COMMONWEALTH OF PENNSYLVANIA
DEPUTY SECRETARY FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The Transitional Housing for Opioid Recovery Demonstration Program Act of 2018

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Good Afternoon. Thank you for the opportunity to provide testimony to you, this afternoon, regarding The Transitional Housing for Opioid Recovery Demonstration Program Act of 2018. I currently serve as the Deputy Secretary for Mental Health and Substance Abuse Services within the Pennsylvania Department of Human Services. Governor Tom Wolf has made fighting the opioid epidemic one of his administration's top priorities. In January 2018, Governor Wolf declared a Disaster Declaration to expand the state's role and response to the epidemic. Since taking office, Governor Wolf has worked to expand the commonwealth's response to this crisis. Most recently, the Governor signed a Disaster Declaration to bolster the administration's response by speeding up and expanding access to treatment, improving tools for families, first responders and others to save lives, and further enhancing coordination and data collection to improve state and local response. The initial declaration was for 90 days and Governor Wolf, recently announced it will be extended for an additional 90 days.

I have been working in the housing/services field for over 20 years. I began working, in the late 1990's, with individuals with a developmental disability or a mental illness, living in their own apartments. This was before Supportive Housing was called Supportive Housing and certainly before it was an evidence based practice. In the early to mid-2000, I worked in New Jersey and Pennsylvania to advance the principles of SH for individuals with a mental illness leaving a state psychiatric hospital or a congregate setting like a group home. I was an original founding member and eventual chair of the New Jersey Supportive Housing Association. I both developed housing projects as well as designed the services to support people living in SH. I am familiar with many of the US Housing and Urban Development (HUD) funding sources such as McKinney-Vento, the original Section 811 program and the new Section 811 Project Based Rental Assistance program. Additionally, I am familiar with different types of federal and state subsidy programs, including tax credit programs. I have implemented Olmstead Settlement agreements using a supportive housing model and based much of my career on ensuring people have access to housing in the community, in an integrated setting, with access to services and supports.

People with mental illness and/or substance use disorder can and do recover with the proper services and supports, including affordable and permanent housing. Housing needs to be permanent and affordable and not transitional or based on a period of 12-24 months. Countless studies have been conducted on the positive outcomes people experience once they have stable housing and access to services. Outcomes include improved health outcomes, reduction in homelessness, reduction in the inappropriate use of emergency rooms' and reduced substance use.[i]

The Services Administration for Mental Health and Substance Abuse Services (SAMHSA) has developed a tool kit for Supportive Housing that providers can utilize to ensure fidelity to the model.[ii] CMS, through its Innovative Accelerated Program (IAP), created technical assistance opportunities for states to learn about how Medicaid can be used to pay for services that people need to be successful in maintaining housing. This particular IAP program brought together experts in services, housing and Medicaid so that each sector could learn each other's systems. Medicaid is not able to pay for housing and so the partnership between housing providers and service providers is key.

While I have been touched by the opioid crisis personally, having lost a cousin to an overdose, as well as professionally in trying to attack this crisis in two different states, I still feel that this legislation, as written, is too narrow of a focus and should address Substance Use Disorder (SUD) in general.

The Committee has requested witnesses' views about a discussion draft of the "Transitional Housing for Opioid Recovery Demonstration Program Act of 2018," circulated by Rep. Barr. The draft bill is well-intentioned, aiming to dedicate resources for residential substance use treatment programs that help people recover from opioid use disorders. However, I would like to offer some suggestions:

1. **Obtaining a Housing Choice Voucher should not be dependent on the consumer's drug of choice. Anyone with a substance use disorder should be eligible for assistance.**

It is absolutely true that permanent and affordable housing coupled with supportive services is a key component to a successful recovery for individuals with an Opioid Use Disorder (OUD). But this is not just true for an individual with an OUD but for all individuals recovering from substance use disorder, including those in recovery from a dependence on alcohol, cocaine, meth-amphetamine, as well as those with a co-occurring mental illness. See below for specific PA statistics:

Year	Affliction	Black or African American	Hispanic or Latino	Non-Hispanic	White
		Diagnosed	Diagnosed	Diagnosed	Diagnosed
2015	Alcohol*	19,634	3,463	897	44,194
	Opiate*	11,963	4,062	1,030	72,204
	Other*	33,784	6,932	1,414	63,420
2016	Alcohol*	22,594	4,071	1,093	51,685
	Opiate*	14,996	4,806	1,243	88,314
	Other*	36,625	7,273	1,530	66,641
2017	Alcohol*	21,429	3,770	1,159	52,521
	Opiate*	15,324	5,405	1,457	94,594
	Other*	37,054	7,577	1,628	71,049

It will be difficult to develop eligibility criteria based on an opioid addiction alone and may set up a have versus have not type of system. As depicted in the chart above, the use of all substances, not just opioids, is problematic for many of Pennsylvania's citizens. Coupled with this is the fact that many individuals have poly-substance use issues and specifying one diagnosis may prove problematic in administering the program in a fair

and equitable way. Substance use providers do not treat one addiction, such as opioid use disorder, with the exception of Opioid Treatment Programs (OTP's). And even within an OTP many people are battling addictions to alcohol and/or benzodiazepines along with their OUD. Providers are equipped to work with individuals who have a range of addictions and treatment needs. Affordable housing is in very short supply and in order to be eligible, people may turn to opioids as a way to gain access to this very important resource. This would be entirely counterproductive to the bill and can cause an unintended consequence.

The voucher program should be open to all individuals with a substance use disorder that should be a component of comprehensive supportive and recovery services that include peer support, employment and job training, counseling and medication assisted treatment, if appropriate. Many individuals complete a continuum of treatment starting with detox and/or in-patient rehabilitation and progress to a halfway house in preparation to return to the community. Many of these services are covered either through the Pennsylvania Behavioral Health Choices Program (PA's managed Medicaid program for behavioral health) or through other funds such as federal block grant, state or county dollars. So, while many of the services are currently funded, there is still a great need for additional funding. I would encourage the committee to work with the House Energy and Commerce Committee to address funding for all services needed to support the recovery process for individuals. Supportive housing is often referred to as the three (3) legged stool…capital, subsidies and services. HUD plays a vital role in two legs of this stool and continuing to add resources, especially for subsidies, can provide someone the opportunity to receive a voucher, in order to further their recovery, and to live in the community permanently.

2. **The demonstration should not impose time limits for participation in the section 8 housing choice voucher demonstration. The vouchers should be permanent and follow the same rules and regulations as the current Housing Choice Voucher Program.**

The housing choice voucher program is one of the nation's most successful public/private partnerships[iii]. Private landlords enter into agreements with public housing authorities (PHA) with the understanding that the voucher subsidy is permanent, save participant termination for a program violation or participant income levels in excess of program requirements. Voucher time-limits is a disincentive to private landlords who want stable clients and do not want the hassle of removing someone from the unit because their voucher ended and they can no longer afford their apartment. Furthermore, participants with complex issues related to SUD/OUD, are not likely to resolve issues related to income or a need for subsidy within arbitrary timeframes. Finally, PHAs may not have the resources to house the participants in this program once their voucher ends due to existing waiting lists and scarce resources.

Permanent Supportive Housing, a strategy that combines affordable housing with intensive coordinated services, has been the primary funding focus for the HUD Homeless Continuum of Care.[iv] Today, HUD has focused efforts on making housing subsidies permanent to ensure success for both families and individuals experiencing homelessness.[v] Providing a temporary subsidy for the OUD population, an arguably more complex population to serve, runs counter to three decades of

evidence suggesting that permanent housing is more effective than transitional housing. Furthermore, the draft legislation characterizes this demonstration as supportive housing, but the lack of permanency runs counter to the idea that permanency is a critical component of supportive housing.

The demonstration talks about using supportive housing as a model but as it is described actually runs counter to the tenets of the model. Supportive housing is a highly effective strategy that combines affordable housing with coordinated services to help people struggling with mental illness, physical health care issues and substance use issues. The key features of supportive housing are permanence and affordability. Tenants typically pay 30% of their income towards rent and have the same rights and responsibilities as any other tenant renting an apartment. There are also a core set of principles that include services that are housing oriented, multi-disciplinary and voluntary but assertive in that staff will continue to provide follow up should someone choose not to engage. The housing is also integrated into the community so individuals have access to all community resources that everyone enjoys. Individuals have a choice in their housing as well as in the services they receive. Finally, the housing is considered low barrier and instead of screening people out of housing, the model screens people into the housing. Again, the point to all of this is the permanency, affordability and access to services that are key to the model. Using a transitional model, that involves losing a subsidy at the end of a defined time period runs counter to the true tenets of the model.[vi] Even after a person has stabilized their life, they may need the housing voucher because their job may not pay enough to afford housing. Housing instability can jeopardize a person's recovery. In fact, the loss of subsidy at the end of 24 months can be a trigger for relapse.[vii]

Housing First or low barrier housing, as described above, has also been studied as a way to engage those who have been resistant to housing or services in the past. This is mostly due to the requirements, such as sobriety, completing a certain program, etc., that were really barriers to individuals accessing housing and services. Although there was no direct substance use intervention, individuals with alcohol dependency living in a Housing First program in Seattle, Washington had ***decreased*** alcohol consumption over time.[viii] A Housing First model in Seattle, Washington serving women that experienced chronic homelessness with co-occurring substance use disorder showed ***reduced*** substance use among women in this program."[ix] This again, just points to the need for permanent vouchers and not compromising someone's recovery with the loss of a voucher.

3. **As the primary grantees of Housing Choice Voucher program, Public Housing Authorities should be involved in this demonstration**

The Housing Choice Voucher program is not an easy program to administer. PHAs have a staff person for every 200 to 300 participants served. This staff compliment is largely dedicated to ensuring compliance with regulations and providing quality customer service to participants and landlords. Most residential substance use treatment or recovery housing providers do not have expertise administering housing vouchers. Distributing vouchers requires understanding fair housing rules, unit inspection, receiving rent payments from clients, and regularly updating clients' eligibility criteria. It might make more sense to employ lessons learned from the HUD-Veterans Affairs Supportive Housing (HUD-VASH) program, which leverages the expertise of PHAs in administering the voucher program with the case management and human services provided by the Veterans Administration. [x]

Because there is no new money recommended in this bill, PHAs are the most likely local entities to be negatively impacted by this demonstration. However, for this demonstration to be effective, we will likely need PHA buy-in and expertise during the planning and implementation phases. In addition, if the demonstration is successful, substance use treatment providers will need PHAs in order to grow the program to help more people. PHAs will not be inclined to be partners if they see substance use treatment providers as having taken their resources.

The legislation allows that an eligible entity to provide a voucher for such assistance to a covered individual through a supportive housing program that provides treatment for opioid use disorders, job skills training and such assistance for a period of 12-24 months. Supportive housing providers typically provide the services as referenced, however, accessing housing is not contingent on participating in these services. Services are voluntary and engagement is decided by the client. In a true supportive housing model, the services and housing are separate. The specifics of operating a housing choice voucher program, as stated above, is complicated due to all the regulatory and compliance issues. Service providers should provide services and housing providers should provide housing.

4. **The legislation does not create additional vouchers for the purpose of the demonstration. In order to address the housing needs of individuals with SUD/OUD, additional vouchers should be created.**

The current program is not able to meet the need of all the individuals and families who could benefit from having a voucher in order to locate and maintain permanent and affordable housing. In fact, three in four renters who are low income are not able to receive assistance due to funding limitations. Demand for vouchers is so high that a majority of housing agencies have closed their waiting lists and agencies are often flooded when waiting lists are re-opened. Families/individuals who do manage to get on a waiting list can wait for years before a voucher becomes available. Surging demand and long waiting lists provide further evidence that the need for affordable housing far outstrips the supply and that current federal voucher funding levels are inadequate to address the current need. Almost 3 million families are currently on a waiting list for a voucher but over 9 million would be waiting if lists had not been closed according to a report, in 2016, by the Public and Affordable Housing Research Corporation. Nearly all of those on the list are seniors, people with disabilities or seniors.[xi] In fact, many of the individuals served by the PA Office of Mental Health and Substance Abuse Services (OMHSAS), could benefit from a housing voucher. There are individuals who are currently being served in a group home or a more congregate setting, receiving a higher level of service than required because there are simply not enough rental vouchers for individuals. If those individuals could move into supportive housing, with a rental voucher, individuals currently in a state psychiatric hospital could be stepped down to the community to create a through put in the continuum. People, however, are stuck because of the lack of rental vouchers/assistance. OMHSAS also serves individuals who are homeless who also have a mental illness and/or a co-occurring substance use disorder. These individuals also require a supportive housing setting coupled with support services. OMHSAS has been able to create some rental assistance vouchers with its own funding, as well as funding for services, including using Medicaid for approved state plan services. However, in a perfect world, the subsidies created by OMHSAS would be a bridge to a more permanent housing choice voucher. This just speaks to the point that

the addition of vouchers would be far more advantageous than just using and recycling existing vouchers. It tends to set up a rob Peter to pay Paul scenario.

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[i] Ehren Dohler, Peggy Bailey, Douglas Rice and Hannah Katch, "Supportive Housing Helps Vulnerable People Live and Thrive in the Community", *Center on Budget and Policy Priorities*, May 31, 2016.

[ii] *Permanent Supportive Housing Evidence-Based Practices,* available at: https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT-/SMA10-4510.

[iii] *The Housing Choice Voucher Program (formerly known as Section 8) is one of the most successful federal housing programs funded by HUD*, available at: http://www.tacinc.org/media/27844/Federal%20Housing%20Programs.pdf:

[iv] "Congress and the U.S. Department of Housing and Urban Development (HUD) have encouraged the development of permanent supportive housing for homeless people since the inception of the McKinney-Vento Act in 1987. https://www.huduser.gov/portal/publications/hsgfirst.pdf:

[v] *Permanent Housing Subsidies Most Effective Intervention to Assure Housing Stability for Families Experiencing Homelessness*, available at: http://nlihc.org/article/permanent-housing-subsidies-most-effective-intervention-assure-housing-stability-families.

[vi] Dohler, et al.

[vii] Carol Pearson, Anne Montgomery, and Gretchen Locke, "Housing stability among homeless individuals with serious mental illness participating in housing first programs", *Journal of Community Psychology*, Vol. 37 | Issue 3, March 3, 2009.

[viii] S. Collins, D. Malone, S. Clifasefi, J. Ginzler, M. Garner, B. Burlingham, M. Larimer,"Project-based housing first for chronically homeless individuals with alcohol problems: Within-subjects analyses of 2-year alcohol trajectories", *American Journal of Public Health*, 102(3), 511-519, 2012.

[ix] Susan Collins, Seema Clifasefi, Elizabeth Dana, Michele Andrasik, Natalie Stahl, Megan Kirouac, Callista Welbaum, Margaret King, and Daniel Malone, Where Harm Reduction Meets Housing First: Exploring Alcohol's Role in a Project-based Housing First Setting", *International Journal of Drug Policy*, Volume 23 | Issue 2, March 2012.

[x] *HUD-VASH*, available at: https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/vash.

[xi] Alicia Mazzara, Housing Vouchers Work: Huge Demand, Insufficient Funding for Housing Vouchers Means Long Waits, *Center for Budget and Policy Priorities*, Blog Post April 19, 2017.