The Coalition of Voluntary Mental Health Agencies, Inc.

Supported Housing:
The Underfunded Future of Mental Health Housing

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A Coalition Report

The Coalition of Voluntary Mental Health Agencies is the umbrella advocacy organization for New York City's mental health community. The Coalition represents more than 100 not-for-profit, community-based providers of mental health services. Collectively, Coalition members serve more than 500,000 clients in all five boroughs and virtually every neighborhood.

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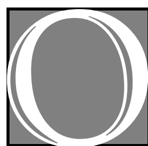
August 2001

ver the last 50 years, residential services for people with mental illnesses have slowly evolved from full-time hospitalization far away from the public eye, to publicly subsidized private housing that is integrated in a community setting. In 1953, for example, the State Psychiatric Centers housed more than 93,000 New Yorkers with mental illnesses. Since that time, this inpatient population has slowly declined and now numbers less than 5,000. Much of this change is due to an emphasis on community-based settings and the increased availability of State-funded community-based residential options for people with serious and persistent mental illnesses (SPMI).

Supported Housing is the most recent incarnation of these community-based residential services . Initiated in 1990 through the New York State Office of Mental Health, Supported Housing combines funding for supportive services with rent subsidies for scattered-site apartments. The program by and large has been a great success–both as a low-cost alternative to more intensive housing programs, and in terms of the independence and stability it provides to consumers seeking long-term housing. Since the program began, however, operating costs have risen much quicker than contract rates. In particular, this rate has failed to account for the dramatic increases in rent costs. As a result, the program's funding base has slowly eroded as fungible service dollars were diverted to cover hard rental costs. This cost creep is now at a crisis level. Rent costs are now so high and service dollars so low that action must be taken in order to maintain the long-term viability of the program.

Providers, nonetheless, remain committed to the program and have been subsidizing it through emergency financing methods even as costs have risen above current contract rates. These emergency measures cannot continue indefinitely. Going forward, it is imperative that rate calculations reflect real costs. Most importantly, this should include a permanent trend factor that keeps pace with market increases. While this program was intended to be the stable bedrock upon which treatment is built, the poor funding of the program and the resultant eviction proceedings to which many consumers have been subjected have seriously jeopardized this mission. By making this change, OMH will ensure consumer safety stability, and satisfaction.

Before Supported Housing

Prior to 1990, only three kinds of publicly funded housing options were available for people with mental illnesses: Community Residences (CRs), Residential Care Centers for Adults (RCCAs) and Family Care. At that time, these programs were fully funded by New York State. All of these models are full service facilities for adults—many of them provide 24-hour supervision. While effective in providing consumers with the support necessary to maintain stable and healthy lives, consumers are limited in the choice of residences and the kind and intensity of services.

The CRs provide service in three primary modalities: Congregate Treatment (CT), Apartment Treatment (AT), and CR/SROs— single room occupancy. These models are distinct from each other in the way they combine services along the three axes of facilities, length of stay, and intensity of service.

The Coalition gratefully acknowledges the contributions to this report made by Richard Cho of The Corporation for Supportive Housing and Lauri Cole.

Congregate Treatment CRs and CR/SROs house numerous consumers in sometimes shared rooms in the same building. Bathroom facilities, and kitchen facilities if they exist, are shared among residents. Apartment Treatment CRs, on the other hand, place consumers in shared apartments that are typically leased on the private market by the provider.

One of the most pertinent elements of the CR models is the amount of time residents are eligible to stay. In this case, residents in Congregate Treatment and Apartment Treatment Community Residences cannot stay in the program longer than two years. These models are, by definition, temporary housing. In contrast, CR/SROs are dubbed 'extended stay.' Though regulations maintain that consumers are expected to move out and on to independent lives, for many, the CR/SRO is, effectively, permanent housing.

Although the service package available to residents is closely correlated with the facility, it is still important to note the differences. Congregate Treatment CRs and CR/SROs provide such services as medication management, group recreation activities and, frequently, a meal plan. Although the service package usually varies somewhat from residence to residence, it can be quite extensive. Typically, residents are supervised on a 24-hour basis, with employees that keep a close eye on activities.

The Apartment Treatment CRs, on the other hand, offer a great deal more freedom of day-to-day activities for consumers. A case manager monitors the consumer by visiting from at least three to five times a week and is on-call 24-hours a day in case of emergency. A daytime activity like day treatment, vocational training, or a psychosocial club is often a condition of acceptance to the program.

RCCAs, are very similar to the Congregate Treatment Community Residences with one primary exception: RCCAs are effectively permanent housing. (Technically permanent housing is referred to as "Extended Stay.") They are designed for clients, like the formerly homeless and those discharged from State psychiatric hospitals, who require long-term housing *and* a great deal of help with normal activities of daily living (ADL).

Family Care, also known as Adult Foster Care, is the other community residential option that preceded Supported Housing. Like a Community Residence, it is single-site, but the number of residents is much smaller—typically fewer than six consumers in any individual setting. Services are provided, most commonly, by an unrelated family which receives a stipend in exchange for its work. This housing model is primarily used in Upstate New York where it accounts for a substantial portion of the number of beds for people with mental illnesses; however, these services are available to a wide variety of adults, not just those with mental illnesses. Licensed by the New York State Department of Health, these programs are monitored by the Human Resources Administration's Department of Voluntary and Proprietary Homes for Adults (DVPHA).

At the time Supported Housing came into existence, all these programs were funded with 100% State funds; since that time, however, the State has 'Medicaid-ized' these programs to the extent allowed under federal regulations. Even so, these programs collectively represent a substantial financial commitment to residential facilities for people with mental illnesses.

Supported Housing

In the mid-1980's, the treatment modality for people with mental illnesses started to shift and increasingly began to include the needs and wants of consumers. To a greater

extent than ever before, treatment began to focus on rehabilitation and recovery in communities. At this time, the State developed a new housing model—Supported Housing—that incorporated these changes. In particular, OMH sought to provide three primary services through a new residential model: home, choice, and community support.

Furthermore, the continuum of care outlined by the housing models that existed prior to Supported Housing was noticeably lacking in permanent housing options in apartment-based settings. Much of the excitement about Supported Housing was a function of its focus on filling this substantial gap in services.

In identifying the goals of home, choice and community support, the state explicitly acknowledged the importance of a stable living environment *and* the role of personal preferences in rehabilitation and recovery. People with mental illnesses are frequently able to achieve high levels of recovery when placed in normalized settings. This includes the opportunity to choose an apartment from those available and within a modest budget. However, the meager support provided by SSI and SSDI—even with a State-based supplement—was, and remains, insufficient to cover the cost of rent in New York State, and New York City in particular. Without additional support for housing these individuals would be unable to independently afford a stable setting that would facilitate treatment.

Features\Type of Housing	**Apartment Treatment**	**Congregate Treatment**	**CR/SRO**	**RCCA**	**Family Care**	**Supported Housing**
Congregate or Apartment	Apartment	Congregate	Congregate	Congregate	In a home	Mostly Apartment, but some Congregate
Building Ownership (Provider/Private)	Mostly private, but some provider	Provider	Provider	Provider	Private	Mostly private, but some provider
Lease (Resident or Provider)	Provider	N/A	Consumer	N/A	N/A	Both
Intensity of Services	Medium	Intensive	Medium	Very Intensive	Medium	Light
Staff Coverage	not 24 hour, but 24-hour on-call	24 hour	24 hour	24 hour	24 hour	not 24 hour, but 24-hour on-call
Programmatic						
Meal Plan option	No	Yes	Yes	Yes	Yes	No
ADL Competency (Activities of Daily Living)	High	Medium	Medium	Very Low	Mixed	High
Medication Monitoring	Sometimes	Yes	Sometimes	Yes	Yes	No
Term of Residence	**Short (<2 years)**	**Short (<2 years)**	**Extended**	**Extended**	**Extended**	**Extended**
Medicaid	Yes	Yes; No when >16	Yes; No when >16	Yes; No when >16	No	No
Licensure	Licensed by OMH	Licensed by OMH	Certified by OMH	Licensed by OMH	Licensed by DOH, monitored by DVPHA	Unlicensed

Aside from the rental subsidy, the primary feature of the Supported Housing model is its capacity to tailor services to the needs of the consumer on an individual basis. This was accomplished through the use of a case manager who acted as a liaison to and advocate for access to additional community-based mental health services. This could include, if necessary, an Intensive or Supportive Case Manager, clinic treatment, day treatment, or even vocational services.

As a general rule, the residents in this program were expected to perform most activities of daily living. Where a gap existed, the case manager could step in to assist with

such activities as housecleaning, budgeting, cooking, transportation and anything else that was necessary to provide a stable living environment. Although not the primary role for the case manager, this function could entail a substantial amount of work.

Soon after its inception, however, those served by this program began to deviate—sometimes sharply—from the ideal of nearly independent performance of activities of daily living. This was done with the explicit encouragement of the State. Caseloads of consumers who require increasing amounts of assistance with their activities of daily living have led, in turn to a strong growth in the burden on case managers.

The flexible service package characteristic of Supported Housing has manifested itself in different ways in actual programs. In a small number of cases, individual providers have negotiated one-time contracts with the state, typically where a specific population is targeted and which requires enhanced levels of service, as in the case of people with co-occurring psychiatric and addictive disorders. Additionally, the flexibility allows the state to vary contract rates from Upstate to Downstate to compensate for a variety of differences, often having to do with rent. In these negotiated cases, providers report contract rates that range from a low of approximately $6,500 to a high of $14,500 per bed per year. By contrast, the adjusted RFP released by OMH in November 2000 proffered a rate of $10,912.

Supported Housing differs from CRs in some fundamental ways. To begin with, unlike other residential options, Supported Housing is not a licensed program. There are no formal regulations to which programs must adhere. While OMH has published guidelines, these merely suggest a service package and lack formal authority. Furthermore, the funding stream for Supported Housing involves a single allocation of funds to cover both the costs of supportive services *and* rental assistance. Apartment Treatment Community Residence options, on the other hand, are funded through two separate lines: one for services, and one for rent costs. This regulatory split permits any and all rent costs to be 'passed-through' to the state, effectively insulating the provider and the consumer from steep and sudden increases.

When Supported Housing was initiated, it filled the necessary gap as a permanent, low-intensity residential program. At that time, CR/SROs and RCCAs were the primary options for permanent housing, but at levels of service that were unnecessary for many people. Apartment Treatment Community Residences, on the other hand, offered the desired less intensive services, but only on a temporary basis.

Furthermore, compared to these licensed programs, Supported Housing was—and continues to be—a relatively low-cost program. Even after the licensed programs became 'Medicaid-ed' in the early 1990's, the unlicensed, un-'Medicaid-ed' Supported Housing program was and still remains more cost effective. It also has the added benefit of providing greater consumer choice and a more appropriate continuum of care.

The original program guidelines recommend seeking local, federal or other state sources for housing funds; the Supported Housing dollars were merely intended to supplement those scarce alternative sources. While the use of alternative funding sources continues to be encouraged, OMH has implicitly recognized its role as the primary funder of Supported Housing.

It is important to note that, despite an initial reluctance to provide large-scale housing, OMH eventually came to embrace this role. Supported Housing is now a central pillar of OMH's treatment strategy for the entire continuum of care. By the end of FY2002, OMH anticipates nearly 10,000

Supported Housing beds statewide—more than twice the total number of beds used in the system of State Psychiatric Centers.[*] Part of the reason for this is that Supported Housing filled an important gap in the continuum of care. Once publicly available, it was quickly utilized by a service sector and a State agency eager to provide permanent housing.

The current crisis: rising rents and a static contract

By and large, the community behavioral healthcare sector has had tremendous success in providing Supported Housing beds to their clients, offering a much desired and necessary service that facilitates choice and maximizes independence. In recent years, however, providers have faced skyrocketing rents in an aggressive rental housing market.

Nevertheless, OMH has only responded erratically, instead continuing to fund beds at levels that are not significantly higher than those set a decade earlier. This is the major issue facing Supported Housing. Agencies contracted by OMH, particularly those in New York City, have been operating their programs on funds that are grossly inadequate. At the current levels, providers are barely able to cover the costs of the rental subsidy and have little left over for the services necessary to help their clients retain the housing and achieve stable, independent lives.

Sadly, agencies have had to use emergency financing tactics where they must now

	Percentage Rent Increase for Length of Lease			
Year	1 year	2 year	2 year*	
90-91	4.50%	7.00%		
91-92	4.00%		6.50%	
92-93	3.00%	5.00%		
93-94	3.00%		5.00%	
94-95	2.00%	4.00%		
95-96	2.00%		4.00%	
96-97	5.00%	7.00%		
97-98	3.00%		4.00%	
98-99	3.00%	4.00%		
99-00	3.00%		4.00%	
00-01	4.00%	6.00%		
An increase of:	43.14%	37.82%	25.79%	
An apartment rented for $550/month in 1990 would now cost:				
Lease Renewal Schedule	Annually	Biennially	Biennially*	
	$787.27	$758.04	$691.83	
*calculated beginning in 1991 because of the two-year cycle.				

[*] *Progress Report on New York State's Public mental health system*, The State Office of Mental Health Center for Performance Evaluation and Outcomes Management, Chip. J. Felton, Associate Commissioner, January 2001

tolerate high client to case manager ratios, place clients in apartments located far from central program offices, or even freeze salaries of direct service staff already burdened with higher caseloads. Many agencies engage in all three practices—merely because costs have so outpaced contract rates. Furthermore, many agencies have begun to draw upon agency operating reserves to cover service costs simply to keep clients in housing. As demand for scattered site housing continues to rise, providers committed to serving the needs of people with mental illnesses have chosen to sign contracts for new supported housing beds, accepting possible financial losses due to the exorbitant costs of rental housing.

Coupled with a clientele that is increasingly needy, the emergency funding has had a direct impact on the services available for consumers. Among other effects, this has led to less frequent contact with case managers and overall reduced access to services. Mental illnesses often lead to feelings of psycho-social isolation which is further exacerbated by the decreased accessibility of the case managers. The remote locations can also lead to geographic isolation. In short, these factors can lead to higher risks of substance abuse, decompensation, and loss of housing.

Rising rents in the New York City rental housing market

At the time of the original RFP for Supported Housing in 1990, OMH calculated the per client annual funding amount of $9,500 based on a monthly rent expense of $550. With $120 paid for by clients through monthly SSI checks, the total share of rent covered by the state, amounted to $430 per month or $5,160 per year. The remaining a total of $4,340 per client per year then had to cover the costs of services. While funding levels at the time were adequate to cover both rent and service costs, OMH has not adjusted its funding to levels that meet the rising costs of rental housing in New York City.

According to the New York City Rent Guidelines Board, which sets rates of increase for apartments subject to Rent Stabilization Law, an apartment rented for $550 per month would today cost $787. *In other words, rents for apartments that are rent stabilized have increased by over 43% over the past ten years.* Moreover, since most apartments are not subject to the Rent Stabilization Law and have rents at much higher rates, these figures tend to understate the actual rise in rents in New York City.

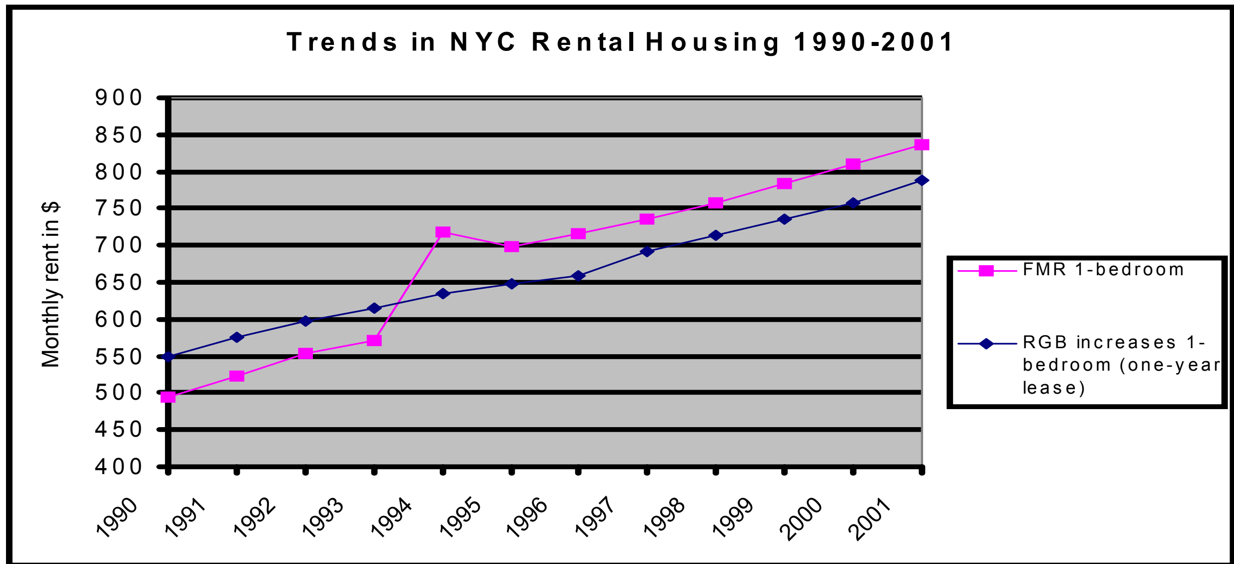
The HUD-defined Fair Market Rent (FMR) for New York City presents an even more telling story. FMRs, which are used by HUD to determine allowable rent levels for Section 8 rental assistance, are rent estimates based upon data collected from the national Census, the American Housing Surveys, and random digit dialing telephone surveys. Where appropriate, the data is grouped with multiple counties to define a Primary Metropolitan Statistical Area (PMSA). In 1990, the FMR for a two-bedroom apartment in the New York City PMSA was set at $593 per month or $7,116 per year. *The most recent FMR for a two-bedroom apartment in New York City is set at $949 per month or $11,388 per year, a ten-year increase in rents of 60%.*[*]

Data on real rent costs collected from agencies in New York City that currently operate Supported Housing beds under OMH contracts reveal that average rents for apartments leased with Supported Housing contracts are $664 per month per client or

[*] HUD's datasets for historical FMRs contain only data for 2-bedroom apartments. The chart above compares FMRs for a 1-bedroom apartment and a 1-bedroom rent-stabilized apartment in New York City for the years 1990-2001. FMRs for 1-bedroom were extrapolated using 2-bedroom increase rates as applied retroactively to 1-bedroom rents for 2001.

$7,968 per year. This number is slightly lower than the FMR for one-bedroom apartments since it averages rents for efficiency studios as well as one-bedroom apartments. Also hidden by this figure is the difficulty with which these apartments were found in a housing search, the location of apartments, and the range of rents paid by agencies. Some providers have reported per client rent payments of up to $1,150 per month! Others have been able to find "deals", but only in locations far from central offices, thus reducing clients' ability and likelihood of accessing services.

The Rent Guidelines Board recently announced the authorized increases for stabilized and controlled apartments as 4% and 6% which will take effect in October of 2001. The steep rise in costs for providers continues to accelerate unabated.



Provider subsidies to the program

In today's rental housing market, providers are often left with substantially reduced funding for services after first making rental payments. With an average rental payment of $7,968 per client per year, and an SSI contribution of $2,160 per year ($180 per month), providers–allocated $9,832 as they were in the RFP initially released by OMH in the fall of 2000–were left with only $4,024 for services per client per year or approximately $335 per month. For many clients, whose rent costs exceed $700, funding available for services is even lower.

Using rent increase rates defined by the New York City Rent Guidelines Board, an apartment rented at OMH's originally assumed rate of $550 per month would now cost $787 per month. By today's standards, with an SSI contribution of approximately $180 per month, the state contribution should be $607 per month or $7,284 per year. Assuming the same ratio of service provision to rent, the total contract today should provide a funding amount of $13,414.

Realistically, though, rent increases have outpaced the increases in costs for client services. Indexing the cost of the case manager to the Consumer Price Index over this same period, the $4,340 cost of services in 1990 would be equal to $5,536 today. Adding this to the current rent costs, the state should be offering $12,820 per bed per year for all Supported Housing contracts—simply to maintain the same level of services as in

the original contract.

In order to cover this difference, providers have scrambled to draw upon other sources of income. Many have resorted to funds from private sources—charitable foundations and non-profit intermediaries. Sadly, many have exhausted the very contingency funds that were designed to help fight the evictions numerous consumers now face. In the worst cases, providers have had to draw upon agency operating reserves to cover costs of case management and other services. Such "patchwork" funding tactics have proved to be only temporary solutions. And as current market conditions continue the trend towards higher costs—both for rents and for supportive services—the financial crisis for providers will only become worse.

The requests for proposals from Fall 2000

Despite years of quiet protest about the low funding rate and the slow creep of supportive services dollars into rental subsidies, providers have continued to accept new contracts. In early October 2000, OMH issued an RFP for additional Supported Housing beds at a funding rate of $9,832 per bed per year. This rate made no provisions for the drastic increases in rent costs since the program's inception and would have led directly to either such drastic cuts in case management as to jeopardize consumers' ability to retain housing, or financial hardship for providers. Faced with few if any actual responses to their RFP and a bevy of letters describing in detail the inability of the proffered funds to cover the operating costs of the program, OMH had to change something.

Eventually, the State Office of Mental Health withdrew the original RFP and reissued it with the addition of $1,080, for a new rate of $10,912 per bed per year. Even though it was significantly short of the $12,820 calculation from the trended rates, this adjustment was a significant step in the right direction. Providers were heartened by this adjustment and the State's attention to the program. Despite the fact that the funds remained below true costs, OMH began to receive proposals from providers who were committed to the needs of consumers and who hoped that the State would eventually come through with realistic remuneration.

A proposal for fiscal 2002

In January of 2001, Governor Pataki proposed important increases for the existing Supported Housing beds that were still funded at close to their original rates. Effectively, this would raise the funding level to the one set by the RFP re-issued in November 2000. Fortunately, this increase was supported by both the Senate and the Assembly and included in the recent passage of the 'austerity budget'. At a cost of $5.2 million, this one-time fix represents a serious step towards repairing the base of the Supported Housing program. Nonetheless, the absence of a forward adjusting trend linked to rent costs remains a serious oversight and represents a major obstacle to the long-term stability of the program

As it is, these increases will come at the last possible moment: throughout New York City and other locales, there have been on-going attempts to evict consumers. While essential, these rate adjustments fail to protect consumers and providers from future rent hikes and the eventuality of eviction proceedings. In the absence of future increases, landlords will be satisfied for the time being only.

The lack of a trended increase will ultimately create a situation in which the rehabilitation and recovery of consumers is seriously threatened. This contravenes the program's intent to establish a stable, permanent housing option for people with mental illnesses. This, in turn, will impact consumers' ability to function on a day-to-day basis and

may in fact, force many formerly homeless consumers to return to the shelters and streets.

In order to maintain the viability of Supported Housing, OMH must redesign the funding formula in such a way that it increases annually to reflect real rent increases—perhaps through the use of an independent index like HUD's Fair Market Rents or even the increase caps determined by the Rent Guidelines Board.

If the problem is not solved today, the future of Supported Housing will only be more grievous. Whereas the eviction papers served to consumers this year numbered in the tens, the next round will surely be higher—perhaps even the hundreds: by the end of 2002 there will be 9,869[*] Supported Housing beds state-wide. With more than 4600 beds in New York City already, it is reasonable to conjecture that most will be vulnerable to the volatile real estate market in our city. The absence of a trended rate increase may very well plunge the majority of Supported Housing residents into the self-same eviction proceedings they are narrowly escaping today.

Supported Housing is an important program for many people with mental illnesses and, without a doubt, the future modality through which OMH will provide residential services.

That Supported Housing will play a substantial role in the near future was further borne out in May 2001 with the release of a study by Dennis Culhane at the University of Pennsylvania's Center for Mental Health Policy and Services Research. This study compared cost of housing for people with mental illnesses in New York City to the cost of services to the homeless and found that New York/New York[§] housing reduced the State's expenditures for services by more than $16,000 per bed per year[‡]. At a current cost of $10,912 per bed, Supported Housing is significantly less expensive—even including a buffer to cover the cost of additional, scalable services and a trend factor for years to come.

Supported Housing is a program that is elemental to the well being of numerous New Yorkers with mental illnesses. With services that can meet a variety of needs, it functions as the stable foundation upon which the long road to recovery and rehabilitation is based. Providing this vital program with a trended adjustment to cover rent increases will eliminate the threat of eviction for consumers and providers. People with mental illnesses deserve stability in their lives, and properly funded Supported Housing can give it.

[*] *Progress Report on New York State's Public mental health system*, The State Office of Mental Health Center for Performance Evaluation and Outcomes Management, Chip. J. Felton, Associate Commissioner, January 2001

[§] The New York/New York (NY/NY) funding stream was a partnership between the State of New York and the City of New York which was designed to alleviate homelessness. Through two agreements, 4,679 individuals with serious mental illnesses were served between 1989 and 1997[‡]. Accompanied by certain eligibility requirements, this funding line created supportive housing under a variety of models—of which nearly 1000 units were Supported Housing.

[‡] Culhane, Dennis P., Stephen Metraux, and Trevor Hadley. May 2001. "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Ulitization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative" Center for Mental Health Policy and Services Research, University of Pennsylvania. Pre-publucation draft.