direct movement to permanent housing by the consumer – usually from chronic homelessness. The Pathways program provides temporary housing (usually 2-3 weeks) in a hotel or YMCA while the consumer and program staff search for housing that meets their choices.
- 🔑 Comprehensive supportive services are offered 24/7 and made readily available, but there is no requirement that *Housing First* tenants participate in these services to remain in housing.
- 🔑 The use of assertive outreach to engage and offer housing to people who are reluctant to enter shelters or engage in services.
- 🔑 A “harm reduction/low demand” approach accommodates alcohol and substance use so that relapse will not result in the individual losing housing.
- 🔑 The continued effort to provide case management and to hold housing for program participants even if they leave the program housing for short periods.

The Pathways to Housing program model relies on a supply of rental subsidies to be able to lease scattered-site apartments from local landlords. Approximately 70 percent of the time, Pathways leases the apartment and then sub-leases to the tenant according to local landlord/tenant law. The Pathways program participant assumes all rights and responsibilities of tenancy. The Pathways program also has funds to help the tenant purchase the necessary furniture, appliances, and personal items they need to set up housekeeping. The model provides “in-vivo” and community-based services through seven-person Assertive Community Treatment Teams (ACT) that provide 24/7 coverage for 60-70 people. Since the program’s inception, over 1,000 people with serious mental illness – most of them chronically homeless and with co-occurring substance abuse – have obtained permanent housing in the community.

“You need different skill sets that you learn and abandon at different times when you are homeless. When you’re on the street, you need to be independent and aggressive. In a shelter, you need to be able to take orders and give up much of your independence. In your own housing, you need to be independent and responsible. Housing First skips all the craziness of different behaviors.”

Social worker with the homeless

Despite those who remain skeptical that the *Housing First* approach can work in their community, early efforts to replicate the success of the original Pathways to Housing program are showing success in the District of Columbia, Philadelphia, Hartford and Portland, Oregon – including a 70 percent reduction in chronic street homelessness in Portland – and outcomes in all these cities that are similar to those achieved by Pathways.²²

HUD's *Housing First* Study

To address issues raised by skeptics, including HUD officials' concern about the "harm reduction" component of this type of permanent supportive housing, HUD commissioned a study to test its effectiveness that included the Pathways Program as well as two *Housing First* programs operated in Seattle and San Diego.

The Seattle and San Diego programs differ in some respects from the *Housing First* model developed by Pathways, whose approach is considered the "ideal" *Housing First* model by many behavioral health professionals because of its scattered-site emphasis. These differences aside, the HUD study showed a similar success rate – 84 percent remaining housed in the community – for a population group whose members were almost all chronically homeless.

“Having an *array of choices* means people will find the program that fits their *needs*, instead of having to force themselves to fit a particular program.

While some *Housing First models* exist, the community has expressed the need to *further diversify* housing and services.”

MAG Regional Plan to End Homelessness, 2005 Update

signature



Facility-Based Residential Support Services

The increasing emphasis on PSH and *Housing First* as preferred practices and approaches for meeting the housing needs of people with serious mental illness/co-occurring disorders does not mean that there is no role for congregate residential settings. Many communities, including Maricopa County, continue to believe that “some homeless people succeed when moving from the streets to emergency shelters to transitional housing programs to permanent supportive housing,” while “others make progress more quickly when they move straight from the streets into permanent housing of their choice through *Housing First*.”²³

That said, it is important to note that despite what many in the community believe, there is no research cited in extensive literature on various congregate residential services and/or transitional housing that suggests these models are evidence-based or promising approaches. In addition, there are no congregate residential services or transitional housing models listed on SAMHSA’s National Registry of Evidence-based and Promising Practices (NREPP). There is no evidence that consumers learn essential skills and progress in their own recovery as a result of moving from one level of care in the continuum to another. And, there is little evidence that consumers learn recovery and independent living skills better in congregate facilities than in independent living settings.²⁴

A person trying to leave a congregate setting typically must start over in terms of obtaining the affordable housing and services they need to be in a more independent setting. The housing subsidy inherent in blended housing and services budgets for congregate facilities is rarely convertible to an affordable housing rental subsidy. Further, on a person-to-person basis, the services cannot necessarily be moved out into the community. This creates barriers and disincentives for both consumers and the system to make the transition into independent housing. In addition, because of the lack of affordable housing resources and associated flexible community services and supports, residential facilities that were designed to provide transitional services can become long-term residences for some consumers.

“The Homeless Industry – shelters, other temporary housing – has ensconced itself at the entry and transitional levels without necessarily asking whether theirs is a good model.”

Housing advocate

Characteristics of Facility-Based Congregate/Transitional Housing

- The services are referred to as “slots” or “beds” as opposed to “units.”
- Consumers are considered to be “residents” as opposed to being “tenants.”
- Consumers are “placed” in a facility rather than “choosing” their own housing.
- There may be a written housing agreement between the resident and the provider, but residents usually do not have full legal rights of tenancy under local tenant-landlord law.
- Services are frequently provided by the same entity that operates (manages, leases, owns) the facility.
- Services and staffing are designed for the facility, and are not typically flexible or tailored to changing resident needs or choices over time.
- In some cases, the receipt of site-based or site-managed services is a condition of occupancy.
- In some cases, residents must move from the facility to another location in order to change the levels and types of services received.
- In some cases, residents do not have choices about roommates or other people sharing the facility, house rules, meal times, etc.



Risks need to be identified and managed to assure that proper clinical criteria are used to access short-term residential facilities, and to assure that sufficient attention is paid to facilitate movement towards independent housing.

Reasons for Facility-Based Residential Services

Nonetheless, there are three reasons typically given for maintaining facility-based congregate services capacity in a local system of care:

1. A short-term residential facility can be used to respond to a crisis and divert a consumer from inpatient hospitalization. Maricopa County has some examples of this type of residential crisis respite facility. In most jurisdictions the average length of stay in a crisis respite facility is 3 to 14 days, during which time the individual's clinical home/lead agency can find the resources to facilitate movement back to the person's home.
2. A respite or short-term transitional facility can be used as a step down from hospital (or jail) placement to prevent homelessness or recidivism. Typically people stay in this type of facility no longer than 90 days while they and their clinical home/lead agency and housing support team (or other supports) arrange for PSH or some other permanent independent housing setting.
3. There may be some consumers for whom there is a community interest in assuring some type of supervised living arrangement that incorporates structure and security, as well as clinical services focused on long-term goals for recovery. These programs typically serve consumers with extensive forensic histories of other high risk behaviors that cannot be tolerated in regular community settings. In the past, this type of facility-based residential service program might have been used for people just coming out of a long stay at a state hospital or who burned out the staff at other community residential facilities. Today, the reality in most large urban systems is that some individuals need these intensive, short-term residential/crisis diversion services.

A De Facto Safety Net

The risk, of course, is that people in these short-term residential facilities might stay for longer periods of time. This is particularly true for people who have no permanent housing or cannot return to an unstable previous housing arrangement. There is some experience in the field to suggest that once people have been in a facility for 30 days, the opportunities for quick progress to a more permanent arrangement are substantially diminished.²⁵

There is also some risk that residential facilities become the de facto "safety net" for other parts of the community's system of care. If the system does not fully adopt recovery-oriented evidence-based and promising service practices in tandem with PSH and *Housing First*, residential facilities can become the default for some consumers. Both types of risks need to be identified and managed by the Regional Behavioral Health Authority (RBHA) and its partners in the community to assure that proper clinical criteria are used to access short-term residential facilities, and to assure that sufficient attention is paid to facilitate movement towards independent housing.

We will have more to say about the continuing use of facility-based residential support services in Maricopa County in the recommendations section of this report.

Gray Land: The SMI Housing System in Maricopa County

Before we can analyze the public housing system in Maricopa County for persons with a serious mental illness, we first must describe it. 

Background

Arnold v. Sarn

It's impossible to analyze housing for the SMI population in Maricopa County without referring to *Arnold v. Sarn*, a lawsuit first initiated in 1981 by consumers to address serious deficiencies in living conditions and community-based supports. The lawsuit was decided in favor of the plaintiffs in 1986 and reaffirmed by the Arizona Supreme Court in 1989; the parties adopted an implementation plan – a “blueprint” – to address the deficiencies identified in the lawsuit in 1991, and in 1996 they stipulated a set of “exit criteria” that would have to be satisfied to end the lawsuit. In 1999, a study (referred to as the Leff Report) estimated that it would cost \$317 million to meet the minimum requirements of *Arnold v. Sarn* (revised upward to \$570 million in 2004).²⁷ The lawsuit is under ongoing review by the Office of the Court Monitor and continues to this day. After 26 years, it's still not clear that any end is in sight.

Deplorable housing conditions for SMI consumers figured prominently in *Arnold v. Sarn*. Many of the original plaintiffs lived in unsafe and filthy flop houses, were victims of abuse in unsupervised group homes, were abused on the streets or housed in locked down facilities with little hope of ever being integrated into the community. Among other things, the lawsuit established that a full continuum of housing options be developed for the SMI class members in the least restrictive manner, that properties be limited to no more than eight SMI members or 25 percent of a housing complex, (to avoid creating “mini-institutions” in the community), and a strategic plan for housing the mentally ill be developed and reviewed on a regular basis.

A State of Emergency

During much of the 1990s, housing and other aspects of behavioral health services in Maricopa County were contracted out to ComCare, the County's Regional Behavioral Health Authority, or RBHA.²⁸ Although ComCare was successful in receiving large federal HUD grants to increase housing options for consumers (matched by state general funds and supportive services), they maintained large waiting lists and had numerous problems with referral and verification processes, agency coordination, case manager performance and a general lack of units. One problem piled on top of another, and in 1997 the State took over ComCare. In 1997, the Governor declared a state of emergency in the public behavioral health system, and ADHS issued a request for proposals in 1998 to address it. ValueOptions (VO), a privately held for-profit behavioral health managed care company, was awarded the contract and began operations in early 1999.

VO's for-profit status is relevant here, because HUD housing contracts are limited to nonprofit providers or units of government. This was not an issue in Maricopa County because of the creation of the nonprofit Arizona Behavioral Health Corporation (ABC) from the dissolution of ComCare. Through a competitive bid process, ABC assumed responsibility for the HUD contracts through HUD and the Arizona Department of Housing (ADOH), with match requirements and some expenses paid for by the RBHA, and continues in that role today. Through another competitive bid process, Magellan, a

WHAT IS HOUSING?

As defined by Arizona Department of Health Services/ Arizona's Division of Behavioral Health Services (ADHS/DBHS, hereafter referred to as ADHS alone), housing is “the total benefits of a place to live and the supports necessary to help individuals and families of behavioral health services create a positive life experience in that residence.”²⁶

In this definition, ADHS conjoins housing as a place of residence and housing as a set of behavioral health service supports. This approach will become relevant later when we discuss the issue of separating housing costs from other aspects of behavioral health services.

“It can take two-three weeks to get an appointment for evaluation [to begin the process of enrolling as SMI in the system]. They won’t give them an immediate appointment. You may not even be able to find them three hours later if you get them an appointment. Three weeks...well.”

Homeless system official

publicly held for-profit managed care company, took over Maricopa County operations from VO in September 2007.

Meanwhile, troubles in the behavioral health system continued apace. In 2000 the Governor was made party to the Arnold v. Sarn lawsuit. She called a special session of the legislature that resulted in the passage of HB 2003, which provided funding from tobacco tax litigation proceeds to purchase housing, vocational rehabilitation and enhanced case management for SMI adults. For the first time, the state began a property acquisition program for Arnold v. Sarn class members.

The *SMI Housing Situation* Today

Today the housing situation for persons with serious mental illnesses in Maricopa County’s public behavioral health system is either much improved, about the same, or still deficient, depending on whom you ask.

When we look at the numbers alone, we can see noticeable improvement, and there is evidence that best practice models in permanent supportive housing (PSH) are beginning to take hold. At the same time, the Court Monitor’s 2006 audit of the system continued to single out housing as one of the areas still deficient under the Arnold v. Sarn exit stipulations, and the National Alliance on Mental Illness (NAMI), in its report card on state mental health systems, gave Arizona a D+ for, among other things, a lack of affordable permanent supportive housing.²⁹ In light of Maricopa County’s rapid rate of population growth and a well documented lack of affordable housing for an ever larger proportion of the general population, it’s not at all surprising to see those same financial and social pressures continuing to overwhelm persons with mental illnesses and other disabilities.

Defining the SMI Housing System

The accompanying diagram of the Maricopa Housing System for persons with a serious mental illness provides a general “flyover” view of its principal components:

THE SMI CONSUMER The person with a serious mental illness/co-occurring substance abuse disorder who utilizes housing and support services in the public behavioral health system to achieve recovery. All measures of the system’s purpose and success start and end with the consumer.

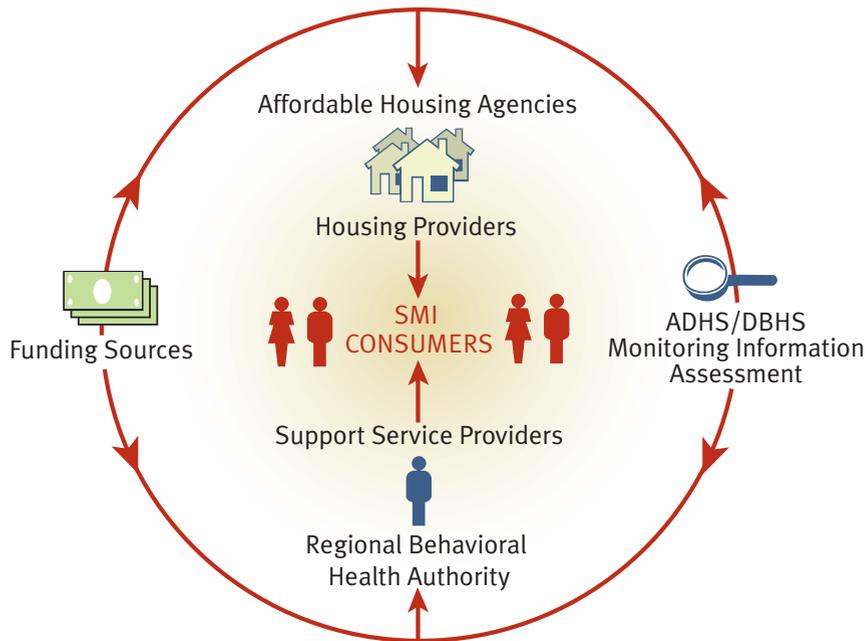
HOUSING PROVIDERS Nonprofit and for-profit property management companies, landlords, developers and contractors who lease, build and/or otherwise make available appropriate housing to SMI consumers.

SUPPORT SERVICE PROVIDERS Agencies that provide a wide range of supportive services for SMI consumers to promote stability and recovery: medical services, case management, rehabilitation, vocational assistance, education, social support, transportation, etc.

AFFORDABLE HOUSING AGENCIES Agencies that are conduits for government affordable housing funding targeted to low income households, including people with mental illness and other disabilities. These include governmental agencies such as the Arizona Department of Housing (ADOH); public housing agencies (PHAs) such as the Maricopa Housing Authority and other public housing authorities; and nonprofit housing agencies such as the Arizona Behavioral Health Corporation (ABC).

ADHS/DBHS The Arizona Department of Health Services/Division of Behavioral Health Services. This Division has responsibility for the behavioral health component of Title XIX (Medicaid, or the Arizona Health Care Cost Containment System-AHCCCS) and Title XXI (Children’s Health Insurance Program), as well as for other populations eligible for public

FIGURE 2: The SMI Housing System



behavioral health services. The Division monitors, assesses, collects/analyzes/disseminates information, and otherwise is responsible for the successful implementation of the public behavioral health system in Arizona.

REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA) Magellan, the Regional Behavioral Health Authority in Maricopa County as of September 2007. The RBHA is a behavioral health managed care company that contracts with ADHS to deliver medical and support services to approximately 70,000 members in the public behavioral health system in Maricopa County, of which approximately 19,500 are classified as seriously mentally ill. Formerly, the RBHA was allowed to provide behavioral health services directly, but that was rescinded in the contract in force today. As a result, Magellan contracts with competing networks of behavioral health service providers in the community to deliver the defined medical and support services, and gives consumers a choice. Magellan operates under a three-year, \$1.4 billion contract with the State, the largest of its kind in the country.

Funding Sources

There are multiple funding sources for the SMI housing within the public behavioral health system in Maricopa County:

U.S. Department of Housing and Urban Development (HUD)

SHELTER PLUS CARE (S+C) S+C is a HUD McKinney-Vento Homeless Assistance program that provides permanent housing rental subsidies for the SMI population and other individuals and families with disabilities (substance, AIDS and related diseases) who qualify under HUD’s homeless definition. The program provides rental subsidy for a variety of housing choices, accompanied by support services funded through other sources. ADOH receives the S+C grants targeted to Maricopa County and administers the program through contracts with ABC. The RBHA provides the mandatory dollar-for-dollar service match required under HUD rules.





SUPPORTIVE HOUSING PROGRAMS (SHP) The McKinney-Vento Homeless Assistance SHP program provides grants to expand housing and related support services for SMI and other disabled individuals and families who qualify as homeless under HUD's definition. Any new SHP funding provided by HUD to localities must be used only for permanent housing and certain housing-related supportive services. Unlike the S+C program, there is no dollar-for-dollar match requirement, but there are certain match requirements for grantees. ABC administers most of these, and the RBHA provides support services.

HUD SECTION 8 HOUSING CHOICE VOUCHER PROGRAM (HCV) The HCV is HUD's major housing assistance program targeted to households with the lowest incomes, including households with SMI and other disabilities. Administered by Public Housing Agencies (PHAs), vouchers are issued to eligible households who then must locate and lease permanent housing in the community that meets HUD's HCV program requirements. Because of federal budgetary limitations, most PHAs have not received any new HCV since 2000-2001. However, "turnover" vouchers are issued by PHAs to qualified households who are on voucher waiting lists. The RBHA provides supportive services.

HUD MAINSTREAM VOUCHERS This is a small HUD program targeted solely to people with disabilities. It is administered by PHAs and nonprofit organizations, and generally operates under the same rules as the regular HCV program. ABC currently administers 125 Mainstream Vouchers. HUD has not provided funding for new Mainstream vouchers since 2002.

HUD 811 This program provides interest-free capital advances to nonprofit sponsors to develop rental housing such as independent living projects, condominiums and small group homes with the availability of supportive services for persons with disabilities. The advance does not have to be repaid so long as the housing remains available for low-income, disabled persons for at least 40 years. Additionally, HUD provides rental assistance that covers the difference between HUD-approved operating costs of the projects and what residents are required to pay (usually 30 percent of adjusted income). The RBHA funds the supportive services component of the Section 811 program. Under the program's current rules, supportive services must be offered to Section 811 tenants, but they cannot be mandated as a condition of tenancy.

SECTION 202 Similar to the Section 811 program in structure, the Section 202 program provides capital advances to finance the development and ongoing operating costs, construction and rehabilitation of supportive housing for the elderly (households aged 62 and older).

HUD'S HOME PROGRAM The HOME program provides formula grants to state and local "participating jurisdictions" to expand housing opportunities for low and moderate income individuals and households. HOME funds can be used for home ownership or to expand rental housing opportunities, including two-year renewable tenant-based rent subsidies. The State of Arizona, the City of Phoenix and Maricopa County all receive HOME funds annually from HUD and invest them in specific activities outlined in the jurisdiction's HUD-approved Consolidated Plan.

State General Funds

State general funds have been used to develop permanent housing for persons leaving the Arizona State Hospital, supervisory care homes or intensive residential programs. Generally, funds are used to lease properties such as four-bedroom homes and to provide necessary support services in accordance with the resident's individual service plan (ISP). Additionally, ADHS receives state support to fund permanent supportive housing (property and services) as part of responding to the Arnold v. Sarn exit criteria.

ComCare Trust

Liquidated assets from the ComCare Trust proceeds (see Background section) are used to develop permanent housing, purchase and lease homes and apartments complexes for priority population class members. They also provide supportive services to help them maintain their independent housing.

HB2003

This piece of legislation passed in 2000 (see Background section above) approved the use of Tobacco Litigation funds to improve deficiencies in the mental health system, including housing. The state has used these funds to expand permanent housing through property acquisition and move-in assistance as well as rehabilitation and case management services for the SMI population.

Arizona Department of Housing (ADOH)

In addition to receiving a number of federal grants for housing, ADOH administers funding sources that can be used for SMI housing in certain instances, such as the Housing Trust Fund and the federal Low-Income Housing Tax Credit Program (LIHTC).

Private Funding

Private funds from foundations and individuals find their way to housing and support services for the SMI population, persons with other disabilities and the homeless population more generally through grants and contributions to a variety of housing and service providers. In 2004, for example, the Maricopa Association of Governments (MAG) reported a total of almost \$18 million from foundations and private donors for housing and homeless services.³⁰ It is difficult to separate out private funding associated with SMI persons in the public system, so we don't track that here.

Separating Out Housing and Service Funds

In the ADHS definition of housing noted earlier, housing is the *total benefits* of a place to live and supports necessary to have a positive experience and achieve recovery.

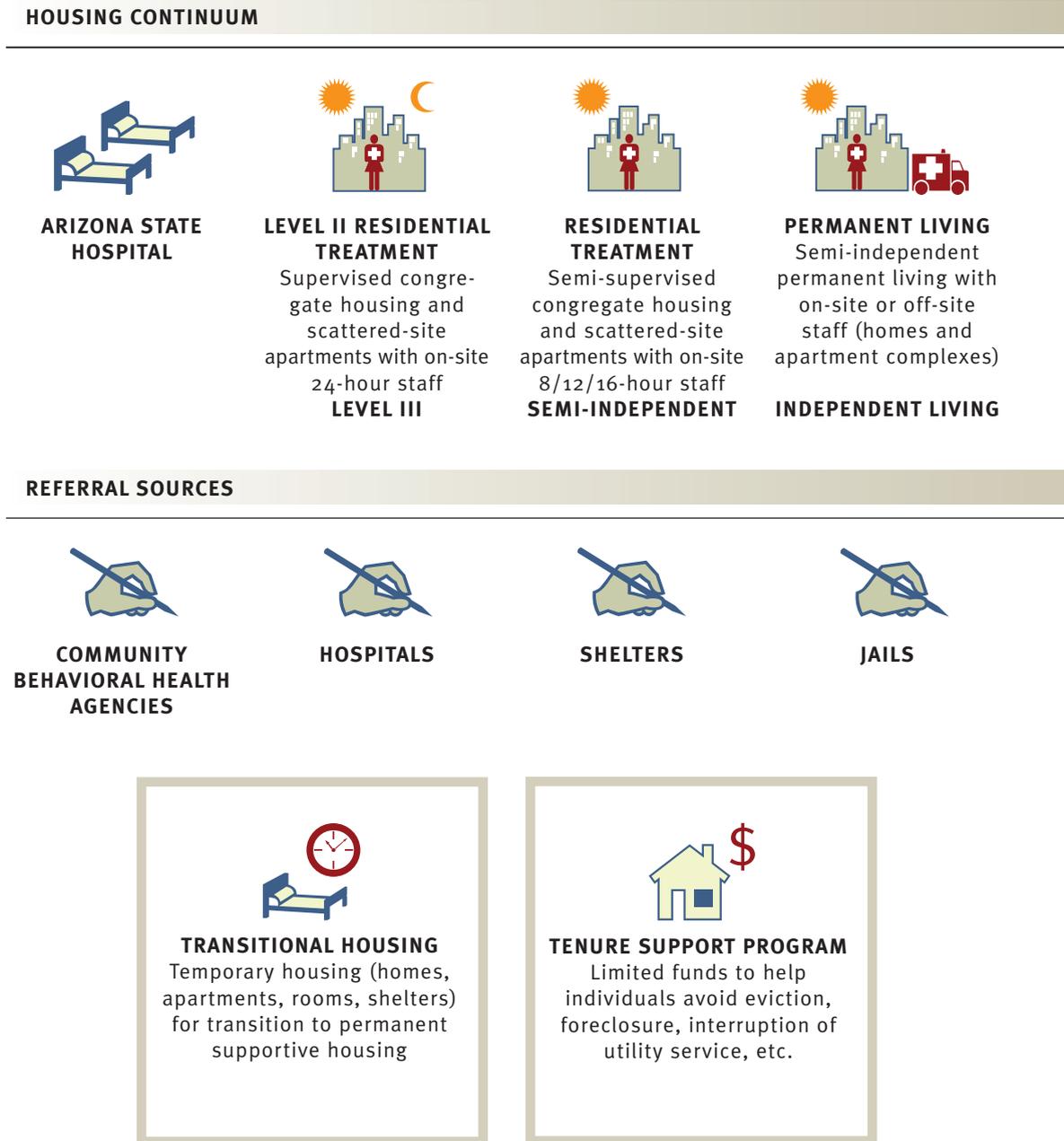
For SMI persons in the system's 24-hour and semi-supervised (16- and 8-hour) residential treatment facilities, many of which are scattered-site apartment settings, facility costs (rent, etc.) are included with other treatment costs in one total benefit package, much like they are in nursing homes and other acute care settings.

While there is justification for this approach, it makes it more difficult to separate out housing costs from supportive service costs, and to make some determination of the extent, adequacy and impact of housing funding streams proper. Also, if some clients can successfully be transitioned to permanent supportive housing, it makes it harder to separate out housing funds that could conceivably follow them to a more independent setting. As it stands, the housing dollars are attached to a program through one total benefit package, rather than separated out and attached to the client alone.

The Housing Continuum

ADHS maintains a housing “continuum” for persons with a serious mental illness, ranging all the way from highly restrictive supervised settings like the Arizona State Hospital to independent apartments and homes with or without on-site support, and home ownership.

FIGURE 3: SMI Housing Continuum



The Continuum *Beyond* the Continuum

To underscore how much of a true *Gray Land* housing for persons with a serious mental illness is, we are compelled to note the diversity of both formal and informal programs, living arrangements and support services provided to this population by churches and faith-based social agencies, families and friends, administrative agencies at the city and county level that manage housing grant programs (including federal programs like Section 8 and 811), and countless individuals who contribute money, time and even their own homes to help others on the road to recovery.

We described the informal pathways of this other “continuum” in community behavioral health in our 2005 *Mind, Mood and Message* report,³¹ but space does not allow us to pursue its dimensions related to housing here. Suffice it to say that if we were to include all of the connections between persons with serious mental illnesses and housing and support services in the community beyond the formal public behavioral health system, the so-called continuum would be impenetrable.



Independent living (apartments, homes) with rental subsidy and access to support services



HOME OWNERSHIP



**SELF-REFERRAL/
FAMILIES**



**COMMUNITY
GROUPS**



**TRANSITIONAL
HOUSING AGENCIES/
PROGRAMS**



**MOVE-IN ASSISTANCE
PROGRAM**

Limited funds to help individuals defray the cost of rent and security deposits, utilities, necessary household items.



RESPITE PROGRAM

Transitional out-of-home safe and therapeutic living environment that provides a brief separation for the client, caregiver and others as necessary.

TABLE 4: Arizona Department of Health Services, Division of Housing Continuum, October 2007³²

Description	Supervised 24-hour Program (Treatment)	Semi-Supervised Housing (Treatment)	State Semi-Independent Housing & Restart	State Independent Housing HB 2003 & HOPE
Number of Units	491	526	149	226
Annual Support Services Costs*	\$26,882,250	\$28,798,500	\$3,263,100	\$8,661,450
Annual Housing Costs**	Rent included in service dollars	Rent included in service dollars	\$1,072,800 State funds	\$1,423,800 State funds
Total Property Acquisition				\$2,500,000
Daily Support Service Costs	\$150/day	\$150/day	\$60/day \$600/month rent	\$105/day, \$525/month rent
Total Costs	\$26,882,250	\$28,798,500	\$4,335,900	\$12,585,250

DEFINITIONS:

SUPERVISED 24-HOUR HOUSING: All adult residential 24-hour treatment programs and co-occurring treatment programs.

SEMI-SUPERVISED: 16/12/8-hour residential programs and/or provider affiliated housing programs.

STATE SEMI-INDEPENDENT LIVING: Independent Living Units – Community Builders program at META and Restart, a transitional respite program for clients.

STATE INDEPENDENT HOUSING HB 2003: Tobacco Tax and community placement funds, HOPE housing voucher funds.

COMMUNITY PLACEMENT: Arnold v. Sarn, ComCare Trust and Casa Buena³³ funding for property acquisition programs for independent living arrangements.

HUD INDEPENDENT SHELTER PLUS CARE AND SUPPORTIVE HOUSING PROGRAMS: All the HUD McKinney Act Homeless Housing Programs.

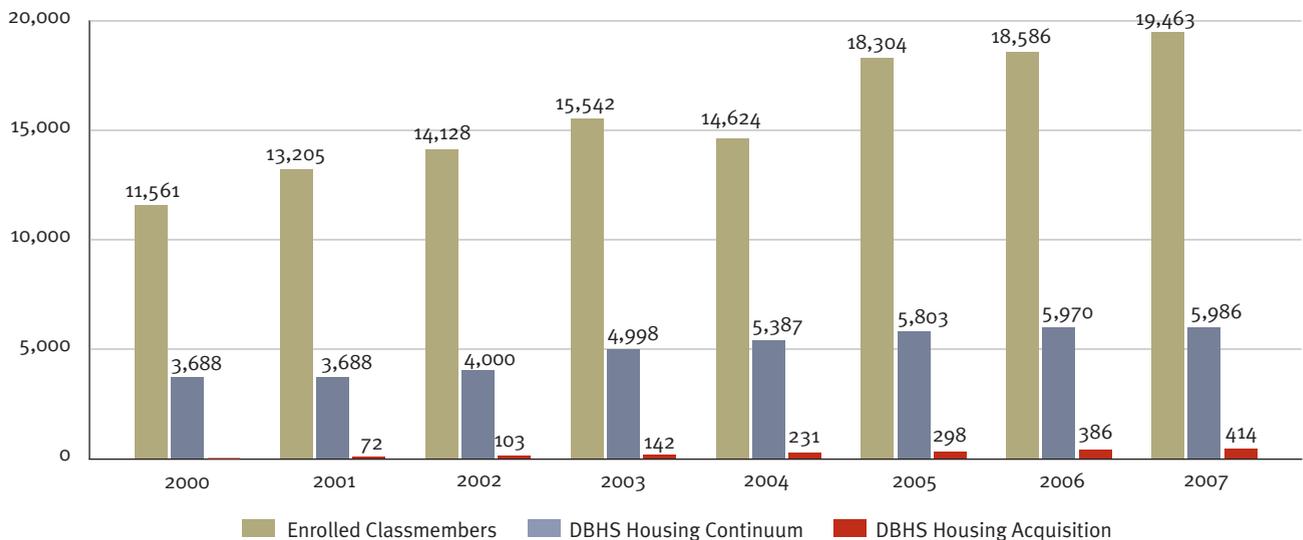
HUD SINGLE ROOM OCCUPANCY (SRO'S): Independent living units in a dwelling where tenants share a bathroom between units.

HUD INDEPENDENT FEDERAL HOUSING: Independent Living units such as HUD Section 8, 811, Public Housing and 202's.

* Funding totals include supportive services and rent subsidy and housing related costs, based on RBHA contracts with service providers.

** Housing Costs and housing related costs such as: rent subsidy, utilities, unit repairs are based on below HUD Fair Market Rents and associated housing costs.

FIGURE 4: ADHS/DBHS Housing Acquisition and Enrolled Classmembers, 2001-2007



Source: ADHS/DBHS Enrollment Report, ValueOptions, April 2007.

Behavioral Health Services

Community Placement and Arnold v. Sarn	HUD Independent Shelter Plus Care & SHP	HUD 811 SRO's	HUD Independent Housing (Section 8, etc.)	Accumulative Numbers
366	1,428	21	2,943	6,150
\$8,015,400	\$11,636,357		\$31,784,400	\$119,041,457
\$2,500,000 (2007 allocation state funds)	\$11,636,357 HUD subsidy	\$226,800 HUD subsidy	\$24,721,200 HUD subsidy	\$41,580,957
\$19,493,273 (cumulative)		\$375,000 Rehab \$700,000		\$23,068,273
\$60/day services	Dollar for dollar cash match		\$900/month case management, \$700/month medications	
\$30,008,673	\$23,272,714	\$1,301,800	\$56,505,600	\$183,690,687

Notes on the ADHS Maricopa County SMI Housing Continuum

Treading Water

In terms of number of SMI permanent housing units alone, ADHS added 2,497 units between 2000 and 2007, or a 68% increase. That sounds impressive until one considers the rate of growth in the Maricopa County SMI population during the same period, which also increased 68% (11,561 in 2000 to 19,463 in 2007). General population growth in the County for the same period is projected to be 26% (3,072,149 in 2000 to 3,880,000 in 2007), underscoring the increase in persons diagnosed with a serious mental illness relative to the rest of the population.³⁴

One interpretation is that the County is treading water in the public system's housing continuum for the seriously mentally ill. See Table 5 for one projection of the number of additional housing units the system would need to just stay even by 2012. This translates into creating almost 400 additional units annually over the next five years, a pace that's slightly faster than the average of 357 new units annually between 2000-2007.

TABLE 5: Treading Water: A 2012 Forecast³⁵

	2000	2007	2012
Total MC Population	3,072,149	3,898,362	4,621,440
Enrolled SMI Class Members	11,561	19,463	25,781
ADHS/DBHS Housing	3,688	6,150	8,145

Beyond Treading Water: How Many New Housing Units are Needed?

Based on the data we have reviewed, this is a difficult, if not impossible, question to answer, considering the wide range of estimates of SMI homeless in Maricopa County (1,400 to 4,500), the number of SMI individuals in jails (1,100 or more), the number of SMI consumers housed temporarily in substandard or otherwise inappropriate housing, and the number of SMI eligible for Title XIX/XXI funding and/or federal/state housing programs. If reasonably accurate and current figures in these categories exist, we have not seen them.

All the same, based on interviews with housing officials and providers who related experiences with large numbers of homeless SMI persons not currently in the public system, and current wait lists averaging 700-800 of those who are (assuming approximately one-half might meet the federal definition of chronically homeless), we estimate that ADHS would need to add an additional 1,000 new units over the linear projection in Table 5 – picking up the pace to roughly 600 new units annually instead of 400 – to make an appreciable dent in the need. Given that the RBHA estimated an unmet need of “as many as 2,000” net new supportive housing units for the County SMI population in 2004,³⁶ we believe this estimate is on the conservative side.

The Right Mix?

Simply looking at the growth in the number of housing units, however, doesn't tell us much. The more relevant question for practice and policy is whether the growth represents the optimum *mix* of housing units on the continuum between more restrictive treatment and congregate settings on one end and more independent housing, characterized earlier as permanent supportive housing (PSH) and *Housing First* models, on the other.

The numbers alone don't provide an answer to what that optimum mix might be, but they suggest some places to inquire further. For example, ADHS reports 1,017 units in residential treatment settings (congregate and scattered-site apartments) with various levels of on-site support at a cost of \$150/day. This compares to 1,428 units S+C and SHP programs at roughly \$22/day and another 2,943 units in other HUD independent housing programs at \$30/day.

Absent any hard clinical evidence of severity of need and intensity of services in individual cases, it is interesting to speculate how many persons currently placed in residential treatment settings might do just as well – or better – in PSH, and might prefer to live in a less restrictive setting if given a choice. While our interviews confirmed that some consumers who have been homeless for a long time and have the most difficult mental illnesses are, in fact, living successfully in HUD-funded PSH housing, they also confirmed that there are a number of individuals in more restrictive settings who don't necessarily need to be there.

Absent the availability of enough PSH in the community to meet the need and the resources necessary to provide the appropriate level of services, this is idle speculation at best. As it stands, the system is perversely incentivized to keep the residential units filled because they are funded by Title XIX dollars, which would have to be replaced by other funding sources in PSH. They function as default housing because other options aren't always available.

A Rock and a Hard Place

This puts ADHS officials between a rock and a hard place: They are committed to pursuing PSH and *Housing First* principles and strategies, but it's hard to transition away from residential treatment settings without other housing options and sources of funding to replace what they already have. Choices are thus forced for reasons of fiscal expediency, and not necessarily to pursue strategies derived from best practices. We will return to this point later.

Progress in PSH

Despite a continuing reliance on residential treatment programs, ADHS has clearly made substantial progress in increasing the number of new permanent supportive housing (PSH) units. Fully 71 percent of the housing continuum consists of HUD S+C and SHP independent housing (1,428) and HUD independent housing (2,943 – Section 8, etc.) ABC, Inc., which administers the S+C and SHP programs, as well as some of the Section 8 housing along with other PHAs, has a long and clear history of using *Housing First* strategies to place chronically homeless persons with serious mental illness into permanent

ABC: A Housing First Model

ABC and its housing contractors have been successfully getting SMI clients into permanent supportive housing for a number of years and model best practices in housing that are now finding their way into systems all across the country.

For example, ABC's programs include an SHP-funded *Housing First* program model that currently serves approximately 225 consumers who were chronically homeless. They have undertaken an aggressive effort to ensure that formerly homeless consumers in their S+C program get onto PHA waiting lists for Section 8 Housing Choice Vouchers, thus permitting them to recycle the valuable S+C rental subsidies controlled by the mental health system to assist other consumers who are currently homeless. This is an excellent strategy to maximize the use of S+C rental subsidies for homeless people, and ABC should be commended for this effort.

supportive housing. Consumers we talked to were especially enthusiastic about the level of support provided by HOM, Inc., one of ABC's housing contractors, who assigns a housing manager to each consumer to ensure their needs are met.

A Gray Land of Definitions and Categories

ADHS's Housing Continuum for persons with a serious mental illness has this in common with most other state and national public housing "systems:" it is a gray land of definitions and categories that makes it hard to establish baseline data and track change in outcomes consistently over time.

For example, previous iterations of the housing continuum in Maricopa County have included treatment in a licensed facility under the category of "independent " and "semi-independent" living with no clear definition or consistency of those terms. More recently, the term 'Housing First' has been used in the context of the residential services continuum as well as to describe immediate access to housing for homeless people. As a result, it is hard to tell from the categories in Table 4 which programs have the fidelity dimensions associated with PSH or are consistent with the *Housing First* best practice model described earlier in this report.

This muddle is drawn to a large degree from the diverse system stakeholders, each of whom has their own definitional and program requirements: federal funding sources (definitions of homeless and chronically homeless), state funding sources (definitions and categories of capital, housing and services); the Arnold v. Sarn Court Monitor (rules regarding placement of class members in units and service process requirements); ADHS (a multitude of definitions and categories to comply with funders, regulators and the Court), and housing/service provider agencies (to comply with, and seek funding from, all of the above).

This mélange of definitions, categories and rules is the chief reason the system is "complicated beyond belief," in the words of Ted Williams, CEO of ABC, Inc. For one cautionary tale of how these definitions and categories can collide, see the summary of the Good Shepherd saga on page 30.

"Here's the problem. It's bureaucracy. You can't do 'Housing First' until all the paperwork is done, and that can take two or three weeks and a bunch of interviews at different times that most people just don't make. So if you're mentally ill, you may never get enrolled for services you're actually eligible for."

Phoenix policeman

"My HOM housing manager is great. She helped me move into my apartment and get settled, plus she checks up on me. I wish everyone [in the system] were like that."

SMI consumer



Good Shepherd: A Cautionary Tale³⁷

The Good Shepherd saga is a classic illustration of why we have titled this report Gray Land.

The Good Shepherd properties – seven complexes scattered around Maricopa County, each with 12-13 units – were originally built by HUD in 1982 to provide housing for the elderly and persons with disabilities. Through a series of disputes regarding poor management, they came up for sale in 2005. Valued at approximately \$5 million, HUD sold them through a competitive bid process to FIBCO, a nonprofit housing provider and community development agency, for a mere \$500,000.

Of this amount, \$375,000 came from ADHS (exclusive of another \$453,000 in subsequent renovation and relocation costs), which saw the properties as a unique and cost-effective way to provide SMI consumers – “priority class members” under the Arnold v. Sarn lawsuit – who were leaving institutional settings, residential programs, supervisory care homes or correctional facilities with an opportunity to “live independently in transitional housing.”³⁸

Housing or a Residential Program?

The salient characteristic of the Good Shepherd properties is that each unit had separate bedrooms and common bathroom and kitchen areas. ADHS, following HUD rules, intended these to be single-room occupancy (SRO) housing, where each individual would have his or her own key to their room, could come and go as they pleased, share the common bath (for every two rooms) and kitchen areas with other residents, and receive off-site services as appropriate by the RBHA. Each resident would pay 30 percent of their adjusted monthly income for rent, and would not be required to participate in structured services as a condition of residence. There would be up to eight class members at each site; the other rooms would be rented to other people with disabilities.

The Court Monitor’s office objected. Under the Arnold v. Sarn Implementation Plan, class members were required to receive treatment in the most normal and least restrictive settings such as apartments and single-family homes. Residential programs were to be limited to eight class members or 25 percent of the total, whichever is greater. Since the properties could only be rented to persons with a disability (HUD rules), it was possible that more than eight disabled persons with mental illness might reside in a unit, which would be in clear violation of the implementation plan.

Not so, replied ADHS. This isn’t a residential program. This is housing as defined by HUD, and as such doesn’t fall under the implementation plan restrictions. Even if it did, the rules on capacity restrictions should be modified to reflect the huge unmet housing need for the SMI population in Maricopa County (a waiting list of close to 900 people) and a static Department housing budget in a period of rapidly rising housing costs. This was safe, affordable and effective housing. Other states used SRO housing for SMI persons with success, and so should Maricopa County.

A Tortuous Exchange

And so ensued a tortuous exchange – filed through a year of pleadings to the Superior Court of Maricopa County to determine whether an evidentiary hearing was warranted – on what terms like ‘housing,’ ‘program,’ ‘residential program’ and ‘institutional setting’ meant; whether the property and intended use were consistent with “professional housing standards,” whether the properties were a necessary and appropriate part of the housing ‘continuum,’ and whether the benefits of the plan outweighed the harm. And so on.

In the end, the Court found for the Plaintiff. They agreed that an evidentiary hearing was not needed, and that the Implementation Plan supported the conclusion that the Good Shepherd properties comprised a “residential program” and, as such, had to abide by the restriction of the number of class members in each unit.

Lessons Learned

What lessons might one take away from this? In our opinion, there are several:

- 🔑 This issue should never have made it to Court. It illustrates a failure of communication, and an unraveling – temporary, we believe – of the trust and spirit of cooperation that have ebbed and flowed over Arnold v. Sarn’s 26-year history. This failure of communication cannot be laid at the feet of particular individuals or parties in the dispute, but at a formal structure that sits over the system by legal edict and discourages frank and open communication unless it can be expressed in confining legalistic definitions. After 26 years, we think even the lawyers on both sides would grow weary of this.
- 🔑 Reading through the court documents, one is struck by the almost complete absence of any reference to outcomes for persons with serious mental illnesses or, for that matter, to consumers at all. Their voices are noticeably absent. Would some of them choose to live in an SRO facility? Are they making progress in recovery? No one can tell from the court documents. The feeling one gets is that of listening to a group of medieval theologians debate how many angels can dance on the head of a pin, while the people outside are trying to go about the daily business of living.
- 🔑 Along those same lines, the Good Shepherd dispute is a textbook example of the ascendancy of process over outcome. Most of the Arnold v. Sarn stipulations on system requirements and performance are expressed in process metrics: how many people can live in one facility, how many get case manager visits, etc. The presumption is that process is related to outcome: follow best practice procedures, and you stand a better chance of getting best practice outcomes. The danger, however, is that process metrics crowd out outcome metrics over time and are treated as de facto measures of system performance. To be sure, this is hardly limited to Arnold v. Sarn. It’s endemic in social services and health care generally, primarily because it’s much easier and convenient to measure simple process criteria than it is to assess complex outcomes that may be the result of factors beyond any defined set of process metrics alone. The labyrinth of rules, regulations and categories to process SMI consumers through equally impenetrable housing options is one of many cases in point.
- 🔑 At the risk of annoying all parties to this dispute, we conclude that both the Plaintiff and Defendant were right. ADHS was presented with a unique opportunity to purchase housing at a price considerably below market value – and with HUD paying the subsidies for consumers. With a shortage of affordable housing, a large waiting list and static housing funding in a climate of rapidly rising prices, they made the right decision to arrange for the purchase of the Good Shepherd properties. The Arizona taxpayer would certainly approve, even if we all agree that the goal is to gradually move to PSH. On the other hand, the State agreed a long time ago to the Arnold v. Sarn Implementation Plan and exit criteria. Given that their own definition of housing is the *total benefits* of a place to live and necessary support services (see page 19), it was a bit of semantic sleight of hand to argue that they were simply providing housing, and not a “residential program,” and as such weren’t under the restrictions of the number of residents in one unit. On that point, the Court reached a defensible conclusion.³⁹

In the end, the Good Shepherd dispute was about the wrong question. It shouldn’t have been about how many people are allowed to live in one unit, but about how to optimally use these properties in the housing continuum to provide the best possible experience to assist SMI consumers in achieving recovery. That’s a question that only consumers, housing and service providers, state and court officials can seek an answer to *together*. That was the case when the Good Shepherd properties came up for sale over two years ago, and it’s still the case today.

Best Practice:

Scattered-Site Housing Development Approaches



Before concluding with an analysis of supportive services issues facing Maricopa County's public housing system for the SMI population and making recommendations for the future, we take a side trip through promising practices in other states to develop scattered-site housing with supportive services. Some of these practices exist in Maricopa County's public behavioral health housing system. For those who would like more information, we have published TAC's *Selective Case Studies in Permanent Supportive Housing*, which is available on our website (www.slhi.org/gray_land), as an addendum to this report.

The states referenced here – Pennsylvania, North Carolina, Louisiana – are all in the process of implementing scattered-site development approaches to ensure that rental units affordable to people who rely on SSI are created as a regular set-aside in affordable housing development projects financed under the federal Low Income Housing Tax Credit program and HUD's HOME program. All differ in some respects but have several elements in common:

- § Systematically utilizing the affordable rental housing development that occurs through other federal “mainstream” affordable housing programs to regularly produce new units of housing that are set aside for a specifically targeted disability or homeless population at affordable rents (e.g., 30 percent of adjusted income).
- § Set-aside policies – typically 5-10 percent – that are mandated as a condition of receiving the federal funds.
- § Partnerships between mental health/human services systems and the affordable housing system, particularly at the state and local government level.
- § Service approaches that emphasize housing retention and housing stability, including the emerging use of a cross-disability Housing Support Team model.

Pennsylvania

In Pennsylvania, the Allegheny County Office of Mental Health (OMH) elected to invest more than \$5 million in savings from their Medicaid-financed behavioral health initiative to expand affordable housing for SMI consumers.

With the active participation and advice of a consumer/family Supportive Housing Advisory Committee, OMH's *Housing as Home* strategic plan adopted six systems-oriented recommendations to facilitate the creation of 220-240 new permanent supportive housing units linked with flexible community-based services and supports designed to sustain tenancy and foster community-based recovery and resiliency for high priority consumers. The strategies were also designed to create and sustain cross-system partnerships between OMH and the region's affordable housing funders/providers, including the Allegheny County Public Housing Authority, City of Pittsburgh Public Housing Authority, and the Pennsylvania Housing Finance Agency.

Bridge Subsidy Program

In addition to the new units created through the Housing Development Fund, OMH set aside an additional \$3 million of re-investment funds to create a more integrated “one stop” approach for high priority consumers moving into new permanent supportive housing

and to lease additional housing units. Through a new Permanent Supportive Housing Provider (PSHP), OMH will help consumers access 60-80 permanent supportive housing units created through the Housing Development Fund and 60 additional units of scattered-site permanent supportive housing funded through a \$1.9 million multi-year project-based leasing program. Some of these units will be occupied by consumers who currently might not be eligible for federal housing assistance (poor housing histories, criminal record etc.) but who could overcome those barriers with a successful tenancy.

Additionally, a new Bridge Subsidy program was created to assist approximately 100 high priority consumers to obtain decent, safe, and affordable housing in the community immediately. Partnerships with local PHAs may help to transition consumers from these temporary bridge housing subsidies to Section 8 Housing Choice Vouchers. A Housing Support Team provides comprehensive housing supports to all 220-240 consumers living in the new permanent supportive housing units. The team also helps to build housing competency across OMH's entire services system.

Other elements of OMH's comprehensive approach include: (1) a Housing Clearing-house designed to manage the permanent supportive housing waiting list, develop a housing library, and develop/manage an affordable housing database accessible to all OMH consumers, families, and providers; and (2) a new Housing Contingency Fund to pay for one-time housing related expenses such as housing search transportation, security deposits, utility hook-ups, and purchase of household furniture and goods.

North Carolina

The North Carolina Department of Human Services, which in 2002 sought to create a model that would work across *all* of the disability populations served by DHS, developed a partnership with the North Carolina Housing Finance Agency (NCHFA) that is embedded within the NCHFA's policies applicable to the agency's federal Low Income Housing Tax Credit (LIHTC) program. So far, this partnership has financed approximately 1,200 new units of permanent supportive housing affordable to people with disabilities at SSI income levels.

The federal LIHTC program is a competitive program administered by every state through policies that are established through the state's Qualified Allocation Plan – a federal program requirement. The LIHTC program is extremely complex, but in its most simple form, affordable housing developers are awarded credits that can cover 40-60 percent or more of the costs of developing a rental housing property – a significant financing tool. In North Carolina, developers awarded an allocation of LIHTC for a specific project are required to set aside 10 percent of the units for people with disabilities, who then receive supportive services funded by DHS.

The Key Program

The LIHTC program produces units affordable to households at 50-60 percent of AMI, but not people with disabilities with incomes at 15-20 percent of AMI. North Carolina struggled with this issue before settling on an approach – the *Key Program* – that provides a state-funded project-based subsidy for the units set aside for people with disabilities – so-called “Targeted Units.” This subsidy is much less expensive than a typical HUD Section 8 Housing Choice Voucher or McKinney-Vento Homeless Assistance program subsidy because it is designed to reduce the rent from 50 percent of AMI to the SSI affordable rent. For example, if the Fair Market Rent is \$800 per month, the LIHTC rent may only be \$600 per month. If the rent affordable to a person on SSI is \$200 (e.g., 30 percent of AMI), the Key Program subsidy in North Carolina only costs \$400 per month, not the \$600 per month that would be needed to pay the Fair Market Rent from the Section 8 Housing Choice Voucher program.





Louisiana intends to seek significant changes in policies so that the supportive services will eventually be covered under Medicaid.

Louisiana

Based on North Carolina's success, Louisiana chose to replicate a component of rental housing recovery strategies in the Katrina hurricane-affected areas. As part of the federal recovery resources provided to the state, the Louisiana Housing Finance Agency (LHFA) has received a significant amount of additional LIHTC to develop over 17,000 units of affordable rental housing. Embedded with the state's policies for those resources is the requirement that developers set aside at least 5 percent of the units in every project for people with disabilities who need permanent supportive housing. Developers were given extra points in the LIHTC competition if they proposed to increase the percentage as high as 15 percent. More than a few developers did exactly that.

As a result, approximately 800+ units of permanent supportive housing are in development or pre-development, and the first units were scheduled for occupancy in late 2007. To provide the supportive services component, the LHFA has entered into a partnership with the Department of Health and Hospitals that will provide supportive services and coordinate tenant selection for the units through a network of Local Lead Agencies. The state also intends to seek significant changes in their Medicaid policies so that the supportive services – which are being initially financed with federal Community Development Block Grant funding provided by Congress for hurricane recovery – will eventually be covered under Medicaid.

Implications for Behavioral Health Housing Policy

The *Housing First* and Scattered-Site Set-Aside approaches being implemented in states like Pennsylvania, North Carolina, Louisiana potentially change the paradigm of housing policy for behavioral health systems across the country, and in addressing chronic homelessness generally:

- 👍 The *Housing First* model is being successfully implemented in Portland, Oregon, which has experienced an astonishing 70 percent reduction in chronic homelessness in just two years, as well as in Philadelphia, San Francisco, Hartford, Fort Lauderdale, Baltimore and other communities across the country.
- 👍 The Scattered-Site Set-Aside policy is generating considerable interest among state Housing Finance Agency officials. During recent years, the more innovative HFAs have been seeking strategies consistent with their mission and financing tools to create more deeply affordable units for people with disabilities and others with incomes below 30 percent of AMI. While each state has unique opportunities and barriers, it is clear that HFAs around the country are re-examining their potential role in meeting the housing needs of people with disabilities.
- 👍 These approaches can be expected to receive increased attention as state human services and Medicaid agencies seek solutions to the housing needs of people with disabilities who are currently living in “restrictive settings.” Under the Supreme Court's *Olmstead* decision, states are guided to create “comprehensive effectively working plans” that help people with disabilities move into the community and also prevent unnecessary institutionalization. Partnerships between state housing and human services agencies to “embed” the creation of affordable housing units within broader affordable housing policy certainly could be considered important components of such a plan.

Challenges Remain

Clearly there remain numerous challenges associated with implementing new permanent supportive housing approaches for people with mental illness and co-occurring disorders:

- Perhaps the most pressing challenge is the lack of new rental subsidies to make housing truly affordable for people with SSI-level incomes. In many states, advocates are “waiting” for the federal government to renew its commitment to provide funding for new rental subsidies for people with disabilities and other populations with the lowest incomes. All the same, certain states are successfully overcoming this barrier through creative approaches that are designed to “fill in the gap” created during recent years as new federal subsidy funding has virtually disappeared. Much can be learned from these efforts.
- Many challenges exist within the behavioral health system itself and involve the difficulties associated with fundamental systems changes necessitated by emerging evidence-based practices and the realignment of service system resources. Each health system implementing the permanent supportive housing model must assess the extent to which it is willing – and able – to reallocate mental health system resources in order to facilitate the creation of new permanent supportive housing.
- Despite its demonstrated effectiveness, the PSH approach and *Housing First* model challenge traditional thinking and may involve changes in behavioral health housing and services philosophy, policies, and practices, particularly for the most vulnerable and highest priority consumers. These systems changes don’t take place over night, but can occur over time as the creation of PSH units becomes a reality in the community and meets consumer needs.



“There’s this church in Phoenix that requires they do a one-hour interview with someone before they place them. This guy fit their description, but he was in jail. They wouldn’t go to the jail to see him, they wouldn’t accept [our] reports of answers to their questions. They wouldn’t bend their rules. We have to go out and fight people who are stuck in their own processes. How do you get them past this culture of being so rigid? They want to do picnics, for God’s sake.”

Police

Best Practice: *System Issues*

Best practices in the development of *Housing First* and PSH approaches require best practices in sophisticated and effective community services and support. Without these, any new housing initiative is doomed at the outset.

On that score, there are a number of promising and successful approaches, some of which are already present – or capable of being implemented – in Maricopa County’s behavioral health system:

The Clinical Home

The first step in achieving service system alignment with PSH and *Housing First* is to assure that each priority consumer has a clearly identified “clinical home,” or core lead agency. This clinical home is expected to be available to consumers on a 24 hour/7 day per week basis, and is responsible for assuring that each consumer receives the attention, services and supports s/he needs to live in PSH and *Housing First*. The clinical home is responsive to, and responsible for, the assigned consumer, wherever they are and whatever services they may be receiving at the time. The clinical home is expected to anticipate and prevent crises and assure coordination with all necessary health, employment, and other human services. The clinical home is intended to work closely with housing providers (including housing support teams as described below) to facilitate housing preparation and tenancy, and to marshal the community services and supports necessary for each person moving into permanent supportive housing.

In Maricopa County, the RBHA (Magellan) is accountable to assure that each priority consumer has an identified clinical home. Typically this would be a case management/ community support organization or local mental health clinic with outreach capacity (e.g., ability to go out to see the consumer rather than requiring consumers to come to an office or facility for services). It appears that Magellan already assures that consumers have an assigned clinical home, at least for the current PSH and *Housing First* programs we reviewed. However, as PSH expands into a larger number of scattered-site locations, there may be an increased need for the RBHA to assure the accountability and responsiveness of assigned clinical home agencies.

Housing Providers – Housing Support Teams

Respondents have described the housing provider services utilized under the auspices of ABC, Inc. to facilitate PSH and *Housing First* efforts for homeless consumers under HUD McKinney-Vento programs in Maricopa County. These housing provider services/functions appear to be very similar to the Housing Support Team model being used or developed in other jurisdictions, and received high marks from the consumers we interviewed.

See the accompanying section on housing support teams for key elements of a successful program.

Implementation of Evidence-Based Practices – *Recovery and Resiliency*⁴⁰

Systems developing PSH and *Housing First* typically place increased emphasis on the expansion of evidence-based and recovery oriented service modalities in the community. Some of these best practice models – integrated dual diagnosis treatment (IDDT) for people with co-occurring mental illness and substance abuse; supported employment; assertive community treatment (ACT/PACT) – are particularly relevant to tenants living in permanent

“At DES [Arizona Department of Economic Security], if they don’t show for an appointment within one- and one-half hours, they won’t be seen. People who are this ill don’t always function well. We are not stepping back as a system and looking at the stress we are imposing on people. We continue to do what we have always done.”

Housing advocate

Housing Support Teams: Key Elements

Pre-Tenancy Assistance

- Conduct an initial assessment of housing preferences and housing history.
- Assist consumers in determining housing preferences if needed.
- Assist consumers in compiling housing information needed for housing applications (credit reports, landlord references, income and asset documentation, etc.).
- Assist in identifying available housing units/rent subsidies, including state and local behavioral health authority funded or leveraged resources.
- Assist consumers in obtaining, completing and submitting housing applications.
- Assist consumers in attending any meetings with housing provider, including arranging for transportation and attending meetings as needed.
- Assist consumers in filing appeals and requests for reasonable accommodation under Fair Housing Law.
- Assist consumers in setting up a system to track application progress.

Move-In

- Assist tenants to understand basics of landlord/tenant law and lease requirements.
- Assist tenants with security deposit, securing furniture and other household items.
- Assist tenants with moving-in activities.
- Assist tenants to establish utilities and telephone.
- Assist tenants in orienting to home and to neighborhood.
- Identify any housing or community living related skills training needed, including home maintenance, shopping, cooking and budgeting.
- Provide community living skills training or make appropriate referrals to the consumer's clinical home/lead agency.

Tenancy Stabilization

- Work with tenants to secure Section 8 or other rental subsidy if unit does not have project-based subsidy or tenant does not have a permanent subsidy source on move-in.
- Establish routine contact with tenants to ensure early detection of any housing issues.
- Provide ongoing housing-related skills training if needed and identify any issues that may require additional training by other parties.
- Intervene with landlords if needed to problem solve.
- Maintain communication with assigned clinical home/local lead agency.
- Coordinate meetings with tenant's case manager and service providers if needed to resolve housing issues.





“2007 was the hottest summer on record, and none of the homeless died because of lack of water. We saw the issue and did something about it. Good things can happen. We just have to come together.”

Mark Halloran CEO, CASS

supportive housing. Other best practices, including medication algorithms and Treatment Outcomes Prospective Study (TOPS)-oriented substance abuse interventions, are integral to the overall implementation of best practices regardless of housing setting.

Both PSH/*Housing First* and community behavioral health best practices are based on new attitudes and understandings of mental illness and the recovery process as much as they are based on new service technology. *A commitment to recovery and resiliency is absolutely critical to effective implementation of the housing strategy.* It is absolutely critical to making both permanent supportive housing and other best practices become integral parts of the overall behavioral health system, and not isolated elements serving a narrow band of consumers.

Whatever It Takes

Recovery is typically not a facile or linear process. Periods of progress are interspersed with setbacks, and there are risks of failure inherent in the process. Recovery happens in natural environments in which both the people in recovery and the people assisting in the recovery process have to make real world choices and live by the consequences.

Recovery represents a fundamental sea change in direction for system managers, service providers and practitioners who have been used to making choices for consumers with the intent of keeping them safe. In a recovery-oriented system of care, the system focuses on doing whatever it takes to assist individuals to make their own choices and take their own actions leading to independence and self-sufficiency. Housing providers, clinical homes for permanent supportive housing tenants, and all others throughout the entire system will share this commitment to recovery and resiliency by necessity. We will return to this point later.

System Performance Metrics Management

The contract between ADHS and the Maricopa RBHA contains extensive requirements for data collection and reporting, some of which can be used to track success in the expansion of PSH and *Housing First*. These metrics, as used by jurisdictions implementing PSH and *Housing First*, are typically consistent with current practices for measuring consumer-focused outcomes, and include:

- ✍ Increased days in independent housing settings.
- ✍ Increased consumer satisfaction with housing.
- ✍ Increased perception of choice in housing.
- ✍ Improvement in measures of recovery (choice, control, empowerment, hope, quality of life).
- ✍ Improvement in measures of independence (employment, income, community participation).
- ✍ Increased participation of high priority consumers in permanent supportive housing (chronically homeless, dual diagnosis, heavy user, etc.).
- ✍ Reduced elapsed time between hospitalization or other critical event and tenancy in permanent supportive housing.
- ✍ Reduced encounters with hospital emergency room and acute inpatient services.
- ✍ Reduced episodes of homelessness.
- ✍ Reduced episodes of arrest/incarceration.

To the extent that some of these performance measures are available in Maricopa County, they can be used community-wide to track progress and assess results of the expansion of PSH and *Housing First* approaches. They can also be used to assure quality improvement within the system by helping to identify problem areas or unintended consequences.

Gray Land: The Housing System and Supportive Services

Before we conclude with specific recommendations to address issues in housing for persons with serious mental illness in Maricopa County’s public behavioral health system, we provide a critical perspective on what is perhaps a tougher nut to crack: the availability and adequacy of supportive services.

Our perspective is informed by a series of interviews both within the formal system – ADHS officials, housing providers/specialists, RBHA staff, consumers – and out in the broader community that interfaces with the homeless at either the formal or informal level – MAG housing officials/specialists, social workers, the faith community, law enforcement officials, landlord representatives, homeless shelter officials and staff.

We heard diverse and even divergent views on where the challenges and opportunities lie. Threading a needle through black and white assertions of who’s doing what, who’s not doing what, who’s responsible and what we ought to be doing about it takes us deep into the gray land in between.

Between Systems

People entering the public behavioral health housing system can come from the streets, jail, courts, public/private agencies, families, churches and self-selection. They must be qualified to enter, which means they have to meet multiple admissions criteria (income restrictions, diagnosis, definitions of homelessness, etc.) and undergo some type of evaluative process.

All of us are more than familiar with qualifying routines to access system-specific services. We go through them in the course of everyday living, and know how frustrating and draining they can be.

Now imagine going through them if you have schizophrenia, an acute bi-polar disorder or major depression, not to mention a drug habit. What’s frustrating for a normal person can be a nightmare for someone with a serious mental illness.

Fault Points

There are a number of fault points in putting together supportive services with housing:

A Cottage Industry

“Homelessness,” as one administrator said, “is a regional problem without a regional solution.”

While the MAG Regional Plan to End Homelessness is making some headway – increased funding, further development of the Homeless Management Information System (HMIS) and Arizona Evaluation Project, the implementation of CASS and the Lodestar Day Resource Center – the delivery of housing and supportive services remains tied to local jurisdictions, each with its own cottage industry of providers who often end up competing across jurisdictions for the same pot of limited state, federal and private resources.

We heard from officials who questioned what they perceived to be a “disproportionate” share of public funding being directed to the SMI homeless (25 percent of the homeless population, but over 60 percent of the funding), while other groups (general population, domestic violence, substance abuse, youth, HIV/AIDS) lagged behind. The truth is that federal funds for the lowest income and most vulnerable people are more scarce than they have ever been. Despite the rhetoric of collaboration and cooperation – which is required

“I was working with a man who had schizophrenia and a heroin habit. He wanted to get off the streets and get clean, but they were having trouble finding housing for him coming out of prison. He was scared as hell. He said, ‘If I go to CASS [Central Arizona Shelter Services], I’m lost.”

Police

to receive HUD funding – competition for these funds is considerably less tidy and more contentious than one would conclude from reading any number of system and regional “strategic plans” which tend to gloss over the differences.

Process is King

Literally everyone we talked to commented on the difficulty of getting people into the system and housing quickly and efficiently. A significant part of the problem, as many define it, is an overly rigid adherence to rules and regulations that define the *process* of qualifying people for services. Instead of getting people into *housing first* and then determining the services interface, persons in various states of mental decompensation find themselves either out on the streets or shuffling between shelters and other temporary facilities, often for months at a time, while someone tries to determine whether they qualify – or are “ready” – for supportive housing.

Informants especially noted the significant number of SMI persons being discharged from County jails to CASS, which becomes their de facto place of residence while the system “figures out” what to do with them. CASS, which can accommodate about 400 homeless persons, can be a dangerous environment for someone with a serious mental illness, according to both law enforcement officials and people working in the homeless

system. The Day Resource Center works to connect these and other homeless individuals with housing and services, but the time it takes to make the connections and follow the rules of various programs and agencies (finding the person, filling out the forms, making an appointment for an interview, arranging for a diagnosis, transportation, etc.), can take weeks and, in some cases, even months.

For one illustration of what the process of qualifying for SMI housing can look like, we include a homeless housing flow chart (Figure 5) from ABC Inc., an affordable housing agency that runs an exemplary permanent supportive housing program in Maricopa County. The process simply takes time. Once people do get housing and supportive services, however, most of them stabilize and begin the process of recovery. Table 6, which documents the length of stay for SMI consumers with HOM Inc., one of the principal housing contractors for ABC, is proof that permanent supportive housing works.

TABLE 6: Length of Stay for Participants with HOM Inc.

Less than 1 year	19%
Less than 2 years	14%
Less than 3 years	10%
Less than 4 years	4%
Less than 5 years	19%
More than 5 years	34%

“I don’t worry too much about my case manager, because I know I’ll have another one in a few months.”

SMI consumer

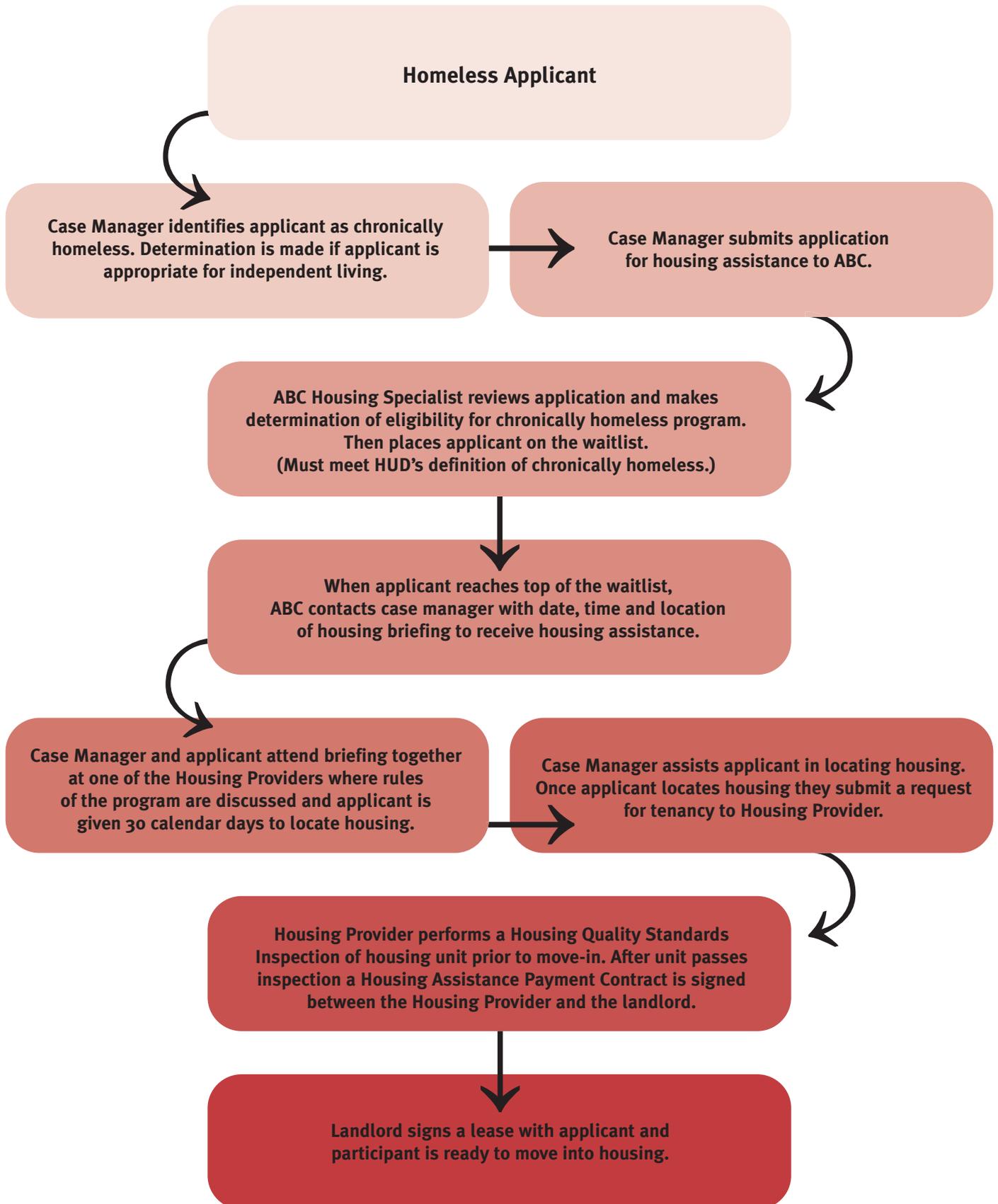
Staff Support

Support services for persons with severe mental illness require professionally trained people. There simply are not enough of them in Maricopa County to meet the burgeoning need.

We heard chapter and verse about the high turnover rate of case managers in the RBHA, where half of the priority clients can have a new case manager every six months. Interestingly, comments from consumers in the system gave high marks to HOM Inc. housing managers assigned to help them and lower marks to the RBHA case managers who, they said, didn’t always show up on a timely basis. Whether this situation will improve under Magellan, the new County RBHA, remains to be seen, but the basic structural deficiencies – low pay, high case loads, lack of trained professionals relative to need – make it an uphill climb.

Much of our interviews with informants about service staffing centered around the availability and placement of Assertive Community Treatment – ACT – teams, a time-tested, best practices method of delivering services to individuals with severe and persistent mental illness. Typically, these are six-eight person teams (psychiatrist, nurse, case manager, case aid(s), employment/benefits specialist, housing specialist, substance abuse specialist, peer specialist) that, based on optimum ratios of one staff per 8-10 clients, cover approximately 60-70 clients each.⁴¹ In *Housing First* programs like New York’s Pathways program referenced earlier, ACT teams are successfully used to provide critical support services as clients progress towards recovery.

FIGURE 5: ABC's Chronically Homeless Flow Chart



Funding More ACT Teams

ADHS estimates that 10 percent of the SMI population in Maricopa County – about 1950 persons – need ACT teams for services. By best practice standards, that translates into 28 or so ACT teams. It is our understanding that the RBHA has 19 ACT teams – nine teams short of national best practice standards. According to ADHS, it costs roughly \$1 million annually to field a fully staffed ACT team. On that basis, the RBHA needs to come up with another \$9 million to staff up to national standard levels, assuming qualified professionals could be recruited in a health care labor shortage market.

Then there’s the issue of where ACT teams are needed. According to a number of persons we interviewed, an ACT team needs to be located at the Day Resource Center because of the large number of SMI clients assisted there. According to ADHS, however, there is an ACT team at the Day Resource Center, but it’s out in the community seeing clients. In our opinion, the fact that there is a difference of opinion on whether an ACT team is available in this location is due in large part to a lack of ongoing communication and sharing of information between the state/RBHA, system service providers and the County’s more general homeless housing system.

Finally, on the subject of adequacy of staff, ADHS has only one full-time person assigned to SMI housing. In the transition from ValueOptions to Magellan, we were unable to determine the staffing resources devoted to housing in the RBHA. Based on the interviews, however, we suspect that, like ACT and case management staffing, the resources are not sufficient to meet the need.

Perceived Barriers to Reform

In our interviews across the SMI housing system, we encountered a number of perceived barriers to reform:

Arnold v. Sarn

The Arnold v. Sarn restrictions on the number of members who can be housed in a facility or complex – eight persons or 25 percent of the total in a complex, whichever is greater – is perceived to be a barrier in developing housing and working with landlords. The Good Shepherd properties, discussed earlier, is one example. Other examples given included developers who were reluctant to build out or otherwise reserve units for qualified SMI clients unless they could be guaranteed that a significant number of units would be rented and supported for the long term. ADHS points to the success of the Tennessee housing plan as an example of what can be achieved if no such restrictions are present. In that state, the largest number of SMI consumers in one location is 32 in a 32-unit apartment complex, although the great majority of units have eight or less.⁴² Some persons we interviewed suggested that ADHS needs greater flexibility to “do housing deals” than Arnold v. Sarn allows.

An Opportunity, Not an Obstacle

We agree that the State needs greater flexibility in putting together optimum housing for SMI consumers. We also agree that, following the intent of Arnold v. Sarn, the goal is to offer consumers opportunities and choices to live in the least restrictive, most independent, home-like settings. Given that all parties say they want to get to the same place – independent permanent supportive housing to aid in recovery – we prefer to frame Arnold v. Sarn as an opportunity rather than a obstacle. The key distinction here is the difference between transitional and permanent supportive housing. If some of the congregate complexes could be designated as short term crisis respite or brief transitional residential serv-

“We [group of 20 congregations] are housing 30-40 people a night on a rotating basis. They have to be clean and sober, and we can’t take the SMI who don’t meet those criteria. We need a place out here [in the East Valley] with mental health services.”

Church pastor

ice programs and house larger numbers of SMI consumers, and if the *Arnold v. Sarn* rules could be modified to allow for more flexibility and greater experimentation in the process of moving from transitional to permanent housing, progress might be made.

The details of the path forward, of course, depend on open, ongoing communication and trust. Without that, nothing is possible.

Housing Restrictions

Housing provider screening can be affected by HUD restrictions and selected local/regional criteria. Among other things, HUD mandates a crime-free/drug-free lease addendum be signed. Priority SMI members who have criminal records and/or a drug habit may be prohibited from moving into certain subsidized housing programs such as public housing. The same may be true for certain local and regional jurisdictions where landlords and housing developers take a “zero tolerance” policy toward crime and drug use. In the face of these restrictions, ADHS has chosen to purchase homes and small apartment complexes directly with HB 2003 and ComCare Trust funds, so consumers with backgrounds that may be prohibited in other settings can be housed and provided with supportive services.

Reasonable Accommodation

These housing restrictions are barriers that all states and communities face, but in our opinion they are not sufficient justification to use state funds to purchase property directly when those funds might be more optimally deployed in leveraging the resources of local, regional and federal housing developers and programs.

In TAC’s experience in states like Massachusetts, Ohio and Connecticut, these barriers are best addressed systematically through the successful application of federal fair housing laws – specifically Section 504 of the Rehabilitation Act and the Federal Fair Housing Act. Both federal statutes (and many state fair housing laws that are “substantially equivalent” to the federal fair housing statutes) require that administrators of federal subsidized housing programs (including owners of federally subsidized housing) provide what is called “reasonable accommodation” in policies and procedures – including tenant selection/screening – in order to improve access to these resources by people with disabilities.

The laws provide, for example, that an owner must disregard certain information on previous tenant history *if* the previous tenant behavior was directly related to the person’s disability, and if it is reasonable to believe that with the provision of supports and services, the behavior would not be repeated. For example, if a person with SMI was living in rental housing, was not receiving services from the mental health system, and did not pay their rent, that tenancy history can be disregarded if it is “reasonable” to assume that with services and supports that behavior would not re-occur. It is important to note that under reasonable accommodation policies, one cannot require that someone accept services. So it is not a lever in that regard. It is more like a “dispensation” to allow the tenant to try again with appropriate support.

These restrictions are barriers enough, but progress can be made through the application of reasonable accommodation policies. Maricopa County housing staff have begun to receive training in this area.

Funding Time Restrictions

Another perceived barrier to developing housing for the seriously mentally ill is a time restriction on the use of certain categories of funds, such as Arizona general funds. If funds are not used in the fiscal year in which they are appropriated, they are required to “revert back” to the general fund. In other words, you “use it or lose it.”

This can be a barrier for developing SMI housing, because it is a “pipeline” process: Properties or “deals” don’t necessarily materialize in a regular, timely fashion, but can take months, even years, to put together. Funds that might otherwise be used to leverage good

“The [SMI] client may go into the house and close the door. They don’t always know how to relate. If they aren’t bringing problems to their case manager, no one sees them. The case manager has all these other clients who are bringing her problems, so why should she see this client when she has all the others to see with immediate needs? So some people just don’t get seen.”

Housing advocate

“You could say that the capitation rates [in the County’s public behavioral health managed care plan] were developed on the assumption that 65,000 people would not be served. The incentive is to enroll Medicaid-eligible SMI, not state-only SMI. If you do nothing, they are still paying.”

Homeless system official

housing projects are therefore potentially wasted if they can’t be allocated within the required time frame. They can also be used in potentially less effective ways – for example, purchasing property directly that happens to be on the market and available quickly, and not using that funding to leverage affordable housing funds that may be coming on line the following year – just to make sure the money is allocated and not reverted back.

Legislators need to understand the “pipeline” nature of housing development and allow a longer time period for the most effective use of these funds when necessary and appropriate. Barring a direct legislative fix, another option is to “pass through” the funds to another agency – especially if it is the state housing finance agency – to meet the current year expenditure test. TAC reports that this is what they are doing in Pennsylvania.

Identifying and Tracking Funding for Housing

We talked with a number of officials who commented on the difficulty of tracking funding for SMI housing, both within the public system and across the entire affordable housing system in the County. In part, this is due to the sheer complexity and fragmentation of the system, the separate program data and financial silos (with little coordination between them) and ongoing organizational and staffing flux in the system.⁴³ System housing veterans and providers told us it has always been difficult to separate out housing funding streams and costs from other system components.

This is partly the result of ADHS funding through contracts with providers that cover both supportive services costs as well as certain housing costs. For example, approximately \$1 million in ADHS funding is being used in a complicated complementary approach to ABC’s \$12 million HUD S+C program to support “housing providers” who function in a Housing Support Team model. These additional funds may help to account for the success of ABC’s *Housing First* program, which has an 80 percent housing retention rate for chronically homeless people and compares favorably with national studies of highly successful programs.

Below the Radar Screen

As a result, some ADHS funding for housing (such as the cost of operating a group home or small apartment complex, providing “move in” assistance to consumers, etc.) is “below the radar screen” in terms of its programmatic purpose and structure. ADHS believes this strategy prevents potential legislative opposition to these practices from surfacing. That may well be true, but it also exacerbates other problems:

- It makes it more difficult to know exactly how much money is being spent on actual housing costs.
- It makes it more difficult for the system to organize these housing activities programmatically, to know what is working and what is not, and to reprogram funds where appropriate to improve system performance.
- It hinders the expansion/replication of promising practices such as the ABC “housing provider” strategy, which is consistent with the Housing Support Team model.
- It makes it more difficult to adopt formalized service system “best practices” policies that could receive additional legislative support and also be recognized as significant achievements within the *Arnold v. Sarn* lawsuit.

Recommendation

Upon review, we recommend that ADHS initiate a process to identify and organize programmatically any funding paying for housing-related costs (i.e., ongoing rental or operating subsidies, including those that support residential treatment settings, security deposits or

other one-time costs, Housing Support Team costs, etc.). This information may already be organized in such a fashion. If so, then a review/analysis of the policies and procedures that pertain to certain funding streams (such as housing operating support for residential treatment settings) would help the system develop a vision and long-term housing transformation strategy. For example, funding now used for residential treatment setting operating support could eventually be reprogrammed to support the operating costs of PSH units if some residential settings could be sold or certain residential leases were not renewed.

Culture and Leadership

We heard many comments about what is perceived to be a lack of aggressive leadership with regard to housing for the homeless generally, and a culture that is friendly and encouraging when it comes to the process of cooperation – task forces, committees, developing formal initiatives – but fragmented and guarded when it comes to the heavy lifting of funding and implementation.

There are noted exceptions to this – the development of CASS, the Maricopa Housing Information System, coming together to ensure that the homeless don't die because of lack of water and basic shelter, innovative *Housing First* programs – but many believe that the focused and sustained leadership that has characterized efforts to reduce homelessness in other cities such as New York, Portland, Denver and Philadelphia is absent in the Valley.

In those places, a powerful and influential leader – a mayor, a business leader – marshaled others in the community to take on the issue. In other places such as Tennessee (see page 46), a housing official with vision and energy got the complete buy-in and support of organizational, political and business leadership from the top down. So far, at least, the general sense we get is that this level of leadership and commitment in the homeless arena generally, and in the SMI housing arena in particular, is lacking here.

Default to the Status Quo

There is no lack of leaders and resources in the Valley. But attention is focused elsewhere – the downtown bioscience campus, for example – and not on the number of persons with serious mental illnesses and other disabilities who are homeless and in need of supportive housing. What would it take to direct leadership's attention to this issue? Someone, or some group of persons, who cares so deeply about the issue that they are willing to risk rattling the cage of powerful interests and build a coalition of leaders because it's the right thing to do for the community.

This is where the culture of an organization like ADHS, MAG, city governments, housing groups and others enters the picture. Cultivating partnerships and advocating for change is inherently risky. Ongoing projects can be delayed – products might not get produced as quickly. So, absent any consistent outside prodding, the tendency is to default to the status quo. Years of planning and study can go by without anything materially changing.

With regard to the housing situation for SMI persons in particular, we were struck by how many references we found in reviewed documents to planned innovative practices in *Housing First* models or new partnerships with the Arizona Department of Housing, and how little evidence we found that someone was assertively following through on these efforts. They may well be doing so, but if they are, it hasn't yet percolated out into the wider housing and provider community.

Based on our interviews, there are bright spots of progress and plenty of good ideas, but many are hunkered down in the daily grind of finding housing and running programs while they await a catalyst to spring them out of their routine.

That catalyst would be a dynamic, forceful, committed and persuasive leader. It could even be themselves.

“Nobody gets elected because they champion the homeless. The homeless themselves don't vote. Politically, it's a fringe issue.”

Housing advocate



“In LA they have this saying: ‘You can die from encouragement.’ Maybe that's true in Phoenix.”

Housing official

The Tennessee *Creating Homes Initiative*⁴⁴

At the end of the day, it all comes down to leadership. The Tennessee *Creating Homes Initiative* (CHI) is one place to look for inspiration.

In 2000, Marie Williams, Executive Director of the Division of Recovery Services and Planning in the Tennessee Department of Mental Health and Development Disabilities, came up with the initial vision of undertaking a state-wide initiative to create and expand affordable, safe, permanent and quality housing for SMI consumers in Tennessee. This would be accomplished through a series of *assertive and strategic* partnerships with local communities, with an emphasis on leveraging resources wherever possible.

How successful was CHI?

- Original goal: 2,005 new units by 2005. Goal surpassed in 2002.
- New goal: 4,010 by 2005. Goal reached in December, 2004.
- New goal: 8002 by 2008.

How was this accomplished?

- By taking an initial \$2.5 million and parlaying it over the following six years into over \$100 million into additional investments into SMI housing (Federal Home Loan Bank, HUD, Tennessee Housing Development Authority, etc.).
- By hiring seven regional and independent housing facilitators with knowledge of their local communities to “do the deals” with developers, landlords, funding sources, etc., and to work with individual consumers and consumer advocacy/support groups.
- By hiring consumer housing specialists to help establish a coordinated information and referral system and “housing academies” in different regions of the state.
- By conducting a public education media campaign to combat stigma and the not-in-my-backyard (NIMBY) syndrome.
- By aggressive coordination with other affordable housing programs in the state and regular outreach to all system stakeholders.
- By creating and applying a systematic and shared information and evaluation system to track progress and evaluate results.

Lessons Learned

- Lots of people have a powerful vision and leadership potential. The difference in Tennessee was that Marie Williams was given the authority, freedom and *support* to pursue that vision. The other critical factor was the unwavering support of the state’s Behavioral Health Commissioner. If it isn’t happening at the top, it isn’t happening.
- The Tennessee model is *Consumer First*. It follows the “whatever it takes” philosophy of recovery and consumer empowerment. It resists the temptation to let the “experts” rule and dictate where, how and when consumers should be housed. Some consumers choose, and thrive in, congregate housing; others do better in independent apartment living with supportive services. The Tennessee model applies the full continuum, while generally limiting congregate living to a maximum of eight persons.⁴⁵ The majority of new units are permanent supportive housing, but they recognize the need for transitional and congregate housing as well.
- The Tennessee model is staffed with independent housing people who build community-up instead of bureaucratic-edict down. They actually have had success persuading landlords and developers to set aside units for SMI persons because “it’s the right thing to do.” The “carrot” isn’t always money.
- CHI worked with the Tennessee Fair Housing Council to create a *Good Neighbors, Healthy Communities* campaign and materials to prepare the way for community acceptance of SMI housing. This isn’t just a few community meetings and a nice brochure. It’s a way of life.
- CHI became aggressive right out of the box in applying for and receiving federal, regional and state grants for housing. It takes more than one person to do this right, and you have to keep it up all the time.
- Throughout the process, CHI networked over 1,100 people across the state in this shared vision and its relentless execution. They created a true learning community that continues to this day.



“We start and end with the consumer. Are they getting better, are they employed and productive? If they want a roommate, we try to develop the options for that to happen. If they want to live alone in an apartment or a home, we build out those options. Housing is part of the means. Recovery is the end.” Marie Williams

Housing Now: An SMI Housing Initiative

Amid the challenges facing those whose responsibility it is to provide housing and supportive services for persons with serious mental illnesses in the County's public behavioral health system, some very good things are on the collective table:

- 🔔 A commitment to *Housing First* and permanent supportive housing strategies.
- 🔔 An impressive track record over the past seven years in increasing the number of PSH units and services available for those with the most serious mental illnesses.
- 🔔 The use of best practice housing support teams through ABC, its housing contractors and other housing providers in the community.
- 🔔 Despite their differences, a continuing openness and willingness of ADHS and the Arnold v. Sarn Court Monitor's office to work together to find ways to successfully address SMI housing issues.
- 🔔 Conversations between ADHS and ADOH on innovative ways to leverage public funds for PSH housing.
- 🔔 A County-wide initiative to end homelessness that, among other things, is making headway in establishing an integrated homeless information management system and convening local jurisdictions to tackle homeless issues through community partnerships.
- 🔔 An increasing awareness among a broad range of community leaders of the necessary connection between a robust health and social system infrastructure, economic development and a sustainable quality of life to position Arizona at a competitive national, even global, advantage.

We believe the timing is good for ADHS and its housing partners in the community to undertake a *Housing Now* or similar initiative to increase the supply of permanent supportive housing for the SMI population in Maricopa County's public behavioral health system – and by extension, throughout the entire state. The groundwork already laid, and some of the emerging best practices sketched in this report and elsewhere, can serve to inform and guide this initiative, but the full details, plan and implementation necessarily await the collective buy-in, ongoing support and involvement of all the system stakeholders, without whom nothing of significance will happen.

In that context, we conclude with a sketch of what the components of such a *Housing Now* Initiative might look like and a rationale for our recommendations:

Principles and Philosophy

- **CONSUMERS FIRST.** A focus on recovery and asset-based community development.
- **HOUSING FIRST.** The principles of practices of getting SMI consumers into stable housing first, and then determining how to plug in program services to assist in recovery, as distinct from first determining whether the person is “ready” or “qualified” for housing.
- **OUTCOMES FIRST.** Accountability driven by a relentless focus on housing outcomes, and not on the processes and regulations that are presumed to lead to optimal outcomes. If something isn't working, try something different.

We conclude with a sketch of what the components of such a Housing Now Initiative might look like and a rationale for our recommendations.

- **FLEXIBILITY FIRST.** A corollary of Outcomes First. Having the freedom and support to adapt to changing environmental conditions.
- **LEVERAGE FIRST.** A focus on leveraging new financial and human resources that can be brought to the table with the strategic use of local, state and private resources. If the leverage opportunities aren't there, develop them.
- **NETWORK FIRST.** Development of real time and virtual knowledge, practice and learning networks. Leverage happens through connection. Nothing happens in isolation.
- **INFORMATION FIRST.** Development of a transparent, up-to-date information system on housing input, throughput and output across the entire public and private affordable housing continuum.
- **LEADERSHIP FIRST.** Disappear into leadership. Encourage the light in others.

Goals

1. 3,000 new housing units by 2012. The first 2,000 units keep up with projected member enrollment growth; the additional 1,000 units begin to make a significant dent in meeting the demand.
2. 36-38 ACT teams operating in the County's public behavioral health system in 2012. This meets national best practice standards and will ensure the appropriate level of support for the most severely ill clients to live successfully in PSH.
3. An integral public relations, media and grass roots organizing campaign to address issues of adequate core funding, stigma, the NIMBY syndrome and political/community leadership.
4. Development of a *Housing Now* training academy for all professional and volunteer staff in the housing and service continuum.
5. A fully integrated, transparent, and constantly updated information system that tracks numbers and types of units, SMI consumers, housing/service financial streams and program outcomes.

Operational Strategies

Strike the optimum balance between tenant-based and project-based resources.

Most mental health systems actively engaged in expanding housing opportunities seek to achieve a balance between tenant-based and project-based resources. Project-based units are critically important to consumers and to the system because they represent a permanent supply of affordable housing set aside for this purpose. However, when project-based housing is developed "from scratch," the process can take two-three (or more) years before a consumer is actually housed. Tenant-based housing can be brought on line in a matter of months. Utilizing both approaches is important because mental health systems simply cannot "build" their way out of the affordable housing crisis that affects all extremely low-income consumers. Generally speaking, TAC suggests having two tenant-based units for every project-based unit created, although local factors may alter this ratio significantly.

While the ratio of tenant-based/project-based resources is appropriate in Maricopa County, the supply of project-based units is problematic because:

- Virtually all of the project-based housing developed so far is not PSH.

- The project-based housing appears to be primarily group settings solely for people with mental illness (e.g., houses with up to eight consumers).
- Documents and interviews suggest that over \$19 million in state funding has been spent to acquire this housing with little leveraging of other federal or state “mainstream” affordable housing funding.

Achieve greater integration with the County’s affordable housing system.

To address issues of using limited state funds for maximum leverage and increasing the supply of PSH housing in the future, ADHS’s vision should track the basic product produced by the affordable housing delivery system: affordable multi-family rental housing units.

Through the federal LIHTC program and tax exempt bonds, state housing finance agencies systematically produce new or rehabilitated rental housing developments at scale that:

- ⊙ Have lower-than-market rents for a subset of the units.
- ⊙ Are located in desirable areas, including those undergoing community revitalization.
- ⊙ Are well-managed and monitored by the state for housing quality and compliance with all laws and regulations governing the housing program.

Unfortunately, the “affordable” rents in these properties are not low enough for people with disabilities who rely on federal Supplemental Security Income (SSI) of less than \$650 per month. The challenge for behavioral health and housing system officials working together is to identify the funding strategies and resources needed to reduce rents so that they are truly affordable to consumers at below market prices. Currently in Arizona, state funding that could be used for this purpose apparently is either: (1) being spent on the acquisition of single purpose properties, or (2) included within behavioral health services contracts.

Financing Strategies

There are several financial strategies to consider in achieving affordable rents, briefly described on pages 32-34 and presented more fully in the case studies addendum to this report published separately (www.slhi.org/gray_land):

In *North Carolina*, the Housing Finance Agency and the Department of Human Services initially used funding from the state’s Housing Trust Fund to “capitalize” a 10-year operating reserve to ensure affordability in a mandated 10 percent set-aside of units in each LIHTC project to people with disabilities at SSI income levels. Later, the state moved to an annually state-funded rental subsidy (the Key Program) to cover this cost.

All parties must acknowledge that providing this funding to ensure affordable rents to consumers receiving SSI is essential – and that it cannot be simply “produced” by the Housing Finance Agency. Once the resources and strategy are in place, this set-aside model produces a regular supply of PSH units in desirable rental properties.

This approach – to utilize the “platform” of a mainstream affordable housing program – accomplishes several key goals:

- ✓ It articulates a clear vision of the behavioral health system’s housing values and principles.
- ✓ It underscores and reinforces the responsibility of the affordable housing system to be part of the solution to the housing crisis that affects very low income people with disabilities with the lowest incomes.
- ✓ It can be replicated through other affordable housing activities, including rental housing financed locally and at the state level through the federal HOME program.

Expand Bridge Subsidy Programs.

As federal housing subsidy funding becomes increasingly scarce, behavioral health systems, including ADHS, are implementing some type of mental health funded “Bridge Subsidy” approach modeled after the Section 8 Housing Choice Voucher program. Whenever possible, these programs are implemented in partnerships with local PHAs. The behavioral health system funded rental subsidy helps the system meet consumers’ housing needs immediately, but with the goal of eventually obtaining a federal Section 8 Housing Choice Voucher for the consumer. PHAs can help implement this model by creating a Waiting List “preference” for people with disabilities who have a Bridge Subsidy – thus accelerating the process of getting a HUD voucher. The ADHS-funded Bridge Subsidy can then be provided to another consumer.

Most behavioral health systems implementing the bridge subsidy model begin with a program of 100-200 subsidies. The fully annualized one-year cost of a 100 unit program can range from \$500,000-\$800,000 depending on the local housing market. Nonprofits such as ABC already administer HUD McKinney-Vento rental subsidies and have little difficulty “ramping up” to add this additional program to their portfolio. Bridge Subsidy programs are typically tenant-based but can also be project-based to help create new units of housing set aside for consumers in larger affordable housing projects developed through the LIHTC program. When used in this project-based approach, they often cost less because the subsidy is used in a LIHTC unit that is already set below the market rent. ADHS should consider expanding this approach.

Re-conceptualize the role of residential treatment programs.

The State of Arizona has a substantial investment in residential treatment facilities in Maricopa County. These facilities are operated by dedicated providers who are assumed to provide high quality services to high priority consumers. These resources have been a valuable component of the overall system of care for both consumers and the communities and neighborhoods in which they live.

As the system transitions to – and more fully adopts – PSH/*Housing First* and the accompanying recovery-oriented, evidence-based practices, there will be opportunities to re-think how some or all of these facilities are used. The primary opportunity is to conceive of these facilities as clinical levels of care or treatment options, typically within one of the three categories outlined on page 18. The purpose of the residential services facility is to provide necessary clinical treatment services, sometimes in conjunction with structure and security, which is expected to have measurable clinical results for the individual. In this way, the facilities will no longer function as default housing because no other options are available.

This re-conceptualization of the facilities’ roles in the system of care may not necessarily result in a substantial change in staffing, program content or costs. But it may significantly change the reasons that someone is approved to enter a facility, the results that are expected to be attained for the consumer while they are there, and the length of time that a person is expected to be there. That would be no small achievement.

Build Strategic Partnerships.

A *Housing Now* Initiative for persons with serious mental illness in the public behavioral health system should be framed and implemented as a substantial and sustainable partnership between a number of key stakeholders in the County’s homeless/housing system, and not just as an “initiative” of ADHS. To be successful, everyone has to have some “skin in the game.” Everyone has to have some authority and responsibility. Everyone has to share the risk and celebrate the success.

In our opinion, the key stakeholders here are ADHS and the “formal” public behavioral health system (RBHA, housing and service providers, consumers), the Arnold v. Sarn Court Monitor (as a problem-solver and solution seeker, not as judge/jury), the Arizona Department of Housing, the Maricopa Association of Governments, and local housing agencies. Based on our interviews, all of these parties are open and willing to work together to create more permanent supportive housing for persons with SMI and other disabilities. All are looking for new opportunities, energy and vision. All are looking for leadership.

Launch Points

Successful initiatives and campaigns never start from whole cloth. They begin by getting the right people together, framing a vision, developing some initial resources and then soliciting partners to participate in discrete projects that can be successful and scaled up to create a broader public movement. A few ideas:

- 💡 ADHS and ADOH could develop a plan to leverage a portion of ADOH housing resources to develop new PSH units along the lines suggested above. If the funds can be committed, they can help to launch the broader initiative over a longer time frame and bring in new partners as successful projects start to come on line.
- 💡 ADHS can commit two or three new ACT teams in a set of pilot projects in partnership with MAG to address the more effective and timely placement of chronically homeless SMI persons in MAG’s system. The CASS location and perhaps another location in the East Valley might be a place to start these projects, and build from there.
- 💡 ADHS and MAG could sit down and discuss ways to integrate MAG’s Homeless Information System and the state’s information systems to more effectively track SMI placement, HUD program information and distribution of resources, coordination of grant applications and program evaluation.

Some of these conversations are already going on, of course, but the trick is to move them out beyond the confines of discrete projects and leverage the leadership and early successes into an aggressive *Housing First* long-term initiative, or something similar. These are just suggestions. No doubt community stakeholders could devise any number of creative ideas to help move this forward.

Invest in Communication and Leadership.

If we heard a consistent theme in all of our interviews, it was a desire for more effective communication and leadership. Since our focus here is primarily the public behavioral health system in Maricopa County, we offer the following suggestions for ADHS specifically:

- **MOVE BEYOND PLANNING, MONITORING AND ASSESSMENT.** These are vital, necessary roles, and obviously the state needs to do them well, but if this is all the state does, it can breed a culture of inwardness and regulatory compliance, and not a culture of assertive and imaginative community engagement.
- **INVEST IN COMMUNICATIONS AND SOCIAL NETWORKS.** How does an organization develop a culture of imaginative community engagement? By bringing people together to build networks of learning, practice and action. This requires a significant communications infrastructure and staffing it with professional “connectors” who are comfortable working independently and building community bridges. ADHS has some of these people. We’ve worked with them. The state also has a significant number of people who are perfectly comfortable filling out forms, filing reports and going with the status quo. That has to change.

- **INVEST IN LEADERSHIP.** Contrary to popular perception, there is no shortage of leaders in Maricopa County’s public behavioral system. What there is a shortage of is a commitment to invest in these leaders and provide them with the freedom and support to do their work. Look at the Tennessee Creating Homes Initiative. No one told the Housing Director no, you can’t do this, it’s too expensive, we’ll never find the resources, the legislature won’t like it. What the Behavioral Health Commissioner did say was yes, you can do this, we’ll do whatever it takes to find the resources and to make you and this initiative successful. The Housing Director, in turn, recruited more leaders out in the communities and gave them they same freedom and support. No wonder they were successful.

Start *Now*

The ingredients of a successful *Housing Now* Initiative in Maricopa County are already in place. This report documents them, and provides a rationale for building on a common commitment to, and understanding of, the principles and practices of permanent supportive housing for persons with serious mental illness and other disorders.

Other states are pursuing this vision, and so can Arizona. Yes, it takes leadership and political will, and yes, the competition for limited public resources is intense, and success is hardly guaranteed, but it’s for certain that nothing will be accomplished without a bold vision and a willingness to take the work on.

The timing is right. Even now, TAC and other groups are working to reform one of HUD’s most important and long neglected programs – the Section 811 Supportive Housing for Persons with Disabilities Program – to provide valuable rental subsidies essential to making the PSH model work. Legislation being drafted by the House Financial Services Committee will, if enacted by Congress, provide 2,000-3,000 or more new project-based rental subsidies each year for the next five years to state and local housing agencies positioned to commit these subsidies to rental housing production.

We recommend that Arizona join other progressive states that share the goal of achieving community integration for people with disabilities through set-asides in “mainstream” affordable housing programs.

The time to start is *Now*.



About the Authors

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Stephen L. Day is co-founder and Executive Director of TAC. He has provided consultation and technical assistance to 35 states, over 100 local jurisdictions, and numerous national policy and advocacy organizations. This includes comprehensive analyses of public mental health or human services systems, multi-year strategic plans, service system improvement and financing strategies, outcome and performance measurement systems, and organizational and human resource development plans.

Ann O'Hara is co-founder of TAC and Director of TAC's Housing Center. She is nationally known for her public policy work to expand affordable housing opportunities for people with disabilities and her expertise in housing programs for people who are homeless or at-risk of homelessness. She has over 25 years experience in the development and administration of the full range of subsidized rental and homeownership programs funded at the national, state, and local level.

For those who would like more information,
we have published TAC's *Selective Case Studies*
in Permanent Supportive Housing,
which is available on our website, www.slhi.org/gray_land,
as an addendum to this report.

Sources and Notes

- 1 e.g., *Into the Light*, 1999, a report on Arizona's public behavioral health system; *The Humpty Dumpty Syndrome*, 2003, a report on fragmentation and integration in mental health; and *Mind, Mood and Message*, 2005, a report on the ways various groups access mental health services in the community.
- 2 Adapted from the Tennessee Creating Homes Initiative, www.housingwithinreach.org.
- 3 National Coalition for the Homeless, "Mental Illness and Homelessness," NCH Fact Sheet #5, June 2006.
- 4 The Department of Housing and Urban Development (HUD) defines *chronically homeless* as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years."
www.mihomeless.org/archives/Chronic%20Homeless%20HUD%20Definition.doc.
- 5 Maricopa Association of Governments (MAG) Regional Continuum of Care Committee on Homelessness, *Regional Plan to End Homelessness, Executive Summary*, 2003.
- 6 Figures supplied by Maricopa Association of Governments (MAG), October 2007.
- 7 "All Our Problem Now," *Arizona Republic*, September 4, 2005; "Counseling, Housing Programs Can Save Lives – and Money," September 5, 2005.
- 8 A 2001 study by Dennis Culhane and others found that it cost \$40,500 per SMI homeless individual for their use of shelters, emergency rooms, psychiatric hospitals and prisons, and a similar amount — \$41,494 — to place them in supportive housing with a spectrum of psychiatric treatment. See Kupersanin, E., "Getting Homes for Homeless is Cost Effective," *Psychiatric News*, June 1, 2001, 36:11, p. 10.
- 9 American Community Survey, Washington, D.C., US Census Bureau, 2005. Available at <http://census.gov/prod/2005/pubs/censr-23.pdf>.
- 10 Houtenville, Andrew J, Senior Research Associate, Employment and Disability Institute, ILR School, Cornell University.
- 11 Data on the number of people who received SSI in 2006 was not available when *Priced Out in 2006* was published.
- 12 <http://www.tacinc.org/Pubs/PricedOut.htm>.
- 13 HUD's Final FY2008 Fair Market Rents, <http://www.huduser.org/datasets/fmr.html>.
- 14 *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-occurring Substance Use Disorders*, 2003, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- 15 See, for example, Yeich, S., et. al., "The Case for a Supported Housing Approach: A Study of Consumer Housing and Support Preferences," *Psychosocial Rehabilitation Journal* 18(2): 75-86, 1994, among other studies.
- 16 O'Hara, Ann, "Housing for People With Mental Illness: Update of a Report to the President's New Freedom Commission," *Psychiatric Services*, July 2007, Vol. 58L7), 907-913. See the study for references for points made.
- 17 *Ibid.*, p. 909.
- 18 Of course, not all mental health systems implemented permanent supportive housing as the last step in the residential continuum. The most progressive systems helped people move into permanent supportive housing immediately upon discharge from a psychiatric hospital. But many systems maintained that people needed to be prepared to move into permanent supportive housing by first acquiring housing readiness skills in a more restrictive setting.
- 19 See Newman, S. (2001), "Housing attributes and serious mental illness: Implications for research and practice," *Psychiatric Services*, 52(10); 1309-1317; Tanzman, B. (1993). "An overview of surveys of mental health consumers' preferences for housing and supportive services," *Hospital and Community Psychiatry*, 44(5), 450-455; and Greenwood, R, et. al. (2005), "Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness," *American Journal of Community Psychology*, 36(3/4): 223-238.
- 20 2007 Advocates Guide to Housing and Community Development Policy, Washington D.C., National Low Income Housing Coalition.
- 21 In Boston, more than 500 units of single purpose congregate supportive housing were developed in the late 1980s and early 1990s for people with AIDS. Many of these properties have extremely high vacancy rates (50 percent or higher) because people with AIDS now have more housing options to choose from and do not want to live in housing identified as "AIDS Housing."
- 22 *2007 Status Report on 10-Year Plans to End Homelessness in Oregon*, <http://campus.sou.edu>; Tsemberis, S, September 24, 2007, personal communication with Ann O'Hara (TAC); *Chronic Homelessness Brief*, March 2007, Washington D.C., National Alliance to End Homelessness.
- 23 *Regional Plan to End Homelessness, 2005 Update*, Maricopa Association of Governments, p. 5.
- 24 There is scant research on the relationship between service site (congregate, independent, etc.) and service modality. Just as there is no research that shows residential settings are useful, there is no research that shows they are detrimental. SAMSHA's National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov) is a good place to inquire further.
- 25 Fisher W and Phillips B, "Modeling the Growth of LongStay Populations in Public Mental Hospitals." *Social Science and Medicine* 30:1341-1347, 1990.
- 26 Arizona Department of Health Services/Division of Behavioral Health Services, *Housing Desktop Manual*, July, 2007, p. 3.
- 27 *Leff Report, 2004 Update of Funding Values*, prepared as part of the Corrective Action Plan of the Arnold v. Sarn 2004 audit.

- 28 Arizona runs a managed care Medicaid system, where behavioral health services are contracted out to regional managed care groups. There are all sorts of relevant issues here – for profit vs. not-for-profit companies, allegations of managing costs instead of care, etc. – but these are outside the confines of this report.
- 29 National Alliance on Mental Illness, www.nami.org.
- 30 *Regional Plan to End Homelessness, 2005 Update*, Maricopa Association of Governments, p. 4.
- 31 www.slhi.org.
- 32 Provided directly by ADHS/DBHS.
- 33 Casa Buena is a nonprofit arm of ValueOptions (VO) the Maricopa County RBHA whose contract expired on August 31, 2007. A portion of VO profits were put into Casa Buena for purchasing property for independent living arrangements.
- 34 It's an interesting question whether this increase is due to better diagnostic techniques, more diagnoses generally, the so-called "medicalization" of human behavior, social and environmental factors, etc. We don't pursue the topic here.
- 35 This is a projection of Maricopa County population growth, SMI class members in the public behavioral health system, and system housing units for SMI class members in 2012. It is based on an average annual population growth of 3.46%, an annual class member growth of 5.78% (averaging the actual growth of 8.11% between 2000 and 2007 + the 3.46% general pop. growth), and it assumes that the 31.9% ratio of housing units/SMI class members in 2000 and 2007 holds steady through 2012. One could assume otherwise, of course, which is the reason all such projections should be interpreted with caution.
- 36 This figure is taken from the City of Phoenix's Consolidated Plan 2005-2010, Section 1, p. 37, <ftp://www.phoenix.gov/pub/NSD/consect1.pdf>. We are unable to determine the methodology the RBHA used to arrive at the estimate.
- 37 Ann O'Hara, a TAC consultant and one of the consultants for this report, was an expert witness for the plaintiff in the Good Shepherd dispute. Neither she nor Steve Day, the other TAC principal, commented on this interpretation of the Good Shepherd dispute, nor did SLHI ask them to. This is SLHI's analysis alone.
- 38 Sorce, Robert J., Arizona Assistant Attorney General, in a letter to the office of the Arnold v. Sarn Court Monitor, April 14, 2006.
- 39 Admittedly, one could make the opposite case, depending on how one interprets the limitations on eight persons per complex or 25 percent of the total, "whichever is greater." It's the interpretation of the latter phrase that presents the difficulty.
- 40 We have published a number of reports on resilience, recovery and mental/community health. See Hughes, R., *Resilience: Health in a New Key*, Fall 2003 and Bonfield, W.C., *Celebration: A Recovery Manifesto*, 2007. Both are available at www.slhi.org/gray_land.
- 41 See Allness, D., Knoedler, W., *National Program Standards for ACT Teams*, http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=50248.
- 42 Information from Tennessee housing officials, November 2007.
- 43 This study was undertaken during the recent transition between ValueOptions and Magellan as the County's RBHA. Updating the status of programs and locating data proved to be a challenge.
- 44 See www.housingwithinreach.org for more information.
- 45 There are exceptions to this, as noted earlier. The largest single congregate facility in Tennessee is a 32-unit complex with 32 SMI persons.

Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on helping people in need and building the capacity of communities to help themselves.

The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic, tap into the expertise of informed citizens, and suggest strategies for action.

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Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially those in need.

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