



Rental Housing Access & Discrimination Experienced by People With Multiple Disabilities

Study of Rental Housing Discrimination on the Basis of Mental Disabilities:
Short Paper 5



RENTAL HOUSING ACCESS & DISCRIMINATION EXPERIENCED BY PEOPLE WITH MULTIPLE DISABILITIES

STUDY OF RENTAL HOUSING DISCRIMINATION ON THE BASIS OF MENTAL DISABILITIES: SHORT PAPER 5

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Abstract

Although housing discrimination testing research limits its focus to one primary disability, such as serious mental illness or intellectual or developmental disability, a significant percentage of people are living with multiple disabilities, chronic health conditions, and age-related conditions that further complicate the search for rental housing as well as housing discrimination research. This paper focuses on the demographics of multiple disabilities experienced by people with mental disability, specifically focusing on three groups: (1) people with mental illness (MI) who also experience a substance use disorder (SUD), physical disabilities, and age-related disabilities; (2) people with intellectual or developmental disabilities who also experience MI,

SUD, and physical or age-related disabilities; and (3) older adults who acquire MI, SUD, and other cognitive disabilities, such as dementia, as they age. Demographic trends are then tied to implications for access to rental housing by these target groups. In addition, this paper discusses implications for research to examine potential discrimination experienced before, during, and after rental housing searches and to study the impact of complex housing, disability, and aging policies, systems, and programming. Specific issues related to cross-disability and housing system coordination and potential promising practices to better meet the needs of this growing, multidisability and aging group are put forth as examples.

Introduction

The U.S. Department of Housing and Urban Development (HUD) recently completed a pilot study of housing discrimination experienced by people with mental disability (MD).¹ The pilot study is specifically focused on documenting housing discrimination in the rental market on the basis of MD faced by two different subgroups within this population: (1) people with a psychiatric disability (PD) or mental illness (MI) and (2) people with an intellectual or developmental disability (I/DD). To date, these two groups have not been the focus on any large-scale housing discrimination-testing research, and this research effort sought to actively involve both subgroups in a pilot test of rental housing discrimination.

The federal Fair Housing Act (Title VIII of the Civil Rights Act of 1968) as amended in 1988 prohibits discrimination in the sale, rental, and financing of housing, or other housing-related transactions, on the basis of seven protected classes: (1) race, (2) color, (3) religion, (4) national origin, (5) sex, (6) familial status, and (7) disability. Housing providers are prohibited from considering these protected characteristics as the basis for rejecting or refusing to negotiate with individuals seeking housing or housing-related services, or from misrepresenting or limiting housing opportunities based on protected characteristics. People with disabilities have three additional protections: (1) multifamily housing with four or more units, built for first occupancy after March 13, 1991, must meet specific, if relatively modest, accessibility design and construction requirements that enable a person using a wheelchair to access and use covered units and common areas; (2) housing providers must make reasonable accommodations to their rules, policies, practices, and services necessary for people with disabilities to equally enjoy the property; and (3) housing providers must enable residents, at the residents' expense, to make reasonable modifications to physical structures necessary for people with disabilities to use and enjoy the property. Although *Olmstead*² ruled that any unjustified segregation of persons with disabilities was a violation of Title II of the Americans with Disabilities Act, it did not grant any new or specific protections for the beneficiaries of this case when leaving an institution.

Testing is an investigative technique that serves as a powerful tool for directly observing differences in treatment in the practices of housing providers and their agents. Testing can be conducted in a variety of configurations, depending on the issues being examined, but the most common and effective approach to observing differences in treatment based on a protected class is matched pair testing. In this type of testing, two testers are assigned profiles that make them similarly situated and qualified for the housing being tested, differing *only* in their membership in a protected class. Designing a testing protocol that will detect discrimination on the basis of MD, therefore, requires ensuring that the testing involves one specific disability group and holds all other variables constant (for example, race, age, income, employment status). This requirement makes it challenging to test for potential housing discrimination against people with MD (MI and I/DD) who also experience co-occurring disabilities, including age-related disabilities. Because a significant proportion of people with MD experience other disabilities as well, this approach to testing potentially oversimplifies the reality of housing discrimination experienced by this population. Some of the most common co-occurring categories of disabilities these groups experience include—

- People with MI who also experience a substance use disorder (SUD), physical disabilities, and age-related disabilities.
- People with I/DD who also experience MI, SUD, and physical or age-related disabilities.
- Older adults who acquire MI, SUD, and other cognitive disabilities, such as dementia, as they age.

The enforcement of fair housing laws is made more challenging when people have multiple disabilities. For example, although a housing provider cannot legally discriminate against a potential tenant on the basis of disability, he or she can do so against people who are currently abusing substances and those who are deemed to pose a significant danger to others (DOJ, 2004). When two or more of these factors (for example, disability,

¹ *Mental disability* is defined as “(1) having a mental or psychological disorder or condition that limits a major life activity, including working; (2) any other mental or psychological disorder or condition that requires special education or related services; (3) having a record or history of a mental or psychological disorder or condition which is known to the employer or other entity covered by this part; or (4) being regarded or treated by the employer as having, or having had, any mental condition that makes achievement of a major life activity difficult” (*Foster v. City of Oakland*, 2009 U.S. Dist. LEXIS 70094).

² The *Olmstead* Decision of the United States Supreme Court in *Olmstead v. L.C.* in 1999 held that, under certain circumstances, public entities must provide community-based services to people with disabilities.

SUD, and posing a direct threat to others) coexist, it can be extremely difficult to determine whether a housing provider's differential treatment toward a potential tenant is legal or illegal.

People with multiple disabilities must navigate multiple and complex systems to search for, pay for, and maintain long-term community living, cutting across housing, medical and health care, and long-term community-living support systems. Each of these critical systems has differing policies, rules, and regulations that consumers must coordinate in order to successfully live in the community and maintain rental housing. This paper focuses on these system-level needs and issues that these groups face.

This paper reviews research in an area that is critical to rental housing access and discrimination but that cannot be addressed in pilot housing discrimination testing because of the numerous and complex variables presented. Findings provide an overview of how multiple disabilities affect the housing search, retention of housing, and the complexities of coordinating rental housing supports for those with multiple disabilities. The paper concludes with examples of promising practices in programming and policy systems change efforts designed to respond to housing access and discrimination issues that this population faces. As such, the findings and the cases also point to implications for future housing access and discrimination research to document the lived experiences of these groups.

Methods

Two methods were used in this paper: (1) a critical appraisal of existing research and (2) accompanying promising practice case studies. The critical appraisal of the literature (Curtin and Fossey, 2007; Guba, 1981; Guyatt et al., 2011) was done across disability, aging, housing, and legal sources to examine and provide a preliminary overview of current trends and patterns related to how the housing search, retention of housing, and coordination of rental housing supports are affected by the experience of multiple co-occurring MD.

To achieve this aim, researchers collected recently published national surveys and reports related to MD and housing and conducted an online database search for recently published research on this topic. Researchers then conducted a critical appraisal review of literature and data sources to be used in this paper. For each data source used, researchers assessed several factors, including whether the study addressed a focused issue

specific to these subgroups, the appropriateness of the research design to address the aims of the research, rigor of data analysis and interpretations, clarity of reported findings, and value of the research to this paper's aim to highlight housing access and discrimination issues. The data sources used in this paper included well-recognized and validated sources of data from United States public and governmental agency documents and reports, including the *Survey of Income and Program Participation* from the U.S. Census Bureau, the *National Survey on Drug Use and Health: Mental Health Findings* from the Substance Abuse and Mental Health Services Administration (SAMHSA), and the *National Core Indicators* from the National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. Researchers then identified data from within these documents relevant to people with MD (MI and I/DD) who experience co-occurring disabilities that may also become exacerbated as they age.

Results and Findings

In 2003, the President’s New Freedom Commission on Mental Health declared that recovery from MI is possible, but that fragmented and inadequate support services often stand in the way of this recovery. Recovery, which means living, working, learning, and fully participating in the community regardless of the presence or absence of symptoms, is contingent on obtaining and maintaining accessible, affordable, integrated housing and appropriate supports (President’s New Freedom Commission on Mental Health, 2003).

People with PD-MI and I/DD who experience co-occurring multiple disabilities often need to navigate multiple systems and policies to obtain accessible, affordable, and integrated rental housing in the community, and they experience numerous challenges within these systems. Coordinating housing rental supports for people with multiple disabilities can be quite complex, and this process can be experienced differently depending on disability types, severity, and other factors, including education level, employment status, economic status, and criminal history.

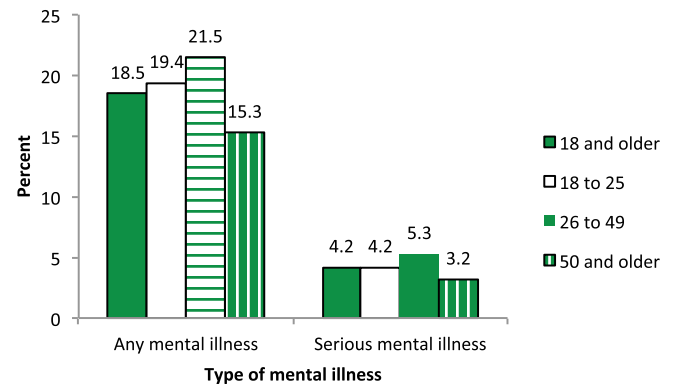
The following sections highlight what we currently know about people with multiple disabilities and their access to rental housing: (1) incidence rates of MI and co-occurring disabilities, (2) housing issues experienced by this population, (3) incidence rates of I/DD and co-occurring disabilities, and (4) housing issues frequently experienced by this population.

Incidence Rate of Co-Occurring MI and SUD

In 2013, an estimated 43.8 million adults age 18 and older were living with MI in the United States, making up 18.5 percent of the population (SAMHSA, 2014). Of these 43.8 million adults, 10 million had a serious mental illness (SMI), which is defined as one that substantially limits at least one major life activity. More people age 26 to 49 experienced MI or SMI in 2013 than did individuals in any other age bracket (SAMHSA, 2014). At a time when more and more Americans are living in rental market housing, the greatest increase is among people age 25 to 54, and particularly among people age 30 to 39 (JCHS, 2013). Therefore, adults with MI and SMI may represent a significant portion of the rental housing market. Figure 1 shows incidence rates of MI and SMI in 2013, broken down by age.

In 2013, approximately 7.7 million people reported experiencing co-occurring MI and SUD in the past year (SAMHSA, 2014). Put

Figure 1. Incidence of AMI and SMI in the Past Year Among Adults, by Age, 2013 Data

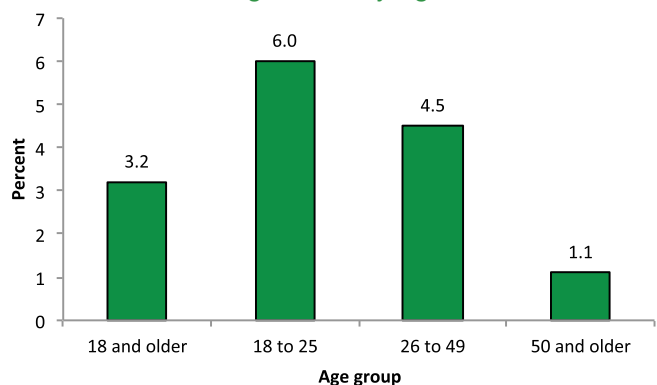


AMI = any mental illness. SMI = serious mental illness.
Source: SAMHSA (2014)

another way, approximately 17.5 percent of people with MI also experienced co-occurring SUD that year. Individuals ages 18 to 25 and 26 to 49 experience co-occurring MI and SUD at the highest rates (6.0 percent and 4.5 percent, respectively). This relatively large proportion of people living with co-occurring MI and SUD also overlaps with the age brackets in which increasing numbers of adults are seeking rental housing in the community (see Figure 2).

Lack of appropriate housing supports and services can lead people with MI and co-occurring disabilities to land in institutions such as nursing homes or institutions for mental disease, to become homeless, or to rotate between these two systems. According to HUD’s 2014 Annual Homeless Assessment Report, in January 2014, approximately 578,000 people were homeless

Figure 2. Incidence of Co-Occurring MI and SUD in the Past Year Among Adults, by Age, 2013 Data



MI = mental illness. SUD = substance use disorder.
Source: SAMHSA (2014)

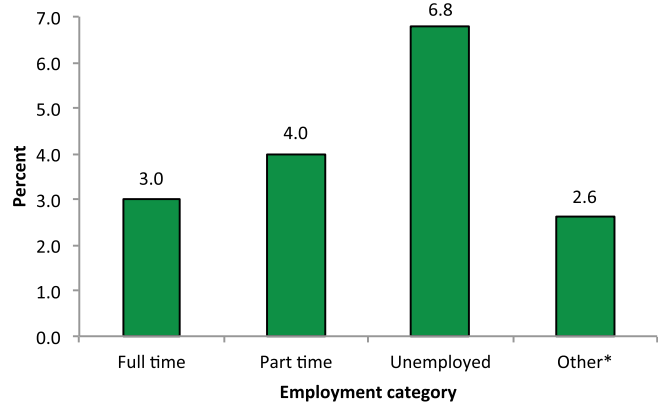
on any given night, and, of this number, slightly more than 84,000 people were identified as chronically homeless (HUD, 2014b). In addition, data from HUD’s homeless assistance programs identified approximately 234,000 people served who were homeless and also had SMI or chronic SUD (HUD, 2014a). People with disabilities make up most of the chronically homeless population, including people with SMI, SUD, physical disability, chronic disease, or two or more of these co-occurring conditions (Burt, 2001; Byrne et al., 2014).

Co-Occurring MI and SUD, by Level of Education, Employment, and Economic Status

Education level, employment, and economic status often go hand in hand, both for people with and without MI. For people with MI and co-occurring disabilities, however, these factors can play a particularly large role in the struggle to obtain and maintain rental housing in the community. Regarding level of education, MI prevalence was higher among adults with some college who did not obtain a degree (20.2 percent) and those who did not complete high school (20.0 percent) than it was for college graduates (17.7 percent) and adults with a high school degree (17.0 percent) (SAMHSA, 2014). Similarly, college graduates were less likely to have co-occurring MI and SUD (2.8 percent) than their counterparts who had attended some college but did not earn a college degree (4.1 percent) (SAMHSA, 2014). This trend resembles that of employment status among adults with MI and co-occurring SUD. In 2013, more unemployed adults (22.8 percent) and part-time employed adults (20.3 percent) experienced any type of MI than did their counterparts who were employed full time (15.4 percent; SAMHSA, 2014). Similarly, more unemployed adults (6.6 percent) experienced SMI than did those who were employed either part time (4.8 percent) or full time (2.7 percent), with full-time workers having the lowest rate of SMI among the three groups (SAMHSA, 2014). This same trend was evident for adults with co-occurring MI and SUD, in that the percentage of unemployed adults who had co-occurring MI and SUD (6.8 percent) was higher than those who were employed part time (4.0 percent) or full time (3.0 percent) (SAMHSA, 2014; see Figure 3).

Economic status follows suit with both education and employment for people with MI and co-occurring SUD, in that in 2013, 26.1 percent of adults whose family income was below the federal poverty level experienced any mental illness (AMI) in the past year (SAMHSA, 2014; see Table 1). Further, adults whose family income was 100 to 199 percent or 200 percent or more of the federal poverty level also experienced significant levels of MI (20.9 percent and 16.0 percent, respectively) (SAMHSA, 2014). Similarly, the percentage of adults who experienced

Figure 3. Co-Occurring MI and SUD in the Past Year Among Adults, by Employment Status, 2013 Data



MI = mental illness. SUD = substance use disorder.
 * Other = students, people keeping home or taking care of children full time, retired or disabled people, or others not in the labor force.
 Source: SAMHSA (2014)

Table 1. Adults With AMI, SMI, and Co-Occurring MI and SUD, by Economic Status, 2013 Data

Economic Status	Percent With		
	AMI	SMI	MI and SUD
Family income below federal poverty level	26.1	7.7	4.8
Family income at 100–199% of the federal poverty level	20.9	5.1	4.0
Family income at 200% or more of the federal poverty level	16.0	3.2	2.6

AMI = any mental illness. MI = mental illness. SMI = serious mental illness. SUD = substance use disorder.
 Source: SAMHSA (2014)

SMI in 2013 was highest among those whose family income was below the poverty line (7.7 percent), followed by those whose family income was 100 to 199 percent of the poverty level (5.1 percent), and those whose family income was 200 percent or more of the poverty level (3.2 percent) (SAMHSA, 2014). Following this same trend, 4.8 percent of adults whose family income was below the federal poverty line had a co-occurring MI and SUD. Only 2.6 percent of adults whose family income was at least 200 percent of the federal poverty line had co-occurring MI and SUD in 2013 (SAMHSA, 2014). These findings clearly point to the complexity of MI, SMI, SUD, and income/poverty rates in the United States, all of which significantly affect market-rate rental housing and potential discriminatory treatment related to accessing housing.

Work can be vital to health, recovery, and social inclusion for people with MI (Boardman et al., 2003), both as a meaningful activity and as a means of improving economic status and securing any type of market-rate rental housing. Most adults with MI want to work (McQuilken et al., 2003) and, when given

the appropriate support, an estimated 60 percent may be able to maintain employment (Marshall et al., 2014). Employment, however, does not guarantee economic stability, nor does it guarantee the ability to access and maintain rental housing in the community (Cook, 2006). For example, Fair Market Rent (FMR) for both one-bedroom and efficiency units consistently represent more than the entire monthly income of someone who receives Supplemental Security Income (SSI) payments (TAC, 2007). In fact, the most recent statistics show that, on average, renting a one-bedroom unit at FMR costs 104 percent of the monthly income of people with disabilities who receive SSI payments (TAC, 2012). This fact is particularly relevant, considering that adults with MI are the second largest population among SSI and Social Security Disability Insurance (SSDI) beneficiaries and are the largest population among people receiving either SSI only or concurrent SSI and SSDI (SSA, 2009; see Table 2).

In addition, even if a person is able to afford rental housing, he or she may encounter stigma when trying to obtain and maintain this housing. Preliminary research shows that the general public may be less likely to lease an apartment to someone who they perceive to have MI (Bahm and Forchuk, 2009; Bordieri and Drehmer, 1986; Corrigan and Penn, 1999). People with MI may be more susceptible to this type of rental housing discrimination than their peers without MI, and people who report a co-occurring MI and physical disability may potentially face more discrimination than those with MI alone (Bahm and Forchuk, 2009; Gouvier and Coon, 2002). Further, Bahm and Forchuk

(2009) found that perceived discrimination/stigma was positively correlated with MI severity and negatively correlated with self-reported health, emotional well-being, and life satisfaction. Although not done on a large-scale rigorous discrimination-testing basis, these findings support the link between multiple disabilities and the potential for increased discrimination in the rental housing market. It also helps to elucidate the negative effect that housing discrimination may have on the health and lives of people with multiple disabilities and the importance of reducing housing discrimination for this population.

MI and Physical Health Issues

In addition to adults who live with SUD, adults who live with MI also struggle with physical health conditions. Of adults living with MI, 68 percent also experience co-occurring medical conditions (Robert Wood Johnson Foundation, 2011). People with SMI are particularly vulnerable to experiencing co-occurring physical health disabilities and chronic conditions, as presented in Table 3. MI, physical health, and SUD are reciprocally linked; that is, they often influence each other, but they also share some of the same risk factors (Lando et al., 2006; Office of Disease Prevention and Health Promotion, 2014; Robert Wood Johnson Foundation, 2011). MI, SUD, and physical health issues, particularly when co-occurring, can make it very difficult to maintain any type of residential stability (National Coalition for the Homeless, 2009a, 2009b).

Table 2. Conditions Causing Limitation in SSI and SSDI Beneficiaries

Condition Causing Limitation	Beneficiaries Reporting Condition (%)			
	All Beneficiaries	SSDI-Only Beneficiaries	Concurrent Beneficiaries	SSI-Only Beneficiaries
Musculoskeletal	36	43	26	30
Mental illness	33	29	34	39
Circulatory system	21	25	15	17
Nervous system	17	18	15	15
Endocrine/nutrition	16	19	15	13
Injury or poisoning	11	14	7	9
Respiratory system	8	7	7	11
Sensory	9	9	11	9
Intellectual/developmental disability	7	3	14	10
Other	35	34	38	34
No conditions limit activities	6	5	7	8

SSDI = Social Security Disability Insurance. SSI = Supplemental Security Income.

Source: SSA (2009)

Table 3. Physical Health Issues Present at Increased Rates in People With SMI

Bacterial infections and mycoses	Tuberculosis*
Viral diseases	HIV,** Hepatitis B/C*
Neoplasms	Obesity-related cancer*
Musculoskeletal diseases	Osteoporosis/decreased bone mineral density*
Stomatognathic diseases	Poor dental status*
Respiratory tract diseases	Impaired lung function*
Urological and male genital diseases	Sexual dysfunction*
Female genital diseases and pregnancy complications	Obstetric complications**
Cardiovascular diseases	Stroke, myocardial infarction, hypertension, other cardiac and vascular diseases**
Nutritional and metabolic diseases	Obesity,** diabetes mellitus,* metabolic syndrome,** hyperlipidemia**

SMI = serious mental illness.

* good evidence for increased risk. ** very good evidence for increased risk.

Source: De Hert et al. (2011)

Incidence of Co-Occurring I/DD and MI

The most recent census information reports approximately 1.2 million adults or 0.5 percent of the U.S. adult population have an I/DD, with an additional 944,000 adults reporting having other developmental disabilities (Brault, 2012). These data do not include those adults with I/DD living in institutionalized settings, however, which was estimated to be nearly 57,000 in 2010 (Larson et al., 2013). Recent estimates of the prevalence of developmental disabilities, including intellectual disability, among children measured nearly 10 million, or 15 percent of children less than age 17 in the United States, showing a 17-percent increase from data gathered a decade earlier (Boyle, et al., 2011). The authors pinpoint the increase was largely because of the rise in diagnoses of autism and attention deficit hyperactivity disorder, which are in turn likely because of increased awareness and service provision for these diagnostic groups. As these children age, they represent a significant disability group within the MD category whose needs related to independent living and rental housing have yet to be studied. The largest and most extensive survey on disability in the United States, the National Health Interview Survey on Disability, was conducted in 1994 and 1995 and provided widely reported and cited statistics on prevalence rates of I/DD. This survey has not been replicated since, however, thus limiting any meaningful updates (Hendershot et al., 2005).

According to the *National Core Indicators* annual reports (NCI, 2014), approximately 35 percent of adults 18 years of age and older with I/DD have a co-occurring MI diagnosis, including mood disorder (22 percent), behavior challenges (15 percent), anxiety disorders (16 percent), and psychotic disorders (10 percent), with respondents potentially living with more than one diagnosis at the same time (see Table 4). Rates of co-occurring chemical dependency, however, were reported as less than 1 percent.

This result may be because of more restricted living situations and life choices for these individuals, or it may represent an issue of underreporting SUD for this population, or it may be related to issues of access to accessible communication for people with I/DD to report such issues.

Table 4. Co-Occurring MI in Adults With I/DD

Co-Occurring MI Condition in Adults With I/DD	NCI National Average (%)
Mood disorder	22
Anxiety disorder	15
Behavior challenges	16
Psychotic disorder	10
Other MI diagnosis	6

I/DD = intellectual or developmental disability. MI = mental illness. NCI = National Core Indicators.

Source: NCI (2014)

I/DD and Other Co-Occurring Disabilities and Conditions

Statistics indicate that 24 percent of adults with I/DD use some type of physical mobility aid or technology, such as a walker or wheelchair (NCI, 2014). Other more common co-occurring conditions for adults with I/DD include seizure disorder (25 percent), cerebral palsy (14 percent), autism spectrum disorder (12 percent), and vision or hearing impairment (10 percent) (see Table 5). Physical or sensory impairments can further affect and compound housing access issues for adults with I/DD, including the need for physical accessibility to entrances and bathrooms for wheelchair and walker users and adapted alarms and other safety devices for those with vision, hearing, and sensory impairments.

Table 5. Co-Occurring Conditions (Non-MI) in Adults With I/DD

Moves with aids or independent wheelchair user	15
Nonambulatory or moves with dependent assist	9
Autism spectrum disorder	12
Cerebral palsy	14
Brain injury	3
Seizure disorder	25
Vision and/or hearing impairment	10
Alzheimer's disease or dementia	2
Down syndrome	9

I/DD = intellectual or developmental disability. MI = mental illness.
NCI = National Core Indicators.

Source: NCI (2014)

I/DD and Education

Access to and participation in higher education is an important indicator to obtaining competitive employment and the financial resources needed to access independent living and rental housing in the community (Migliore, Butterworth, and Hart, 2009). Although the Individuals with Disabilities Education Act ensures that people with I/DD both with and without co-occurring conditions are able to receive public elementary and secondary education services, rates of post-secondary education for young adults with I/DD are among the lowest rates of any disability group. A study in 2007 showed that, of all young adults with I/DD accessing vocational rehabilitation services, only 3.4 percent attended any kind of post-secondary education, and only 1.5 percent completed any program through an educational institution (Migliore, Butterworth, and Hart, 2009).

Table 6. Data on Employment for People With I/DD

Community Employment Issue	Community Employment Status	NCI National Average (%)
Has a paid job in the community	Yes	15
	No	85
Wants a paid job in the community	Yes	49
	In-between	7
	No	44
Type of paid employment in the community (average hourly wage)	Individually supported (\$8.48) ^a	35
	Group supported (\$6.44)	32
	Competitive (\$8.15)	33

I/DD = intellectual or developmental disability. NCI = National Core Indicators.

^a NCI definitions for employment status are *community-based setting*: integrated place where most people do not have disabilities; *individually supported*: individuals are receiving public-funded support/services to get/maintain their job, and the job is one that is primarily done by people without disabilities; *group supported*: individuals are receiving public-funded supports/services to get/maintain their job, and the job is one that is primarily done by people with disabilities; *competitive*: individuals are not receiving any public-funded supports/services to get/maintain their job, and the job is one that is primarily done by people without disabilities.

Source: NCI (2014)

Transition and Postsecondary Programs for Students with Intellectual Disabilities, awarded through the Office of Postsecondary Education and funded through the reauthorization of the Higher Education Act in 2008, led to the creation and expansion of higher education opportunities for people with I/DD (Grigal et al., 2013). Results from this initiative show that 54 percent of participants leaving the programs after 2 years earned some type of credentials, with 48 percent of these participants engaging in competitive employment or other career development activities, 30 percent reporting paid employment, and 82 percent reporting wages at or above the minimum wage (Grigal et al., 2013).

I/DD and Employment

Employment is recognized as a major factor in helping people with I/DD make the transition from institutional to community-based housing and in providing residential stability (U.S. Senate, 2013), because it provides more financial resources and subsequent options for renting or owning a home. Most adults with I/DD are not employed in the community, however, despite an interest in pursuing work opportunities (NCI, 2014; see Table 6).

Although adults with I/DD and co-occurring MI have similar rates of community employment than that of the general I/DD population, they tend to have lower hourly wages than those without MI (NCI, 2011b; see Table 7). The most recently available National Core Indicators data reported that only 15 percent of respondents with I/DD had paid work in the community. For those respondents who did have community employment, only one-third of people reported having competitive employment (NCI, 2014).

Table 7. Community Employment for People With I/DD Only and People With Co-Occurring I/DD and MI

I/DD only	31.5	201.00	6.40	43	66
Dual diagnosis	30.6	170.00	5.81	35	56

I/DD = intellectual or developmental disability, MI = mental illness.

Source: NCI (2011b)

Given the increasing focus on ensuring access to equitable education and employment for people with I/DD, increasing numbers of people with I/DD and those with I/DD and co-occurring MI and physical disabilities will also be looking for market-rate rental housing in the communities in which they work.

I/DD and Housing

The Research and Training Center on Community Living (2012) estimates that 56 percent of adults with I/DD live in their family home, 23 percent live in congregate settings of four or more people (including institutions and nursing homes), 11 percent live in a group or foster home setting, and 10 percent live in their own home or apartment and not with family (Larson et al., 2014). Although housing trends indicate that most adults with I/DD live in a family member’s home, people with I/DD and co-occurring MI are much less likely to live with family and more likely to live in group homes, institutions and nursing facilities, or other situations, which may include rental housing (NCI, 2011b; see Figure 4).

As illustrated in Figure 4, less than 20 percent of adults with I/DD with or without co-occurring diagnoses live independently in a home or rental apartment. The Arc (2015) identified five factors contributing to these low levels of home rental or ownership, including lack of affordable and available housing,

accessibility issues for those also experiencing physical or sensory impairments, lack of supports to prevent institutionalization or homelessness, caregiver aging issues, and potential housing discrimination for this population.

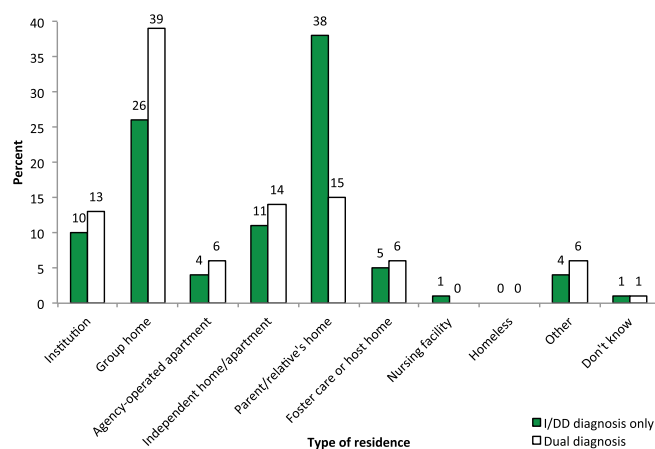
The Technical Assistance Collaborative (2012) reported that people with disabilities who rely solely on SSI for income are priced out of nearly every rental market in the United States unless they have permanent subsidy assistance, with many rents for studio and one-bedroom apartments exceeding the entire monthly SSI benefit. In 2010, nearly 600,000 adults with I/DD nationwide received Medicaid Home and Community-Based Services (HCBS) Waivers, which in some states can be used to obtain housing within the community; however, the level of funding and availability of supports to be used toward housing expenses vary significantly by state (Larson et al., 2013). The population of people with I/DD, however, who are now making the transition to least-restrictive community-living options in response to Olmstead Decision lawsuits and systems changes is growing. Therefore, we can expect to see this population increasingly trying to access market-rate rental housing.

Older Adults With Co-Occurring MI and Other Disabilities

The rate at which adults are living to old age in the United States is steadily increasing. The U.S. Department of Health and Human Services Administration on Aging (HHS, 2013), using data from the 2008 census, reported that the number of Americans age 65 and older is expected to reach 20 percent of the total population by 2040 and continue to increase thereafter (HHS, 2013; see Figure 5).

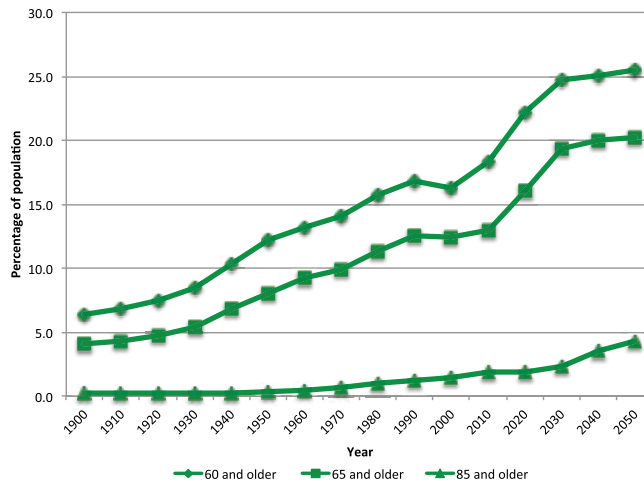
In 2013, nearly 5.3 million people (12.2 percent) age 65 and older in the United States experienced MI (SAMHSA, 2014). The percentage increases to 20.4 percent when neurological disabilities like dementia are included (Karel, Gatz, and Smyer, 2012). Depressive disorders and dementia-related symptoms are identified as most common MI related issues among older adults, with SUD also being of concern (Institute of Medicine, 2012). Up to 19 percent of adults 65 and older experience

Figure 4. Type of Residence, by Diagnosis



I/DD = intellectual or developmental disability.

Source: NCI (2011)

Figure 5. Older Population by Age, 1900–2050

Source: HHS (2013)

depression (NAMI, 2009a), which is often experienced as a secondary condition, co-occurring with other physical and emotional health conditions such as diabetes, Parkinson's disease, and chronic pain (Cahoon, 2012). The World Health Organization (WHO, 2013) reported that mental health and physical health frequently affect one another reciprocally. For example, older adults with heart disease experience depression at higher rates than those who do not have physical health conditions, and, similarly, untreated depression can exacerbate the effects of heart disease in older individuals (WHO, 2013). Alzheimer's disease and other forms of dementia are also significant co-occurring diagnoses in older adults, with 5 million Americans age 65 and older living with Alzheimer's disease as of 2014 (Alzheimer's Association, 2015).

When MI co-occurs, or perhaps even occurs for the first time for older adults, everyday function can be significantly disrupted, which, in turn, disrupts housing and community-living status. In some cases, this co-occurrence may cause older adults to leave their long-term homes and consider options such as market-rate rental, independent living, supported or assisted living, or nursing home situations. In the market-rate rental scenario, trying to find and apply for rental housing as an older adult with MI and concomitant physical health conditions represents a difficult challenge that a significant and growing percentage of older adults face.

Older Adults and Substance Use Disorder

Up to 700,000 older adults were diagnosed with alcohol use conditions in 2010, and another 100,000 were diagnosed with drug use conditions that year (Institute of Medicine, 2012). These numbers may be even higher, given that MI and SUD problems are often overlooked, underreported, misdiagnosed,

and undertreated in this population because of stigma associated with MI and the potential threat to maintaining independent living (CDC/NACDD, 2008; De Mendonça Lima, 2004; WHO, 2013).

Older Adults With Multiple Disabilities and Housing

The U.S. Census Bureau's 2013 American Housing Survey (sponsored by HUD) shows that approximately 35 percent of owner-occupied older adult households (65 years and older) include at least one disabled person, and 8 percent include a person with an MD. Because many, if not most, of these homeowners purchased their homes before acquiring age-related disabilities and chronic conditions, their homes may no longer be accessible to them and they may be forced to consider moving, including moving to market-rate rental housing such as senior independent living complexes. In addition, these older adults may need in-home personal assistance and accessibility features in their home and in their community, adding a component of reasonable accommodation to their rental housing needs (U.S. Census Bureau, 2005; U.S. Census Bureau, 2013).

Not all older adults with MI have owned their own homes, however, and may be at risk for losing existing market-rate rentals. In fact, 47 percent of older adult households who reside in rental units include at least one person with a disability, and 13 percent include a member with an MD (U.S. Census Bureau, 2013). Further, there are more people ages 65 to 79 and 80 and older who have disabilities than there are accessible housing units (JCHS, 2014). Further, adults age 80 and older are two times more likely to have a disability than they are to live in homes that have at least three accessibility features (JCHS, 2014). These individuals may need to endure long waiting lists of several years or more to obtain affordable senior housing, which may or may not be adequately accessible. In addition, senior housing sites may be hesitant to accept or have policies restricting tenants who have a history of MI or SUD, even though both occur together for a significant portion of older adults (HHS, 2003). Systemic and financial issues, such as the delay in obtaining affordable housing and the inability to afford rental housing, and individual or societal issues related to disclosing MI and SUD, can lead to homelessness or institutionalization for many of these older adults (HHS, 2003).

I/DD and Aging

The life expectancy for adults with I/DD has steadily increased during the past several decades, with individuals with mild I/DD seeing life expectancy on par with the general population and those with moderate to severe I/DD often living into their 50s

and 60s (Bittles et al., 2002). With this increasing life expectancy has also come an increasing incidence of aging related issue within this population, including Alzheimer’s disease, dementia, and other sources of memory changes (Moran et al., 2013; Perkins and Moran, 2010; see Table 8).

Recent research has indicated that *the incidence of dementia in adults with I/DD more than 65 years of age is five times that of the general population* (Strydom et al., 2013). In addition, adults

Table 8. Common Contributors to Memory Changes in Adults With I/DD

Condition	Presentation
Sensory deficits	Hearing loss Vision loss, low vision, depth-perception changes
Metabolic disturbances	Electrolyte abnormalities Hypoglycemia/hyperglycemia B12 or folate deficiencies Undetected thyroid dysfunction Anemia Toxic medication levels Toxic adverse medication effects
Coexisting mood disorder	Either newly detected or subacute worsening of baseline mood disorder
Pharmacologic concerns	Polypharmacy Drug-drug interactions Altered pharmacokinetic properties
Sleep problems	Sleep apnea Other undetected sleep disorders
Seizures	Undetected or worsening seizure disorders
Pain	Undiagnosed or undertreated pain
Mobility problems	Mobility disorders and loss of functionality
Psychosocial or environmental stressors	Changes in routine at home or work Death or impairment of close family and friends Reactions to threatening situations
Other conditions associated with cognitive deficit	Chronic subdural hematoma Brain tumors Multiple sclerosis HIV/AIDS Cryptococcal infection
Considerations for adults with Down syndrome	Early development of cataracts Increased risk of keratoconus Conductive hearing deficits Thyroid dysfunction Obstructive sleep apnea Celiac disease Atlantoaxial instability Spinal stenosis Osteoarthritis

I/DD = intellectual or developmental disability.
Source: HHS (2013)

with Down Syndrome typically experience even higher rates of Alzheimer’s disease with earlier onset because of genetic factors. (Livingston and Strydom, 2012; Strydom et al., 2010). The National Task Group on Intellectual Disabilities and Dementia Practices (NTGIDDP, 2012) estimates that at least 54,000 older adults with I/DD are living with dementia in the United States, although no current national statistics more accurately determine the incidence.

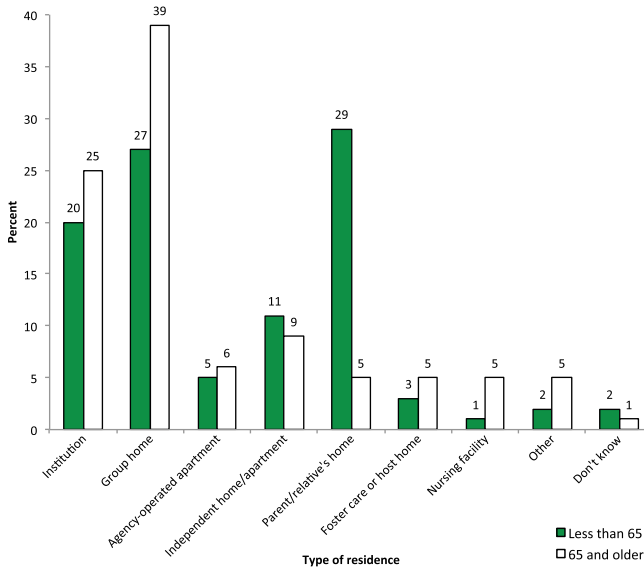
Aging Adults with I/DD also experience higher rates of heart disease, high blood pressure, high cholesterol, diabetes, stroke, arthritis, asthma, and obesity, which can lead to premature death or poorer health when aging (Reichard, Stolze, and Fox, 2011). *In a survey of adults with I/DD age 65 and older, 44 percent of respondents reported co-occurring MI, 21 percent a physical disability, 11 percent legally blind, 9 percent hearing loss, and 7 percent having Alzheimer’s or dementia (NCI, 2011a).* Any, or all, of these co-occurring disabilities can significantly influence rental housing access and discrimination issues, particularly as this population lives longer and also has aging caregiver issues that may threaten their ability to stay in family homes.

The increase in care demands associated with developing age-related conditions for adults with I/DD often comes as families, particularly parents, are less able to provide direct care, often because of their own aging issues (Heller and Factor, 2008; Livingston and Strydom, 2012). Compounded with this increase in care needs, families of people with I/DD often have few formal supports and poor access to services (Heller, 2008; NTGIDDP, 2012). Although older adults with I/DD experience many of the same physical changes and age-related chronic diseases as the general aging population, they are more likely to experience inadequate or poorly managed health care, unrecognized health conditions, and poor coverage of health promotion and preventative care (Perkins and Moran, 2010). Health outcomes for older adults with I/DD are often poorer than that of the general population, and thus can exacerbate rental housing access and potential discrimination.

Older Adults With I/DD and Housing

With the increased rates of dementia and chronic diseases that can affect physical health and functioning of people aging with I/DD, paired with increasing support needs that family caregivers often have difficulty meeting, adults with I/DD more than 65 years of age are more likely to live outside the family home and also more likely to live in an institution or nursing facility than those less than 65 years of age (see Figure 6). Although many older adults with I/DD continue to live at home throughout their lives (NTGIDDP, 2012), many families seek alternative

Figure 6. Type of Residence for People With I/DD, by Age



I/DD = intellectual or developmental disability.
Source: HHS (2013)

housing as caregivers experience age-related declines, primary caregivers die, and caregiving needs for older adults with I/DD increase. Individuals with I/DD who were living independently in the community may also face challenges to remaining in their housing because they experience common age-related cognitive and physical declines and increased difficulty obtaining health care, because outlined in the previous section.

Housing Policy Issues Across Multiple Disability Populations

As described in the previous section, people with co-occurring MI and SUD may have multiple disability-related needs that can complicate the process of obtaining and maintaining market-rate rental housing (National Coalition for the Homeless, 2009a).

Federally funded public and subsidized rental housing—both tenant- and project-based—provides housing for different populations, including people with disabilities. Across all programs, 1,175,636 “disability families” are either currently living in public housing, in private sector housing with a housing choice voucher or in some type of federally subsidized housing (HUD, 2015).³ In recent years, changes in the different programs have expanded opportunities for integrated accessible housing through both development of housing units and designated

housing choice vouchers. The exact number of units designated for people with disabilities is unknown, as is how many may be occupied by people with multiple disabilities. What we do know is that several subsidy programs target people with disabilities; however, no program is solely intended to benefit people with MD or people with multiple disabilities.

The Non-Elderly Persons with Disabilities (NED) vouchers enable families with a person with a disability to locate and secure suitable and accessible housing on the private market. Although NED vouchers are like regular housing choice vouchers, the public housing authority (PHA) will provide the voucher holder a list of known accessible units to help in the housing search process, and when, and if, the voucher is returned, it must go to another NED family. Furthermore, NED Category 2 vouchers were issued specifically to help facilitate the transition of non-elderly people with disabilities currently residing in nursing homes or other healthcare institutions into the community. The 5-year Mainstream tenant-based voucher program funded through Section 811 is specifically for people with disabilities. As with NED, Mainstream vouchers are required to continue to be used by people with disabilities upon turnover.

In a similar arrangement, in the HUD-Veterans Affairs Supportive Housing (HUD-VASH) program, HUD provides the rental assistance and the U.S. Departments of Veterans Affairs provides case management and clinical services via its medical centers and other community resources. Although not intended to move people with disabilities into the community, HUD-VASH can help veterans with disabilities who are homeless and keep others from being institutionalized.

To date, more than 400 PHAs have been awarded approximately 55,000 vouchers specifically for nonelderly disabled families. Although a newer program, HUD-VASH has nearly 60,000 vouchers. By comparison, the 5-year Mainstream voucher is a much smaller program with less than 7,000 vouchers. In total, these targeted vouchers represent about 6 to 7 percent of the total voucher program in the United States, which is at about 2.1 million households assisted. By comparison, it is estimated that about 29 percent of nonelderly households with someone who has a disability—about 627,000 households—were using vouchers (TAC, 2014). This percentage is closer to 50 percent when elderly disabled households are included (Center on Budget and Policy Priorities, 2015). In either case, most households that include one or more people with disabilities are not using vouchers from these special programs.

³ A disabled family, according to HUD, means a family whose head, spouse, or sole member is a person with a disability. It may include two or more people with disabilities living together, or one or more people with disabilities living with one or more live-in aides.

In the past 10 to 15 years, a small portion of PHAs have been permitted to designate as “elderly only” buildings that had previously been for people who were “elderly” or with disabilities regardless of age (NAMI, 2014). Currently, 128 PHAs across the United States have plans approved that designate 63,806 housing units specifically for people with disabilities or for senior families (at least one person must be 62 years of age or older). Most of these are one bedroom or studios (96 percent) and most are for senior families (91 percent). By current estimates, 2,553 public housing units are solely for people with disabilities, another 3,190 units are for both senior families and people with disabilities, and 58,603 units are for senior families that may include people with disabilities older than age 62. This designation has also been permitted in HUD-assisted multi-family housing where about one-fourth of the units are now designated for elderly people only, but only 5 percent are designated for people with disabilities (NCD, 2010).⁴

In addition, although Section 811 has effectively created housing for people with disabilities and the Melville Act of 2010 has incentivized more integrated housing approaches (for example, no more than 25 percent of units in the Section 811 property under the Project Rental Assistance [PRA] approach can be designated for people with disabilities) (TAC, 2011), most housing built under this program in the past continues to be segregated.

Further, some state budgets put funding for services and state-funded housing assistance programs (SFHAPs) in competition with one another, making funding allocations to one at the expense of the other (TAC, 2014). Finally, although SFHAPs have been useful for many people with MI, they are not without limitations. For example, because of difficulties in meeting the demand for SFHAPs, many states have enacted strict eligibility criteria developed to meet population-specific priorities. Of the 77 SFHAPs profiled in TAC’s *State Funded Housing Assistance Programs* report (TAC, 2014), only 8 target people with disabilities of any kind, and 23 specifically target people with SMI. In addition, although 52 of these SFHAPs are considered “Subsidy Programs” in that they provide long-term assistance for housing costs rather than one-time or short-term assistance to address an immediate housing crisis, many struggle to transition recipients to a more permanent form of federal housing assistance (TAC, 2014). This approach can affect the fluidity of the intended program and limit the number of households that can take advantage of this form of assistance. Together, these issues may leave many adults with MI and co-occurring MI and SUD without the services and supports they need to apply for, obtain, and maintain rental market housing long term.

⁴ Although it is not possible to correlate any changes in population using aggregated data, we did find that, according to the most current HUD data, 344,692 households in public housing are considered a disability family (HUD, 2015). Of this population, 201,205 are nonelderly and 143,487 are elderly, and most do not have children (85 percent). Comparing these data with the National Council on Disability report (NCD, 2010), we found 210,760 nonelderly households and 135,218 elderly households with a disability living in public housing (NCD, 2010). What has also changed slightly is the overall proportion in public housing based on distribution by age of householder: in 2008, nonelderly-headed households were 22 percent of the total in public housing and now are 21 percent, while elderly-headed households were 11 percent in 2008 compared with 15 percent now (HUD, 2015; NCD, 2010).

Promising Practice Case Studies and Implications To Address the Needs of People With MI and I/DD With Multiple Disabilities as They Age

As demonstrated in this critical appraisal, a significant and potentially growing population of people with PD-MI and I/DD are experiencing multiple disabilities that may interfere with and affect access to rental housing and potential discrimination related to obtaining this housing and staying in it over time. Much of this research points to specific system and policy implications that involve cross-coordination of housing and community-living supports across different disability and aging systems and programming. This section highlights several examples of promising practices in state and regional/local communities that address this complexity and coordination. These cases also highlight how different strategies can be used in different communities to customize this coordination of housing and supports, yet still contribute to potential increased housing access and opportunities for these populations.

The Case of Louisiana: Breaking Down Silos and Coordinating Housing With Community-Living Supports Across Disability and Aging Systems

Louisiana began developing a 3,000 cross-disability permanent supportive housing (PSH) initiative in 2007 and 2008 in the Gulf Opportunity Zone (southern Louisiana) as part of the state's recovery plan to the natural disaster Hurricane Katrina in 2005. PSH combines deeply affordable rental housing with voluntary, flexible, and individualized community-based services to assist people with the most severe and complex disabilities⁵ to live successfully in the community. State-level partnerships among the Louisiana Housing Corporation (LHC), the Office of Community Development's Disaster Recovery Unit, and the Department of Health and Hospitals (DHH) provided the framework for leveraging hurricane recovery resources to reach the 3,000-unit PSH goal.

Nearly 1,200 PSH units were created as a result of innovative state policies incorporating small set-asides of PSH units in

affordable rental properties financed through the Low-Income Housing Tax Credit (LIHTC) program, Housing Trust Fund, Small Rental Repair, and Piggy Back Programs. Permanent rental subsidies awarded by Congress ensured the remaining units were secured in the private rental market through a mix of scattered-site leasing and PSH projects, and the affordability of all 3,000 units for those with the lowest incomes.

The Louisiana Public Housing Authority, a program of the LHC, manages the program and the 3,000 subsidies. Because the Community Development Block Grant (CDBG) program was designated only as a "startup" for services, the state modified their Medicaid (HCBS and 1915[i]) programs and other state and federal programs so tenant services can be sustained over-time. The program has successfully housed more than 2,480 households with disabilities across the Louisiana Gulf Coast, of whom 42 percent were homeless, with good housing retention rates and average monthly Medicaid cost reductions among those served. More than 70 percent of the households have multiple or co-occurring disabilities and most qualify for Medicaid and SSI or SSDI.

State officials, disability and homeless advocates and stakeholders used this opportunity to create one state-driven PSH system that could help accomplish two policy goals—end chronic homelessness and reduce reliance on expensive and unnecessary institutional settings within the context of the Olmstead Decision. The PSH leaders gave priority to access for the most vulnerable people with disabilities. They did not place readiness criteria or restrictions based on the severity of individual's disabilities. By doing this, they took steps to overcome access and discrimination barriers that often accompany targeting this population.

The leaders adopted a cross-disability Housing First⁶ community support team service model directly linked to the PSH units; service providers do not manage or operate housing. People have the opportunity to move to another unit when preferred or as a deterrent to eviction and most owners/property managers remain in the program over time. Service providers serve as

⁵ The tenants must have one or more of the following disabling conditions—MI, SUD, developmental disability, chronic health condition, or physical disability—and must be in need of permanent supportive housing.

⁶ Housing First is an approach of providing permanent supportive housing to single homeless adults with MI and co-occurring SUD.

a clinical home with linkages to the other needed community and support services focused on the tenant's housing-related access and support needs. Formal liaison functions, including an eviction-prevention process, were created, with responsibilities assigned to services managers, supportive housing authority management staff, and property managers.

One hallmark of the program has been the flexibility of the program's leadership to evolve and make adjustments as it has grown and faced challenges. Initially the DHH entered into agreements with six organizations, primarily local human service authorities to manage outreach, referrals, waiting lists, and contract for supportive services. This model worked well initially as the organizations were embedded in their communities and they were able to get their program up and running in a timely manner. Because the program funding was shifting with supportive services being reimbursed by fund sources other than CDBG, the state and managed care organizations have been taking over more of the management responsibilities. The work in Louisiana is far from finished; below are lessons learned from this program highlighting housing access and discrimination issues.

- Mandating PSH as a set-aside in the LIHTC and small rental repair programs and assistance from a Piggyback program helped launch the PSH program; the PSH program prioritized a quick staff response approach to property managers' concerns while advocating for and assisting tenants to become self-advocates.
- Cross-agency collaboration, including establishing liaison responsibilities, helped increase access and reduce evictions long term.
- The Louisiana PHA has given high priority to monitoring tenant selection and requesting property managers to accept tenants with challenging credit and criminal histories.
- Supportive service providers and referring agencies have given a great deal of attention to unit selection, matching locations to prospective tenant's expressed choices and concerns.
- The program has had more success with larger rather than smaller property owners.
- Some supportive services providers were challenged with adapting to the Housing First model especially serving individuals who were chronically homeless or those who had been institutionalized for a long period of time or repeatedly over time.

- Service providers were able to adapt their practice to provide supportive services to people across the range of disabilities although meeting Medicaid requirements was more challenging. The program has offered continuous technical assistance, training and coaching to assist providers to coordinate across services and programs in a consumer-directed manner.
- Individuals referred directly from institutions were less likely to access the program because the time needed to make transition arrangements and decisions often exceeded the time available units could remain vacant. This timing issue in coordinating transition out of institutions using housing voucher, bridge subsidies or other housing assistance, remains a key cross-systems policy issue to tackle.

Additional Promising Practices Across States and Communities

Pennsylvania and North Carolina both have developed small set-asides of units in affordable rental properties financed through their LIHTC program for people with extremely low incomes to give people with disabilities more access to quality integrated rental housing. In North Carolina, the set-asides are explicitly set aside for people with disabilities; in Pennsylvania, owners are required to enter into an agreement with appropriate referring entities (including those supported by the Commonwealth's Department of Human Services) to assure that sufficient referrals are received from households who are income eligible and in need of the accessibility features.

North Carolina has implemented the Department of Health and Human Services (DHHS)/ Housing Finance Agency *Targeting* Program, a state-driven PSH initiative. Today more than 2,000 multifamily rental units are provided across the state through a mandate that 10 percent of the units in every new federal LIHTC property be reserved for PSH tenants. The DHHS and local lead agencies (LLAs) assist people who have extremely low incomes and multiple disabilities and who may be homeless to gain access to and maintain permanent independent housing in apartment communities participating with the Targeting Program.

The Pennsylvania Housing Finance Agency (PHFA) LIHTC Qualified Allocation Plan (QAP) has included a threshold requirement for developers to make a subset of their low-income units affordable to people at or below 20 percent of the area median income, adjusted for family size. In their 2015 QAP, the PHFA required a LIHTC application financing plan that evidences that at least 10 percent of the low-income units in urban areas

and 5 percent of the low-income units in suburban/rural areas. Through 2014, 843 units have been set aside for this purpose. The Department of Human Services supports LLAs in single or multiple counties to enter into an agreement with a developer to make referrals to the 20 percent units and to assure services are available to tenants to sustain their tenancy long term. The DHS requests LLAs enter into agreements with referring and services organizations across the full spectrum of agencies serving people with a range of disabilities, including people with multiple disabilities. LLAs manage the referral process, tenant selection, assist with housing search, tracks referrals, and assist with tenancy disputes. The LLAs also manage the 2013 awarded 811 PRA (in startup phase) program referral process that, in Pennsylvania, gives priority to individuals referred directly from institutional settings.

In Philadelphia, a single clearinghouse in the Office of Supportive Housing manages tenant selection and referrals for people with multiple disabilities to rental housing that is subsidized by five different funding sources. This requires the clearinghouse to not only help provide choices for housing search but also manage what types of subsidy an individual may be entitled to at the time of their referral. The city's goals in combining these functions into one clearinghouse are to provide more integrated housing options to people across multiple disabilities, reduce management redundancies and improve timeliness of referrals and allocate more attention to working with landlords and property managers. Clearinghouse staff are skilled in negotiating with owners and can assist prospective tenants and their service providers with eligibility determinations and move-in challenges.

The New Jersey Housing Mortgage and Finance Agency (NJ HMFA) and the Department of Human Services (DHS) have recently entered into a new agreement for the NJ JMFA to operate a housing clearinghouse, Supportive Housing Connection (SHC). The SHC will manage an array of existing and new state-funded housing subsidies and the 811 PRA rental subsidies (should New Jersey be awarded 811 PRA subsidies) for people with behavioral health disorders and people with I/DD, coordinating services across these different groups. DHS has also centralized the oversight of housing, tenant selection, and referrals for these two populations into an Office of Housing. DHS initiated this agreement to (1) meet their goals for giving priority and expanding choices for individuals who are exiting institutions, and (2) separating housing and services so choice of housing is not dependent on required services but instead on

a consumer-driven choice model. To manage rental subsidies and deliver services under a single contract, 45 providers are under contract with the DHS behavioral health division. This agreement maximizes resources but more importantly is being designed to reduce the time between people being referred and getting access to quality housing units, establishing priorities and giving people more choices of providers and housing. The NJ HMFA has the ability to attract more quality private rental resources because of their role in financing affordable housing.

Other states and local communities are taking steps to provide better housing access to individuals across multiple disability groups. Washington State is focusing their 811 PRA subsidies on individuals being identified through their Money Follows the Person (MFP) program and Maryland is demonstrating how strong state leadership can be the driving force to create a strong coordinated outreach system to improve access to private market housing.

The Georgia Department of Community Affairs (DCA) took a major step to prioritize its fair marketing approach. Using its QAP as a tool and policy, DCA is requiring each project selected for an award of LIHTCs to submit and have approved an Affirmatively Furthering Fair Housing marketing plan, outlining how each new LIHTC project will market units to underserved tenants, including tenants with multiple disabilities. The marketing plans must adhere to a number of requirements, including (1) outreach efforts to each service provider, homeless shelter or local disability advocacy organization in the county in which the project is located; (2) a strategy to establish and maintain relationships between the management agent and community service providers; (3) a referral and screening process that will be used to refer tenants to the housing, and to make reasonable accommodations to facilitate the admittance of people with disabilities and the homeless into the program; and (4) marketing of properties to underserved populations 2 to 4 months before occupancy to ensure a quicker and smoother transition.

All these promising practices have the potential to improve housing access and decrease housing discrimination with people with PD-MI and I/DD, specifically with people who are experiencing multiple disabilities and aging in place at the same time. These programs and sites also offer a rich groundwork for future housing access and discrimination research projects to compare the effectiveness and effect of these innovative programs with other sites that have not yet implemented these changes.

Synthesis, Conclusions, and Implications for Future Housing Research

This critical appraisal of existing disability and aging research highlights the housing access needs and potential discrimination of a growing and significant population of people with PD-MI and I/DD who are living and aging with multiple disabilities and chronic conditions. This population includes three major groups.

1. People with PD-MI who have concurrent SUD, cognitive, physical, and age-related conditions and disabilities.
2. People with I/DD who have concurrent MI, SUD, physical, and age-related conditions and disabilities.
3. Adults older than age 60 who have the same set of concurrent disabilities and who are now aging with them and/or who newly acquire these disabilities after they become seniors.

The presence of multiple disabilities has been shown to influence overall function and independent living status, and ergo, also affect housing status, choice, and need for reasonable accommodations and supports within that housing. Although at the same time, given the Olmstead Decision and system policy changes emanating from it, these people represent the very groups whose rights to least restrictive community-living options with supports should be protected. This least restrictive community-living mandate is difficult to implement, however, particularly when it involves cross-cutting coordination of housing AND community-living supports across systems and policies which have traditionally been “siloeed” or cordoned off to specific disability and age groups. In reality, this review shows the need for coordination among mental health, developmental disability, physical disability, and aging services, given the significant number of people who experience one or more of these functional issues and conditions at the same time. Of critical significance is the need for coordination across—

- Disability and age-related systems.
- Medicare and Medicaid Home and Community-Based Services Waivers and other community-living support programs.
- Affordable, accessible, and integrated housing systems and programs.

In addition, findings show that other key factors further complicate housing for people with multiple disabilities, including concurrent SUD or history of SUD, incarceration or criminal history, poor socioeconomic status and history of subsidized income, and homelessness. For a significant portion of the population of people with MD, these concurrent issues make rental housing access and potential discrimination related to it a very difficult challenge; however, we can expect to see growing numbers of people from this population attempting and wanting to move into integrated rental housing in the community. Therefore, this issue merits focused research to document the lived experiences of individuals with multiple disabilities, specifically related to accessing rental housing and expanding to also include home ownership.

To date, housing discrimination testing has not addressed the complex needs of these groups. As appropriate to the science, housing discrimination testing initially has focused on one specific disability group and held other variables constant, including age, socioeconomic status, and race/ethnicity, or has excluded individuals with multiple disabilities, SUD, or history of incarceration. Such a focus also increases the rigor of findings relative to legal issues of discrimination. As we move forward in studying the effect of housing on community living, health, participation, and quality of life, however, so too should the research also reflect the complexity of the lived experiences of people with multiple disabilities as they age and attempt to age in place in a community-living and housing situation of choice. More sophisticated multivariate group testing methodologies could begin to examine significant research questions related to the effect of multiple disabilities and related circumstances (for example, poverty, access to a housing voucher or home and community-based waiver, SUD history) on access to market-rate rental housing. For example, studies that compare the housing access and discrimination issues experienced by the following groups would appear to be indicated, given the statistics related to their occurrence.

1. People with PD-MI with and without SUD history.
2. People with I/DD with and without co-occurring PD-MI.
3. People with PD-MI and I/DD who experience physical and age-related disabilities and conditions as they age or as after they become older adults.

4. People with PD-MI and I/DD who have adequate income to obtain market-rate rental housing compared with the same group who come in using housing vouchers or HBC waivers or compared with those who have none of these resources and attempt to go into rental housing living on subsidies or in poverty.
5. People with PD-MI and I/DD who receive *coordinated* housing and community-living supports or who participate in demonstration and other systems change initiatives in their states and communities compared with those who live in communities that have not yet implemented these initiatives.

In addition to getting in the door[misplaced modifier; this sentence says that “research” is getting in the door—please rewrite for sense], research that documents the effect of coordinated housing and community-living supports on long-term maintenance of rental housing over time for people with PD-MI and I/DD with multiple disabilities is also needed and may also document different discrimination issues that surface only in the long term or in light of emergencies, exacerbations, major life events, and aging. These issues and longitudinal qualitative and quantitative research related to them may also inform strategies to decrease premature or unwanted institutionalization, nursing home placement, and homelessness, societal issues that are experienced by a significant proportion of people with PD-MI and I/DD.

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