New England Journal of Public Policy

Volume 8
Issue 1 *Special Issue on Homelessness: New England and Beyond*

Article 24

3-23-1992

Housing, Community Support, and Homelessness: Emerging Policy in Mental Health Systems

Paul J. Carling
University of Vermont

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Emerging Policy in Mental Health Systems

Paul J. Carling, Ph.D.

This article summarizes the dramatic changes in public policy through which public mental health systems are attempting to meet the housing and community support needs of persons with severe and persistent mental illnesses, including those who are homeless. It traces the historical approach to meeting these needs through defining people principally as patients and providing some combination of psychotropic medications, outpatient therapy, and structured, supervised quasi-institutional settings such as group homes, shelters, and segregated single-room-occupancy, or board-and-care facilities. A transition phase in public policy has emphasized defining these individuals essentially as service recipients who need greater or lesser amounts of community support services to avoid institutionalization. This policy focus, while less institutionally oriented than past policies, did little to alter the kinds of housing approaches planned for them. An emerging set of values and policies, which represents a paradigm shift in the field, now focuses on these persons first as people and as citizens, with rights, responsibilities, and needs like those of all citizens. Implications of this new set of policies for mental health systems are discussed.

This article summarizes emerging trends in providing individuals with serious and persistent mental illnesses, including those who are homeless, with decent, safe, and affordable housing, along with the supports they need to participate fully in the lives of America's communities. Meeting these needs is a significant public policy challenge, one which has been the subject of considerable debate, as well as what appears to be a somewhat surprising policy consensus in recent years. On the one hand, the literature describes the "failure of deinstitutionalization" and the need for "asylum,"[1] the national crisis of homelessness,[2] the low quality of community and hospital programs in mental health,[3] and the orientation toward "maintenance" rather than rehabilitation[4] in most public mental health service systems. Although mental health policies stress the need for community support systems,[5] most resources are still used for institutional programs,[6] and the broad implementation of "model" community support programs appears to be a rare phenomenon.[7] The literature also includes debates about the lack of attention to consumers' rights.[8]

Paul J. Carling, who teaches courses in public mental health systems and psychiatric rehabilitation at University of Vermont, Department of Psychology, is executive director, Center for Community Change through Housing and Support, Burlington.

On the other hand, we also find significant attention paid in the literature to the development of more effective community support services,[9] acknowledgement of the importance of consumer empowerment,[10] more responsive and respectful clinical interventions,[11] and a clearer emphasis on meeting basic needs for homes, jobs, and friends, which all citizens share.[12]

Considering these dramatically conflicting views, it has been suggested that the field is in the midst of a "paradigm shift." Ridgway and Zipple summarize the major dimensions of this shift as a home (not residential treatment settings); choice (not placement); normal roles (not a patient or client role); client control (not staff control); social integration (not grouping by disability); in vivo learning in permanent settings (not transitional preparatory settings); individualized flexible services and supports (not standardized levels of service); and a focus on the most facilitative environments, and on long term supports (rather than on the least restrictive environment, and "independence").[13]

The implications of this paradigm shift for public policy have been described by Carling[14] as representing a fundamental change in assumptions about the people that systems serve, from an era of institutional and facility-based thinking that characterized people essentially as "patients," to a "transitional" period in which people were seen principally as "service recipients" needing a primarily professional support system,[15] to a world view in which people are seen as "citizens" with a potential for, and a right to, full community participation and integration.[16] In this respect, it is interesting to note the parallel evolution of public mental health policy in Canada, in which the case is the major policy thrust — rather than being focused on "community support systems," as in the United States — emphasizing a "framework of supports,"[17] in which it is assumed that people should be primarily sustained through self-help and peer support, then draw on "folk" or "natural" support systems, such as friends, family, neighbors, and coworkers, then on such generic community services as common social outlets, generic health care, and so forth, and *only then* on the professional mental health system. That system's purpose is *not* to be the primary treater or intervenor, but the force which bolsters the other support networks, so that reliance on professional interventions is either minimally necessary or significantly reduced over time.

It is clear that the field of public mental health is in the midst of a major rethinking of the nature, characteristics, and needs of the people it serves and the roles and responsibilities that derive from dramatically different ways of thinking about its "customers." To answer critical questions about whether such a process of rethinking is likely to effect major changes in public policy nationally, to facilitate the restructuring of federal, state, and local programs designed to meet the needs of these individuals, and, most important, lead to observable changes in the life opportunities for these persons, however, it is important to understand the evolution of these changing policies.

During the early years of press attention, the public perception of homelessness, as well as federal, state, and local policies, focused on people with a mental illness who are homeless, seemed to assume that these persons represented a distinct subgroup whose characteristics and needs were fundamentally different from those of other people with serious and persistent mental illnesses or of citizens in general who carried no label.[18] Such policies and programmatic responses were fueled by the public perception linking homelessness and mental illness into one amorphous group of "strange" or "marginal" people. In this context, it is clear why the predominant response of federal, state, and local government, as well as of mental health professionals, has once again been a focus

on treatment in specialized settings. Alternative approaches are possible, of course, but until recently, few systems seemed prepared to tackle what, for mental health policymakers, has seemed an overwhelming issue: the lack of affordable housing and limited availability of high quality, flexible, and attractive community support services.

In fact, there is considerable evidence that the apparent link between homelessness and mental illness is much more complicated. A high proportion of people with mental illness have never been hospitalized;[19] it is extremely difficult to ascertain the effects of homelessness, as contrasted with those of mental illness, on the human psyche; many people with serious mental illness appear to be "episodically homeless," moving in and out of a condition of homelessness, often linked to the availability of income or the use of mental health residential programs or hospitals; and the use of widely differing definitions of homelessness, including some that categorize all individuals in psychiatric hospitals or residential programs as "at risk of homelessness" has become increasingly problematic.[20]

Do people with mental illness who are homeless systematically differ from those with mental illness who have a home? There are few studies where people with mental illness live. A broad range of studies[21] on where people with this label *want* to live, however, reveals a high level of transience and residential instability.

This article assumes that there are no fundamental differences between people with mental illnesses in general and those who, at a given time, happen to be homeless. There are, to be certain, particular service approaches that appear to be more relevant to people who are homeless while they are being served, but at least at present, there does not appear to be any substantial evidence that the fundamental needs of these individuals differ in any significant ways from those of others who are served in public mental health systems.

Background and Scope of the Problem

Since the late 1950s, this country has significantly reduced public hospital use and expanded community services.[22] A focus on stable housing linked to supports, however, has emerged only in the last ten years.[23] Although research has been relatively scant in this area, major public policy studies have concluded that a majority of the 1.7 to 2.4 million Americans considered "long term mentally ill" based on diagnosis, disability, and duration of disorder[24] live in inadequate housing, lack needed supports, or are homeless.[25] The problem is complex: without active rehabilitation, many persons lack the skills and supports necessary for successful community living. The recurring nature of psychiatric disabilities may also result in the loss of housing with repeated hospitalizations.[26] Housing discrimination is rampant, as landlords refuse to rent to these individuals.[27] Most people with psychiatric disabilities are poor, with average annual incomes from $3,000 to $7,000, and unemployment rates as high as 85 percent.[28] A recent national study of the extent to which individuals on a Supplemental Security Income (SSI), the most typical income source for individuals served by public mental health systems,[29] concluded that *there is not a single county* in the United States where these individuals can afford either an efficiency or one-bedroom apartment, using the federal Department of Housing and Urban Development's (HUD) standard of affordability. This lack of income, coupled with the stigma and public rejection associated with mental illness, appears to represent the major barrier that people who are homeless and mentally ill face in their quest for decent housing.

Failure of public mental health systems to focus on decent and stable housing means that as many as one third of inpatients remain in psychiatric hospitals unnecessarily.[30] Others cycle through emergency rooms and general hospitals in costly and often inappropriate stays.[31] Others are "placed" in "custodial" nursing and boarding homes, which lack rehabilitation or treatment, contribute to declines in functioning, and are often exploitative.[32] The lack of stable housing and support substantially burdens families,[33] who serve as case managers and landlords with little or no support. Those who do find housing often live in very low-income neighborhoods with substandard dwellings and high crime rates. "Oversaturation" of these neighborhoods by people with disabilities often leads to community backlash.[34] An increasing number are homeless: studies reported that as few as 10 percent and as many as 75 percent of people who are homeless have severe psychiatric disabilities[35] although they have not necessarily used mental hospitals.[36] Finally, these individuals compete for housing with other low-income groups, most of whom are generally viewed as more suitable tenants.

As public outrage about homelessness has grown, along with the public perception linking most or all homeless people with deinstitutionalization, and given traditional role definitions for mental health and traditional assumptions about the incapacities of "mental patients," many mental health systems have, at least initially, remained passive as a whole new industry of service providers began developing alternative "facilities" for this new "special population" of people with mental illness, such as shelters and segregated single-room-occupancy hotels.[37]

The Affordable Housing Crisis

The housing problems faced by people served by public mental health systems are compounded by dramatic changes in the current housing scene, where a decade-long decline in affordable housing stock, and the rising cost of housing in relation to income, reduce access to decent housing for *all* people with limited incomes. Home ownership is out of reach of the middle class, as is decent housing, for most people at or below the poverty level. These trends have included a cut of nearly 80 percent in federally assisted housing for low-income and special-needs groups since 1981, and a dramatic increase in homelessness in all parts of the country.[38]

Because disabilities can be economically catastrophic, people with disabilities are disproportionately represented among the "very poor" — those with 20 percent of median income — and even lack access to "affordable housing" programs, which typically require 50 percent to 80 percent of median income. Paradoxically, since access to affordable housing has become a national crisis, the public's support for increased federal and state spending and taxation for this purpose is at an all-time high.[39] Thus, even as federal housing programs were being cut in 1988, Congress was drafting sweeping new affordable housing legislation to reverse these trends,[40] as well as new disability-related legislation. Passage of the National Affordable Housing Act, the Fair Housing Amendments Act, and the Americans with Disabilities Act all represent a major set of opportunities to introduce innovative strategies for more successful community integration to the public agenda through a focus on housing.

Mental Health's Response

Historically, the mental health field has considered housing a social welfare problem and defined its role as "treatment." The public housing field, reflecting societal stigma, contends that mental health consumers need "specialized residential programs," for which mental health is responsible.[41] Housing needs are ignored: residential services typically produce treatment facilities, not housing. Transitional halfway houses "proliferated in the 1960s. In the 1970s, the concept of a "residential continuum" emerged, including "quarterway" and "halfway houses";[42] "three-quarterway houses";[43] "family foster care";[44] "crisis alternative models";[45] "Fairweather Lodges";[46] "apartment programs";[47] "boarding homes";[48] "nursing homes";[49] and "homeless shelters".[50] These programs have typically been segregated, professionally staffed, and congregate in nature.[51]

The Current State of Practice

A national survey of over twenty-five hundred community residential programs in all states serving adults with psychiatric disabilities[52] found that a relatively small number of agencies actually provide these services in most states. In spite of the continuum model, few agencies offer more than one option. Most programs were large congregate facilities, accounting for fewer than a quarter of the settings but most of the residents. Newer supervised apartment programs use larger numbers of standard-size households, an approach more consistent with "normalization" principles.[53] Intermediate care facilities, nursing homes, and shelters had few formal ties with mental health services. Transitional housing, with time limits, was not as common as expected. Most programs provided long-term services. Residential services, although assumed to be "intensive," are staffed primarily by paraprofessionals who have not been trained in the traditional mental health care disciplines. Follow-up services were essentially informal, suggesting that efforts to assist clients to find and maintain stable housing may be relatively weak. Sixty thousand individuals received services from these residential programs. Extrapolating that figure to the survey universe, the authors concluded that, nationally, fewer than 5 percent of people with psychiatric disabilities live in such settings.[54] This is consistent with state estimates that between 2 percent and 5 percent of people with psychiatric disabilities are served in residential programs.[55] Individuals served were primarily young adults with diagnoses of major mental disorders. Using a functional rating scale, over half the programs served persons with moderate to severe disabilities. The rest served people who were either gravely disabled or functional; surprisingly, these programs served *twice* as many persons who were functional as they did those who were gravely disabled. This finding contradicts the popular notion that residential programs serve those with the most severe disabilities and raises serious concerns as to whether such scarce resources should be serving so many persons who are functioning relatively well.

Evaluation of Residential Program Approaches

Our knowledge about "what works" in residential programs is hampered by both methodological and conceptual problems. Few evaluations of community residential

services have been rigorous enough for conclusions to be drawn.[56] Also, since the goals of community programs are rarely well defined, most outcome evaluations have been conceptually flawed. The most frequent evaluation question is whether community programs are more successful than institutional treatment in helping persons achieve more independent living. In six major reviews covering several hundred "alternatives to hospitalization," only a handful of studies met basic criteria of experimental design.[57] Taken as a whole, these studies indicate that community-based treatment is virtually always as effective as or more effective than hospital-based treatment in helping people with psychiatric disabilities achieve employment outcomes, gain reentry into the community, and reduce the use of medication and outpatient services. Apparently, any of a wide range of community services can assist in achieving some measure of community integration.

With regard to residential programs, Cometa, Morrison, and Ziskoven,[58] reviewing a total of 109 studies, concluded that evidence of the effectiveness of transitional halfway houses in reducing recidivism and improving economic self-sufficiency and community adjustment was "highly suspect." So transitional residential programs may in fact be preferable to institutional care, but according to this review, they fall considerably short of helping people achieve lasting housing or community integration.

Perhaps the most intriguing findings in this area came from an extensive study of sheltered care environments conducted by Segal and Aviram[59] and a review by Tabor,[60] which indicated that characteristics of the *community* are more important than characteristics of *residents* in predicting the degree to which people actually participate in community life, while specific characteristics of the facility were the least important factor. These studies suggest that outcome research should be reframed to focus on where people live and how they spend their time, rather than only on the interventions that professionals provide. There have been few rigorous evaluations of specific residential programs, and even fewer attempts to examine professionals' success in helping people get and keep normal housing. Lack of information on program effectiveness is a critical deficit, which can result in grossly inefficient use of resources and, most important, seriously curtailed opportunities for people with psychiatric disabilities, particularly those who are homeless.

Problems with Traditional Approaches

It is clear from the literature on residential services and on the emergence of new models, that residential programs do not, per se, meet housing needs. In fact, serious questions have been raised about confusing residential treatment and housing, or assuming that people who are institutionalized or homeless need such programs prior to "independent living."[61] The growing acceptance of a rehabilitation approach[62] demystifies acquiring stable housing by defining it as a process of building critical skills and supports to "choose," "get," and "keep" the housing one desires. A range of research and training activities undertaken by the Center for Community Change (CCC) at the University of Vermont, partly in collaboration with Boston University's Center for Psychiatric Rehabilitation, has revealed significant dissatisfaction among consumers, their families, and service providers with the concept of a "residential continuum" and with the "transitional services" model. In a summary, Carling and Ridgway[63] criticize the notion that "transitional" stays in residential settings is a simplistic approach to "independent living," which creates major difficulties for the indi-

vidual including: (1) having to learn skills that are mostly relevant to group living; (2) chronic dislocation through successive moves, since improvement in functioning requires a physical move; and (3) an ultimate return to family, boarding home, hospital, or homelessness, due to the inattention of many treatment-oriented systems to stable housing.

Similarly, the "residential continuum" allocates resources to separate facilities rather than to services and supports linked to normal housing. The transition and the continuum concepts often require participation in a service program in order to receive housing. These trends are particularly evident in the national explosion of shelters for people who are homeless, and of segregated "housing programs for the homeless." Such programs have, in part, been encouraged by federal policies and resource allocation strategies, such as are found in HUD's Section 202 and early McKinney Act programs, which required that housing be both segregated and congregate in nature. The findings are also echoed in the literature on developmental disabilities.[64] Based on these findings, Randolph et al.[65] recommended that the field move away from the concepts of a residential continuum, transitional and congregate programming, and focus instead on housing and supports; and that the field establish consumers' preferences and choices as the single most important determinant of the housing and support options available. So how can this approach be implemented?

Mental Health and Cross-Disability Literature

Two reviews of the research on psychiatric disabilities[66] summarize effective ways to provide people, including those who are homeless, with decent housing and ongoing support and conclude that: (1) this disability is not a lifelong degenerative process; (2) most people can maintain homes, jobs, and friendships; (3) services must be highly flexible to respond to individual needs; people with the most severe disabilities need the most individualized approaches; (4) people *can* make positive choices about needed supports; (5) people don't define themselves principally as "chronic mental patients," but value independence and productivity more than any other treatment outcomes.

Mental health also has much to learn from other groups who need special supports in their housing: people with low incomes, those who are elderly, and those with developmental disabilities, including mental retardation. A review of the research on housing and community integration for *all* disability groups[67] concluded that: (1) housing needs are similar for all groups, although support needs vary; (2) supports are the critical determinant of whether people can remain in their chosen housing; (3) housing problems relate less closely to disability than to economic and social factors such as poverty, affordable housing, and discrimination; (4) strong differences of opinion often exist between professionals and consumers about specific needs for housing and supports, regardless of disability group; (5) choices and control over one's environment are critical necessities; consumers want to be centrally involved in planning and managing their own housing and services; (6) elders and people with disabilities, without in-home supports, are plagued by transience, dislocation, and the risk of institutionalization; and (7) the model of a residential continuum is increasingly beset by conceptual and practical problems. This review concluded that the broader disability community is increasingly emphasizing normal housing and the need to avoid transforming housing into service settings. Thus,

community integration approaches avoid congregation and segregation, and instead focus on building relationships between disabled and nondisabled individuals.

Consumer Preferences

Finally, the preferences of consumers, including those who are currently homeless, are emerging as a powerful determinant of the need for housing and supports. In a countywide needs assessment in Washington State, Daniels and Carling[68] reported on data from providers and their clients about their perceptions of the need for housing and supports. Professionals and consumers held virtually opposite views about housing and support needs, with professionals favoring transitional, highly staffed residential programs for the great majority of consumers, and consumers expressing preference for normal housing with flexible supports. Most consumers preferred to live with one other person, rather than alone or in a larger group. The first statewide study of consumers' preferences for housing and supports was conducted in Vermont,[69] involving a random sample of individuals who were homeless, in the state hospital, or receiving community services. Most persons preferred to live in their own apartment or house (and, in fact, given financial support, to own their own housing), rather than in a mental health–operated facility, single-room-occupancy hotels (SROs), with their family, or in a community care (boarding) home. The major barrier consumers saw to realizing this preference was a lack of adequate income. Most people wanted to move to a better location, have more space in better repair, and have more freedom and autonomy. People in SROs were the least satisfied of all respondents, including those in the state hospital and those who were homeless. The most preferred characteristics of living situations were freedom and autonomy, permanence, security, and privacy. These preferences did not differ significantly across the three groups of respondents.

Traditionally, the field has assumed that many people need live-in staff to assist them during crises to teach them skills. Only one tenth of the respondents, however, wanted live-in staff. Most preferred that staff be available by telephone, or in person if necessary, on a twenty-four-hour basis. As contrasted with traditional "placement" into group settings, most people preferred *not* to live with other consumers, feeling that it was difficult enough to cope with their own problems. Instead, they wanted to live with a friend or romantic partner. In this and over forty-three similar studies reviewed by Tanzman,[70] it is clear that consumers, whether homeless, in a state hospital, or in community programs, can articulate their needs for housing and supports and overwhelmingly prefer integrated housing.

Consumer perspectives were also solicited in a national housing policy forum[71] attended by a group of nationally recognized consumer leaders, all of whom had been homeless. Individuals recounted their own experiences with homelessness and residential programs, and concluded with the following recommendations. The group felt that systems should develop the housing options that most people prefer, independent or shared apartments with support services; that integrated, decent, and permanent housing should be developed in safe neighborhoods, near shopping, services, and transportation. They urged that support services focus on helping people develop skills, manage stress, deal with landlords, manage money, and seek support.

With regard to income, the group urged that disability benefit levels be improved and that special funds be made available to help people move into and keep hous-

ing, including loan funds for security deposits, rent subsidies, and creating employment opportunities. Participants called for improved case management with lower caseloads and higher pay and urged the creation of new staff roles, such as a personal care attendant model. They urged that staff be specifically trained to help people choose, acquire, and keep housing, and to value and respond to the consumers' perspective on needs. They urged that consumers be hired and trained as service providers, as outreach workers, case managers, skills teachers, and program managers.

Participants called for the development of self-help options, including user-run housing. They pressed for greater input into decision making, by conducting housing forums, using ex-patients to collect information, and always involving consumers in planning and developing housing and supports. They encouraged public education efforts to reduce stigma, including teaching public officials about consumers' concerns. The group urged tighter regulation of board-and-care homes, and stressed the need for further legislation for affordable housing. Finally, they emphasized the importance of working in coalitions, and keeping the public's awareness of this issue at a high level. Throughout this forum, participants stressed that the major barrier that mental health systems face in working with homeless people with mental illness is one of credibility: that mental health services are seen as unattractive and, in fact, dangerous, in that any involvement with "the system" puts one at risk for involuntary treatment.

The Emergence of a Supported Housing Approach

In summary then, the information gleaned from the community support and rehabilitation literature in mental health, from other fields, and from people with mental illness themselves, including those who are homeless, suggests that the key ingredients of community integration are a focus on consumer goals and preferences, an individualized and flexible rehabilitation process, and a strong emphasis on normal housing, work, and social networks.[72] In the field of mental health, this approach has been termed "supported housing."[73] The National Association of State Mental Health Program Directors approved a policy statement that sharpens their focus and endorses the concept of "supported housing." It reads:

> All people with long-term mental illness should be given the option to live in decent, stable, affordable and safe housing, in settings that maximize their integration into community activities and their ability to function independently. Housing options should not require time limits for moving to another housing option. People should not be required to change living situations or lose housing options when their service needs change, and should not lose their place of residence if they are hospitalized. People should be given the opportunity to actively participate in the selection of their housing arrangements from among those living environments available to the general public . . . Necessary supports, including case management, on-site crisis intervention, and rehabilitation services should be available at appropriate levels and for as long as needed by persons with psychiatric disabilities, regardless of their choices of living arrangements. Services should be flexible, individualized and provided with attention to personal dignity. Advocacy, community education and resource development should be continuous."[74]

"Supported housing" is organized around three central principles: (1) consumers choosing their own living situations; (2) consumers living in normal, stable housing, not in mental health programs; and (3) consumers having the services and supports

required to maximize their opportunities for success over time. Reviews of characteristics of local supported housing programs,[75] and of related state-level innovations,[76] provide information on the specifics of this approach.

Implications for Public Policy

Systems that are moving toward a supported housing approach face significant challenges. Traditional funding streams, program requirements, administrative approaches to resource allocation and management, and even staff skills are not oriented toward intensive support for consumers in normal housing and work settings, particularly to individuals who reject traditional services, often for very legitimate reasons. Systems interested in being more responsive, rather than developing more residential programs, often emphasize developing better community services, increasing consumers' income through employment and subsidies, building relationships with the public and private housing sectors to access and develop housing, focusing on tangible outcomes from their service providers, and restructuring their policies, funding, and regulations to be consistent with these outcomes. Further, they attempt to fully involve consumer representatives in key aspects of their decision making.[77] Systems that have moved even further have curtailed future group home development or have begun "decongregating" these programs.[78] Key to success is a clear mission that articulates the role of consumers in this process, the types of housing options, and the types of services that will actually be available.

The Need for Further Research

As public policy appears to shift away from an expectation that transitional or other residential facilities will meet any significant proportion of the need for stable housing and community supports for people with mental illness who are currently homeless, more research into questions of where and how consumers prefer to live, successful strategies for facilitating meaningful client choices, for developing housing and supports, for developing relationships with people without disabilities, documentation of the costs and benefits of housing and support initiatives, identification of clinical interventions best suited to normal housing, and an elaboration of the role of peer support in community success, will all be vital. Research on supported housing has largely consisted of descriptive studies of current programs.[79] This is appropriate given the early state of evolution of the supported housing approach. In order to demonstrate the effectiveness of this approach, further studies that assist the field in putting into operation this set of concepts, as well as studies that assess its impact on consumers and their families, are essential.[80] Carling, Randolph, Blanch, and Ridgway[81] concluded that further research is *not* needed on hospital versus community alternatives per se or on the efficacy of residential treatment settings (for example, group homes), particularly since these settings are so rarely operationally defined. The key unresearched questions, according to that review, are: Where do people with mental illness live? Who is especially at risk of homelessness? Where do people want to live? and How can we help them succeed there? In the final analysis, this policy shift will also require a shift from professionally defined to consumer defined research, focusing more on the commonalities between people with and without disabilities and defining "success" in terms of the aspects of quality of life that are important to all citizens. ❧

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