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Ending Homelessness among Mentally Disabled People

Steven A. Hitov

This article examines some of the many shortcomings of the mental health system operated by the Massachusetts Department of Mental Health (DMH) and explores the impact of that system on single homeless individuals who suffer from some form of serious or long-term mental disability. To afford that discussion context, however, the article first briefly examines those forces which have, and have not, significantly contributed to the large number of mentally disabled homeless persons. It suggests certain changes, including a shift in departmental focus from hospitals to community services and the creation of a housing subsidy system exclusively for DMH clients, which would allow DMH to end its current practice of at best ignoring, and at worst actually causing, the homelessness of mentally disabled people.

The Deinstitutionalization Mythology

When discussing the disproportionate¹ presence of mental illness among individuals who are currently homeless, one is often encouraged to address the relation between that phenomenon and the process of state mental hospital deinstitutionalization that has been under way for approximately thirty years. This is not a useful undertaking for several reasons. First, it assumes that there is somehow a significant causal relationship between the two. At least for Massachusetts, this is demonstrably incorrect. A study of homeless adults done for the state Department of Mental Health (DMH) determined that the "average" such person was thirty-eight years old, and that just about half the population was under age thirty-five.² While DMH has reduced its inpatient population from 20,000 in 1960 to just over 2,000 today,³ over half of that decrease was accomplished by 1970. Further, the people discharged during that period had typically been institutionalized for years at a time. Thus, they could not, as a group, represent the currently homeless unless DMH hospitalized and discharged them when they were veritable children. Otherwise they would now simply be too old to yield the profile revealed by the DMH study. Whatever their fate, those who were discharged and neglected twenty-five years ago do not constitute a significant percentage of today's homeless.

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A second shortcoming of focusing on deinstitutionalization is its suggestion that homelessness among those who suffer from a mental disability is somehow a medical rather than a social problem, one that has presumably resulted from prematurely discontinued treatment. At best this entices one and, as we shall see, has led DMH to focus on varying forms of "treatment," rather than housing, as a potential solution. At worst, it suggests that reinstitutionalization may be a viable response to homelessness. The data on this topic simply do not support such a conclusion. In separate studies conducted in Massachusetts, New York, and Ohio, researchers determined that while approximately 30 percent of the homeless people they interviewed had major mental health problems and most of them needed *some* mental health services, only 5 percent to 7 percent would even benefit from, much less require, inpatient care to meet their needs.⁴ Unless we as a society are willing to forcibly hospitalize vast numbers of people who do not require such care in order to "capture" the relatively few who might, reinstitutionalization cannot possibly be viewed as a rational response to the problem of homelessness among those with mental disabilities. This is particularly true when one considers that the current average cost of maintaining a person in an institution in Massachusetts ranges between \$126,000 and \$178,000 per year.⁵ Even people who are so frustrated with the persistence of homelessness that they might otherwise be tempted by this "out-of-sight-out-of-mind" approach must rethink their position or be willing to shoulder enormous tax increases in support of their viewpoint.

Unfortunately, the focus on deinstitutionalization is not merely a benign mistake. It serves both to misdirect one's attention when searching for solutions, and also, intentionally or otherwise, to obfuscate the fact that the current crisis of homelessness is the direct and predictable result of more than a decade of government policies aimed at dismantling the very structures that formerly allowed large numbers of desperately poor people to maintain a home. While the correlation between the Reagan administration's attack on public and subsidized housing⁶ and the current rise in homelessness is now widely recognized as a true social disaster, it is one that predictably had a disproportionate impact on poor people with mental handicaps, who regularly lose out when competing with others for increasingly scarce housing resources.

Compounding the woes of this already embattled group was the less well-known attack that Ronald Reagan waged specifically against them. Between 1981 and 1983, the Social Security Administration arbitrarily terminated the Supplemental Security Income and Social Security Disability benefits of approximately 50,000 people who suffered from mental disabilities.⁷ While subsequent lawsuits were successful in having benefits restored to two thirds of those who had been terminated, that still left almost 17,000 people with mental disabilities without what was almost certainly their only source of income. It is the stuff of fantasy to assume that large numbers of these people did not become homeless as a result of having that income abruptly terminated.

In addition, it is almost certain that significant numbers of those who ultimately had their benefits restored were nonetheless rendered homeless, given that landlords are neither required nor inclined to forgo collecting rent while tenants are busy disputing the actions of the federal government. Once housing is lost, the restoration of benefits often does little to help an individual regain a place to live, for the front-end costs of acquiring housing (first month's rent, security deposit, finder's fee, and moving expenses) are almost always beyond the ability of a poor person to pay.

Thus, deinstitutionalization in fact has had little to do with the current general epidemic of homelessness among the mentally disabled. When the federal government

decides to wage a war on the poor, it should come as no surprise that the most vulnerable among those living in poverty will be disproportionately affected. Given that the Reagan administration's economic smart bombs were specifically targeted upon affordable housing and people with mental disabilities, it would indeed be a minor miracle if the mentally ill were not overrepresented among the single homeless.

DMH's Inside-Out Service System

While it is incorrect to focus on deinstitutionalization as *the* cause of homelessness, it is nonetheless important to recognize that the mental health system operated by DMH does regularly contribute to homelessness among the mentally ill, both directly and indirectly. As this part of the article will demonstrate, the "medical model" of service delivery utilized by DMH has largely been, when viewed either economically or as a matter of social policy, a failure for everyone except the professionals who staff it, and has proved especially ineffective in addressing the mental health needs of the homeless.

The current system has historically, conceptually, and financially always started with hospitals, and only then, almost as an afterthought, considered other options for allowing people with mental health problems to continue or resume functioning as contributing citizens in their communities. The results of such a hospital-centered, doctor-driven approach are, as a matter of resource allocation, quite appalling. DMH is currently expending 42 percent of its resources (over \$192 million) on inpatient care, which serves only 6 percent of its clients.⁸ As of May 1991, more than 500 of 2,156 inpatients⁹ were being detained solely because DMH had not located or developed sufficient community placements for them.¹⁰ So, in addition to spending enormous amounts of money on a tiny fraction of its clients, DMH is expending almost 25 percent of that sum — more than \$45 million — on people who, it admits, do not require, and almost certainly do not desire, such care.

Unfortunately, the misallocation of resources is not the only, or even necessarily the most egregious, cost of the DMH service delivery system. The hospital-centered medical model views life in the community as a privilege to be earned by those who have required hospitalization. All DMH inpatients, regardless of their condition, start with enforced confinement¹¹ on a locked ward — sometimes in seclusion — and then proceed to earn the "privilege" (so described by the DMH Inpatient Policy Manual) of increased freedom. Initially a person may be given permission to go to unlocked parts of the facility, then onto the grounds, and ultimately to visit the community. At all times, however, even this limited freedom is subject to the person's willingness and ability to comply with all of a facility's rules, no matter how petty or seemingly unrelated to treatment. Independence, either of thought or action, is not a characteristic highly valued, or wisely exhibited, within a DMH facility. The inpatient system is so control oriented that, regardless of treatment needs, facilities have been known to discharge people directly to the streets or to shelters, even in the dead of winter, because of perceived violations of "program" rules (such as taking legal, but unprescribed, medications). In short, the inpatient system is one in which clients are afforded only rudimentary rights and client choice has little or no meaningful role.

If one then views community placements, as DMH does, as a person's "next step" following an inpatient experience like that just described, it is not surprising that DMH has chosen to develop "programs," rather than housing, for those seeking to

return to the community. Of the approximately 3,255¹² people now being served in DMH residential settings, probably fewer than 100 are residing in DMH's most touted independent living initiative, apartments administered by the Massachusetts Housing Finance Agency (MHFA) to which DMH and the Department of Mental Retardation have negotiated access.¹³ The vast majority of people who count on DMH for residence in the community are living not in houses but in programs.

Programs differ from housing in several critical respects, both in human and financial/development terms. First and foremost, programs reflect the medical model mentality that perceives people with mental disabilities as perpetual patients, with the resultant infantilization that so often accompanies that status. Additionally, or perhaps merely as an example of that infantilization, programs often require unrelated adults to share not only their housing, but even their bedrooms. Nearly 65 percent of the settings for DMH residential services are located in buildings in which only other DMH clients live.¹⁴ In nearly a third of those settings, people are forced to share their bedrooms with someone not of their choosing.¹⁵ This is not how most adults choose to live, and even DMH recognizes that it is often clinically dysfunctional.¹⁶ Groups of eight unrelated adults simply do not often choose to live together. Indeed, the skyrocketing national divorce rate suggests that more and more groups of two are experiencing difficulty in achieving this feat.

Nonetheless, communal living is exactly what DMH demands of most of its clients in residential programs. The stress of such an environment is compounded by the fact that a person must conform not only to the norms of general tenancy, but also to any treatment requirements that DMH decides accompany the program. In this way, programs perpetuate the control and compliance regimes of the inpatient facilities. Should someone decide that he does not like or no longer needs the type of treatment that is being offered in a given program, he is faced not only with the loss of services but with the specter of imminent homelessness.¹⁷ This is hardly an environment in which one is likely to question the services being rendered. As a result, consumer choice and input, and ultimately the quality of any services offered, are also victims of the current DMH system.

At the opposite end of the human experience spectrum, but of equal importance, is the situation in which a person is quite happy with a given program and therefore flourishes in it. Such a scenario suggests a happy ending, but that is not always the case. A person who has come to consider a program of a given intensity level to be home, and thrives there, risks being removed from her home exactly because she is doing so well. The "better" she does, the greater the chance that she will have to move to a lower intensity program so that someone else can benefit from the program she found to be so rewarding. While from a medical perspective the person might be expected to be joyous about her perceived improvement, from a human perspective she is more likely to be distraught at the prospect of losing perhaps the first true home she has known. Perversely, this possibility builds in an incentive for a person not to do too well if she indeed likes her situation. Thus, even an apparently "successful" program may prove in the long run to be injurious.

Human costs are not the only ones associated with a system that assumes it must provide residential programs in order to return people to the community. While it now appears that, as a result of the Governor's Special Commission inquiry, Massachusetts has finally decided to address the abysmal condition — both finances and quality of care¹⁸ — of its public inpatient psychiatric facilities, that undertaking is

being made more difficult by the method of community service delivery utilized by DMH. The commission has called for the creation of 700 additional community placements by the end of June 1993 to accommodate current inpatients¹⁹ who do not now or will not by then need inpatient care. This initiative is part of an overall plan to reduce the inpatient capacity of state facilities while, it is hoped, improving, but at a minimum not reducing, the quality of care currently being provided to anyone.

The commission has identified two major problems in accomplishing the creation of the additional community placements. Both, as it turns out, are problems that exist solely because of the limited approach to community care employed by DMH. First, because so many of DMH's present and projected residential settings are program oriented and congregate in nature, they require substantial lead time, and money, just to acquire and develop the property in which they operate. Consequently, the ability to respond even to anticipated need is quite limited. The financial and logistical ability to accommodate unanticipated demand is nonexistent. This reality has led DMH to perceive that it is caught in a chicken-and-egg situation in which it recognizes that it can save money by discontinuing unnecessary inpatient care, but cannot afford to do so because it lacks the finances and properties necessary to provide more appropriate and cheaper, but by no means inexpensive,²⁰ care in the community.²¹ Thus, the entire system is constantly backed up by the difficulty of developing programs of varying intensity levels necessary to respond to ever-changing client need.

Unfortunately, as the commission report also recognizes, the problems for the typical DMH community residential program do not end when the money has been found to finance it. Because the programs so often create congregations of DMH clients, the now familiar NIMBY (not-in-my-back-yard) syndrome regularly rears its provincial head. Neighborhoods and even whole cities all too frequently attempt to erect barriers to the siting of community residences. While the law is increasingly clear that such efforts are illegal, defeating them and winning over a neighborhood is both difficult and time-consuming work. Moreover, it is work that often turns what should be a very private affair, namely, a person's desired choice of residence, into a public, if not a political, debate. This process only exacerbates the already lengthy delays inherent in developing necessary community resources.²²

The inability of the current community residential system to respond on an "as needed" basis has a disproportionate negative impact on homeless individuals with mental disabilities, many of whom are "pink-papered," that is, forcibly admitted pursuant to M.G.L. c. 123, §12, to DMH inpatient facilities following acute psychiatric episodes on the street. Such individuals definitionally enter the facilities in need of housing as well as acute care, but their inpatient stays are often quite short, varying in length from overnight to one or two weeks. While, as a matter of law, people admitted pursuant to Section 12 are entitled to an individual service plan (ISP) designed to assess and address both their medical and social needs,²³ in practice ISPs are almost never afforded to such short-term inpatients. As a consequence, the homeless mentally disabled receive virtually no assistance even in applying for the public benefit programs for which they may be eligible before they are again discharged.

Further, because of the chronic shortage of community placements and the inherent difficulty of creating and siting new ones of the type now most often utilized, it should come as no surprise that DMH maintains lengthy waiting lists for such placements and is reluctant at best to insert a more recently admitted inpatient at the top of such a list simply because he happens to have absolutely nowhere to live. As a

result, homeless individuals who have been pink-papered to DMH facilities are regularly discharged by those facilities right back to the street or to a singles shelter, where they must sleep in crowded, open barracks with numerous other equally poor and otherwise troubled people and walk the streets from dawn to dusk each day while the shelters are closed. As one might easily predict, many of those so discharged quickly wind up back in the facility, often in worse condition than upon their initial admission. This practice is so pervasive, and so inherently clinically inappropriate, that in the past year, following two years of ultimately fruitless negotiations, two separate lawsuits seeking to curtail it have been filed against DMH.²⁴

The present system constantly undermines independence by demanding and rewarding compliance, in the guise of teaching personal responsibility, and enforces that demand by tying it directly to the provision of housing. It is a system that is both enormously expensive and wasteful, at least partly because it continues to elevate the perceived need for treatment above the obvious need for food and housing. In short, it is a system in need of a total overhaul if it is ever to achieve the national goal, set forth in the recently enacted Americans with Disabilities Act,²⁵ of integrating as many disabled citizens as possible, as fully as possible, back into the community.

Providing Housing with Desired Supports

As the Governor's Special Commission has determined, the entire DMH delivery system must be revamped if it is ever to operate effectively and efficiently. Many of the reforms suggested in the commission report are worthy of careful consideration and likely to lead to more humane service. Certainly the general thrust of the report, that citizens with mental disabilities are both better and more efficiently served in their community, is one that should be embraced as a matter of public policy, but in any event will soon have to be adopted as a matter of law.²⁶ Nonetheless, despite its considerable merits, the commission report's approach to actually providing community residential options can best be described as "do more of the same." As noted above, such an approach, if not doomed to failure, is at least so cumbersome that it is probably politically impossible to sustain the will to accomplish it. More important, it would merely perpetuate, although relocate, the segregation and disempowerment of the mentally disabled. Hence, at a time when Massachusetts is finally taking a hard look at its mental health system, it is critical that it start down the road toward a delivery model that will actually work.

The cornerstone of a functional community mental health system must be stable housing that is not conditioned on a person's willingness to participate in treatment. Only in this way can DMH overcome its addiction to the medical model that has been such a dismal failure at realizing community care. The separation of housing from treatment will foster the very independence that DMH purports to desire, as it will for the first time allow services to be consumer driven. When not faced with the Hobson's choice of accepting all offered services in order to be housed or rejecting those services and facing homelessness, people will clearly indicate which services they find helpful by utilizing those which are and rejecting those which are not.

This is not to say that persuasion should be forsaken as an option, or that people should not be made aware of the possible adverse consequences of any given course of conduct. However, it will force such persuasion to be just that, and not coercion. Such an approach, in turn, will offer DMH planners useful guidance in future pro-

gram development and offer private not-for-profit providers a market incentive to be responsive to the perceived needs and preferences of their consumers. In short, citizens with mental disabilities will actually have a meaningful voice in meeting their needs.

If housing is to be the foundation of the community mental health system, how is it best provided? The answer to this question must take into consideration the problems that the mentally disabled have traditionally experienced in gaining access to housing. DMH has realized since at least 1985 that part of the cause of homelessness among those with mental disabilities is that such people regularly lose out when competing with other groups for any scarce resource, especially housing.²⁷ Therefore, any housing assistance provided in conjunction with a true community mental health system must be targeted and reserved exclusively for the mentally disabled.²⁸ Further, it must be designed to afford the target population the greatest choice possible, in order to redress the past and present proclivity of society (and DMH) to segregate those with mental health problems. Next, it must be reasonably plentiful, so that DMH can eliminate the dual shameful practices of unnecessarily detaining those who do not require inpatient care and discharging vulnerable people directly to the streets or to overcrowded and devitalizing shelters. Finally, but of paramount importance if the system is to address the issue of homelessness among the mentally handicapped, the housing must be affordable. Market-rate apartments in Massachusetts Housing Finance Agency developments are no answer for this population.

Fortunately, an option exists that would meet all the above criteria. Rather than attempting to "develop" either residential milieus or even housing, DMH should immediately implement a housing subsidy program funded, if necessary, entirely with current mental health dollars. The program would operate much like the federal Section 8 Existing Housing program, which requires a person to pay no more than 30 percent of his or her income toward a predetermined fair market rent (FMR) for existing private housing in the community, and then pays the landlord the difference between the tenant's share and the FMR. The program would be available only to those eligible to receive services from DMH who lack an appropriate, affordable place to call home. If financially necessary, it could be further limited to DMH's priority population, those with a serious or long-term mental impairment. Thus, a finite population eligible for such a housing benefit²⁹ would not be competing with the general population to acquire it.

Included in the eligible population, whether defined broadly or narrowly, would always be those who have been admitted as inpatients at a DMH facility. This, in conjunction with the housing search and other ISP services discussed below, should completely eliminate both the long waiting lists for placement and the discharge of homeless people to the streets or shelters. Few have claimed that there is a shortage of housing in this country, only that there is a critical shortage of affordable housing. By operating its own subsidy program, DMH would gain for its clients ready access to the existing private housing market, which, especially when the rental market is soft, is only too eager to rent to those whose rent payments are government guaranteed. Because the subsidies would be mobile and travel with the mentally disabled, the program would also accomplish community integration to the maximum extent possible while achieving the generally accepted programmatic benefit of having service dollars follow the beneficiary, not the provider.

Finally, the subsidy must not be tied to the acceptance of treatment or services of any kind. Rather, it would be available to any DMH (priority) client who lacked a suitable place to live. While clients might reasonably be required to listen to what other services existed, they would be entirely free to reject them all and accept only the housing subsidy.

Among the services available must be knowledgeable and flexible assistance in searching for habitable housing. While such a service would assist people to find housing, it would not decide which housing a person would choose or with whom, if anybody, the person should live. It would be fine for two or more people to choose to live together, but such a living arrangement would never be forced on anyone. The Massachusetts experience with housing search workers employed by the Department of Public Welfare (DPW) to help homeless families locate qualifying apartments is quite instructive regarding the value of this kind of assistance, as is the method utilized within the Homelessness Unit of Greater Boston Legal Services (GBLS). Before the recent softening of the housing market, only about 50 percent of the unassisted families with Section 8 certificates were successful in renting an apartment before their certificates expired.³⁰ In contrast, over 90 percent of the families who had housing search workers assigned by DPW were able to rent within the same time frame. This discrepancy in results reflects the irrational and labyrinthine nature of the country's affordable housing system and demonstrates graphically that it takes professional help for almost anyone to negotiate it successfully.

While citizens with mental disabilities, taken as a group, may be more difficult to house than poor families,³¹ I, in my job assignment to break down the legal barriers facing homeless mentally disabled people, have so far failed to house only one of the clients who have sought assistance from GBLS in the past two years. Once GBLS is successful in acquiring a housing subsidy for a client, it assigns a student intern from the Boston University School of Social Work to work with that person to locate a qualifying apartment owned by a landlord willing to participate in the program. Like interns in a law office, the students can offer their opinions to clients, but ultimately it is the clients' wishes that control. If a client chooses to make a "bad" decision, that is his or her right. In fact, our clients have made very few such decisions (at least in my opinion) and have proved to be every bit as diligent and creative in their housing search as one might expect from a person afforded the possibility of access to a decent, affordable home for perhaps the first time in his or her life.

Nonetheless, the social work students play a valuable role in the process. First, they provide a nonjudgmental companion with whom the homeless disabled person can share any anxieties that he may be experiencing in the search process. They also provide a "professional" presence when the client interviews for a particular apartment, thus overcoming or easing the unfounded fears that a landlord may have about dealing with a mentally disabled person. Finally, the students are willing "to do what it takes"³² to ensure a successful result. So far, this category has included such endeavors as helping a client acquire and move furniture on a Saturday, purchasing two telephones (one was stolen on the client's last night in a singles shelter) so that he would not feel isolated in the new apartment, and arranging to have a broken television repaired to provide a client with entertainment and company. This is exactly the sort of hands-on approach that is sometimes necessary and that DMH must be willing to provide.

Again, the mechanism exists to do the sort of housing search to ensure that the proposed DMH subsidy system will work. DMH employs large numbers — although

never enough — of case managers, who are supposed to help plan an inpatient's smooth return to the community. While case management is another DMH service that has suffered at the altar of hospital worship, it must and can be revived to serve citizens in the community. A good start in this direction would be to employ ex-patients as case managers and assistants to case managers. They would bring a wealth of experience and understanding to the job and, predictably, be more willing "to do what it takes," nonjudgmentally, to help a person avoid what is often the horror of institutionalization. As one New York consumer case manager ironically explained, his employment has allowed him to look back on his twenty years of institutionalization not simply as a maddening waste of his life, but also as on-the-job training for his new endeavors.³³ Employing ex-patients for this purpose can only benefit everyone involved.

Whatever the source or background of case managers, there must be many more of them and they must be trained, at a minimum, to do housing search and public benefits applications for people who desire those services. It is a veritable crime that so many obviously disabled homeless individuals pass through DMH facilities without anybody's assisting them to acquire the Supplemental Security Income (SSI) and Social Security Disability (SSDI) benefits to which they are almost certainly entitled. Locating homeless individuals and getting them to apply for assistance are two of the major hurdles in maximizing their income. In addition, an application for either SSI or SSDI requires substantial medical documentation.

Thus, it is absurd that when DMH is holding such a person in a hospital, it makes no effort to see that the person receives these federal benefits. Instead, homeless people are disgorged as they enter, often with either no income at all or the lesser, but entirely state paid, stipend available from General Relief. Therefore both the individual and the state are worse off financially because of DMH's current practices. Case managers and other DMH employees who learn nothing but housing search and income maximization will have gone a long way toward increasing the stability of life in the community for many citizens with mental disabilities.

Once DMH has, as part of its mission and *raison d'être*, provided affordable housing, facilitated access to public benefit programs, and offered employment to those who need and desire such assistance, it can begin to offer other, treatment-oriented services to assist clients to maintain and enjoy their place in the community. As previously noted, these services, by becoming consumer driven, will be more likely to exhibit the flexibility necessary to accommodate the individual needs and preferences of the people they are designed to serve.

What then is wrong with this seemingly wonderful system? The answer, in short, is nothing. The two concerns most often raised by those wed to the medical model of control and compliance are that the system is viable only for the less impaired and that it would be too expensive to implement. Neither claim is supported by the available data or by experience in other states that closely resemble Massachusetts in size and nature.

In 1989, the Center for Community Change through Housing and Support conducted a national survey of 378 supported housing programs.³⁴ It evaluated programs using criteria that included basing housing on people's choices, using integrated regular housing, providing flexible supports, not imposing program requirements, and maintaining housing during periods of crisis or hospitalization. In other words, it sought and found programs operated pursuant to the approaches described in this article. The survey discovered that individuals served in supported housing settings

tended to be more, not less, disabled than those served in more traditional residential programs. Because the system is premised on stable, varied housing options buttressed by flexible service supports, the severity of the handicap that can be accommodated is limited only by the creativity of those providing support.

Nor would a model premised on the provision of a housing subsidy to each DMH client who lacked a home cost any more than the current system. Indeed, it could operate much more effectively than the present system for less money than is now being spent.³⁵ A single person can be subsidized in his or her own apartment in Massachusetts for no more than \$5,000 per year, or just over \$400 per month.³⁶ This is an incredible bargain when one considers that the cost, largely underwritten by state and municipal governments, of maintaining a person in a singles shelter is more than \$30 per night, or almost \$1,000 per month. For the cost of inappropriately sheltering each mentally disabled person, DMH could affordably and, even with absolutely no services, more appropriately house two of them.

DMH and the city of Boston statistics indicate that, statewide, somewhere between 500 and 2,500 people who are "on the street" might need and qualify for the subsidy proposed here. Even using a worst-case scenario, each of those people could be housed for a total annual cost of no more than \$12 million. If one then factored in the 500 people being detained solely because DMH lacks a more appropriate place for them, the total annual cost of housing all those DMH clients who needed it would be \$15 million. As we have seen, DMH acknowledges that it is currently spending three times that amount annually just to detain inappropriately the latter group of 500 people.

The short-term savings are compelling, as is the flexibility such a system affords. Since a subsidy is simply money, it entails no development time. So DMH could accommodate fluctuations in demand for the most difficult component of community care, space, without either lengthy delays in times of increased demand or vacant buildings when demand wanes. Further, but of critical importance, the existing private housing would be dispersed throughout the community, thereby avoiding the siting problems incurred by more concentrated housing arrangements and best serving the national goal of maximum integration. Necessary and desired services and supports would then be supplied where the client lived, rather than the client being made to live where those services are available, but not necessarily desired. The system would benefit the disabled and other community members alike. Even those DMH clients who continued to require long-term inpatient care would benefit by hospitals of a more manageable size with a staff better able to pay attention to each individual's needs.

However, a DMH subsidy program would most dramatically benefit the "homeless mentally ill." The medical model looks at this group and sees mentally disabled people who happen to be homeless. Starting from this perspective it attempts to "cure," or at least control, the illness, and refuses to or has no professional interest in housing those for whom treatment proves unavailing. A true community model of care based on affordable housing would view the same group as homeless people who happen to have a mental disability. Even, or perhaps especially, if their homelessness is caused by or related to their mental disabilities,³⁷ it makes absolutely no sense, either medically or socially, to ignore the symptom — homelessness — because the infirmity cannot be corrected. A similar approach with regard to a physical disability would have doctors refusing to prescribe painkillers for a person with a chronically bad back because they could not, or the patient would not let them, diagnose or cure

the cause of the pain. Each of these approaches is equally absurd, but only the former is practiced.

DMH should provide a subsidy to each of its clients who requires one in order to avoid homelessness, whether or not the person is interested in any of the other services that the agency may have to offer. This is exactly the approach, taken in Ohio and New York, which is getting rave reviews from the mental health professionals responsible for administering the programs.³⁸ Indeed, exhibiting a rationality rarely demonstrated by a bureaucracy, New York has included such assistance as a furniture grant and an emergency needs fund to ensure that those it discharges from its inpatient facilities do not end up both mentally disabled and homeless. The essential point is that even if the former condition is considered a given, the latter need not be.

Equipped with the proper perspective, a targeted subsidy program and flexible supports, DMH could end homelessness among the mentally disabled population of the commonwealth almost immediately. Further, it could do so without spending any more, and perhaps less, money than it now does. At a time when its delivery system is being reexamined anyhow, DMH should jettison its reliance on a medical model that has arguably contributed to, but unarguably failed to address, the problem of homelessness among those with mental disabilities. By adopting a subsidy system just for its clients, with services developed to address their expressed needs, DMH would provide better care, integrate and empower the disabled as the law will soon require, and perhaps most important, end homelessness among that portion of the commonwealth's population for which the Department of Mental Health is legally responsible. ♪

Notes

1. For health planning purposes it is generally assumed that approximately one percent of the overall population suffers from some form of serious or long-term mental illness. The best available data concerning the single homeless suggests that roughly 30 percent of that population has serious mental health problems. See note 4 and accompanying text.
2. See Virginia Mulkern, *Homelessness Needs Assessment Study: Findings and Recommendations for the Massachusetts Department of Mental Health* (1985), ii. Hereafter cited as *Homelessness Needs Assessment*.
3. Boston Emergency Shelter Commission, *Commitment and Compassion* (Winter 1990–1991): p. 10.
4. See Mulkern, *Homelessness Needs Assessment*, and *Access*, a publication of the National Resource Center on Homelessness and Mental Illness, 3, citing studies by Roth et al. in Ohio (1985) and Struening in New York (1986).
5. *Actions for Quality Care*, Report of the Governor's Special Commission on Consolidation of Health and Human Services Institutional Facilities, Executive Summary, June 1991, 8. Hereafter cited as *Commission Report*.
6. Between 1980 and 1988, the federal budget authority for needed low-income housing dropped from \$27.9 billion to \$9.7 billion. *The Closing Door*, National Coalition for the Homeless, December 1990.
7. See Sarah Glazer, *The Mentally III*, in *Editorial Research Reports*, February 13, 1987, 72.
8. *Commission Report*, 3.

9. *DMH Comprehensive Mental Health Service Plan, Edition 4.0*, May 1991, 117. Hereafter cited as *Comprehensive Plan*.
10. *Commission Report*, 3.
11. While, pursuant to M.G.L. c. 123 (1988), Massachusetts, in theory has both voluntary (section 10) and involuntary (sections 7, 8, 11, and 12) inpatients, it is the practice of DMH facilities not to accept voluntary patients. Thus, a person is either brought to a facility against his or her will and admitted and retained pursuant to sections 7, 8, and 12, or voluntarily seeks treatment and is admitted pursuant to section 11, on a "conditional voluntary" basis. Under section 11, a person who is unsatisfied with the care is not free to leave, but rather must give the facility three days' written notice of the intention to leave. During this period, the facility may petition a court to have the person committed pursuant to sections 7 and 8. Since the court hearing need not be, and most often is not, scheduled for fourteen days after the DMH request, a person who enters a facility "voluntarily" can be forced to remain for up to seventeen days against his or her will without an opportunity for impartial review.
12. *Commission Report*, 3.
13. *Ibid.*, 33. This arrangement has resulted in a total of fewer than 140 apartments being occupied by clients of DMH and DMR. Fewer than 25 of those apartments are subsidized, which, given the substantial market rents charged by MHFA developments, means that the vast majority of independent-living situations being provided by DMH are going to its wealthier clients. MHFA market-rent apartments are not a financially viable option for the homeless, even if they could get accepted for occupancy at such developments. See note 22.
14. *Comprehensive Plan*, 119.
15. *Ibid.*
16. *Ibid.*
17. As a further reflection of the fact that such programs are not really housing in any meaningful sense, DMH, and unfortunately some courts, take the position that people living in DMH residential settings are not entitled to the protection of Massachusetts landlord-tenant law before they can be removed from a program.
18. Only one of DMH's fifteen adult inpatient facilities has been able to meet the HCFA/JCAHO minimum standards for accreditation. *Commission Report*, 5, 6.
19. It must be stressed that these placements will serve only current inpatients. The approximately 4,000 community placements that will exist after adding these 700 new ones will meet only one third of DMH's perceived overall need. *Commission Report*, 28.
20. The cost of community placements ranges between \$30,000 and \$70,000 per person per year, with an average cost of \$55,000. *Commission Report*, 29.
21. *Comprehensive Plan*, 114-15.
22. Even DMH's major effort to arrange truly independent, albeit expensive, living situations, that is, the agreement with MHFA for access to 3 percent of its units built since 1979, is not as expeditious as it may appear to be. The final decision regarding whether to accept a person as a tenant rests with the management of the MHFA development, not with DMH. While DMH often attempts to facilitate acceptance, MHFA developments are, in my experience and that of others who attempt to house the homeless, among the most demanding and least flexible in their tenant selection practices. This fact has two negative effects. First, it induces DMH to seek to house only its "most worthy" (read compliant) clients. Second, the extensive verifications required by the developments again slow down the process of housing those who need a place to stay.
23. Pursuant to 104 C.M.R. section 16.03(2)(c), anyone admitted to a DMH inpatient facility under M.G.L. c. 123, sections 10, 11, or 12 "shall be eligible for . . . an ISP." The goals of the ISP process are set forth at 104 C.M.R. section 16.01(2).

24. *Williams et al. v. Forsberg et al.*, Civ. No. 91-3835E (Superior Ct., Suffolk Co.), and *J.S. and D.M. v. Weld et al.*, Civ. No. 90-7275F (Superior Ct., Suffolk Co.). In the *Williams* case, the plaintiffs claim that DMH's discharge practices constitute the ongoing common law tort of negligent discharge, and that, based on that and several other statutory and constitutional theories, DMH should be ordered to provide the type of subsidy program suggested later in this article.
25. Americans with Disabilities Act of 1990 (ADA), P.L. 101-336, 104 Stat. 327, July 26, 1990. Section 2(a)(8) of the Act provides that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." People with mental disabilities are specifically included in the coverage of the act by section 3(2)(A).
26. The ADA sections that govern the provision of government services, including mental health services, took effect on January 27, 1992. The legislative history of the act makes it clear that Congress intends services to be provided in the most integrated setting possible, even if doing so is either logistically or financially less convenient for the provider. H.R. Rep. No. 485(III), 101st Cong., 2d Sess. 50 (1990).
27. *Homelessness Needs Assessment*, Executive Summary, 130.
28. While the housing assistance provided by DMH must be reserved exclusively for the mentally disabled, the actual housing acquired with that assistance should to the greatest extent possible be in normal, integrated settings open to all members of the general public.
29. Since DMH and its doctors believe themselves capable of defining and recognizing mental illness, a major problem in operating a general housing program is thereby overcome. In seeking to assist the general homeless population through various housing initiatives, Massachusetts has felt constrained to develop elaborate and often bizarre definitions of the "worthy" homeless in order to protect itself from what it believes would otherwise be an epidemic of voluntarily induced homelessness endured solely to gain access to affordable housing. It is highly unlikely that, even for the substantial benefit of affordable housing, someone would voluntarily seek the stigma still associated with mental illness. Even a person who might do so would presumably not be able to fool a DMH doctor. Hence, quality control should not be a significant problem in the proposed program. See note 19 for DMH's estimate of the maximum number of people who might qualify for such a program.
30. In the Section 8 program, a certificate is valid for no more than four months. If a person is unable to find a qualifying apartment within that period, the person's right to a subsidy expires and the certificate is given to the next person on the waiting list. There would be no purpose for such a time limit in the program run by DMH. Unlike the Section 8 program, the number of eligible people is relatively small and a subsidy would be offered to everyone who needed one. Thus, there would be no need to pass the subsidy along if it were not converted into an apartment within a fixed period of time.
31. While the barriers to housing the mentally disabled are all too well known, the routes around or through those barriers are a relatively well-kept secret. For example, most people, including many DMH case managers and a significant number of local housing authorities, do not realize or acknowledge that mentally disabled persons are eligible for so-called elderly housing developments or categorically eligible for almost all federal subsidies. Nor is it widely recognized that the superficially neutral determination of whether an applicant is "capable of independent living" is in fact an illegal and therefore impermissible inquiry into the nature and extent of a person's disability. While the list of legal solutions to acquiring housing for the disabled is too lengthy to be catalogued here, the point is that housing search workers can be trained to recognize illegal procedures and respond to them. Once they have mastered the field, they will become familiar with housing opportunities for the disabled that are not necessarily available to other members of the general public.
32. To borrow a phrase from the Vermont Center for Community Change through Housing and Support, a pioneering organization in the sorts of solutions suggested in this article.
33. Statement of Dick Gelman, Bronx, New York, May 29, 1991, at the Ninth National CSP Learning Community Conference in Washington, D.C.

34. See a newsletter of the center, *In Community*, 1, no. 1, (June 1991): 6.
35. Exactly how much the proposed model would cost in the long run is largely an unknown, because the calculus depends on many policy decisions that would be made along the way concerning the nature and quality of supports. The center study discussed in the text found that as the severity of the impairments being accommodated increased, so did the cost of providing such accommodation. This model could be made to cost as much as the one now used by DMH, but it would provide more complete and effective services. The center therefore suggests that the supported model may not always be less expensive, but it will never be more expensive for any given level of care. In all cases, moreover, because of the underlying human assumptions of the model, it will provide *better* care for each dollar expended.
36. The median FMR for a studio apartment in Massachusetts is \$465, while that for a one bedroom is \$561. Representing DMH's maximum liability per person, this would almost always be reduced by one or both of the following factors. First, the tenant would contribute 30 percent of his or her income toward the cost of the apartment. If the person were receiving, for example, SSI at the current rate of \$520 per month, the tenant share of approximately \$160 per month would reduce the cost to DMH, even based on the full median FMR, to \$400 per month. However, especially in a soft market, apartments are almost always available for less than the FMR in any particular area. While the 1990 one-bedroom FMR for Medford, a city within five miles of Boston, was \$739, the actual average rent of all the Section 8 one-bedroom apartments administered by the Medford Housing Authority that year was just under \$510 per month. When the predictable tenant share is deducted from this figure, the cost to DMH is even less than that cited in the text.
37. Judging from late 1991 newspaper articles and so-called think pieces, it is becoming increasingly popular to blame the homeless for their condition. Presumably this phenomenon reflects the traditionally short attention span and low frustration threshold of the American public, which, after unsuccessfully throwing very little money and even less thought at a problem, is more than willing to blame a victim for his or her own fate. The in-vogue argument along these lines points to the mentally disabled homeless and suggests that those who think the problem is housing "just don't get it." In fact, the problem *is* housing, or at least affordable housing, which is an enormously scarce resource. While a person's mental disability may help explain why she in particular is homeless if she has been asked to compete in the open market for that resource, it is no indication that she cannot live in a community if reasonable accommodation is made for his or her handicap. A subsidized housing program exclusively for those with mental disabilities is just such an accommodation.
38. Statements of Grace Lewis, state housing coordinator, Ohio DMH, and Robert Myers, director of local operations and community capital, New York Office of Mental Health, delivered May 30, 1991, at the Ninth National CSP Learning Community Conference in Washington, D.C.