Housing for People with Disabilities: A Review of State Olmstead and HUD Consolidated Plans

Lynn McCormick¹, Alex Schwartz², and Chiara Passerini³

Abstract

Although some scholars have discussed the serious shortage of appropriate housing for people with disabilities, planners and housing policy makers have been largely silent on this issue. We summarize the literature, to date, about the housing needs of people with disabilities in the United States. We investigate what progress states have made in addressing these needs since the Americans with Disabilities Act (1990) by examining recent court-ordered state Olmstead plans and their U.S. Department of Housing and Urban Development (HUD) Consolidated plans. We find that states are mostly aware of the size and housing needs of people with disabilities but have not yet developed sufficient programming.

Keywords
housing, social services, public health

Introduction

Although the American with Disabilities Act and subsequent court decisions such as the Olmstead case occurred several decades ago, the lack of affordable and appropriate housing for people with disabilities remains a critical issue in the United States. Some argue it will soon become a crisis. Yet, the academic planning field—long involved in housing policy (von Hoffman 2009)—has largely ignored the issue. This article aims to bring planners up-to-date on the topic, contribute to what is known about state actions to deal with the problem, and to show why it should be a priority for planning.

One of us, a parent of a daughter with a developmental disability, searched the literature produced by our fields of urban planning and public policy and found surprisingly little, almost nothing, to help in understanding how professionals in our fields were involved in planning government programs and services to support adults with disabilities to live independently in their communities. What kind of housing should I seek for her, what kind of employment supports could assist her, what kind of urban form would help her live without the ability to drive a car? These are questions that planners should be answering but are largely not.

As people with disabilities age and become adults, they require not only social services—which disability specialists and social workers plan—but also transportation, jobs, affordable housing, and other features of an integrated community life. Planners deal with all of the latter. Focusing on this constituency could provide planners and policy makers with new opportunities to build equitable communities. Planners have long sought to better integrate low-income and other marginalized populations through various efforts (e.g., Cabrera and Najarian 2013; Deng 2007). Planners now work to better incorporate these groups into civic discourse in the policy-making sphere and into consideration by planning educators (e.g., Innes and Booher 2004; Myers 2015; Sen et al. 2017). Planners have also recently enthused over creating walkable neighborhoods, which locate shops and employment nearby (e.g., Talen, Menozzi, and Schaefer 2015) as well as produce health benefits (e.g., Talen and Koschinsky 2014). As a large proportion of people with disabilities cannot drive, they need to live in such walkable areas that are rich with transit options. Not only can Transit-Oriented Developments help cut auto dependence and ameliorate climate change (Handy 2017), but they could also provide a built form that is more accessible for people with disabilities while integrating them more fully in civil society. Some planners are looking at how the built environment influences the availability of community services for those who are aging in place (Warner, Homsy, and Morken 2017). This work and other knowledge that planners have developed could also enhance plans and policies for people with disabilities.
The paucity of attention given to disability in the planning and housing literature is readily apparent. The *Journal of American Planning Association* (*JAPA*) and the *Journal of Planning Education and Research* (*JPER*) each published one article related to people with disabilities since 2000; *Housing Policy Debate* (*HPD*) published three. Meanwhile, these journals were fairly prolific in their coverage of housing in general: *JAPA* published 120 articles since 2000, *JPER* 114, and *HPD* 328. Key journals in the disability field, not surprisingly, published much related to disability during this time but a limited amount on housing. The two fields are largely unconnected. We suggest this poses problems for the provision of sufficient housing for people with disabilities. Put another way, the acute and rapidly growing need for physically accessible and financially affordable housing for people with disabilities is an issue of great relevance for planners, one that merits more attention than it currently receives.

By summarizing the literature on housing for people with disabilities and also analyzing related state plans, we seek to prompt planners to pay greater attention to this important issue and to show that housing for people with disabilities should be a new frontier for planning. We first provide an overview of the incidence of disability in the United States and a brief history of the disability movement. We then review the literature that covers housing for people with disabilities. Subsequently, we analyze state plans for disability services that the Olmstead decision mandates and state Consolidated Plans (ConPlans) that the federal U.S. Department of Housing and Urban Development (HUD) requires for receipt of federal Housing and Community Development Block Grant funds. We conclude with a summary of states’ progress in meeting the housing needs of people with disabilities, while offering ideas for future research.

**People with Disabilities and Their Housing Needs**

**Disability in the United States**

Estimates of the U.S. population with disabilities vary. According to the American Community Survey (ACS) of 2016 (five-year estimates), 41.4 million people, 13.0 percent of the total population, experienced one or more disability. The incidence of disability is much higher among residents in “group quarters,” which encompass institutional settings (e.g., prisons, nursing homes, psychiatric hospitals) and non-institutional environments such as college dormitories and military housing. Of the eight million inhabitants of group quarters, the ACS estimates that 35.0 percent have a disability, as do 53.4 percent of the institutionalized group quarters population. Overall, most people with disabilities, 93.2 percent, reside in private households (Table 1). About 25.6 percent of all households (using 2000–2010 data, Altman and Blackwell 2016) and 28.9 percent of all families in 2000 included a member with a disability (Wang 2005).

The ACS employs six major categories of disability: in hearing, vision, cognition, ambulatory ability, self-care, and independent living. The ACS reports on these disabilities for the civilian noninstitutionalized population. Ambulatory difficulties are the most prevalent, affecting 20.6 million people, 6.6 percent of the noninstitutionalized population. Cognitive difficulties rank second, affecting nearly fifteen million people, 4.7 percent of the population (see Table 2).

**Table 1.** Overview of U.S. Population with Disabilities, 2016 (Five-Year Average): Distribution of Disabled Population by Type of Residence.

<table>
<thead>
<tr>
<th>Total Number of People with Disabilities</th>
<th>Percentage of Total U.S. Population</th>
<th>Percentage of All with Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population with disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in households</td>
<td>41,412,561</td>
<td>13.0</td>
</tr>
<tr>
<td>in group quarters</td>
<td>38,586,236</td>
<td>12.4</td>
</tr>
<tr>
<td>in institutional group quarters</td>
<td>2,826,325</td>
<td>53.0</td>
</tr>
<tr>
<td>in other group quarters</td>
<td>718,002</td>
<td>17.4</td>
</tr>
</tbody>
</table>


Note: The table covers the entire U.S. population.

**Table 2.** Incidence of Disability by Type (Civilian Noninstitutionalized Population).

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Total</th>
<th>Percentage of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any disability</td>
<td>39,272,529</td>
<td>12.5</td>
</tr>
<tr>
<td>With a hearing difficulty</td>
<td>11,089,041</td>
<td>3.5</td>
</tr>
<tr>
<td>With a vision difficulty</td>
<td>7,231,542</td>
<td>2.3</td>
</tr>
<tr>
<td>With a cognitive difficulty</td>
<td>14,806,529</td>
<td>4.7</td>
</tr>
<tr>
<td>With an ambulatory difficulty</td>
<td>20,649,180</td>
<td>6.6</td>
</tr>
<tr>
<td>With a self-care difficulty</td>
<td>7,877,505</td>
<td>2.5</td>
</tr>
<tr>
<td>With an independent living difficulty</td>
<td>13,940,629</td>
<td>4.4</td>
</tr>
</tbody>
</table>


Note: The table focuses on the civilian noninstitutionalized population; that is, they omit members of the armed forces and people in prisons and other institutional settings.
The ACS defines cognitive difficulties as “serious difficulty concentrating, remembering, or making decisions” as a result of a “physical, mental, or emotional condition.” It includes intellectual and developmental disabilities, as well as dementia and certain types of mental illness.

The incidence of disability increases with age, but all but the very youngest age groups include many people with disabilities. Table 3 shows that while 25 percent of all people aged sixty-five to seventy-four years and 50 percent of people aged seventy-five years and older have a disability, these two age groups account for just 41 percent of all people with disabilities. People with disabilities who are thirty-five to sixty-four years account for 13 percent; young adults aged eighteen to thirty-four years make up an additional 11 percent of the population with disabilities.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population</th>
<th>Percentage of Total Population with Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 years</td>
<td>154,569</td>
<td>0.8</td>
</tr>
<tr>
<td>5–17 years</td>
<td>2,887,442</td>
<td>5.4</td>
</tr>
<tr>
<td>18–34 years</td>
<td>4,350,319</td>
<td>6.0</td>
</tr>
<tr>
<td>35–64 years</td>
<td>15,837,938</td>
<td>12.9</td>
</tr>
<tr>
<td>65–74 years</td>
<td>6,628,920</td>
<td>25.4</td>
</tr>
<tr>
<td>75 years and older</td>
<td>9,413,341</td>
<td>50.0</td>
</tr>
</tbody>
</table>


Note: The table focuses on the civilian noninstitutionalized population; that is, they omit members of the armed forces and people in prisons and other institutional settings.

The Integration Movement to Bring People with Disabilities into the Community

For several decades, disability activists have pushed to bring about greater integration of people with disabilities into community settings. Increasing public awareness of the often-inhumane conditions in state-run institutions for the disabled hastened their closure. Today, community-based settings are seen as most liberating and appropriate. The passing of the Americans with Disabilities Act (ADA) and the Supreme Court’s Olmstead decision mandated that states and local governments seek the most integrated setting possible for those with disabilities in schools, public facilities, housing, transport, and other situations. Other efforts to modify the built environment for those with disabilities started even earlier.

The issue of housing accessibility for those with mobility impairments gained awareness in the 1950s when veterans with disabilities returned from the prior two wars. Congress passed the Architectural Barriers Act (ABS) in 1968 and the Rehabilitation Act in 1973. These require that facilities and services supported by federal funding must be accessible to people with disabilities and that federally subsidized housing ensure that 5 percent of units be accessible. Progress in regard to accessibility has been fostered by the “visitability” movement, which aims to change home construction practices to be barrier free and to ensure any resident and his or her visitors of easy mobility. Some states and local governments have passed mandated or voluntary visitability laws (Burns and Gordon 2010; Maisel, Smith, and Steinfeld 2008; Smith 2010; Smith, Rayer, and Smith 2008). The Universal Design movement emerged from these earlier accessibility efforts. UD aims to create products and environments that can be used by anyone, with or without a disability (Burgstahler 2015).

Demands for better housing for people with disabilities also emerged out of the disability rights movement and its promotion of deinstitutionalization for those living in large state institutions. Since the 1960s, the deinstitutionalization movement has resulted in the closure of many institutions and relocation of the residents elsewhere (209 such institutions closed between 1960 and 2011) (Kim, Larson, and Lakin 2001; Lerner and Pollack 2015). The deinstitutionalization movement aims to increase the integration of people with disabilities into the community at large—moving from prior segregated living arrangements to community settings with support services. Integrated living arrangements help people with disabilities participate more fully in civic affairs while achieving greater self-determination and independence (Priaulx 2015; Young 2010).

Disability-distinct organizations were founded in the early 1900s (e.g., Disabled Veterans of America founded in 1920), which eventually led to cross-disability organizations, greater political organizing, and passage of the ADA in 1990. The ADA stipulates that people with disabilities cannot be discriminated against or denied services by a local or state government agency or any place of public accommodation. Subsequent regulations specify that people with disabilities should be able to get services and live in the most integrated and appropriate setting (called the Integration Mandate) (Lerner and Pollack 2015). Furthermore, the ADA specified that people with disabilities could not be discriminated against in regard to any housing-related transaction including zoning for and the accessibility of housing (Burns and Gordon 2010; Lerner and Pollack 2015; Young 2010).

The Olmstead case, in 1999, resulted in a Supreme Court ruling mandating that government services support the movement of people with disabilities into the least restrictive setting. As the ADA website explains, Olmstead “prohibited the states from making funding decisions based on their desire to keep their institutions full” (ADA n.d.). Two institutionalized women—Lois Curtis and Elaine Wilson—with mental and developmental disabilities who wanted to live in the community, brought the case forward. The Supreme Court ruled in their favor, interpreting the ADA to mandate that states must place people with

Table 3. Incidence of Disability by Age (Civilian Noninstitutionalized Population).

<table>
<thead>
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<th>Age Group</th>
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disabilities in community settings instead of institutions where possible. The Court realized it would take time for full compliance so it determined that states could start by developing a compliance plan, which could include a waiting list of those to be integrated. The Olmstead decision evolved from initially focusing on people with disabilities in state institutions to all people with disabilities anywhere who require institution-level services (Bliss and Wells 2010; Lerner and Pollack 2015; National Disability Rights Network [NDRN] 2009). States are assumed to be making progress, to the extent that their resources allow, if they are transitioning people out of institutions “at a reasonable pace” (Bliss and Wells 2010, 718). Bliss and Wells (2010), comparing Olmstead with Brown v. the Board of Education, for school desegregation, argue that full integration will not occur, as under Brown, until the courts mandate that states make progress under Olmstead immediately.

Current Housing Issues Facing People with Disabilities

Researchers note the current shortage of appropriate housing for adults with disabilities and predict this will worsen in future. One factor influencing supply includes the insufficient availability of government-funded supports and services that people with disabilities require to live independently. This is a critical issue, but one over which planners have little influence. Home and Community Based Services (HCBS), financed by Medicaid, are seriously underfunded. States can support HCBS services, cap them, or not offer them at all (Lerner and Pollack 2015; Musumeci and Claypool 2014). This differs from services provided to individuals in nursing homes, which states must provide.

A second supply issue is the dearth of accessible housing for those with mobility-related disabilities. Even though some planners and architects are promoting better access through Universal Design, much more needs to be done. A recent study found that about one-third of all housing stock is potentially modifiable to become accessible; however, less than five percent is, currently, for those with moderate mobility issues (and even less for those requiring wheelchair access; Bošher et al. 2015). These estimates vary regionally, as well, such that some places have less than one-third of stock that can be modified.

A third issue—also important to planners—is the lack of affordable housing in general. Millions of households spend more on housing than they can afford. In 2015, more than 40 percent of all renters paid more than 30 percent of their income on rent, including 22 percent who paid at least half of their income on rent. Among low-income renters, housing cost burdens are especially acute (almost half of whom pay at least 50%) (HUD 2017).

Housing affordability problems are especially severe for people with disabilities, who often depend on Supplemental Security Income (SSI) for their livelihood (Dawkins and Miller 2015; Smith, Rayer, and Smith 2008; Southwest Autism Research & Resource Center 2009). SSI provides very little income for its recipients. An SSI payment to an individual in 2017 was $735 monthly, or only 73 percent of the federal poverty level (Justice in Aging 2017). Cooper et al. (2013) estimate that a single-person household, dependent only on SSI funding, must pay 104 percent of his or her income for a one-bedroom apartment, or 90 percent for a studio, using national average rents. This means many people with disabilities are homeless or forced to live in substandard housing and more dangerous neighborhoods (e.g., Cooper et al. 2013; Trueland 2009). Some end up in nursing homes—the segregated institutional environment that the deinstitutionalization movement sought to avoid.

Even though some people with disabilities live in federally subsidized housing, a large proportion are not served at all (Dawkins and Miller 2015). In 2012, 96 percent of public housing authorities (PHAs) had waiting lists for public housing and 99 percent had such lists for Housing Choice Vouchers, with approximately 4.4 million low-income families waiting for either (Public and Affordable Housing Research Corporation 2016). PHAs may or may not prioritize people with disabilities on these lists.

Demand for housing by people with disabilities is growing. First, experts expect the number of people with mobility issues to increase due to the aging baby-boom generation. One study estimates that about 21 percent of households will have at least one resident with a mobility disability by 2050 (Smith, Rayer, and Smith 2008). Second, people with intellectual or developmental disabilities are now living longer—as is the general population—because of improved health care (Glasson et al. 2002; Hogg et al. 2001). Thus, people with disabilities now live with their families longer than ever, which becomes problematic when family members can no longer care for them due to their own disability or death—when those with a disability must find new caretakers and often a new home.

In this environment, progress in moving people with disabilities out of state institutions according to Olmstead has moved slowly. However, the involvement of housers has improved this situation. HUD and state housing agencies were late in participating in Olmstead planning because the deinstitutionalization movement initially involved only those providing supports and services to people with disabilities, like the federal U.S. Department of Health and Human Services (HHS) and similar state agencies (Miller, Milstein, and O’Hara 2000). HUD’s involvement has increased over the years. Collaborating with HHS, its Housing Capacity Building Initiative for Community Living Project aims to stimulate state and local government
collaborations among housing and human services agencies. This collaborative grew out of President Obama’s initiative in 2009, the Year of Community Living, under which federal agencies were tasked with coordinating their efforts in regard to Olmstead planning (Administration for Community Living, HHS 2015; White House 2009). Subsequently, HUD and HHS announced funding to state housing agencies for rental assistance to people with disabilities with extremely low incomes.12 Targeted to those at risk of institutionalization or homelessness, the federal government offered almost $98 million to thirteen states through the Section 811 Project Rental Assistance Demonstration Program (PRA Demo; U.S. HHS 2013). States continue to form partnerships between their human services and housing agencies (Arienti and Sloane 2013)—an important effort that needs continued support.

**Analyses of State Plans**

Given this environment facing people with disabilities, we sought comparative information on how various states tackled these challenges. We start with the court-mandated state Olmstead plans, which have been evaluated before; we are especially interested in their details on housing. We also evaluate state actions for those with disabilities in their HUD-required Consolidated Plans.

**Prior Analyses of Olmstead Progress**

Several studies investigated states’ progress on community integration, in their Olmstead plans (Fox-Grage, Coleman, and Folkemer 2004; Musumeci and Claypool 2014; NDRN 2009; Ng, Wong, and Harrington 2013, 2014; Priaulx 2015). O’Hara and Day (2001), Harkin (2013), and Christensen and Byrne (2015) also studied the housing and built environment components of these plans. All note the slow progress of most states.13 These studies found the following:

- many states show no measurable goals for progress, instead offering vague and general policy recommendations;
- many states are not utilizing new Federal programs for expanding their community-based supports and services;
- transition out of state institutions has proceeded faster for people with intellectual or developmental disabilities, versus those with physical disabilities;
- many states continue to keep their institutions full while giving new community-based supports and services to people with disabilities who already live in the community;
- even where states have moved people with disabilities out of institutions, they move them into other segregated congregate care facilities (e.g., group homes, nursing homes);
- many states cite fiscal difficulties for slow progress, even though courts determined this was insufficient grounds for inaction.

**Our Analysis of Olmstead Plans**

We analyze Olmstead plans to determine whether new progress has been made since earlier evaluations. We found that thirty-six states have official Olmstead plans. Nine states do not, but have other plans that discuss efforts to help residents with disabilities. As these plans resemble the Olmstead plans, we treat them as equivalent. Five states had not submitted a plan, official or not, all of which have been or are in litigation over their apparent noncompliance with Olmstead.

This section covers the housing-related activities the forty-five states, with Olmstead (or similar) plans, have identified. We look at the kinds of housing assistance covered; the populations and disabilities targeted; and the federal, state, and local programs to be used in states’ plans.

We developed a rubric to assess various aspects of each plan, including the following:

- overall length (pages);
- year of completion and revision;
- duration;
- geographic scope;
- numeric goals with regard to housing for people with disabilities; the types of disabilities targeted by the plan (e.g., intellectual/developmental, Alzheimer’s Disease); or other specific populations targeted (e.g., people who are elderly, veterans, homeless, or institutional residents);
- mention of housing and related subsidy programs (e.g., Section 811, Low-Income Housing Tax Credits, Medicaid); and
- types of housing programs and services covered (e.g., rent subsidies, supportive services).

Some states prepared their Olmstead plans quickly; others have yet to do so. States submitted their initial Olmstead plans between 2000 and 2013. The mean year of submission is 2004. Thirteen states (30% of those with submitted plans) made at least one revision to their plans; two (Colorado and Delaware) have filed two or more revisions. The year of revision ranges from 2003 to 2014, but most were submitted after 2011.

The plans vary widely in time frames, level of detail, and length. The time periods covered vary from a single year (usually updated annually) to twenty years, with a mean of five years. Twelve states (27%) do not specify any duration. In terms of page length, admittedly a crude measure of their complexity and detail, the plans vary from just two pages (Kentucky) to 176 (Alaska), with a mean of forty-nine pages. The plans for eight states (18%) are less than ten pages long.
Only fourteen (31%) of the forty-five plans specify a numeric goal for the number of individuals with disabilities the state aims to assist. These goals vary widely, from five hundred persons to nearly two million. However, the time frame to achieve these goals also varies widely, from one year to twenty years, to an unlimited period. When annualized (we treat plans that do not specify a duration as operating over twenty years), the goals vary from 150 individuals a year to 320,000. The median annual target for the fourteen states that provide numeric goals is 475. The states with the most ambitious targets include Georgia (320,000 annually), New Jersey (190,000), Massachusetts (130,000), and Maryland (55,800). The states with the lowest annual numeric targets include North Carolina (150), Hawaii (260), and Washington (three hundred). However, Washington’s target may be low because it has already moved a higher share than nationally of people needing long-term care out of institutions (32%) and onto HCBS (68%) (Eiken et al. 2017). Only eight states (18%) offer specific goals about housing (although housing is mentioned elsewhere by others).

All of the forty-five states with Olmstead Plans fund supportive services to help residents with disabilities live in the community. Ten states (22%) fund supportive services only. Thirty-four states (76%) also provide some form of housing subsidy for residents with disabilities. In addition, thirty-nine states (or 87%) provide training or technical assistance to housing providers; twenty-eight states (or 62%) are developing databases of available and appropriate units.

Focusing on the thirty-four states that provide housing subsidies, twenty-one (47% of those with state plans) help residents with disabilities cover their housing costs and subsidize the development and/or acquisition of new housing for them. Nine states (20%) only provide rental subsidies; four (9%) only subsidize the development or acquisition of new housing. In addition, fifteen states (33%) provide some form of assistance for people with disabilities seeking to purchase homes or remain in one they own (see Table 4).

**Targeted populations and disabilities.** The Olmstead plans refer to a variety of population groups and disabilities. While some refer to their targeted populations in general terms, such as “people with physical and developmental disabilities,” others designate specific populations and disabilities for intervention. Figure 1 shows the groups that Olmstead plans target. Not surprisingly, given that the primary object of the Olmstead decision is to foster deinstitutionalization, all of the forty-five states with plans emphasize individuals leaving mental hospitals, nursing homes, and other institutions. About half (twenty-one) of the plans also seek to serve individuals who have never been institutionalized. Thirty-seven (82%) of the plans refer to the elderly and twenty-eight (62%) to elderly persons who are disabled. Thirty-one plans (69%) target low-income individuals, but just as many also serve higher income people with disabilities. Nineteen plans (42%) include provisions to help people who are homeless or those at risk of homelessness. Two plans (4%) target veterans with disabilities. Although these other groups—for example, the elderly, the homeless—may also include people with disabilities, we are especially interested here in plans that specifically mention disability.

In terms of disabilities, the plans on average refer to 2.5 broadly defined conditions. The most frequently cited disabilities include developmental disabilities (forty-two, or 93%, of the plans), mental illness (twenty-nine or 64%), physical disabilities (twenty-seven or 60%), HIV/AIDS (seven or 16%), and traumatic brain injury (seven or 16%). Four states (9%) referred to people with Alzheimer’s or other forms of dementia; four states (9%) singled out autism spectrum disorders and other behavioral issues. People with intellectual disabilities were highlighted in four plans (9%) as well (see Figure 2).

**Subsidy programs.** The states rely on federal, state, and local resources to fund their housing initiatives for people with disabilities. Figure 3 shows the subsidy programs cited in the Olmstead plans. They include project-based Section 8 (cited by nineteen states or 42% of those with plans), Housing Choice Vouchers (seventeen or 38%), Medicaid (sixteen or 36%), Section 811 for persons with Disabilities (fourteen or 31%), Community Development Block Grants (ten or 22%), the Low Income Housing Tax Credit (seven or 16%), and HOME Partnerships Investment Block Grants (five or 11%).

Although Medicaid is primarily known as a medical and long-term-care assistance program for individuals with low incomes, it can be used to help people with disabilities access supportive or other community-based housing. The Olmstead plans refer most frequently to two Medicaid programs: Real Choice Systems Change and Money Follows the Person. Importantly, however, Medicaid cannot be used as a rent subsidy; it funds supportive housing services (e.g., helping clients understand the rental process) and institutional “infrastructure” to promote community integration.

Twenty (45%) of the forty-five states refer to state or local funding sources to implement their housing goals. Four states (9%) (Indiana, Missouri, New Jersey, and Ohio) draw from state housing trust funds, even though forty-seven states currently operate such funds (Schwartz 2014). In sum, the plans suggest that states have focused more on helping people with disabilities learn about and access existing housing subsidy programs than on devising new programs or giving people with disabilities preference in allocating available subsidies.

Our analysis of the Olmstead plans, in many ways, mirrors earlier analyses, in that progress is uneven (several states still have no plan), and while about one-third of the plans contain numerical goals and timelines, most do not. Most states focus first on reducing their institutional populations with disabilities—not surprising given the issue litigated in Olmstead. No states planned to create new subsidy programs for people with disabilities or to increase funding for existing...
Table 4. Housing Assistance Provided by States in Olmstead or Related Plans.

<table>
<thead>
<tr>
<th>Housing Assistance Programs</th>
<th>No. of states</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>None (Services Only)</td>
<td>10</td>
<td>AZ, AK, HI, MN, NE, MS, TN, UT, WA, WY</td>
</tr>
<tr>
<td>Tenant-Based &amp; Project-Based Subsidies</td>
<td>21</td>
<td>AK, CA, CO, DE, IL, IN, MA, MI, MN, NC, ND, OK, OR, PA, VA, NV, NH, NJ, NY, OH, VT, WI, MD</td>
</tr>
<tr>
<td>Tenant-Based Subsidies Only</td>
<td>9</td>
<td>AL, GA, IA, KY, MO, ME, NC, ND, OH</td>
</tr>
<tr>
<td>Project-Based Subsidies Only</td>
<td>4</td>
<td>AL, CO, IL, IN</td>
</tr>
<tr>
<td>Home-Ownership Assistance</td>
<td>15</td>
<td>ME, MN, MO, MN, NH, NY, OH, VT, WI, MD</td>
</tr>
</tbody>
</table>

Figure 1. Populations targeted in Olmsted and related plans.
programs. Thus, the lack of support for affordable housing in general appears to be holding progress back—a point noted in earlier evaluations of Olmstead plans.

Analysis of State Consolidated Housing and Community Development Plans

As Olmstead plans are not required to be updated regularly, we also looked at state Consolidated Housing and Community Development plans (ConPlans) for indication of more recent progress in meeting the housing needs of people with disabilities. HUD requires states to produce a five-year plan for utilizing funds from several federal block grant programs. These ConPlans are implemented through annual action plans. The ConPlans prioritize each state’s upcoming housing and community development needs, which give insight into the extent to which the needs of people with disabilities have been incorporated. State ConPlans cover only nonmetropolitan areas that are not entitled to receive formula allocations of federal funds.

Figure 2. Disabilities targeted in Olmstead and related plans.

Figure 3. Housing-related subsidies cited in Olmstead and related plans.

Note: ESG = Emergency Solutions Grants; USDA = United States Department of Agriculture.
themselves (U.S. HUD 2016). Even so, state plans should indicate overall state priorities regarding people with disabilities and should, therefore, mirror what is in their Olmstead plans. We collected the most recent state ConPlans, available on the Internet as of June 2016.

State agencies prepare ConPlans based on a template provided by HUD that requires information on the need for affordable housing by residents with low incomes who are homeless, characteristics of the homeless population, characteristics of the housing market in the state, fair housing goals and obstacles, and a five-year strategic plan to guide future use of federal block grant funds. States must also assess the housing needs of special needs residents who are “not homeless but require supportive housing [which] includes” the elderly; the frail elderly (requiring assistance with daily tasks); people with drug additions, HIV/AIDS, and mental, physical, or developmental disabilities; and people who have experienced domestic violence and other categories identified by a state (e.g., farmworkers, veterans). We developed a rubric for analyzing these plans that looked at

- the types of special needs populations included in various sections of the plans (i.e., in the needs assessment, current programs, and priority future needs sections),
- the types of housing programs and services planned for these populations.

State awareness of people with disabilities. In 2000, the Technical Assistance Collaborative policy group urged housing and disability activists to raise awareness about the needs of people with disabilities by ensuring that accurate data were used by state housing agencies (Miller, Milstein, and O’Hara 2000). Some progress since then has been made. Today, we found that thirty-five states (70% of the total) included fairly comprehensive needs statements on the size and needs of their populations with disabilities in their most recent ConPlans. Mississippi, for example, in the section on the special needs populations, provides data on the size and needs of people who are elderly; who have disabilities, HIV/AIDS, or addictions; and who have experienced domestic violence. Regarding people with disabilities, Mississippi’s 2015–2019 ConPlan states,

Data from the 2013 Five-Year American Community Survey for Mississippi showed a total population of persons with disabilities of 419,994 in non-entitlement areas, with an overall disability rate of 16.5 percent. (State of Mississippi [MS] 2016, 88)

The data are disaggregated by age, gender, and type of disability. Furthermore, the ConPlan states,

The Housing and Community Development Survey also asked participants to rank the need for services and facilities for persons with disabilities. The results . . . indicate a strong need for housing for both persons with physical and developmental disabilities. (MS 2016, 89)

On the contrary, some states (30%) have yet to notice this population. Missouri, for instance, in response to the same question on special needs residents, provides only data on its HIV/AIDS residents. In another section asking the state to estimate the number of people with disabilities or domestic violence experience needing housing assistance, Missouri provided no response (State of Missouri n.d., 19). Oklahoma’s answer to this prompt was the following:

This information is not available at this time. The state is drafting a Request for Proposals for a new Statewide Housing Needs Assessment, which upon completion should provide this information. (State of Oklahoma 2014, 26)

Current programs to serve people with disabilities. When asked about current programs and services for their special needs residents, thirty states (60%) listed specific programs, facilities, and services that are available to people with disabilities. Delaware, for example, lists the five long-term care facilities in the state that serve those with developmental and intellectual disabilities, as well as mental health, substance abuse, or other serious health issues. It goes on to state the following:

With increasing attention at both the national and state levels on compliance with the Americans with Disabilities Act and the Olmstead Supreme Court decision of 1999, housing and service providers in Delaware have been shifting dramatically away from institution-based care toward supportive housing options in community-based settings. DHSS has been the main driving force behind this shift, chiefly by partnering with DSHA and with private and nonprofit housing service providers to offer service enhanced housing to DHSS clients: the housing provider will administer tenant-based or project-based rental assistance, while DHSS or one of its contractors offers wraparound supports and services to ensure the client’s continued success living independently in the community . . . . (State of Delaware [DE] n.d., 71)

Both these indicators—state responses on demographic data for people with disabilities and programs enacted to serve them—suggest that a majority of state housing agencies have a clear picture of the size, needs, and existing programs to serve people with disabilities.

Future need priorities. To assess what states plan to do to address the housing needs of people with disabilities, we looked at their priorities for the upcoming five years, as well as specific plans for the upcoming year. About one-quarter to more than one-third of states indicated disability-targeted plans. However, it is difficult to identify the leading states, as some focused on people with disabilities in their long-term plans but ignored them in projects for the next year, or vice versa.
The section, SP-25 Priority Needs, covers states’ five-year priorities. States must list each priority need and goal area they have for spending their ConPlan-designated federal funding, describe the proposed action or program to meet the need, and specify the population that is targeted. State plans list a wide range in the total number of needs/goals mentioned—from one (Wyoming) to fifty-six (Pennsylvania). The average set of distinct needs to be covered by the ConPlans for each state is about nine.

States must also list the groups each need targets. Counting the various groups mentioned by all states under their priority need areas, we see that people who are elderly are most likely to be targeted (of all 481 separate priority needs areas all the states listed, 206 or 43% of the total, targeted people who are elderly). States targeted those with HIV/AIDS in 159, or 33% of the total needs, and people who are homeless (140 needs) and with addictions (141) next, at 29% of all needs. People with disabilities come in fifth (in 132 or 27% of all needs). Of these 132 needs areas, 37 percent represent proposals to preserve or develop affordable rental housing for those with disabilities, 12 percent for housing services (including rent assistance), 11 percent for rehab or purchase assistance to homeowners, and another 11 percent for developing emergency shelters or transitional housing for people with disabilities who are also homeless. Other proposals (e.g., for fair housing programming targeting people with disabilities) are also listed, but by much fewer states.

For each needs statement, states list one or many constituency groups to target. Counting any of the categories for people with disabilities (mental, physical, or developmental), eight states (16% of all fifty states) do not mention them at all in this section. By contrast, twenty-nine states (58%) list people with disabilities for various needs statements, but target them along with a long list of other special needs populations (e.g., elderly, domestic abuse survivors, people with HIV/AIDS, the homeless, etc.). Thus, any one of the constituencies can use the program—there is no guarantee that people with disabilities will be served.

On the contrary, some states target those with disabilities alone as the population to be served by the proposed new program in a needs statement. Ten percent of all states (five) are proposing new programs for this group separately. Another eight states (16%) propose new programs for people with disabilities but may also include one other special needs group (often the elderly) in the needs statement. Therefore, added together, 26 percent of all states propose programs that serve people with disabilities exclusively or almost so. This quarter of states seems to show more commitment to serving the housing needs of people with disabilities.

Another way we assessed states’ seriousness in serving people with disabilities was to look at what they proposed to do for the next year specifically. Twenty-two states (44% of all states) mentioned the word “disability” or “the ADA” in this section. Of these, however, only eighteen (36%) included any details, indicating they had substantial plans to serve people with disabilities soon. These details offered a clearer picture of what states are doing for people with disabilities.

For example, four states mentioned they received Section 811 federal funding to subsidize apartment rentals for this constituency. Arizona explained,

ADOH partnered with the Arizona Department of Economic Security (ADES), Arizona Department of Health Services (ADHS) and the Arizona Health Care Cost Containment System (AHCCCS) to apply for 811 PRA funds. ADOH was awarded and will eventually receive $2.95 million which will be utilized to provide monthly rental subsidy payments for up to fifty-four (54) individuals with developmental disabilities and their families. Eligible participants will live in rental units developed through Low-Income Housing Tax Credit Program or other multi-family financing available through ADOH. (State of Arizona n.d., 81)

A few states mentioned that new programs were to be implemented to achieve progress in their Olmstead plans. Minnesota, for example, said that it is

in the process of implementing its Olmstead Plan . . . As part of this plan, the State’s housing programs are implementing a comprehensive strategy to ensure people with disabilities have choices about where they live, with whom, and in what type of housing. (State of Minnesota 2016, 83)

Some states focused specifically on housing accessibility. For instance, Massachusetts wrote,

Working with the Executive Office of Health and Human Services (EOHHS), the DHCD has been involved in . . . efforts to increase housing opportunities and quality of life for persons with disabilities. In its work with EOHHS, its commissions, and various advocacy groups, DHCD has identified potential design approaches in new construction, adaptive re-use, and preservation projects . . . These include the application of the principles of universal design and visitability. The Department will work with the development community during 2015 to implement these approaches. (Commonwealth of Massachusetts n.d., 74)

Delaware described a plan for a technical solution to move people with disabilities into the mainstream housing market:

As part of the implementation of the Section 811 PRA Demo Program, DSHA has partnered with the nonprofit technology firm Socialserve.com to develop an online referral system for program applicants. The Prescreening, Assessment, Intake and Referral (PAIR) Service will conduct a basic eligibility check of applicant information . . . The PAIR Service will interface with DelawareHousingSearch.org, the online housing locator supported by a DSHA-led collaboration of public and nonprofit partners. Participating property managers will update information about anticipated
and real vacancies, and the PAIR Referral List Manager will refer applicants to units as they become available.

The longer-term goal for the PAIR Service is to incorporate other housing resources as separate “modules,” particularly SRAP [vouchers] and the mandatory 5% of LIHTC units that will be set aside for special populations. A shared application system will help move Delaware towards a system where people with disabilities can simply apply for housing instead of individual programs. (DE n.d., 77)

From this assessment, which states are leading in housing provision for adults with disabilities? This proved difficult to determine. The two indicators of a disability focus—five-year priorities and next year plans—do not show a consistent pattern. Of the twenty-two states mentioning “disability” in their next year plans, only three have also created separate priority need areas for this population. These states—Delaware, Pennsylvania, and Virginia—also have Olmstead or related plans. Accordingly, one might conclude that these are leaders in disability-related housing. Similarly, four states did not indicate programs for people with disabilities anywhere in their five-year or next year plans—Alabama, Kansas, Maine, and Michigan (Kansas also lacks an Olmstead Plan). One might conclude these states lag in this effort.

Conclusion

The ConPlan priorities bear similarities with those in the Olmstead plans—the elderly is the top priority in both. However, whereas states rank those with HIV/AIDS high in importance under the ConPlans, they rank them less important in Olmstead plans. States prioritize those with physical and developmental disabilities lower in their ConPlans than they do in their Olmstead plans. Furthermore, neither the Olmstead plans nor ConPlans recognize the pending housing need that occurs when people with disabilities out-live their family members. That is, states are not developing plans for helping the bulk of people with disabilities stay in the community when family members cannot care for them.

Our analyses of state Olmstead and Consolidated Plans also show that while most states have become more aware of the housing needs of their citizens with disabilities, less than half are doing something about it. In the ConPlans, a majority (about two-thirds) of states identified the size and needs of their population with disabilities. But fewer than that (36% at most) proposed new programs or services in the coming years to cover them. Nevertheless, these states are forging ahead, using ConPlan and other funding sources to make progress. Scholars should investigate these leaders in greater detail.

In addition, our analysis of the Olmstead plans found slow progress toward the goal of integrating people with disabilities into community settings. These plans were also mostly vague and often without numerical benchmarks to determine progress (only one-third had such targets). None of the states planned to develop new subsidy programs for people with disabilities or to increase funding of existing programs. These findings mirror prior analyses of Olmstead plans (Christensen and Byrne 2015; Fox-Grage, Coleman, and Folkemer 2004; Harkin 2013; Musumeci and Claypool 2014; NDRN 2009; Ng, Wong, and Harrington 2013, 2014; O’Hara and Day 2001; Priaulx 2015). In addition, few, if any, plans address the need to find new community-based housing options for people with disabilities who currently reside with aging parents.

Even so, scholars and practitioners indicate a growing national crisis in meeting the housing needs of people with disabilities. Certainly, this slow progress in the face of escalating needs is due, in part, to the recent recession, which hurt state governmental coffers. Potential cuts in Medicaid under the Trump administration budget and health care plans, if enacted, will worsen state budgets further as the federal portion of Medicaid will be lowered (Paradise 2017). Also, people with disabilities must compete for scarce federal resources for affordable housing with other vulnerable populations (e.g., people with low incomes, those who are homeless). Of course, these other populations include people with disabilities—but also those without—so this competition between groups still exists. Perhaps, however, progress has not been sufficiently stimulated due to the relatively weak crossover between scholars and practitioners from the two fields who focus on services for people with disabilities (e.g., disability specialists, social workers) versus those focusing on housing policy. This split was reflected in the fact that planning and housing agencies were late to recognize how Olmstead impacted future housing needs. More communication between these specialties could bring greater scholarly and political pressure to bear in solving these needs.

Some work has been done by planners and housers on case examples of effective housing models (see, for example, Arienti and Sloane 2013; Smith 2010; Walker and Seasons 2002). More could be done examining which governmental levels seem to be more successful at forging ahead with these issues. For example, an examination of metropolitan ConPlans would give information about what is happening at the local level. This might show what extent information about lower level successes is funneled up to state actors overseeing the Olmstead planning process. Planners and housers could also continue tracking Olmstead and ConPlans as to how well housing needs for people with disabilities are being met. It would also be useful to document how local governments and other actors financially accommodate declining federal resources for supports and services and housing stock improvements.

People with disabilities constitute a large and growing segment of the U.S. population. Addressing their housing needs so that they can live their lives in the community ought to be a priority for the planning profession. Merely helping increase the overall production of new housing units will help ease this housing crisis. But planners can help in other
ways (e.g., developing financing and design models for families who provide their own group homes). At a recent meeting of parents with adult children with disabilities that one of us attended, several local officials acknowledged that government provision of housing for people with disabilities was underfunded; they urged parents to “think outside of the box.” Creative planners can help with this task.

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Notes
1. We searched journals abstracts for keywords from 2000 to the present, using Proquest Research Library database or journal publishers’ archives.
3. For example, the American Journal of Intellectual and Developmental Disabilities published 446 articles on people with disabilities during this time period, but only two on housing. The Journal of Disability Policy Studies published slightly more in housing (ten).
4. Other data sources yield different estimates of disability prevalence, depending on definition and/or sampling frame. The U.S. Survey of Income Program Participation (SIPP), for example, estimates that 18.7 percent of the civilian noninstitutionalized population had at least one disability in 2010, and 12.6 percent had a severe disability (Braut 2012).
5. Periodic studies report the progress of deinstitutionalization in different states (e.g., Lakin et al. 2004; Prouty, Coucouvanis, and Lakin 2005; Smith et al. 2011).
6. Some federal programs have attempted to assuage this shortfall such as Real Choice Systems grants (time-limited grants given to states between 2001 and 2010), Medicaid’s Money Follows the Person (MFP) Program (2005 to 2016), and the Affordable Care Act (2010). These offered states funding or incentives to update their antiquated supports and services systems and increase the use of Home and Community Based Services (HCBS) (Lerner and Pollack 2015; Mann 2012; Peebles and Kehn 2014; Reaves and Musumeci 2015).
8. Defined as having at least a minimum set of structural features like zero-step entrances (Bo’sher et al. 2015).
9. U.S. Department of Housing and Urban Development (HUD) defines this as being housing cost burdened; it expects housing to cost only 30 percent of household income.
10. Specifically, 47 percent of all renters earning up to 50 percent of their area’s median family income pay at least half of their income on rent (HUD 2017).
11. The year 2012 was the last year public housing authorities were surveyed about their waiting lists.
12. As defined by HUD, these are people whose incomes are 30 percent or lower than the area median income.
13. Truven Health Analytics has tracked state Olmstead progress by comparing expenditures for institutional versus home-based services (see, for example, Eiken et al. 2017). Spending on HCBS surpassed that for institutional services for the first time in 2013 for the country as a whole (Ng et al. 2016).
15. Florida, Idaho, Kansas, New Mexico, and South Dakota.
16. Available from the authors.
17. We asked seven states to define “developmental disability.” All of them referred to the definition stated by the ADA, which is as follows: “a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all the impairments that are covered” (U.S. Department of Justice, Civil Rights Division, Disability Rights Section 2009).
18. Medicaid’s Real Choice Systems Change grants assist states and other eligible organizations develop institutional infrastructure to help seniors and people with disabilities live in integrated community settings. Congress has appropriated more than $245 for the program since it began in fiscal 2001. However, these funds are not used to provide housing subsidies; they are meant to help states improve services for community integration of the elderly and disabled and for training, recruitment, and retention of direct service workers (Shirk 2007; see also Kehn and Lipson 2014). Congress established Medicaid’s MFP demonstration program to help state Medicaid programs in transitioning Medicaid beneficiaries out of institutions into a greater choice of community-based settings. By mid-2013, forty-five states had MFP grants, with forty-one states having active programs (Orshan et al. 2013). However, MFP funds are no longer available. States worry that this will force them to discontinue their housing services (Watts, Reaves, and Musumeci 2015).
19. These funds include the Community Development Block Grant Program (CDBG), the HOME Investment Partnerships Program, the Emergency Solutions Grants Program (ESG), and the Housing Opportunities for Persons with AIDS Program (HOPWA).
20. Cities and other jurisdictions that receive federal housing and community development block grants are required to submit their own Consolidated Plans (ConPlans) to HUD.
21. The years that five-year state ConPlans cover vary: thirty-six states’ plans covered 2015–2019, five from 2013–2017, three from 2014–2018, one (Minnesota) from 2012–2016 (its next five-year plan was also consulted), and five states covered 2016–2020.
22. We especially compared state responses from these sections: NA-45 Non-Homeless Special Needs Assessment, MA-35 Special Needs Facilities and Services, and SP-25 Priority Needs.
23. States target each priority need area to one group (e.g., people with disabilities) or to many or all of the special needs populations simultaneously.
25. In one statement proposing more affordable housing in California, the populations served include “the low income, large families, families with children, elderly, rural, chronic
homelessness, individuals, mentally ill, chronic substance abuse, veterans, persons with HIV/AIDS, victims of domestic violence, unaccompanied youth, frail elderly, persons with mental disabilities, persons with physical disabilities, persons with developmental disabilities, persons with alcohol or other addictions” (State of California n.d., 43).

26. States had to answer this question in their ConPlans: Specify the activities that the jurisdiction plans to undertake during the next year to address the housing and supportive services needs identified in accordance with 91.215(e) with respect to persons who are not homeless but have other special needs. Link to one-year goals.

References


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