

Community and Choice

Housing Needs for People with Disabilities in Delaware

Executive Summary



**Delaware Housing Coalition
and
Housing Sub-Committee of the Governor's Commission on Community Based
Alternatives for People with Disabilities and State Council on Persons with Disabilities**

April 2012

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A LETTER FROM THE STUDY WORKING GROUP

With this report, *Community and Choice: Housing Needs for People with Disabilities in Delaware*, the state's affordable housing and disability communities culminate the first stage of a continuing effort to better understand the scope and nature of the housing needs for people with disabilities in the state, in order to provide more effective and appropriate responses.

The Housing Sub-Committee of the Governor's Commission on Community Based Alternatives for People with Disabilities and the State Council for Persons with Disabilities joined with the Delaware Housing Coalition over the past many months, making use of a renewed and enhanced sub-committee to serve as a working group for this report. Because the need is multifaceted and the data scattered, we have been engaged in an effort that has had many challenges. However, that is exactly why a workgroup of this sort was needed.

Among the estimated 108,500 people with disabilities in the State of Delaware, incomes are typically lower than among those without disabilities, with a higher overall percentage in poverty or at risk of falling into poverty, and a much higher need for housing assistance. The need for accessible, affordable housing is a major barrier to people with disabilities living in the community, and housing needs severely limit the options of people with disabilities choosing to live in the least restrictive setting of their choice. Independence, choice, and integration are critical and still overlooked issues which must be factored into the consideration of housing needs for people with disabilities.

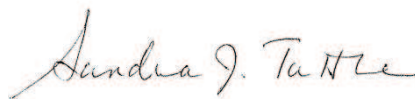
There are many changes afoot which have promise of leading to better and more appropriate housing solutions for people with disabilities in Delaware. We have tried, along with the articulation of the need, to accurately describe some of those potential solutions. Our recommendations, organized by the areas of accessibility, affordability, community, and systems provide an outline of them.

We will continue to act, via the Housing Sub-Committee, to develop proposals and policies toward implementing such solutions. We will also work through the three-year statewide comprehensive community-based housing planning initiative, now in mid-course, that was begun by the Homeless Planning Council and the Delaware Housing Coalition, in order to raise the housing needs of people with disabilities to the level of a standard consideration in state and local planning.

We welcome your partnership in making the housing needs of people with disabilities better and more widely understood and encourage your participation in, and support of, our ongoing efforts.



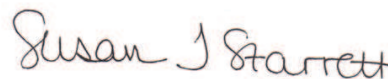
Daniese McMullin-Powell, Co-Chair
Housing Sub-committee



Sandra Tuttle, Co-Chair
Housing Sub-committee



Ken Smith, Executive Director
Delaware Housing Coalition



Susan Starrett, Executive Director
Homeless Planning Council of Delaware

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INTRODUCTION: THE NEED FOR A FRESH REVIEW

There are an estimated 36.4 million people with disabilities in the United States, and 108,500 people with disabilities in the State of Delaware. An additional approximately 4,600 people in Delaware live in nursing facilities and are excluded from these numbers, though many likely have disabilities. In Delaware, 11% of adults aged 18-64 and 31% of adults over 65 have a disability. As the population ages – with 30% of Delaware’s population projected to be over 60 by 2040 – the number of Delawareans with disabilities will only increase.

People with disabilities typically have lower incomes than those with no disabilities, are far more likely to be in poverty, and are more likely to need housing assistance. People with severe disabilities that interfere with their ability to work or with activities of daily or independent living are even more likely to be in poverty, an estimated 26% compared to 17% of all people with disabilities and 10% of people with no disabilities. An estimate for Delaware produced for this report suggests there are likely at least 4,600 nonelderly very low income renter households with both disabilities and severe housing needs in Delaware – households in need of rental assistance. The need for accessible, affordable housing is a major barrier to people with disabilities living in the community, and housing needs severely limit the options of people with disabilities to live in the least restrictive setting of their choice.

In the mid-2000s, the Housing Sub-committee of the Governor’s Commission on Community Based Alternatives for People with Disabilities developed a strategic plan (one part of the overall strategic plan of the Commission) to improve affordable housing opportunities for persons with disabilities and remove this major hurdle to independent living and a community based model of care. The lack of clear, reliable data on the scope of housing needs among people with disabilities in Delaware was a challenge even then.

Despite several steps forward and new information, the state’s housing and disability communities have still struggled with the need to better understand the scope and nature of the housing needs of people with disabilities in Delaware in order to provide appropriate responses. With multiple unique subpopulations, each with distinctive needs and their own network of service providers, advocates, and data sources, simply assembling the information that is available into a coherent whole is itself demanding.

To revisit this topic, the Housing Sub-Committee and the Delaware Housing Coalition joined together to make use of a renewed and enhanced sub-committee to serve as a working group, which held its first meeting in February 2011. The Housing Sub-Committee’s leadership worked to ensure participation, encourage wide collaboration in the work, and provide guidance and insight. Delaware Housing Coalition facilitated the study and implemented the work plan (data gathering, research, analysis, report). Through the working group model, the sub-committee collected data, conducted focus groups and interviews, collectively reviewed research products, and discussed and refined the study’s recommendations. The Delaware State Housing Authority (DSHA) provided assistance with data collection, research and analysis. The various divisions of the Department of Health and Social Services (DHSS) provided data, input and feedback on the report.

To improve the availability of affordable and accessible housing for people with disabilities in Delaware, the working group offers four broad recommendations:

- **Accessibility:** Increase the availability of and access to rental and homeownership opportunities with accessibility features;
- **Affordability:** Increase the availability of and access to affordable housing for people with disabilities;
- **Community:** Build a community-based system of care with a range of housing options; and
- **Systems:** Improve the affordable housing and disabilities services systems that serve people with disabilities.

A full report with extensive information on housing needs and a more complete discussion of the recommendations is available online.

As Delaware’s housing and disabilities services systems work to prioritize community care and settings for people with disabilities, we should be able to serve more people, better, with fewer resources – hopefully allowing these systems to begin to absorb the natural increases in people needing assistance. However, many different pieces must come together for successful transitions to community care to work, at the individual, agency, and system levels.

ACKNOWLEDGEMENTS

Governor's Commission on Community based Alternatives for People with Disabilities: Housing Sub-committee

Sandy Tuttle, Co-Chair

Daniese McMullin-Powell, Co-Chair

PARTICIPATING ORGANIZATIONS

Arc of Delaware	Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
City of Dover	Division of Substance Abuse and Mental Health (DSAMH)
City of Wilmington	Dover Housing Authority
Community Legal Aid Society, Inc. (CLASI) Disabilities Law Project	Federal Home Loan Bank of Pittsburgh (FHLB)
Connections CSP	Homeless Planning Council of Delaware
Delaware Division of Human Relations	Independent Living Council
Delaware HIV Consortium	Milford Housing Development Corporation (MHDC)
Delaware Housing Coalition	Ministry of Caring
Delaware State Housing Authority (DSHA)	NAMI Delaware
Department of Services for Children, Youth and their Families (DSCYF)	National Multiple Sclerosis Society / DE Chapter
Developmental Disabilities Council (DDC)	New Castle County
Division of Developmental Disabilities Services (DDDS)	State Council for Persons with Disabilities (SCPD)
Division of Long Term Care Residents Protection (DLTCRP)	United Cerebral Palsy of Delaware
Division of Medical and Medical Assistance (DMMA)	Wilmington Housing Authority
	WSFS Bank

REPRESENTATIVES

Carol Barnett, DSAAPD	Daniese McMullin-Powell, DMMA
Vince Boehm, Developmental Disabilities Council	Don Moore, United Cerebral Palsy of Delaware
Lisa Bond, DSAAPD	Meghan Morgan, DDDS
Darlene Bonney, Ministry of Caring	Anne Mountain, Ministry of Caring Bethany House
Merton Briggs, NAMI Delaware	Vincent Petroff, Delaware Human Relations Commission
Dave Buches, Federal Home Loan Bank	Renee Purzycki, DLTCRP
Carrie Casey, New Castle County	Paul Reynolds, New Castle County
Dianne Casey, DE HIV Consortium	Al Rose, Developmental Disabilities Council
Chris DiSanto, Connections CSP	Eugene Rudder, Wilmington Housing Authority
Vincent Garlick, New Castle County	Stacie Shriver, DDDS
Marlena Gibson, Delaware State Housing Authority	Jo Singles, Support Staff, SCPD
Brian Hartman, CLASI, Disabilities Law Project	Michael Skipper, WSFS Bank
Tracey Harvey, City of Dover	Bobby Smith, Dover Housing Authority
Kyle Hodges, State Council for Persons with Disabilities	Ken Smith, Delaware Housing Coalition
Carlyle Hooff, DSAMH	Susan Starrett, Homeless Planning Council of Delaware
Cliffvon Howell, DSAMH	Fred Traute, MHDC
Joe Hughes, DSAMH	Debra Veenema, National Multiple Sclerosis Society / DE Chapter
Yolanda Jenkins, DSCYF	Vaughn Watson, City of Wilmington
Patricia Kelleher, Arc of Delaware	
Lottie Lee, DSAAPD	

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Michelle Carre, Delaware Apartment Association	Wendy Nurse, DSAMH
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Bea Chesaroni, New Castle County Department of Community Services	Renee Purzycki, DLTCRP
Meagan DeCrappeo, National Low Income Housing Coalition	Stacey Slacum, USDA Rural Development
Bob Goodhart, Division for the Visually Impaired, DHSS	Melissa Smith, DSAMH
Kyle Hodges, SCPD	Valerie Smith, DDDS
Cliffvon Howell, DSAMH	Susan Starrett, Homeless Planning Council of Delaware
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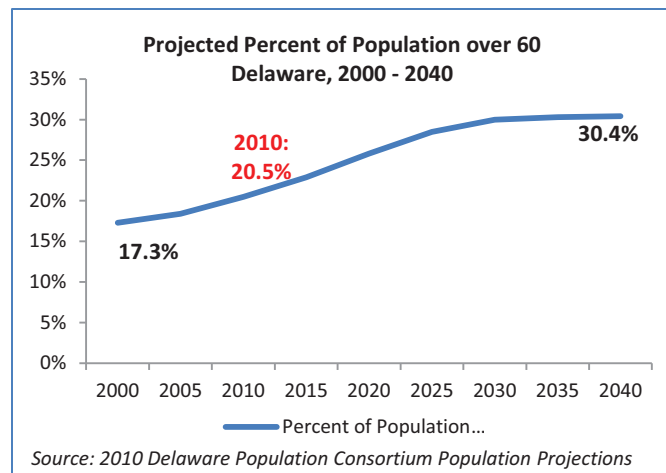
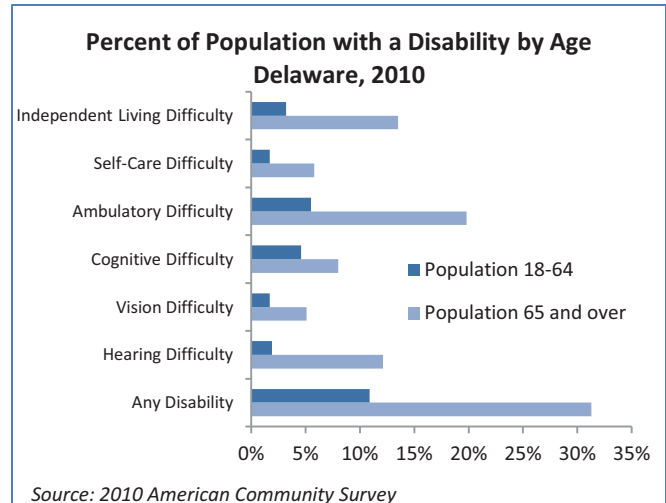
DELAWAREANS WITH DISABILITIES

There are 36.4 million people with disabilities in the United States, or 11.9% of the population; in Delaware, 12.3% of the population (108,444 Delawareans) is estimated to have a disability.¹ People living in institutions are excluded from these estimates: an additional 4,591 people were living in nursing facilities or skilled nursing facilities in Delaware in 2010. Older people are far more likely to have a disability: 31% of individuals 65 or over report one or more disabilities, compared to 11% of those aged 18-64 and 4% of those under 18.

An important measure that cuts across disability populations and is indicative of more severe disabilities is activities of daily living (ADLs) and instrumental activities of daily living (IADLs). People with difficulty completing activities of daily living may need supportive services to assist with these activities. “Self-care difficulty” includes personal care like dressing and bathing, and “Independent Living Difficulty” includes difficulty doing errands alone like shopping or visiting a doctor’s office. In Delaware, an estimated 18,375 people (2.2% of population) have difficulty with self-care and 36,108 (5.4% of population) have difficulty with independent living.

People who need assistance with ADLs or IADLs are likely to need personal support, either from a family member or other personal caregiver, or supportive services arranged from another provider. Older individuals are more likely to have difficulty with self-care and independent living, with 14.5% of the population over 65 (17,748 people) in Delaware needing assistance with independent living activities.

The number of people who will need this sort of assistance is only projected to grow in the coming years. As the population ages, higher rates of disability among older age groups will slowly increase the overall percentage of the population living with a disability: the number of individuals with disabilities will grow faster than the population as a whole. From 2010 to 2040, the percent of Delaware’s population over 60 is projected to increase from 20% to 30% of the population.² While the overall population in Delaware is projected to increase about 16% from 2000 to 2040, the population over 60 will increase 150%. Using rates of disability from the American Community Survey and population projections, the percent of the population with any disability is projected to increase from 13% of the population in 2010 to 16.8% of the population in 2040.³



LONG-TERM POVERTY

For many people with disabilities, challenges to employment and the need for federal income supports with low earnings and asset limits create a cycle of long-term poverty which is difficult to escape. Efforts to improve their employment opportunities or build assets are often thwarted by low earnings and asset limits for vital programs like SSI and SSDI, and many employment opportunities do not offer enough earnings potential to fully replace these programs.

It may be challenging for people with disabilities to acquire and maintain employment. When they are employed, it is more likely to be on a part-time basis and/or in lower-income occupational groups, and those in the labor market are far more likely to be unemployed. Only 1/3 of workers with a disability are employed part-time, compared to about 1/5 of those with no disability.⁴ In Delaware, an estimated 35% of people with a disability aged 16 – 64 participate in the labor force, compared to 78% of the same age group with no disability. Those who are in the labor force are more likely to be unemployed, at 15.6% in 2009 compared to 9.2% of people without a disability.⁵

The 2008-2010 ACS estimated that people with a disability in Delaware had median annual earnings of \$20,331, compared to \$31,991 for people with no disability. Given the challenges to securing and maintaining employment, especially employment that would provide for self-sufficiency from federal income support programs, people with disabilities are much more likely to live in poverty. In Delaware, 16.7% of all individuals with a disability were estimated to have poverty level income, compared to 10.5% for those with no disability.⁶ This split is even greater for working-age people with disabilities (18-64): the poverty rate for this group is 19.7%, compared to 8.9% for working-age individuals with no disability.

Table 1: Poverty Rates and Median Earnings by Disability, Delaware, 2008-2010

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

Poverty-level income itself is an inadequate measure of material hardship and need, as the level is so low: the federal poverty threshold for one person in 2009 was \$11,161 (those under 65; for those over 65, \$10,289)⁷. A family or person may have double that income and still face serious housing and other needs. In Delaware, almost 40% of people with disabilities have income below 200% of the poverty level, and they make up about 19% of those in poverty in Delaware.⁸

Among those who are homeless, about 35% of whom have a disability, incomes are often so low as to be practically negligible. The 2011 Delaware Point-in-Time study showed that 43% of individuals surveyed who were homeless had no income whatsoever, and 25% had income of less than \$500 a month⁹. Many of these individuals count state General Assistance (approximately \$90 a month) as their only income. Overall, 68% of individuals surveyed reported income of less than \$500 per month.

People with disabilities may need to rely on Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) as their main source of income. In Delaware, the Social Security Administration (SSA) reports that 9,253 non-elderly adults with disabilities received SSI benefits in 2009.¹⁰ This works out to an annual income of just over \$8,000, well below the 2009 federal poverty threshold of \$11,161. As a percent of the median income, SSI is 17% of the one-person median income for Delaware.

Research has also found that people with disabilities are far more likely to experience long term poverty (36 months or more of poverty-level income), and those in long-term poverty are far more likely to have disabilities, especially disabilities of long duration. Costs for transportation, medical care, and assistive technology all make low income an even greater barrier to living independently in the community.

Poverty-level income is compounded by higher costs for services, especially health care expenditures, resulting in much higher rates of material hardships among people with disabilities in poverty. Material hardships include food insecurity, hunger, or not getting needed medical care. People with more severe disabilities are even more likely to experience material hardship, even among people with income below poverty level.

Low asset limits in critical federal income support programs may also contribute to long-term poverty as they create barriers for people with disabilities to save and to make investments that may improve their circumstances long-term, including education, assistive technology, transportation and homeownership. Current asset limits for Supplemental Security Income, for example, have not been raised since 1989, at \$2,000 per person or \$3,000 per couple. While other important programs' eligibility and asset limits are controlled by states (for example, Medicaid and Supplemental Nutrition Assistance Program (SNAP)), low asset limits in these key federal programs remain a major barrier. Delaware has eliminated asset tests in its Medicaid and SNAP (food stamp) programs.

In Delaware, almost 40% of people with disabilities have income below 200% of the poverty level.

People with disabilities make up 19% of those in poverty in the state.

CUT OFF FROM THE FINANCIAL MAINSTREAM

Low-income people face barriers to accessing the financial mainstream, and these may be even more pronounced for people with disabilities with the additional challenges they may face with transportation, communication, and accessibility. A 2007 survey of taxpayers with disabilities found that 30% reported no savings or investments at all, compared to 12 percent of taxpayers without disabilities.¹¹ The IRS estimates that \$1 billion in Earned Income Tax Credits (EITC) refunds annually go unclaimed by taxpayers with disabilities nationally. They are also less likely to even have a bank account: a Government Accountability Office (GAO) report found that more than half of Supplemental Security income (SSI) payments were made by check principally because the recipients did not have a bank account for direct deposit.

There are numerous links between disability, especially severe disabilities, and unemployment, low earnings, poverty, and material hardship. People with disabilities, particularly severe disabilities, are especially likely to be in poverty long-term. Asset limits for critical income support programs remain low, further inhibiting the ability of people with disabilities to build assets. For many households, homeownership is the most tangible opportunity to develop assets. People with disabilities may also benefit from investing in assistive technology, which can be

expensive depending on their needs; modifications to a home they already own; purchasing a vehicle with modifications; or being able to invest in education, starting a small business, or homeownership. Asset-building programs have gained momentum as a strategy to help people escape poverty but often do not consider the unique needs of people with disabilities.

HOUSING CHALLENGES FOR ALL DELAWAREANS

The ongoing recession and persistently high unemployment hit lowest income households earliest and hardest, in an environment where the largest employment growth was already among lower-wage jobs in lower-wage industry sectors. The foreclosure crisis has also put upward pressure on rents as millions of households, with battered credit, lost savings and often unemployed, return to renting in a housing market that had added little multifamily rental stock through the homeownership boom years. Decreases in home prices are of little help to the most vulnerable households. HUD's *Worst Case Needs* report shows a surge in worst case needs from 2007-2009; in this same time period, there was no increase in housing assistance proportionate to the surge in very low-income renters.

Fair market rents for a 2 bedroom apartment in Delaware range from \$750 in Sussex County to \$1,077 in New Castle: nowhere in the state can an individual earning minimum wage afford even an efficiency (0 bedroom) apartment. The National Low Income Housing Coalition (NLIHC) estimates that 54% of renters in Delaware cannot afford the fair market rent on a 2 bedroom apartment.¹² An estimated 42% of Delaware's renter households have income below 50% of median (very low income).¹³ Of these 36,150 households, 75% (27,130) are cost burdened (paying more than 30% of their income for housing) and 48% are severely cost-burdened (paying more than 50% of their income). Among the state's poorest households (<30% of median), 62% (12,845 of 20,570) of renter households are severely cost-burdened. These households are the state's most vulnerable, most precariously housed and at risk of homelessness.

62% of extremely low-income renter households in Delaware (12,845 households) are severely cost-burdened: paying more than 50% of their income for housing.

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

In Delaware, as in the nation, there is a universal scarcity of housing assistance for the most vulnerable households. Statewide, approximately 25% of households on public housing authority (PHA) waiting lists for public housing and Housing Choice Vouchers are either elderly or include a person with a disability. There are approximately 25,000 families on PHA waiting lists and waiting lists for privately owned affordable sites.¹⁴

FOCUS GROUP FEEDBACK

From April – May 2011, the study working group hosted six focus groups to gather feedback from consumers and others to inform this report. Groups included: Aging and Physical Disabilities; Intellectual/Developmental Disabilities; Substance Abuse/Mental Health; HIV/AIDS; Housing Developers and Service Providers; and Foster Youth.

Volunteer facilitators asked a series of general open-ended questions about housing for people with disabilities, barriers to housing, the housing system in Delaware, and sources of information about housing. There was also opportunity for open discussion. The groups were generally very well attended and included many consumers as well as advocates and service providers. The groups proved a valuable source of information for the report and provided feedback that influenced the review of needs but especially the report’s recommendations.

In Delaware’s housing system and the housing system for people with disabilities, focus group participants reported seeing a lack of coordination, and the systems that are exceedingly difficult to navigate. Multiple waiting lists and confusing and varying eligibility criteria were particularly noted. While participants frequently commented that the existing subsidized housing for people with disabilities is incredibly valuable and improves the housing situation and security of many with disabilities in Delaware, the system also does not acknowledge the importance of integration as well as accessibility and affordability.

In regards to accessing information about housing, a frequently repeated comment in almost all focus groups was the fragmented system for information: there is no one person or place to explain all the options and point people in the right direction the first time. People frequently just get a barrage of phone numbers and lists of organizations to sort through on their own. Luck and word of mouth from others often finally connect people to the programs they need and are eligible for. Persistent stigma associated with disabilities, especially HIV/AIDS and substance abuse and mental health disabilities, was noted as a major barrier as housing discrimination and source of income discrimination continue. The critical need for subsidies, either project-based or tenant-based, to reach extremely low incomes was a strong point among developers and service providers.

Some common items noted in response to a question about what could be done differently in Delaware included:

- **Increase options** – there should be a full continuum of housing opportunities. There is a lack of new options and housing initiatives in Delaware, and some creative options have not been explored.
- **Improve coordination** among PHAs to benefit consumers, especially unifying and opening waiting lists. Accessing, getting on and monitoring multiple waiting lists and policies are major challenges.
- **Aging in Place** - Think more broadly and strategically about “aging in place” and increasing general (and perceived) demand for universally designed/adaptable/visitable homes. We tend to think about it in terms of helping people remain in the homes they have via modifications and services, but we must also think about aging in place in terms of creating housing that is designed to facilitate aging in place.
- **Matching people to units** – Managers report that they have difficulty filling accessible units; consumer advocates report that they cannot access accessible units. Access to real-time information on available units with accessibility and other detail is needed, as is a steady stream of referrals if units are set-aside.
- **Transportation** – transportation and isolation can be major challenges in more rural areas for group homes and all community housing situations.

Finally, three major themes across all the groups were:

- 1) Accessibility and the supports required to live in the community are fluid and unique to the individual. A range of responses is required to meet a range of needs: different age groups, different combinations of needs, different levels of services needs, different living situations;
- 2) Choices for consumers should include a variety of housing settings and situations. Congregate or clustered settings with peer support and independent apartments with tenant-based rental assistance should both be options. People must have meaningful choices: to live independently, with family, with roommates, etc. Choices are meaningful when all are realistic, feasible options with sufficient supports and are consistent with the ADA's integration mandate.
- 3) Moving to living independently can be a major adjustment for individuals too, with new responsibilities, new concerns, and household needs. Supporting people to transition to or remain in the community is not as simple as just getting them into housing, but providing long-term support and ensuring that housing and services are designed in such a way as to make living in the community realistic, sustainable, and beneficial to the consumer.

BARRIERS AND RECOMMENDATIONS

Through the collection of national and state data and the qualitative feedback from the focus groups, the working group identified four major areas (Accessibility, Affordability, Community Care, and Systems) where there are barriers to housing for people with disabilities in Delaware and recommendations to address and improve each.

ACCESSIBILITY

There is a substantial gap between the need for and supply of accessible homes. This gap is a barrier to ensuring that people with disabilities can live and receive services in their homes and communities. Even though the majority of people say they wish to remain in their homes and communities as they age, most single-family homes are still built with little to no accessibility features. Many who need accessibility features do not have them, and this will surely remain the case as the population ages and most new housing is still not built to facilitate accessibility. The lack of accessible housing means some people unnecessarily remain in institutions and others who live without needed accessibility features may be at increased risk for falls and injuries that may lead to institutionalization.

A complex web of overlapping statutory and regulatory provisions govern accessibility requirements, especially for publicly funded projects. Most requirements for accessibility are applied only to multifamily or multifamily rental housing. All multifamily projects, regardless of funding source, are required to meet the accessibility standards outlined in the Americans with Disabilities Act (ADA) of 1990, which provides for accessibility in public accommodations and commercial facilities. Public accommodations includes all new construction effective January 26, 1993 and impacts any rental office, model unit, public bathroom, building entrances, or any other public or common use area.

What do we mean by “accessibility”?

Accessibility in housing can range from some basic features to full accessibility. Ultimately, accessibility is unique to the person in the home and the specific features he or she needs.

In this report, “**full accessibility**” means that a unit is built to meet all requirements for an accessible unit as set by a national standard (usually ANSI). These features should allow full use of a unit by most people with disabilities.

“**Basic access**” includes the most basic features to allow someone with a mobility disability to enter and have basic use of a home: one no-step entrance, 32 inch door clearance through the first floor, and at least a half-bathroom on the first floor with clearance for a wheelchair. This is also sometimes referred to as “visitability”. Basic access features are far less costly when built into the design of a home when it is constructed and make it easier to adapt the home for long-term use.

“**Universal Design**” is an approach to design that incorporates products, building features and elements which, to the greatest extent possible, can be used by everyone. This generally includes basic access features above and may include others, such as lever door handles, faucets and switchplates, and a covered no-step entry, for example.

ACCESSIBLE ASSISTED RENTAL HOUSING

Section 504 requires that 5% of sites with public funding or financing be fully accessible. Sites constructed since the enactment of the FHAA in 1991 are also subject to its requirements for basic accessibility in all first-floor and elevator-accessible units in multifamily sites. Understandably, the numerous standards can lead to some confusion in the general housing community about the definition of accessibility.

We have little information about the number of accessible housing units. Some limited estimates about the potential number of accessible multifamily rental units are available, but nothing on single family homes, regardless of tenure. Statewide, an estimated 234 privately owned assisted affordable rental units are fully accessible. This information is unfortunately unreliable. Some older sites may have fewer than 5% of accessible units, and accessible units in older sites may also not meet current accessibility standards. When sites are fully rehabilitated using the LIHTC or other programs, they are brought up to current accessibility requirements and standards. In addition, numerous sites, especially ones built more recently, may have units that are not fully accessible but do include some accessibility features. As this is not required, the number of these units is far more difficult to track. An estimated 850 units in Delaware’s assisted housing stock have some other accessibility features.

Table 2: Estimate of Accessible Assisted Rental Units, Delaware, 2010

	Accessible Units	Units	Percent
Fully Accessible Units			
Public Housing – Fully Accessible (Actual units)	119	2,702	4.4
Assisted Rental Housing – Fully Accessible Units (estimate)	234	11,331	2.1
<i>Subtotal – Fully Accessible Units</i>	<i>353</i>	<i>14,033</i>	<i>2.5</i>
Units with Some Accessibility Features			
<i>Assisted Rental Housing – Some Accessibility Features (estimate)</i>	<i>854</i>	<i>11,331</i>	<i>7.5</i>
Total – Fully Accessible Units and Units with Some Accessibility Features	1,207	14,033	8.6
<i>Sources: Analysis of Impediments to Fair Housing Choice, July 2011, and Delaware State Housing Authority</i>			

ACCESSIBLE MARKET-RATE OR UNASSISTED RENTAL HOUSING

Accessibility of market-rate housing is a concern as well: tenant-based rental assistance programs rely on the ability to find units in the private market, although many voucher holders do live in income-restricted (LIHTC or other) sites that do not have project-based rental assistance. Statewide, there are approximately 4,500 Housing Choice Vouchers and the State Rental Assistance Program is expected to serve 150-200 people in FY 2012: all of these households seek housing in the general rental market. Voucher holders frequently find accessible units in Low Income Housing Tax Credit (LIHTC) sites. In these sites, all built or rehabilitated since 1990 and with at least 5% accessible units, rents are typically within the allowable voucher payment standard and accessible units are often available. Other new multifamily sites may also have accessible units, but higher rents. As focus increases on providing tenant-based rental assistance for community placements for people with disabilities, the demand for accessible units will likely increase.

All multifamily housing built after March 13, 1991 is subject to the design and construction requirements of the Fair Housing Act (1988), regardless of funding source. However, the vast majority of existing rental housing was built before 1991: 75% of rental housing in Delaware was built before 1990, and only 42% of the rental housing stock in Delaware is in buildings with 5 or more units.¹⁵ Almost 40% of Delaware’s rental housing stock is single-family attached or detached homes.

There is little data available on the extent of accessibility features in unassisted rental housing, although knowing the prevalence of single-family homes and older multifamily units in the rental housing stock, accessible units, especially affordable ones, are likely very limited. We can at best make some rough assumptions about the extent of accessibility in Delaware’s overall rental housing stock. Assuming that 3% of rental units in structure of 5 or more units are accessible to either ANSI standards or with some mix of accessibility features suggests an estimated 1,107 fully accessible rental units in the state.

Table 3: Estimate of Accessible Multifamily Rental Units in Delaware

	Units	Percent of Renter-Occupied Stock
Total Renter-occupied units	88,771	100.0%
Units in structures with 5 or more units	36,917	41.6%
Assumption: 10% of rental units in structures of 5 or more units have basic access	3,691	4.2%
Assumption: 3% of rental units in structures of 5 or more units are fully accessible	1,107	1.2%
<i>Source for base numbers: U.S. Census Bureau, 2008-2010 American Community Survey</i>		

REHABILITATION AND ACCESSIBILITY NEEDS FOR HOMEOWNERS

There are an estimated 6,155 homeowner households with at least one member with a mobility or self-care disability with income below 50% of AMI (very low income) in Delaware; another 4,785 with income from 50-80% of AMI (low income).¹⁶ These approximately 11,000 homeowner households with low incomes likely have limited ability to invest in major accessibility renovations if needed. Further, more than half (52%) of these households have housing problems (cost burden, overcrowding or substandard conditions).¹⁷

Unmet need for home accessibility features is substantial: about 13% of wheelchair users reported needing automatic or easy-to-open doors and elevators, lifts, or stair glides, and 50% of people who use wheelchairs must use steps or stairs to get into their homes.¹⁸ About half reported difficulty entering or exiting their homes. Assuming similar percentages of needed home accessibility features apply to the estimated 10,472 people who use wheelchairs in Delaware, over 1,000 households in Delaware may need ramps or street-level entrances; 1,200 bathroom modifications; 650 stair glides; and 900 widened doorways or hallways.

DSAAPD reports that the wait time for assistance through their programs, which have a lifetime limit of \$15,000 of assistance, is usually about a year. As the result of the implementation of the Diamond State Health Plan Plus (DSHP Plus) initiative on April 1, 2012, individuals eligible for Medicaid who are enrolled in the Elderly and Disabled Medicaid Waiver will transition to a managed care system of delivering long-term care services. The new benefit package will include home modifications to help people remain in their homes. Many individuals who need wheelchair ramps and are currently on waiting lists will get them more quickly through DSHP Plus.

Programs offering general home rehabilitation assistance have waiting lists several years long. These programs sometimes also provide assistance for accessibility modifications, usually small modifications when larger rehabilitation projects are being done. Loan programs are also available but are less widely used, as most households cannot afford to make payments on a loan and need grant assistance.

Especially for elderly households, the lack of accessibility features in their homes can lead to unnecessary institutionalization, sometimes due to injuries from falls. Accessibility modifications may understandably be a low priority compared to other pressing material and medical needs. Among elderly (65 or over) households with disabilities who expressed needing home modifications, about 50% of households who needed accessible kitchens,

bathrooms, ramps, doors or hallways had them. Overall, only about half of elderly households with disabilities have the modification that they explicitly state they need.¹⁹

While state-level data on homeowners with disabilities are not available by age, disability, tenure and income all together, 52% of homeowner households in Delaware with very low incomes (<50% of median) have at least one member who is 62 or over.²⁰ Considering the high prevalence of disabilities and increased need for assistance with ADLs and IADLs among older adults, it is likely that many of these households have members with disabilities and potentially accessibility needs. Applying prevalence rates for people over 65 to these data suggest approximately 6,200 very low-income elderly homeowners with any disability in Delaware, 3,800 with an ambulatory disability. These households are likely to have a need for minor or major accessibility modifications.

Table 4: Estimates of Very Low Income (VLI) Elderly Homeowner Households with Disabilities, Delaware

Very low-income (VLI) elderly owner-occupied households	Households	
	Rate	Estimate
		17,690
With any disability	34.8%	6,156
With an ambulatory disability	21.6%	3,821
With a self-care disability	6.5%	1,150
With an independent living disability	14.5%	2,565
<i>Source: Households: HUD 2006-2008 CHAS data; Rates: U.S. Census Bureau, 2008-2010 American Community Survey</i>		
<i>Note: Individuals can report more than one disability, so the estimates should not be totaled.</i>		

BASIC ACCESSIBILITY NEEDS ACROSS THE POPULATION AND HOUSING STOCK

As the population ages, and disability rates increase with age, there will be substantial increase in the number of persons with intermittent or long-term disabilities. Nationally, an estimated 21% of households will have at least one disabled resident in 2050, using physical limitation (long-lasting mobility impairments) as the measure of disability, and 7% when using the measure of self-care (Activities of Daily Living - ADLs) difficulty. There is a 60% probability that a newly built single family detached unit will house at least one disabled resident during its expected lifetime using the first measure (physical limitation), and a 25% probability using the self-care/ADLs measure. When visitors are accounted for, the probabilities rise to 91% and 53%.²¹

There are too many flexible variables and too little reliable, detailed data both about specific needs and the existing housing stock to estimate a certain number or percentage of new housing units in Delaware which must be accessible and at what level. However, the available data can lead us to several broad conclusions:

- 1) As the population ages, the likelihood that a housing unit will house people with disabilities, either temporarily or long-term, increases significantly;
- 2) Accessibility features are a vital support for all people to age in place and live independently and in the community as long as possible: by 2040, 30% of Delaware's population will be over 60; and
- 3) With many varying levels of physical disability and functional limitations, full accessibility may not be needed by all, but the greatest majority of people may find benefit from basic access (visitability) and

universal design features that can be supplemented with additional modifications as necessary: no-step entries, wide doors and hallways, one accessible bathroom and bedroom.

RECOMMENDATION 1: INCREASE THE AVAILABILITY OF AND ACCESS TO RENTAL AND HOMEOWNERSHIP OPPORTUNITIES WITH ACCESSIBILITY FEATURES.

1.1 IMPROVE REAL-TIME INFORMATION ON AVAILABLE ACCESSIBLE AND AFFORDABLE UNITS FOR CONSUMERS.

Multifamily site managers and developers report problems filling accessible units, but consumers and advocates report difficulty in finding accessible and affordable units. To help bridge this information and communication gap, ideally, Delaware should develop:

- a) An online housing registry that could bring together real-time information on accessibility and availability of units. Beyond accessibility information, this could also be a general affordable housing resource, as no such real-time information on vacancies is currently available in Delaware. Key searchable information should include vacancies and waiting list information, location, and accessibility features. Ideally, site managers use the website as a marketing tool and maintain current information about additional items of interest to potential renters such as security deposits, pet policies, utilities included in rent, and others.
- b) Real-time information on households/individuals who need housing from the Department of Health and Human Services (DHSS). DHSS is working on having an agency-wide list of individuals waiting/looking for housing to be updated monthly.

1.2 REDUCE FAIR HOUSING BARRIERS TO AFFORDABLE AND ACCESSIBLE HOUSING.

42% of fair housing complaints in Delaware from 2000 – 2010 were disability-related.²²

Fair housing remains a barrier to securing and maintaining affordable and accessible housing for people with disabilities. People with disabilities continue to face stigma and its effects in almost all areas, and discrimination in housing persists. Multifamily site managers report that many accessible units are occupied by households without disabilities, but it is not clear how informed people are on their right to identify themselves as someone with a disability in order to receive fair housing accommodations. Similarly, the public and housing providers need to be educated about the need for accommodations for persons with disabilities. Education and training on fair housing responsibilities should be tailored to specific audiences, such as multifamily managers, landlords, elected officials and local government leaders and staff. The Division on Human Relations and its partners should continue and expand fair housing training in the state.

Source of Income discrimination (SSI, SSDI, housing assistance like HOPWA) is a common fair housing issue for people with disabilities. Adding Source of Income as a protected class in the state's fair housing laws would benefit this population. Fair housing advocates and legislators should consider and advance legislation to add source of income as a protected class in the state's fair housing laws.

For people with substance abuse or mental health disabilities, registry as a sex offender creates additional barriers as it precludes their consideration for publicly subsidized housing. The Delaware Interagency Council on Homelessness (DICH) worked with the Department of Corrections to develop a process to assess low-risk sex offenders, which would allow for case-by-case assessments of these individuals rather than a blanket prohibition that prevents any consideration of them. Implementation of this assessment process would improve housing options for people with disabilities who are low-risk registered sex offenders and may be currently institutionalized, homeless, or at high risk for institutionalization or homelessness. There may be opportunities to improve access for other offenders as well via similar partnerships.

1.3 ESTABLISH A COMMON VOCABULARY AND SET OF STANDARDS FOR ACCESSIBILITY FEATURES.

Throughout the course of community outreach for this study, we received repeated comments as to the major challenge posed by confused and differing understandings of key terms. Different agencies and developers use terms differently and sometimes inconsistently. This is particularly an issue for “visitability” (referred to as basic access in this report) and “universal design”, where no clear regulated standards exist.

There is a need for clear definitions of various levels of accessibility everyone in the state can refer to: Universal Design, basic access/visitability, adaptability, accessibility. It might be ideal for a statewide entity like DSHA to set its own standards for UD and basic access that would likely be adopted by many other funders and could be a statewide point of reference, like DSHA’s Minimum Construction Standards. Indeed, the lack of such national or local standards is likely a key barrier to increased incentives for accessibility features that improve livability and visitability. Several states have identified their own construction standards and manuals for universal design and visitability: for example, both Florida and Virginia have universal design manuals which provide specifications for what meets that designation, and Oregon mandates and defines visitability (basic access) in their construction standards.

1.4 INCREASE THE PREVALENCE OF BASIC ACCESSIBILITY FEATURES IN ALL NEW HOMES.

There is a 60% probability that a newly built single family detached home will house at least one resident with a physical disability during its expected lifetime.²³

Across the population, the most widespread need is not always for fully accessible units, but units with basic accessibility features that allow for basic access and essential needs. While there are already requirements for fully accessible units in publicly funded rental sites and visitability/basic access in all first-floor multifamily units, there are no requirements at all for the type of housing that makes up the vast majority of the housing stock – single family attached and detached homes. Different from working to set-aside a set percentage of units in a particular type of housing, advocates for visitability and/or universal design are working to ensure that as many homes as possible, across the entire housing stock, are initially built to be as accessible as possible for everyone. Just a few key features can ensure basic access for people with disabilities: one no-step entry, at least 32 inches of clear passage through the entire first floor, and at least a half-bathroom on the first floor. Additionally, either a bedroom on the first floor or a room that can be used as a bedroom can also be included as a basic access feature. Basic accessibility features will meet the needs of many with physical disabilities, ensure visitability from friends

and family with disabilities, and account for needs that arise from temporary disabilities. In single-family homes, retrofitting costs for entryways, clear passage and basic bathroom facilities can be very costly. Incorporating basic access features can substantially reduce future costs to modify a home.

There are several examples of both mandates and voluntary programs to increase the number of homes built with basic access or visitability features. From a production standpoint, mandatory programs are far more successful in producing units than voluntary programs, although mandatory programs are often strongly opposed by related industry groups and subsequently difficult to enact. In some states and jurisdictions, a compromise has been applying a mandate only to homes built with public support or financing. However, depending on the size of the jurisdiction and how much new construction of single-family homes is developed with federal funds, this approach typically affects very few homes compared to overall development in a community.

The state of Delaware and jurisdictions within the state should consider effective incentive programs to increase the number of homes built for basic access or visitability. We understand there are various regional differences and challenges in the type of foundation commonly used and other considerations, but we should encourage builders, advocates and local officials to work together to identify creative solutions to these challenges while still developing homes with accessibility features to meet the needs of the state's population. In particular, basic access should be incorporated in proposals to provide incentives for projects that meet other goals, such as access to transportation, affordability, and mixed income or mixed use development.

Improved understanding of the need for accessible housing both within the housing industry and among households would also likely increase the prevalence of basic access features in new homes. The vast majority of new homes are not built with even the most basic access features, and are often not even available options. However, people are also not demanding these features, despite numerous surveys reporting that people overwhelmingly desire to remain in their homes as they age and a high likelihood that a new home will be occupied by someone with either a temporary or permanent disability in its useful life. Affordable housing and disability advocates should establish communication with the development and real estate industries to improve understanding of the disability housing market and conducting outreach to developers on the need and demand.

1.5 EXPAND AND COORDINATE RESOURCES FOR ACCESSIBILITY MODIFICATIONS FOR HOMEOWNERS AND HOMEBUYERS.

10,940 low-income homeowner households in Delaware have at least one member with a mobility or self-care disability.²⁴ An estimated 6,156 very low income elderly homeowners in Delaware have at least one disability. Nationally, only about half of elderly homeowners with disabilities report having the home modifications they need.²⁵

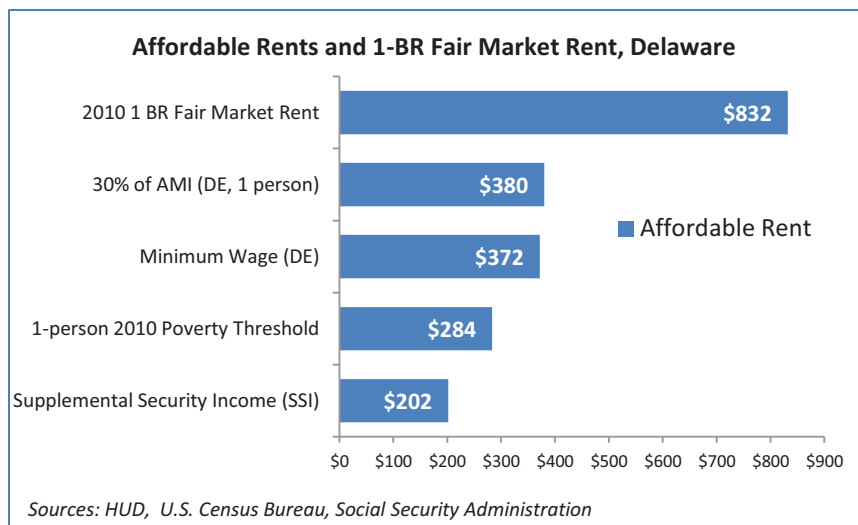
There is an ongoing need for accessibility rehab assistance, as well as value in improving the coordination among housing rehab programs and accessibility-specific rehab programs operated by non-housing agencies. Housing rehab programs are often performing some accessibility modifications, and households getting accessibility modifications from accessibility-specific programs may have other housing rehab needs. With cuts in recent years to the Community Development Block Grant (CDBG) program, resources for homeownership rehab are scarce. Recommendations in this area include:

- a) Consider opportunities to improve coordination between housing rehab and accessibility rehab programs. The partnership between CDBG and the Weatherization Program in Kent and Sussex Counties, where Weatherization addresses windows, doors and related items and CDBG addresses other needed repairs, may be a good model to evaluate.
- b) Expand resources for housing rehab and accessibility rehab programs.
- c) Identify sources of assistance for homebuyers at the point of purchase, including ranging up to moderate income. This may be a small niche need, but families with accessibility needs looking to purchase a home are often very limited by the available stock. A loan that could be used at the point of purchase to make modifications would be a useful resource.
- d) Review building requirements for accessibility items (like ramps) between the counties and municipalities. Operators of rehab programs complain about very different and sometimes burdensome requirements varying from county to county, which can significantly impact costs.
- e) Many single-family homes are vacant, distressed, or entering the rental housing stock due to the foreclosure crisis and struggling housing market. As we seek ways to keep homes in active use and reduce vacancies, we should explore incentives to encourage investors to rehabilitate single family homes for accessible rentals.

Government jurisdictions funding housing rehabilitation and accessibility modifications and nonprofit service providers of both rehabilitation and accessibility modifications should come together to examine their program offerings, eligibility requirements, funding, and needs for their services to explore new ways to coordinate and improve services to consumers.

AFFORDABILITY

For those with extremely low incomes or who rely on SSI or SSDI, rental assistance is absolutely vital to live independently in the community. A one person household with extremely low income in Delaware can afford only \$380 a month in rent, \$450 less than the fair market rent for a one bedroom apartment. For a person with SSI as their only source of income (\$674/month), they can afford only \$200 a month in rent. Statewide, only 6.5% of rental units have rent below \$400 a month, and only 29% have rent below \$800 a month. The lack of affordable



and accessible housing is a major barrier to people with disabilities who are at risk of homelessness; at risk of institutionalization; transitioning from institutions into the community; and to the development and success of a community-based system of care for people with disabilities.

WORST CASE HOUSING NEEDS FOR PEOPLE WITH DISABILITIES IN DELAWARE

The U.S. Department of Housing and Urban Development defines “worst case housing needs” as households with very low incomes (below 50% of the area median for their household size) who do not receive government housing assistance and are severely cost burdened (pay more than 50% of their income for rent), live in severely inadequate conditions (overcrowded or substandard), or both. These households are precariously or unsafely housed, and at high risk for homelessness – the nation’s most critical housing needs. People with disabilities are more likely to have worst case needs: nationally, 38% of very low income nonelderly renter households with disabilities have worst case needs.²⁶

For this study we have replicated an estimate of worst case housing needs in Delaware. This estimate suggests there are approximately 4,600 very low-income renter households with severe housing problems with disabilities in Delaware, and is supported by other estimates of nonelderly households with disabilities and worst case housing needs.²⁷

Table 5: Estimate of Worst Case Housing Needs Among Households with Disabilities, Delaware, 2006-2008

	Delaware
Total renter households	86,290
Very low income (VLI) renter households (<50% AMI)	36,150
Estimate - VLI renter households with housing subsidy	12,784
Estimate: VLI renter households with no housing subsidy	23,366
VLI renter households with severe housing problems (worst case needs)	18,235
Worst Case Needs Estimate: VLI renter households with a nonelderly member with disabilities with severe housing problems²⁸	4,559
<i>Source for renter household and housing problem data: HUD 2006-2008 CHAS data</i>	

SUMMARY OF DELAWARE LOCAL DATA

It is difficult to summarize the diverse housing needs of people with diverse disabilities into one number or even one table. For purposes of this report, we are most concerned with the number of people or households in need of affordable accessible rental housing or rental assistance. In addition, by population these estimates may come from widely different sources and reflect different levels of need: one estimate may be of people actually homeless, one of people who are housed but need rental assistance with supportive services to live independently. The following table summarizes the data on needs gathered from local sources for this report.

Table 6: Summary of Local Data on Housing Needs

Population	Need	Source
People with HIV/AIDS	250 on TBRA waiting list	Delaware HIV Consortium
People with Intellectual/Developmental Disabilities (ID/DD)	150 individuals estimated at-risk due to aging caregivers	DHSS: Division of Developmental Disabilities Services (DDDS)
Substance Abuse/Mental Health	882 DSAMH consumers in need of stable housing (nursing home, corrections facility, other institution, unknown, or homeless) 406: Mental Health 306: Substance Abuse 116: Co-occurring MH/SA 54: Unknown	DHSS: Division of Substance Abuse and Mental Health (DSAMH)
Elderly and Adults with Physical Disabilities	300 (Diversions and transitions from LTC facilities from FY 13 - 17) 100 (Transitions from DHSS LTC Facilities) 250 (Other referrals from APS, ADRC, and other sources from FY 13-17) <i>Likely all (650) fully accessible units</i>	DHSS: Division of Service for Aging and Adults with Physical Disabilities (DSAAPD)

The above table suggests a total need for assistance for approximately 1,950 individuals or households. These are conservative estimates, as the case of the DSAMH point-in-time analysis is a good example. While 882 DSAMH clients were identified as in need of stable housing in that analysis, over 2,000 listed SSI or SSDI as their primary source of income. These individuals are highly likely to be precariously housed, cost-burdened and in need of rental assistance, or doubled-up with family or friends when they would prefer to and could live independently. DDDS is currently serving 1,923 people with intellectual or developmental disabilities who are currently stably housed with family or friends, but as their families age, many of these people may also need housing assistance. DDDS estimates 150 people may be at risk due to aging caregivers and need housing assistance in the near future. Approximately 242 people with ID/DD who are receiving services from DDDS are over 50 years of age.

In addition, we have very limited information about people with physical disabilities who may be similarly precariously housed in the community or in private nursing homes and able to transition to the community. The estimated need from LTC facilities suggests a need for at least 650 either assisted accessible units or market-rate accessible units with tenant-based rental assistance.

Estimates from HUD’s CHAS data show 2,260 extremely low-income (<30% AMI) renter households and 1,445 owner households with at least one member with a mobility or self-care disability with a housing problem (cost burden, overcrowding or substandard conditions) in Delaware. Expanded to include very low-income households (<50% AMI), there are 3,235 renter households and 3,225 owner households with income below 50% AMI, at least one member with a mobility or self-care disability, and a housing problem in Delaware.

Youth aging out of foster care are an additional high-risk population; estimates of the number of youth expected to be aging out of the foster care system provided by the Department of Services for Children, Youth and their Families suggest a need for approximately 300 units of rental assistance.

DEMAND FOR ASSISTED ACCESSIBLE UNITS

Caseworkers and advocates regularly report great difficulty locating accessible affordable rental housing. However, rental housing owners and developers also report vacancies and difficulty filling fully accessible units. Some sample review of data from people in the Money Follows the Person (MFP) program suggest that the issue may be more one of a need for subsidy and a mismatch in unit locations and sizes.

The Division for Medicaid and Medical Assistance (DMMA) provided the study working group with summary data on 110 current or former residents of long-term care facilities who either had or were attempting to transition to living in independent housing, approximately half of whom had transitioned and half remained in institutions. Some summary notes about the population:

- 62% were seeking either an efficiency or one bedroom unit.
- 66% had Supplemental Security Income (SSI) listed as their only source of income (\$674/month); the rest relied on SSDI with a few having additional income from pensions or worker's compensation.
- The majority – 65% - were seeking units in New Castle County, with about 17% each seeking units in Sussex or Kent Counties.

The large number of people seeking smaller units and relying on SSI as their only income suggests that some of the problem may be related to the size and affordability of available units, not purely a need for fully accessible units. In non-elderly rental housing sites, efficiency and one-bedroom apartments are rare as they are not highly popular with the target market. In addition, new rental housing construction in the past two decades has been more concentrated in Kent and Sussex Counties: these sites are likely to have more accessible units. However, as new sources of federal project-based subsidy have been almost nonexistent for many years, new family sites are also unlikely to be subsidized.

All of the people in the MFP program rely primarily on SSI, SSDI or a combination of the two for their income: while benefits may vary slightly, they are clearly living on extremely limited incomes and their ability to afford even affordable rental housing is very limited. At the maximum SSI benefit of \$674, a person could only afford a rent of \$225 a month, leaving only \$450 for all other expenses. Even at the average SSDI benefit of \$1,128, a person can only afford a rent of \$338. All of these people would generally need rental assistance – not simply an affordable unit, but either a project-based or tenant-based subsidy - to live independently in the community.

RECOMMENDATION 2: INCREASE THE AVAILABILITY OF AND ACCESS TO AFFORDABLE HOUSING FOR PEOPLE WITH DISABILITIES.

2.1 INCREASE THE AVAILABILITY OF LOW INCOME HOUSING TAX CREDIT (LIHTC) PROPERTIES TO PEOPLE WITH DISABILITIES, ESPECIALLY THOSE WITH EXTREMELY LOW INCOMES.

An estimated 4,559 renter households with disabilities in Delaware have worst case housing needs: no housing assistance and severe cost burden, overcrowding or substandard conditions.²⁹

For the past two decades, the federal Low Income Housing Tax Credit (LIHTC) program has been the nation’s main vehicle for providing financing for the new construction and rehabilitation of affordable rental housing. However, it is difficult to reach extremely low-income households in the LIHTC program without additional rental assistance. On some occasions, the LIHTC has been used to support projects targeted to people with disabilities. However, the development of set-aside, non-integrated units for people with disabilities is no longer an appropriate strategy. The settlement agreement between the State of Delaware and the U.S. Department of Justice does not permit the clustering of people with known disabilities in non-integrated housing, which not only prevents the further development of such housing but also may challenge the viability of some already existing affordable clustered housing. In the future, set-aside units for people with disabilities should be fully integrated into typical housing in multifamily developments, and we will need to find ways to improve the availability and affordability of these sites to people with disabilities.

One broad strategy to increase the availability and affordability of LIHTC sites to people with disabilities and extremely low incomes is to enact policies requiring, or strongly encouraging, the integration of units for persons with disabilities. These units need not all be fully accessible but ideally should all be subsidized. There are numerous models nationally for successfully encouraging the development and set-aside of units for persons with disabilities. Successful programs also develop the structures to ensure that a steady stream of referrals are available, that people are connected to any supportive services they need to live independently, and units are affordable to the target population.

There are many ways this can be structured, and many models available. Some states simply require that a percentage of all units be set aside for people with disabilities with extremely low incomes, and expect developers to identify how to make the units affordable or make available some state-level source of project-based subsidy for those units. Instead of a requirement, some states simply provide incentives for developers to include and set-aside affordable units. In either case, most also require a Memorandum of Understanding between the developer and a local agency who will be responsible for providing referrals and ensuring that residents have services.

Upcoming changes to the federal Section 811 program, which was previously used almost exclusively for the development of and housing subsidies for group homes and apartments only for people with disabilities, will further emphasize integration and coordinating support for special needs units with mainstream affordable housing development programs at the federal level. As part of these changes, new resources will be available for housing finance agencies and nonprofit developers to integrate subsidized units for persons with disabilities in multifamily developments.

A new stream of competitive funds would allow housing finance agencies (HFAs) to use project-based Section 811 subsidies in new or rehabbed multifamily sites financed through the LIHTC, HOME, or housing trust funds. This program is expected to be available in 2012: to apply, state housing finance agencies must demonstrate partnerships with the state Medicaid agency to ensure referrals and services. Nationally, nonprofit developers will also be able to apply directly to HUD for new Section 811 subsidies to provide project-based subsidy for up to 25% of units in a site for new projects. Delaware’s LIHTC Qualified Allocation Plan (QAP) could encourage developers to pursue this option, although should consider limiting the maximum percentage of units to 20%, the level identified as a maximum in the State of Delaware’s recent settlement with the Department of Justice.

Again, in both of these scenarios, Delaware’s housing and disability services systems must be prepared to ensure that people get the support they need to live independently and that residents and rental assistance if necessary are available to ensure units can be filled.

2.2 EXPAND INCENTIVES FOR BASIC ACCESS AND UNIVERSAL DESIGN FEATURES IN AFFORDABLE HOUSING.

Broader, more flexible, levels of accessibility allow for the greater use of units by households with various accessibility needs, short-term accessibility needs, and visitation by friends and family with disabilities. Funders should add incentives for different levels of accessibility – such as livability (“universal design”) and basic access (“visitability”) – not just full-Section 504-compliance.

In 2010, the Delaware State Housing Authority added five points (out of 135) to its Qualified Allocation Plan (QAP), for utilization of Low Income Housing Tax Credits, in order to reward applications that proposed to increase the percentage of units built to full accessibility standards beyond the required 5% to 10, 15 or 20%. In that year, all of the successfully ranked projects sought these points, for a total of 46 out of 355 units developed fully accessible (13%). Response in 2011 was similarly strong.

While the above incentives for additional fully accessible units have been successful, most affordable housing funding programs in Delaware do not currently include incentives for the inclusion of other basic access or additional universal design features. We encourage public and private funders to consider effective incentives to promote additional basic access and universal design features. In addition, basic access should be considered not only for typical rental and homeownership units, but also permanent supportive housing and other situations, and developers should be allowed to budget and pay for these features.

2.3 CONTINUE TO INVEST IN PERMANENT SUPPORTIVE HOUSING.

Best practices in the provision of housing for people who are homeless call for a focus on permanent supportive housing as the primary means to reduce and end chronic homelessness. Permanent Supportive Housing balances the provision of affordable housing with access to services that help people regain their ability to live independently and become self-sufficient. As reflected in the Delaware Interagency Council on Homelessness (DICH)’s ten-year plan to end chronic homelessness (2007), additional investment in new housing should be targeted to permanent supportive housing as opposed to adding to the state’s system of emergency shelters and

transitional housing programs. Permanent supportive housing allows us to focus our resources and services on preventing and ending homelessness for Delawareans.

Even as the state increases its attention to integrated community-based housing models, there will still be a need and a role for permanent supportive housing that focuses on those with the most complex challenges. Delaware should continue to prioritize permanent supportive housing as one of our important responses to homelessness, including investing in its development and ensuring operating and/or rental subsidies to support it. There is also some existing housing stock which is affordable and accessible that may be at risk. The terms of the state's settlement agreement with the U.S. Department of Justice preclude the use of congregate housing, even when tenants have rights of tenancy and their own units within a congregate arrangement. The housing and disability communities need to look for ways to preserve this housing stock.

2.4 IMPROVE ASSET-BUILDING OPPORTUNITIES FOR PEOPLE WITH DISABILITIES.

40-50 percent of the 6 million people receiving SSI are considered unbanked: they have no checking or savings account.³⁰

Many people with disabilities, facing poverty or very low incomes, have few opportunities to develop assets and to purchase a home. Homeownership is one of the key tax-advantaged means lower income households use to build assets and save. However, the services and systems to support asset-building and home purchase are also not always well-connected to disability services systems. Beyond buying a home, asset-building has many other benefits, and people with disabilities may need or choose to use their savings for many other purposes: education, small business, accessibility modifications for existing homeowners, or purchase of major assistive technology items. Homeownership counseling and financial literacy programs should all ensure they are actively marketing to and reaching people with disabilities with their services.

Asset limits for key support programs are a major barrier to asset development for people with disabilities. Individual Development Account (IDA) savings are usually excluded from these asset limits. Existing IDA programs should allow people with disabilities to save for other major investments, such as a modified vehicle, home modifications, communications or other assistive technology. The Delawareans Save IDA program matches savings up to \$1,500 per person or \$3,000 per household, at \$1.50 for each \$1.00 saved. Homeownership, education and training and small business investments are all eligible savings goals. CFED's Assets & Opportunity Scorecard lists Delaware's IDA policy as weak or minimal, mainly due to the lack of state funding for IDA programs.³¹ In addition, the Delawareans Save program, like many IDAs, does not allow some expenses that might be beneficial for people with disabilities and ultimately allow them to increase their incomes and savings, such as assistive technology or a modified vehicle.

At the state and local level, efforts to improve asset-building opportunities for people with disabilities include improving access to financial literacy, credit repair, asset-building, homeownership counseling and tax preparation programs for people with disabilities; and developing specialized loan and savings programs to assist people with disabilities to purchase assistive technology they need; and expanding financial case management/coaching services to include specialized assistance to help people with disabilities weave together the various work incentive and asset-building programs while maintaining eligibility for federal income supports.

PRIORITIZING HOUSING CHOICE AND COMMUNITY CARE

Four main factors call for improving access to community-based services and supports. First, people over 60 years of age will continue to grow as a percent of the overall population, which will lead to significant increases in demand for long term care and supportive services. The aging of the baby boomer generation and extensive in-migration of older households to retire in southern Delaware means that in 2010, 20.5% of the population in Delaware was over 60 years of age; by 2040, this is projected to increase to 30.5%. Older individuals, especially those over 75, are far more likely to need long-term services and supports.

Secondly, this aging population and increased demand for long-term services may herald financial crisis for public programs that are already overextended: the vast majority of long-term care services are paid for with public programs. Over decades, these systems have developed in ways that favor institutional care over supports to serve people in their homes. The median annual cost of a private room in a nursing home in Delaware is \$89,060; 30 hours a week of home care may cost \$32,760.³² In 2009, Delaware ranked 50th among the states on the percent of Medicaid spending for older people and adults with physical disabilities going to Home and Community based Services (HCBS), at 13.2%.³³ Nationally, 36% of spending for these populations was directed to HCBS. Even if housing assistance is also required, serving people in their homes and communities can be considerably less expensive than facility-based care. The typical estimate is that a person who is able to be served in their home can average less than half the costs of institutional care. One study indicated a 63% reduction in per person spending for a nursing facility waiver program compared to institutionalization.³⁴ Expressed other ways, for the annual cost of one nursing home stay, two to three people can be served in their home or community.

In addition, numerous surveys, both national and local, reflect people's desire to remain in their communities as long as possible. People want services to support them in their homes and to remain in their homes as long as possible. Further, many measures of quality of life are far improved when high-quality services are delivered in peoples' homes and communities rather than institutional settings.

Finally, systems not only *should* be built around community-based care and the assumption that people can live in the community with appropriate supports, they *must* prioritize care in the community. In 1999, the U.S. Supreme Court rejected the state of Georgia's appeal to enforce institutionalization of individuals with disabilities in a 6-3 ruling in the case *Olmstead v. L.C.* While the process of deinstitutionalization was in progress in many states, this ruling brought attention to the sometimes slow pace, significant number of individuals still in institutions nationwide, and ongoing preference for institutional settings for persons with disabilities who could live in less restrictive settings. The 'integration mandate' of the Americans with Disabilities Act requires public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The *Olmstead* case upheld the ADA's integration mandate, and thus, like the ADA, applies to all qualified disabilities. People must be able to receive services in the most integrated setting possible considering their needs: the "most integrated setting" is one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

Settlement Agreement between State of Delaware and U.S. Department of Justice

While this report reviews needs and provides general recommendations for people with disabilities in Delaware, people with serious mental health conditions are at the center of a recent Settlement Agreement between the United States Department of Justice (USDOJ) and State of Delaware, signed on July 15, 2011. This Settlement Agreement is the result of an extensive investigation by the USDOJ which resulted in multiple findings and subsequent negotiations to revise Delaware's service delivery system for people with serious and persistent mental illness (SPMI).

The USDOJ findings were based on the federal Americans with Disabilities Act and Olmstead legal decisions and the Agreement mandates that the State meet both of these federal standards. Specifically on the subject of housing, the State is required to identify 650 newly funded and integrated housing units over the next four years. The Agreement's Implementation Timeline (p. 13) states:

E. Supported Housing

1. By July 11, 2011, the State will provide housing vouchers or subsidies and bridge funding to 150 individuals. Pursuant to Part II.E.2.d, this housing shall be exempt from the scattered-site requirement.
2. By July 1, 2012 the State will provide housing vouchers or subsidies and bridge funding to a total of 250 individuals.
3. By July 1, 2013 the State will provide housing vouchers or subsidies and bridge funding to a total of 450 individuals.
4. By July 1, 2014 the State will provide housing vouchers or subsidies and bridge funding to a total of 550 individuals.
5. By July 1, 2015 the State will provide housing vouchers or subsidies and bridge funding to a total of 650 individuals.

While group homes and other congregate settings may not be institutions, the day-to-day routines, rules and systems of these programs may result in segregation. Supportive housing – integrated throughout the community, with the option for people to live independently while still receiving the support they need – is usually a more integrated setting and an option that is currently limited on the continuum of housing for people with disabilities in Delaware. While congregate and clustered settings in the community, with the benefits they offer of peer support and sense of community, should remain an option for those who prefer them, we need to similarly ensure there are independent settings available as well.

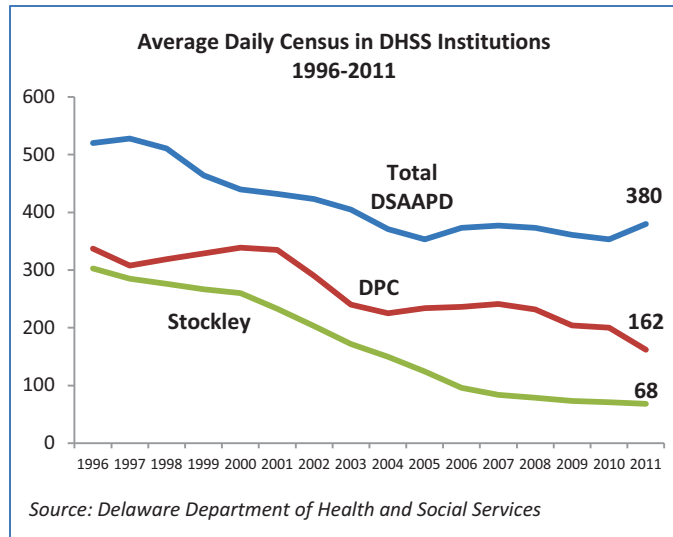
PRIORITIZING COMMUNITY CARE IN DELAWARE

In recent years, DHSS and its divisions have been working steadily to reduce institutional bias and the number of beds and individuals in state-run facilities. The Delaware Psychiatric Center (DPC) and mental health and substance abuse care systems have been particularly in focus. July 2011, DHSS announced a five-year strategy to expand community services, housing, supported employment opportunities and a statewide crisis team, agreed upon with the U.S. Department of Justice at the conclusion of their three year investigation into conditions in the DPC.

DHSS initiatives to prioritize community care and transition people living in institutions to the community have resulted in significant declines in the number of people in state-supported institutions. Since 1996, the average daily census for all DHSS long-term care facilities (Governor Bacon Health Center, Delaware Hospital for the Chronically Ill, and the Emily P. Bissell Hospital), excluding the Delaware Psychiatric Center and Stockley Center, fell from 520 to 380 in 2011, close to 30%. Over that same time period, the average daily census at the DPC fell from 337 to 162 (-52%) and at the Stockley Center, from 303 to 68 (-78%). From FY 2012 – 2014,

DHSS intends to further reduce the number of beds in public long-term care facilities by 114 beds spread across three facilities.

Despite these reductions in census at state-run institutions, a strong bias remains for institutional care. By population, services for people with intellectual/developmental disabilities are far more likely to be delivered in the community. In FY 2010, 75% of Medicaid Long Term Care expenditures for this population were spent for community-based care via the HCBS DD Waiver. This includes care for approximately 1,000 people. Of non-DD Long-term Care expenditures, 10% were spent on community-based care in FY 2010; this includes care for approximately 4,600 people.



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

- 42% thought it likely that either they or their family member will need LTC services in the next five years.
- 50% are not very or not at all confident in their ability to afford the annual \$81,000 cost of a nursing home in Delaware.
- 51% of respondents with incomes less than \$50,000 a year say they plan on relying on government programs to pay for their LTC.³⁵

In December 2009, the percentage of all nursing facility residents for which Medicaid was the primary payor was just under 57%, representing about 2,421 Medicaid residents.³⁶ The 2,421 Medicaid nursing facility residents translates into a 1.8% prevalence rate of institutionalization among Delaware's elderly age 65 and older.

Assuming a constant rate of institutionalization, by year 2030, the number of nursing home residents paid by the DMMA will increase to 4,626. On an annualized cost basis, this translates into well over \$150 million more in new Medicaid-funded nursing home stays or a combined total of over \$320 million spent on nursing homes per year. This also assumes the annual cost of nursing home services remains static; it may be more realistic to assume the cost of care will gradually increase over time and, thus push institutional spending to even higher levels. Transforming Delaware's system of care to prioritize community-based services will help avoid further expansion of institutional settings and the higher costs associated with institutional care.

RECOMMENDATION 3: BUILD A COMMUNITY-BASED SYSTEM OF CARE WITH A RANGE OF HOUSING OPTIONS.

3.1 CONTINUE TO PRIORITIZE COMMUNITY-BASED CARE BY REDIRECTING RESOURCES FROM INSTITUTIONAL CARE TO COMMUNITY-BASED SERVICES AND PROVIDING FOR HOUSING NEEDS.

In 2009, Delaware ranked 50th among the states on the percent of Medicaid spending for older people and adults with physical disabilities going to Home and Community Based Services (HCBS), at 13.2%, compared to 36% nationally.³⁷

People can and should have choices about their environment, activities, services, work, socialization, and employment: systems must provide services in the least restrictive setting possible. While the process of deinstitutionalization has been long in progress nationwide, it has sometimes been slow. Significant numbers of people remain in institutions nationally and ongoing preference for institutional settings and systems that continue to steer people to institutional care. Creating permanent change means transforming systems to truly prioritize community care and building collaboration across disciplines, sectors and departments.

DHSS has already taken many steps towards the development and strengthening of community-based systems of care for people with disabilities in Delaware. This includes:

- Changes to Medicaid managed care and waiver programs to increase the use of home and community based services (HCBS);
- The Money Follows the Person program, a joint program of DSAAPD and the Division of Medicaid and Medical Assistance to expand nursing home to community transition efforts that was recently extended through 2016;
- Development of the Delaware Aging and Disability Resource Center (ADRC) as a one-stop access point for aging and disability information and resources, options counseling and service enrollment support;
- Efforts to reduce the census in state-run long-term care facilities, including an independent assessment of the current residents of the five facilities operated by DHSS and a successful diversion program to reduce future admissions by helping people referred for LTC to remain in the community; and
- Numerous initiatives in the Division of Substance Abuse and Mental Health (DSAMH) to expand and enhance Delaware's community mental health services, including expanding Mobile Crisis Services and walk-in centers, supported employment, expand Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams, and changes to oversight of psychiatric hospitalizations.

Across DHSS, these initiatives should be continued to support community-based care for people with disabilities and maximum independence and integration in the community.

Finally, community-based care may mean different resources, strategies, and housing options for different populations. For people with developmental and intellectual disabilities, supports for families, family caregivers, and long-term plans for care as families age are especially critical. For people with substance abuse and mental health disabilities, developing the capacity of the state's community mental health system and assessing systems

for institutional biases to prevent unnecessary institutionalization, reduce readmissions, and prevent late-stage interventions more likely to result in institutionalization are important strategies. For all populations, building a community-based system of care must include planning and providing for housing needs and housing assistance, whether through tenant-based assistance, housing assistance added to the package of services from current community-based care providers, or other methods appropriate for different populations.

3.2 ENSURE A RANGE OF HOUSING OPTIONS AND MEANINGFUL CHOICES FOR PEOPLE TO LIVE AND RECEIVE CARE IN THE COMMUNITY.

At least 2,000 people with disabilities in Delaware need rental assistance to live stably and independently in the community.

Housing strategies for persons with disabilities should ensure a continuum of options and choices, from supports that allow living with family, to independent living in community, to congregate settings, or seeking homeownership when appropriate. There is no one size fits all approach, and a range of different housing options must be available and affordable in order for people with disabilities to have meaningful choices about their housing situation.

Three key strategies to ensuring a range of housing options are to 1) continue to expand tenant-based rental assistance programs; 2) identify new models to build a continuum of housing options for people with disabilities; and 3) ensure a full range of community supports to create and sustain successful transitions to community care.

Tenant-based Rental Assistance (TBRA)

Delaware should continue to expand programs providing rental assistance for households to rent units in the private market. Model programs in Delaware have been very successful to date, including the Delaware HIV Consortium's longstanding TBRA program for people living with HIV/AIDS and vouchers for people with substance abuse and mental health disabilities managed by Connections and supported through the Continuum of Care. The successful development and implementation of the State Rental Assistance Program (SRAP) should continue this trend. While SRAP was funded to serve 150 households in FY 2012, the need for the program far outstrips available resources. As of February 2012, DHSS has a pool of 95 SRAP applicants who are still in need of assistance and have not yet been submitted to DSHA because DHSS has nearly exhausted the number of vouchers reserved for their clients. TBRA will be in even higher demand as DHSS and the homeless assistance system continue to work to help people with disabilities to live in the community, transitioning people who are currently in long-term care facilities or congregate settings.

New Models

To ensure a continuum of housing options and settings, the housing and disability services systems should consider new models to broaden the housing opportunities available for people with disabilities and ensure the opportunity to live in the least restrictive and most integrated setting possible. Supports for shared housing and roommate matching in particular are tools that people with disabilities and advocates identified as potentially useful. Actions to support these may include developing programs to link potential roommates and ensuring that various program guidelines allow for roommate or shared housing situations.

Supports for New Renters

Another aspect of prioritizing community care is recognizing the full range of supports needed for a successful and sustainable transition. For people with disabilities who have never – or not for a long time – lived independently, acquiring and maintaining rental housing (applications, security deposits, lining up resources, utilities, basic household needs, and navigating transportation) can be just as challenging as moving to homeownership and require ongoing support in managing new responsibilities and addressing new concerns.

There are some existing examples and recent steps in this area in Delaware. The Assertive Community Treatment (ACT) model employed by DSAMH and service providers in the substance abuse/mental health field in Delaware includes these services, and in late 2011 DHSS engaged in two new contracts with nonprofit service providers to provide housing placement services to 180 DHSS clients statewide. Additionally, the case management provided through the Money Follows the Person (MFP) program provides a model of intensive case management that includes assistance locating, securing and transitioning to rental housing. DHSS, DSHA and service providers should explore the possibility of a network of housing case managers to offer housing counseling for rental housing similar to homeownership counseling.

3.3 CONTINUE TO DEVELOP AND IMPLEMENT DIVERSION STRATEGIES TO PREVENT INSTITUTIONALIZATION AND REDUCE READMISSIONS.

A key strategy of prioritizing community care is preventing initial unnecessary institutionalization and reducing subsequent readmissions. Systems should be structured to quickly redirect people at risk of institutionalization to the least restrictive community based setting and connect them to the necessary supports to ensure they can remain in the community as long as possible. These efforts have already proved very successful: in February 2011, DHSS implemented a diversion program to provide community support to individuals who have been referred for long-term care. From February to September 2011, 115 out of 139 individuals (83%) who had been referred for long-term care were able, with connections to services, to remain in the community. Continuing to expand such programs and ensuring that all populations are covered will help people with disabilities to remain in the community as long as possible and avoid unnecessary institutionalization by connecting them with appropriate supports.

For the elderly and people with physical disabilities, transitions between care settings and at hospital discharge are points when people are particularly vulnerable. Care Transitions Delaware is undertaking major initiatives to strengthen transitions between care settings to improve health outcomes and promote individual choice. DSAAPD is partnering with hospitals and other organizations to build upon existing discharge planning strategies to reduce hospital readmissions and prevent unnecessary nursing home placements.

For people with psychiatric and substance abuse crises, avoiding involuntary commitment is a strategy to help people avoid entering the cycle of institutionalization. Hotlines, mobile crisis teams and walk-in crisis centers all allow people in crisis to receive services without being removed from their homes or community. In a new partnership, DSAMH's Mobile Crisis services have partnered with some local hospitals to evaluate consumers with psychiatric and substance abuse crises in their Emergency Departments to reduce the number of involuntary commitments and create immediate links to community behavioral health services. Assertive Community Treatment (ACT) teams also provide a range of coordinated services to people in their homes and communities,

and have been found to reduce hospitalization rates and durations of stays and in assisting people to access mainstream resources to secure and sustain housing and employment. ACT teams have been the center of Delaware’s mental health service delivery system since 1988, but there is a need for more funding and services, as well as a need to ensure that diversion strategies and coordinated services to support community care are in place for all populations.

3.4 IMPLEMENT THE DELAWARE POLICY STATEMENT *EXEMPLARY PRACTICES IN DISCHARGE PLANNING*, ESPECIALLY AT STATE-OPERATED INSTITUTIONS AND PRISONS, TO IMPROVE CONNECTIONS TO PERMANENT HOUSING AND PREVENT SUBSEQUENT HOMELESSNESS.

The 2007 Delaware Interagency Council on Homelessness (DICH) 10-Year Plan to End Chronic Homelessness identified the lack of consistent and applied formal discharge policies and procedures as a major barrier to preventing and ending homelessness. The plan recommended a collaborative group come together to review and strengthen discharge and aftercare planning strategies to ensure that appropriate linkages with housing and community-based care are in place to prevent subsequent homelessness. As stated in the 10-Year Plan, “No person should leave a hospital, nursing home, or residential treatment program without an identified transitional or permanent place to live (not an emergency shelter), the necessary entitlements or employment income to pay for it, and the supportive services needed to sustain it.”³⁸

In 2008, a joint committee of the Delaware Interagency Council on Homelessness and Commission on Community based Alternatives for People with Disabilities followed through on this recommendation and produced a Delaware policy statement, *Exemplary Practices in Discharge Planning*. While the development of uniform policies was a major step forward, efforts to ensure statewide implementation are ongoing. Implementing effective, uniform discharge planning is a critical task to preventing unnecessary repeat institutionalizations, homelessness, and ensuring that people are transitioned to stable, permanent housing with the supports they need to remain in the community.

3.5 IMPROVE COMMUNITY PLANNING TO BENEFIT COMMUNITY QUALITY OF LIFE FOR ALL RESIDENTS AND FOSTER REAL INTEGRATION FOR PEOPLE WITH DISABILITIES.

Integration into the community means more than just the physical location of a home. It must include access to public or private transportation that is accessible, within reasonable range of a person’s home, and affordable, and allow for involvement in community activities such as work, volunteer and civic engagement, recreation, worship and shopping.

Transportation can be particularly challenging and isolating, and connections to transportation are especially important for housing for persons with disabilities. Transportation is a critical and expensive variable which can undermine an affordable housing opportunity. People with disabilities are among those (also including the elderly, children, and the poor) who are effectively disenfranchised by habitual automobile-oriented planning and development. When housing is not wisely located in areas with convenient public transportation this exacerbates all the problems that may make daily life difficult for people with disabilities.

Beyond transportation, for community-based solutions to work, there must be adequate community. People with disabilities and their allies recognize unresolved conflicts between goals, such as independent living, on the one hand, the need for support, on the other, without which life can be accompanied by a tremendous sense of isolation and anxiety. Compact, mixed use development can provide for more walkable neighborhoods, convivial streetscapes, and a diversity and energy that are welcoming and reassuring, helping to foster human contact and mutual aid. Community planning and design that successfully incorporate these features contribute to quality of life for all residents, not only people with disabilities.

SYSTEMS

Participants in the focus groups convened to inform this report spoke frequently of the challenges in navigating the housing and disabilities services systems. Improving these systems is also a key part of building a community-based system of care. There should be no “wrong door” for a person with a disability looking for assistance; they should be able to find the right help when they need it with their first point of contact. Housing assistance and disabilities services should complement each other to ensure that they receive the supports they need to remain in the community.

RECOMMENDATION 4: IMPROVE THE AFFORDABLE HOUSING AND DISABILITIES SERVICES SYSTEMS THAT SERVE PEOPLE WITH DISABILITIES.

4.1 CONTINUE TO BUILD AND IMPROVE CONNECTIONS BETWEEN AND WITHIN THE AFFORDABLE HOUSING AND DISABILITIES SERVICES SYSTEMS.

Efforts to expand rental housing opportunities for people with disabilities must focus on prioritizing integrating people and affordable units into the community. A blend of tenant-based and project-based rental assistance strategies will ensure both that vouchers are available for people to choose their own homes as well as that affordable units are set-aside for people with disabilities in typical multifamily developments.

A key part of both of these strategies is the development of connections and communications between the disability services and housing systems. To function effectively, these programs must ensure that people who choose to live in the community receive the supportive services and housing assistance they need from these two diverse systems in a coordinated way. In addition, at the most basic level, we have to be sure that there are units for people to live in, and, when developers set-aside units for people with disabilities, that there are people to live in the units. This requires a high level of partnership and interaction between a number of agencies: the partnership between DSHA, DHSS and the Department of Services for Children, Youth and their Families (DSCYF) in the implementation of the new State Rental Assistance Program (SRAP) and pursuing federal program opportunities are excellent examples of these initiatives.

PROGRAM PROFILE: DELAWARE STATE RENTAL ASSISTANCE PROGRAM (SRAP)

SRAP was developed as a partnership between the Delaware State Housing Authority, Department of Health and Human Services, and Department of Services for Children, Youth and their Families. The program provides rental assistance to low-income Delawareans who require affordable housing and supportive services to live safely and independently in the community. Target populations include people living in state-run long-term care facilities, kids exiting foster care, and homeless individuals and families. A key advocacy point for the program has been the cost savings associated with helping people to live stably in the community as opposed to institutions or moving in and out of service systems: these families and individuals are often in the state's care ultimately due to a lack of affordable housing. Providing rental assistance via SRAP is estimated to cost \$8,000-\$10,000 per household annually.

With its experience in the administration of the federal Housing Choice Voucher (Section 8) program, DSHA administers the rental subsidies (reviewing applications, approving participants, inspecting rental units, making payments to landlords, annual tenant recertification and ongoing compliance), and DHSS, DSCYF and their partners and contractors screen and refer applications to DSHA and fulfill the program's supportive services component through the provision of home-based care.

SRAP was first funded in the 2011 legislative session to begin operation in FY 2012, with \$1.5 million in funding expected to serve 150-200 households. In August 2011, the program became operational. DSHA and its partners supporting SRAP are requesting an increase to \$3 million for the program in FY 2013.

SRAP was developed out of an earlier pilot program, Step Up, funded from the state Housing Development Fund (HDF) from 2007-2011. Through an RFP allocation process, nonprofit service providers were able to combine rental assistance through Step Up with supportive services. \$1.4 million in HDF allocations over three years served 147 families/individuals. The Step Up pilot program demonstrated the very positive outcomes for consumers when housing assistance was coordinated with supportive services.

4.2 IMPROVE TRIAGE ASSESSMENT OF CONSUMERS' HOUSING NEEDS AND STATEWIDE DATA COLLECTION ON THESE NEEDS.

Improving discharge policies and initial housing needs assessment at intake and annual recertification is a homelessness prevention strategy. Members of the study working group have worked together and with DHSS to reformat a model [federal housing needs assessment matrix](#) into one that can be used in Delaware. Ideally, this assessment should be incorporated into the intake process across all key DHSS divisions. Expanded assessment of consumers' housing needs at initial intake should improve quality of services and improve identification of individuals who are precariously housed and at risk of homelessness.

If implemented uniformly across all DHSS Divisions, the new assessment form could be an incredibly valuable source of information on housing needs. Currently, the DHSS Divisions all use different registry systems tailored to

their populations. They may have extensive housing information or little to no housing information; or they may have fields for housing questions that are often not recorded. Uniform questions and measures across all Divisions will greatly improve the availability and quality of data about the housing needs of DHSS' clients. Implementation of the new assessment form across DHSS will be challenging, but is vital to both improving services and improving the data available on housing needs long-term. Beyond DHSS, a uniform housing assessment could also be implemented in all systems and institutions which frequently serve people with disabilities, including the Department of Corrections (DOC) and Department of Services for Children, Youth and their Families (DSCYF).

For some populations, peer support programs may also be a source of ongoing qualitative information about housing needs. Peer-operated resource centers which provide supports to people with mental health and substance abuse problems are regularly in touch with people who need housing, have lost their housing, and other housing issues. These programs, staffed and managed by people who themselves have disabilities, have their 'ear to the ground' regarding the needs of people with similar problems in ways that service providers might not.

In addition, to facilitate future efforts to assess the housing needs of people with disabilities, the state should improve the collection and maintenance of information about the baseline inventory of housing targeting specific populations. While DHSS Divisions maintain information about housing where they provide assistance, some populations have large networks of supportive housing that is not assisted by DHSS and thus little or no information on the entire inventory may be available. An assessment of existing resources is a critical part of assessing needs; information about the existing inventory of supportive housing should be easily accessible and maintained. We encourage DSAMH, DSAAPD and DDDS to develop, maintain and centralize inventory information for their target populations.

4.3 FOSTER AND IMPROVE COORDINATION AMONG THE STATE'S PUBLIC HOUSING AUTHORITIES (PHAS), BOTH AMONG THEMSELVES AND WITH PROVIDERS OF SERVICES TO PEOPLE WITH DISABILITIES.

Efforts to improve coordination and interchangeability among DE's Public Housing Authorities (PHAs) on their waiting lists and eligibility requirements would benefit consumers. This was a repeated comment in almost all focus groups: it is extremely challenging to navigate and get transportation to get on multiple waiting lists, understand different eligibility requirements and monitor one's status on multiple lists.

Public housing authorities are critical partners in the effort to prevent and end homelessness and critical providers of housing for people with disabilities and low incomes. A main recommendation from the U.S. Interagency Council on Homelessness is that PHAs review and streamline their administrative policies and procedures to reduce barriers and improve access for people with disabilities and who are homeless. This may include things like reducing background and credit checks, how communication with people without a permanent mailing address is handled, documentation requirements, waiting list management, and sharing information across public agencies. In Delaware, a very small state with five public housing authorities where many households are willing to take a unit wherever they can, reviewing and streamlining policies and procedures is not only important for each PHA but across all PHAs. Improving the portability of vouchers across Delaware's PHAs, a recommendation in the 2011 *Analysis of Impediments to Fair Housing Choice*, is also an important improvement to benefit consumers.

Coordination with service providers may also improve access and service to consumers. For example, allowing people with disabilities who are transient to list their service provider's address and phone number as a point of contact may improve notification when they reach the top of the waiting list. Currently, if attempts to reach them by phone or mail are unsuccessful, people go to the bottom of the list. For people with disabilities who are housed, using their service provider as a kind of emergency contact who can step in to resolve problems before they result in eviction may also help people to remain housed once they do get assistance. As another example, DHSS has recently engaged with the Wilmington Housing Authority in a pilot diversion program to assist residents at risk of being evicted due to housekeeping issues, frailty and late rent issues. WHA will contact DHSS when residents who are elderly are having housekeeping or rent issues potentially leading to eviction. A DHSS contractor will do an assessment to determine the resident's needs and connect the resident to services to prevent eviction.

The study working group understands that some of these are large, challenging, and long-term issues, but given the size of the state and small number of public housing authorities, improved coordination to benefit consumers and potentially also improve efficiency in the delivery of services is an important endeavor.

4.4 IMPROVE THE HOUSING SYSTEM'S COMMUNICATION WITH CONSUMERS AND DEVELOP MORE ACCESSIBLE, CENTRALIZED, USER-FRIENDLY SOURCES OF INFORMATION.

Delaware's housing system is difficult to navigate (multiple waiting lists, eligibility requirements, etc.) and to even get there, people face a fragmented system for information: there is no one to explain all the options and point people in the right direction the first time. Those who are successful usually end up finding the right program through long trial and error, word of mouth, or luck. Many specific populations have their own resource directories, which have different or incomplete housing information, and housing-specific directories can be so comprehensive that they leave people adrift in options.

Three key resources on housing and services are the DSHA [Housing Services Directory](#), the [Delaware 211](#) website and phone system, and DSAAPD's new [Aging and Disability Resource Center](#). A cooperative initiative is needed to ensure these resources share and report the same timely information and give people as much detail as possible about potential providers and eligibility requirements. For example, the 211 website is not searchable by County; both the 211 website and ADRC give little detail about what services different providers offer and listings should be reviewed for appropriateness. DSHA's Housing Services Directory includes very comprehensive and annually updated housing information, but it is a static publication, not a searchable website. We recommend the providers of these various directories and referral services work to improve coordination and links between their services.

4.5 FACILITATE INPUT ABOUT DISABILITY HOUSING NEEDS INTO THE VARIOUS HOUSING AND DISABILITY PLANNING PROCESSES.

The Housing Sub-committee of the Governor's Commission on Community-based Alternatives, which has served as the working group for this report, should be kept active as a venue to continue communication between the disability and housing systems. It should also be a central location to facilitate input about the housing needs of people with disabilities and priorities for meeting those needs into the many planning processes in both the housing and disability systems. Each field alone has numerous different planning processes, including:

- Comprehensive Plans created by Counties and municipalities to guide land use, which include a Housing Element on housing needs;
- 5-Year Consolidated Plans and annual Action Plans created by HUD-funded jurisdictions (the Delaware State Housing Authority, New Castle County and Cities of Wilmington, Newark and Dover)
- Annual Plans developed by the five public housing authorities (PHAs);
- Strategic plans and other plans developed by Divisions in the Department of Health and Social Services (DHSS), such as the State Plan on Aging; and
- Strategic plans developed by nonprofit service providers and affordable housing providers;

All plans should be strongly encouraged to include elements, where relevant, to advance the priorities and recommendations in this report to:

- Increase the availability of and access to rental and homeownership opportunities with accessibility features;
- Increase the availability of and access to affordable housing for people with disabilities;
- Build a community-based system of care with a range of housing options; and
- Improve the affordable housing and disabilities services systems that serve people with disabilities.

APPENDIX: MATRIX OF RECOMMENDATIONS

Accessibility	Affordability	Community	Systems
Increase the availability of and access to rental and homeownership opportunities with accessibility features.	Increase the availability of and access to affordable housing for people with disabilities.	Build a community-based system of care with a range of housing options for consumers.	Improve the affordable housing and disabilities services systems that serve people with disabilities.
Improve real-time information on available accessible and affordable units for consumers.	Increase the availability of Low Income Housing Tax Credit (LIHTC) properties to people with disabilities, especially those with extremely low incomes.	Prioritize community-based care by redirecting resources from institutional care to community-based services and providing for housing needs.	Continue to build connections between and within the affordable housing and disabilities services systems.
Reduce fair housing barriers to affordable and accessible housing.	Expand incentives for basic access and universal design features in affordable housing.	Ensure a range of housing options, meaningful choices and adequate supports for people to live and receive care in the community.	Improve triage assessment of consumers' housing needs and statewide collection of data about these needs.
Establish a common vocabulary and set of standards for accessibility features in the affordable housing industry.	Continue to invest in permanent supportive housing.	Continue to develop and implement diversion and transition strategies to prevent institutionalization and reduce readmissions.	Foster and improve coordination among the state's Public Housing Authorities (PHAs), both among themselves and with providers of services to people with disabilities.
Increase the prevalence of basic access features in all new homes.	Improve asset-building opportunities for people with disabilities.	Implement the <i>Exemplary Practices in Discharge Planning</i> , especially at all state-operated institutions and prisons, to improve connections to permanent housing and prevent subsequent homelessness.	Improve the housing system's communication with consumers and develop more accessible, centralized, user-friendly sources of information.
Expand and coordinate resources for accessibility modifications for homeowners and homebuyers.		Improve community planning to benefit community quality of life for all residents and foster real integration for people with disabilities.	Facilitate input about disability housing needs into the various housing and disability planning processes.

ENDNOTES

- ¹ U.S. Census Bureau, 2010 American Community Survey.
- ² Delaware Population Consortium, 2010 Population Projection series. http://stateplanning.delaware.gov/information/dpc_projections.shtml
- ³ 2009 rates of disability prevalence by age and sex were applied to the Delaware Population Consortium's 2010 Population Projection series by age and sex. The 2009 rate of disability by age and sex was held constant through 2040. http://stateplanning.delaware.gov/information/dpc_projections.shtml
- ⁴ The CPS covers individuals 16 years of age and older in the civilian noninstitutionalized population.
- ⁵ Current Population Survey, calculated by the Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics
- ⁶ U.S. Census Bureau, 2008-2010 American Community Survey.
- ⁷ U.S. Census Bureau Poverty Thresholds. <http://www.census.gov/hhes/www/poverty/data/threshld/index.html>
- ⁸ U.S. Census Bureau, 2008-2010 American Community Survey.
- ⁹ Homeless Planning Council of Delaware, *2011 Point in Time Study Report*. http://www.hpcdelaware.org/documents/2011_PIT_Data_Presentation.pdf
- ¹⁰ U.S. Social Security Administration, *2010 Annual Statistical Supplement*. Washington, DC. 2011. <http://www.ssa.gov/policy/docs/statcomps/supplement/>
- ¹¹ Internal Revenue Service, Department of the Treasury, *Characteristics of Disabled Taxpayers Ages 18 to 59: Study of Filing Patterns and Preferences for Receiving Tax Information and Services*. Pub. 4640. Washington, DC: IRS. 2009.
- ¹² National Low Income Housing Coalition, *Out of Reach 2011*. <http://nlihc.org/oor/oor2011/>
- ¹³ U.S. Department of Housing and Urban Development, 2006-2008 Comprehensive Housing Affordability Strategy (CHAS) Data. Compiled by the Delaware State Housing Authority. <http://www.huduser.org/portal/datasets/cp.html>
- ¹⁴ Approximately 13,600 on PHA waiting lists (source: *Analysis of Impediments to Fair Housing Choice*, 2011, and DSHA); at least 3,000 on LIHTC site waiting lists as of 12/31/10 (source: DSHA); and 8,170 on project-based Section 8 waiting lists as of 12/31/11 (source: DSHA).
- ¹⁵ U.S. Census Bureau, 2008-2010 American Community Survey.
- ¹⁶ U.S. Department of Housing and Urban Development, 2005 – 2007 CHAS Data. Compiled by the Delaware State Housing Authority. <http://www.huduser.org/portal/datasets/cp.html>
- ¹⁷ Ibid.
- ¹⁸ LaPlante, Mitchell P., *Demographics of Wheeled Mobility Device Users*. Paper presented at the conference on Space Requirements for Wheeled Mobility, October 9-11, 2003. <http://www.ap.buffalo.edu/ideaproto/Space%20Workshop/Papers/Mitchell%20LaPlante/Demographics%20of%20Wheeled%20Mobility%20-%20Mitchell%20P%20LaPlante.pdf>
- ¹⁹ Louie, Josephine. *The Housing Modifications for Disabled Elderly Households*. Joint Center for Housing Studies of Harvard University, September 1999. http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/louie_w98-8.pdf
- ²⁰ U.S. Department of Housing and Urban Development, 2006-2008 CHAS Data. Compiled by the Delaware State Housing Authority. <http://www.huduser.org/portal/datasets/cp.html>
- ²¹ Smith, Stanley, Rayer, Stefan and Smith, Eleanor. "Aging and Disability: Implications for the Housing Industry and Housing Policy in the United States", *Journal of the American Planning Association* 74, no. 3. 2008: 289-306.
- ²² Mullin & Lonergan Associates. *Delaware State Consortium Analysis of Impediments to Fair Housing Choice*. Dover, DE: Delaware State Consortium, 2011. http://www.destatehousing.com/FormsAndInformation/Publications/impediment_part0.pdf
- ²³ Smith, Stanley, Rayer, Stefan and Smith, Eleanor. "Aging and Disability: Implications for the Housing Industry and Housing Policy in the United States", *Journal of the American Planning Association* 74, no. 3. 2008: 289-306.
- ²⁴ U.S. Department of Housing and Urban Development, 2005 – 2007 CHAS Data. Compiled by the Delaware State Housing Authority. <http://www.huduser.org/portal/datasets/cp.html>
- ²⁵ Louie, Josephine. *The Housing Modifications for Disabled Elderly Households*. Joint Center for Housing Studies of Harvard University, September 1999. http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/louie_w98-8.pdf

²⁶ U.S. Department of Housing and Urban Development, Office of Policy Development and Research. *2009 Worst Case Housing Needs of Persons with Disabilities: Supplemental Findings of the Worst Case Housing Needs 2009: Report to Congress*. Washington, DC. March 2011. http://www.huduser.org/Publications/pdf/WorstCaseDisabilities03_2011.pdf

²⁷ Pelletiere, Danilo and Kathryn P. Nelson. *Leveraging the AHS to Better Estimate Housing Needs of Persons with Disabilities*. Paper prepared for presentation at the American Housing Survey User Conference, Washington, DC. March 8, 2011.

Recent research from the National Low Income Housing Coalition (NLIHC) comparing rates of disability prevalence and housing needs in the American Housing Survey (AHS), the data source used in HUD's *Worst Case Needs* report, and the American Community Survey (ACS), show that despite efforts to coordinate survey questions on disability, the ACS still shows higher rates of disability than the AHS, from 38 to 99% higher for the six different disability questions, and the disparity tends to be highest for nonelderly renters.

Comparison figures estimated with the American Community Survey and adjusting for the higher rates of disability prevalence shown in more detailed national surveys like the National Health Interview Survey (NHIS) and Survey of Income and Program Participation (SIPP) suggest the national total is likely substantially higher. Pelletiere and Nelson's attempt to create state-level estimates using AHS data and ACS geography suggests that 61% of adult nonelderly households with disabilities in Delaware have worst case housing needs, or approximately 5,000 households: in line with the higher estimate of 4,559 produced for Delaware.

²⁸ VLI renter households with housing subsidy calculated using information on public housing and Housing Choice Voucher residents from data reported by the Delaware Public Housing Authorities in September 2010 for the statewide Analysis of Impediments to Fair Housing Choice, the number of HUD- and RD-subsidized multifamily units (Project-based Section 8, Section 202, and USDA RD 515 Rental Assistance) from DSHA's Preservation Database, occupancy of HUD-subsidized units from HUD's Picture of Subsidized Households Data, 2008; and Occupancy of RD-subsidized units, RD Multifamily Occupancy Report 2010. Severe housing problems include cost burden over 50% of household income, inadequate kitchen or plumbing facilities, or overcrowding. Estimate produced using percentage of nonelderly very low-income renter households with a disability as reported by the ACS (25.2%).

²⁹ Estimate developed for this report. See Table 5.

³⁰ Hartnett, Johnette and Davies, Tobey. "Disability-Inclusive Asset Building: New Strategies for Achieving Real Economic Impact for Americans with Disabilities," in *Opportunities for Community Development Finance in the Disability Market*, 39-53. Boston: Federal Reserve Bank of Boston, 2010. <http://www.bos.frb.org/commdev/cdevfin-disability-market/index.htm>

³¹ CFED, 2011 Assets & Opportunity Scorecard. <http://cfed.org/scorecard/>

³² Reinhard, Susan C., Enid Kassner, Ari Houser and Robert Mollica. *Raising Expectations: A State Scorecard on Long-term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*. September 2011. <http://www.longtermscorecard.org>

³³ Ibid.

³⁴ Kitchener, M., Ng, T., Miller, N., & Harrington, C.; Institutional and Community-Based Long-Term Care: A Comparative Estimate of Public Costs; *Journal of Health & Social Policy*, Vol. 22 (2), 2006.

³⁵ Bridges, Katherine and Danielle Goodwin. AARP. *The Road Ahead: AARP Survey on Community Services in Delaware*, March 2009. http://www.aarp.org/home-garden/livable-communities/info-04-2009/de_hcbs_09.html

³⁶ American Health Care Association, compilation of OSCAR data, December 2009. http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx

³⁷ Reinhard, Susan C., Enid Kassner, Ari Houser and Robert Mollica. *Raising Expectations: A State Scorecard on Long-term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*. September 2011. <http://www.longtermscorecard.org>

³⁸ Delaware Interagency Council on Homelessness, *Breaking the Cycle: Delaware's Ten-Year Plan to End Chronic Homelessness*. 2007. http://destatehousing.com/FormsAndInformation/Publications/delaware_ten_yr_plan.pdf p. 33.