Housing and Supports for Persons With Mental Illness: Emerging Approaches to Research and Practice

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Objective: An approach referred to as "supported housing," based on principles of consumer choice, integrated community housing, and flexible services, is replacing residential treatment facilities for persons with psychiatric disabilities. To improve understanding of the new approach, its evolution, and issues involved in its implementation, this paper reviews studies of the effectiveness of traditional housing programs and early reports of the development of supported housing programs. Methods: A data base of more than 4,000 journal articles and book chapters published over the past 15 years was searched; both research studies and policy analyses were included. Results and conclusions: Because of national and state policy shifts toward supported housing and growing evidence that both consumers and their families favor this new approach, supported housing models appear to be increasingly replicated throughout the U.S. Innovative financing strategies, such as forming coalitions to develop housing or creating capital funds, have been implemented. Results from studies of established programs indicate that support services for consumers should include working with individuals to formulate their housing and support goals; financial assistance in acquiring long-term stable housing; help in searching for an apartment and moving; assistance in managing money and participating in leisure activities; assistance with medication; ongoing monitoring of needs; crisis support; and peer support. Future research should focus on promoting consumers' choices and organizing flexible services to help them succeed in the community.

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During the last decade, the critical need for stable housing linked to effective supports has emerged as a major policy issue within the mental health field (1). In the early 1980s, it was found that a majority of the 1.7 to 2.4 million Americans with "long-term mental illness" based on diagnosis, disability, and duration of disorder (2) lived in inadequate housing, lacked needed supports, or were homeless (3,4). These problems continue today.

The reasons for this situation are complex. The nation has been undergoing an affordable-housing crisis, homelessness is becoming more widespread, and the mental health field has been unclear about its responsibility and about the most effective approaches for addressing these issues within its traditional service system. In this review, each of these problems is explored, and an approach to housing that has recently emerged in response to the problems—namely, supported housing—is described.

The affordable-housing crisis

Two factors have reduced access to housing for all people with limited incomes: a decade-long decline in affordable-housing stock and the rising cost of housing in relation to income. This combination puts home ownership out of reach of many middle-income Americans and decent housing out of reach of most people at or below the poverty level. Many people with psychiatric disabilities who have reported average annual incomes from $3,000 to $7,000 rely on Supplemental Security Income (SSI) as their primary income source and have unemployment rates as high as 85 percent (5), making their access to decent housing tenuous at best.

Since 1981 federally assisted housing for low-income and special-needs groups has been cut by nearly 80 percent, which represents a decline of the national investment in affordable housing from 7 percent of the federal budget in 1978 to .7 percent in 1988 (6). During these years homelessness has dramatically increased.

Because disabilities can be economically catastrophic, disabled people are disproportionately represented in the group labeled "very poor," or those well below the poverty level. A recent national study comparing SSI income and affordability of housing found that there is not a single county in the United States where people with only SSI income can afford to rent either an efficiency apartment or a one-bedroom apartment (7). It also is difficult for individuals with psychiatric disabilities to maintain SSI as a stable source of income. Segal and Choi (8), for example, found that among board-and-care residents eligible for SSI, those with the most severe psychiatric disabilities spent the least amount of time as SSI recipients because of revolving-door hospitalizations and inadequate coordination of treatment and benefits.

In addition, housing discrimination based on stigma is a day-to-day reality; many landlords refuse to rent to individuals with psychiatric disabilities, cutting off access to available rental housing. A recent study found that more than 40 percent of landlords immediately rejected individuals with a known psychiatric disability who were otherwise qualified applicants (9).

Many of those who find independent housing in the community live in very low-income neighborhoods where substandard housing and high crime rates are typical. Concentration of people with disabilities in these neighborhoods often leads to community backlash, referred to as the NIMBY (Not In My Back Yard) syndrome (10,11). In addition, community opposition to mental health residences is widespread (12,13), even though claims that they have adverse effects on neighborhoods appear to be groundless (14).

These findings, along with results of studies of consumers' perceptions of the housing problem (15), suggest that low income and stigma rather than psychiatric disability itself may be the major barriers to housing. These barriers are especially vexing, given the results of studies of the preferences of consumers of mental health services indicating that most prefer their own apartment in housing that is integrated—that is, not developed specifically for people with a label or disability—and in an urban area. Much of the affordable housing stock in urban areas, such as welfare hotels and boarding homes, has been lost to gentrification.

The crisis of homelessness

Because of the decline in affordable housing, increasing unemployment, and the erosion of community services for people with psychiatric disabilities and with alcohol and substance abuse problems, homelessness has become a widespread phenomenon in the United States. Estimates are that 736,000 Americans are homeless on a given night and that 2.3 million are homeless over the course of a year (6). In addition, 27 million Americans are considered "shelter poor" and at risk of homelessness (16). Estimates of the proportion of homeless persons who have serious mental health problems range from 25 percent to 90 percent (17–19), although major methodological questions have been raised about the definition of homelessness and about methods for estimating the size of the homeless mentally ill population (20,21). Furthermore, many of these studies fail to make important distinctions between key subpopulations of homeless persons, such as women (22,23) and minority groups (24).

Although the popular press often equates homelessness with deinstitutionalization policies, there is considerable debate about the extent to which homelessness is a consequence of the disabling nature of mental illness (25) or is itself a precipitant of psychiatric disability (26). Research studies tend to overestimate the number of homeless people with mental illness by describing some behaviors as characteristic of mental illness rather than of homelessness itself (27). Grunberg and Eagle (28) have described a process called shelterization, which is similar to early accounts of learned helplessness in psychiatric hospitals. Shelterization is characterized by decreased interpersonal responsiveness, neglect of personal hygiene, increased passivity, and increased dependence on others.

Several strategies for addressing the housing and support needs of homeless people with psychiatric disabilities have emerged, some based on National Institute of Mental Health (NIMH) demonstration projects. Several studies have reported that the priorities for most homeless persons are social resources and support rather than mental health treatment and that key needs related to housing stability are engaging the individual in a relationship focused on basic needs and providing case management and linkages with other services (22,29,30). A comprehensive outreach approach that offers health and mental health services and focuses on the perspectives and demands of clients, work options, and supported housing has been reported to be effective in helping most people overcome homelessness (31–33).

Goering and associates (34) summarized service principles essential for working with people who are homeless. First, normal community living in long-term or permanent housing is the desired goal. Second, permanent housing with flexible supports rather than residential treatment programs is the preferred model. Third, consumer involvement in planning and governing is essential. Fourth, a commitment to ongoing review of both the quality of housing and the adequacy of services is necessary. Despite these findings, others continue to call for new forms of "asylum" (35) or for a variety of institutional solutions (36).

Responses by the mental health field

Traditional residential programs. The mental health field's response to people who need both housing and treatment is undergoing significant change. Historically, mental health agencies have viewed housing as a social welfare problem and have defined their role exclusively in terms of treatment. Public housing agencies, in turn, have contended that consumers need specialized residential programs and have viewed housing needs as a responsibility of mental health agencies (1). Thus housing needs have often been ignored. When mental health systems have responded to housing needs, they have typically combined treatment

Series Highlights Housing and Supports

A series of papers on housing and support services are featured in this issue of *Hospital and Community Psychiatry.* All but one were written at the request of guest editor Paul J. Carling, Ph.D., executive director of the Center for Community Change Through Housing and Support in Burlington, Vermont. Four papers on supported housing are published in this section, beginning with Dr. Carling's review of traditional and supported housing approaches. Brief reports in the series begin on page 490, and related commentaries appear on pages 413 and 496.

needs and living needs in a residential service or program.

These residential services include a variety of models, such as quarterway and halfway houses (37), family foster care (38), Fairweather Lodges (39), apartment programs (40,41), boarding homes (42), and nursing homes (43). "Crisis alternative models" may involve group residences, family settings, or apartments reserved for crisis intervention (44–46). Shelters for homeless persons and transitional or permanent "housing for the homeless" have become the latest in a series of quasi-institutional solutions to housing and support needs (47,48). Practically speaking, consumers have typically been offered therapeutic facilities, not housing.

Despite broad development of residential programs in the last decade, a recent national survey of more than 2,500 community residential programs serving adults with psychiatric disabilities found that in most states only a small number of agencies actually provide the residential services described above (49). Few agencies surveyed offered more than one program option, and most programs involved large congregate settings. Agencies that took the newer approach that incorporates supervised apartments and supportive housing offered services to a large number of households, each of which served a small number of people. Intermediate care facilities, nursing homes, and shelters had few formal ties with mental health services. Transitional housing also was not as common as expected; most programs provided long-term housing. Surprisingly, residential services were not intensive but were staffed by paraprofessionals who had received little mental health training (50).

Although some of the residential programs surveyed explicitly attempted to incorporate a rehabilitation approach (51–53), others were oriented toward what is known as maintenance (1). Follow-up services were informal and inconsistent. Residents were primarily young adults with major mental disorders. The programs served twice as many persons who were functional as they did those who were gravely disabled, raising questions about the use of scarce public resources in this area. Most of the residential programs were developed to combine housing and services in a single setting; such programs were typically segregated, professionally staffed, and congregate in nature.

Empirical knowledge about what components of residential programs are effective is hampered by both methodological and conceptual problems. Despite their proliferation, no commonly used nomenclature for these programs exists, which makes evaluation of their impact especially difficult. Furthermore, in five major reviews that included studies of several hundred programs considered to be alternatives to hospitalization (54–58), only a handful of studies met basic criteria of experimental design.

Taken as a whole, however, the studies indicated that community-based treatment is virtually always as effective as or more effective than hospital-based treatment in helping people with psychiatric disabilities find and maintain employment, reenter 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.

Results of 109 studies of residential programs indicated that the effectiveness of transitional halfway houses in reducing recidivism, improving economic self-sufficiency, and improving community adjustment was "highly suspect" (59). Transitional residential programs may in fact be preferable to institutional care, but they fall short of helping people achieve community integration (60). In fact, serious questions have been raised about the failure to distinguish between residential treatment and housing and about the assumption that people need to live in residential programs before living independently (61).

It has been suggested that the notion of providing help through a series of time-limited stays in specialized residential settings so that residents can achieve independent living is simplistic (1). First, this idea confuses a person's need for stable affordable housing with his or her need for treatment. Thus acquiring housing (a basic human need—and some would contend a basic right) becomes contingent on accepting treatment, an especially problematic notion in what purports to be a voluntary service context. As treatment needs change, individuals may experience chronic dislocation through successive moves, because improvement in functioning often requires a move to another residential setting. In addition, alternative housing is often not available at precisely the time that a person's needs change. Such a residential continuum also focuses on preparing people for living in their own housing, whereas the results of rehabilitation studies suggest that the most effective way to learn such skills is in the actual environment in which they will be applied (62).

Furthermore, the idea that people will move from specialized residential settings to independent living without any mental health supports appears to be contradicted by the fact that many people with psychiatric disabilities need ongoing, yet flexibly available support. Finally, specialized facilities are generally not desired by consumers themselves but instead represent professional notions of what consumers need (63).

The failure to focus on needs for permanent housing has had multiple effects. Many individuals remain in psychiatric hospitals because of the lack of housing (4). Others cycle through emergency rooms and general hospitals in costly and often inappropriate stays (64,65). Many others have been moved to custodial nursing and boarding homes, which typically lack active rehabilitation or treatment, contribute to decline in functioning, and are often exploitive (43,60,66,67). In addition, lack of permanent housing and support options often results in substantial burden on families, who serve as case managers and landlords with little or no support (68–70). Although residential facilities consume the majority of resources allocated to housing, only 2 to 5 percent of people with

psychiatric disabilities are offered the option of living in them (49).

Emerging integrative approaches to housing. The mental health field has a great deal to learn from other groups who require special housing supports: people with low incomes, those who are elderly or homeless, and those with developmental disabilities, including mental retardation. A recent comprehensive review of the research related to housing and community integration for all of these groups reached several broad conclusions (71). First, housing needs are similar for each of these groups, although support needs are more varied. Second, supports appear to be the critical factor in whether people can remain in housing of their own choice. Third, housing problems are less closely related to disability than they are to economic and social factors such as poverty, the shortage of affordable housing, and discrimination.

Fourth, professionals and consumers in all disability groups often disagree strongly about specific needs for housing and supports. Fifth, choices about and control over one's environment are critical necessities regardless of special need; consumers wish to be centrally involved in planning their own housing and supports and want the opportunity to manage their own services. Sixth, because of the lack of in-home supports and services, elderly people and people with disabilities are plagued by transience, dislocation, and the risk of institutionalization. Finally, the model of a "residential continuum" is increasingly beset by conceptual and practical problems.

The review further concluded that disabled groups and low-income groups are increasingly emphasizing normal housing and the need to avoid transforming housing into service settings. Thus community integration approaches to housing avoid congregation and segregation and focus instead on building relationships between disabled and nondisabled individuals or those with various income levels.

Two recent reviews of outcome studies of persons with psychiatric disabilities (62,72) have implications for housing and support needs. Both reviews reached similar conclusions. First, they concluded that a psychiatric disability is not necessarily a lifelong degenerative process that requires more intensive supports over time. Second, most people with psychiatric disabilities can maintain homes, jobs, friends, and families. Third, mental health services must be highly flexible to be responsive to individual needs, which vary over time; people with the highest level of disability seem to have the most individual needs.

The fourth conclusion was that, given a choice, most people do not define themselves principally as chronic mental patients; instead, they value independence and productivity more than any other treatment outcomes. Fifth, people can make positive choices about the kind and intensity of supports they receive. Consumers seem to use residential facilities, such as boarding homes, as they define their need at a given time, rather than as the program planners intended these settings to be used (42)—an indication that people will exercise choice regardless of whether options are available.

A growing body of information describes what kinds of housing and supports consumers actually want. A recent review of 43 consumer housing and support preference studies conducted nationally, presented by Tanzman in this issue (73), concluded that people with psychiatric disabilities generally want the same kinds of housing that other citizens want. The review also indicated that most people with psychiatric disabilities, whether homeless or living in psychiatric hospitals, residential programs, with families, or in their own housing, generally place the highest value on privacy and autonomy; prefer not to live with other mental health consumers, despite prevailing placement policies; want integrated housing; want mental health services but not on a live-in basis; and see a lack of income as the major barrier to achieving their housing goals.

A national housing policy forum of consumer leaders who have themselves been homeless and who have lived in residential program facilities, and who also have worked in programs serving people with psychiatric disabilities, provided concrete suggestions for implementing systems to achieve desired outcomes (15). Systems should develop the housing options that most people prefer. Housing should be decent, safe, permanent, and near shopping, services, and transportation. Services should be voluntary and skills oriented and should focus on benefits, flexible funding, and jobs. Case management should be expanded, using a personal-care-attendant model. Staff need training related to housing and choice. Consumers should be hired to provide and manage services. More self-help and empowerment options are needed.

The forum concluded that public education is needed to reduce stigma. More regulation of board-and-care homes and more legislation to provide affordable housing are necessary. Coalitions to work on housing issues must be developed. In short, the consumer leaders favored a shift from a traditional mental health approach to an adaptation of the independent living model that has been successful for people who have severe physical disabilities (74,75).

Implementing supported housing

Emerging strategies. The mental health field is in the midst of a paradigm shift in regard to people with the most severe disabilities (76–78). The shift is from an era of institutional and facility-based thinking through a transitional period in which people were seen principally as service recipients needing a comprehensive community support system (79) to a view of people principally as citizens with a potential for, and a right to, full community participation and integration (72,80). Data from community support programs and from rehabilitation studies in the area of mental health as well as from other fields, and reports from consumers themselves, suggest that the key ingredients for achieving community integration are a focus on consumers' goals and preferences, an individualized and flexible rehabilitation process, and a strong

emphasis on normal housing, work, and social networks (71,76).

More specifically, in the area of housing, the paradigm is shifting toward homes, not residential treatment settings; choices, not placement; normal roles, not client roles; client control, not staff control; physical and social integration, not segregated and congregate grouping by disability; in vivo learning in permanent settings, not preparatory learning in transitional settings; individualized flexible services and supports, not standardized levels of service; most facilitative, not least restrictive, environments; and long-term supports and interdependence, not independence (78).

In the field of mental health, this approach has been termed supported housing and is organized around three central principles: consumers choose their own living situations; they live in integrated stable housing, not in mental health programs; and they receive the services and supports required to maximize their opportunities for success over time. It can be argued that the underpinnings of this approach are not new but have evolved from innovative community-based approaches. Developers of the PACT (Program in Assertive Community Treatment) model, which originated in Madison, Wisconsin, and which has been replicated nationally, argued in their earliest writings that "special living arrangements" should be avoided (81). The PACT approach has evolved from a crisis alternative model to one that stresses independent living in normal housing (82–84).

In most instances, successful programmatic implementation of supported housing at the local level has been facilitated by state-level interventions (85), such as increasing consumers' access to affordable housing, increasing the number of state staff working on housing issues, developing housing units, and increasing consumers' incomes, such as through rent subsidy approaches. Legislative mandates and financial incentives also have been used to encourage service providers to offer more flexible support services. States have promoted consumers' involvement in the mental health system by encouraging their participation in state-level decision making and by providing financial support to consumer organizations.

Because of national and state policy shifts toward supported housing (86–88), this approach appears to be increasingly replicated throughout the United States (89). Examples of its use are beginning to appear in the literature, including adaptations of the approach focused on consumer empowerment and on cultural diversity (90) and programs for youths in transition (91). The approach has also been used in combination with an assertive community treatment approach in urban areas (92) and with programs involving nonprofessional staff and volunteers (93). The approach has also been used in Canada (94).

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The supported housing approach has been employed as a strategy for "decongregating" traditional residential programs (95) and as an alternative to transitional housing for people who are homeless (34). A study of its use with people who had severe psychiatric disabilities and behaviors presenting extreme treatment challenges suggested several critical skills and supports that should be incorporated into supported housing programs (96). They included help in searching for an apartment and moving; assistance with managing money, structuring time, and participating in leisure activities; medication management; crisis support; and limit setting. The study recommended recruiting staff who can establish rapport quickly and who see themselves as client advocates. Key organizational supports that were suggested were transportation, telephone support, flexible funds, minimal paperwork, low caseloads, and a policy of supporting independent decisions of staff.

Supported housing has also been the focus of a multilevel evaluation of systems, programs, and clients in a five-state, ten-site, NIMH national demonstration program. This study concluded that nearly all clients who entered these programs, whether they were homeless or were referred from hospitals or residential programs, were living in integrated apartments at the end of the three-year evaluation (97). In some sites, the housing was more scattered throughout the community than in others. Most housing was privately owned, although some units were owned by mental health agencies. The housing was generally very decent. All programs provided services to help clients search for and move into housing units, all had services to help clients keep their housing, and most provided financial assistance with rent.

Programs provided a broad range of community support services (case management, crisis services, mental health services, rehabilitation, and peer support), and case management caseloads averaged between two and 15 clients. Services were available from eight to 16 hours a day. All services were available in participants' homes if they preferred. Projects were not focused as much on self-determination as the conceptual model might suggest: most programs picked a housemate whom the participant could accept or reject. Few programs offered more than one or two housing choices. Some programs held the lease to the housing. Most programs expected that clients who received housing would also participate in services. Thus implementation of supported housing varied widely on nearly every dimension.

It is also clear from current studies that a variety of special issues are involved in the practical implementation of supported housing (89), including the need for special supports during the moving period; the ar-

rangement of ongoing support and monitoring of needs, including the development of a crisis plan; the usefulness of successful role models for those just beginning to live in their own housing; and the special needs of women (32,98), homeless persons (98–100), parents, and those who have alcohol and substance use problems (96). Cultural and racial issues are also critical (24). Important differences exist in the implementation of supported housing in rural areas (101) and in urban areas (102).

Several creative approaches to housing finance have surfaced in recent years (103,104). These strategies are used for three purposes: to gain access to existing housing, to preserve existing housing, and to develop new affordable housing. Access to existing housing has been gained through rent subsidy programs created at the state level in connection with or as an alternative to the federal Section 8 subsidy program. Contingency funds to help with furnishings, utility hookups, other start-up costs, and emergency housing payments have been established.

To preserve existing affordable housing, organizations have set up limited pools of capital dollars to purchase and renovate housing, usually in cooperation with other low-income advocacy groups. To develop housing, a variety of approaches have been used. Capital funds formerly used by mental health agencies for residential treatment facilities have been targeted to develop integrated housing in partnership with others. Distressed properties have been purchased for development. Another approach is to create capital funds that can internally subsidize the cost of housing so that it remains perpetually affordable. In addition, public and private funds have been mixed, such as in limited equity ventures or the use of tax credits.

Many of these innovative financing strategies have been refined through the Robert Wood Johnson Foundation Program on Chronic Mental Illness, a nine-city demonstration project to develop system-wide housing and supports for people with psychiatric disabilities (105). Another creative example is the use of back payments from an SSI lawsuit to develop housing (104).

Challenges. Even with these policy and program developments and creative financing approaches, legitimate concerns have been raised, as in Hatfield's paper (106) in this issue, about whether people with psychiatric disabilities will be able to compete for housing on the open market and about whether landlords will be willing to keep housing open while a person is experiencing a crisis or in the hospital. In fact, as indicated by Knisley and Fleming's paper (107) in this issue, mental health agencies that have broadly implemented supported housing have found that a variety of organizational changes are needed to ensure that housing will continue to be accessible to consumers. Such changes include the establishment of housing development corporations; the creation of funding strategies, such as the ongoing payment of rent during hospitalization; and the creation of service strategies, such as intensive case management.

Hatfield's paper (106) also raises concerns about loneliness and social isolation of those who choose to live alone. In fact, a national evaluation of the implementation of supported housing (85) found that isolation was a real problem for many consumers, and that mental health agencies, with the exception of exemplary programs, were generally not yet effective in countering the problem of loneliness. Persons in residential facilities also experience loneliness; social integration often occurs only with focused efforts (108), and even then, social relationships with people without disabilities are not addressed (109). Consumer advocates point to the centrality of self-help and mutual support groups as a partial solution to this problem (15).

Hatfield (106) is also concerned that group homes will not be available to those who want them when supported housing is widely implemented. The lack of availability of specific options desired by consumers is a major concern, because even in supported housing programs, which focus on the importance of choice (97), choice in housing appears to be given much less emphasis than the underlying philosophy of rehabilitation would suggest. In fact, "placement" still appears to be the dominant approach in the mental health field. The placement approach is further strengthened by the enormous pressures on mental health systems to reduce the use of costly facilities by transferring people, often quickly, to other settings, effectively reducing choice even further.

The supported housing philosophy clearly specifies that choice is paramount; if an individual wishes to live in a residential treatment facility or a group arrangement, that choice should be respected. Whether such choices will be honored, however, in increasingly difficult financial times is an open question. Because group homes are increasingly defined as treatment settings, they may fall under the same limited-access and rationing approaches that hospital beds do; people who want to use hospital beds as housing are routinely denied that option.

Hatfield (106) also expresses concern about whether supported housing will cost more than traditional approaches. Systematic cost data are not yet available to make these comparisons. The cost of implementing a variety of supported housing programs in the NIMH demonstration project averaged $8,000 to $9,000 per year for each person with a severe psychiatric disability (85,97). The provision of comprehensive community support services to people with the most severe psychiatric disabilities in Dane County, Wisconsin, averaged about $12,000 per year (110), confirming results of early studies of the assertive community treatment program, which suggested that this approach was a cost-effective alternative to hospital care (45).

A more recent statewide study in Tennessee suggested that the state could save nearly $800 million over the next 20 years by converting from a facility-based system to one that uses state-of-the-art community support services (111). No systematic comparison of costs of residential programs exists. However, the studies described here, although they are certainly not conclusive, do not appear to suggest that a home-based

housing and supports approach would be any more expensive than traditional residential treatment. In fact, the findings suggest that such comparisons may even be specious, in that the focus of the facility-based programs is increasingly on treatment, not on long-term housing.

A few studies have documented family preferences for housing for their affected family member (70, 112–116). In general, families see an enormous need for affordable housing and better community services, and they have roughly equal preferences for residential program models and for supported housing. One conclusion that could be drawn from these studies is that the housing need is so desperate that virtually any option is acceptable. Interestingly, family and professional assessments about what consumers need appear to vary at least partly as a function of what is available in a given area.

Consumers also differ with professionals about what they need, although to a lesser extent than families do. For example, in an assessment of needs in Washington State, mental health professionals believed that consumers primarily needed residential programs, whereas consumers preferred integrated housing with supports (117). In contrast, a more recent study in Vermont, a state in which community support services are more widely available, revealed little difference between consumers' and professionals' perceptions of need, both of which heavily emphasized a supported housing approach (113). In the Vermont study, families continued to see a need for group homes or residential programs, although they concluded that the need for housing and supports in integrated settings was greater.

The future of residential services programs is a crucial policy issue. Although it appears that states are funding fewer of these facilities (49) and that the settings themselves are evolving (95), the field shows little consensus as to whether they represent a set of institutions whose time has passed or a resource that, with adaptations, will be a valuable element of the service system of the future. The latter policy perspective has been articulated by Fields (118), who contends that a full range of residential treatment programs and widespread availability of affordable permanent housing with supports are both essential elements of a fully delineated system of services for people with psychiatric disabilities.

He also contends that residential treatment is essential to prevent institutional care of those who would otherwise remain in hospitals, jails, or nursing homes. Residential care is thus a specific treatment element and one of the critical supports in an overall supported housing approach. Although this question continues to fuel debate, evidence suggests that as the mental health field develops more responsive services, even people with the most severe psychiatric disabilities can be successfully served with a supported housing approach (96,119).

The need for further research

As public policy appears to be shifting away from an expectation that residential facilities will meet a significant proportion of the need for stable housing and community support services, additional research is needed. Such studies should address consumers' housing preferences and should investigate successful strategies for facilitating meaningful client choices and for developing housing and supports. Costs and benefits of housing and support initiatives need to be documented, and clinical interventions best suited to normal housing should be identified. Also important will be an elaboration of the role of peer support in community success.

Research on supported housing has largely consisted of descriptive studies of current programs (120), although several outcome studies have focused specifically on supported housing. In a recent study, for example, clients who had a history of involuntary hospitalization and who were assigned to a supported housing program were compared with clients who had voluntarily selected that program (121). After nine months in the program, the involuntary clients rated higher on such risk factors as history of suicide attempts, self-neglect, homelessness, and medication noncompliance. The involuntary clients were much higher users of supported housing services, case management, psychiatric services, and shelter services. They had a higher one-year rehospitalization rate. However, they used substantially fewer inpatient days in the six months after entering the program than in the six months before.

A similar program reported successfully reducing hospitalization rates with clients termed more difficult to serve through the use of scattered-site housing and multidisciplinary teams that included psychiatrists; the teams were available on a mobile basis, 24 hours a day (121).

To investigate the effectiveness of the supported housing approach, further studies that help operationalize the approach, as well as studies that assess its impact on consumers and their families, are essential. A review of research on community integration of people with psychiatric disabilities conducted by my colleagues and me concluded that further research is not needed on community alternatives to hospitalization or on the efficacy of residential treatment settings (for example, group homes), particularly since these settings are so rarely operationally defined (71). The key unresearched questions noted in that review were, Where do people with mental illness live? Where do they want to live? and, How can we help them succeed there?

Finally, as was noted in that review (71), answering the questions requires a shift from research as defined by mental health professionals to that defined by consumers. Such a shift is consistent with recent calls for research on psychiatric disability to focus more on the commonalities between people with and without disabilities and to begin defining "success" in terms of quality-of-life variables such as physical and material well-being; relations with other people; social, community, and civic activities; personal development and fulfillment; and recreation (72).

The supported housing approach itself suggests a broad research

agenda (122). In promoting consumers' active choice of housing and supports, for example, we need to better understand the process of choice and how to help people make choices. We need more knowledge of the role of control and autonomy in promoting success. Further information on what kinds of housing consumers prefer, what services and supports are helpful, and how they might best be provided is essential. We need to better understand consumers' capacity to manage their symptoms and their own lives and to assist each other, both individually and through consumer-operated services.

We also need to develop effective ways to organize services that help people with the most severe disabilities succeed in housing of their choice and that support their families as well. Key issues to be explored include strategies for achieving flexibility and individualization of services and the continuity of relationships. In effect, we need to discover the ways in which services can eliminate the perceived need for specialized living arrangements (123).

Finally, we need to understand the impact of choice versus placement on success and how particular types of housing strategies contribute to success. Broad dispersion of housing, for example, versus physical proximity clearly may have an impact on the capacity of consumers to support each other and on the availability of staff. Even as we help people become part of the larger community, we should explore the positive value of housing arrangements shared by consumers or former patients.

To better facilitate integration of persons into the community, it would be helpful to study the impact of different living arrangements on integration outcomes. Such factors would include the size, location, and type of housing and its appearance and stability as well as the number of tenants. Integration of tenants could be measured by the number and type of their relationships and activities that involve people without disabilities. Through expanded research on consumer choice, housing, and supports, we can begin building the critical knowledge base necessary to achieve community integration for people with psychiatric disabilities.

Summary and conclusions

In summary, the mental health field has begun to make significant progress in reconceptualizing its roles and responsibilities for housing and supports. New knowledge about what consumers want and about the needs of families are emerging, as are new policies, funding mechanisms, and programs through which agencies and systems can respond to these needs. As the field continues to experience major change, it is both significant and hopeful that this change is resulting in an increased focus on the basic need for a home and in a deepening commitment to pursue strategies that will help people with psychiatric disabilities have their own homes with the supports they want.

This paradigm shift mirrors similar shifts in the broader fields of disability and affordable housing. Because access to affordable housing has become a national crisis, the public's support for increased federal and state spending and taxation for housing is at an all-time high (125). Thus even as federal housing programs are being cut, Congress has passed new housing legislation. The National Affordable Housing Act and the Fair Housing Amendments Act are intended to further promote housing integration, including integration of people with psychiatric disabilities. The Americans With Disabilities Act is a landmark piece of legislation that specifically promotes the goal of full community integration for people with psychiatric disabilities. These larger trends will continue to shape the mental health field's response to housing and support needs.

The supported housing approach, although an exciting response to some of the limitations of traditional approaches, brings with it many difficulties and challenges, largely because it represents a far more ideal way of thinking about people and their needs than is reflected in current attitudinal, programmatic, and funding realities (80). By advocating major change throughout a system, the supported housing approach also flies in the face of many vested interests, both professional and economic. Systems that take such an approach can easily become overwhelmed with the goal of basing housing on consumers' preferences, especially because community mental health service providers are typically acting in "crisis mode," with little time to ask anyone else's views. Listening to consumers, whether formulating new goals with an individual or planning a new statewide approach to housing, takes more time than that required by current approaches. Furthermore, policymakers and professionals may not like much of what they hear from consumers, and most of the resources and tools they have to create housing are useful only for facility-based approaches.

Similarly, services are rarely organized to support people wherever they wish to live. Systems and local agencies have significant real estate holdings in their facilities. Often they do not have management or practice-level staff who have skills in housing access, preservation, financing, and development, nor do they have the relationships that they need with private and public housing systems, such as developers and local public housing authorities. Mental health systems face resistance from local agencies, from professional groups, and from other advocates in moving too quickly toward a consumer-driven approach.

Implementing supported housing also takes resources that are currently unavailable in many mental health systems, at least in the form they are needed. Resources that need to be created include rent subsidies, pools of capital that can be accessed quickly to make opportunistic deals, flexible funds for furnishings for consumers, expanded case management, and crisis services. All of these resources may represent bureaucratic nightmares in some systems. In such cases, trying to implement supported housing often makes it clear to a mental health system that the major barriers clients face are, in fact, the characteristics of the system itself. But despite these formidable barriers to change, it seems clear that most states are moving in this direc-

tion, albeit at very different paces and with differing strategies.

However, for all of these reasons it is also clear that although policy change in this area can proceed relatively rapidly, implementing a supported housing approach is a long-term proposition for most mental health systems. Policies, planning practices, financing structures, staff roles, and relationships with and expectations of service providers and other government agencies (for example, housing authorities and management information systems) all need to change. It is likely that in most systems residential facilities and group-living settings will continue to be used, even as other systems begin decongregating them.

In this way, supported housing is no different from any other change in the mental health field: implementation is always widely variable. The difference with supported housing, however, is its ripple effect on other aspects of the system. Once a mental health system begins to take consumers' choices and voices seriously, for example, it is exceedingly difficult to make decisions based on more traditional methods.

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