

GAO

Report to the Chairman, Subcommittee
on Housing and Urban Affairs,
Committee on Banking, Housing, and
Urban Affairs, U.S. Senate

August 1992

PUBLIC HOUSING

Housing Persons With Mental Disabilities With the Elderly





United States
General Accounting Office
Washington, D.C. 20548

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**Resources, Community, and
Economic Development Division**

B-238897

August 12, 1992

The Honorable Alan Cranston
Chairman
Subcommittee on Housing and Urban Affairs
Committee on Banking, Housing, and
Urban Affairs
United States Senate

Dear Mr. Chairman:

As you requested, we are reporting on issues arising from the admission of nonelderly persons with mental disabilities to public housing for the elderly. This report contains matters for consideration by the Congress and recommendations to the Secretary of Housing and Urban Development aimed at more effectively serving the needs of nonelderly persons with mental disabilities who reside in these housing units.

We are sending copies of this report to congressional committees and subcommittees interested in housing matters; the Secretary of Housing and Urban Development; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties. Copies will be made available to others on request.

Additionally, supplemental materials upon which parts of this report are based—a detailed legal memorandum and data from our national survey of public housing agencies—are being forwarded to you under separate cover and will be made available to others upon request.

This work was performed under the direction of Judy A. England-Joseph, Director of Housing and Community Development Issues, who can be contacted at (202) 275-5525. Major contributors to this report are listed in appendix X.

Sincerely yours,

J. Dexter Peach
Assistant Comptroller General

Executive Summary

Purpose

Reported problems from housing nonelderly persons with mental disabilities in federally assisted public housing for the elderly have led to congressional concern that local public housing agencies are not able to provide quality housing for either group. The Chairman, Subcommittee on Housing and Urban Affairs, Senate Committee on Banking, Housing and Urban Affairs, asked GAO to (1) examine the problems associated with housing these groups together; (2) review the need for additional support services for persons with mental disabilities living in public housing; and (3) review the laws and regulations governing the selection and admission of people with mental disabilities to public housing and other federally subsidized housing.

Background

Public housing is owned and operated by about 3,100 local government agencies, called public housing agencies (PHA), which are subsidized and overseen by the Department of Housing and Urban Development (HUD). Of about 1.2 million lower-income households served by the program, over one-third are estimated to include the elderly, age 62 and over. PHAs place nonelderly people with mental disabilities in public housing designated for the elderly largely because public housing law defines "elderly families" to include people who have disabilities whether or not they are elderly.

Results in Brief

Households having nonelderly persons with mental disabilities occupy about 9 percent of the public housing units for the elderly that GAO studied. In response to GAO's nationwide questionnaire, PHAs reported that persons in about 31 percent of these households cause moderate or serious problems, such as threatening other tenants and having disruptive visitors. According to PHA management, these problems take more time to resolve than problems created by the elderly. The number of nonelderly persons with mental disabilities in public housing for the elderly is increasing, according to PHA interest groups.

While about 78 percent of PHAs reported that mental health services are provided in their communities, GAO could not assess the adequacy of these resources because available data do not indicate the extent to which these services are used by residents of public housing. Where services do exist, cooperative agreements between PHAs and local mental health service providers have helped to ensure that needed mental health care is available to nonelderly residents of public housing who have disabilities. The use of such agreements is widely supported by housing and mental health officials.

The rights of nonelderly persons with mental disabilities to reside in federally subsidized housing primarily serving the elderly vary by federal program. Owners or sponsors of housing provided under three rental housing programs (the sections 202, 221(d)(3), and 236 programs) may lawfully limit occupancy to the elderly and exclude all nonelderly persons, including those with mental disabilities. In contrast, excluding nonelderly persons with mental disabilities from public housing for the elderly or from section 8 rental housing would violate the antidiscrimination requirements of the Fair Housing Act and the Rehabilitation Act of 1973. This contrast exists because of differences in the language of the statutes governing the respective programs.¹

Principal Findings

Extent of Problems

Only about 9 percent (29,000 units) of the public housing units for the elderly in GAO's survey (330,000 total units) are occupied by nonelderly persons with mental disabilities. However, according to PHA managers responding to the questionnaire, a far greater percentage of nonelderly tenants with mental disabilities (31 percent) than elderly tenants (6 percent) exhibit behavior that creates moderate to serious problems for agency management and staff and for other households. When disruptive behaviors occur, PHA management and staff often have to spend a considerable amount of time reassuring frightened elderly tenants. According to PHA managers, while elderly tenants also cause problems, generally they are less problematic and take less time to resolve.

In GAO's survey, medium-sized, large, and the largest PHAs indicated that problems with nonelderly tenants with mental disabilities living in public housing for the elderly had increased over the previous year (25 percent, 49 percent, and 58 percent, respectively). Recent HUD data suggest that the population of nonelderly tenants with mental disabilities is rising in large PHAs. According to housing officials, the shift from institutional to community-based mental health care, recent regulations that prohibit discrimination in housing, and the lack of affordable housing have all contributed to the growing numbers of nonelderly tenants with mental disabilities in public housing for the elderly. (See ch. 2.)

¹A legal analysis and the results of our national survey of public housing agencies, upon which parts of this report are based, are available upon request (see ch. 1).

Support Services

According to mental health experts, support services can enable most people with mental disabilities to live successfully in public housing. However, on the basis of limited information, GAO found that the availability of these services varies at public housing agencies. Where services are available, mental health experts and public housing interest groups GAO contacted advocated using cooperative agreements between local mental health service providers and public housing agencies. These agreements have helped ensure that persons with mental disabilities receive housing and mental health services. According to public housing managers in Danbury, Connecticut, and LaSalle County, Illinois, where such agreements exist, tenants who receive these services exhibit few or no behavioral problems. HUD and the Department of Health and Human Services (HHS) support efforts by PHAS and mental health service providers to enter into cooperative agreements. The two agencies are developing guidance, including a model cooperative agreement, to assist such efforts. (See ch. 4.)

Rights of Persons With Mental Disabilities

From analyzing program statutes, antidiscrimination laws, and case law that affect housing persons with mental disabilities with the elderly, GAO concluded that excluding or segregating nonelderly persons with mental disabilities under the public housing program and the section 8 private-market rental assistance program violates antidiscrimination statutes. By contrast, GAO believes that owners or sponsors of housing provided under three other federally assisted programs serving the elderly—the sections 202, 221(d)(3), and 236 programs—may lawfully limit occupancy to the elderly, thereby excluding nonelderly persons with mental disabilities. This contrast exists because of differences in the language of the statutes governing the respective programs. (See ch. 5.) GAO also found that PHAS are having difficulty in determining whether applicants are suitable for tenancy because HUD regulations, based on the antidiscrimination statutes, prohibit PHAS from inquiring into the nature or severity of applicants' handicaps, even though they are expected to make accommodations for tenants with handicaps. (See ch. 3.)

Recommendations

To assist PHAS in addressing the needs of tenants with mental disabilities, GAO recommends, among other things, that the Secretary of HUD require PHAS to actively seek out mental health service providers as partners in cooperative agreements. To assist such efforts, GAO recommends that the Secretary work with HHS to issue guidance now being developed for all PHAS on establishing cooperative agreements with local mental health

service providers. As planned, a model cooperative agreement should be included in such guidance.

To provide the Congress, through HUD, with an initial assessment of the sufficiency of mental health services available to public housing tenants, GAO also recommends that the Secretary of HUD direct PHAs to report to HUD on situations where local mental health providers do not exist or are unable to enter into cooperative agreements because of insufficient resources. (See ch. 4.)

Matters for Congressional Consideration

On the basis of information in this report, other studies, and any congressional oversight hearings, the Congress should consider addressing the issue of housing nonelderly persons with mental disabilities with the elderly. Actions that the Congress could consider include, but are not limited to, the options discussed in this report. (See ch. 6.) In considering options the Congress will need to reconcile the rights and needs of both groups in a manner that is fair and equitable to both.

Agency Comments and GAO's Evaluation

HUD, HHS, the American Association of Retired Persons (AARP), the Council of Large Public Housing Authorities (CLPHA), the Mental Health Law Project (MHLP), and the National Association of Housing and Redevelopment Officials (NAHRO) commented on a draft of this report. (See apps. III to VIII.) In commenting on the draft report, HUD did not express agreement or disagreement with GAO's recommendations. In its comments, HHS stated that it and HUD would issue the model cooperative agreement that the two agencies are developing. MHLP supported GAO's recommendations, while AARP, NAHRO, and CLPHA questioned whether the draft recommendations went far enough to address problems discussed in the draft report. GAO recognizes that its recommendations will not resolve all the problems noted by the commenters. However, GAO considers them to be an appropriate starting point in dealing with this complex problem.

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Abbreviations

AARP	American Association of Retired Persons
ADA	Americans with Disabilities Act
CLPHA	Council of Large Public Housing Authorities
GAO	General Accounting Office
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
MHLP	Mental Health Law Project
NAHRO	National Association of Housing and Redevelopment Officials
NIMH	National Institute of Mental Health
PHA	public housing agency
SMHA	State Mental Health Agency

Introduction

The Department of Housing and Urban Development's (HUD) public housing program is the oldest and one of the largest federal programs for assisting lower-income households in obtaining affordable rental housing. HUD funds the construction of locally owned public housing units designated for lower-income households, including the elderly. According to public housing officials from around the country, the number of nonelderly tenants with mental disabilities in public housing for the elderly has grown. Many of these officials claim that behavioral problems of nonelderly tenants with mental disabilities, as well as significant lifestyle differences between them and elderly tenants, are impeding the housing agencies' ability to provide quality housing for either constituency. Congressional concern about this situation led to this study.

Nonelderly Tenants With Mental Disabilities Reside in Public Housing for the Elderly

About 3,100 local government agencies called public housing agencies (PHAs) own and operate public housing. PHAs operate under contract with HUD, which is responsible for, among other things, providing guidance for, overseeing, and subsidizing local administration of public housing programs. Public housing agencies serve about 1.2 million households estimated to include over 400,000 "elderly households" residing in either family projects or projects for the elderly.¹ The United States Housing Act of 1937, as amended, defines "elderly families" to include individuals with handicaps.

Federal housing law provides that persons with handicaps, including people with mental disabilities, may reside in public housing designated for the elderly. While HUD regulations define the elderly as persons at least 62 years of age, individuals with mental disabilities are of any age with a mental impairment that distinguishes them from other individuals with handicaps. According to the American Psychiatric Association, mental disorders fall into two overall categories. The first comprises clinical syndromes, such as mood disorders, anxiety, substance abuse, and schizophrenia. The second includes developmental disorders, such as mental retardation and personality disorders.

Besides nonelderly people with mental disabilities being defined as elderly families, several other factors have led nonelderly people with mental disabilities to enter public housing for the elderly:

Deinstitutionalization: Deinstitutionalization refers to an overall reduction in the use of state mental hospitals and a general increase in reliance on

¹Each household refers to the occupants of one unit.

community mental health and other social service resources to meet the needs of people with mental disabilities.

Implementation of Antidiscrimination Statutes: HUD finalized in 1988 and in 1989 regulations implementing federal laws concerning antidiscrimination. The antidiscrimination laws prohibit, among other things, discrimination in housing against persons with mental disabilities. HUD's regulations guarantee people with mental disabilities access to public housing if they are otherwise eligible.

Lack of Affordable Housing: People with mental disabilities generally have very low incomes and, as a result, have been affected by the depletion of the affordable housing stock, such as single-room-occupancy hotels. Also, these individuals are often single and need efficiencies or one-bedroom units, which frequently are the kind of units in public housing for the elderly.

HUD's Rules Affording Preferences: In 1988 HUD finalized its preference rules for priority admission to public housing. The regulations give preference to individuals who have been displaced from their residence, live in substandard housing, or pay more than 50 percent of their family income for rent. People with mental disabilities often meet one of these criteria and thus benefit from this rule.

Objectives, Scope, and Methodology

The Chairman, Senate Subcommittee on Housing and Urban Affairs, Committee on Banking, Housing and Urban Affairs, asked us to review various issues concerning housing nonelderly people with mental disabilities with the elderly in public housing designated for the elderly. Accordingly, we reviewed

- the nature and extent of problems associated with nonelderly people with mental disabilities residing in public housing for the elderly (see ch. 2);
- issues in screening applicants with mental disabilities for admission to public housing (see ch. 3);
- the delivery of mental health services to people with mental disabilities in public housing and need for additional support services for these people (see ch. 4);
- the laws and regulations governing the eligibility, selection, and admission of people with mental disabilities to public housing and other federally subsidized rental housing (section 202 housing, section 8 housing, section

- 221(d)(3) housing, and section 236 housing, all of which serve both elderly and households with disabilities) (see ch. 5); and
- the procedures particular PHAS use to select, admit, and evict tenants with mental disabilities (see app. I for our findings and the methodology we used).

Consideration of problems associated with the mixing of nonelderly people with mental disabilities with the elderly raises issues not directly addressed in our review. These issues primarily concern the federal and state roles in providing housing and mental health services for people with mental disabilities and legal and fiscal constraints that serve to limit governmental options and protect individual rights. Chapter 6 of this report discusses legislative options proposed by interested parties to address problems caused by nonelderly tenants with mental disabilities in public housing for the elderly (see ch. 6).

To determine the nature and extent of problems associated with nonelderly people with mental disabilities residing in housing designated for the elderly, in mid 1990 we mailed a questionnaire to a stratified sample of 1,073 PHAS selected on the basis of their size. In this questionnaire, we inquired about problems that nonelderly tenants with mental disabilities and elderly tenants cause in public housing projects for the elderly and in family public housing projects.² Data reported represent PHAS' estimates of the type and level of behavioral problems; our overall results are representative of an estimated 2,644 PHAS, or approximately 85 percent of all PHAS. However, because (1) some PHAS do not have both projects for the elderly and projects for families and (2) some PHAS did not respond to all questions, data reported for individual questions will frequently represent fewer than 2,644 PHAS (see app. II for additional details on how we conducted our survey). As with all sample surveys, this survey is subject to sampling error. Sampling errors define the upper and lower bounds of the estimates made from the survey. Sampling errors for the estimates in this report were calculated at the 95-percent confidence level.

Generally, PHAS do not maintain data on applicants' or tenants' handicaps because they are generally prohibited by antidiscrimination regulations

²Our survey defined mentally disabled households as households where one or more members (which may include head of household) have or are perceived to have such conditions as schizophrenia or affective disorders or personality disorders (e.g., obsessive compulsive disorder) or mental retardation or organic brain syndrome or specific learning disabilities.

from inquiring into the nature or severity of handicaps.³ As a result, we asked PHAS to give their best estimates of these data. Additionally, while our estimates of service availability broadly apply to all people with mental disabilities, our report focuses on the availability and need of services only by people with mental illness. We made this distinction because, according to almost all state and local mental retardation/developmental disability officials we contacted, people with mental retardation and other developmental disabilities living outside of hospitals generally reside in group homes in the communities we visited. Furthermore, according to a national mental retardation/developmental disability research program director, the presence of people with mental retardation or other developmental disabilities in public housing appears to be very small.

Additionally, in determining the nature and extent of the problems associated with nonelderly tenants with mental disabilities in public housing for the elderly, we reviewed a HUD report on this issue as well as a survey conducted by the National Association of Housing and Redevelopment Officials (NAHRO).⁴ We also obtained examples of specific nonelderly tenant behavior during preliminary work at public housing for the elderly sites in Dallas, Texas; Pittsburgh, Pennsylvania; and Montgomery County, Maryland.

To examine issues in screening applicants with mental disabilities for admission to public housing, we interviewed officials at five PHAS located in Danbury, Connecticut; Denver, Colorado; Minneapolis and St. Paul, Minnesota; and Seattle, Washington (see app. I for how we selected these PHAS). At the five PHAS, we interviewed program officials and reviewed relevant documents. We also interviewed HUD officials from the Office of Fair Housing and Equal Opportunity, Office of Public and Indian Housing, and regional and area offices. We reviewed pertinent HUD documents and policy guidance. Furthermore, we interviewed officials from two national PHA interest groups, NAHRO and the Council of Large Public Housing Authorities (CLPHA). NAHRO represents 2,157 PHAS, or about 70 percent of PHAS nationwide, and CLPHA represents 55 large PHAS, or about 40 percent of all large PHAS.

³A PHA must maintain information on an applicant's or tenant's disability to the extent it is necessary to determine the individual's eligibility or make an accommodation to that disability.

⁴HUD Report to Congress: Housing Mentally Disabled Persons in Public Housing for the Elderly, 1991, and the NAHRO Deinstitutionalization Survey, 1989, respectively.

To examine the delivery of mental health services to people with mental illness and the need for additional support services funding, we reviewed the federal/state mental health system, including the local community support network for each of the five PHAs we visited, and federal mental health statutes. We interviewed numerous experts on mental health and/or housing issues, including officials at HUD; the National Institute for Mental Health (NIMH); the National Association of State Mental Health Program Directors and its research institute; CLPHA; and NAHRO. We also interviewed representatives of state, county, and local mental health providers, including housing specialists, mental health consumer and advocacy groups, and academic researchers supported by the Robert Wood Johnson Foundation and NIMH. Finally, we reviewed literature on the provision of community-based mental health services, including housing services.

Our work provided detailed data on the federal, state, and local mental health planning and treatment network, including examples of successful local programs. However, we could not determine the need for additional resources, particularly for support services, because national data on the availability of mental health support services and/or the extent to which they are used by public housing tenants are unavailable.

To evaluate the clarity and consistency of laws and regulations regarding the eligibility, selection, and admission of people with mental disabilities to public housing and other assisted housing programs, we reviewed the laws, regulations, and relevant case law governing the operations of the programs themselves, as well as the Social Security Act, the Rehabilitation Act of 1973, and the Fair Housing Act.

We performed our review between March 1990 and September 1991, with updates through May 1992, in accordance with generally accepted government auditing standards.

**Availability of
Questionnaire Results and
Legal Analysis**

This report contains selected results from our questionnaire and summarizes our legal analysis of the rights of people with mental disabilities to occupy federally assisted rental housing. For the complete set of questionnaire responses and sampling errors and the entire legal analysis, return the post card included in this report. If the post card is missing, please address your request to:

U.S. General Accounting Office
ATTN: Ms. Lisa Connolly
Room 1842
441 G Street, N.W.
Washington, D.C. 20548

Agency Comments on Our Methodology and Our Evaluation

We solicited comments from HUD, the Department of Health and Human Services (HHS), CLPHA, NAHRO, the American Association of Retired Persons (AARP), and the Mental Health Law Project (MHLF). Several of these organizations commented that our report should have addressed additional issues or have been carried out in a different way. In this vein, CLPHA and NAHRO criticized our review for not including other issues they considered important, such as the (1) needs and desires of the elderly or (2) appropriateness of mixing younger persons with the elderly in public housing. We agree that these issues are important. Yet, our work, while extensive, focused on those issues needed to respond to the Chairman's request. However, we have added a brief discussion of intergenerational conflict to chapter 2.

AARP recognized the extensive research in our review and stated that it will serve as an important data base for those formulating a reasonable and equitable policy for serving both elderly and younger public housing tenants. However, AARP indicated that we should have considered a larger question of whether public policy has failed to adequately serve the needs of persons with disabilities. We agree that consideration of our findings in this manner could be useful but would require a much expanded review.

HHS questioned whether our data were valid because, among other things, PHA respondents to our questionnaire were nonclinical observers of tenant behavior. We respond to this concern in chapter 2.

Various comments indicated that the report generally would have benefitted from input from elderly and/or nonelderly households with disabilities. We agree that such input would likely have provided insight into individual tenant feelings on the mixing of generations, problem behavior, and the need for additional service resources. Yet, collecting survey data from a representative sample of households would have been unrealistic since HUD does not maintain a mailing list of individual households. This information exists only at each of approximately 3,100 PHAS.

Chapter 1
Introduction

MHLP expressed satisfaction with our study, noting that our undertaking required us to consider civil rights law, mental health policies, housing procedures, management training, intergovernmental relations, perceptions about age and disability, and federal regulations.

Although commenting on other aspects of our draft report, HUD offered no substantive comments on our methodology.

PHAs' Views on Problems With Nonelderly Tenants With Mental Disabilities

Nationwide, for public housing units represented in our survey, PHA managers estimated that nonelderly tenants with mental disabilities occupy between 8 and 10 percent of the units in public housing for the elderly. According to PHA managers responding to our survey, between 28 and 34 percent of these households reportedly cause moderate or serious problems for PHA management and other tenants. Both the population of nonelderly tenants with mental disabilities and the level of problems caused by such tenants are greater in large PHAs. Problems include loud and abusive language, noisy activities at all hours, threats, and occasionally physical attacks. In comparison, the percentage of nonelderly persons with mental disabilities living in family projects is estimated to be between 4 and 5 percent. Reportedly, between 16 and 20 percent of these individuals cause moderate or serious problems for tenants and management in family projects.

When disruptive behaviors arise, PHA management and staff often have to spend a disproportionate amount of time resolving problems precipitated by the tenants with mental disabilities and reassuring elderly tenants. While from 6 to 7 percent of elderly tenants also cause moderate or serious problems for PHA management and other tenants, these problems do not take as long to resolve, according to PHA managers. Compared to 1989, in 1990, more PHAs reported increasing, rather than decreasing, problems with nonelderly tenants with mental disabilities living in public housing for the elderly. In this vein, six times as many large PHAs (those having 500 or more units) reported increasing rather than decreasing problems. While recent HUD data suggest and public housing interest groups report a rise in the population of these households in large PHAs, we do not know if problem behavior will also increase along with any increase in the population of nonelderly tenants with mental disabilities.

Population of Nonelderly Tenants With Mental Disabilities Is Relatively Small

Nonelderly people with mental disabilities occupy a relatively small percentage of the units in both projects for the elderly and family projects. Projects for the elderly differ from family projects in that tenancy is generally restricted to families defined as elderly.¹ Nationwide, in response to our questionnaire, PHAs estimate that the nonelderly people with mental disabilities occupy 28,810 ($\pm 1,498$) of 329,867 ($\pm 10,137$) units (8.8 percent (± 0.37 percent)) in public housing for the elderly. In contrast, PHAs estimated that nonelderly people with mental disabilities occupy 4.6

¹PHAs must give preference to elderly families when determining priority for admission to projects for the elderly. If there are not enough vacancies, the PHA may give a preference to near-elderly families (those whose head, spouse, or sole member is between 50 and 61 years old). If the PHA wants to admit single people, including the near-elderly single, it must obtain HUD approval.

Chapter 2
PHAs' Views on Problems With Nonelderly
Tenants With Mental Disabilities

percent (± 0.13 percent) of the units in family projects (31,569 ($\pm 1,027$) of 691,056 units ($\pm 11,800$)).

The concentration of nonelderly people with mental disabilities occupying public housing for the elderly tends to be greater in large PHAs (see fig. 2.1).² Specifically, the proportion of these tenants in large, medium-sized, and small PHAs is 11.0 percent, 6.4 percent (± 1.2 percent), and 3.2 percent (± 1.0 percent), respectively.³ In family projects, they occupy 4.9 percent, 3.9 percent (± 0.6 percent), and 2.6 percent (± 0.7 percent) of units, respectively.⁴

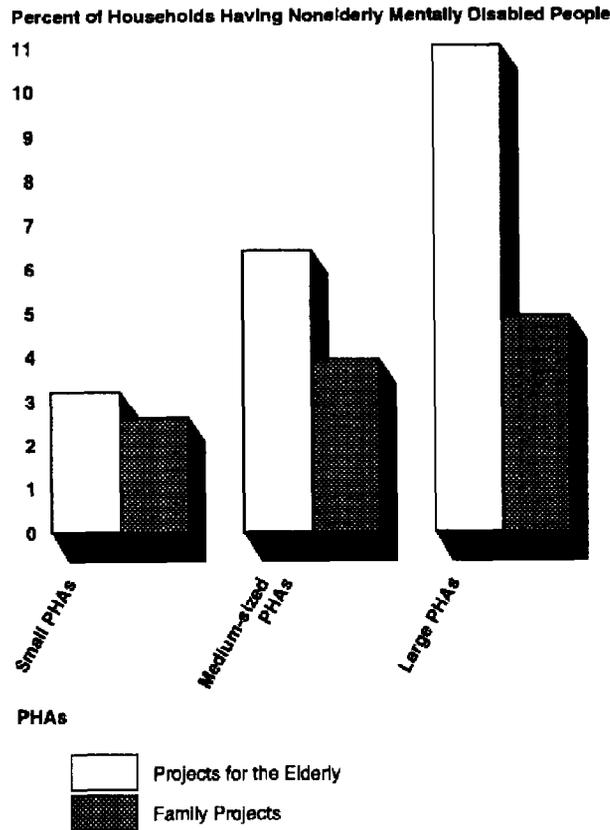
In response to comments on a draft report, we analyzed our survey data from PHAs with 1,250 or more units. We found that people with mental disabilities occupy about 12 percent of units in public housing for the elderly in such PHAs.

²For the purposes of our questionnaire, large PHAs are those with 500 or more units (large PHAs account for almost 60 percent of public housing units for the elderly); medium-sized PHAs are those with 100 to 499 units; and smaller PHAs have 99 or fewer units. Medium-sized and smaller PHAs account for about 30 percent and 10 percent of public housing units for the elderly, respectively.

³Because we queried all larger PHAs, the results for these PHAs are not subject to sampling error.

⁴HUD, in commenting on our draft report, indicated that the number of nonelderly persons with mental disabilities may be understated in family projects because, if such persons are part of a family, their handicap status need not be established because the family would be admitted as a family.

Figure 2.1: Proportion of Households With Nonelderly Members With Mental Disabilities in Public Housing



Note: Numbers are based on estimated distributions of public housing for the elderly with 204,367 households in large PHAs, 106,705 households (±9,595) in medium-sized PHAs, and 36,402 households (±3,742) in small PHAs. For family public housing, numbers are based on estimated distributions of 681,284 households in large PHAs, 145,401 households (±11,207) in medium-sized PHAs, and 30,648 households (±3,487) in small PHAs.

Nonelderly Tenants With Mental Disabilities Cause a Disproportionate Share of Problems

According to our questionnaire results, more than 3 in 10 of the nonelderly tenants with mental disabilities in public housing for the elderly exhibit behaviors that cause moderate to serious problems for other tenants and PHA management and staff, as compared with only about 1 in 15 elderly tenants in the same housing. PHA managers said that problems created by nonelderly tenants with mental disabilities take longer to resolve than those created by the elderly.

**Chapter 2
PHAs' Views on Problems With Nonelderly
Tenants With Mental Disabilities**

PHA managers reported that about 8,835 (± 814) of 28,614 ($\pm 1,488$), or 30.9 percent (± 2.3 percent), nonelderly tenants with mental disabilities in public housing for the elderly are exhibiting behaviors that are moderate or serious problems for management.⁵ About another 19 percent cause some problems, while the remaining 50 percent cause minor or no problems for PHA management or other tenants (see table 2.1). In contrast, 17.4 percent (± 0.8 percent) of the 31,411 ($\pm 1,026$) nonelderly tenants with mental disabilities in family projects reportedly exhibit behaviors causing moderate to serious problems for management.⁶

Table 2.1: Seriousness of Problems Caused by Households With Nonelderly Members With Mental Disabilities Residing in Public Housing for the Elderly

Who is affected	Extent of problem (In percent)				
	None	Minor	Some	Moderate	Serious
Other households	37	13	19	14	17
Management and staff	37	14	18	13	18

Note: Numbers are based on estimated distribution of 1,189 (± 80) PHAs answering the questions regarding nonelderly causing problems for other households and 1,190 (± 80) PHAs answering the questions regarding nonelderly causing problems for management and staff. For the estimates in this table, no sampling error exceeds 2.6 percent.

The percentage of moderate to serious problems reported varies by PHA size. For PHAs with 500 or more units, about 35 percent of the nonelderly tenants with mental disabilities reportedly cause moderate or serious problems for management. For medium-sized and small PHAs, the proportion of these tenants causing moderate or serious problems drops to 21.7 percent (± 10.4 percent) and 10.6 percent (± 6.6 percent), respectively.

In response to CLPHA comments on our draft report, we analyzed our data from PHAs with 1,250 units or more. These PHAs reported that about 39 percent of nonelderly tenants with mental disabilities cause moderate to serious problems for management. These data are consistent with the data reported above—that larger PHAs report higher levels of problem behaviors than smaller PHAs.

Poor housekeeping, disruptive visitors, alcohol abuse, and excessive noise are frequent causes of moderate and serious problems for other tenants

⁵Based on approximately 28,614 of the estimated 28,810 units for PHAs responding to this question.

⁶In commenting on our draft report, HUD indicated that one reason problem rates associated with persons with mental disabilities may be lower in family projects than in projects for the elderly is that the same event (e.g. noise late at night) is not as unusual or disruptive in a family project as in a project for the elderly.

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and PHA management and staff (see table 2.2). Poor housekeeping could include physical damage requiring costly repairs; disruptive visitors could include individuals that threaten elderly tenants or participate in noisy, late night activities, according to building managers of public housing for the elderly. While the elderly also cause moderate or serious problems, a smaller proportion of elderly exhibit such behavior—about 6 to 7 percent, according to PHA managers. Moreover, greater percentages of large PHAs report that the elderly and nonelderly people with mental disabilities create moderate or serious problems than do all PHAs nationally.

Table 2.2: Extent of PHAs Reporting Moderate to Serious Problems in Public Housing for the Elderly

Problem	Percent of PHAs reporting			
	Nationwide results		Large PHAs	
	Nonelderly mentally disabled	Elderly	Nonelderly mentally disabled	Elderly
Poor housekeeping	25	9	37	20
Visitors that disrupt community	22	5	39	12
Alcohol abuse	20	8	40	26
Excessive noise	20	3	34	5
Lack of personal cleanliness	19	7	33	16
Excessive demands on management	19	6	30	15
Bizarre behavior	19	4	33	11

Note: Columns 1 and 2 are based on estimated distributions of 1,252 PHAs (±81) and 2,260 PHAs (±80), respectively. The sampling errors for these estimates did not exceed 4 percent in column 1 and 2 percent in column 2. Columns 3 and 4 are based on 239 PHAs and 304 PHAs, respectively. Because we sent questionnaires to all large PHAs, their results are not subject to sampling errors.

PHA officials told us that staff are experienced with the problems elderly people cause and aware of available resources to assist elderly tenants. The behavior of elderly tenants, overall, is less problematic for PHA staff and requires less time to address. PHAs managers we interviewed also indicated that elderly tenants are more responsive to staff assistance than nonelderly tenants with mental disabilities. However, officials at the PHAs we visited, with one exception, did not believe they had the training needed to effectively address the behavioral problems of nonelderly tenants with mental disabilities. Consequently, PHA staff need to spend more time resolving these problems. For example, in St. Paul, three PHA human resource coordinators, serving all tenants in 16 high-rises for the

elderly, reportedly spend more than 50 percent of their time responding to the service needs and behavioral problems of nonelderly tenants with mental disabilities.

Mixing of Generations May Worsen Problems

Intergenerational conflict between nonelderly tenants with mental disabilities and elderly tenants is a serious problem, according to PHAs and representatives of the elderly. As a result, the impact of problems in public housing for the elderly reported in our survey is probably heightened by such conflict. Furthermore, HUD indicated that the admission of any group of young singles to projects for the elderly may have an adverse impact on quality of life as seen by older persons.

Elderly tenants may also fear people with mental disabilities. For example, according to a mental health official with experience in state and local housing and treatment issues, the elderly generally were educated in an era when people with mental disabilities were perceived to be dangerous and thus institutionalized. Elderly tenants may not be aware that advances in mental health care have enabled such individuals to live and receive treatment outside of institutions and in their own communities, according to the mental health official.

CLPHA, NAHRO, and AARP all told us that the elderly should be able to live (in an elderly by age environment) apart from nonelderly tenants who tend to have significant lifestyle differences. (We address the legal and policy implications of segregated housing in chs. 5 and 6.)

PHAs Visited Illustrate Problems Created for Management, Staff, and Other Tenants

At the PHAs we visited, nonelderly people with mental disabilities occupy different proportions of units in public housing for the elderly—from 17 percent in Seattle to 10 percent in Danbury. At four of five PHAs we visited, the extent of behavioral problems caused by nonelderly people with mental disabilities in public housing for the elderly was moderate or serious. PHA officials also told us that nonelderly tenants with mental disabilities frequently make excessive demands on agency personnel that require considerable time to address. The following sections discuss problems at four large PHAs we visited.⁷

⁷The fifth PHA we visited, Danbury, a medium-sized PHA, reported no problems because support services are available, sufficient, and used and because, for the most part, the nonelderly mentally disabled (under 50 years of age) are offered and accept placement in subsidized housing other than public housing for the elderly.

Minneapolis PHA

Minneapolis PHA managers estimate that 35 percent of the public housing units for the elderly are occupied by nonelderly tenants with disabilities.⁸ Reportedly, in almost one-third of the cases, persons with mental disabilities exhibit behaviors that cause moderate to serious problems for management and staff. These behaviors include abusing drugs and alcohol, threatening or attempting violence against other tenants, having visitors that cause problems, and making suicidal threats (10 threats in 1989).

Excessive demands on agency personnel, including demands that cannot be met, were considered a very serious problem. For example, according to PHA management, nonelderly tenants with mental disabilities have made unspecified threats seeking to remove the elderly from their buildings. Generally, management responds to problem behavior by meeting with tenants and discussing possible solutions, such as referrals to community services. However, given the large portion of nonelderly people with mental disabilities in these projects, these problems remain, according to the PHA's Assistant Director. Finally, one project for the elderly in Minneapolis—Elliot Twin Towers—provides an exception to these findings in that the site manager is able to arrange for the provision of needed services for project residents (see ch. 4 for a discussion of this project).

St. Paul PHA

The St. Paul PHA estimates that 10 percent of its public housing units for the elderly are occupied by nonelderly tenants with mental disabilities, but only 10 percent of these households cause moderate to serious problems for management and staff. Officials at HUD's area office in Minneapolis attributed St. Paul's relatively small number of problems, in part, to effective interaction with local mental health service providers.

Despite the small percentage of nonelderly tenants with mental disabilities causing problems, those causing problems place excessive demands on agency personnel. Some also frighten other tenants. For example, PHA staff told us about a nonelderly tenant with a mental disability who held loud parties and had guests who threatened elderly tenants. Attempting to assist the tenant, PHA staff arranged for mental health treatment, which the tenant subsequently refused. After considerable time and effort, the tenant was evicted. In such situations, PHA staff spend considerable time not only handling the tenant's behavioral problems but also allaying the fears of elderly tenants.

⁸Minneapolis combined households with nonelderly mentally and physically disabled persons in its survey response.

Denver PHA

Denver PHA managers estimate that while 16 percent of public housing units for the elderly are occupied by nonelderly tenants with mental disabilities, 70 percent of these households cause moderate to serious problems for management and staff. These problems include excessive demands on agency personnel, loud noise, bizarre behavior, and destruction or theft of property. Denver also reported personal uncleanliness as a serious problem.

Management stated that substantial time is needed to resolve problems involving nonelderly tenants with mental disabilities because the problems are ongoing. A housing manager will try to resolve a problem by referring the tenant to community services, but housing managers have limited knowledge of what kinds of services are needed for people with mental disabilities and what services are available. PHA management told us that nonelderly tenants with mental disabilities who receive services generally do not exhibit problem behaviors.

Seattle PHA

Seattle PHA managers estimate that 17 percent of public housing units for the elderly are occupied by nonelderly tenants with mental disabilities and that 65 percent of these households cause moderate to serious problems for management and staff. In addition to excessive demands on agency personnel, other serious problems are excessive noise, violence, threatened or attempted suicide, and drug abuse. According to a PHA manager, in one instance, a nonelderly tenant with a mental disability reportedly stole an item from a neighbor and began harassing and verbally threatening the neighbor after the theft was reported to the police. Other tenants complained because the same tenant yelled in the hall.

Behavioral Problems
May Be Increasing

More PHAs report that problems caused by the nonelderly tenants with mental disabilities in public housing for the elderly have been increasing rather than decreasing, particularly in large PHAs. Furthermore, while the number of nonelderly people with mental disabilities in public housing for the elderly is relatively small, recent HUD data suggest that the percentage of such people in public housing is rising. Additionally, PHA interest groups and mental health policy experts expect that this population will continue to rise in public housing for the elderly.

PHAs Reported That
Problems Have Been
Increasing

Our 1990 survey asked PHAs to compare the extent of problems currently caused by nonelderly tenants with mental disabilities in public housing for the elderly with that of the previous year, 1989. As compared to 1989, 24.9

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percent (± 3.2 percent) of PHAs reported that nonelderly tenants with mental disabilities residing in projects for the elderly caused more problems in 1990 for management/staff (see table 2.3). About half that number, or 14 percent ($+3.0$ percent), reported that nonelderly tenants with mental disabilities caused fewer problems for PHA management and staff. The remainder reported that the problems were about the same as the previous year or that no problems occurred at either time. Significantly more large PHAs cited an increase in problems than did medium-sized PHAs. Small PHAs tended to report no problems at either time or fewer rather than more problems.

In response to CLPHA comments on our draft report, we analyzed our data from PHAs with 1,250 or more units. About 58 percent of these larger PHAs reported that nonelderly tenants with mental disabilities residing in projects for the elderly caused more problems in 1990 than in the previous year.

Table 2.3: Change in Extent of Problems for Management Caused by Nonelderly Tenants With Mental Disabilities, 1989 to 1990

Extent of Problem	Percent of PHAs nationally	Percent of PHAs by size		
		Large	Medium	Small
No problems	24	8	23	34
Fewer problems	14	8	13	17
Same level of problems	33	33	35	30
More problems	25	49	25	9
Unknown problems ^a	5	1	3	9
Total^b	100	100	100	100

Note: Distributions are based on 239 large PHAs, 635 medium-sized PHAs (± 54 PHAs), and 378 small PHAs (± 60 PHAs). With the exception of the missing data numbers (unknown problems), sampling errors for nationwide results, medium-sized and small PHAs did not exceed 3.9 percent, 5.9 percent, and 8.8 percent, respectively.

^aThis category includes responding PHAs that did not answer and those that could not supply a response.

^bTotals may not add to 100 because of rounding.

Population of Nonelderly Tenants With Mental Disabilities in Public Housing May Be Increasing

Recent HUD data suggest that the number of nonelderly people with mental disabilities being admitted to public housing is increasing. For 97,713 admissions to PHAs with 500 or more units during the 12-month period ending February 1992, HUD data showed that 29,739 were defined as elderly. Only 14,436 of these people were 62 years of age or older. The remaining 15,303 admissions (approximately 51 percent) were nonelderly

persons with disabilities and/or handicaps. Furthermore, February 1992 HUD data also indicated that nonelderly people with disabilities and/or handicaps comprise approximately 28 percent of PHA tenants defined as elderly in PHAs with 500 or more units. HUD data did not differentiate between mental or physical disabilities nor did it break out admissions or tenant population data in projects for the elderly separate from PHA-wide data.

At the time of our survey, in large PHAs about 80 percent of units in public housing for the elderly were occupied by households designated elderly by age (62+ years of age). Units occupied by households with nonelderly members with mental disabilities represented 11 percent, while units occupied by other households, including those with a member with a physical disability, represented approximately 5 percent of tenant population. The remaining units were vacant. In family public housing, units occupied by households with a member with a mental disability were also greater in number than units occupied by households with a member with a physical disability.

Therefore, if admissions of nonelderly households to public housing for the elderly in large PHAs are occurring at the rate of over 50 percent as indicated by HUD data for all admissions to large PHAs (500+ units), and given PHA interest groups' indication that admissions of households with a nonelderly member with a mental disability to public housing for the elderly are increasing in large PHAs, then such households will likely comprise an increasing portion of the public housing for the elderly population in large PHAs.

According to housing officials, continued deinstitutionalization, recent antidiscrimination regulations, and the lack of affordable housing are all factors that have led nonelderly people with mental disabilities to seek public housing and could continue to do so. Two other factors could also influence the situation. First, according to officials from the five PHAs we visited and from public housing interest groups, mental health service providers and advocates for people with mental disabilities are helping people with mental disabilities to complete and submit applications for admission to public housing. Second, nursing home reform is expected to result in people with mental disabilities either leaving or not entering nursing homes and seeking public housing. Specifically, the Omnibus Budget Reconciliation Act of 1987 comprehensively reformed the statutory authority that applies to nursing homes participating in the Medicare and/or Medicaid programs. The 1987 act requires that states establish

pre-admission screening programs for individuals with mental illness or mental retardation seeking admission to a nursing home. These programs are to determine whether the individuals need the level of services provided by a nursing home or whether they could live elsewhere.

The 1987 act also requires that all nursing home residents, including people with mental disabilities who were admitted prior to January 1, 1989, be reviewed annually to determine whether they still require treatment in a nursing facility. If treatment is no longer required, they are to be discharged. According to the program director for NIMH's Community Support Program, such discharges could increase the demand for public housing. The director pointed out that this situation could be exacerbated by the thousands of individuals with mental disabilities living with aging parents who will no longer be able to care for them. These individuals with mental disabilities may eventually lose their housing if they lose those family supports.

Finally, it is unclear what impact the preference rule discussed in chapter 1 will have on the population of tenants with mental disabilities in public housing for the elderly. According to our questionnaire results, about 11,655 households (± 980), or 62 (± 2.0) percent of the nonelderly people with mental disabilities, have received a preference since the rule became effective in July 1988. However, the elderly also benefit from the preference rule. For example, the director of the Danbury PHA told us that, because of high rental costs in Danbury, elderly applicants also usually receive a preference because they pay more than 50 percent of their income for rent. Similarly, Seattle PHA officials reported that about 95 percent of elderly applicants on the waiting list have received a preference, compared to about 79 percent of nonelderly applicants with mental disabilities. On the other hand, the Cranston-Gonzalez National Affordable Housing Act of 1990 expanded from 10 percent to 30 percent the maximum number of units a PHA may exempt from preference rule requirements. Regulations implementing this provision had not been promulgated as of May 1992. On balance, the future impact of the preference rule on admissions to public housing for the elderly will vary by factors such as the relative income of the elderly and nonelderly applicants and rent levels in PHA communities.

Conclusions

The lack of affordable housing and recent antidiscrimination regulations, among other factors, are contributing to an increase in nonelderly tenants with mental disabilities who reside in public housing for the elderly. While

this group occupies a relatively small portion of public housing units for the elderly—about 9 percent—the percentage is greater in large PHAs and may be rising. Even with this potential growth and the fact that almost 50 percent of large PHA managers indicated problems increasing over the year prior to our survey, we cannot predict the future behavior of nonelderly tenants with mental disabilities.

Potential growth in the population of nonelderly people with mental disabilities in public housing for the elderly and possible problems associated with that growth must be considered in light of legal considerations bearing directly upon their rights to reside in public housing and other assisted housing programs (we discuss these rights in ch. 5). HUD occupancy policies provide PHAs with guidance on admitting people with disabilities; if necessary, HUD regulations provide guidance on evicting tenants (ch. 3 and app. I examine HUD occupancy policies and discuss the occupancy policies of PHAs we visited). Community-based support systems, including mental health services, are often available, and in some cases PHAs work well with local providers (in ch. 4 we discuss, among other things, the mental health service network and efforts under way to provide needed services). Still, unless mental health and other services are sufficient and used by this population, PHAs may face growing managerial problems. Given these considerations and others, in chapter 6 we discuss approaches for addressing congressional concerns about providing quality public housing for both the elderly and for nonelderly people with mental disabilities.

Agency Comments and Our Evaluation

HHS expressed concern about the validity of our data. Specifically, it noted that (1) PHA managers responding to survey questions on problem behavior were nonclinical observers, (2) the standards PHAs used for assessing problem behavior were unclear, and (3) the term “mentally disabled” as used in the report was unclear. We agree that PHA managers responding to our survey are almost assuredly nonclinical reporters of tenant behavior. (We did not ask them to make clinical judgments; rather, we asked them to report on their perceptions, as managers of public housing, on tenant populations and on problems posed for them and public housing tenants.) Nevertheless, PHA managers' estimates of the number of nonelderly persons with mental disabilities and on problems they reportedly cause may be subject to an unknown degree of error. Readers should keep this in mind in considering the results that we report. Readers should also keep in mind information from other sources presented in this report which generally supports our questionnaire results. Regarding HHS' concern about

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the standards PHAs used for assessing problem behavior, our survey instrument included a standardized set of response options that deal with managers' observations of tenant behavior. Finally, regarding HHS' concern about the definition of the term "mentally disabled" provided to survey respondents, we believe the definition was clearly stated in our questionnaire (see footnote 2 in ch. 1).

AARP, CLPHA, and NAHRO all considered the predominant problem to be the mixing of populations in public housing. Still, nonelderly single persons with mental disabilities need appropriately sized assisted housing, which is commonly found in public housing for the elderly. Alternative public housing units found in family projects contain mostly two-, three-, and four-bedroom units. We agree with HUD's comment that it would be a waste of valuable housing resources for a one-person family to live in these larger units.

CLPHA commented that housing opportunities for the elderly are being constricted by increasing nonelderly admissions. MHLP claimed the opposite—that nonelderly households with disabled members are filling vacancies in public housing for the elderly that existed before PHAs admitted nonelderly applicants with disabilities. Neither group offered vacancy data to support its position. On this issue, HUD reported to the Congress that an important reason for the increase in the number of younger persons with disabilities being admitted to projects for the elderly was vacancies in these projects. Our questionnaire results did not provide data on vacancies to either confirm or refute CLPHA's or MHLP's contentions.

CLPHA, NAHRO, and AARP generally commented that our data were out of date, minimized existing problem behavior, and did not inform the Congress about the significantly increasing numbers of nonelderly persons with disabilities being admitted to public housing for the elderly. To support their position, they cited HUD's multifamily tenant characteristics system data. We agree that more recent data would better reflect current conditions. However, our survey data, collected in the second half of 1990, are the only systematically collected data of which we are aware on problem behavior in public housing nationwide. These data, coupled with other more current information in the report, do not minimize the situation; rather, they demonstrate that problems exist that need attention.

To support their position that an increasing number of nonelderly persons with disabilities are being admitted to public housing for the elderly, interest groups cited more recent HUD multifamily tenant characteristics

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system data. However, HUD's data do not discern between disability (mental, physical, recovering substance abusers, or others) or between public housing setting (elderly or family). Thus, the data cannot be used to make assessments solely regarding persons with mental disabilities in public housing for the elderly, which is the subject of this report.

HUD Guidance Unclear Regarding PHAs' Latitude in Screening Persons With Mental Disabilities for Admission to Public Housing

In July 1991 HUD updated its existing guidance for PHA managers to use in screening people with mental disabilities for admission to public housing. This revised guidance addressed two issues of particular concern to PHAs. First, PHAs were having difficulty adjusting their programs to meet the special needs of people with mental disabilities applying for residency because HUD's antidiscrimination regulations prohibited them from inquiring into the nature or severity of applicants' handicaps. Second, PHAs were unsure how to judge applicants' suitability for residency if they had never lived on their own and had no rental history. According to PHA interest groups, however, the new guidance is so broad that it is unclear how far PHAs can go in questioning applicants about their disabilities. It is also unclear how PHAs should proceed if they cannot obtain reliable information on applicants' suitability for tenancy.

PHAs Say Regulations Impede Their Ability to Screen Applicants

After determining that an applicant is eligible to live in public housing for the elderly, the PHA determines whether the applicant is suitable for tenancy. How a PHA makes that judgment is subject to HUD regulations designed to, among other things, prevent discrimination in housing. But according to PHA interest groups, those regulations have made it difficult to adequately screen applicants.

To evaluate whether an applicant is suitable for tenancy, a PHA essentially assesses whether the applicant would comply with the lease agreement. Accordingly, HUD regulations direct PHAs to examine the applicant's history of meeting financial obligations, especially paying rent. It also determines whether the applicant has a history of destroying property and disturbing neighbors and/or has living or housekeeping habits that could adversely affect the health, safety, or welfare of other tenants. If a person with a mental disability can demonstrate a history of meeting financial obligations, caring for a rental unit, and not disturbing others, destroying property, or engaging in criminal activity, then the PHA determines that the applicant is suitable for public housing, including housing designated for the elderly. Conversely, if any tenant, including one with a mental disability, seriously or repeatedly violates material lease terms, the tenant faces lease termination and eviction.

If the PHA determines that an applicant with a mental disability does not meet one or more of the criteria described above, it must consider any mitigating circumstances the applicant describes. For example, untreated mental illness can be associated with disorganized thought patterns and failure to attend to day-to-day activities such as paying rent.

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HUD regulations also require PHAS to consider "reasonable accommodations" so that people with mental disabilities can live in public housing. According to HUD, "reasonable accommodations" are adjustments in the rules, policies, practices, or services governing occupancy. However, PHAS need not make adjustments that create an undue financial and administrative burden on the housing program or that in any fundamental way alter the nature of the program, which for PHAS is to provide housing for low-income families. Reasonable accommodation could be provided, for example, by allowing an applicant to live in a larger unit than the PHA would normally allow so that the individual could have a live-in aide, who would assist the individual in meeting his or her lease agreement.

Both in determining the suitability of an applicant for public housing and in attempting to design reasonable accommodations for people with mental disabilities, PHAS, according to their interest groups, say they have been hampered by regulations implementing the Fair Housing Act, as amended. This act prohibits discriminatory housing practices because of a handicap or family status, as well as because of race, color, religion, sex, and national origin. HUD's regulations, adopted in 1989 to implement the act, thus generally prohibited PHAS from asking about the nature or severity of a person's disability. However, that prohibition made the management of public housing difficult. As the executive director of the Danbury Housing Authority pointed out, PHAS were liable for not making reasonable accommodations, yet were prevented from asking questions of an applicant that would help determine what accommodations should be made.

In addition, HUD's 1989 regulations provided PHAS no guidance on how to screen applicants who had no rental history. People with mental disabilities may have no such history because they have never lived on their own. If the applicant has a rental history, PHAS can use that information to assess whether he or she would be a successful tenant. Without that information, though, PHAS seek alternative references, such as physicians in hospitals and family members, to find out whether the applicant has a history of disturbing neighbors, destroying property, or failing to pay debts. However, PHAS feel that this information could be unreliable if the party contacted is motivated to help the person find housing, regardless of his or her true ability to uphold a lease agreement. Four PHAS we visited agreed that determining the suitability of applicants for tenancy was a problem if no rental history existed.

HUD Revised Its Guidance to Help PHAs Screen Applicants

In July 1991 HUD revised its Public Housing Occupancy Handbook to set out its policy and to provide technical assistance to PHAs for admitting people with handicaps to public housing. Under the U.S. Housing Act of 1937, PHAs are vested with the prime responsibility for operating public housing programs. In keeping with this public housing program legislation, HUD's new guidance was broad enough to allow PHAs latitude in admitting new tenants.

Under the new guidance, PHAs are allowed to inquire about the nature and severity of an applicant's disabilities in certain circumstances—specifically, when applicants are initially judged to be unsuitable for tenancy but reasonable accommodation is under consideration. According to the guidance, a PHA can “make inquiries to the extent necessary to . . . verify an individual's handicap to determine whether a reasonable accommodation in rules, practices, or services requested by a handicapped applicant may be necessary.”

HUD's revised guidance also counsels PHAs on secondary sources of information they can use to help determine the suitability of applicants who have no rental history. The guidance lists as sources personal and institutional references, doctors, therapists, and service agency personnel. In addition, it advises PHAs to use home visits and interviews with PHA staff to obtain information.

PHA Interest Groups Believe New Guidance Lacks Needed Detail

According to two PHA interest groups, CLPHA and NAHRO, HUD's new guidance is not specific enough to help PHAs judge the suitability of an applicant with a mental disability for residency in public housing. Even with this guidance, PHAs are unsure whether their actions would violate antidiscrimination statutes.¹

According to these groups, several questions remain regarding PHAs' latitude in screening applicants. Specifically, the guidance does not explain exactly what questions PHAs can ask of applicants. Nor does the guidance detail what constitutes a reasonable accommodation for an individual with a mental disability. Furthermore, HUD's new guidance does not say whether PHAs may reject applicants with mental disabilities who lack both rental histories and surrogate references, such as family members and doctors. Additionally, three of the five PHAs we visited—Denver, Minneapolis, and Seattle—indicated a problem with the

¹In its comments on our draft report, MHLP speculated that the time needed to resolve problems created by tenants with mental disabilities might be a function of incomplete and inconsistent HUD directions on admissions, screening, eviction, and reasonable accommodations.

lack of guidance on reasonable accommodations for nonelderly people with mental disabilities and on screening of such applicants.

HUD Screening Regulations Need Improvement

HUD's relatively broad regulations do not sufficiently focus on the treatment of persons with handicaps in general, or with mental disabilities in particular, in the screening process. These regulations are susceptible to implementation in a manner that may have at least the effect of discriminating against persons with handicaps (see ch. 5 for a further discussion). As a result, PHAs are concerned about exactly what questions they can legally ask while screening applicants. Furthermore, in commenting on our draft report, HUD indicated that its Fair Housing Act regulations addressing this subject may need revision.

Conclusions

PHAs should use their best judgment in screening nonelderly applicants with mental disabilities and in providing reasonable accommodations to such applicants and tenants if possible. To assist their efforts, more detailed HUD guidance setting out the questions that may be asked of applicants would be useful and should help address PHAs' concern about compliance with fair housing law. Alternatively, nonelderly tenants with mental disabilities, like all tenants, face eviction if they seriously violate lease terms. (Other approaches to assist PHAs in serving this population and our assessment of the legality and practicality of such approaches are discussed in ch. 6.)

Recommendation

To assist PHAs in screening all applicants, including those with mental disabilities, we recommend that the Secretary of HUD provide fair housing guidance that details the questions that can be asked of any applicant to public housing.

Agency Comments and Our Evaluation

Generally, CLPHA, NAHRO, AARP, and MHLP agreed that HUD needs to improve its applicant screening guidance. We agree and, after considering the comments to our draft report, have added the above recommendation to this effect. In its comments, HUD did not state whether it believed its guidance to be adequate, but said that it might be necessary to revise its fair housing regulations. HHS provided a technical comment on a matter discussed in this chapter. This comment is addressed in appendix IV.

Support Services Can Help Nonelderly Persons With Mental Illness to Live Successfully in Public Housing

The State Comprehensive Mental Health Plan Act requires that states develop plans for a coordinated, community-based system for delivery of mental health services throughout the state. States provide over 80 percent of state-controlled funding for the system; communities, rather than the state or federal government, organize the delivery of services. Nonelderly tenants with mental illness in public housing can benefit from mental health services when they are available and accessible to those who need them. However, the organizational frameworks and delivery networks vary across the nation. While between 74 and 82 percent of PHAS reported that mental health services are provided, the lack of data on the use of available services by public housing tenants or their adequacy hinders an assessment of whether additional resources are needed.

Cooperative agreements between PHAS and local mental health providers can facilitate provision of housing, mental health, and other support services through case management. Individual case managers can help arrange for such services and thus provide the opportunity for both elderly and nonelderly people with mental illness to be successful public housing tenants. In our work at five PHAS, we observed the benefits that can arise from such agreements as well as the drawbacks when such agreements do not exist. HUD and HHS are cooperatively developing guidance to help PHAS and mental health service providers enter into cooperative agreements.

Federal Mental Health Statute Sets Out State Responsibilities

The State Comprehensive Mental Health Plan Act of 1986 requires that states submit annual comprehensive mental health services plans to HHS. These plans are to provide for establishing community-based care systems for people with serious mental illness.¹ The plans cover a 3-year period and must include, among other things, descriptions of mental health, rehabilitation, employment, housing, education, and medical and dental care services to be provided to children and people with serious emotional and mental disorders. The act also requires that case management services be provided to individuals with serious mental illness who receive substantial amounts of public funds or services. Public housing residents would meet this criterion, according to the director of NIMH's community support program. Case management involves having a single person—or, if possible, a team of persons—responsible for maintaining a long-term, supportive relationship with the client. According to NIMH, the case manager is a helper, service broker, and advocate for the client. Case management functions include client identification and outreach,

¹Our review of the organization and delivery of services is limited to service needs and availability for people with mental illness because few other individuals with mental disabilities, including mental retardation and other developmental disabilities, appear to reside in public housing.

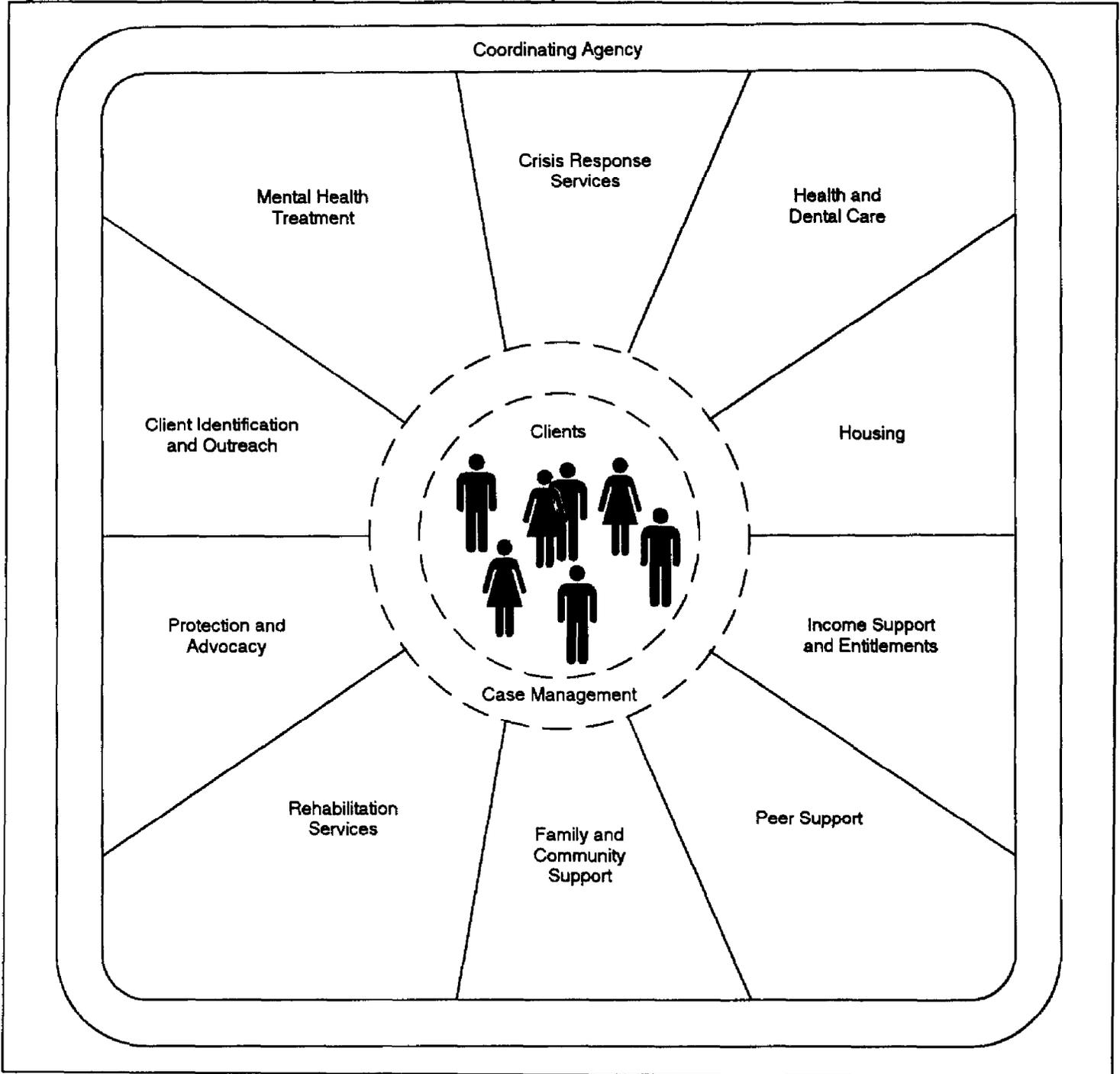
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assessment, planning, linkage between service providers, monitoring and evaluation, direct service provision, crisis intervention, resource development, and system and client advocacy.

According to the act, state mental health plans must describe how services will be coordinated within the state. Services are organized into a system of care through local case management and a coordinating agency at the community level, such as a city or county government. The act requires HHS to provide technical assistance to states in developing and carrying out these plans. As part of this technical assistance, NIMH, the responsible agency within HHS, provided states with a model plan for a community-based system of care in 1987 (see fig. 4.1). HHS developed the plan to encourage states to work with localities to plan for community-based systems. Under such systems, people with mental illness, including those in public housing, may receive support services in their own communities. In fact, recent congressional action supported community-based services for public housing tenants with mental illness. Section 507 of the Cranston-Gonzalez National Affordable Housing Act of 1990 amended the U.S. Housing Act of 1937 to allow PHAS to use operating subsidies to help pay for a management staff member to coordinate supportive services at projects where there are a sufficient number of persons with disabilities or frail elderly persons. However, HUD had not requested nor has the Congress appropriated money to provide specific funding for service coordinators.

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Figure 4.1: A Client-Centered, Comprehensive Mental Health System



Source: NIMH.

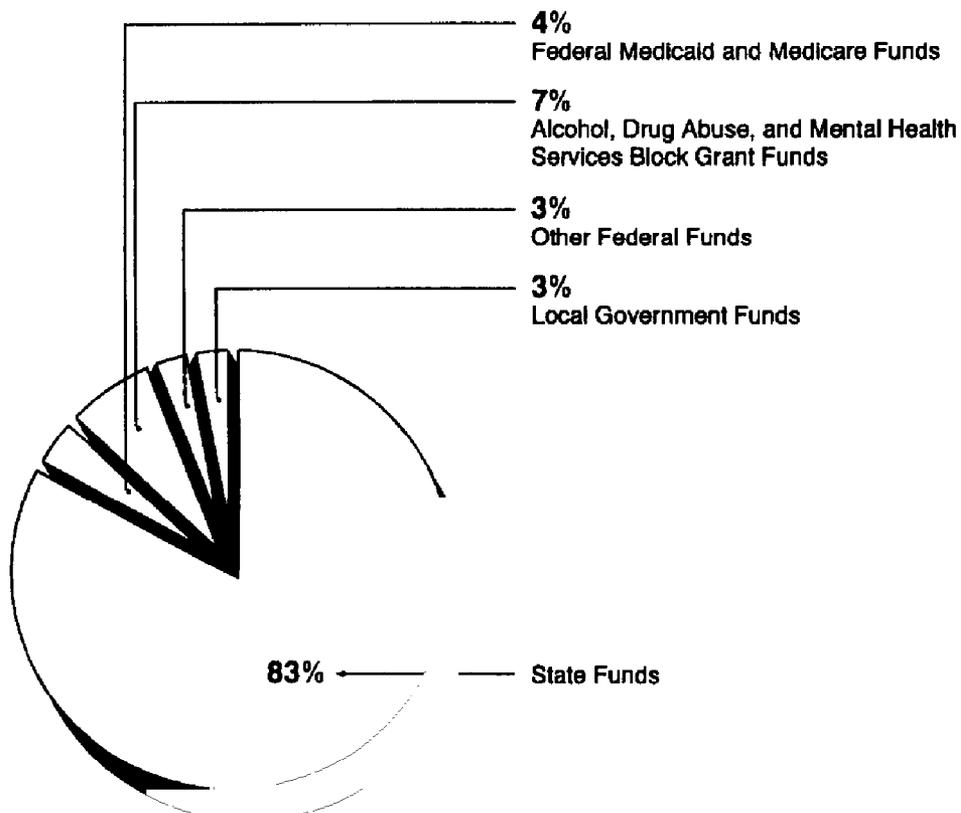
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State mental health agencies (SMHA) oversee the delivery of community-based mental health services. While some SMHAs directly operate community programs, the majority of states contract with community mental health providers or provide grants and contracts to city and/or county governments. Two of the states in our review, Colorado and Connecticut, contract directly with community providers, while the other two, Minnesota and Washington, provide grants and contracts to city and/or county governments. Mental health services are organized and delivered by community providers in Denver and Danbury and by the county government in Minneapolis, St. Paul, and Seattle.

State sources provided more than 80 percent of SMHA-controlled funds for community-based mental health programs in fiscal year 1987. Other sources of these funds include (1) Medicaid and Medicare; (2) HHS block grants for social services and alcohol, drug abuse, and mental health services; (3) Supplementary Security Income and Social Security Disability Insurance through HHS; (4) vocational rehabilitation through the Department of Education; and (5) housing assistance from HUD. Figure 4.2 illustrates, by source, SMHA-controlled revenue for fiscal year 1987 (latest available data).

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Figure 4.2: Fiscal Year 1987
SMHA-Controlled Revenues for
Community-Based Mental Health
Programs, by Source



Source: National Association of State Mental Health Program Directors Research Institute Biennial Study, April 1990.

Other funding sources exist for community-based services. According to National Association of State Mental Health Program Directors Research Institute data available from 36 states, community-based programs receive, on average, 51 percent of their funds through SMHAs. Other sources of funds include third-party payments, local funds, and other non-SMHA-controlled funds.

Services Are Available, but Their Accessibility, Use, and Adequacy Are Unknown

Mental health and other community-based support services are provided in the large majority of PHA communities responding to our survey. Yet, according to an NIMH report, "most communities lack an adequate range of supported housing options and suffer from a lack of coordination among social service agencies" and services are not widely available in all communities.² Furthermore, coordination between service providers is particularly important for people with severe mental illness, who may have trouble negotiating complex bureaucracies. For example, according to the Director of the Center for Community Change through Housing and Support, to live at a survival level people with mental illness often must secure services from various federal, state, and local agencies.³ The sufficiency of funding for these services is also in question.

The availability of community-based services for nonelderly people with mental illness in PHAs varies nationwide. Between 74 and 82 percent of the PHAs represented in our nationwide survey reported that mental health services (including psychological rehabilitation, counseling, and monitoring of medications) are provided to a majority of residents with mental disabilities in public housing for the elderly. Our survey did not ask PHA managers to assess whether services were being provided to their nonelderly tenants with mental disabilities at levels sufficient to serve their needs because (1) PHA managers are not trained to make such assessments and (2) they are generally prohibited from inquiring into the nature and severity of tenant disabilities.

About 2.6 percent (± 1.2 percent) of PHAs reported that mental health services were provided on site by the agency to the majority of nonelderly tenants with mental disabilities in public housing for the elderly, while 18.9 percent (± 3.3 percent) indicated that such services were provided on site by another agency. Forty percent (± 4.0 percent) of PHAs reported that they provide these tenants with on-site referral to off-site community resources, such as vocational rehabilitation, and 23 percent (± 3.4 percent) of PHAs indicated that another agency provides such referral services on site, according to our questionnaire results. The provision of these and other services is shown in table 4.1.

²NIMH Report to the Congress, *Deinstitutionalization Policy and Homelessness*, May 23, 1990.

³The Center is a national research, technical assistance, and training organization dealing with housing and community support service issues.

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Table 4.1: Service Provided for the Majority of Nonelderly People With Mental Disabilities in Public Housing for the Elderly

Available Services	Percent of PHAs reporting
Client outreach	68.4 (±4.0)
Case management	72.8 (±3.8)
24-hour crisis assistance	59.6 (±4.1)
Mental health care	77.9 (±3.5)
Drug/alcohol abuse counseling	68.5 (±4.0)
Medical care	72.8 (±3.7)
Dental care	59.4 (±4.1)
Meal programs	81.1 (±3.4)
Family and community supports	69.0 (±4.0)
Referral to community resources	81.8 (±3.4)
Recreation and socialization	75.3 (±3.7)

Note: Percentages reported include both on- and off-site services. Our data are based on an estimated 1,252 (±81) PHAs with nonelderly tenants with mental disabilities reporting service provision.

These services are provided either on site or off site. According to an expert in community-based mental health support service issues, the location of services can be significant because (1) transportation may not be available or affordable for people with mental illness, who generally have low incomes, and (2) some people with mental illness have a tendency to isolate themselves and not leave their residences.

Access to services varied at the five PHAs we visited. For example, Danbury and Minneapolis indicated availability of all services either on site or off site. Moreover, Minneapolis PHA officials volunteered information on the adequacy of services. While they reported that services, with the exception of crisis assistance, were available either on site or off site with transportation, they also told us that the majority of services were inadequate to meet the needs of nonelderly tenants with mental disabilities. Similarly, Seattle PHA officials said that, because of limited mental health service resources, case managers often are unable to provide follow-up services to nonelderly clients with mental illness once they have entered public housing.

PHAs do not maintain data on the utilization of available services by residents of public housing for the elderly. Also, even when services are available, nonelderly people with mental illness may not always use them. For example, the Director of the Mental Health Division in King County, Washington, told us that the time-consuming, impersonal, and inflexible

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nature of the service system discourages people with mental illness more so than others from using the services. Seattle PHA officials told us that nonelderly individuals with mental disabilities in treatment commonly are admitted to housing and then, unless required by the legal system, refuse further mental health services.

Adequacy of Funding Not
Assessable

For public housing tenants, data are not available to assess the adequacy of funding for community-based mental health services. While NIMH publishes national data on utilization of mental health services, including outpatient services, the data are not broken down by the client's type of residence (such as public housing).⁴ Additionally, other mental health services that may be offered by local agencies are not included within data collected by NIMH. As a result, we cannot assess the extent to which nonelderly public housing tenants with mental disabilities are now receiving services or if services being provided are adequate to meet their needs.

On the basis of their overall knowledge of state and local programs, experts in mental health and housing issues whom we interviewed agreed that resources allocated for community-based mental health services, including case management services, were insufficient to meet client needs. For example, the Program Director of NIMH's Community Support Program and the chair of the National Association of State Mental Health Program Directors' standing committee on housing and residential services told us that additional funding for community mental health services, including case management, was needed. Furthermore, the directors of the National Alliance for the Mentally Ill and of the Center for Community Change through Housing and Support agreed that community-based services remained underfunded. According to the directors, the majority of state mental health funding was allocated for inpatient mental health services, but most people needing mental health services reside outside hospitals. In addition, National Association of State Mental Health Program Directors Research Institute data for fiscal year 1987 indicate that 62 percent of SMHA-controlled expenditures were for inpatient services; outpatient services accounted for 20 percent and the remainder for residential, mixed, and other services.

⁴Mental Health, United States, 1990, NIMH.

Community Support Services Can Prevent or Mitigate Behavioral Problems

According to mental health experts, community-based mental health and other support services can enable most people, of all ages, with mental illness to live successfully in public housing for the elderly or elsewhere in the community. With medication, counseling, and/or support from family, friends, and mental health professionals, people with mental illness are living successfully in the community. Case management is equally important, since the service needs of this population are diverse. Case managers identify the services an individual with mental illness needs, arrange for those services to be delivered, and attempt to ensure that they are provided.

Case managers can serve as a friend or counselor for clients with mental illness whose service needs vary significantly. According to a joint publication of the National Alliance for the Mentally Ill and the Public Citizen Health Research Group, mental illness can be episodic in nature. The director of the alliance also told us that young individuals with mental illness often resist outpatient treatment. Therefore, a trusted counselor can prevent a serious episode requiring hospitalization by monitoring self-administration of medication and by encouraging visits to psychiatrists when needed. Additionally, individuals other than mental health professionals can arrange for support services.

The director of a nationwide clearinghouse on self-help indicated that serving the needs of people with mental illness in public housing requires on-site case management and the establishment of trust. According to that official, self-help groups can provide these ingredients in an effective and cost-efficient manner. In a self-help group, trained individuals with mental illness under treatment can provide the case management function to other people with mental illness. Similarly, the director of the Center for Community Change Through Housing and Support noted that such consumer-run mental health programs can supplement traditional service provision in areas where case management resources are insufficient or where such resources are only office based. According to the National Association of State Mental Health Program Directors, client-operated self-help and mutual support services should be available in each locality as alternatives and adjuncts to existing mental health delivery systems. Furthermore, according to this association, state financial support should be provided to help ensure self-help groups' viability and independence.

On-site building managers at public housing can also provide a form of case management. According to the on-site manager of a demonstration project at the Elliot Twin Towers in Minneapolis, his interaction with

nonelderly tenants with mental illness in the project prevents serious behavioral problems. Part of this interaction consists of accessing community support services on behalf of tenants with mental illness. He attributed his success to his interest in all residents, including people with mental illness, and to his background as a social worker. While this is only one example, it shows that in communities with support services, managers with training, motivation, and time can effectively provide the case management function.

Cooperative Agreements Facilitate Service Delivery

Cooperative agreements between PHAS and local mental health service providers facilitate the provision of case management, including mental health services, to residents of public housing for the elderly. The agreements, which can be written or verbal, generally serve to provide coordinated delivery of housing and support services. Some PHAS have entered into such agreements and found that service delivery helps individuals with mental disabilities to be successful tenants.

Coordinated service delivery is one of the guiding principles underlying NIMH's community-based mental health system. Service providers and researchers with expertise in housing and mental health issues told us that people with mental illness, including residents of public housing, can behave like other tenants when case management and community supports are accessed. Furthermore, coordination between PHAS and mental health providers facilitates providing these services. Cooperative agreements are a good first step for PHAS and mental health providers to develop an understanding of their mutual responsibilities to people with mental illness, according to the chairwoman of the National Association of State Mental Health Program Directors' committee on housing and residential programs.

While numerous factors, including continued commitment by local mental health service providers and resource availability, will influence the effectiveness of the linkage between housing and other service providers, establishing cooperative agreements has widespread support among PHAS and their interest groups, mental health service providers and advocates, and representatives of clients with mental illness we contacted. HUD and HHS also support efforts to establish cooperative agreements.

Cooperative Agreements Take Different Forms

In LaSalle County, Illinois, an agreement between the housing agency and the mental health center provides for mutual referrals of their clients.

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Through these referrals, the county housing agency provides several housing options for individuals with mental illness (including those in public housing for the elderly, group homes, and shared housing) with flexible supports, including case management services provided by the county mental health center. As a result, the PHA has few problems with nonelderly tenants with mental illness as well as few complaints from the elderly about residing with nonelderly people with mental illness, according to the director of services at the LaSalle County PHA.

In Denver, no formal agreement exists between the PHA and the local mental health service provider, but some nonelderly tenants with mental illness in public housing for the elderly receive case management services directly from the local service provider. PHA and mental health service provider officials told us that these individuals do not exhibit housing-related behavioral problems, but others without case managers often exhibit such behavioral problems.

The Danbury PHA established a written agreement with the local mental health service provider. In this case, all tenants with mental illness receive an array of services, including on-site case management, crisis assistance, and referral to community support services. As a result, no housing-related behavioral problems exist, according to both the public housing director and the director of the local mental health case management provider.

Officials from public housing interest groups support the establishment of cooperative agreements to address behavioral issues of nonelderly tenants with mental illness in public housing for the elderly. The director of the Council of Large Public Housing Authorities, also a former PHA executive director, said that establishing a cooperative agreement with a local mental health provider enabled her former agency to admit numerous individuals with mental illness who otherwise would have been considered unsuitable for tenancy.

HUD and HHS to Provide
Guidance on Cooperative
Agreements

HUD and HHS plan to jointly fund development of technical assistance for PHAs and mental health service providers, including illustrations of successful approaches to using cooperative agreements. First, NIMH with HUD support is preparing a case study book that may include, among other things, case studies of how local programs have integrated public housing, mental health, and other services that help people with mental illness to adjust to public housing and prevent disruptive behaviors. The book is scheduled to be published by September 1992. Additionally, as part of an

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interagency agreement, a HUD/HHS working group on residents with mental disabilities in public housing for the elderly will develop a monograph discussing, among other things, the responsibilities of PHA and mental health service providers and their opportunities for serving people who are mentally ill. The monograph will include a model cooperative agreement. As of May 1992 HUD officials could not tell us when the monograph was to be published.

A HUD contractor is developing a guidebook for PHAs to use in meeting the antidiscrimination requirements for housing nonelderly tenants with mental disabilities in public housing for the elderly. The draft guidebook contains a section on cooperation between federally funded housing providers, mental health agencies, and consumer groups. As of May 1992 HUD officials could not tell us when the guidebook was to be published. In addition, HUD will be letting a contract for development of a "Guidebook for Assisted Housing Program Providers: Section 504 and Persons with Mental Disabilities," which it expects to issue in September 1992.

Service Coordinators
Could Facilitate Provision
of Available Services

Service coordinators could provide a valuable service to persons with disabilities as well as the frail elderly, as envisioned by the Congress. While such positions may not be needed in each PHA, they could prove very useful in helping individuals unable to arrange for needed services on their own. They could also be very useful in identifying and arranging for services in communities where such resources are in limited supply. In this vein, service coordinators could seek out local service providers in order to establish cooperative agreements. Yet, as previously mentioned, HUD has not requested funding for this position authorized under section 507 of the Cranston-Gonzalez National Affordable Housing Act of 1990.

Conclusions

Availability and use of community-based mental health and other services can enable nonelderly people with mental illness to be successful tenants. According to our survey, about 78 percent (± 4.0 percent) of PHAs reported that mental health services are provided in their communities, but even where such services are available, we do not know whether they are sufficient or are being utilized. Still, cooperative agreements can establish lines of communication and cooperation between PHAs and local service providers, thus facilitating provision of needed case management services. While the success of cooperative efforts is influenced by continued commitment by PHAs and mental health service providers and by other factors, such as funding availability, community-based case management

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for mental health services remains a requirement of the Mental Health Plan Act. Therefore, establishing cooperative agreements is consistent with congressional goals and is a good initial step toward serving such clients and reducing reported behavioral problems of tenants with mental illness in public housing. We endorse HUD's and HHS' current efforts to provide technical assistance on establishing cooperative agreements.

Recommendations

To assist PHAS in addressing the service needs of tenants with mental illness, we recommend that the Secretary of Housing and Urban Development require PHAS to actively seek out mental health service providers for the purpose of entering into cooperative agreements for case management services. Furthermore, to facilitate such agreements, we recommend that the Secretary work with HHS to issue guidance now being developed for all PHAS on establishing cooperative agreements with local mental health service providers. As planned, a model cooperative agreement should be included in such guidance.

We further recommend that the Secretary direct PHAS to report on situations where local mental health providers do not exist or are unable to enter into cooperative agreements because of insufficient resources. This information would begin to provide a nationwide assessment of the sufficiency of mental health services available to public housing tenants. It will also provide the Congress, through HUD, an initial assessment of the need for targeted resources. Such resources could enable PHAS to contract directly for on-site delivery of case management services.

Matter for
Congressional
Consideration

In order to assist PHAS in establishing cooperative agreements and coordinating service delivery, the Congress should consider providing appropriations for the public housing service coordinator position authorized under section 507 of the Cranston-Gonzalez National Affordable Housing Act of 1990.

Agency Comments
and Our Evaluation

Although it was given the opportunity to do so, HUD did not comment on the recommendations in this chapter. HHS, in response to our recommendations, indicated that it and HUD would issue a model cooperative agreement. While recognizing that cooperative agreements should be helpful, HHS added that problems will continue to exist unless individuals with mental illness have an adequate range of housing options

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and support services. We agree, and HHS' comments are generally consistent with the actions we propose.

MHLP commented that our recommendations are sound and will be reinforced as more information becomes available on programs and practices that have worked. While AARP, CLPHA, and NAHRO generally support establishment of cooperative agreements, they emphasized that significantly more service resources were needed to provide needed services.

NAHRO and CLPHA perceived a disparity between our reporting of (1) inadequate service resources and (2) recommending use of cooperative agreements. We see no disparity. If community-based mental health resources are generally insufficient across states, as reported to us by numerous observers, then cooperative agreements to organize the efficient use of existing services takes on even greater importance. In this vein, our second recommendation is designed to provide the Congress with a short-term indicator on the extent of need for targeted resources to assist nonelderly tenants with mental disabilities.

Furthermore, to assist PHAS' efforts to arrange for service delivery for their tenants, this chapter now includes a matter for congressional consideration—to provide funding for the PHA service coordinator position authorized under section 507 of the National Affordable Housing Act of 1990.

Rights of Persons With Mental Disabilities to Reside in Federally Subsidized Housing for the Elderly

This chapter analyzes the rights of persons with mental disabilities to reside in housing for the elderly provided under the following five federally subsidized housing programs: conventional public housing, section 202 housing, section 8 housing, section 221(d)(3) housing, and section 236 housing.¹ The analysis is based on an examination of the statutes governing the operation of the five programs, of federal antidiscrimination laws that protect the housing rights of persons with mental disabilities, and of judicial decisions interpreting those laws.

Several factors make it difficult to formulate definitive legal conclusions. For one thing, the program statutes, with one exception, do not expressly address this issue. Furthermore, while there is a substantial body of case law relevant to the scope of protection afforded to persons with handicaps, including persons with mental disabilities, under federal antidiscrimination laws, very few court decisions have dealt with the specific issue addressed in this chapter. However, as detailed in the discussion below, our analysis of the program statutes, in relation to the court decisions interpreting federal antidiscrimination laws, suggests the following conclusions: (1) sponsors of section 202 housing may lawfully choose to restrict admission to elderly persons and exclude nonelderly persons with mental disabilities; (2) owners of housing provided under the section 221(d)(3) and 236 programs may lawfully adopt policies restricting admission to elderly persons, so long as such policies are not a pretext for excluding persons with mental disabilities; and (3) persons with mental disabilities may not be excluded or segregated with respect to elderly housing under the conventional public housing or section 8 programs.

Eligibility Requirements for the Federally Subsidized Housing Programs

The five major federally assisted housing programs serving the elderly that we are considering were established over a period of nearly 40 years.² All five programs limit eligibility for admission to lower-income families or persons. However, the programs provide certain other eligibility features that differ in important respects.

¹The conventional public housing program involves assistance to governmental entities (local public housing agencies) to provide housing for lower-income families. The section 202 program assists private, nonprofit corporations or public agencies to provide housing and related facilities for lower-income elderly or handicapped individuals or families through low-interest-rate loans. The section 8 program makes housing affordable to lower-income families by making rent contributions to private landlords. The section 221(d)(3) and section 236 programs were designed to assist private owners in developing newly constructed or substantially rehabilitated apartment buildings through low-interest-rate loans.

²The conventional public housing program was established in 1937; section 202 in 1959; section 221(d)(3) in 1961; section 236 in 1968; and section 8 in 1974.

Section 202

The statute governing the section 202 program expressly limits eligibility to “elderly or handicapped families.” The two terms are defined separately under the statute. The term “elderly” is limited to households of one or more persons, one of whom is 62 or over. “Handicapped” includes the following three classes of persons: (1) the developmentally disabled, (2) the physically handicapped, and (3) the mentally handicapped. Furthermore, the section 202 law specifically states that the program’s purpose is to provide not only housing but also related facilities for residents.³

Section 221(d)(3) and
Section 236

The section 221(d)(3) and section 236 programs, unlike section 202, which limits eligibility to elderly or families with handicapped members, were established to serve lower-income families and individuals in general. The statutes governing both programs define the terms “elderly” and “handicapped” separately, as under the section 202 program. Elderly families are limited to households composed of one or more persons, at least one of whom is 62 years of age or over.⁴ The governing statutes both contemplate that some projects will be “designed primarily for occupancy by elderly or handicapped families.”

Conventional Public
Housing and Section 8

Unlike the section 202 statute, the United States Housing Act, which governs the conventional public housing and section 8 programs, is concerned with providing housing for lower-income families generally. While single individuals do not generally qualify as “families,” this act includes elderly and individuals with handicaps or disabilities within the statutory definition of “families.” It also includes all persons with handicaps or disabilities, regardless of age, within the statutory definition of “elderly families.” The act further provides that, in determining priority for admission to public housing projects designed for “elderly families,” a preference shall be given to “such families.”

Conventional public housing is the only one of the five programs we are considering in which the housing is owned and operated by governmental

³The Cranston-Gonzalez National Affordable Housing Act, passed in November 1990, has made significant changes in the section 202 legislation with respect to future housing to be provided under the program. Under the new act, separate housing will be provided for the elderly and for persons with disabilities. The act also provides that, “notwithstanding any other provision of law,” project owners of housing for persons with disabilities may, with HUD approval, limit occupancy of housing for persons with disabilities to persons with similar disabilities, e.g., housing for physically handicapped persons to the exclusion of mentally disabled persons.

⁴Under both statutes, the term “handicapped person” is defined by reference to the definition in the section 202 statute.

entities (local public housing agencies). Although the section 8 program, like conventional public housing, is governed by the United States Housing Act, the program, unlike conventional public housing, typically involves housing that is privately owned and operated.

Federal Laws Prohibiting Housing Discrimination Against Persons With Handicaps

Section 504 of the Rehabilitation Act of 1973 and section 804 of the Federal Fair Housing Act, as amended in 1988, both prohibit housing discrimination on the basis of handicap. Both statutes also require that owners of federally assisted housing make reasonable accommodations so that an otherwise unsuitable applicant may be admitted to assisted housing. However, the statutes do not require that the owners undergo undue financial and administrative burdens to accommodate a person with handicaps. Nor are owners required to make a unit available to a person who would constitute a direct threat to the health or safety of other tenants or who might be expected to cause substantial physical damage to the property of others. While similar in these respects, there are a number of significant differences in the nature and scope of protection afforded under these two antidiscrimination statutes.

First, section 504, which is patterned after Title VI of the Civil Rights Act of 1964, is a general civil rights statute with broad application prohibiting discrimination in a wide variety of federally assisted programs and activities, including housing.⁵ By contrast, the Fair Housing Act applies specifically to discrimination in housing whether or not the housing is provided with federal assistance.

Second, section 504 prohibits discrimination solely by reason of a person's handicap; whereas the Fair Housing Act has been interpreted by the courts as not requiring that a person's handicap be the sole factor, but rather simply one significant factor.

Third, under the Fair Housing Act, as construed by the courts, a person needs to show only that an owner's conduct had a discriminatory effect regardless of the owner's intent. Under section 504 of the Rehabilitation Act, it is not clear whether a person would have to demonstrate discriminatory intent, or under what circumstances a showing of discriminatory effect will suffice.

⁵The Americans with Disabilities Act (ADA), enacted in 1990, extends the prohibitions of section 504 to state or local government programs whether or not they receive federal assistance. Thus, public housing is subject to the ADA, as well as section 504 and the Fair Housing Act.

Fourth, the Fair Housing Act requires HUD and all other federal agencies to carry out their programs in a manner affirmatively to further the purposes of the Fair Housing Act. Section 504 contains no such affirmative action requirement.

Finally, the Fair Housing Act makes it unlawful not only to discriminate in the sale or rental of housing but also “to otherwise make unavailable or deny” a dwelling because of a handicap of the buyer or renter. The courts have interpreted the quoted phrase as a “catchall,” banning a wide variety of discriminatory housing practices. Section 504 of the Rehabilitation Act does not contain a similar catchall provision.

Rights of Admission to Elderly Housing Projects

The statutes governing the operation of the five federally subsidized housing programs under consideration, with one exception, do not explicitly address the right of nonelderly persons with mental disabilities to be admitted to housing for the elderly. Moreover, although there have been numerous cases interpreting section 504 and the Fair Housing Act,⁶ very few cases have directly addressed this specific issue. Indeed, only two court decisions are squarely on point.

However, the substantial body of case law under these antidiscrimination laws—particularly concerning the Fair Housing Act—has established certain important principles concerning the scope of protection afforded to protected classes and provides guidance on the issue of admission of nonelderly persons with mental disabilities into elderly housing. An analysis of these principles in relation to each of the program statutes provides a basis for drawing conclusions with respect to each of these programs.

The two court decisions squarely on point both involved the section 202 program and both upheld the exclusion of nonelderly persons with mental disabilities from 202 projects for the elderly and mobility impaired. Both decisions fully considered the effect of section 504 of the Rehabilitation Act, as well as the program requirements of section 202. However, both decisions were rendered before passage of the 1988 Fair Housing Amendments Act.⁷

⁶Persons with disabilities have the same protections against housing discrimination under the Fair Housing Amendments Act of 1988 as racial minorities and other protected classes have had since enactment of the original Fair Housing Act in 1968.

⁷In addition, both decisions concerned housing provided before passage of the Cranston-Gonzalez National Affordable Housing Act.

Section 202

Two U.S. courts of appeals have held that, under section 202, a project sponsor may elect to serve some, but not necessarily all, of the eligible classes and therefore may refuse to admit nonelderly persons with mental disabilities to a project serving the elderly and mobility impaired.⁸ In reaching this conclusion, the courts stressed that the 202 statute repeatedly used the word "or" in referring to elderly or handicapped housing.

The courts also emphasized the differing service needs of the different categories of persons eligible under the section 202 program, pointing out that sponsors of section 202 housing are required to provide not only housing but also services supportive of the needs of persons residing in that housing. The fact that, in the courts' view, the different classes of eligible persons have different needs provided further support for the courts' holding that sponsors could elect to serve one or more of the eligible groups but were not required to serve all.

Both courts also held that the exclusion of nonelderly persons with mental disabilities from a section 202 project does not violate section 504 of the Rehabilitation Act. The courts' rationale was that the nonelderly persons with mental disabilities who had been denied the housing had been rejected, not because of their handicaps, but because they were neither elderly nor mobility impaired. Therefore, they were not otherwise qualified and were not excluded solely because of their handicaps, as required by section 504. Both courts suggested that their decisions might have been different if the excluded persons had been elderly as well as having a mental disability. The courts also stressed that section 504 was not an affirmative action program and that project sponsors were not required to modify the purpose of the program or undergo undue financial burdens to accommodate all persons with handicaps.

These two decisions were rendered before passage of the 1988 Fair Housing Amendments Act, which added persons with handicaps to the classes of protected persons. As previously discussed, there are several important differences between the Fair Housing Act and section 504 of the Rehabilitation Act that arguably could have altered the courts' decisions. Specifically, unlike section 504, which requires that discrimination be demonstrated on the basis of the exclusion of persons solely because of their handicap, under the Fair Housing Act discrimination can be demonstrated when handicap is one significant factor in a person's

⁸Brecker v. Queens B'nai B'rith Housing Development, 798 F.2d 52 (2d Cir. 1986) and Knutzen v. Eban Ezer Lutheran Housing Center, 815 F.2d 1343 (10th Cir. 1987).

exclusion. Moreover, while the decisions of both courts stressed that section 504 is not an affirmative action program, the Fair Housing Act contains specific legislative mandates requiring HUD and other federal departments and agencies to carry out their housing programs in a manner affirmatively to further the purpose of the Fair Housing Act. Finally, under the Fair Housing Act, a person needs only to demonstrate that particular conduct has a discriminatory effect, regardless of a person's purpose or motivation.

While these differences between section 504 and the Fair Housing Amendments Act are important, it is doubtful that they are of sufficient significance to override the principal basis for the earlier court decisions—that the statute governing the section 202 program specifically authorized project sponsors to serve only some, but not necessarily all, of the classes of persons eligible to participate in the program. Thus, under the program statute, sponsors of section 202 housing are authorized to reject nonelderly persons with mental disabilities in favor of admitting other classes of eligible persons. There is no indication in the Fair Housing Amendments Act or its legislative history that the Congress intended to withdraw that authority under the section 202 program.⁹

Section 221(d)(3) and
Section 236

As noted above, the 221(d)(3) and 236 programs, unlike the section 202 program, which limits eligibility to elderly or families with handicapped members, were established to serve lower-income families and individuals in general. The statutes governing both the 221(d)(3) and 236 programs define the terms "elderly" and "handicapped" separately, as under the section 202 program, and both statutes contemplate that some projects will be designed primarily for occupancy by elderly or families with handicapped members. However, neither statute makes repeated use of the disjunctive word "or," which the Brecker and Knutzen courts stressed in determining that the section 202 statute provided express authorization to exclude nonelderly persons with mental disabilities from elderly projects. Also unlike the section 202 program, neither the 221(d)(3) nor the 236 program carries any requirement that support services be provided to tenants.

⁹As noted above, under the Cranston-Gonzalez National Affordable Housing Act, separate housing will be provided in the future for elderly persons and for persons with disabilities. Moreover, the act expressly permits project owners of housing for disabled persons, with HUD's approval, to limit admission to persons with similar disabilities, i.e., physical disabilities, while excluding persons with mental disabilities.

In light of these differences, we do not believe that the section 221(d)(3) and section 236 statutes can reasonably be read to provide the express legislative authorization for project owners to exclude nonelderly persons with mental disabilities that the Brecker and Knutzen courts found in the section 202 statute.

However, neither governing statute expressly requires owners of housing provided under the programs to admit the full range of eligible lower-income families, nor does either statute explicitly prohibit individual project owners from adopting a policy limiting admission only to elderly persons or families. In short, in our view, the program statutes neither add to nor detract from whatever authority a project owner may have to adopt such a policy. The issue is whether the adoption of such a policy, whereby nonelderly persons with mental disabilities are excluded, would violate section 504 of the Rehabilitation Act or the Fair Housing Amendments Act. We believe it would not.

Section 504 prohibits exclusion solely on the basis of a person's handicap. Under the Fair Housing Amendments Act, handicap may not be even one significant factor in the exclusion. Further, the Fair Housing Amendments Act prohibits conduct that has the effect, as well as the purpose, of discriminating against persons with handicaps.

Measured against these standards, we do not believe that a policy of restricting admission to elderly persons or families to a project subsidized under the 221(d)(3) or 236 programs violates either antidiscrimination law. Under such a policy, all nonelderly persons—whether or not they have mental disabilities—would be excluded. By the same token, all otherwise eligible elderly persons—those who have mental disabilities and those who are not—could be admitted. Thus, age, not mental disability, would be the factor on which admission or exclusion would be based.¹⁰

In our view, so long as the policy, as carried out in practice, is not a pretext for excluding persons with mental disabilities or members of other protected classes, the exclusion of nonelderly persons with mental disabilities would not be solely because of their mental disability, nor would mental disability be even one significant factor in their exclusion.

Further, the effect of the policy would not be to single out for discriminatory treatment persons with mental disabilities or members of

¹⁰The Age Discrimination Act prohibits age discrimination in federally assisted programs. HUD regulations implementing that act for purposes of HUD programs specifically authorize age distinctions that provide special benefits to the elderly (see 24 C.F.R. § 146.13(f)).

other classes protected by the antidiscrimination laws. Nor would the adverse effects fall with disproportionate impact on persons with mental disabilities or other protected classes. It would fall equally on all nonelderly persons. In short, so long as all nonelderly persons—not just those who have mental disabilities—are excluded and no otherwise eligible elderly person with mental disabilities is excluded, the policy does not contravene the antidiscrimination laws.

Conventional Public Housing and Section 8

There is one key difference, relevant here, between the United States Housing Act, which governs the operation of both the conventional public housing and section 8 programs, and the statutes governing the other federally subsidized housing programs. The United States Housing Act defines “elderly families” to include not only persons at least 62 years of age but also persons with handicaps and disabilities, regardless of age, including nonelderly persons with mental disabilities. By contrast, the section 202 statute, as well as the statutes that govern the section 221(d)(3) and 236 programs, define “elderly or handicapped families” separately, limiting “elderly families” to households composed of one or more persons, at least one of whom is 62 years of age.

Thus “elderly families,” under the express language of the United States Housing Act, is a limited category, consisting of persons who are at least 62 years of age and have handicaps or disabilities, regardless of age. These are the only persons entitled to a preference for projects designed for elderly families. There is no basis under the United States Housing Act for distinguishing between them. Nor, in our view, is there any authority under that act, express or implied, for excluding persons with handicaps, including nonelderly persons with mental disabilities, from particular elderly projects, or segregating them in projects separate from those that house persons 62 years old or more.

It is in the light of the above statutory framework that we address the issue of whether the exclusion or segregation of nonelderly persons with mental disabilities with respect to elderly public housing or section 8 projects would violate section 504 of the Rehabilitation Act and the amended Fair Housing Act. We have concluded that such exclusion or segregation would violate these antidiscrimination laws.

In the Brecker and Knutzen cases, the U.S. courts ruled that the exclusion of nonelderly persons with mental disabilities from section 202 projects was not because of their handicap but because they were neither elderly

nor mobility impaired, the two classes of eligible persons the sponsors, pursuant to express statutory authority, had chosen to admit. Therefore, they were not otherwise qualified and were not excluded solely because of their handicaps, as required by section 504.

By contrast, under the United States Housing Act, the statutory authority that the Brecker and Knutzen courts found in the section 202 statute to justify exclusion of nonelderly persons is wholly lacking. Under the United States Housing Act, nonelderly persons with mental disabilities have the same right as other “elderly families,” including the right to a preference, to be admitted into elderly projects.

Thus, in contrast to the unsuccessful plaintiffs in Brecker and Knutzen who, the two U.S. courts of appeals ruled, were not otherwise qualified for admission to the section 202 projects, nonelderly persons with mental disabilities are otherwise qualified for admission to all public housing and section 8 projects for elderly families. It is their mental disability, not their age, that qualifies them.

A policy of excluding or segregating persons with handicaps would single out this one protected group—nonelderly persons with handicaps—for discriminatory treatment. No other group—protected or not protected—would be adversely affected because only persons with handicaps and persons at least 62 years of age qualify as “elderly families” under the United States Housing Act and enjoy a preference for admission to elderly housing projects. The adverse effects of the policy would fall with disproportionate impact on this protected group. Therefore, their exclusion or segregation with respect to such projects can be viewed as solely because of their mental disability, in violation of section 504. At the least, mental disability constitutes one significant factor in their exclusion or segregation, in violation of the Fair Housing Amendments Act. Such exclusion or segregation also has the purpose and effect of discriminating against this protected class of persons, in violation of the antidiscrimination laws.

In addition, it is no defense under section 504 or the Fair Housing Amendments Act to claim that the exclusion or segregation of persons with mental disabilities would be limited to nonelderly persons with mental disabilities, while elderly persons with mental disabilities could be admitted freely. Those antidiscrimination laws protect the housing rights of all persons with handicaps and do not permit discrimination or segregation against any such persons.

Preferences and Tenant Selection Criteria

The laws governing each of the federally assisted housing programs provide preferences for admission to certain classes of individuals and families among all those who satisfy the programs' eligibility requirements. In addition, owners and sponsors of such housing exercise some degree of discretion in selecting tenants from among individual applicants.

Preference Laws and Regulations

The laws and regulations governing preferences differ somewhat among the federally subsidized housing programs we reviewed. For conventional public housing and section 8, the United States Housing Act of 1937 contains two preference provisions bearing on the admission of persons with mental disabilities into public housing for the elderly.

First, the act and HUD's implementing regulations generally require that, for at least 70 percent of the units, preference must be given to families who, as discussed in chapter 1, either (1) occupy substandard housing (including homeless families¹¹ and families living in homeless shelters), (2) are paying more than 50 percent of their income for rent, or (3) are involuntarily displaced.

Second, regarding admission to public housing for elderly families, as discussed above, the act and HUD's regulation require that preference be given to such families. Thus, under these preference provisions, elderly families (defined under the act to include persons with mental disabilities) that meet one of the three preference criteria receive a priority over other persons or families that are eligible for admission to elderly public housing. As we discuss in chapter 2, nonelderly persons with mental disabilities often qualify for a preference.

Under the section 202 program, no specific preferences are required among otherwise eligible applicants. However, section 202 housing is eligible for section 8 assistance, in addition to assistance through HUD loans. For section 202 projects that receive section 8 assistance, HUD regulations require that the same preferences be given as under section 8.

HUD regulations governing the section 236 program provide a preference for displaced persons. However, the regulations also provide that, in projects designed for persons with handicaps or elderly, displacees receive a preference only if they are also handicapped or elderly. Displaced persons also receive a preference in section 221(d)(3) housing.

¹¹Homeless people coming from institutions automatically receive a preference (regardless of how long they spent in the institution).

However, unlike the section 236 program, no specific preference is given to the handicapped or elderly.

Tenant Selection Criteria

Tenant selection necessarily involves screening applicants for such purposes as ensuring that they satisfy the eligibility criteria governing participation in the program and that they will neither damage the property nor threaten the health or safety of the other tenants. Our review of the laws and regulations governing federally subsidized housing programs disclosed that, with the exception of conventional public housing, they do not provide specific requirements or standards regarding the tenant selection process. Under the other programs discussed in this chapter, which involve private owners of private housing, tenant selection is the prerogative of the owner. However, the housing provided under these programs is subject to the prohibitions against discrimination on the basis of handicap contained in section 504 of the Rehabilitation Act and the Fair Housing Amendments Act. Thus, to the extent particular tenant selection practices serve to discriminate against persons with mental disabilities, they violate one or both of these antidiscrimination laws.

The laws and regulations governing tenant selection in conventional public housing contain certain restrictions. Specifically, HUD regulations require that public housing tenant selection standards and criteria be in compliance with state, local, and federal laws, including nondiscrimination requirements. The regulations also prohibit PHAS from adopting tenant selection policies and procedures that automatically deny admission to a particular group of eligible applicants.

In addition, HUD regulations contain specific provisions that both require PHAS to screen eligible applicants during the tenant selection process and place restrictions on how such screening may be conducted. For example, the regulations require PHAS to preclude admission of applicants whose habits and practices reasonably may be expected to have a detrimental effect on the other tenants or the project environment. HUD regulations set forth the standards for tenant selection criteria, focusing on information reasonably related to whether the conduct of the applicant in present or previous housing has been such as would not be likely to interfere with other tenants so as to adversely affect their health, safety, or welfare or the physical environment or financial stability of the project.

Under HUD's recently revised Public Housing Occupancy handbook, PHAS generally may not inquire if an applicant has a handicap or inquire as to

the nature or severity of a handicap. However, they may make such inquiries, to the extent necessary to determine an individual applicant's eligibility, level of benefits, or need for reasonable accommodations.

The HUD regulations appear to be even-handed, requiring both that PHAs, in keeping with their responsibilities as housing owners and managers, screen for undesirable tenants and that the screening process focus on individual attributes and not attributes imputed to particular groups of which the applicant may be a member. Moreover, the regulations, as far as they go, in our opinion do not conflict with the antidiscrimination laws.

However, the regulations are relatively broad and do not sufficiently focus on the treatment of persons with handicaps in general, or with mental disabilities in particular, in "screening" or other aspects of the tenant selection process. They are susceptible to implementation in a manner that may have at least the effect of discriminating against persons with handicaps. Thus, in one recent case, Cason v. Rochester Housing Authority, a federal district court ruled that a PHA's requirement that all applicants must demonstrate an "ability to live independently" had a discriminatory effect against persons with handicaps in violation of the amended Fair Housing Law.¹²

Conclusions

Several factors make it difficult to formulate definitive legal conclusions on the rights of nonelderly persons with mental disabilities to reside in federally subsidized housing primarily serving the elderly. The statutes governing the operation of these programs generally do not explicitly address this issue. Furthermore, although a substantial body of case law concerns the nature and scope of protection under federal antidiscrimination laws that protect persons with handicaps, very few cases have concerned the relationship of those laws to this specific issue.

However, an analysis of each of the program statutes in relation to the case law interpreting the antidiscrimination laws provides a basis for certain conclusions. We believe that owners or sponsors of housing provided under the section 202, section 221(d)(3), and section 236 programs may lawfully limit occupancy to elderly persons or families and exclude nonelderly persons with mental disabilities. By contrast, we have concluded that exclusion or segregation of nonelderly persons with mental disabilities with respect to elderly housing under the public housing or

¹²748 F. Supp. 1002 (W.D. N.Y. 1990). Following the Cason decision, HUD issued a memorandum to its regional offices providing guidance on this matter.

section 8 programs violates section 504 of the Rehabilitation Act of 1973 and the Fair Housing Amendments Act.

Agency Comments and Our Evaluation

CLPHA and MHLP expressed disagreement with several of the legal conclusions in our draft report. They also tended to disagree with each other. MHLP disagreed with our conclusion that restricting admission to persons age 62 or over in connection with housing provided under sections 202, 221(d)(3), and 236 programs would not violate antidiscrimination laws. CLPHA expressed disagreement with our conclusion that exclusion or segregation of nonelderly persons with mental disabilities from public housing for the elderly would violate antidiscrimination laws. After reviewing their comments, we believe that our original overall interpretations and conclusions are correct. Appendix IX provides a detailed analysis of these comments.

HUD expressed no disagreement with any of our legal conclusions but suggested, in connection with our discussion of the section 221(d)(3) and 236 programs, that we conduct analysis to be sure there is no violation of the Age Discrimination Act. We have done so and, as incorporated in this final report, have concluded that on the basis of HUD's own regulations, bona fide policies restricting admission to persons or families 62 or over do not violate ADA. We have also incorporated several technical corrections and additions suggested by HUD.

HHS agreed with our analysis and conclusion that exclusion or segregation of nonelderly persons with mental disabilities or mental illness violates antidiscrimination laws.

AARP agreed with our conclusions regarding the sections 221(d)(3), 202, and 236 programs. AARP did not appear to disagree with our conclusion that, under the Rehabilitation Act of 1973 and the Fair Housing Amendments Act, exclusion or segregation of nonelderly persons with mental disabilities in connection with public housing for elderly families is legally impermissible. NAHRO did not offer comments on our legal conclusions.

Issues Raised in Housing Nonelderly Persons With Mental Disabilities in Public Housing for the Elderly

It is essential that the rights and needs of both elderly and nonelderly persons with mental disabilities be reconciled in a manner that is not only lawful but fair and equitable for both groups. To address issues surrounding nonelderly tenants with mental disabilities in public housing for the elderly, the Council of Large Public Housing Authorities has developed a formal position paper. Other groups including the National Association of Housing and Redevelopment Officials, the Mental Health Law Project, and the American Association of Retired Persons have informally discussed these issues with us. Additionally, pending legislation calls for amending the public housing statutory definition of an elderly family and providing designated housing. We have divided the legislative proposal, CLPHA's approach for serving the nonelderly tenants with mental disabilities, and information provided from the other groups into four general categories, including (1) changing the statutory definition of "elderly family" and providing designated housing, (2) providing alternative housing, (3) improving applicant screening, and (4) improving delivery of community services. What we believe are the implications of each approach, including parts which may be legally objectionable under current law, are also discussed below.

Redefining "Elderly Family" and Providing for Designated Housing

Pending legislation (H.R. 5334) would amend the public housing statutory definition of an elderly family by limiting it to persons age 62 or older. The bill allows that a PHA, subject to HUD approval, may provide designated housing projects (or portions of projects) for (1) only elderly families or (2) mixed housing (only elderly, disabled, and handicapped families). Other provisions include:

- Current tenants that are not of the type of family for whom the project is designated may not be evicted unless they occupy a unit that is larger than appropriate and the PHA makes available an appropriately sized unit in another project.
- PHAS must assure HUD that designating projects would not result in serving fewer public housing tenants with handicaps or disabilities than were assisted before the designation.
- PHAS administering section 8 assistance and designating public housing projects or portions of such projects for occupancy by "only elderly families" must provide section 8 assistance on behalf of nonelderly handicapped and disabled families served by the agency.
- No less than 5 percent of public housing modernization funds for fiscal years 1993-95 shall be reserved to reconfigure units to meet the needs of persons with handicaps or disabilities in portions of designated projects.

- To the extent funds are provided by the Congress, PHAS are required to provide service coordinators to coordinate supportive services.
- HUD is to issue regulations establishing criteria for occupancy (including eviction) in federally assisted housing.

The potential impact of this legislation is unclear because it hinges on (1) decisions by PHAS in designating elderly or mixed housing, (2) how tenants will be placed in this housing, and (3) funding availability. For example, one possibility might involve PHAS providing both types of designated housing but elderly families choosing only projects designated solely for them. In this scenario, the mixed housing by default would then be occupied solely by nonelderly disabled or handicapped families. Another possibility, assuming appropriations for section 8 rental assistance dedicated to nonelderly handicapped or disabled families, would likely result in greater assimilation of such families into the community at large. The implications of these possibilities for people with mental disabilities, as well as other topics, such as reserving modernization funds, are discussed in the following sections.

Provide Alternative Housing Opportunities for Tenants With Mental Disabilities

The CLPHA approach to housing nonelderly persons with mental disabilities calls for PHAS to provide alternative housing choices, given the PHA's available housing. For example, PHAS could provide nonelderly applicants with mental disabilities and current tenants a choice among (1) units in newly designated mixed housing serving one- and two-person households, (2) units in newly designated buildings for those with disabilities with on-site support services, (3) section 8 rental assistance enabling them to rent from private landlords, and (4) units in family buildings. Providing these alternative housing opportunities would require specific legislative authority. Such legislation would make clear that current nonelderly tenants with disabilities could choose to relocate but would not be required to do so. Each alternative choice is discussed below.

Units in Mixed-Population Buildings

One housing choice under the CLPHA approach envisions PHAS designating specific buildings for mixed populations. These buildings would permit occupancy by one- and two-person households, including not only nonelderly persons with mental disabilities but also the elderly, nonelderly singles, and others with disabilities. Like other proposals for alternative housing options using existing PHA housing, designating only certain buildings for mixed populations would likely require congressional authorization and the availability of significant amounts of housing stock.

Separate Buildings or Designated Areas Within Buildings With Support Services

To provide this housing choice, the Congress would need to authorize PHAS to designate buildings that are currently used by both the elderly and persons with handicaps as buildings for persons with disabilities, including those with mental disabilities. Alternatively, if there were not enough vacancies in these buildings, the Congress could either fund construction of new buildings or authorize PHAS to designate specific floors exclusively for nonelderly tenants with mental disabilities in existing buildings. In both cases, CLPHA's proposal envisions the provision of support services.

Alternative housing proposals recognize the need for support services to enable persons with mental disabilities to function independently wherever they reside. However, from a policy perspective, establishing separate buildings for nonelderly persons with mental disabilities might be considered a form of reinstitutionalization if large numbers of such tenants were segregated into high-rise buildings.

Dedication of Section 8 Rental Assistance

Under this approach, PHAS could reserve a portion of section 8 rental assistance for nonelderly applicants with mental disabilities. To provide this choice, congressional authorization would likely be necessary. While this proposal appears most in line with the deinstitutionalization policy goal—to mainstream persons with mental disabilities throughout our communities, unless additional funding is made available, section 8 rental assistance for other needy households would be reduced.

Provision of Units in Family Public Housing Buildings

Under another housing choice envisioned in the CLPHA approach, nonelderly individuals with mental disabilities could reside in appropriately sized family units in greater numbers. However, because most family units are not appropriately sized, this approach would require modifying existing multi-bedroom units to create one-bedroom and efficiency units and/or constructing such appropriately sized units. We believe public housing modernization funds could be used for unit modification while construction of new units would require specific appropriations. The funding required in this approach might significantly reduce funding availability for modernizing other public housing. Limited funding availability might also prohibit new construction. Nevertheless, NAHRO, in commenting on our draft report, stated that modernization decisions should be made by the locality.

Another problem is created when residents of family projects harass tenants with handicaps or elderly tenants. According to HUD comments on our draft report, PHAS have reported such harassment and, in some cases, have converted existing one-bedroom units to create larger family units because of the problem.

An alternative approach for utilizing family public housing—shared housing and group housing—has already been implemented successfully at one PHA. Group housing requires the availability of vacant multi-bedroom units. As implemented in LaSalle County, Illinois, nonelderly tenants with mental disabilities live in a shared housing situation with provision of support services. Such housing arrangements may have an on-site case manager similar to a group home.

This approach has certain advantages. It would open up a public housing relocation option to nonelderly persons with mental disabilities. Moreover, community mental health service providers would find it easier to provide on-site services to clients who reside in one location. At the same time, however, group housing can work only if vacant multi-bedroom units are available, individuals are willing to participate, and needed support services are provided.

Improve PHAs' Ability to Effectively Screen Applicants With Mental Disabilities

PHAS remain unsure about their rights to inquire about applicant handicaps, according to PHA interest groups. While HUD's revised Public Housing Occupancy Handbook guidance discussed in chapter 3 addresses this issue, it does not provide detailed guidance. This lack of detailed guidance can be viewed as consistent with public housing authorizing legislation, which provides great latitude to PHAS in implementing their housing programs.

CLPHA has offered proposals that would enhance PHAS' ability to effectively screen nonelderly applicants with mental disabilities. Antidiscrimination regulations currently prohibit PHAS from inquiring into the nature and severity of individual disabilities except in certain circumstances (i.e., when verifying an applicant's disability in order to provide a reasonable accommodation). PHAS also lack detailed guidance on (1) what inquiries are allowable, (2) what reasonable accommodations should be made for applicants with mental disabilities, and (3) how to screen applicants who have no rental histories. Proposals to address these issues include allowing PHAS to make more screening inquiries and having HUD provide detailed screening guidance.

Specifying Allowable Inquiries

According to CLPHA, some PHAS have proposed that they be allowed to make whatever inquiries they deem necessary in order to determine if the applicant needs mental health services, including daily medication, and can be expected to comply with the lease. This approach, referred to as pre-screening, would allow PHAS to be proactive by attempting to arrange for needed services. A similar approach calls for screening applicants with mental disabilities by a screening committee with at least one member from the mental health service community. Additionally, some PHAS have used lease addendums to address behavioral problems of tenants with mental disabilities, according to NAHRO. Such addendums have required nonelderly tenants with mental disabilities to continue accessing mental health care as a condition of tenancy. NAHRO supports use of such agreements, while HUD guidance advises against their use.

While these proposals might help PHAS to more accurately determine the suitability of nonelderly persons with mental disabilities as tenants and to meet such persons' special needs, the proposals would likely be held to constitute discrimination in violation of the antidiscrimination laws because they treat nonelderly persons with mental disabilities differently from others. For example, the use of a special lease addendum requiring continued receipt of mental health services and/or self-administration of medications would likely be held discriminatory because it would impose terms and conditions of tenancy for persons with mental disabilities different from those required of persons without such a disability. Moreover, the pre-screening proposal is susceptible to special abuse in that PHAS might make suitability determinations based on subjective fears associated with an individual's mental disability and not on legitimate objective criteria, such as ability to pay rent and maintain a unit.

Detailed Guidance Could Help PHAs Serve Persons With Mental Disabilities

PHAS are concerned about complying with antidiscrimination statutes. To comply with these statutes and avoid law suits, CLPHA and NAHRO have requested HUD to provide PHAS with detailed guidance on (1) the nature and extent of allowable screening inquiries, (2) what constitutes reasonable accommodations for persons with mental disabilities, and (3) when they can reject an applicant without a tenant history.

These proposals would require that HUD provide detailed guidance beyond that contained in HUD's revised Public Housing Occupancy Handbook. Specifically, in the guidance envisioned, HUD would detail exactly what questions PHAS can ask, of whom they can ask the questions, and what information is sufficient to determine if a person is suitable for tenancy.

Further, HUD would provide detailed examples of what constitutes a reasonable accommodation for a person with mental disabilities. As MHLP indicated in commenting on our draft report, there is no statutory provision that would allow PHAs to exclude applicants on the basis of their inability to produce documentation of their ability to comply with a lease. Therefore, exclusion of people with mental disabilities on such grounds might be held discriminatory in violation of federal antidiscrimination laws.

Providing such detailed guidance might answer many PHA questions in this area. However, the mere fact that the PHA acted on HUD guidance would not immunize it from a court finding of discrimination, either intentional or in effect. For example, in Cason v. Rochester Housing Authority, the court ruled that the PHA's practice of requiring applicants to demonstrate an ability to live independently was discriminatory in effect because it resulted in fewer assisted housing opportunities for applicants with disabilities.

Improve Delivery of Services for Nonelderly Tenants With Mental Disabilities

Service provision proposals from groups representing PHAs, the elderly, and the people with mental illness generally call for additional funding for services in public housing and for greater reliance on available community resources. These proposals recognize that a full range of community-based support services may be needed to enable nonelderly persons with mental disabilities to live successfully in the community. However, state and local control of funding and delivery of many support services, including mental health, complicates their delivery in federally assisted housing. This complication results from state resource limitations and state and local assessments of where to allocate limited resources.

We recommended, in chapter 4, that PHAs seek to enter into cooperative agreements with local service providers to facilitate delivery of available services to nonelderly tenants with mental disabilities in public housing for the elderly. Beyond our recommendation, two alternative service-funding proposals—a mandated set-aside and a dedicated grant program—address the issue of insufficiency in services for nonelderly tenants with mental disabilities of public housing for the elderly. A third proposal emphasizes greater utilization of existing resources.

Federal Mandate/Set-Aside for Service Delivery in Public Housing

The federal Alcohol, Drug Abuse, and Mental Health block grant program to states funds 7 percent of SMHA-controlled, community-based mental health services. CLPHA has proposed mandating that states direct a portion

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of these resources to fund mental health services in public housing. While the Congress could mandate such a set-aside, unless additional funding were provided, this proposal would likely result in a reduction of services elsewhere in the community. Additionally, we believe that federal mandates without accompanying resources assume that federal officials are better qualified to conduct state and local needs assessments than local officials.

Dedicated Grant Program
for Mental Health Service
Provision in Public
Housing

An alternative proposal offered by a PHA director calls for the Congress to appropriate funds for PHAs to contract with nonprofit providers for needed services if state and municipal mental health service providers are unable or unwilling to provide on-site services to nonelderly residents of public housing with mental disabilities. This proposal envisions a competitive grant program based on demonstrated need. Serving numerous clients living in close proximity would be more efficient under this proposal. NAHRO generally supports dedicated grants for service provision. However, according to HHS, authority already exists to serve mentally ill individuals in public housing through the Projects to Assist in Transition from Homelessness program authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (P.L. 101-645, Title V, Subtitle B.)

Better Use of Existing
Services

This proposal by the Mental Health Law Project calls for better reliance on existing service resources and expertise. For instance, PHAs can identify and consult with state and local mental health service officials and providers. Access to state officials is already available through the state mental health planning process discussed in chapter 4. Furthermore, local mental health officials can provide advice to PHA officials on appropriate reasonable accommodation strategies. Appropriate strategies might directly address individual mental health needs and thereby mitigate behavioral problems. Additionally, the American Association of Retired Persons proposed that the Congress fund, within PHAs, the public housing service coordinator position authorized under section 507 of the National Affordable Housing Act, which we offer as a matter for congressional consideration in chapter 4. Better use of existing resources is consistent with our recommendation that PHAs enter into cooperative agreements with local mental health service providers.

Use of services is a matter of individual choice. Therefore, the success of service efforts, however sufficient, depends upon individuals' willingness and ability to use them regardless of where they reside.

Conclusions

Approaches presented above seek to address issues in public housing for the elderly identified in our report—applicant screening, time-consuming behavioral issues surrounding housing of nonelderly tenants with mental disabilities, their need for affordable housing, and their need for case management services to arrange for mental health and other community support services. Generally, these proposals raise antidiscrimination issues or additional funding requirements. As such, the Congress faces difficult choices in addressing these issues.

Matters for Congressional Consideration

We believe that the issues discussed in this report call for congressional action. Therefore, we believe that the Congress should consider addressing the issue of housing the nonelderly mentally disabled with the elderly on the basis of the information contained in this and other reports and any congressional oversight hearings. Actions that the Congress could consider include, but are not limited to, the options discussed in this report. In considering these actions the Congress will need to reconcile the rights and needs of both groups in a manner that is fair and equitable to both persons with disabilities and the elderly.

Agency Comments and Our Evaluation

HUD generally agreed that the Congress should consider addressing the issue of housing nonelderly persons with mental disabilities with the elderly in an effort to reconcile the needs of both groups.

AARP, CLPHA, and NAHRO all expressed strong support for a policy alternative that would, generally, provide the elderly with the choice of living apart from nonelderly households. CLPHA asked that we recognize the value of its approach—generally to provide PHAS with maximum flexibility in offering, and selecting housing appropriate to individual needs. Although CLPHA recognizes that additional resources would make its suggestions far more successful, we believe its proposal provides insufficient detail to assess its value, including the cost of its proposal. According to HUD, most family public housing projects have only two-, three-, and four-bedroom units. Therefore, it appears that the only housing units that PHAS could provide in meaningful numbers, without significant additional resources for either major reconfiguration of family units and/or significant additional section 8 rental assistance, would be in formerly mixed-population high rises for the elderly. Furthermore, segregating in large facilities households that have disabled members of any age may be viewed as reinstitutionalization. CLPHA also expressed doubt that mental health experts or advocates believe that high rises of 100 or 200 units are an appropriate place to house

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people with mental disabilities in concentrations approaching 100 percent. Yet, given the likely unavailability of additional funds to provide section 8 rental assistance and to convert scarce multi-bedroom family units to single and efficiency units, CLPHA's proposal would very likely result in such concentrations if PHAS were authorized to establish disability-specific buildings.

NAHRO disagreed with what it referred to as our "discouragement of providing a series of alternatives from which disabled applicants can choose." We did not discourage these alternatives but rather assessed the practicality and legality of such alternatives under current law and budget constraints.

HHS and MHLP offered technical comments on this chapter, which we address in appendixes 4 and 6.

Occupancy Practices at Five Public Housing Agencies Follow HUD Policies

The five public housing agencies we reviewed had generally similar selection, admission, and eviction practices, although there were some differences in the way they were applied. The overall similarity is not surprising as the Department of Housing and Urban Development sets out guidelines in this area and audits PHAS' occupancy policies for compliance at least every 4 years. HUD audited the St. Paul and Denver PHAs in 1990, the Minneapolis PHA in 1989, the Seattle PHA in 1988, and the Danbury PHA in 1987. The occupancy policies of these PHAs all complied with HUD regulations.

Reasoning for Selecting the PHAs We Visited

To determine how PHAs select, admit, and evict tenants, among other things, we visited five PHAs located in Danbury, Connecticut; Denver, Colorado; Minneapolis and St. Paul, Minnesota; and Seattle, Washington. We selected the five PHAs for a variety of reasons. St. Paul was included because it has been active in bringing problems with housing people with mental illness to public attention. We selected Minneapolis and Seattle because of reports of significant behavioral problems with the nonelderly tenants with mental disabilities. We chose Danbury because of reported success in integrating housing and mental health services and Denver because it is one of the nine project cities participating in the Robert Wood Johnson Foundation Program on Chronic Mental Illness. This program—cosponsored by HUD and organizations such as the National Governors Association and U.S. Conference of Mayors representing state and local government—supports a range of community-based programs, including supervised housing for people with chronic mental illness.

Eligibility Determination Procedures

For both the elderly and nonelderly people with mental disabilities, eligibility for admission to public housing is determined by income and family composition. All five PHAs in our review use forms to document information about income, assets, previous residence, family composition, and disability status. These PHAs accepted documentation of receipt of social security benefits by nonelderly applicants as proof of disability status. If social security documentation is lacking, PHAs required physicians to certify applicants claiming a disability.

Suitability Determination Procedures

PHAs screen all applicants to determine their suitability for tenancy. Accordingly, PHAs evaluate whether an applicant can reasonably be expected to pay rent and maintain the unit and whether an applicant might have a detrimental effect on other tenants or the building or engage in

criminal activity. To make this determination, PHAS verify information on application forms, interview applicants, check applicants' tenant history and/or other references, conduct home visits, and examine police records. PHAS also review applicants' history of meeting financial obligations, especially paying rent, and check for any history of disturbing neighbors, destroying property, and poor housekeeping. All five PHAS in our review screen applicants in accordance with these practices.

Some applicants for public housing, including individuals with mental disabilities, have never lived on their own and/or lack rental histories. As a result, such applicants cannot provide references from landlords. In all five PHAS we visited, all applicants without tenant histories are requested to provide references from alternative sources, such as family members or doctors.

According to these PHA officials, such applicants provide alternative references that the PHAS use to assess their suitability for tenancy. Although the five PHAS ask for alternative references, St. Paul, Minneapolis, and Seattle officials told us that obtaining references from people other than landlords was very time consuming. One Denver official indicated that the lack of references from landlords left doubt about applicants' suitability for tenancy. In Danbury, the local mental health provider commonly volunteers assessments when a rental history is unavailable. The PHA considers this reference credible when determining an individual's suitability for tenancy.

As required by HUD, all PHAS in our review consider mitigating circumstances and provide reasonable accommodations for applicants with disabilities and tenants otherwise considered unsuitable for tenancy or continued occupancy. Officials at the five PHAS we visited told us that applicants with disabilities have been admitted on the basis of mitigating circumstances. For example, the Minneapolis, St. Paul, and Seattle PHAS have admitted applicants who have a history of delinquent rental payments when third-party payees accepted responsibility for paying the monthly rent. Similarly, all five PHAS in our review have, on occasion, provided a reasonable accommodation for a nonelderly applicant with a mental disability and a rental history indicating unsuitability for tenancy. Each PHA indicated that a reasonable accommodation was provided based on the applicant's participation in a mental health program. Additionally, Seattle and St. Paul officials told us they provided reasonable accommodations at times after the applicants and/or their references volunteered information on the nature of their disability.

Similar accommodations are also provided for existing tenants. For example, in Seattle, a tenant with a mental disability faced eviction because he paced the floor, preventing a neighbor below from sleeping. In this case, a reasonable accommodation was provided by moving the tenant with the disability to a first-floor unit.

Selection Criteria Procedures

Following determination of an applicant's eligibility and suitability, PHAS consider tenant selection criteria. According to HUD's occupancy handbook, tenant selection entails, among other things, consideration of the appropriate size and type of unit. Selection preferences are also considered under the federal preference rule discussed in chapter 1.

As previously discussed, all PHAS in our review, including Danbury to a limited extent, place nonelderly tenants with mental disabilities in public housing for the elderly. According to a HUD official, these tenants are both eligible for such housing and, usually being single, match well with one-bedroom and efficiencies found in public housing for the elderly. All five PHAS we visited provide a federal preference to eligible applicants, including people with mental disabilities. For example, in Minneapolis, 600 of 830 households with nonelderly individuals with mental disabilities (72 percent) that took up residence in public housing since the preference rule became effective in July 1988 received a preference; all 280 nonelderly tenants with mental disabilities in Seattle and all eight such households in Danbury have received a preference since the rule became effective. In St. Paul 255 such households (85 percent) and in Denver 15 such households (50 percent) also received a federal admissions preference during the same period.

PHA Eviction Procedures

HUD occupancy audits review, among other things, PHAS' procedures for termination of tenancy to determine if they are in compliance with HUD's regulatory criteria. These criteria require that leases be terminated if there are serious or repeated violations of material lease terms by any tenant—for example, failure to pay the rent or to fulfill obligations of tenancy, such as not disturbing neighbors. According to HUD, the five PHAS we visited were in compliance with HUD's regulations.

Before eviction, PHAS in our review provide tenants an opportunity to informally or formally contest the termination of the lease, as required by HUD. If termination is upheld, PHAS then start eviction action in court following appropriate notice to vacate. Because of differences in

**Appendix I
Occupancy Practices at Five Public Housing
Agencies Follow HUD Policies**

individual cases, the time from the notification to actual eviction varied from an average of 2 months in St. Paul to 8 months in Danbury. Both Denver and Seattle reported an average of 3 months and Minneapolis, 6 months.

Scope and Methodology

This appendix supplements the material presented in chapter 1 on how we conducted our questionnaire effort and review at five PHAS.

How We Conducted Our Questionnaire Effort

To determine the nature and extent of behavioral problems and the type of services provided in PHA communities, we sent a questionnaire to a stratified sample of 1,073 PHAS.

Data Base Development

To secure a listing of PHAS from which to draw a sample, we used several data bases from HUD and the National Association of Housing and Redevelopment Officials. We reviewed these data bases for potentially duplicate listings and missing names and addresses. Additionally, we obtained a list of PHA names and addresses from the National Association of Housing and Redevelopment Officials. We used this list to fill in as many incomplete entries from the HUD data bases as possible.

Sampling

For sampling purposes, we divided the PHAS into three groups: large (500 or more units), medium-sized (100-499 units), and small (up to 99 units). We sent a questionnaire to all large PHAS and to samples of small and medium-sized PHAS. Table II.1 shows the population sizes, sample sizes, and number of respondents by PHA size and number of units covered.

Table II.1: Population of PHAs, Sample Sizes Drawn, and Number of Respondents

Size of PHA	Number of PHAs	Number of units	PHAs sampled	Units sampled	PHAs responding	Units in response
Small	1,520	74,069	350	16,783	288	67,049
Medium	1,222	266,922	350	76,816	308	252,106
Large	373	938,783	373	936,653	318	885,651
Total	3,115	1,279,774	1,073	1,030,252	914	1,204,806

Questionnaire Distribution, Response, and Editing

We mailed 1,073 questionnaires in June 1990. For those agencies that did not respond, we sent a follow-up mailing; we also called large PHAS to encourage responses. We examined ambiguous response patterns and made follow-up calls to PHAS to clarify unclear responses. In cases where our analysis indicated that responses for individual questions were not reliable, no summary statistics were reported. Additionally, we did extensive follow-up calling to obtain missing data and advised PHAS

initially unwilling to respond that questionnaire responses would be presented as estimates.

Our data collection efforts ended in December 1990. Overall, we obtained 914 usable responses for a response rate of 85.2 percent. Our results are representative of 2,644 (± 64) PHAs.

Data Limitations

PHAs do not maintain data on the type of applicant or tenant handicaps because they are generally prohibited by antidiscrimination regulations from inquiring into the nature or severity of handicaps. As a result, we asked PHAs to give their best estimates of these data. While PHA managers are not clinically trained observers of behavior, they were asked to give their views since they have direct contact with tenants. Additionally, HUD, in commenting on our draft report, stated that self-reporting of historical data is not always reliable. With few exceptions, most data are historical in nature and are subject to measurement error. In some cases, estimates can be derived to address parts of measurement error, such as sampling errors, but others will likely remain as having unknown effects.

Because (1) many PHAs have multiple buildings and (2) services, if available, may not be available in all buildings, we asked PHAs about services provided to the majority of nonelderly tenants with mental disabilities and elderly households. In addition, the data reported represent services provided on site or off site, but they do not show the extent to which services were utilized.

The New York City Housing Authority is the largest PHA in the country with 154,785 units, about 13 percent of the nation's total. Yet, well over 95 percent of these units were located in family projects. This PHA was unable to respond to our questions concerning people with mental disabilities because (1) it does not record data for this population and (2) estimates were impractical due to the agency's enormous size. The Chief of the housing authority's Analysis Division told us that, to complete the questionnaire, we would likely have to directly survey management at each of 41 projects that include elderly high rises. We determined that such an effort was impractical given logistical considerations and the small likelihood of obtaining consistent and reasonably complete data from these projects.

The precision of our estimates is indicated with a confidence interval at the 95-percent level. Since we used a probability sample to develop our

estimates, each estimate has a measurable precision, or sampling error, which may be expressed as a plus/minus figure. A sampling error indicates how closely we can reproduce from a sample the results that we would obtain if we were to take a complete count of the universe using the same measurement methods. By adding the sampling error to and subtracting it from the estimate, we can develop upper and lower bounds for each estimate. This range is called a confidence interval. Sampling errors and confidence intervals are stated at a certain confidence level—in this case, 95 percent. For example, a confidence interval at the 95-percent level means that in 95 out of 100 instances, the sampling procedure we used would produce a confidence interval containing the universe value we are estimating.

Methodology for Review of PHAs We Visited

In order to examine how PHAs select and admit tenants and to gather information concerning mental health and other support service availability, we carried out reviews at five PHAs. We reviewed HUD occupancy policy as set forth in HUD regulations and handbook guidance, including the Public Housing Occupancy Handbook and the Public Housing Occupancy Audit Handbook. Furthermore, at each PHA we visited, we examined how PHAs select and admit tenants through (1) interviews with PHA management, (2) reviews of PHA occupancy policies established in their tenant selection and assignment plans, and (3) simulated applicant interviews.

We conducted simulated applicant interviews by acting the role of elderly applicants and applicants with handicaps for public housing for the elderly. PHA admissions staff followed normal procedures, including eligibility determination, and then reviewed subsequent screening procedures, including questions asked regarding suitability for tenancy and references required for verification of tenant history. We also reviewed notification and appeal procedures for both elderly and handicapped applicants.

To gather information on the availability of mental health community support services in PHA communities we visited, we discussed this topic with PHA personnel and local service providers. We also interviewed the directors of the local mental health service coordinating agencies and reviewed their annual mental health plans as well as such plans for the states of Colorado, Connecticut, Minnesota, and Washington.

Comments From the Department of Housing and Urban Development

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
THE SECRETARY
WASHINGTON, D.C. 20410-0001

February 24, 1992

Ms. Judy A. England-Joseph
Director, Housing and Community
Development Issues
United States General Accounting
Office
Washington, D.C. 20548

Dear Ms. England-Joseph:

Enclosed for your review are the Department of Housing and Urban Development's (HUD's) comments on the General Accounting Office (GAO) Draft Report entitled "Public Housing: Problems in Housing the Mentally Disabled with the Elderly." Overall, I believe the Report represents a thorough effort to address a difficult problem with which the Department has been wrestling for some time.

Within the existing statutory framework, the Department has moved to help public housing authorities deal with the management problems that result from placing mentally disabled young people in developments where the majority of residents are elderly. HUD held a two-day conference to deal with the issues and provided guidance to PHAs on screening potential residents. The Department will provide further guidance this year, in the form of two guidebooks, covering the public housing program and other housing programs.

I agree with GAO that Congress should consider addressing the issue of housing the nonelderly mentally disabled with the elderly in an effort to reconcile the needs of both groups in a fair manner.

Very sincerely yours,

A handwritten signature in dark ink, appearing to read "Jack Kemp".

Jack Kemp

Enclosure

**Appendix III
Comments From the Department of Housing
and Urban Development**

Now on p. 45.
See comment 1.

GENERAL COMMENTS

1. The Report refers to several HUD initiatives (see, e.g., Page 51) but fails to give a complete or cohesive picture of HUD's efforts to grapple with these policy issues. A chronology of such efforts would include the following:

- o In June 1988 the House Appropriations Committee requested that HUD study the problem of the growing number of non-seniors with physical or mental handicaps who were moving into senior citizen highrises, particularly public housing. HUD responded in December 1990 with a report entitled "Housing Mentally Disabled Persons in Public Housing Projects for the Elderly" which included:
 - (1) the results of a field survey to determine the extent of the problems surrounding admitting the chronically mentally ill to elderly projects;
 - (2) a summary of a colloquy with housing and mental health experts;
 - (3) successful management responses to the problem; and
 - (4) the availability of other housing resources and support services.

The HUD report also detailed actions public housing authorities (PHAs) could take to address this problem.

- o In September 1990 HUD sponsored a two day conference to address the issue of housing the chronically mentally ill (CMI) in public housing and provide guidance to PHAs on a series of crucial issues involving: housing the mentally ill and the elderly together, providing services for persons with mental disabilities, screening, tenant selection, and evictions.
- o HUD developed a set of Questions and Answers, which dealt specifically with CMI screening and tenanting issues. The Questions and Answers were subsequently expanded to include other Section 504 issues, and are disseminated during town meetings held throughout the country.

Appendix III
Comments From the Department of Housing
and Urban Development

- o In September 1990, HUD hired a contractor to develop a Guidebook for use by PHAs. This guidebook, entitled Guidebook for PHAs: Meeting the Housing Needs of People with Mental Disabilities Under Section 504 and the Fair Housing Act, is in final draft at this time. It is anticipated that once comments from all HUD offices are incorporated the document will be available for dissemination to the public in April 1992.

- o HUD's Office of Fair Housing and Equal Opportunity (FHEO) is finalizing the Statement of Work and Factors for Award for the companion guidebook, which will be entitled A Guidebook for Assisted Housing Program Providers: Section 504 and Persons with Mental Disabilities. This guidebook will be designed to help assisted housing providers, including all of the Section 8 programs, Section 202, Section 221 (d)(3) and (d)(4), and Section 811 meet the needs of persons with mental disabilities. The projected date for completion of this guidebook is September 1992.

2. Before PHAs objected to the admission of "mentally disabled" individuals to projects for the elderly, PHAs complained about problems between senior citizens and young people with physical disabilities who lived in the same buildings. The restrictions on the admission of "non-elderly" individuals (that is individuals under the age of 62 who are not disabled, handicapped or displaced) has meant that persons with disabilities are the only individuals who have had access to the program as a whole and to elderly projects in particular.

See comment 2.

The overall tone of the report supports the view of the PHAs that the problems resulting from housing mentally disabled individuals is primarily a consequence of their disability. Mental health advocates, on the other hand, often assert that the behavior of persons with mental disabilities is, on the whole, no worse than that of similar "normal" persons. It may be that the admission of any group of young singles to projects for the elderly would have an adverse impact on quality of life as seen by older persons.

See comment 3.

3. There are two factors affecting the tenancy in projects for the elderly that this report ignores: dwelling size availability and the physical design of the buildings and the apartments. Elderly projects, generally, are made up of efficiencies and one-bedrooms, with occasional two-bedroom apartments. These dwelling sizes, along with the definition of eligible family, limit

Appendix III
Comments From the Department of Housing
and Urban Development

tenancy in those projects to one or two persons per dwelling. Most family projects have only two, three, and four-bedroom dwellings. It would be a waste of valuable housing resources for a one-person family to live in these projects. PHAs, therefore, have placed single disabled tenants where the small apartments are, in the projects for the elderly.

CLARIFICATIONS/CORRECTIONS

Now on p. 2.

Page 3: "PHAs place [eligible mentally disabled people] in public housing designated for the elderly largely because public housing law defines "elderly families" to include people who are disabled but not elderly."

See comment 3.

The statement needs some clarification. The definition of "elderly family" in public housing law includes the mentally disabled. Often these applicants are single and need efficiencies or one-bedroom apartments. These types of apartments are generally found in elderly projects, and that is the reason why PHAs end up placing single disabled people in public housing where the residents are primarily elderly persons.

Now on p. 10.

Page 13: "Mentally disabled individuals are generally either mentally ill, mentally retarded, or developmentally disabled."

See comment 4.

It should be noted that mental retardation is in fact a developmental disability. Use of both terms is therefore unnecessary.

Now on p. 12.

Page 15: "PHAs do not maintain data on applicants' or tenants' handicaps because they are generally prohibited by anti-discrimination regulations from inquiring into the nature or severity of handicaps."

See comment 5.

A PHA must maintain information on an applicant's or tenant's disability to the extent it is necessary to determine the individual's eligibility or make a reasonable accommodation to that disability, as required by law. In some situations, a PHA may have to learn more about an applicant's disability to determine his or her suitability for tenancy. This would occur if the disability had previously played a role in negative tenant behavior.

Now on p. 20.

See comment 6.

Page 19: It would be worthwhile to note that one reason problem rates associated with the mentally disabled may be lower in family housing (16-20%) than in elderly housing (28-34%) is that the same event (e.g. noise late at night) is not as unusual or disruptive in a family development as in an elderly development.

**Appendix III
Comments From the Department of Housing
and Urban Development**

See comment 7.

Page 20: The appropriate unit of analysis for the mentally disabled population percentages may more properly be developments rather than PHAs. Some developments have disproportionate numbers of mentally disabled residents, and this information is lost in PHA-wide statistics.

See comment 8.

Page 20: "Projects for the elderly differ from family projects in that tenancy is restricted to families defined as elderly . . ."

Tenancy in projects for the elderly is not restricted to elderly families. PHAs must give a preference to elderly families when determining priority for admission to elderly projects. If there are not enough elderly families to fill current or expected vacancies, the PHA may give a preference to near-elderly families (those whose head, spouse or sole member is between 50 and 61 years old). If the PHA wants to admit single people, including the near-elderly single, it must obtain HUD approval. [Singles are those who are not elderly (age, disability or handicap), displaced by governmental action or the remaining member of a tenant family.] Approval generally is given when there are not enough elderly families on the waiting list to fill the vacancies or the project is not in a suitable location for the elderly.

Now on p. 18.
See comment 9.

Page 20: The number of nonelderly mentally disabled may be understated in family projects because, if such persons are part of a family, their handicap status need not be established because the family would be admitted as a family.

Now on p. 21.
See comment 10.

Page 23: Clarification is needed as to whether the percentages used in Table 2.2 refer to PHAs that report at least one instance of the described problem. If GAO has information on the number of problems within PHAs, it would be helpful to include it at this point in the report.

Now on p. 25.
See comment 11.

Page 24: The Report states that the nonelderly mentally disabled population in housing for the elderly varies from 10 to 17% in the PHAs they visited. On page 25, however, the text states that "Minneapolis PHA managers estimate that 35 percent of the public housing units for the elderly are occupied by nonelderly disabled tenants." The disparity could be due to the fact that 35% is the entire non-elderly population (physically disabled, CMI, developmentally disabled). This should be clarified.

Now on p. 24
See comment 12.

Page 27: GAO surveyed PHAs, asking them to compare the extent of current problems caused by non-elderly mentally disabled tenants with the problems caused the prior year. It bears noting that self-reporting of historical data is not always reliable.

**Appendix III
Comments From the Department of Housing
and Urban Development**

Now on p. 26.

Page 29: "In family public housing, units occupied by households with a mentally disabled member were also greater in number than units occupied by physically disabled or other households."

See comment 13.

Ending the sentence with "other households" implies that there were more households with a mentally disabled member than there were households that did not have a mentally disabled member.

Now on p. 27.
See comment 14.

Page 30: In the last paragraph, GAO provides specific numbers on the nonelderly mentally disabled with preferences. GAO does not provide these numbers for the elderly population. If GAO has that information, it would be useful in the report.

Now on p. 31.
See comment 15.

Page 34: The second full paragraph begins with a description of HUD's section 504 regulations. The discussion should mention the fact that the Department's regulations are consistent with the Government-wide section 504 guidance promulgated by the Department of Justice.

Now on p. 32.

Page 35: The word "passed" should be changed to "adopted" or "promulgated" when referring to regulations.

Now on p. 46.
See comment 16.

Page 51: The first full paragraph refers to a Guidebook for PHAs to use in meeting the requirements of civil rights laws in housing the nonelderly disabled in public housing. HUD expects to issue this Guidebook in April 1992. In addition, HUD is letting a contract for development of a Guidebook for Assisted Housing Program Providers: Section 504 and Persons with Mental Disabilities. HUD expects to issue this Guidebook in September 1992.

Regarding the publication date of the monograph, HUD cannot provide a firm publication date because the monograph must also undergo formal clearance by HHS. The monograph is presently in draft form.

Now on p. 55.
See comment 17.

Page 63: If admission to or exclusion from housing is based on age, analysis is required to be sure that there is no violation of the Age Discrimination Act which prohibits age discrimination in Federally-assisted programs.

Now on p.56.
See comment 18.

Page 63: Last paragraph, second sentence, and first paragraph, first sentence of page 64. These sentences indicate that the term "elderly family" includes only persons who are at least 62 years old and handicapped persons. They leave out people with disabilities.

**Appendix III
Comments From the Department of Housing
and Urban Development**

Now on p. 27.
See comment 19.

Page 66: The report states incorrectly that the National Affordable Housing Act provision increasing the limit on skipping over Federal preference holders to 30 percent has already been implemented by Federal regulations.

Now on p. 58.
See comment 20.

Page 66: The "Preferences Laws and Regulations" section should note that homeless people coming from institutions automatically receive a preference (regardless of how long they spent in the institution).

Now on p. 59.

Page 68:

"Under HUD's recently revised Public Housing Occupancy handbook, PHAs generally may not inquire if an applicant has a handicap or inquire as to the nature or severity of a handicap."

See comment 21.

This is not completely correct: PHAs may inquire to the extent necessary to determine an individual applicant's eligibility, level of benefits or need for reasonable accommodations.

Now on p. 60.

Page 69: Following the Cason decision HUD issued a memorandum to PHAs to provide guidance on this matter. A copy is attached.

Now on p. 64.

Page 73: last line- The word "by" should be "be."

Now on p. 64.

Page 73: In the "Dedication of Section 8 Rental Assistance" section, GAO could mention that HUD has an interagency agreement with HHS through which a grant has been made to the San Diego County Mental Health Authority. This grant provides the Authority funds to investigate uses of four special housing types with Section 8 tenant-based vouchers and certificates, including provision of on-site services to the mentally disabled.

See comment 22.

In addition, GAO could mention here the Notice of Funding Availability (NOFA) which makes available \$17.9 million during FY 1992 to support approximately 750 Section 8 rental vouchers. These vouchers make up a joint program established by HUD and the Department of Veterans Affairs (VA) to benefit homeless mentally ill veterans.

Now on p. 64.
See comment 23.

Page 74: A factor in considering whether to place the elderly or handicapped in family developments is whether residents of the family developments will harass them. PHAs have reported cases of such harassment and, in some cases, have converted existing one-bedroom units to create larger units because of the problem.

**Appendix III
Comments From the Department of Housing
and Urban Development**

Now on p. 66.
See comment 24.

Page 77: The first full paragraph discusses guidance that HUD might provide to detail the questions that can be asked of applicants to public housing. Since HUD's Fair Housing Act regulations already address this subject (24 CFR 100.202(c)) it might be necessary to revise the regulations.

See comment 25.

The report says Section 8 New Construction is subject to the same requirements as public housing, but it does not examine whether there are similar problems (anecdotal information would indicate there are not) or why (private landlords may be keeping young people out).

Now on p. 76.
See comment 26.

Page 87: GAO asserts that there is no sampling error in responses from large PHAs, because there was complete coverage of these PHAs in the survey effort. However, Page 87 states that 885,651 out of 938,783 units in the larger PHAs were covered by the survey. This is substantial, but not complete, coverage. There is an additional inconsistency here in that the survey does not cover 154,785 units in the NY City Housing Authority, which is greater than the difference between 938,783 and 885,651.

The following are GAO's comments on the Department of Housing and Urban Development's letter dated February 24, 1992.

1. Our draft report provided to HUD referred to several initiatives taken by HUD in responding to issues surrounding people with mental disabilities in public housing. Most noteworthy, in our opinion, are (1) the interagency agreement that, among other things, will result in guidance for PHAS for establishing cooperative agreements with service providers and (2) the Guidebook on Section 504 and the Fair Housing Act: Meeting the Housing Needs of People With Mental Disabilities (see ch. 4). Our report does not comment on HUD's initiative to develop a guidebook for assisted housing providers because it would be premature for GAO to comment on an initiative that is still getting under way.
2. This final report includes a new section within chapter 2 that recognizes the issue of intergenerational conflict between the elderly and nonelderly people with mental disabilities.
3. The draft report provided to HUD and this final report point out that people with mental disabilities are often single and need efficiencies or one-bedroom units, which frequently are the type of units in public housing for the elderly (see ch. 1).
4. We agree. The point is clarified in this final report (see ch. 1).
5. HUD's technical correction is incorporated into this final report (see ch. 1).
6. HUD's observation has been added to this report (see ch. 2).
7. We agree with HUD's observation. However, HUD does not maintain a mailing list of public housing developments for the elderly that would have been needed for us to collect and analyze project specific data.
8. HUD's technical correction is included in this final report (see ch. 2).
9. HUD's technical correction is included in this final report (see ch. 2).
10. We did not collect data on the number of problems within PHAS. Furthermore, we believe that table 2.2 accurately describes the percentage of PHAS reporting moderate to serious problems resulting from the listed behaviors.

11. We addressed this point in footnote number 8 in chapter 2 of our draft and final report.
12. This final report notes HUD's point in our section on data limitations (see app. II).
13. If taken independently from the previous two sentences in our draft report, we agree. To avoid such a misreading, this final report further clarifies the data.
14. Questions on the number of elderly tenants receiving preferences were not included in our survey. We discuss the number of elderly and nonelderly people with mental disabilities receiving preferences at the PHAS we visited in chapter 2 and appendix I.
15. We do not believe that inclusion of information on Department of Justice section 504 guidance is needed.
16. This final report provides HUD's updated publication dates as well as information on a Guidebook for Assisted Housing Providers: Section 504 and Persons with Mental Disabilities (see ch. 4).
17. HUD's comment has been incorporated into this final report (see ch. 5).
18. HUD's comment has been incorporated into this final report (see ch. 5).
19. HUD's comment has been incorporated into this final report (see ch. 2).
20. We do not believe that HUD's comment adds materially to our legal analysis.
21. HUD's comment has been incorporated into this final report (see ch. 5).
22. Discussion of HUD's interagency agreement is contained in chapter 4 of this final report.
23. HUD's reporting of harassment is included in this final report (see ch. 6).
24. We concur with HUD's observation and this final report recommends that HUD provide fair housing guidance that details the questions that can be asked of any applicant for public housing (see ch. 3).

25. In accordance with the Subcommittee's request, this report primarily examines problems in public housing for the elderly.

26. HUD refers to respondent error. Because we sent surveys to all large PHAS, there is no sampling error to be reported. Furthermore, the New York City Housing Authority provided estimates on the number of units in family and in "elderly" projects in their housing stock but not on behavioral problems of households with nonelderly people with mental disabilities. As a result, their 154,785 units are included in the units in these responses.

Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 21 1982

Ms. Judy A. England-Joseph
Director, Housing and
Community Development Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. England-Joseph:

Enclosed are the Department's comments on your draft report, "Public Housing: Problems in Housing the Mentally Disabled With the Elderly." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "R. Kusserow".

Richard P. Kusserow
Inspector General

Enclosure

**Appendix IV
Comments From the Department of Health
and Human Services**

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
(HHS) ON THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT
REPORT "PUBLIC HOUSING: ISSUES IN HOUSING THE
MENTALLY DISABLED WITH THE ELDERLY"

We appreciate the opportunity to comment on this draft report. Although the draft report is generally informative regarding the current situation in which mentally disabled people are living in public housing with the elderly, we believe that there are several points which need further clarification.

See comment 1.

First, we believe that the data which serves as the basis of the report was obtained from an extremely narrow reference group. We have reservations about the validity of data collected from only housing managers regarding the behavior of nonelderly mentally ill disabled clients. In general, these are estimates of problems made by non-clinical reporters. The numbers in this report are based on "guesses" by public housing authority (PHA) officials who do not keep statistics on the numbers of nonelderly mentally disabled persons in their buildings or on the number and types of "problems" they cause. We believe that the report should include a qualification clarifying the limitations of the data.

See comment 2.

Second, we believe the standard for assessing problematic behavior is not clearly defined. What are characterized as serious problems by PHA staff often appear to be deviations to their routines, or behavior different (not necessarily problematic) than that of elderly residents. Perhaps the percentage of nonelderly mentally disabled people causing problems in family projects (17.4 percent) is much lower than those in elderly public housing (30.9 percent) because of these different standards. Many of these differences appear to be related to age rather than disability. We believe that the standards need to be better defined.

See comment 3.

The report also does not clearly indicate who are included in the term "mentally disabled." "Mentally disabled" includes both people with mental illness or mental retardation/developmental disabilities. The fact that both of these groups are a part of the Department of Housing and Urban Development (HUD) definition of "mentally disabled," and are both eligible for public housing, raises concerns about whom the PHAs were thinking about when answering questions. While this report suggests that its focus is nonelderly mentally ill individuals, given the other methodological shortcomings of the report, we have no confidence that this distinction was clear to all informants. The report should include two caveats: (a) the term "mentally disabled," as used in this report means only people with mental illness; and (b) it appears that this distinction was not made to the informants. The implications are substantial when you consider who would need to be involved in the recommended cooperative agreements.

**Appendix IV
Comments From the Department of Health
and Human Services**

See comment 4.

See comment 5.

In addition, we would like to make two other points. First, the lack of interviews in New York City represents a gap in this report. Second, the report should provide some discussion on the reasons for the trend that the larger PHAs seem to have more problems.

The recommendation suggesting the development of cooperative agreements between PHAs and mental health service providers should be helpful, but problems will continue to exist unless mentally ill individuals have an adequate range of housing options with varying degrees of structure and support.

RECOMMENDATIONS

To assist PHAs in addressing mentally disabled tenant service needs, the Secretary of HUD should require PHAs to actively seek out mental health service providers for the purpose of entering into cooperative agreements for case management services. Further, to facilitate this, we recommend that the Secretary of HUD work with HHS to issue guidance now being developed for all PHAs on establishing cooperative agreements with local mental health service providers. As planned, a model cooperative agreement should be included in such guidance.

We further recommend that the Secretary of HUD direct PHAs to report on situations where local mental health providers do not exist or are unable to enter into cooperative agreements due to insufficient resources. This information would begin to provide a nationwide assessment of the sufficiency of mental health services available to public housing tenants. It will also provide Congress, through HUD, a initial assessment of the need for targeted resources. Such resources could enable PHAs to contract directly for on-site delivery of case management services.

DEPARTMENT COMMENT

We support GAO's analysis that exclusion or segregation of nonelderly mentally ill disabled violates anti-discrimination statutes.

With regard to the recommendation for a model cooperative agreement, in January 1990, the Secretaries of HUD and HHS signed a Memorandum of Understanding with the ultimate goal of more effectively helping poor families and individuals move toward independent living and economic independence. The homeless mentally ill population was identified as one of the three target groups to be assisted by this effort. Based on the findings of the Task Force on Homelessness and Severe Mental Illness, and building on the ongoing collaboration

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between the two Departments, HUD and HHS will be issuing a model cooperative agreement as recommended in this report.

TECHNICAL COMMENTS

Now on p. 2.
See comment 6.

Page 3 - last paragraph. It seems unlikely that there are communities without any available mental health services. Therefore, what does it mean that 78 percent of the PHAs reported mental health services were provided in the community? Are 22 percent of PHA managers unaware of community resources?

Now on p. 2.

Page 3. It should be noted that during the period from 1986-90, the National Institute of Mental Health (NIMH) Community Support Program funded 16 service demonstration projects on treatment, outreach, crisis intervention, and case management services for elderly mentally ill individuals. The projects in Denver, Seattle, and Baltimore included services provided in inner city public housing. This would have provided additional data that could have been used in this report.

Now on p. 2.

Page 3 - third paragraph. The questionnaire given to PHA managers indicated that 31 percent of the nonelderly mentally disabled clients exhibited behavior that caused them problems. Given the limited resources and services to assist mentally disabled people who live in public housing, it is remarkable that 69 percent of them were not causing problems.

Now on p. 3.
See comment 7.

Page 5 - first paragraph. The report states that PHA staff often have to spend a considerable amount of time reassuring frightened elderly tenants, but there is no information about how much time is spent working with disruptive mentally disabled people who "frighten" the elderly tenants.

Now on p. 3.
See comment 8.

Page 5 - second paragraph, last sentence. In addition to the reasons presented, another reason why the population of mentally disabled people is rising in public housing is that it is the only housing that many can afford.

Now on p. 4.

Page 6 - first paragraph. This paragraph addresses a very important point. When agreements for support services for the mentally disabled exist, there are few behavioral problems in public housing.

Now on p. 4.

Page 7 - The first recommendation states that HUD and HHS issue guidance for all PHAs on establishing cooperative agreements with local mental health service providers. There are entities responsible for mental health services in virtually every county of every State. Many of these entities (local governments, provider agencies, community mental health

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centers) have the capacity to enter into agreements to provide mental health and support services to the mentally disabled (young or old) living in public housing.

In addition, the Community Support Program grants to the elderly mentally ill living in public housing showed that the most successful services and supports were provided directly, through assertive outreach, rather than by primarily referring clients to "mainstream" services.

Now on p. 10.
See comment 9.

Page 12 - Introduction. This section should be modified to explain that this report deals only with issues related to nonelderly people with mental illness rather than the nonelderly mentally disabled population.

Now on p. 12.

Page 15 - first paragraph. Surveys were sent to 1,073 PHAs. Unfortunately, no surveys were sent to tenants directly.

Now on p. 21.
See comment 10.

Page 22. The table suggests that all the information on the "numbers of individuals" causing moderate to serious problems is based on a question about the severity of problems caused by individuals and not a question about how many individuals cause problems.

Now on p. 22.
See comment 11.

Page 24 - last paragraph. Since it is suggested that there is no placement of nonelderly mentally disabled persons in elderly public housing at the Danbury PHA, the statement about "no problems" is misleading.

Now on p. 22.

Page 24 - last paragraph. The explanation for the success of PHA in Danbury, Connecticut should be qualified. ".... Danbury, a medium sized PHA, reported no problems because support services are available, sufficient and used and because, with few exceptions, the nonelderly mentally disabled (under 50 years of age) are offered and accept placement in other subsidized housing rather than public housing for the elderly." Therefore, this program should not be held out as a model of public housing for other cities.

See comment 12.

Now on p. 23.

Page 25 - last paragraph. Another part of the study to be emphasized is that in St. Paul, Minnesota there is a relatively small number of problems with nonelderly mentally ill tenants because of "effective interaction with local mental health service providers."

Now on p. 24.

Page 26 - last paragraph. The study showed that in Denver a large percentage of the households with nonelderly mentally ill tenants caused moderate to excessive problems for management and staff. However, PHA management indicated that "tenants with mental disabilities that receive services generally do not exhibit problem behaviors."

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Now on p. 27.
See comment 13.

Page 31 - second paragraph. Another factor contributing to the increase in the number of nonelderly mentally ill in public housing for the elderly is the low level of income of the mentally disabled in the community.

Now on p. 28.
See comment 14.

Page 31 - second paragraph. To cite deinstitutionalization as a causal factor contributing to the increase in nonelderly mentally ill disabled clients in public housing seems unfounded. The bulk of deinstitutionalization occurred well before the current increases. The commitment to house people in less restrictive environments is a policy/philosophy which requires alternative community housing. Citing deinstitutionalization as a cause inappropriately suggests reinstitutionalization as a solution.

Now on p. 31.
See comment 15.

Page 34 - second paragraph. This is a poor example of mitigating circumstances since psychopharmacologic agents rarely cause memory loss. A better example would be the following: Untreated mental illness can be associated with disorganized thought patterns and failure to attend to daily activities (e.g., paying rent). Appropriate treatment and support would obviate this risk.

Now on p. 35.
See comment 16.

Page 39 - first paragraph, last sentence. "According to NIMH, the case manager is a helper, service broker, and advocate." This is a too narrow and "folksy" definition. Case management functions include identification and outreach, assessment, planning, linkage, monitoring and evaluation, direct service provision, crisis intervention, resource development, and system and client advocacy.

Now on p. 36.
See comment 17.

Page 40 - fourth line. There is no "entitlement" to support services. This language should be replaced to read, "...mentally ill people, including those in public housing, require support services..."

Now on p. 40.
See comment 18.

Page 43 - third sentence. The specification of a precise number (5-10) of services needed for "survival" should be deleted. How was "survival level" defined? Is this number based on any research study?

Now on p. 43.
See comment 19.

Page 46 - Insert "most" before non-elderly in the first sentence under Community Support Services Can Prevent or Mitigate Behavioral Problems.

Now on p. 44.
See comment 20.

Page 48 - third paragraph, first sentence. Delete "ideal." There is no ideal system offered by NIMH.

Now on pp. 67 and 68.
See comment 21.

Page 78, last paragraph - It is not appropriate to suggest any new Congressional Mandates when the authority already exists to serve mentally ill individuals in public housing via the

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Projects to Assist in Transition from Homelessness (PATH) program, authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (P.L. 101645, Title V, Subtitle B).

The following are GAO's comments on the Department of Health and Human Services' letter dated February 21, 1992.

1. While PHA managers are not clinically trained observers of behavior, they were asked to give their views since they have direct contact with tenants. The final report includes a qualification indicating the limitations of our data (see app. II).
2. See comment one. Additionally, we have added a section to chapter 2 of this final report that recognizes the issue of intergenerational conflict between the elderly and persons with mental disabilities.
3. The survey instrument sent to PHA managers included a definition of households with mental disabilities that included both people with mental illness and mental retardation/developmental disabilities (see ch. 1 for the definition). Therefore, data reported on problem behavior include PHAS' estimates for all households with members with mental disabilities. Our discussion of applicant screening and of legal issues also concerns all people with mental disabilities. HHS correctly comments that our discussion of services is limited to services needed by people with mental illness. Our rationale for limiting our review to the service network available for people with mental illness is discussed in chapter 1 of this final report.
4. The data limitations presented by the absence of data on problems attributed to tenants with mental disabilities from the New York PHA are included in appendix II of both the draft and this final report.
5. We do not believe that data concerning changes in individual behavior over a 1-year period provide evidence of a trend. Also, our survey responses do not provide information on why very large PHAS have more problems.
6. HHS raises a question that should be answered by implementation of our recommendations. PHA managers may simply not be aware of available mental health services in their communities. If they seek out such service providers in order to enter into cooperative agreements and cannot locate them, or if services are insufficient, they, according to our recommendation, should report that information to the Congress through HUD.
7. This issue is addressed in the draft and final report (see ch. 2).

8. The draft and this final report discuss the need for affordable housing by nonelderly people with mental disabilities (see ch. 1).

9. As discussed in comment 3, our report concerns problems attributed to all households with members with mental disabilities as well as screening issues with regard to and legal rights of all people with mental disabilities. This final report explains that our discussion of services concerns only people with mental illness of the population of people with mental disabilities in public housing for the elderly (see chs. 1 and 4).

10. Table 2.2 provides a global assessment of the proportion of PHAs that reported moderate to serious problems with each behavior listed. As such, the title is accurate.

11. We disagree. The discussion of Danbury in chapter 2 indicates that, at the time of our review, for the most part, tenants with mental disabilities under 50 years of age were placed in other subsidized housing. But the few households with younger (under 50 years of age) nonelderly people with mental disabilities who were residing in Danbury's public housing for the elderly were not exhibiting problem behavior.

12. We disagree with HHS' interpretation of the Danbury example. While only a few nonelderly tenants with mental disabilities reside in public housing for the elderly in Danbury, these tenants do not exhibit problem behavior. This results, we believe, in large part from the availability and use of case management services facilitated through a cooperative agreement between the PHA and local mental health service provider. Use of services and not PHA size is the message that HHS appears to have recognized earlier in its comment supporting the position that "when agreements for services for the mentally disabled exist, there are few behavioral problems in public housing."

13. See comment 8.

14. While deinstitutionalization policy is a major causal factor for people with mental disabilities residing in the community, we concur with HHS' point that deinstitutionalization policy may not be a significant factor contributing to an increase in the population of nonelderly people with mental disabilities in public housing for the elderly. Accordingly, we have deleted this factor from our conclusion in chapter 2 of this final report.

15. The final report substitutes HHS' example for the example in our draft report.

16. The sentence in question is a direct citation from an NIMH document. To address HHS' concern, this definition is supplemented by HHS' description of the case management function in this final report (see ch. 4).

17. This final report has been revised to avoid the implication that these are entitlements.

18. This final report was changed to reflect the HHS comment.

19. This final report was changed to reflect the HHS comment.

20. This final report was changed to reflect the HHS comment.

21. We disagree. While the authority to assist formerly homeless people with mental illness exists under the Projects to Assist in Transition from Homelessness program, we are reporting what interested parties suggested as approaches for addressing identified problems. The PATH program was not cited by any interested party. Citation of PATH authority has been included in this final report (see ch. 6).

Comments From the American Association of Retired Persons

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



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FORMAL COMMENTS ON

Public Housing:
Issues in Housing the Mentally Disabled with the Elderly

A Report to Congress by the
U.S. General Accounting Office

Submitted by
The American Association of Retired Persons

February 4, 1992

For further information, contact:

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Comments From the American Association
of Retired Persons**

February 4, 1992

Ms. Judy A. England-Joseph
Director, Housing and Community Development Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. England-Joseph:

On behalf of the American Association of Retired Persons ("AARP" or "the Association"), I thank you for the opportunity to review and comment on your proposed report, "Public Housing: Issues in Housing the Mentally Disabled with the Elderly."

The issues surrounding the policy of housing young disabled individuals in elderly public housing are among the thorniest facing housing policy decision-makers today. GAO is to be applauded for doing this extensive research and report, which will serve as one important data base for those formulating a reasonable and equitable policy for serving both older and younger public housing tenants.

This data will be most useful if considered in a much broader policy context that includes how the current situation came into being and how public policy might be redirected. Lacking that perspective, the GAO report misses the obvious conclusion: the elderly public housing program has had to bear the brunt of a failure of public policy with regard to disabled persons, especially the homeless mentally disabled. Our comments will address these issues through three crucial points:

- o The current situation is the unintended consequence of vague statutory definitions that have been inaccurately interpreted by HUD and amplified by subsequent legislation.
- o The rapidly growing concentration of nonelderly individuals with disabilities in "elderly" public housing reflects the absence of alternatives for the disabled. Continuation of this failed policy is not in the interests of nonelderly disabled persons or of older residents of public housing.
- o Adequate and equitable solutions to the current situation will require greater flexibility and more resources for public housing as well as other housing and services programs. Public policy should promote both age-distinct housing that has successfully served older people and housing and services that integrate individuals with disabilities into the broader community.

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I. A History of Unintended Consequences

Federal intervention in the provision of housing began during the Great Depression and was designed to aid young working families faced with a severe housing shortage. Indeed, single-person households, which predominate among the older and disabled households now served by federal housing programs, were not originally even eligible for public housing.

After World War II, housing policy was reoriented to address the disproportionate levels of poverty and unsuitable housing experienced by older people. In 1956, public housing law was revised to make single older individuals eligible as "elderly families." Public housing authorities began to build elderly housing with one-bedroom and efficiency apartments suited to single individuals and childless couples. Today, far more older people are served by public housing than any other project-based federal housing program.

Housing programs serving older persons have been a tremendous success. Waiting lists are very long at most sites, vacancy rates are generally well under the industry average, and turnover rates are extremely low. Studies of a more qualitative nature have found high resident satisfaction due to a feeling of security in a supportive community environment.

However, the success of elderly public housing has been seriously eroded by the recent move toward serving increasing numbers of younger disabled tenants. Statutorily, these problems are rooted in a 1962 change to the "elderly family" definition. To make them eligible for public housing, Congress included disabled individuals under the definition of "elderly families." It is critically important to note that no housing or civil rights statute creates a right to admission to projects designated for older persons by nonelderly persons with disabilities. Indeed, both the Fair Housing Amendments Act of 1988 and the National Affordable Housing Act of 1990 affirmed the social importance of "housing for older persons," including housing provided by federal assistance programs.

Other federal housing programs continue to admit only older residents. AARP strongly concurs with the conclusion of the report's legal analysis that "GAO believes that owners or sponsors of housing provided under three other federally assisted programs serving the elderly - 221(d)(3), 202, and 236 - may lawfully limit occupancy to the elderly and exclude nonelderly persons including those who are mentally disabled" [page 6].

A history of HUD administrative interpretations, not legislative mandate, is largely responsible for segregating younger persons with disabilities in elderly public housing. HUD has chosen to interpret the eligibility definition as requiring that younger individuals with disabilities live in the same projects as older persons. Moreover, HUD policy is responsible for providing units

See comment 1.

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for single individuals only in elderly projects, making otherwise eligible single individuals largely ineligible for admission to family projects.

As the GAO report notes, subsequent laws have amplified the effects of the eligibility definition. The Rehabilitation Act of 1973 expanded the definition of "handicapped" to include mental disabilities and added legal protections for handicapped renters. The Fair Housing Amendments Act provided additional protections, in particular the requirement that "reasonable accommodation" be made for disabled individuals.

Recent years have also seen increasingly strong efforts by advocates of the disabled to protect individuals with disabilities from forced institutionalization and to enable them to find housing in the community. As the path of least resistance, young disabled persons have been admitted to elderly public housing in rapidly accelerating numbers.

II. The Situation Today

The situation in elderly public housing today can best be characterized as untenable for all residents. The GAO report outlines some dimensions of the problem, namely:

- o Nonelderly persons with disabilities, especially those with mental disabilities, are concentrated in elderly projects, particularly in projects operated by large public housing authorities (PHAs) [page 20];
- o The situation is shifting quite rapidly in the direction of more admissions of nonelderly persons with disabilities to elderly projects -- HUD data, more recent than that included in the GAO report, indicate that more than half of admissions to elderly projects during 1991 were nonelderly persons with disabilities [pages 28 and 29];
- o Public housing managers report that "nonelderly mentally disabled tenants cause a disproportionate share of problems," especially in large public housing authorities which have the greatest concentration of nonelderly disabled tenants [pages 21 and 22];
- o Managers of elderly housing are far more likely than managers of family projects to report that nonelderly tenants with mental disabilities "are exhibiting behaviors that are moderate or serious problems for management" [page 22];
- o "PHA staff need to spend more time resolving these problems [behavior problems of nonelderly mentally disabled tenants]. On the other hand, the behavior of elderly tenants, overall, is less problematic for PHA staff and requires less time to address." [page 24]; and

Now on p. 25.

Now on p. 19.

Now on p. 20.

Now on p. 21.

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- o "PHAs reported that problems have been increasing," especially in large public housing authorities where nearly half (49 per cent) of the responding PHAs reported worse problems in 1990 than in 1989.

See comment 2.

Despite these findings, the GAO report seems to minimize both the magnitude of the problems associated with housing older tenants and younger disabled tenants in the same buildings and the scope of the solutions required to adequately address those problems. The Executive Summary characterizes the number of nonelderly, mentally disabled tenants as a "small percentage," a characterization that does not comport with reports from housing authorities and data from HUD.

Unfortunately, minor tinkering cannot solve the problem. For example, GAO's recommendation that PHAs seek partners among mental health services providers may be useful advice but is simply not an adequate response to the magnitude of the problem. Similarly, better guidance from HUD would certainly be helpful, but falls woefully short of a solution.

See comment 3.

GAO'S report does not even begin to portray the degree of disruption and pain that current policy has caused in the lives of individual residents, older and younger. Strong, supportive communities have been shattered by suspicion, conflict, and fear. Public housing managers report that projects that once had low vacancy and turnover rates now see older tenants leaving and few being admitted. Stretched thin by these problems, few management resources remain to adequately serve older residents.

Elderly housing projects are far from ideal for younger tenants as well. Life style differences with older tenants generate conflicts that would be largely ignored in other settings. Few social services are offered to meet their needs. Younger disabled tenants are often ostracized by other tenants and find themselves, once again, living in an environment in which they are segregated from the broader community.

In addition to the disruption caused to thousands of lives, the wholesale replacement of older residents with younger disabled tenants represents a major loss of housing stock for low-income older renters. Older renters have, on average, lower incomes, own fewer assets, and pay a higher portion of their incomes on rent than nonelderly renters. Waiting lists are long at most federally assisted housing for the elderly. Despite this need, low-income older renters have lost far more units of public housing over the past two years than were funded during that time under the Section 202 program for elderly housing.

See comment 4.

The GAO report stops short of drawing the obvious conclusion -- the elderly public housing program has had to bear the brunt of a failure of public policy with regard to disabled persons of all ages. Younger disabled persons are being placed in elderly

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projects, not because they want to live with older people, but because there are no reasonable alternatives. The federal government and the states have been only too eager to deinstitutionalize those with disabilities because of the expense of providing institutional care. However, they have not provided the alternative housing and community-based supportive services necessary to meet the needs of persons with disabilities.

The current zero-sum budget game has created a grim Dickensian world where two of America's neediest groups are pitted against each other for limited resources. Younger disabled persons are being resegregated into disability ghettos, generally with little support from social service providers, housing managers, or fellow tenants. Older residents are being denied the benefits and services associated with age-distinct housing; indeed, many are being denied the possibility of assisted housing at all.

Looking Ahead for Solutions

While the current situation rests on a peculiar statutory definition of "elderly," legislative change that would simply use a more common sense definition would create still further problems by denying public housing eligibility to nonelderly individuals with disabilities. Since the root cause of the problem of housing older people and younger disabled people in the same buildings is the lack of housing and services options for individuals with disabilities, any solution must address those needs. New and existing resources will have to be marshaled in a multifaceted approach that takes into account very different needs of nonelderly individuals with disabilities and older persons.

Key to serving disabled people of any age is a firm national commitment to providing supportive services in residential settings. The national tragedy of homelessness was brought about, in part, by deinstitutionalization without such a commitment to providing alternative, service-enriched housing. Specifically, AARP recommends:

Alternative Housing Options

- o Public, Indian, and various assisted housing programs should be able to offer age-specific housing for the elderly -- as provided by the Fair Housing Amendments Act.
- o To meet the responsibilities of serving disabled and older persons, PHAs should be given the tools to do the job properly, including:
 - Vouchers and/or certificates linked with services for disabled people of all ages, similar to the HOPE for Elderly Independence program.
 - Age-specific housing for the elderly.

See comment 5.

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- Disability-specific housing, where appropriate and where the option is with the tenant to choose such a facility (i.e., give public housing agencies the authority to provide housing similar to that provided under the Section 811 program).
- New development funds to produce or purchase appropriate units for persons with disabilities in scattered site housing or family projects.
- Targeted modernization funds to convert units in family projects for the use of disabled individuals or families.

Services and Housing

- o Entitlement programs should promote services in residential settings through a social insurance (rather than a welfare) program serving disabled people of all ages.
- o HUD should provide the facilities, management, and matching resources needed to provide services to disabled people.
- o Funding for the Congregate Housing Services Program should be substantially increased in order to establish more service-enriched housing for older and younger persons with disabilities at selected housing sites.
- o HUD should provide adequate guidebooks, management training, and technical assistance on the provision of housing and services to older and disabled people.
- o Services coordinators should be provided in elderly public housing projects as authorized by Section 506 of the National Affordable Housing Act.

Screening and Termination

- o Screening of potential tenant should focus on the ability of tenants to meet the terms of the lease.
- o Screening should, however, be implemented to find more appropriate arrangements for potential tenants who have a history of disruptive behavior.
- o Special screening for disabilities should only be used to determine eligibility for special programs targeted to the disabled and frail (e.g., the Congregate Housing Services Program).
- o Lease addenda should be used to enlist formal support from services providers. They should be viewed as one mechanism

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whereby tenants, who would otherwise be refused admission, can establish a "reasonable accommodation" and thereby gain a lease.

- o Ultimately, tenants must know, in advance, that leases will be terminated for repeated and serious violations of lease agreements.

In conclusion, AARP strongly believes that this nation should provide both age-specific housing for older persons and housing and services that address the needs of disabled persons of all ages. The Association urges the Congressional committees that commissioned this study to move quickly to meet both of these objectives. Thank you again for the opportunity to comment on this important study. If we can be of any further assistance on this or any other issue, please do not hesitate to contact Don Redfoot of our Federal Affairs staff at 434-3800.

Sincerely,



John Rother
Director
Legislation and Public Policy

The following are GAO's comments on the American Association of Retired Persons' letter dated February 4, 1992.

1. According to our survey data estimates, more nonelderly people with mental disabilities live in family public housing than in public housing for the elderly.
2. As of the fall of 1990, PHA survey responses indicated that the population of nonelderly people with mental disabilities in public housing for the elderly was relatively small. Recent HUD data indicate that households headed by nonelderly persons with disabilities now occupy approximately 28 percent of all PHA units. Additionally, between March 1991 and February 1992, nonelderly households with disabilities made up about 51 percent of new admissions to all public housing units nationwide. These data are limited to PHAs with 500 or more units. The data do not isolate public housing for the elderly apart from PHA-wide statistics, and also do not isolate households headed by nonelderly persons with mental disabilities from households headed by persons with other disabilities. Therefore, there are no available HUD data comparable to the population statistics we report.
3. Our data indicate that serious problems exist in public housing for the elderly, especially in large PHAs. Furthermore, while current policy has resulted in the mixing of populations, we have no evidence indicating that it is the cause of individual problem behavior or its impact on others.
4. We can only respond to comments concerning the subject population of our study—people with mental disabilities. In this regard, we agree that the lack of housing alternatives is very likely the cause of the increasing number of nonelderly tenants with mental disabilities in public housing for the elderly. We also believe, on the basis of our interviews with state and local mental health officials, that existing community-based support services are very likely insufficient to meet overall existing need.
5. We agree that simply changing the definition of "elderly" would create still further problems. Furthermore, we also agree that any approaches taken to address the housing and service needs of the elderly and people with mental disabilities should take into account the different needs of both groups.

Comments From the Mental Health Law Project

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

MHLP MENTAL HEALTH LAW PROJECT

February 5, 1992

Judy A. England-Joseph, Director
Housing and Community Development Issues
United States General Accounting Office
Resources, Community and Economic Development Division
441 G Street, N.W.
Room 1842
Washington, D.C. 20548

Re: Public Housing: Issues in Housing the Mentally Disabled With the Elderly

Dear Ms. England-Joseph:

Thank you for providing us with the opportunity to comment on the draft report about "mixing." The wide variety of issues and topics that your staff covered in order to develop answers to Senator Cranston's questions demonstrates the complexity of an undertaking in which civil rights laws, mental health policies, housing procedures, management training, intergovernmental relations, perceptions about age and disability and federal regulations are all implicated. Overall, the report would have benefitted from input from tenants of all ages with and without disabilities. However, as the report itself indicates, more data needs to be collected and this report provides a good start in that direction.

The report's recommendations are sound and will be reinforced as we collect more information on programs and practices that have worked. The report correctly concludes that we know enough at this point about what makes housing successful for all tenants so that major statutory changes are unnecessary. We would have liked to see recommendations aimed at serving the mental health needs of the elderly, as well as education programs for tenants of all ages about disability and aging issues.

We recommend that the final version of this report and all

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RONNIE MUMFORD					

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future GAO reports stop referring to people with mental disabilities as "mentally disabled people." People are no more defined by their disabilities than they are by their race or color. Continuing to refer to tenants with disabilities as "the non-elderly disabled" unnecessarily and unintentionally reinforces the stigma associated with disabilities. Our specific comments follow.

Comments

See comment 1.

Page 2: Senator Cranston's questions contain assumptions that the report should articulate. One question assumes that housing non-elderly tenants with mental disabilities with elderly tenants, with and without disabilities, causes problems. This report alone demonstrates that is not necessarily so and that adequate housing management addresses tenancy problems that may or may not exist in more homogeneous populations. The Senator's other question addresses the need for greater support services for tenants with disabilities and, by implication, implies that elderly tenants as well as younger tenants without disabilities do not need or would not benefit from support services. The report -- and the investigation -- would benefit from an articulation and analysis of these assumptions.

Now on p. 2.
See comment 2.

Page 3: While the report indicates the percentage of tenants with disabilities who cause problems, it does not indicate the percentage of elderly tenants, with and without disabilities, or non-elderly single tenants without disabilities (eligible for public housing as of last year's legislation) who cause problems. Both CLPHA and NAHRO have reported that the numbers of very old tenants (80+ years old) have increased and are expected to increase. This is a significant fact that should be included and analyzed because of the incidence of Alzheimer's, alcohol abuse, and behavioral problems resulting from over-medication experienced by older tenants as well as their lack of sufficient access to physical and mental health care programs.

Now on p. 3.
See comment 3.
Now on pp. 4, 44, and 45.

Pages 4 - 5: The important finding concerning cooperative agreements should be amended to include the fact that "mixing" does not result in problems where tenants have access to support services (reported at pages 5-6 and pages 49 and 50).

Now on p. 4.
See comment 4.

Page 6: The list of PHA's at the top of the page should include Wilmington, Delaware and Denver, Colorado.

See comment 5.

The conclusion that 221(d)(3) and 236 housing providers may exclude non-elderly applicants is incorrect. (See our discussion of Chapter 5., infra.)

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Now on p. 4.
See comment 6.

Page 7: The report omits one approach that has proved its value in the Elliott Twin Towers Demonstration Project and in other PHA's around the country: improving management and increasing funds to PHA's. Improved management results in part from training (which the report does mention several times) and increased funding which would pay for resident managers/service coordinators and increased security, if the Minneapolis model were followed. Even if the GAO does not want to recommend increased funding, the data your staff collected certainly justifies a training recommendation which could be provided by local mental health agencies with or without a cooperative agreement.

Now on pp. 10 and 11.
See comment 7.

Page 13: The second sentence of the Deinstitutionalization definition is incorrect and should be deleted. Please call me or Claudia Schlosberg for more detail.

With regard to the income levels of people with mental disabilities, I believe that either NIMH or the National Association of State Mental Health Program Directors has statistics showing that such people rank at the bottom of low income populations.

Now on p. 11.
See comment 8.

Page 14: With regard to preferences, low income elderly, low income families and individuals also "benefit from this rule." The report implies that "the mentally disabled" benefit more from preferences than do other low income consumers which obviously is not true.

Now on p. 13.
See comment 9.

Page 15: The statement that people with developmental disabilities either live in hospitals or in group homes is not true. Many live with their families as well as in multi-family housing, public family and elderly housing, coops, condos, SRO's, shelters, supported housing and substandard housing. The Association for Retarded Citizens, the President's Committee on Mental Retardation, or the National Association of Private Residential Resources might have data on the numbers of Americans with developmentally disabilities living in public housing.

Now on pp. 21 and 22.
See comment 10.

Page 21: After stating that PHA managers complain that resolving problems created by non-elderly tenants takes longer than resolving problems created by elderly tenants, the report lists only 2 of 4 possible explanations for this complaint: that managers lack training and have less familiarity with available resources for tenants with mental disabilities than for elderly tenants. One of the other possibilities is that managers are less likely to be sympathetic to the non-elderly tenants, especially if they believe the housing is "elderly housing" and don't understand that non-elderly tenants are equally eligible for the housing. The other is that HUD has provided incomplete

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and inconsistent directions on admissions, screening, eviction and reasonable accommodations. While the report addresses the last reason in chapter 4, it would be helpful to mention all four reasons in this chapter. It would also make the chapter more balanced if it included discussions of at least the Danbury and Elliott Twin Towers project since they, too, reflect management views on "mixing."

Now on p. 21.
See comment 11.

Page 23: It would be relevant to know how many of the PHA's that report problems with tenants who have mental disabilities are on HUD's list of "distressed" (i.e. badly managed) PHA's, or using other data to determine whether such a correlation exists. Each of the PHA's in which "mixing" has been successful, according to the report, have been described as well managed in conversations I have had with HUD officials and tenant representatives.

Now on p. 23.
See comment 12.

Page 25: The description of the Minneapolis PHA is flawed because it excludes the findings from the Elliott Twin Towers Demonstration Project. It was because of the success of the Project that the City appropriated funds for the Housing Authority, at its request, to increase the numbers of housing managers for all of the buildings, not just elderly housing.

Now on p. 23.
See comment 13.

Page 26: The description of the St. Paul tenant implies that tenants with disabilities are held to a lower standard for eviction when they must, in fact, be held to the same standard as other tenants. The example also doesn't reflect whether or not mental health professionals were involved in counseling either the troublesome tenant or his neighbors. This might be an appropriate place to discuss the benefits of having mental health professionals, rather than housing managers, provide mental health counseling and services. Neither mental health nor housing professionals want housing providers to take on mental health tasks. Thus, the St. Paul example might have had a different outcome or might have been resolved sooner had the PHA had the kind of cooperative agreement that the report recommends.

Now on p. 32.
See comment 14.

Page 34: In the last paragraph, the second sentence should read: "... financial and administrative..." not "financial or..." (See HUD Section 504 regulations, 24 C.F.R. Sec. 8.24 (b)).

Now on p. 32.

Page 35: Since the HUD regulations accurately reflect the Fair Housing Amendments Act, the problem for PHA's resulted more from HUD's failure to explain how to implement the statute and the regulations, rather than the regulations themselves. For example, in Rochester Housing Authority v. Cason, the PHA and the plaintiffs' attorneys developed a set of screening and admission materials that both meet Fair Housing Act standards and the PHA's

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need for useable and effective management documents. I have been told that the Housing Authority has found the documents especially useful with regard to applicants who have no rental history.

Now on p. 35.
See comment 15.

Page 38: If the source material contains more data on the content of the cooperative agreements and how the PHA's use them, it would be helpful to have that information in the report.

See comment 16.

Nowhere in the report is the fact mentioned that elderly consumers also need and can benefit from mental health services, especially if they are located close to the elders' housing. Attached is an article on the issue written by the current Deputy Director of the National Institute on Aging.

Now on p. 36.
See comment 17.

Page 40: The recently proposed Administration budget includes no funds for the service coordinators authorized in Cranston-Gonzalez and the budget also slashes operating funds in general for PHA's.

Now on p. 41.

Page 45: While the Minneapolis officials may be correct that mental health services are inadequate, this information conflicts with the accomplishments of the Elliott Twin Towers Project.

Now on p. 43.

Page 47: Too often government reports omit discussions of self-help groups. Fortunately, they are included in this report.

Now on p. 43.

Page 48: While it is important to include the Elliott Twin Towers Project, it would be even more useful to include the data showing that improved management, an on-site manager and increased security resulted in high tenant satisfaction and low (if any) evictions for cause. This data would help shift the focus away from blaming the victim and toward instituting proven management practices.

Now on p. 47.

Page 52: It's not clear whether mental health personnel are participating in developing guidance for mental health agencies on how to work with PHA's, which is likely to be as important as developing guidance for PHA's.

Now on pp. 49-66.

Pages 53 - 70: This chapter presents legal conclusions that are incorrect both with regard to the 202 program and the 221(d)(3) and 236 programs. None of these programs may legally restrict admission to elderly persons.

See comment 18.

The report concludes that the 202 program permits restrictive admission policies based on the Brecker and Knutzen cases. Both cases were decided on Section 504 grounds and before the Fair Housing Amendments Act was passed. To prove a 504

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violation, the plaintiffs had to show that they were denied admission "solely" because of their handicap. Under the Fair Housing Act, handicap need only be one consideration among other possibly valid factors for plaintiffs to establish a prima facie case. Second, the courts are split as to whether it is necessary to prove intent in order to establish a 504 violation. Plaintiffs need show only that a defendant's action has the effect of discriminating in order to prove a Fair Housing Act violation.

While the report reviews these arguments, it does not conclude that it is unclear whether the Brecker and Knutzen cases would be decided in the same way today. Instead the report states that there is no legislative history to override the alleged 202 authorization "to reject nonelderly mentally disabled persons in favor of admitting other classes of eligible persons." p.61. In fact, before the Reagan Administration, HUD administered the 202 program according to Congressional intent that admission decisions be made on the basis of service needs, as the National Affordable Housing Act now makes clear, and not on the basis of descriptive nominative adjective.

The House Committee on Banking, finance and Urban Affairs agreed with the pre-Brecker approach and advised HUD that Brecker had been wrongly decided. In their Report on the Housing, Community Development and Homelessness Prevention Act of 1987, the Committee said:

It has come to the Committee's attention that HUD has adopted a policy that permits a sponsor to limit tenancy in a Sec. 202 building to elderly persons or to the elderly and physically handicapped but excluding developmentally disabled persons, and other handicapped persons. See Brecker....Such a policy is contrary to the purpose of Sec. 202 and of this Act, which are designed to maximize housing opportunities for the elderly and the handicapped.

There exists an acute shortage of housing for handicapped persons. Handicapped persons capable of living independently in housing primarily for the well elderly should be permitted to do so. Such integrated living arrangements encourages handicapped persons to obtain employment, become self-supportive and avoid isolation from the general society....

...[T]he Committee expects HUD to enforce this new legislation in a way that maximizes the opportunity for persons with disabilities to reside in all types of housing financed in whole or in part by HUD. Particularly in the case of Sec. 202 housing specifically financed to house the elderly, no sponsor should exclude from occupancy a physically or mentally or handicapped, developmentally

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disabled person who is capable of living independently.
H.R. Rep. No.122, 100th Cong. 1st Sess. 45.

Apart from the 504 and Fair Housing Act distinctions, the Brecker and Knutzen cases apply only to Section 202 housing that provide services. While 202 providers are required to file service plans in order to become eligible for 202 funding, the fact is that many 202 projects do not include gerontological services or any services. Many provide transportation vans to carry tenants to shops and doctors' offices, but these kinds of services are helpful to both elderly and younger tenants with mobility impairments. They are not services that address age-specific needs. At the least, therefore, the report should be amended also to reflect the need to conduct a fact-based analysis of specific 202 projects before determining whether they may legally restrict admissions to elderly applicants.

With regard to the National Affordable Housing Act, footnote 4, at page 55, incorrectly characterizes its provisions by saying that the Act permits "housing for physically handicapped persons to the exclusion of mentally disabled persons," based solely on their diagnoses. The Act says:

Notwithstanding any other provision of law, an owner may, with the approval of the Secretary, limit occupancy within housing developed under this section to persons with disabilities who have similar disabilities and require a similar set of supportive services in a supportive housing environment. Section 811(i).

This language was not intended to focus on distinguishing between mental, physical and developmental disabilities per se, but on the service needs of specific individuals. Thus, if three applicants who were addicted to cocaine, one with a mental disability, the second with a physical disability and the third with a developmental disability and each required substance abuse counseling, they would all be eligible for housing that provided that service. This interpretation of the Act is reinforced by the Act's inclusion of a civil rights compliance section that specifically mentions the Fair Housing Act. Section 811(j) (2).

If I understand the argument with regard to 221(d) (3) and 236 programs, the report concludes that those statutes do not provide any prohibition against a selective admissions policy because they define "elderly" and "handicapped" separately while the U.S. Housing Act defines "elderly families" to include "handicapped persons" for public housing and Section 8 purposes.

In fact, the 221(d) (3) and 236 definitions of "elderly family" are the same as the public housing definition.

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Furthermore, at 12 U.S.C. Sec. 1715z-1(j)(2), the 236 definition of "family" says that it "shall have the same meaning as in section 1715l. 12 U.S.C. 1715l(f) defines "family" for the 221(d)(3) program as follows:

...Any person who is sixty-two years of age or over, or who is a handicapped person within the meaning of section 1701q of this title, or who is a displaced person, shall be deemed to be a family within the meaning of the terms "family" and "families" as those terms are used in this section.

Thus, both the 236 and 221(d)(3) programs contemplated elderly and handicapped persons as eligible tenants. It is not correct to conclude that the statutes are neutral on the question of selective admissions.

In addition, the report itself states that Section 8 programs do not permit selective admissions. pp.63ff. Since both the 236 and 221(d)(3) programs are financed in part with Section 8 funding, that fact reinforces the conclusion that selective admissions are not permissible in those programs. The same may well be true for 202 programs also.

It would be helpful if the report provided the numbers of 236 and 221(d)(3) housing units that are implicated in the "mixing" issue. Since most of the buildings funded under these programs were intended to house families with children, there may be very few units which house younger adults with disabilities or single elderly tenants.

Pages 71-2: In discussing the reasons not to change the definition of "elderly family," the report should include information about the number of vacancies that existed in "elderly buildings" before PHA's admitted non-elderly applicants with disabilities. Based on current demographics, it appears likely that insufficient numbers of elderly applicants will fill those vacancies. It is also likely that the non-elderly will not find other housing, given the current shortage of subsidized or affordable low cost housing, and will join the ranks of the homeless if they lose their eligibility for "elderly" housing. This information further buttresses the GAO's recommendation that Congress focus on encouraging better management practices and improving access to support services.

Page 72: In the section discussing segregated housing for people with disabilities, the report should reflect the fact that CLPHA's attorney, Christopher Horning, has written that this approach would constitute re-institutionalization. The report should also point out that segregating people with mental disabilities, or mental and physical disabilities may be an

Now on pp. 62 and 63.
See comment 19.

Now on p. 63.
See comment 20.

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overreaction to problems at worst caused by 9% of that group, thereby punishing the other 91%. Some mention of the potential conflict that such segregation would cause with Section 504, the Fair Housing Amendments Act and the Americans With Disabilities Act would also be appropriate, especially since less drastic alternatives (such as the Danbury and Elliott Twin Towers approaches) exist.

See comment 21.

In the Section 8 discussion, the report states that "providing mental health services would be more difficult if clients were widely dispersed. Finally, if support services are not provided, the problems that now arise in public housing would likely by [sic] shifted throughout the community." Both statements should be deleted. They are not only misleading, they suggest concentrating people with disabilities into one area for the administrative ease of the service providers -- a medical model approach that does not reflect current mental health policy and conflicts with the principles of integration underlying Section 504, the Fair Housing Act and the Americans With Disabilities Act.

If serving people with disabilities throughout the community were too difficult and costly, the Danbury approach would have failed. The "problems that arise in public housing" cannot be treated generically, as if the specific conditions of a particular public housing project had no impact on a tenant's well-being, much less his or her behavior. Sociologists like Irving Goffman established more than forty years ago that people's behavior is dependent in significant part on their milieu. Were it not so, none of us would behave differently among friends from the way we behave with people who are indifferent or hostile to us.

More important, the sentence not only implies that people with mental disabilities will always cause problems, no matter where they are, what they're doing, or whom they're with, but it contradicts the report's own findings that good management and the availability of mental health support services eliminates "the problems." Nothing is cited to support the sentence because it is pure hypothesis and it diminishes the otherwise thoughtful tenor of the report.

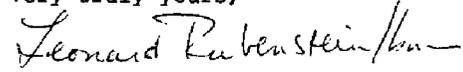
Now on p. 67.
See comment 22.

Page 77: The report raises the possibility that "HUD guidance would set out whether PHAs may reject mentally disabled applicants lacking both rental histories and surrogate reference, such as family members and doctors." This suggestion should be deleted. There is nothing in the housing statutes, much less the civil rights statutes, that would permit PHAs to exclude a class of applicants based on their inability to produce documentation of their ability to comply with a lease.

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The issues raised by the Senator's questions and by your report are important to all low-income housing consumers. We appreciate the diligence and persistence that your staff displayed in forging through masses of data and complex regulations. We hope that you find our comments helpful and that you will call if you think we may provide information or additional resources.

Very truly yours,



Leonard Rubenstein, Director



Bonnie Milstein, Director
Community Watch Program

Enclosure

The following are GAO's comments on the Mental Health Law Project's letter dated February 5, 1992.

1. MHLP does not suggest that our work was influenced by any assumptions that may or may not be contained in the Chairman's letter. We do not believe that speculating on the bases for these presumed assumptions would be useful.

2. The percentage of all elderly tenants, with and without disabilities, causing problems is discussed in chapter 2 of our draft and final report. Furthermore, as requested by the Subcommittee, our review focused on issues concerning nonelderly tenants with mental disabilities in public housing for the elderly.

3. We found that cooperative agreements can assist nonelderly people with mental illness to be successful tenants when available resources are accessed. However, support service resources may not always be sufficient to meet client needs and some tenants may refuse available services. Therefore, cooperative agreements can help to minimize problems but not necessarily eliminate such behavior.

4. We did not perform work in Wilmington and cannot comment on that PHA's use of cooperative agreements. Chapter 4 of our draft and final report discusses use of services by tenants of the Denver PHA in the absence of a cooperative agreement between the PHA and local mental health service provider.

5. On the basis of our analysis of MHLP's comments, we believe our conclusions are correct (see ch. 5 and app. IX).

6. Mental health provider representatives can assist in tenant orientation programs. Such participation takes place in the Providence Housing Authority tenant orientation program, according to a Providence housing agency official. She told us that this effort, while informative, has not been useful in addressing elderly tenants' fear of nonelderly tenants with mental disabilities. Such fear continues as a result of problem behavior by nonelderly tenants with mental disabilities.

We believe that training of PHA management can also be provided by mental health officials. Development and implementation of such training to meet identified PHA needs could be arranged as part of the cooperative agreements we recommend (see ch. 4).

7. Following additional discussions with MHLP staff, we agree. The sentence has been deleted from this final report.

8. We disagree. Our draft and this final report states that all persons meeting preference criteria receive priority admission.

9. Mental retardation/developmental disability officials we contacted in state or local communities we visited, with the exception of Seattle (King County), told us that people who are mentally retarded or developmentally disabled generally reside in group homes. Furthermore, the President's Committee on Mental Retardation referred us to the University of Minnesota's Affiliated Program on Developmental Disabilities. The director of the Program's Center on Residential Services and Community Living told us that good national data on the residences of people with mental retardation or other developmental disabilities who live in places not specifically licensed to serve such individuals are not available. He added that based on limited data and the Center's interviews with state housing officials, it appears that the presence of such people in public housing is very small. We have revised this final report to recognize the source of our statement.

10. MHLP's observations on incomplete and inconsistent HUD directions are consistent with comments from PHA interest groups and, therefore, have been added to this final report in chapter 3. Also, we have no evidence to support what MHLP offers as a possibility concerning PHA managers' sympathies toward nonelderly tenants.

11. Establishing a correlation between the extent of problems and the quality of management at PHAs, as MHLP suggests, would not provide insight into the relative significance of other possibly important variables, such as whether services were sufficient and were utilized by nonelderly tenants with mental disabilities. Data on these latter variables are generally unavailable. As a result, we do not believe that the analysis MHLP suggests would be productive.

12. We do not believe that the Elliot Twin Towers experience is representative of conditions in other Minneapolis PHA projects for the elderly. In fact, according to the manager of Elliot Twin Towers, the PHA objected to continually funding the project because vacancy rates were high and it cost more to operate than other projects for the elderly.

13. We agree that tenants with mental disabilities must be held to the same standard as other tenants. Additionally, mental health counseling and services must first be accessed to enable successful treatment of individuals requiring such services.

14. MHLP's correction is included in this final report.

15. We found cooperative agreements to be simple one- or two-page documents or verbal in nature. Success of such agreements is likely more related to the willingness of housing and service providers to make them work than to the content of such agreements.

16. MHLP's observation that elderly consumers also need and can benefit from mental health services is included in chapter 4 of this final report.

17. The lack of funding for service coordinators authorized under section 507(b) of the Cranston-Gonzalez National Affordable Housing Act is discussed in chapter 4 of this final report. To assist PHAs to enter into cooperative agreements and to coordinate service delivery, this final report recommends that the Congress consider providing appropriations for the public housing service coordinator position authorized under section 507.

18. On the basis of our analysis of MHLP's comments, we believe our conclusions are correct (see ch. 5). Also, see appendix IX for our analysis of these and other comments.

19. HUD annually collects PHA-wide occupancy data, including numbers of units (1) occupied, (2) available to be occupied but vacant, and (3) vacant but not available. HUD does not maintain these data for public housing projects for the elderly separate from PHA-wide data.

20. Our draft and final report recognize that this option may be considered a form of reinstitutionalization (see ch. 6).

21. MHLP's comments that our statement in the section 8 rental assistance discussion suggests that people with mental disabilities (1) should be concentrated into one area for the administrative ease of service providers and (2) will always cause problems. We do not believe either to be the case. In fact, we believe combining such housing assistance with needed service resources to be the approach most in line with

deinstitutionalization policy. To avoid any confusion on this issue, the statement in question has been deleted from this final report.

22. We agree that there is no statutory provision that would allow PHAs to exclude applicants on the basis of their inability to produce documentation on their ability to comply with a lease. Therefore, exclusion of nonelderly people with mental disabilities on such grounds might be held discriminatory in violation of federal antidiscrimination laws. This observation has been added to this final report in chapter 6.

Comments From the Council of Large Public Housing Authorities

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

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February 10, 1992

VIA MESSENGER

Ms. Judy A. England-Joseph
Director, Housing and Community Development Issues
U.S. General Accounting Office
441 G. Street, N.W., Suite 1842
Washington, D.C. 20548

Re: Comments On Draft Report on the Mentally Disabled in Public Housing

Dear Ms. England-Joseph:

On behalf of the Council of Large Public Housing Authorities ("CLPHA"), I wish to thank you for the opportunity to review and comment upon your proposed report, "Public Housing: Issues in Housing the Mentally Disabled With The Elderly." Unfortunately, I must be candid in saying that we believe the draft report obscures both the crisis nature of the problem facing public housing and the degree to which the crisis has been created by choices, both of action and inaction, made by HUD. Accordingly, it obscures both the urgency of Congressional action and the ability of Congress to make targeted reforms which would significantly contribute to resolving the crisis.

Rather than reviewing your draft sentence by sentence, we propose to address our comments to the following propositions:

The GAO data is out of date and fails to alert Congress that an increasing majority of admissions to "elderly" public housing projects are now non-elderly persons, that housing opportunities for low income elderly are being constricted, and that the status quo has persons with mental disabilities being reinstitutionalized in public housing highrises lacking appropriate services.

The GAO legal analysis fails to consider in any manner the legal rights of the elderly, attaches undue significance to inadvertent legislative phrasing, and anticipatorily discredits valid legislative remedies.

The GAO has offered feel-good assurances about the capacity of the mental health delivery system to allow public housing highrises to be operated as mental health institutions without staff.

CLPHA Comments on Draft Report - The Mentally Disabled in Public Housing, Page 1

**Appendix VII
Comments From the Council of Large Public
Housing Authorities**

The GAO report inadequately addresses concrete policy options which could help improve conditions now.

See comment 1.

The GAO data is out of date and fails to alert Congress that an increasing majority of admissions to "elderly" public housing projects are now non-elderly persons, that housing opportunities for low income elderly are being constricted, and that the status quo has persons with mental disabilities being reinstitutionalized in public housing highrises lacking appropriate services.

The data presented in this report was apparently gathered in a survey conducted among 1073 PHAs in March of 1990. Two years later, the numbers - and the words accompanying them - utterly fail to convey the magnitude of the problem facing some large public housing authorities today. CLPHA members are operating "elderly" buildings today whose populations in some cases are over 75% non-elderly. One PHA recently informed us that their waiting list for elderly housing is only 9% elderly. I have contacted our members for up-to-date occupancy statistics and will be supplementing these comments in the very near future.

The first weakness in your data is that it is thoroughly outdated. Inexplicably buried in your report is recent HUD data showing that 50% of new admittees to elderly public housing are non-elderly. Some of our members report considerably higher rates, and report as well that the rates for new additions to their waiting lists for "elderly" projects are higher still - 70%, even 90% non-elderly. Even using HUD average data, however, points up an incredibly dramatic turnover. If authorities of over 500 units represent almost 60% of the total units (330,000), then an annual turnover of 26,640 elderly units is a 13% turnover rate. As a result, the elderly/non-elderly balance is *on average* shifting by some 6 1/2 percentage points each year, and an authority with a 10% non-elderly population one year might well have a 23% figure only two years later.

See comment 2.

Simple mathematics, however, will fail to capture the dynamics of the situation. One of the pervasive weaknesses of your draft report is that it ignores the elderly as a population - their needs and their desires. CLPHA's members report that "tipping" is a real and powerful phenomenon - that once a building's population crosses a threshold of non-elderly occupancy, the elderly conclude it is not for them, and any who have options leave. Similarly, eligible elderly do not apply for residency (as evidenced by the 9% elderly waiting list I mentioned above), and within a few years the only remaining elderly are those with no other options - who frequently themselves have disabilities, age-related or otherwise.

It is not our role - nor that of the GAO - to pass judgment on the motivations of these elderly. We are confident that the phenomenon is going on and that it will go on so long as present policies remain in effect. The GAO draft report invites Congress to fiddle in ignorance that Rome is burning.

CLPHA Comments on Draft Report - The Mentally Disabled in Public Housing, Page 2

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Housing Authorities**

An additional weakness in your data arises from the aggregation of data for all authorities over 500 units. We strongly suspect that high occupancy rates by non-elderly persons with disabilities tend to be concentrated in large urban authorities of several thousand units or more. We also have the impression that the higher occupancy rates occur in the Northeastern, North Central and Western Coastal cities - a variation perhaps reflecting in complicated ways the manner in which a city identifies and provides for its disabled citizens, the presence of other support mechanisms, the strength of advocacy and legal services, and similar factors. In any case, our understanding is that in major metropolitan areas like Boston, Milwaukee, Minneapolis-St. Paul, Seattle, and countless others, the overall occupancy figures are vastly higher than one would understand from your report. A more sophisticated statistical presentation by the GAO would illustrate this fact.

See comment 3.

The disparate impact of this situation on large urban authorities is of considerable policy significance. Congress should not be led to believe that median figures adequately portray some sort of reality, when many of the nation's largest authorities have occupancy rates for non-elderly disabled which are two, three, four, or more times the median.

If we continue on the present course, in many large cities we will soon effectively convert an elderly housing system to a system for reinstitutionalizing people with disabilities. It is not CLPHA's role to judge whether housing for low-income seniors is more or less important than housing for low-income people with disabilities. We doubt, however, that Congress would choose such wholesale replacement as a matter of policy. We further doubt that there is a mental health expert or advocate in the country who believes that high rises of 100 or 200 units are an appropriate place to house people with mental disabilities in concentrations approaching 100%, even if those buildings were staffed at a level no PHA can afford.

An honest approach to solving the problem in public housing today requires accurate and thoughtful data. We believe the GAO should update its survey to obtain current data on populations, new admissions, and new admissions to waiting list, and should isolate the data for authorities over 1250 units. We further believe that the survey should try to determine the views of the people involved as a necessary step in evaluating both what will happen in the absence of a deliberate choice, and what those affected think of the options.

See comment 4.

The GAO legal analysis fails to consider in any manner the legal rights of the elderly, attaches undue significance to inadvertent legislative phrasing, and anticipatorily discredits valid legislative remedies.

The draft report concludes that the "exclusion or segregation" of persons with disabilities would violate "antidiscrimination laws". In so doing, it fails utterly to recognize the legal complexities when the rights of two groups interact, and thus slights the rights of the elderly.

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We start by observing that while there may be isolated voices calling for the "exclusion or segregation" of people with disabilities, this is certainly not the view of CLPHA nor, to our knowledge, of NAHRO. What CLPHA has insisted is that the chronologically elderly have the right to live apart from the non-elderly if they so choose. This is a right which is unquestioned in any other economic stratum of our society, and which has been implicitly recognized by Congress in exempting elderly residences from aspects of the Fair Housing Amendments Act dealing with discrimination against families with children, in creating the 202 program as reaffirmed in NAHA Section 801, and elsewhere. As a matter of class equity, there is no justification for denying poor public housing residents a right granted to every other senior citizen. We believe your report disserves Congress and the public by failing to highlight this anomaly.

If it is lawful for the elderly to choose to live in an age-segregated setting, how is it unlawful for a PHA to offer them that option? Your analysis suggests that the statutory definition of "elderly family" makes it so. Legislative interpretation is a question of legislative intent, however, and the history of that particular definition is totally bereft of any indication that Congress contemplated, much less chose, the forced integration of these two groups.

You further suggest, more subtly, that once Congress has lumped the two groups together, any separation is necessarily discriminatory. The analysis produces the bizarre conclusion that while it is perfectly legal for Congress to create programs for elderly housing or disabled housing, once Congress has inadvertently joined the two with an "and" instead of an "or" it is suddenly discriminatory to separate them. The analysis also leads inescapably to the awkward conclusions that a) the division of public housing into "family" and "elderly" projects is illegal, and b) that public housing programs treating people with disabilities with more consideration than routinely accorded the elderly or families with children are as illegal as the reverse. Accordingly, we must question the report's favorable words about programs in Danville, Connecticut and LaSalle County, Illinois, both of which have special mechanisms to divert the disabled out of elderly highrises.

CLPHA believes it is legal to offer both the elderly and the disabled options which recognize their special needs, desires and rights. The elderly include elderly with disabilities, a figure estimated at approximately 30%. Since the selection criteria would be age-based, there could be no showing that the "sole reasons" (per Section 504) for giving that option was handicap. Nor would there be any discriminatory intent violative of the Fair Housing Act, since PHAs would be doing no more than offering the elderly a legal option, while offering the non-elderly (as well as the elderly not wishing the separate option) continued mixed or enriched-service housing with options appropriate to their needs.

Your legal analysis ultimately turns on a simplistic disparate impact analysis. It is mathematically undeniable that allowing elderly-only housing may in the short run

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increase the percentage of disabled-only public housing. Observance of societally recognized elderly rights, however, is a compelling governmental interest which would, in Fair Housing analysis, excuse any disparate impact. More important, your analysis fails to recognize that the reason elderly-only housing has no disparate impact on the disabled in society at large, but may have one within elderly public housing, is precisely that statutory eligibility rules have stripped out of that universe the entire "mainstream" into which protected classes are supposed to merge. You cannot blame the elderly because Congress has chosen to restrict young non-disabled singles in public housing.

Finally, CLPHA objects not just to the conclusion that elderly-only choice is not presently legal, but to the implication that it is an option which is disreputable and therefore not to be considered by Congress. It is precisely because the question is murky and realistically incapable of definitive legal resolution, that Congress should clarify it. The report should clearly state that while the legality of options for elderly choice (as well as any other special needs approaches in public housing) has been questioned, such options do not violate fundamental principles of nondiscrimination in this country and may appropriately be recognized by Congress if it chooses to do so as a policy matter. Congress may well be disturbed at the segregation of people with disabilities in public housing - but it should not be led to believe this stems from the choices of poor elderly rather than from the structure of our housing markets and subsidy systems.

The GAO has offered feel-good assurances about the capacity of the mental health delivery system to allow public housing highrises to be operated as mental health institutions without staff.

The draft report makes room both for the reports of the PHAs surveyed that support services were desperately inadequate, and for the bland assurances of mental health advocates that it could be otherwise if existing resources were more efficiently used. We believe that any credible report has got to confront and resolve this disparity. The understanding of CLPHA from its members is that local mental health support services are simply incapable of meeting the needs of PHAs' populations - a perception that appears to be shared by the mental health experts you cite.

Public housing authorities recognize that with or without supportive services, with or without separate elderly housing, they will be the primary housers of persons with mental disabilities for the foreseeable future. If adequate resources are available for both on-site staff and off-site services, PHAs can meet the needs of people with disabilities for shelter that is decent, accessible, and emotionally comfortable. Without those resources, "elderly" high-rises risk becoming Bedlams in the truest historic sense of that phrase. It is the experience of housing managers that some disabilities, such as alcoholism, lead to behavior which is enormously

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See comment 5.

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disruptive of others' rights of quiet enjoyment and that housing large numbers of such people together requires enormous staff resources. Cooperation agreements and the like are a necessary first step - but no one should be permitted to believe for a second that they are any more than that, or any substitute for real resources.

See comment 6.

We would also point out that those authorities you laud for close cooperation with their area agencies are relatively small and somewhat atypical. Further, as we observed above, we are dubious that their policies would withstand scrutiny under the discrimination analysis you advance. We do not say that to detract in any manner from their work, which we understand to be impressive. If, however, their success is based on placing people in housing situations most appropriate to their needs (not elderly highrises) as determined on some consultative basis involving doctors and/or social workers, we would suggest that the GAO should evaluate the legality of this approach, its cost on a national basis, and its appropriateness as a model. We would suggest that there is considerable similarity between what these two authorities do, and what CLPHA has urged that all authorities be permitted to do.

The GAO report inadequately addresses concrete policy options which could help improve conditions now.

See comment 7.

Since CLPHA, apparently alone among affected interest groups, has advanced a coherent package of reforms addressing the problem of mixed populations, we believe it would be more useful to present that package as a whole. We believe your efforts to mix in the scattered suggestions of others has resulted in an adulteration, and in some cases misstatement, of CLPHA's suggestions.

See comment 8.

First, it is a keystone of CLPHA's approach to the problem of mixed populations that both PHAs and individuals have the maximum flexibility in offering, and selecting, housing appropriate to individual needs. In theory, then, a PHA could offer both elderly-only housing and service-enriched housing which might be attractive to people with particular disabilities. We stress first that while this approach would require legislative approval (at least given HUD's current interpretation of law), it would not require new resources in and of itself. Each PHA would simply be allowed to use its existing resources in the most flexible manner possible, a process which might result in no change at one authority, but numerous initiatives at another. Clearly additional resources would make the process far more successful, but we ask the GAO to recognize the genuine value in the basic approach.

See comment 9.

The report identifies one approach which would modify the definition of elderly family to exclude people with disabilities; it does not identify others, such as CLPHA's, which modify the definition so as explicitly permit separate housing while still recognizing the obligation of PHAs to house people with disabilities. I enclose a recent draft of a legislative proposal which would do this.

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See comment 10.

We object to your characterization of some options as "legally objectionable." They may not be expressly permitted by current law; it is precisely that ambiguity which requires Congressional resolution. They would not be "legally objectionable" were Congress to endorse them. We are confident, as we stated above, that CLPHA's proposals are entirely consistent with the spirit of antidiscrimination laws.

See comment 11.

We take strong issue with your characterization of service-enriched buildings as another form of reinstitutionalization. Such buildings would be offered as an option to those who wish to take advantage of the particular environment; others could live in an ordinary mixed building under CLPHA's plan. The housing options we propose are precisely those authorized by Congress to be established by private providers (see, e.g., NAHA Title VIII, Section B, Supportive Housing for People With Disabilities, and Subtitle C, Shelter Plus Care program). What is reinstitutionalization is to allow people with disabilities to become segregated, without services or choice, by inaction as present trends continue.

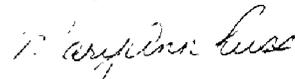
See comment 12.

While your treatment of CLPHA's screening proposal is somewhat more balanced, it is still not entirely accurate. As you may know, CLPHA has created an entire methodology for screening in a manner respectful of both the needs of PHAs and the rights of people with disabilities. This methodology was approved by the court in *Cason v. Rochester Housing Authority*. Unfortunately, HUD has declined numerous opportunities to approve or disapprove it. CLPHA does not see significant legal changes needed with regard to screening, so much as it sees needed a resolution within HUD of an open conflict between the Fair Housing and Public Housing branches which result in totally inconsistent and contradictory instructions being given. Your investigation might well look into the extent and effect of this division.

CONCLUSION

I regret that I cannot be more positive about the draft you have shared. Please be assured that CLPHA and its members stand ready to assist you in regathering the necessary data and in sharing our ideas and resources with you. The situation in elderly public housing worsens daily and cries out for constructive solutions based not on dogma, but on honest confrontation of facts, a willingness to think openmindedly about the spirit and objects of antidiscrimination law, and honesty about asking no more of PHAs than we as a society are willing to pay for.

Sincerely,



MaryAnn Russ, Executive Director
CLPHA



Christopher Hornig, Esq.
Reno, Cavanaugh and Hornig

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¹ The Report throughout uses a standard for "large" PHAs of 500 units or more. As HUD uses 1250 units as the dividing line, there may be some confusion in your data.

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**CLPHA's Position Paper
on Mixed Populations in
Elderly Housing**

**Council of Large Public Housing Authorities
Position Paper on Mixed Populations in Elderly Housing
November 1991**

At the present time public housing buildings that were designed and built chiefly for older people house a very disparate group with widely varying needs and conflicting lifestyles. People who are over 62, some of whom are quite frail, live with younger individuals with disabilities. Older residents are afraid and angry - they feel that PHAs are not honoring their commitment to provide decent, safe and sanitary housing in a suitable environment. Likewise, many younger people with disabilities see their concentrations in "elderly" housing as re-institutionalization rather than mainstreaming.

CLPHA believes that any response to this issue should increase rather than limit housing options for all the people who now live in public housing for the elderly. To that end, CLPHA supports actions that HUD can take that will help reduce friction and increase livability in elderly buildings and CLPHA intends to pursue legislation that will expressly permit PHAs to designate buildings for the elderly, mixed populations and, as appropriate, for people with disabilities. The following precepts guide our position:

- Every civil rights law, including the Fair Housing Act permits age-distinct housing. Currently, only the low income elderly are forced to live with younger people;
- To be most fair and to have the best chance for broad support, any solution to the problem of mixed populations should offer increased housing choices to all eligible residents and applicants;
- Each PHA's solution must be tailored to its own needs and its own stock. HUD can provide general and technical guidance, but must permit flexibility so long as the rights of all eligible persons are protected;
- A PHA needs assessment should precede any division of the housing stock. Following such assessment, and in accordance with its findings, each PHA should be permitted to offer the following housing choices to one and two person families (based on available housing stock):
 - * Elderly-only housing, only for persons 62+, (or 55+) including elderly people with disabilities;
 - * Mixed housing, which could include elderly, non-elderly singles, and people with disabilities;
 - * Enriched housing, which would include disability-specific services provided by the PHA or outside agencies;

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* Family housing, insofar as units of the appropriate size and type are available;

* Section 8 certificates or vouchers, but only if the public housing and section 8 waiting lists are merged.

The key to this range of choices is that each applicant, rather than the PHA would select the type of housing (not necessarily the specific location).

- HUD should revise the Tenant Selection and Assignment Plan requirements to permit applicants to make choices by unit type, rather than simply the one or three offers permitted under Plan A or Plan B. For example, an elderly person with a disability could choose elderly-only housing, a mixed building, enriched housing (for his/her disability), family housing or a certificate or voucher.
- PHAs would be permitted to designate entire buildings or portions of buildings according to the data collected in their needs assessment;
- Current tenants who are lease compliant should not be forced to move;
- HUD should issue technical guidance on how to combine the public housing and Section 8 waiting lists;
- In its future NOFAs, HUD should grant a preference to PHAs who use CIAP, MROP or Development funds to adapt units to better meet needs identified in their needs assessment. This could include efficiency unit combinations, subdividing larger units in family developments (when appropriate), creating more barrier-free units outside of elderly complexes, converting large scattered site units to group homes, etc;
- HUD must recognize that one of the consequences of cut-backs in support services to people with special needs is that vacancies may increase in both elderly housing and in units for people with disabilities. If an applicant is unable to obtain some service necessary to ensure lease compliance, the PHA must reject him/her;
- HUD must build on its relationship with HHS to press for a set-aside of support services for the residents of assisted housing. Without appropriate support services our buildings do not serve our clientele or achieve our mission of decent, safe and sanitary housing. If money is unavailable through HHS, HUD should consider a program equivalent to CHSP for non-elderly people with disabilities.

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- It is unwise and unfair to predicate separate housing for the elderly and people with disabilities on purportedly different needs for support services. Some people in both groups will not need any support services to be fully lease compliant, while others in both groups will need exactly the same services. A services-based rationale will either have little effect in achieving separation or will provide an easy legal standard for anyone challenging the separation.

The following are GAO's comments on the Council of Large Public Housing Authorities' letter dated February 10, 1992.

1. PHAS provided survey responses during the latter part of 1990. As discussed in chapter 1, our data refer only to households with nonelderly members with mental disabilities. CLPHA's more current occupancy statistics mix all nonelderly households and, as such, are not comparable to our data. The HUD data cited by CLPHA also mix all nonelderly households in both family and elderly projects and, as a result, are also not comparable. Still, we recognize that significant numbers of households with nonelderly members with mental disabilities are likely included in both the CLPHA and HUD data. The potential growth in the number of households with nonelderly members with mental disabilities in PHAS with over 500 units is discussed in chapter 2 of our draft and this final report.
2. Examination of the needs and desires of the elderly would address important issues; however, they would have to be balanced against the needs and desires of all nonelderly households residing in public housing—not just households with people with mental disabilities. As discussed in chapter 1, these issues are beyond the scope of the review we were requested to carry out.
3. CLPHA points to occupancy rates in the nation's largest public housing agencies that, as previously stated, combine all nonelderly households with disabilities residing in public housing for the elderly. Such data cover a larger population than our data and are not comparable. We analyzed our data for PHAS with 1,250 or more units (HUD's definition of large PHAS). We found that nonelderly people with mental disabilities occupied about 12 percent of public housing units for the elderly in the PHAS responding to our survey. We also found that about 39 percent of these households cause moderate to serious problems for PHA management and staff. With regard to problems over the year prior to our survey, about 58 percent of these PHAS reported that problems with households with members with mental disabilities had increased. We included this analysis in chapter 2 of this final report.
4. On the basis of our review of CLPHA's comments, we believe our legal analysis to be correct (see ch. 5 and app. IX for a detailed discussion).
5. We believe that additional resources are very likely needed for community-based mental health services. But because of the lack of national data on residence of client served, we cannot assess the extent to

which residents of public housing are currently receiving such services. Furthermore, we recognized the need for such an assessment to assist the Congress if it chooses to address what appear to be increasing problems, especially in larger PHAS. Our third recommendation is designed specifically to provide the Congress with an initial assessment of this issue (see ch. 4).

6. CLPHA's contention that households with nonelderly people with mental disabilities are excluded from public housing for the elderly is not based on the facts as reported to us by the LaSalle County, Illinois, and Danbury, Connecticut, PHAS. In the LaSalle County PHA, such tenants are placed in both elderly high rises and in family public housing units. In the Danbury PHA, nonelderly applicants with mental disabilities usually accept available section 8 assistance, but elderly public housing is also available to and used by nonelderly people with mental disabilities.

7. To avoid any possible misrepresentation of CLPHA's suggestions, we have included its position paper on "Mixed Populations in Elderly Housing" immediately following CLPHA's official comments in this appendix.

8. We recognize the value of allowing each PHA to use its existing resources in the most flexible manner allowed by law. If legislation enabling CLPHA's proposal to be implemented were enacted, we would still question CLPHA's proposal for service-enriched housing, given its own contention on page 5 of its comments that "local mental health support services are simply incapable of meeting the needs of PHAS populations."

9. Identification and analysis of all variations of separate housing approaches are beyond the scope of this review.

10. Our analysis of various approaches was conducted under current law. To further clarify our position, we have added "under current law" to this final report.

11. It is our opinion that segregating people with mental disabilities into high-rise public housing projects would be a form of reinstitutionalization. Again we question CLPHA's proposal for service-enriched housing, given its contention on page 5 of its comments that "local mental health support services are simply incapable of meeting the needs of PHA's populations."

12. While both CLPHA and NAHRO officials have informed us, generally, that PHAS have received inconsistent instructions from HUD public housing

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management and fair housing office staff, we know of no inconsistent written guidance. Additionally, it would be impractical for us to attempt to obtain nationally reliable data concerning the content of verbal instructions.

Comments From the National Association of Housing and Redevelopment Officials

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



NAHRO National Association of Housing and Redevelopment Officials
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February 3, 1992

Ms. Judy A. England-Joseph
Director, Housing and Community
Development Issues
U.S. General Accounting Office
820 First Street, N.E.
Washington, D.C. 20002

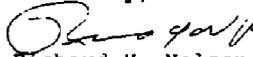
Dear Ms. Joseph:

The National Association of Housing and Redevelopment Officials (NAHRO) is pleased to provide you with our preliminary comments on your proposed report, Public Housing: Issues in Housing the Mentally Disabled with the Elderly.

The issue this report addresses is one that our members, public housing authorities (PHAs) across the country, view as one of the most critical and challenging issues today in public housing. We hope that your office considers the comments attached herein and seeks to make appropriate changes to the report. We look forward to reviewing any further drafts of the report.

If you have any questions or wish to discuss our comments, please contact Marcia Sigal, Housing Programs Officer, at (202) 429-2960.

Sincerely,


Richard Y. Nelson, Jr.
Executive Director

Attachment

Jack Quinn, PHM, President; Robert L. Armstrong, Senior Vice President; Corina Robertson, Vice President - Communities; Kurt Creager, Vice President - Community Revitalization and Development; Mary James, PHM, Vice President - Housing; Tom M. Oliver, Jr., Vice President - Finance; Lana Balka, PHM, Vice President - Professional Development; Richard Y. Nelson, Jr., Executive Director.

**Appendix VIII
Comments From the National Association of
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NAHRO Comments on Proposed GAO Report: Public Housing: Issues
in Housing the Mentally Disabled with the Elderly

General Comments

NAHRO is concerned that the report does not include an examination of the special characteristics of "elderly" housing in the discussion of the nature and extent of the problem. The report is remiss in that the issue of mixing younger persons with disabilities with an aging often frail population is not addressed whatsoever. The report seeks to inappropriately focus the cause and solution of this problem on the lack of services in public housing for residents with mental disabilities.

We found that, in many cases, the discussion was incomplete and conclusions unfounded. Further, the conclusions and findings in the report would seem to provide several additional recommendations not included in this draft.

We hope these preliminary comments will be considered by GAO and that certain revisions will be made to the report.

Specific Comments

Chapter One: Introduction

In its Report to Congress on Housing the Mentally Disabled last year, the U.S. Department of Housing and Urban Development estimated that 44 percent, or 537,000 units are occupied by elderly households. The HUD estimate is based on a study conducted for HUD in 1979. NAHRO's 1989 survey indicated approximately 40 percent of public housing units are occupied by elderly or disabled residents. On Page Twelve and elsewhere throughout the report, the GAO reports that only one quarter of the households in public housing are estimated to include the elderly. This large discrepancy between the NAHRO/ HUD estimates and the statistic stated as fact in the GAO report should be investigated.

The nature of the problems associated with mixing mentally disabled residents with elderly residents is not limited to those with mental illnesses. Congress asked for an analysis of the nature and extent of the problems arising from mixing residents with mental disabilities with elderly residents. NAHRO members believe that the nature of the problem stems from mixing an older and younger population together living an elderly housing environment.

See comment 1.

See comment 2.

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A clash in lifestyles within the elderly housing environment occurs from this mix, compounded by a set of disruptive behaviors exhibited by nearly one third of the non elderly persons (with all kinds of disabilities). The nature of the problem is that the current statutes governing the public housing program define all non elderly disabled persons as elderly.

See comment 3.
Now on p. 12.

The GAO confines the report examines the "mixed populations" issue in the context of elderly public housing residents living illnesses (Page 15). Other mentally disabled populations are not evaluated based on the assumption that they are typically housed in other residential settings, particularly group homes. We do not accept as fact that most people with mental retardation and other mental disabilities generally live in group homes. How does GAO know that most people with mental retardation or developmental disabilities live in group homes? No data is presented to support this assertion. To focus solely on service availability for residents with mental illnesses instead of all non elderly residents with mental disabilities essentially precludes a proper evaluation of the problems associated with mixing elderly and mentally disabled residents.

See comment 4.

The survey instrument used by GAO for this study defined mentally disabled households as households where one or more members have or are perceived to have such conditions as schizophrenia or affective disorders or personality disorders or mental retardation or organic brain syndrome or specific learning disabilities. PHAs were asked to give the surveyor their best estimate of the number of persons residing in public housing and the number of persons exhibiting certain behaviors based on the definition provided. Therefore, the set of services purported to be needed to address problems caused by residents with mental disabilities must include services for the types of disabilities included in GAO's definition.

See comment 5.

Further, anecdotal information from our members clearly tells us that management problems and extraordinary tenant complaints stem from housing persons with many different kinds of disabilities. Although the scope of the study is limited to residents with mental disabilities, a significant number of persons with disabilities such as drug and alcohol abuse or physical impairments exhibit several of the behavioral problems listed in Table 2.2, and therefore cause the kinds of managerial problems and tenant complaints described in Chapter Two of the report. Recent changes in the definitions of disabled and handicapped in both housing and disability rights

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statutes have led to the definition of disabled and handicapped to include persons with substance abuse problems and AIDs victims. When Congress expanded the definition of elderly to include persons with handicaps more than twenty years ago, the definition and common perception of "handicapped" persons were those who are physically impaired.

Chapter Two: PHA Management Views On Problems With Non-elderly Mentally Disabled Tenants

HUD data on tenant characteristics indicate that as of the end of calendar year 1991 the number of non elderly disabled and handicapped residents living in public housing for the elderly had risen to approximately 28.2 percent. The same figures for the period ending in July 1991 showed the percentage of non-elderly disabled/handicapped residents to be about 27.5 percent. This statistic was derived from actual PHA reporting forms, accounting for approximately one half of all occupied public housing units. These data are alarming. Non elderly residents now occupy more than one quarter of "public housing for the elderly".

Although the GAO estimates from its survey that only 9 percent of households have mentally disabled individuals, this data was collected almost a year and half ago. Recent HUD data show that, for the six month period from July 1991 to December 1991, the rate of admission of non-elderly disabled applicants to elderly public housing is about 50 percent of all available units. It is unknown what kind of disabilities these applicants and residents have, but the fact remains that to continue at this rate of admission will substantially alter the composition of elderly public housing.

Moreover, NAHRO PHA members frequently report that the changing composition of elderly public housing is directly related to the higher turnover of elderly residents and the PHAs ability to market their building to elderly applicants who view these developments as unsafe. These higher turnover rates coupled with marketing problems could very likely contribute to whole buildings becoming occupied with residents with several different kinds of disabilities. And, if these problems described here continue, arguments against separate housing for residents with disabilities based on the premise that this will create "reinstitutionalization" of disabled residents will very likely apply to at least some public housing sites through out the country.

See comment 6.

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See comment 7.

The report presents information on the seriousness of the problems and the extent or range of problems caused by non-elderly residents with mental disabilities. However, in considering the extent of the problem and its impact on management, the cost incurred due to these problems should also be evaluated. If property management staff is spending more of their time responding to behavioral problems or if additional PHA staff must be assigned to address these problems, other property management tasks may go undone, causing further problems throughout the PHA. Also, in many PHAs, staffing patterns and budgeting for elderly housing have traditionally differed significantly from family housing. These new problems have created unexpected costs for the PHA. Most PHAs do not have the resources to hire additional staff or pay for additional services. This money would have to be authorized and appropriated by Congress.

In discussing the problems arising from housing non-elderly mentally ill residents in elderly public housing, the report correctly states that most PHA staff do not have the training and experience to effectively address the behavioral problems of these residents.

See comment 8.

In reviewing the descriptions of the case studies, please note that none of the PHAs identified the cause of the problems as the lack of services for mentally disabled. Rather, the provision of services is a management technique that some PHAs have been lucky enough to afford or secure in their community. Although in some circumstances the provision of services has helped to mitigate and reduce the number of problems, this approach does not necessarily significantly reduced the staff's administrative or managerial burdens resulting from mixed populations.

See comment 9.

The report discusses survey results with respect to increases or expected increases in the number or extent of problems caused by mentally disabled residents. Twenty-five percent of PHAs reported more problems due to these residents. Our PHA members indicate that the number of problems caused by all non-elderly disabled residents has been increasing as the number of these residents living in elderly housing has increased. Given the HUD data indicating that currently half of all persons admitted to public housing for the elderly are non-elderly disabled residents, one could certainly surmise that an increase in the number of problems stemming from disruptive behaviors (exhibited by all non-elderly disabled residents) is likely.

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We concur with the GAO report's discussion of factors which could influence increases in the number of non-elderly mentally disabled people. Background information and analysis on the changing demographic characteristics of low income citizens needing housing assistance would be extremely useful here. Understanding how this population has changed and may continue to change should be taken into consideration by Congress not only in addressing the issue of mixed populations, but in planning and funding all future federal housing assistance.

With respect to the impact of the preference rules on this situation, it is disappointing that the GAO did not also collect data on the number of elderly residents or applicants receiving federal preference. This would have provided a valid comparison to the data reported here on the preferences non-elderly disabled residents have received, and therefore a basis for an analysis of the impact of the federal preference rules on this issue.

Comments on Chapter Two Conclusions

The survey verifies that behaviors exhibited by residents with mental disabilities are causing problems for management, staff and other residents in public housing for the elderly. Behaviors exhibited by residents with mental disabilities, such as excessive noise or visitors which disrupt the community, are exacerbated and magnified by the fact that these behaviors occur in an elderly housing environment.

We appreciate the fact that GAO cannot predict the future behavior of non-elderly mentally disabled tenants and therefore cannot predict whether the problems associated with mixing populations will continue or increase. However, we believe that based on the experience of public housing managers it is likely that number and type of problems will continue and will increase as long as the definition of elderly includes non-elderly persons.

Chapter Three: HUD Guidance Unclear Regarding PHAs' Latitude In Screening The Mentally Disabled For Admission To Public Housing

This chapter describes the view of PHAs that HUD guidance on applicant screening and compliance with new Fair Housing laws is lacking and too broad. We were surprised that the GAO report does not investigate this view, but rather, concludes

See comment 10.

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that PHAs should just use their best judgement. Since HUD is the federal agency charged with monitoring compliance with Fair Housing laws in public housing programs, we believe that HUD must provide additional guidance, assistance and monitoring in this area.

Chapter Four: Community Support Services Can Assist The Non-elderly Mentally Ill To Live Successfully In Public Housing

See comment 11.

NAHRO and our PHA members strongly support cooperative agreements which assist all residents access needed services. This support stems from the premise that these services can improve the quality of life for all residents needing them. The report seems to imply however, that services and cooperative agreements will prevent the problems associated with mixed populations, and therefore PHAs should be required to seek them out in the community. Yet, in the same chapter, the GAO quotes the National Institute of Mental Health report which states that often services and coordination are not available for service supported housing options.

We do not understand how forcing PHAs to develop these agreements is going to overcome the fact that these services do not exist or there is a lack of funding for them. Moreover, the report presents no strong data to support the assumption that the lack of services is the cause of these problems. Therefore, we believe the report presents no real argument in support of this recommendation.

See comment 12.

The lack of coordination of services for low-income residents described in this report is exactly the reason why NAHRO has advocated so strongly for service coordinators. This chapter notes that Congress authorized (NAHA, Section 507 (b)) the use of operating subsidies for PHAs to employ service coordinators. It should also be noted that HUD did not request funding for this in their budget request, nor did Congress appropriate funds for this provision.

See comment 13.

It would be naive to portray the application of services as a panacea for the problems arising from housing non-elderly disabled residents. Cooperative agreement cannot insure that services will be provided by mental health providers, especially if funds are not available. PHAs' experiences with cooperative agreements and promises of service assistance has varied throughout the country and over time.

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See comment 14.

The report states that the adequacy of funding for community-based mental health services for public housing residents cannot be assessed due to lack of data. It is unclear why the GAO does not suggest that this data be collected by the NIMH or other mental health organizations. Mental health experts assert that community-based assistance can enable the non elderly mentally ill residents to have successful tenancies. This would seem to be a valid reason to recommend that federal agencies and mental health organizations try to assess the cost of these services. Instead, GAO only recommends that PHAs be required to report to HUD on whether or not mental health providers are unwilling or unable to supply services.

If the goal of this reporting requirement is to gather data on the availability and cost of providing mental health services to public housing residents, this information should be provided by the federal and state mental health agencies, rather than housing agencies. In its cooperative efforts with HHS, HUD should request that such a study be undertaken, the results of which should be reported to the Congress. Such information would provide Congress with the information it needs to make federal policy about combining housing and services.

See comment 15.

The GAO report does not present data that demonstrates that combining services and housing in decreases and/or prevents problems associated with mixed populations. Nonetheless, the report presents the requirement of cooperative agreements as its only substantive recommendation for actions to address the issue of mixed populations. Yet despite the acknowledgement that there is already a lack of funding for mental health services we are surprised that GAO has not recommended to Congress that funding for mental health services for this population be increased.

It is true that in some cases we know that cooperative agreements and services can increase the possibility that non-elderly mentally disabled residents will have successful tenancies. It is also true that PHAs would like to have services available to residents and that they often view services as a successful management tool. But the availability of this tool is contingent upon funding and availability for services over which the PHAs have not control.

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Chapter 5: Rights Of Persons With Mental Disabilities To Reside
in Federally Subsidized Housing For The Elderly

See comment 16.

This chapter should include the current statutory definitions of elderly, elderly family, handicapped and disabled as they apply to the public housing program. This would give the reader an opportunity to understand the characteristics of the groups being discussed in the report.

As stated earlier, NAHRO believes at least part of the problems caused by mixing populations stems from the mixing of elderly and non elderly residents. It would appear that the Congress recognizes the need for age-specific housing and special housing for persons with disabilities. In the most recent housing legislation, Congress authorized and funded the Section 202 Elderly, Section 811 Supportive Housing for Persons With Disabilities, Shelter Plus Care, Congregate Housing Services Program. The GAO report offers their opinion that without a change in the public housing statutes, that current fair housing laws prevent PHAs from offering age-specific public housing or even specific housing which addresses the needs of persons with certain types of disabilities (i.e. group homes for recovering substance abusers) It is clear that Congress will need to clarify the definition of elderly, handicapped and disabled to demonstrate their intent.

Chapter 6: Approaches For Addressing Issues Raised In Housing
Non-elderly Mentally Disabled Tenants In Public Housing

See comment 17.

"It is essential that the rights and needs of both the elderly and non-elderly mentally disabled be reconciled in a manner that is not only lawful but fair and equitable to both groups." Although NAHRO certainly supports this statement, we find it surprising that GAO offers this moralizing warning as it is inconsistent with the content of their own report. As stated earlier, no substantial discussion of the housing needs of low income elderly is included in the report, which would only be fair in a report on the nature and extent of the problems associated with housing persons with mental disabilities in public housing for the elderly.

The special housing needs of elderly residents must be considered in any discussion of mixed populations. Congress has certainly recognized the elderly as the special group, because it purposefully identified elderly families as a distinct group eligible for housing assistance and gave elderly families priority for admission to elderly housing.

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See comment 18.

Taken alone, changing the definition of elderly in the public housing program may or may not decrease the number of units available to them. In fact, in the long term, more housing assistance throughout the public housing inventory would probably become available. Right now, because of the definition and the configuration of the units in family units, non-elderly disabled residents are forced to live only with elderly people which seems contrary to the goals of choice and mainstreaming. Other housing assistance options such as a reconfiguration of units within family developments, Section 8 assistance, new smaller sized units should all be available. PHAs must be allowed flexibility to address the housing needs of low-income applicants with a variety of housing options.

See comment 19.

NAHRO does not agree with the GAO's discouragement of providing a series of alternatives from which disabled applicants can choose. Although not all PHAs would immediately be able to provide all four of the options described in the report, this concept is the most practical approach for Congress to pursue, because it would allow for age-specific housing while at the same time provide new housing options not now available to non-elderly disabled residents.

GAO's arguments against the alternatives are poorly drawn. Separate buildings or designated areas for persons with disabilities has already been supported by Congress in the Section 202 and 811 programs, as well as the CHSP program. Furthermore, if the admission rate described earlier in this letter continues, several existing "elderly" buildings will "tip" and become institutions as well. The current definition and unit configuration in public housing forces already forces most non-elderly disabled residents to live in elderly housing. This could be viewed as a form of institutionalization by some.

See comment 20.

The discussion on dedication of Section 8 assistance is extremely disturbing. The report states, "...providing mental health services would be more difficult if clients were widely dispersed. But this report also states that mental health professionals don't know how many services are actually being provided on site to low-income mentally disabled public housing residents. How can the GAO assume that the Section 8 assistance will make service delivery more difficult because they (residents) will be dispersed? It's entirely possible that Section 8 assistance will help many tenants access services more readily, because they can choose housing located near the services they need and want.

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See comment 21.

Although GAO worries about the cost of reconfiguration of units in family projects to smaller size units and its impact on other modernization needs, this is a decision that should be made by the locality in the context of its priorities and resources. Without an examination of cost it seems premature to raise any objections that suggest this approach might significantly reduce funding for other modernization needs.

See comment 22.

One note about using services to mitigate behavior problems. PHAs have been using a valuable tool, a lease addendum, which enhanced the usefulness of service provision as a way to address behavioral problems and avoid eviction. If behavioral problems cause lease violations, then the PHA used the addendum to require any tenant to correct those violations as a condition of continuing tenancy. In the case of mentally disabled residents, often the lease addenda have taken the form of contracts for mental health services which demonstrate that the resident is attempting to get help to change his or her behavior. HUD recently issued guidance which implies that services may not now be made a condition of tenancies. This was a useful tool for PHAs that NAHRO believes was mistakenly removed by HUD. The GAO should have included a discussion of this approach when commenting on HUD guidance to PHAs as well as the use of support services in public housing.

See comment 23.

We generally support dedicated grants for services to public housing residents, in part for the same reason that we do not support a HUD requirement that PHAs seek out cooperative agreements and report to HUD on the responsiveness of their local mental health agency. PHAs have found that the success of cooperative agreements is mostly dependant on the resources available. Dedicated funding could help to address that problem.

Another proposal presented in the report, to make better use of existing services, is an admirable idea and should be supported by both housing and mental health provider. To pursue this proposal or any other which involves utilization of PHA staff will require additional funding from Congress for additional PHA staff and training. In our estimation, regular housing managers cannot coordinate or provide needed mental health services. The one example cited in the report, the responsive manager at Elliot Twin Towers, can not be duplicated given the current PHA staffing system. Congress needs to appropriate more funds to pay for individuals who are trained in both property management and social work.

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See comment 24.

Summary

The problems stemming from housing the non-elderly disabled in elderly housing is caused primarily by the mixing of older and younger populations. The GAO report has framed and focussed the "nature" of the problem improperly, because it does not include a substantive discussion of the needs of elderly residents' differences in lifestyles.

In examining the nature and extent of the problem, the text of the GAO report did not address the impact of living in a "mixed" environment versus an all elderly environment, nor how the mixing of the populations impacts on the housing and service needs of elderly residents. Table 2.1 shows the extent to which problems caused by non elderly mentally disabled residents affect the elderly. Thirty one percent of other households, that is elderly residents, are affected by moderate to serious problems caused by non elderly mentally disabled households. The GAO study fails to evaluate or cite studies on the impact of non elderly residents on the elderly living environments or the benefits of age-specific housing.

We also believe the report should include a discussion on the legislative history and intent of Congress in creating housing designated for the elderly. Also, we suggest that the GAO survey should include some questions for residents, which certainly would give the Congress and HUD another perspective on the nature and extent of the problems, in terms of the impact on this problem on the quality of life in these developments. The impact this problem is having on the cost to manage these developments should also be included.

See comment 25.

The conclusions arrived at by the GAO report are incorrect. The conclusion presented is that the problems arising out of mixing populations is caused by a lack of services. This is incorrect. The problem is caused by the mix of younger (non elderly) residents with elderly residents. The problem is not caused by the fact that PHAs are not able to secure social and mental health services.

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Some PHAs are able to mitigate the problems by assuring that mental health and other social services are being provided to non-elderly disabled residents. This approach has met with varying degrees of success. However, no PHA, including the ones presented by the GAO as "case studies", agrees that services remove the problems, rather, services seem to reduce the number and severity of the problems. In other words, while the services address the problem, the lack of services does not cause the problem.

The nature of the report's recommendations are weak: impose another federal mandate on PHAs (get mental health services for their residents) over which PHAs have no control, authority or funding to secure.

NAHRO strongly believes that Congress must help PHAs by creating a variety of housing options to address the housing needs of both the elderly and non-elderly disabled residents by clarifying the definition of elderly and authorizing several housing options that PHAs can offer to both groups. Despite the lack of enthusiasm in the GAO report for them, the list of alternatives listed in Chapter Six of the GAO report is a good start.

The following are GAO's comments on the National Association of Housing and Redevelopment Officials' letter dated February 3, 1992.

1. We reviewed our "elderly household" population estimates questioned by NAHRO. On the basis of PHAS responding to our survey, we estimate that the number of households with an elderly member (age 62 and above) residing in either projects for the elderly or family projects is over 400,000, or about 35 percent of all public housing units, which this final report clarifies. The estimate of elderly households contained in our draft report included only those elderly (age 62 and above) residing in public housing for the elderly.
2. We were not asked to review issues surrounding other nonelderly households with disabilities. As a result, we do not have data to assess NAHRO's position. As we indicate in chapter 2 of this final report, housing and elderly representatives we contacted reported that mixing elderly tenants with nonelderly tenants with disabilities is the predominant problem.
3. Mental retardation/developmental disability officials we contacted in state or local communities we visited, with the exception of Seattle (King County), told us that people with mental retardation or other developmental disabilities generally reside in group homes. Furthermore, the President's Committee on Mental Retardation referred us to the University of Minnesota's Affiliated Program on Developmental Disabilities. The director of the Program's Center on Residential Services and Community Living told us that good national data are not available on the residences of people with mental retardation or other developmental disabilities who live in places not specifically licensed to serve such individuals. He added that on the basis of limited data and the Center's interviews with state housing officials, it appears that the presence of such people in public housing is very small. This final report indicates the source for our comments (see ch. 1).
4. We limited our review to the mental illness service network because, as we point out in comment 3, there appear to be few people who are mentally retarded or developmentally disabled residing in public housing.
5. We do not know the nature and extent of problems caused by other nonelderly households residing in public housing for the elderly because, as requested, the scope of our study was limited to issues surrounding residents with mental disabilities only.

6. We disagree. The data cited by NAHRO come from HUD's Multifamily Tenant Characteristics System. This system does not provide data on units in public housing for the elderly apart from PHA-wide units. Additionally, the data do not identify households with nonelderly members with mental disabilities—the subject of our review—but groups together all households headed by nonelderly people with disabilities. These data are further limited to PHAs with over 500 units. Yet, because we believe that significant numbers of nonelderly tenants with mental disabilities are likely included in the HUD data cited by NAHRO, our draft and final report cite these data in chapter 2. We also agree that, if nonelderly individuals with disabilities are and continue to be admitted at an approximately 50-percent rate to public housing for the elderly, the composition will be substantially altered.

7. The cost incurred by PHA management in dealing with tenant problem behavior cannot be evaluated from our survey data or from data gathered during interviews of PHA officials.

8. We agree. Furthermore, we did not identify the lack of services as a cause of tenant problem behavior.

9. We disagree. See comment 6 above.

10. We revised this report to recommend that HUD provide fair housing guidance that details the questions that can be asked of any applicant for public housing (see ch. 3).

11. We disagree. Our recommendations, taken together, require, among other things, that (1) PHAs attempt to enter into cooperative service agreements and (2) PHAs report to HUD if service resources are lacking, thus preventing the establishment of such agreements. Such action should assist PHAs in arranging for services for people with mental illness and, in the absence of sufficient service resources, provide the Congress with national data needed to assess the need for additional resources. With regard to coordination of services, NAHRO attributes a conclusion to us that we neither stated nor implied.

12. NAHRO's comment has been verified and is reflected in this final report. Additionally, this final report states that the Congress should consider funding for the service coordinator position authorized under section 507 of the National Affordable Housing Act.

13. We agree that cooperative agreements and services taken alone will not guarantee successful tenancies by nonelderly persons with mental disabilities. Still, cooperative agreements can be a first step in facilitating provision of needed services. As we indicate in chapter 6 of our draft and this final report, the success of service provision efforts, where available, depends on individual tenant ability and willingness to access such services.

14. HHS (NIMH) plays a relatively small role in funding and oversight of community-based mental health services. According to the National Association of State Mental Health Program Directors, state mental health agencies fund or license over 83,000 units of local government and over 21,000 mental health organizations. Data are not collected in a uniform manner by these organizations. For example, according to an NIMH official, differing state definitions of case management preclude an accurate cost comparison of that activity across states. Therefore, PHAS reporting on the insufficiency of local mental health services for their tenants would provide the Congress with a near-term indicator on the need for additional service resources to assist such individuals, an indicator that the existing mental health service network is not organized to provide.

Furthermore, we agree that mental health organizations could provide cost estimates for providing mental health services, as could vocational rehabilitation organizations and income support providers estimate the cost of their support services. Still, such estimates would have little meaning without knowledge of the level of service need and existing use of such services by nonelderly tenants with mental illness in public housing for the elderly.

15. NAHRO misinterprets our message. We do not define the nature of the problem to be the mixing of populations as does NAHRO. Our message concerns provision of services that can assist people with mental illness to be successful tenants. Additionally, we believe that an analysis of national data on the level of service availability for and use by nonelderly tenants with mental illness in public housing for the elderly is needed to determine the need for additional resources. The cost of such services could likely be estimated by state mental health organizations once the level of need is established. In this final report we recommend that the Congress consider funding the service coordinator position authorized under section 507 of the National Affordable Housing Act of 1990 in order to assist PHAS in establishing cooperative agreements and coordinating service delivery.

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16. We disagree. A recitation of the very lengthy statutory definitions in question would not serve to illuminate the issues surrounding the rights of people with mental disabilities to reside in federally assisted housing for the elderly.

17. The special housing needs of elderly and nonelderly people with mental disabilities are worthwhile subjects for a much larger review and, as such, beyond the scope of this study. We do not believe that our draft or final report treats elderly people unfairly.

18. We do not see nor does NAHRO explain how more housing assistance would be available to nonelderly households with disabilities without significant additional resources to provide for appropriately sized units.

19. We do not take a position on any of the approaches discussed. We do, as requested, discuss the legal and practical implications of such approaches.

20. In discussion of the section 8 rental assistance alternative, this final report deletes reference to service provision being more difficult if clients are widely dispersed. We recognize the possibility that people with mental illness may be able to find section 8 rental units near their service providers and be willing and able to travel to such providers, and that some communities, such as Danbury, Connecticut, may have sufficient community mental health resources to reach out to such clients.

21. We disagree. If a PHA were to undertake more than just very limited reconfiguration of units, it might well significantly reduce funding for other modernization needs.

22. As we indicate in chapter 6, we believe that the use of special lease addendums would likely, under current law, be held discriminatory.

23. We recognize the benefit of trained PHA staff to assist in coordinating provision of services to all tenants. This final report states that the Congress consider funding PHA service coordinators authorized by section 507 of the National Affordable Housing Act of 1990 (see ch. 4).

24. It was not within the scope of this report to evaluate the appropriateness of the Congress' decision to define nonelderly people with mental or other types of disabilities as elderly families and thus mix populations. The Congress could have amended the definition for public

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housing when it crafted the National Affordable Housing Act of 1990 but did not. We believe that this report provides the Congress with the data it requested concerning the nature and extent of the problem resulting from the mixing of generations in public housing for the elderly.

25. We neither state nor imply that problems arising out of mixing of populations are caused by a lack of services. Yet we would agree that problems that we report are exacerbated by the mixing of populations and have added a section in chapter 2 on this issue.

Analysis of Comments on the Rights of Persons With Mental Disabilities to Reside in Federally Subsidized Housing for the Elderly

Of the six agencies and organizations that provided comments on the draft report, two—the Mental Health Law Project (MHLP) and the Council of Large Public Housing Authorities (CLPHA)—expressed disagreement with one or more of the legal conclusions reached in the draft report.¹ The perspectives and points of disagreement of the two organizations differed sharply.

MHLP appeared to agree with our conclusion that exclusion or segregation of nonelderly persons with mental disabilities in connection with public housing for the elderly would violate federal antidiscrimination laws. However, MHLP disagreed with our conclusion that restricting admission to persons 62 or over in connection with housing provided under the sections 202, 221(d)(3), and 236 programs would not violate those laws.

CLPHA, which confined its comments to public housing for the elderly, disagreed with our conclusion that exclusion or segregation of nonelderly persons with mental disabilities would violate federal antidiscrimination laws. We address the comments of each of these organizations separately.

Mental Health Law Project

As noted above, MHLP disagreed with our conclusions regarding the legality under federal antidiscrimination laws of restricting admission to persons 62 or more in connection with housing projects under the 202, 221(d)(3), and 236 programs.

¹The other four agencies and organizations had the following comments on the report's legal conclusions:

The Department of Health and Human Services agreed with our analysis and conclusion that exclusion or segregation of nonelderly mentally ill disabled persons violates antidiscrimination laws.

The Department of Housing and Urban Development (HUD) expressed no disagreement with any of our legal conclusions but suggested, in connection with our discussion of the section 221(d)(3) and section 236 programs, that we conduct analysis to be sure there is no violation of the Age Discrimination Act (ADA). We have done so and, as incorporated in the report, have concluded that, on the basis of HUD's own regulations, bona fide policies restricting admission to persons or families 62 or over do not violate the ADA. We have also incorporated several technical corrections and additions suggested by HUD.

The American Association of Retired Persons expressed agreement with our conclusions regarding the sections 221(d)(3), 202, and 236 programs and did not appear to disagree with our conclusion that, under the Rehabilitation Act of 1973 and the Fair Housing Amendments Act, exclusion or segregation of nonelderly mentally disabled persons in connection with public housing for elderly families is legally impermissible.

The National Association of Housing and Redevelopment Officials did not express disagreement with any of our legal conclusions.

Section 202

Our report points out that the Brecker and Knutzen cases, decided by the U.S. Courts of Appeals for the Second and Tenth Circuits, respectively, both upheld policies of section 202 sponsors that restricted admission to persons 62 or over. The principal basis for both decisions was that the statute governing the section 202 program expressly authorized project sponsors to serve one or more, but not necessarily all, of the classes of persons eligible to participate in the program. As further support for their decisions, the two courts noted that sponsors of 202 housing are required to provide supportive services to tenants and that different classes of eligible persons may have differing service needs.

MHLP notes, as does our report, that while the two cases considered section 504 of the Rehabilitation Act of 1973, both were decided before passage of the 1988 Fair Housing Amendments Act. MHLP summarizes some of the differences between the Fair Housing Act and the Rehabilitation Act and states that the report should have concluded that, "it is unclear whether the Brecker and Knutzen cases would be decided in the same way today [in light of the intervening passage of the Fair Housing Amendments Act]."

Our report also spells out the differences between the Fair Housing Act and the Rehabilitation Act. We believe these differences are important ones. Nonetheless, we continue to believe the differences are not of sufficient significance to override the principal basis for the Brecker and Knutzen decisions—that the statute governing the section 202 program expressly authorized project sponsors to serve one or more, but not necessarily all, of the classes of persons eligible to participate in the program. As we stress in the report, there is no indication in the Fair Housing Amendments Act or its legislative history that the Congress intended to withdraw that authority under the section 202 program.²

MHLP also argues that "the Brecker and Knutzen cases apply only to section 202 housing that provide services" and that many 202 housing owners provide services that do not address age-specific needs. Therefore, MHLP contends that, "at the least," the determination of whether individual 202 projects may legally restrict admissions to elderly applicants must be based on a fact-based analysis of the kinds of supportive services actually provided.

²MHLP quotes from a report of the House Committee on Banking, Finance, and Urban Affairs expressing disagreement with the Brecker decision. The Committee report expressed the view that limiting tenancy in a section 202 project to elderly persons, but excluding developmentally disabled and other handicapped persons, was contrary to the purpose of section 202. However, the Congress acts through legislation, not through the issuance of committee reports. The Congress did not enact legislation to overturn either the Brecker or Knutzen decisions.

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As we read Brecker and Knutzen, the principal basis for the two U.S. Courts of Appeals' decisions was that the statute governing the 202 program expressly authorized project owners to restrict admissions to persons 62 or over. While both courts also noted the differing service needs of the different categories of eligible persons, this was not the principal basis for the two decisions. It only constituted further support for the decisions, both of which were based principally on the respective courts' interpretation of the 202 governing statute as expressly authorizing the restriction on admissions. In fact, in the Brecker case, the district court noted that the only service offered by the project owner was a full-time "social coordinator." Nonetheless, the court upheld the restrictive admission policy. Accordingly, we do not agree that the decisions would have been different if it had been shown that the kinds of services actually provided met the needs of persons with mental disabilities as well as elderly persons.³

Sections 221(d)(3) and 236

MHLP disagrees on two grounds with our conclusion that a bona fide policy by owners of 221(d)(3) or 236 housing restricting admission to persons 62 or over does not violate either the Rehabilitation Act or the Fair Housing Act.

First, MHLP appears to dispute the report's statement that the statutes governing the 221(d)(3) and 236 programs define the terms "elderly" and "handicapped" separately, as under the section 202 program.⁴ It argues that the definition of "elderly family" under the two programs is the same as the public housing definition, i.e., "elderly family" includes both persons at least 62 years of age and persons with handicaps, regardless of age. MHLP states:

³MHLP also takes issue with the report's interpretation of a provision of the Cranston-Gonzalez National Affordable Housing Act authorizing owners of housing developed under the new Supportive Housing for Persons with Disabilities Program to limit occupancy to "persons who have similar disabilities and require a similar set of supportive services in a supportive housing environment." MHLP disagrees with our reading of this language as permitting housing for physically disabled persons to the exclusion of mentally disabled persons. In MHLP's view, this language was not intended to focus on distinguishing among persons with different disabilities, but rather on the service needs of specific individuals. Thus, according to MHLP, persons with different kinds of disabilities who all are addicted to cocaine "would all be eligible for housing that provided that service." We agree that all of the above individuals are "eligible" for housing that provides the service they need. However, to the extent MHLP is arguing that the quoted statutory provision does not permit project owners to limit occupancy to persons with physical disabilities, while excluding persons with mental disabilities, we disagree.

⁴As the report notes, under the 202 statute, the term "elderly" is limited to households of one or more persons, one of whom is 62 or over. 12 U.S.C. § 1701q(d)(4).

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"[B]oth the 236 and 221(d)(3) programs contemplated elderly and handicapped persons as eligible tenants. It is not correct to conclude that the statutes are neutral on the question of selective admissions."

On this basis, MHLF argues that, as in public housing, owners of housing under the two programs may not lawfully establish a policy of admitting only persons 62 or over.

We believe this ground for disagreement with our legal conclusion is based on a misreading of the statutes governing the 221(d)(3) and 236 programs. As the report states, the two statutes define the terms "elderly" and "handicapped" separately, as under the statute governing the 202 program. Indeed, each expressly cites the 202 statute in defining those terms.

The 202 statute restricts the term "elderly" to households of one or more persons, one of whom is 62 or over, while it defines the term "handicapped" to mean persons with a variety of physical or mental impairments, regardless of their age. 12 U.S.C. § 1701q(d)(4). Similarly, the 221(d)(3) statute refers separately to "[a]ny person who is sixty-two years of age or over, or who is a handicapped person within the meaning of section 1701q [the section 202 statute]. . . ." (Emphasis added.) 12 U.S.C. § 1715l(f). The section 236 statute, from which MHLF quotes, explicitly states: "[T]he term 'elderly or handicapped families' shall have the same meaning as in section 1701q. . . ." 12 U.S.C. § 1715z-1(j)(2)(B).

Furthermore, MHLF is incorrect in its assertion that "the 221(d)(3) and 236 definitions of 'elderly family' are the same as the public housing definition." Neither of the two governing statutes contains any reference to the public housing definition of "elderly family." Indeed, neither even defines the term "elderly family."

We agree with MHLF that elderly persons or persons with handicaps are eligible tenants under the two programs. However, under the governing statutes, so are persons displaced by governmental action, regardless of their age. Indeed, under these statutes, all other lower-income persons—those who are less than 62, not handicapped, and not displaced by governmental action—are also eligible tenants. See, e.g., 12 U.S.C. § 1715l(f).

Thus, there is no question that elderly persons and persons with handicaps, as well as other lower-income persons, are eligible tenants under the two programs. However, as stated in our report:

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"[N]either governing statute expressly requires owners of housing provided under the programs to admit the full range of eligible lower income families, nor does either statute explicitly prohibit individual project owners from adopting a policy limiting admission only to elderly persons or families."

Contrary to MHLP's contention, we believe the statutes are neutral on the question of selective admissions. As we state in the report, "in our view, the program statutes neither add to nor detract from whatever authority a project owner may have to adopt such a policy [of restricting admission to elderly persons]." The report concludes that such a policy would not violate either the Rehabilitation Act or the Fair Housing Act, "so long as the policy, as carried out in practice, is not a pretext for excluding mentally disabled persons or members of other protected classes." As we point out in the report, "age, not mental disability, would be the factor on which admission or exclusion would be based."

Second, MHLP points out that the report concludes that owners of housing for elderly families provided under the section 8 program may not exclude nonelderly persons with mental disabilities. MHLP then states:

"Since both the 236 and 221(d)(3) programs are financed in part with Section 8 funding, that fact reinforces the conclusion that selective admissions are not permissible in those programs."

MHLP adds: "The same may well be true for 202 programs also."

We believe this ground for disagreement—that because owners of section 8 projects for elderly families may not exclude nonelderly persons with mental disabilities, neither may owners of 221(d)(3) or 236 projects that receive section 8 assistance—is based, at least in part, on a misconception of the nature and form of the section 8 assistance to housing provided under the two programs.

Contrary to MHLP's assertion, housing projects under the 221(d)(3) and 236 programs are not "financed in part with Section 8 funding." The two programs are Federal Housing Administration programs, established under the provisions of the National Housing Act. They are not, as in the case of section 8, public housing programs established under the provisions of the United States Housing Act.⁵ Housing projects under the two programs are financed through the assistance of Federal Housing

⁵Furthermore, the section 8 program was established in 1974. The 221(d)(3) and 236 programs had been terminated by that year. Thus, no new housing under these programs was being constructed or financed by the time the section 8 program came into being.

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Administration mortgage insurance, plus subsidies designed to reduce rents to levels within the means of lower-income families and individuals.⁶ They are not financed, either in whole or in part, under section 8.

The section 8 assistance takes the form of payments to owners of projects under the two programs on behalf of eligible tenants, sufficient to permit the tenants to pay 30 percent of their incomes toward the rent. We do not believe these payments transform the 221(d)(3) or 236 projects into section 8 projects, nor that the definitional language of the public housing law should be substituted for that of the statutes governing the two programs under which the housing was financed. MHLP does not point to any statutory provision or legislative history suggesting that the Congress intended any such result, nor are we aware of any.

Thus, we are unpersuaded that 221(d)(3) or 236 projects that receive section 8 assistance are subject to admission requirements different from those to which projects that do not receive such assistance are subject. All such projects are provided and financed under specific provisions of the National Housing Act, not section 8 of the United States Housing Act, and, in our view, are subject to the requirements of their own governing statutes, not those of section 8. As discussed above, we do not believe those statutes, read in conjunction with the federal antidiscrimination laws, prohibit project owners from maintaining a policy restricting admission to elderly persons or families.⁷

**Council of Large
Public Housing
Authorities**

As noted above, CLPHA confined its comments to public housing for the elderly and expressed disagreement with our legal conclusion that exclusion or segregation of nonelderly persons with mental disabilities would violate federal antidiscrimination laws.⁸ The basis for our conclusion is as follows:

The public housing law (United States Housing Act of 1937, as amended), unlike the statutes governing the 202, 221(d)(3), and 236 programs, defines

⁶In the case of the 221(d)(3) program, the subsidy takes the form of a below-market interest rate. In the case of the 236 program, the subsidy takes the form of interest reduction payments sufficient to reduce the monthly mortgage payments to the amount they would have been if the interest rate had been 1 percent.

⁷We are equally unpersuaded of MHLP's point about section 202 housing receiving section 8 assistance. Under the statute governing the 202 program, as construed by the Brecker and Knutzen courts, project owners are expressly authorized to restrict admission to elderly persons.

⁸CLPHA's disagreement was on both legal and policy grounds. This response is limited to discussing CLPHA's legal objections.

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the term “elderly families” not only to include persons at least 62 years of age, but also to include persons with handicaps, regardless of age, including nonelderly persons with mental disabilities. These are the only two classes of persons entitled to a preference for projects designed for elderly families. A policy of excluding or segregating nonelderly persons with mental disabilities would single out this one protected group for discriminatory treatment.

Therefore, our report concludes that their exclusion or segregation with respect to public housing projects for the elderly can be viewed as solely because of their mental disability, in violation of the Rehabilitation Act. At the least, mental disability constitutes one significant factor in their exclusion or segregation, in violation of the Fair Housing Amendments Act.

CLPHA disagrees on the following grounds.

First, while CLPHA apparently concedes the threshold basis for our legal conclusion—that the Congress defined “elderly families” in the public housing law to include not only persons at least 62 years of age, but also persons with handicaps, regardless of age—CLPHA asserts that this was done “inadvertently.” CLPHA also states on this point:

“Legislative interpretation is a question of legislative intent . . . and the history of that particular definition is totally bereft of any indication that Congress contemplated, much less chose, the forced integration of these two groups.”

We cannot agree with CLPHA’s assertion that the Congress “inadvertently” defined “elderly families” to include all persons with handicaps, regardless of age, as well as persons 62 or over. We assume that when the Congress passes legislation, it does so with full knowledge of the meaning of the statutory language it enacts. Moreover, CLPHA points to no legislative history or other support for its assertion.

We do agree that legislative interpretation is a question of legislative intent. However, we believe the inquiry into legislative intent should focus on an examination of the text of the relevant statutes—in this case, the United States Housing Act, section 504 of the Rehabilitation Act of 1973, and the Fair Housing Amendments Act. Those statutes, read in combination, lead us to the conclusion that exclusion or segregation of nonelderly persons with mental disabilities is unlawful.

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We have found nothing in the legislative history of those statutes—nor, as noted above, does CLPHA point to any—that is inconsistent, let alone in conflict with, that conclusion. As CLPHA suggests, the legislative history is silent on this point. We cannot infer from this silence, as CLPHA apparently does, that the Congress intended a result contrary to the one which the statutory language requires. Nor do we accept CLPHA's characterization of the protections against discriminatory exclusion and segregation of persons with handicaps, contained in the Rehabilitation Act and the Fair Housing Act, as "forced integration."

Second, CLPHA notes that, in the Fair Housing Amendments Act, the Congress exempted certain "housing for older persons" from the sections covering discrimination against families with children. CLPHA also notes that the Cranston-Gonzalez National Affordable Housing Act changed the 202 program to establish separate programs of Supportive Housing for the Elderly and Supportive Housing for Persons with Disabilities.

While the Fair Housing Amendments Act exempts certain "housing for older persons" from the sections dealing with families with children, we point out that the act provides no such exemption with respect to fair housing protections for persons with handicaps. The Cranston-Gonzalez National Affordable Housing Act amended the 202 program to establish separate programs for the elderly and for persons with disabilities. That same act made numerous changes in the public housing law. However, the Congress chose to leave undisturbed the public housing definition of "elderly families" as including persons with handicaps, regardless of age, as well as persons at least 62 years of age.

Third, CLPHA claims that our legal analysis turns on a "simplistic disparate impact analysis." CLPHA then argues that "Observance of societally recognized elderly rights . . . is a compelling governmental interest which would, in Fair Housing analysis, excuse any disparate impact."

We do not agree that our legal analysis turns on a "disparate impact analysis," simplistic or otherwise. In the report, we conclude that exclusion or segregation of nonelderly persons with mental disabilities with respect to public housing for the elderly can be viewed as solely because of their mental disability and that, at the least, mental disability constitutes one significant factor in their exclusion or segregation. We added, "Such exclusion or segregation also has the purpose and effect of discriminating against this protected class of persons, in violation of the antidiscrimination laws." (Emphasis added.)

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We also question whether a policy of ensuring "elderly-only" housing rises to the level of a compelling governmental interest that would justify what otherwise would be a violation of the Fair Housing Amendments Act. To ensure that certain "housing for older persons" could lawfully exclude families with children, the Congress provided an explicit exemption in the Fair Housing Amendments Act. As noted above, the Congress provided no such exemption with respect to fair housing protections for persons with handicaps. Accordingly, we do not believe the exclusion or segregation of persons with mental disabilities with respect to public housing for the elderly can be justified, whether on the basis of a claimed compelling governmental interest or otherwise.⁹

Fourth, CLPHA states that approximately 30 percent of the elderly have disabilities. These persons, as contrasted with nonelderly persons with mental disabilities, would not be excluded or segregated in nonelderly projects. On this basis, CLPHA claims that neither section 504 of the Rehabilitation Act nor the Fair Housing Act would be violated. This report explicitly addresses this point, as follows:

"[I]t is no defense under section 504 or the Fair Housing Amendments Act to claim that the exclusion or segregation of mentally disabled persons would be limited to nonelderly mentally disabled persons, while elderly mentally disabled persons could be admitted

⁹In one recent Fair Housing Act case, a federal district court, after ruling that a city ordinance prohibiting placement of licensed residential facilities for retarded or mentally ill persons within 1,320 feet of existing facilities had a discriminatory effect, then held that the city had shown that its conduct was necessary to promote a compelling governmental interest, that of avoiding the clustering of homes that could lead the mentally ill to cloister themselves and not interact with the community mainstream. Thus, in the court's view, the ordinance furthered the goal of integrating the handicapped into the community. *Familystyle of St. Paul v. City of St. Paul*, 728 F. Supp. 1396 (D.Minn. 1990), *aff'd*, No. 90-6059 (8th Cir. Jan 8, 1991).

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freely. Those antidiscrimination laws protect the housing rights of all handicapped persons and do not permit discrimination or segregation against any such persons."¹⁰

¹⁰CLPHA also claims that our analysis

"leads inescapably to the awkward conclusions that a) the division of public housing into 'family' and 'elderly' projects is illegal, and b) that public housing programs treating people with disabilities with more consideration than routinely accorded the elderly or families with children are as illegal as the reverse."

With respect to CLPHA's first claim, we fail to see how, under our analysis, it is illegal to divide public housing into family and elderly projects. The public housing law contemplates both family and elderly projects. Persons at least 62 years of age and handicapped persons, regardless of age, are defined in the statute as "elderly families" and both receive a preference for projects designed for elderly families. In our view, neither the Rehabilitation Act nor the Fair Housing Act precludes this division. Indeed, the Fair Housing Act expressly permits housing for elderly persons, as provided under the public housing program, with occupancy limited to elderly persons as defined in the program. 42 U.S.C. § 3607(b)(2)(A).

As to CLPHA's second claim, we stress that federal antidiscrimination laws require only that persons with disabilities be treated the same as others, not that they be accorded more consideration than accorded to the elderly or to families with children.

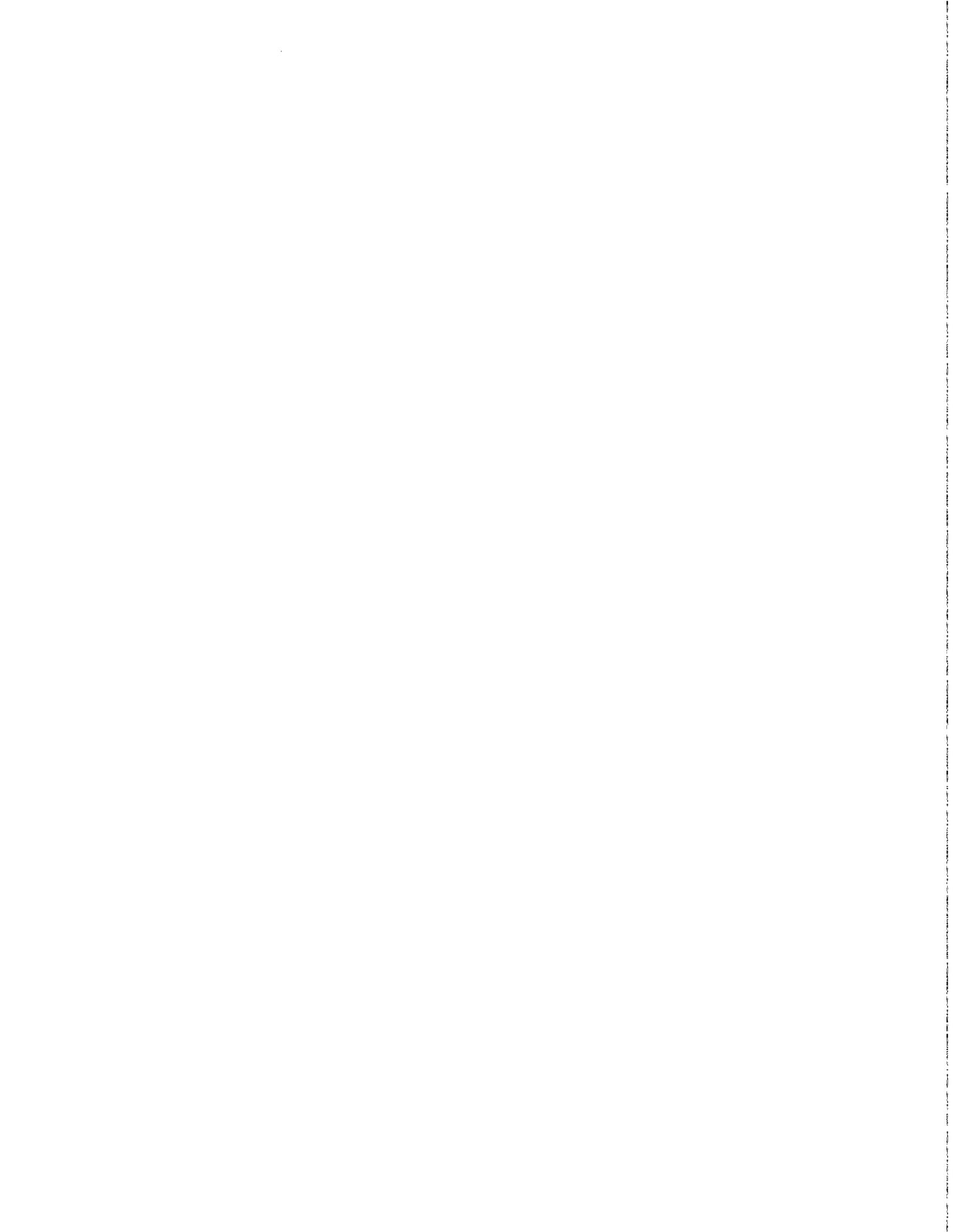
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