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CRITICAL QUESTIONS FOR THE DEVELOPMENT OF HOUSING THAT SUPPORTS RECOVERY

By
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There is no doubt that recovery—i.e., having a satisfying life as a person with a serious mental illness—depends first and foremost on having a decent place to live and that many people need help to have decent housing.

It's amazing that that was not recognized in the initial phase of deinstitutionalization. The Community Mental Health Centers Act of 1963 called for vastly reduced use of state hospitals and for the provision of five critical community services to make this possible—crisis services, inpatient treatment, outpatient treatment, partial hospitalization, and community education. Not a word about housing. Hard to believe! Now there is no question about the need for housing for people with serious mental illness.

There are, however, questions about what sort of housing should be made available. Should it be transitional or permanent? Should it be in congregate facilities or scattered in units in the community? Should it be open only to people who are "ready to" live in a community setting or should people be given a place to live even if they don't meet standards of readiness? Should housing programs for people with co-occurring serious mental illness and substance use disorders require abstinence or use principles of harm reduction? Should housing be provided in places only for people with serious mental illness or should it be provided in places for mixed populations? Should it be in subsidized generic housing or in specialized settings? Should mental health housing provide care for people who also have chronic physical conditions and/or dementia or should they be transferred to nursing homes as they age?

There are no correct answers to these questions. It depends on the individual abilities and preferences of people with serious mental illness, and it depends on local circumstances. What sort of housing stock is available?

What is the tolerance of a neighborhood for people who are different? What are the political circumstances? What can be funded? These are the kinds of issues advocates try to address systemically, but frankly there is too much need and too little time for ideal solutions.

A few words about each of these questions.

Transitional vs. permanent: Housing programs for people with serious mental illness were originally designed to be transitional—roughly speaking from hospital to halfway house to supported apartments to independence. Not a great model for people whose illness is very frequently recurrent. Nor a great model for grown-ups who don't want to live like college kids in shared rooms with community meetings, etc. And not a great model for people who are, like most of us, stressed out when they move. Of course, transitional housing is useful for some people, but for many getting into a place they can call home permanently or for as long as they like is the better solution.

Congregate vs. scatter-site: The transitional model assumed that congregate living is a higher level of care than living in apartments scattered throughout the community and that as a person with a serious mental illness gets better, they need a less intensive level of care. It's just not so. For some people living in congregate settings, with services on site, permanently, is what works best. For others getting into an apartment on their own as fast as possible is the way to go, particularly if they have a hard time living with other people. Individualization of housing type is a key to successful housing.

Readiness vs. housing first: Early on, it seemed self-evident that people needed to be "ready to" live in the community before they could be given a place to live. That translated into reasons for excluding people from housing programs. People with histories of violence/crime had a particularly hard time getting into housing programs as did some people with histories of substance use disorders. Believe it or not, some residences required that a person with a history of substance abuse—alcohol or illegal drugs—had to live outside a hospital for six months without using substances before they were ready for housing. Where were they supposed to live while waiting for admission? With family? On the street? NYS responded to this ridiculous standard of readiness by developing state operated community residences, which proved that many people who were thought not to be ready in fact were.

Now almost everyone subscribes to the housing first model. Get people into permanent homes, provide mobile support services, and tolerate behavior

such as use of drugs and alcohol so long as it does not result in significant harm.

Abstinence vs. harm reduction: Is harm reduction with regard to substance abuse a good enough goal for housing providers or should abstinence be required. Obviously there continues to be a debate about this. Equally obviously, it seems to me, there's a need for both kinds of program. Some people can only thrive if they abstain totally. Others can use alcohol and drugs safely.

Segregated vs. mixed populations: Unfortunately, in my view, service systems for people with serious mental illness or other problems tend to be designed to serve people with similar problems together. Wouldn't it be better to help people blend into the mainstream? Wouldn't it be better to provide them housing in apartment buildings or neighborhoods where people without serious mental illness also live? Maybe, but that's far easier said than done, and for many people living in a setting with onsite services is better than living more or less on their own dispersed in the community. Here again individualization is the key.

Subsidized generic housing? For those for whom integration into the mainstream is the best option, there's a large policy question about whether their housing should be the responsibility of the mental health system or on the system responsible for the development of affordable housing, with subsidies for people with disabilities, including serious mental illness, to cover the rent. Over the years some mental health officials have been tempted by the argument that housing should not be their responsibility any more than income supports are their responsibility. Careful! History has made it abundantly clear that people with serious mental illness do not fare well in the competition for affordable housing. Are subsidies a way to pay for housing? Sure, but the mental health system needs to be sure that people with serious mental illness are not short-changed.

Treatment of chronic physical conditions and dementia: Sad to say, people with serious mental illness who find a home in the mental health system frequently are forced into long-term care in nursing homes as they age because they develop chronic physical conditions and/or dementia, which can be tricky to manage in mental health housing programs. For interesting historical reasons, which I have written about elsewhere, care for dementia and other chronic conditions is not regarded as a responsibility of the mental health system. Should this continue or should the mental health system finally take continuity of care seriously and, like a family, accept a lifetime responsibility for those who need it?

The questions I have touched on above are all complex and very tough to answer. But they are fundamental to development of housing programs for people with serious mental illness, and each, I think should be continuously confronted so as to improve housing programs and insure that they contribute to recovery, that is to having a personally satisfying and meaningful life.

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