Housing for People with Serious Mental Illness: Approaches, Evidence, and Transformative Change

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Recommended Citation
The evolution of housing approaches for people with serious mental illness is described and analyzed. A distinction is made between three different approaches to housing: (a) custodial, (b) supportive, and (c) supported. Research evidence is reviewed that suggests the promise of supported housing, but more research is needed that compares supported housing with different supportive housing approaches. It is argued that the current move to a supported housing approach represents a fundamental shift or transformative change in mental health policy and practice. Strategies to facilitate this shift are discussed.

Key words: housing approaches, mental illness, homelessness, housing first

Prior to the 1950s and 1960s, people with serious mental illness were confined to mental hospitals (Foucault, 1965). Goffman (1961) characterized these hospitals as “total institutions” that encompassed all aspects of life for the patients who resided within them. Mental hospitals typically had “long stay” wards for so called “chronic mental patients,” and some even had their own graveyards where deceased patients were...
buried. With the advent of deinstitutionalization in the 1950s and 1960s, many people who had been patients in mental hospitals were released into the community. In Canada, for example, there was a 70% drop in the inpatient population of provincial mental hospitals between 1965 (69,000 patients) and 1981 (20,000) (Nelson, 2006). Similar reductions in the inpatient populations of psychiatric hospitals occurred in the U.S. (Bachrach, 1976) and U.K. (Scull, 1977). With public welfare and new psychotropic medications, people with serious mental illness could be maintained at a subsistence level within the community (Scull, 1977).

Deinstitutionalization was not accompanied by the development of community supports (Bachrach, 1976). Even though many of the problems faced by people admitted to psychiatric hospitals are social, economic, or interpersonal in nature, the support that they received upon discharge in the early days of deinstitutionalization, and still today in many cases, usually consisted solely of medication (Harris, Hilton, & Rice, 1993). This lack of support has led to numerous challenges. For example, in their study of psychiatric aftercare in Toronto, Goering, Wasylenki, Farkas, Lancee, and Freeman (1984) found that six months after discharge from psychiatric facilities in Toronto, one-third of the sample was readmitted to the hospital, only 38% were employed, 68% reported moderate to severe difficulties in social functioning, and 20% were living in inadequate housing. In Denmark, Munk-Jørgenson (1999) found increased suicide rates, incarceration in correctional facilities, and hospital admissions in the aftermath of deinstitutionalization.

The type of housing and support that former patients receive after discharge is the focus of this paper. The paper is divided into three sections. The first section reviews the evolution of housing approaches from the early days of deinstitutionalization in the 1950s in North America, the U.K., western Europe, and Australia and New Zealand to the present; the second part examines published research evidence regarding different housing approaches; and the last section includes both a theoretical analysis and practical strategies for changes in housing approaches.
The Evolution of Housing Approaches: From Institutions to Housing to Homes

Trainor, Morrell-Bellai, Ballantyne, and Boydell (1993) traced the evolution of housing approaches for people with serious mental illness. They argued that housing has shifted from a custodial approach to a supportive housing approach to supported housing. An overview of some of the important qualities of these three approaches is provided in Table 1.

Table 1. Characteristics of Housing Approaches for People with Serious Mental Illness

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Custodial Housing</th>
<th>Supportive Housing</th>
<th>Supported Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical settings</td>
<td>Board-and-care homes, foster families</td>
<td>Group homes, halfway houses, clustered apartments</td>
<td>Independent apartments</td>
</tr>
<tr>
<td>Role of consumer</td>
<td>Patient</td>
<td>Resident</td>
<td>Tenant, citizen</td>
</tr>
<tr>
<td>Role of staff</td>
<td>Care provider</td>
<td>Rehabilitation agent</td>
<td>Facilitator</td>
</tr>
<tr>
<td>Locus of control</td>
<td>Staff control</td>
<td>Residents have little control over where or with whom they live and the services they receive; potential for shared control over household decisions</td>
<td>Consumer control</td>
</tr>
<tr>
<td>Nature of intervention</td>
<td>In-house staff provides care services</td>
<td>In-house staff provides rehabilitation services</td>
<td>Staff from outside provides supports that are consumer controlled and individualized</td>
</tr>
</tbody>
</table>

Adapted from Parkinson, Nelson, and Horgan (1999).
Custodial Housing: The Medical Model in the Community

Housing emerged as a significant problem in the era of deinstitutionalization, with many former patients living in "psychiatric ghettos," consisting of for-profit board-and-care homes, semi-institutional facilities, foster families or poor quality rental housing (Dear & Wolch, 1987; Murphy, Englesmann, & Tcheng-Laroche, 1976; Rochefort, 1993). Psychiatric survivor Pat Capponi (1992) has provided a compelling narrative of the despair and alienation that she and others experienced living in a board-and-care home for former psychiatric patients in Toronto. In these settings, there are many areas of concern: (a) many ex-patients share rooms, thus not affording residents with privacy; (b) the physical quality of the housing is often poor; (c) there tends to be a care and dependency orientation of staff towards residents; and (d) residents have little control (Parkinson, Nelson, & Horgan, 1999). Typically in board-and-care homes, residents receive custodial care, consisting of medications and meals, much like what they received in mental hospitals, but little in the way of active rehabilitation or support that would enable them to become more independent and better integrated within the community.

Supportive Housing: The Residential Continuum Approach

In response to the limitations of custodial housing noted above, mental health professionals began to develop housing that provided active rehabilitation programs with a focus on the promotion of life and social skills, independence, and work. Quarterway houses, halfway houses, group homes, lodges, and supervised apartments are exemplars of this approach (Nelson, Aubry, & Hutchison, 2009). These settings integrated treatment and housing in a single, group or congregate setting, and were often organized in terms of a residential continuum. In theory, the residential continuum consisted of a range of settings varying in terms of the intensity of rehabilitation services provided and the amount of autonomy afforded (Ridgway & Zipple, 1990). As residents' functioning improved, they were expected to move to a less restrictive setting (e.g., from a halfway house to a quarterway house). Problems with this approach soon became apparent. Few communities were able to develop a full continuum of housing; resident progress
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led to disruptive moves away from settings where they had developed supportive relationships; and the end of the continuum, independent housing, consisted of housing for which there was no financial or rehabilitation support.

Supported Housing: The Housing First Approach

In the U.S., Paul Carling (1995) introduced the idea of supported housing. The essence of this approach is that mental health consumers “choose, get, and keep” the housing that they prefer. Support staff assists consumers in finding permanent “homes,” not specialized housing programs. Rent supplements, provided by the Section 8 program of the U.S. Department of Housing and Urban Development, are an important ingredient of this approach, as they provide consumers with the financial means to access housing that is available in the community for anyone (typically private apartments). Section 8 certificate holders pay no more than 30% of their income on rent; the balance is covered by government. There are no requirements that consumers be in treatment, sober, asymptomatic, etc. to obtain supported housing; they receive “Housing First.” Finally, another important feature of supported housing is that housing and support are de-linked or are independent of one another.

The “Pathways to Supported Housing” program in New York City is an excellent example of supported housing in practice (Tsemberis & Eisenberg, 2000). Pathways is:

... founded on the belief that housing is a basic human right for all individuals, regardless of disability, the program provides clients with housing first—before other services are offered. All clients are offered immediate access to permanent independent apartments of their own. (Tsemberis & Eisenberg, 2000, p. 488)

Pathways combines supported housing with Assertive Community Treatment (ACT) and a variety of other support services to help consumers function independently and integrate within the community. The original Pathways program has worked successfully with a very challenging population of people with serious mental illness, a history of homelessness
and substance abuse problems (Tsemberis, Gulcur, & Nakae, 2004). Moreover, the "Housing First" approach has been adopted in several U.S. cities (National Registry of Evidence-based Programs and Practices [NREPP], 2007).

Research Evidence

While it appears that the different housing approaches are guided by different values and assumptions regarding people with mental illness, there is a need to understand how these different approaches work and how effective they are in improving consumer outcomes, such as housing stability and quality of life. There has been a great deal of interest in research evidence regarding the effectiveness of different housing approaches in recent years. Over the last 35 years, there have been 20 different published reviews of this literature, with 13 of these reviews appearing from 1999 to 2009 (see Table 2).

Custodial Housing

Overall, the research does not support custodial housing as an effective approach for people with serious mental illness (Parkinson et al., 1999). For example, in an early study comparing foster family care with a control group of patients who remained in a psychiatric hospital, Murphy et al. (1976) found no differences between the two groups on several outcome measures over an 18-month follow-up period. In a 10-year follow-up of sheltered care residents in California, Segal and Kotler (1993) found that sheltered care was associated with a reduction in independent social functioning and an increase in assisted social functioning. In other words, residents became more dependent over time in custodial housing. In a comparative evaluation of different types of housing in southwestern Ontario, residents of board-and-care homes did not show the same gains in personal growth, community involvement, and independence as those residing in supportive group homes or supportive apartments (Nelson, Hall, & Walsh-Bowers, 1997). Moreover, in the qualitative component of this research, residents of board-and-care homes made the following comments about their housing:
We can tell them what we believe is wrong, but they always make their own decisions and we never know what it's about. . . . We have house meetings every five months, but the staff does what they want anyway.

The living room is overcrowded. Everybody here should have their own rooms. Right now there's three in one room. (Participants in Nelson et al., 1997)

Supportive Housing

There is more evidence regarding the effectiveness of supportive housing. An early, well-controlled, 40-month longitudinal study of supportive housing is Fairweather, Sanders, Cressler, and Maynard's (1969) randomized trial of the Lodge program, in which formerly hospitalized patients lived together in a congregate facility in the community. They found that relative to patients receiving "treatment as usual," the members of the Lodge group showed significant improvements over time in terms of reduced hospitalization and increased competitive work. While much of the research on supportive housing suffers from methodological problems, the overall conclusion of recent reviews of this literature (Leff et al., 2009; Nelson, Aubry, & Lafrance, 2007; Parkinson et al., 1999) is that supportive housing is associated with many positive outcomes for people with serious mental illness.

Supported Housing

The Housing First approach has recently generated a great deal of research on: (a) consumer preferences for housing; (b) the importance of choice and control in supported housing; (c) the implementation of supported housing; and (d) the outcomes of supported housing.

Consumer preferences for housing. In supported housing, it is important to ask people with mental health issues where they would like to live, rather than assuming that professionals know best where consumers should live. In a review of the literature on consumer preferences for housing, Tanzman (1993) found that most consumers: want independent housing (their own homes or apartments); want to live with a friend
### Table 2. Literature Reviews on Housing and Mental Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Focus of review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>Rog, D. J., &amp; Raush, H. L.</td>
<td>Reviewed studies of halfway houses for people with mental illness.</td>
</tr>
<tr>
<td>1978</td>
<td>Carpenter, M. D.</td>
<td>Reviewed research on the effectiveness of transitional housing program for people with mental illness.</td>
</tr>
<tr>
<td>1978</td>
<td>Colten, S. I.</td>
<td>Reviewed the literature on different models of community residential treatment.</td>
</tr>
<tr>
<td>1979</td>
<td>Cometa, M. S., Morrison, J. K., &amp; Ziskoven, M.</td>
<td>Reviewed studies of halfway houses for people with mental illness.</td>
</tr>
<tr>
<td>1979</td>
<td>Hall, G. B., Nelson, G., &amp; Smith Fowler, H.</td>
<td>Reviewed the informal systems, policy/planning, and geosocial contexts of housing for people with mental illness.</td>
</tr>
<tr>
<td>1979</td>
<td>Nelson, G., &amp; Smith Fowler, H.</td>
<td>Reviewed correlational and outcome studies of supportive housing for people with mental illness.</td>
</tr>
<tr>
<td>1987</td>
<td>Ogilvie, R.</td>
<td>Reviewed implementation and outcome studies of supportive and supported housing for people with mental illness.</td>
</tr>
<tr>
<td>1997</td>
<td>Parkinson, S., Nelson, G., &amp; Horgan, S.</td>
<td>Reviewed correlational studies and outcome studies of custodial, supportive, and supported housing for people with mental illness.</td>
</tr>
<tr>
<td>2000</td>
<td>Rosenheck, R.</td>
<td>Reviewed outcome studies of outreach, case management, and housing programs for homeless people with mental illness.</td>
</tr>
<tr>
<td>2001</td>
<td>Newman, S. J.</td>
<td>Reviewed correlational and outcome studies of housing for people with mental illness.</td>
</tr>
<tr>
<td>2002</td>
<td>Fakhoury, A., Murray, G., Shepherd, S., &amp; Priebe, S.</td>
<td>Reviewed correlational and outcome studies of different types of housing for people with mental illness.</td>
</tr>
<tr>
<td>2002</td>
<td>Chilvers, R., Macdonald, G. M., &amp; Hayes, A. A.</td>
<td>Reviewed controlled outcome studies of supported housing for people with mental illness.</td>
</tr>
<tr>
<td>2003</td>
<td>Evans, G. W., Wells, N. M., &amp; Moch, A.</td>
<td>Reviewed correlational studies of housing and mental health for non-clinical populations.</td>
</tr>
<tr>
<td>2004</td>
<td>Rog, D. J.</td>
<td>Reviewed outcome studies of supportive and supported housing for people with mental illness.</td>
</tr>
<tr>
<td>2004</td>
<td>Macpherson, R., Shepherd, G., &amp; Edwards, T.</td>
<td>Reviewed outcome studies of supportive and supported housing for people with mental illness.</td>
</tr>
<tr>
<td>2005</td>
<td>Frankish, C. J., Hwang, S. W., &amp; Quantz, D.</td>
<td>Reviewed the literature on homelessness and health, including mental health.</td>
</tr>
<tr>
<td>2005</td>
<td>Hwang, S. W., Tolomiczenko, G., Kouyoumdjian, F., &amp; Garner, R.</td>
<td>Reviewed outcome research on a variety of interventions (including housing) for homeless people (including people with mental illness).</td>
</tr>
<tr>
<td>2007</td>
<td>Nelson, G., Aubry, T., &amp; Lafrance, A.</td>
<td>Reviewed controlled outcome studies of housing, case management, and assertive community treatment for homeless people with mental illness.</td>
</tr>
<tr>
<td>2008</td>
<td>Kyle, T., &amp; Dunn, J. R.</td>
<td>Reviewed correlational and outcome studies of housing for people with mental illness.</td>
</tr>
<tr>
<td>2009</td>
<td>Leff, H. S., et al.</td>
<td>Used meta-analysis to examine the effects of different housing models on outcomes for people with mental illness.</td>
</tr>
</tbody>
</table>
or romantic partner, not other people with mental health issues; identify low-income as the major barrier to obtaining good quality housing; and want staff support available on a 24-hour basis, but not live-in staff. In a survey of 300 people with serious mental illness in southwestern Ontario, Nelson, Hall, and Forchuk (2003) found that 79% of the sample wanted to live in an apartment or their own home, but only 38% of the sample lived in the type of housing that they preferred. Similarly, in a study in Montreal, 77% of consumers preferred to live in their own apartment, a supervised apartment, or social housing (Piat et al., 2008). This research clearly demonstrates that mental health consumers prefer to have their own, independent housing.

The importance of choice and control in supported housing. There has also been some research on the basic premise that having choice and control over housing and support is associated with positive outcomes for mental health consumers. This research has shown that resident choice and control are related to independent functioning (Nelson, Hall, & Walsh-Bowers, 1998), housing satisfaction, residential stability, and psychological stability (Srebnik, Livingston, Gordon, & King, 1995), and mastery and reduced psychiatric symptoms (Greenwood, Schaefer-McDonald, Winkel, & Tsemberis, 2005). In a study of homeless people with mental illness in three Ontario cities, Nelson, Sylvestre, Aubry, George, and Trainor (2007) found in both cross-sectional and longitudinal analyses that consumers’ perceptions of choice and control over their housing and support were positively related to their quality of life, the quality of their housing, and their functioning in the community (as rated by support workers). Similarly, in the previously mentioned consumer preference survey of 300 mental health consumers, Nelson et al. (2003) found that those who lived in the type of housing they preferred enjoyed a significantly better quality of life than those living in housing that they did not prefer. Together these studies support a fundamental premise of supported housing that consumer choice and control over housing is good for one’s mental health, and they challenge the notion that professionals know what is best for consumers.

The implementation of supported housing. While supportive
housing and supported housing once stood in sharp contrast to one another, over time there has been more of a blurring of these two approaches. Some of the principles of supported housing (e.g., permanency of housing, individualized support) have infiltrated congregate supportive housing programs. For this reason, it is important to clearly specify and operationalize the key ingredients of supported housing and to evaluate the extent to which they are implemented.

Some research has started to do this. In a multisite evaluation, Rog and Randolph (2002) used a stakeholder approach to generate both the core dimensions of supported housing (e.g., housing choice, separation of housing and services, service choice) and indicators of these dimensions. Each indicator was then operationalized on a five-point scale with a rating of five being closest to the ideal of supported housing and a rating of one being furthest away from the ideal. Instruments were then developed to collect data from program managers, staff, and residents on each indicator for each dimension. These data were used to compare 43 supported housing programs with 129 comparison housing programs. While there were differences between these two types of housing, there was considerable overlap in the distributions of ratings between these two program types and considerable variability within the two program types. Thus, rather than a clear distinction between what is supported housing and what is not, the results indicated that there is more of a continuum of supported housing.

In a more recent study, Wong, Filoromo, and Tennille (2007) identified the following core domains of supported housing: consumer choice, typical and normalized housing, resource accessibility, consumer control, and individualized and flexible support. They also developed a set of indicators for each domain and gathered data from archival sources, a provider survey, and a consumer survey for 27 supported independent living programs. Like Rog and Randolph (2002), they found considerable variability in the degree to which the programs approximated the ideal qualities of supported housing.

Clearly more work is needed on the implementation of supported housing programs and the degree of fidelity to the model of supported housing. This is important because without such data, outcome studies of supported housing
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will not be able to discern what the core ingredients are that contribute to positive outcomes.

The outcomes of supported housing. Research has also examined the outcomes of supported housing. In a recent review of the literature, Nelson, Aubry, and Lafrance (2007) located four studies that compared supported housing with standard care or treatment as usual. In a study in San Diego in which formerly homeless people with mental illness were randomly allocated rent supplements under Section 8, those who received the Section 8 certificates showed a significant improvement in housing stability over a period of two years compared with those who did not (Effect Size [ES] = .57). In New York City, Tsemberis and colleagues have reported the results of two evaluations of the Pathways supported housing program for homeless individuals with mental illness. The first of these was a quasi-experimental comparison of Pathways with the residential continuum of housing over a period of five years (Tsemberis & Eisenberg, 2000), while the second was a randomized trial of these two approaches over a period of two years (Tsemberis et al., 2004). Those assigned to Pathways received rent vouchers and ACT support services. Both studies reported dramatic increases in housing stability for those in Pathways compared with those living in residential continuum housing (ES = .92 in Tsemberis & Eisenberg, 2000; ES = .77 in Tsemberis et al., 2004). Finally, in a four-city (Cleveland, New Orleans, San Diego, San Francisco) randomized trial of supported housing for homeless people with mental illness, Rosenheck, Kasprow, Frisman, and Liu-Mares (2003) found significant improvements in housing stability over a period of three years for those who were assigned to supported housing (ES = .51). These studies have also shown that supported housing improves housing choice, quality, and satisfaction, reduces use of hospitalization, and leads to decreases in drug and alcohol use (Cheng, Lin, Dasprow, & Rosenheck, 2007).

In the most recent published review of this literature, Leff et al. (2009) similarly concluded that compared with other types of housing, permanent supported housing has the greatest impact on housing stability, reduction of hospitalization, and housing satisfaction.

While all of the published controlled outcome studies of
Housing First have been carried out in the U.S., new multi-site studies of Housing First are either underway or in the planning stages in Canada (Mental Health Commission of Canada [MHCC], n.d., “At home”), France (Eric Latimer, personal communication, 2010), and western Europe (Jose Ornelas, personal communication, 2010).

Supported Housing vs. Supportive Housing

Few studies have directly compared supported housing with the linear residential continuum of supportive housing. The two studies of Pathways cited above (Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004) have found superior outcomes for supported housing over the residential continuum on housing stability and housing choice outcomes. However, in a study of homeless individuals with mental illness in Boston, Goldfinger et al. (1999) reported somewhat contrary results. Participants were randomly assigned to independent apartments or staffed group living residences. While both groups showed high levels of housing stability after 18 months, members of minority groups living in independent apartments had significantly more days homeless than those in group living situations. In another study in New York City using a quasi-experimental design, Siegel et al. (2006) found no significant differences in housing tenure at an 18-month follow-up for people with mental illness and a history of homelessness living in supported housing or community residences. Those living in supported housing reported significantly more satisfaction with autonomy and their economic situation, but also more isolation, than those living in community residences.

McHugo et al. (2004) randomly assigned homeless people with mental illness to either “integrated” or “parallel” housing. The integrated approach bore some resemblance to supportive housing because support and housing were closely linked, while the parallel housing bore some resemblance to supported housing because support and housing were de-linked. However, many of the people in parallel housing lived in congregate facilities. After 18 months, those in integrated housing reported more stable housing, higher life satisfaction, and a greater reduction of psychiatric symptoms than those in parallel housing. It should be noted that neither of the latter
two studies employed rent vouchers, so that a basic element of supported housing was missing in this research. From the few studies that have been conducted, it is unclear whether independent supported housing or congregate supportive housing has differential effects on consumer outcomes.

Ameliorative vs. Transformative Change

In this section, I analyze the evolution of housing approaches for people with serious mental illness using theory regarding change in human systems, as it is important to understand what the changes in housing approaches represent. Are changes more or less a repackaging of old approaches ('old wine in new bottles'), or do they represent something that is fundamentally new and different? Recent reports in the U.S. (National Empowerment Center and the Recovery Consortium, 2006; President’s New Freedom Commission on Mental Health, 2003) and Canada (Mental Health Commission of Canada, 2009) have used the language of transformative change, so it is important to understand what transformation means in the context of mental health policy and practice.

Watzlawick, Weakland, and Fish (1974) made a theoretical distinction between first-order and second-order change, which has important implications for housing for people with serious mental illness. First-order change involves change within a system, with no questioning of the fundamental values or structures that guide the system. Nelson and Prilleltensky (2010) have referred to first-order change as ameliorative because the goal of this type of change is improvement of the existing system. In contrast, second-order change is concerned with a change in the values and structures of the system. This type of change has been called transformative because it entails a fundamental alteration in the way the system operates. Corrigan and Boyle (2003) made a similar distinction in their analysis of mental health system change, contrasting evolutionary and revolutionary approaches to change. Importantly, Watzlawick et al. (1974) asserted that the way that a problem is initially framed or constructed defines the type of change process, ameliorative or transformative, that will be used to address the problem.
Ameliorative Change

When the problems of psychiatric institutions were recognized, the primary change that was believed to be needed was to move services from the institutions to the community. However, it is apparent from Table 1 that custodial housing replicates the key features of psychiatric institutions. There is still a focus on care services (medication and meals) rather than rehabilitation, and patients continue to have little control over their living environment. Most important is the relationship between mental health consumers and the staff of custodial housing. Staff retains most if not all of the power in custodial housing, keeping patients in a dependency position.

While supportive housing shifts to more of a rehabilitation orientation, residents gain only partial control over these living environments, which remain segregated settings in the community. Former patients have little control over where and with whom they live, and they are required to participate in the rehabilitation activities provided by staff in these “non-normalizing” settings. Supportive housing is clearly an improvement over institutional or custodial housing in the community, but the fundamental status of the patient as a service-recipient is unchallenged. In custodial or supportive housing, mental health consumers and family members are not asked what they think is needed, and they are not included as important stakeholders in the change process.

Transformative Change

Values and power are important in transformational efforts that strive for fundamental change in the structures of social systems (Nelson, Lord, & Ochocka, 2001; Nelson & Prilleltensky, 2005). In a new paradigm in mental health, the person with a mental health struggle is viewed as a tenant in his or her housing, a person with rights and the potential to contribute to society, not as a patient or client to be supervised or managed. As well, there is a focus on strengths and the potential for recovery, not on the person’s deficits or illness. Moreover, in a transformed mental health system, consumers become active participants in planning, services, and research, with real power, voice, choice, and control. A major barrier to implementing this value is that professionals are sanctioned
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by society as experts who have the power to diagnose and treat mental illness. Another important assumption for a new paradigm in mental health is that of social inclusion. People with mental health struggles should not only be in the community, they should be valued members of the community. Finally, there is the need for social justice and a more equitable allocation of resources. Policies and supports need to be put in place to overcome the poverty in which many mental health consumers live.

Supported housing is an example of transformative change in housing approaches for people with serious mental illness. At the individual level, there is a transformation from patients or clients of housing to tenants with rights; at the relational level, helping relationships are transformed from on-site staff supervision to individualized, consumer-directed supports; at the organizational level, housing and support are de-linked, thus taking mental health professionals out of the landlord role; at the community level, there is a transformation from stigma and exclusion in specialized, segregated housing to integration into normal housing and communities; and at the societal level, the rent supplements afford people greater access to and control over finances and housing (Carling, 1995).

**Strategies for Transformative Change**

While there is currently substantial interest in the Housing First model of supported housing, many people with serious mental illness still live in custodial housing, in substandard private rental housing with no financial supplements for rent, in shelters, or on the streets. In 2002, a total of 4864 beds, or 44% of the total number of government-funded beds for people with mental illness in Ontario, were in custodial housing (Centre for Addiction and Mental Health, 2002). While 56% of the beds are in supportive or supported housing, clearly there is a need for housing policy for people with serious mental illness to catch up with current thinking and research that supports the effectiveness of supportive and supported housing in improving outcomes for mental health consumers. Nelson et al. (2009) have suggested change strategies that can be used to shift the paradigm in housing and mental health.

*Building a vision and values.* There is a need to challenge
assumptions and build a vision and values that are consistent with the Housing First approach. There still exist today many myths and misconceptions about mental illness, including views that people with mental illness are dangerous, unpredictable, incapable of making their own decisions, and in need of care. These victim-blaming, stigmatizing assumptions, beliefs, and values are the deep structures of systems (Foster-Fishman, Nowell, & Yang, 2007). For transformative change to occur, these assumptions must be directly confronted and replaced with an alternative vision of recovery and a set of values (citizenship, holistic health, power, social inclusion, and social justice) that guides the journey towards that vision (Sylvestre, Nelson, Sabloff, & Peddle, 2007).

The Kirby report on mental health in Canada (Kirby & Keon, 2006), Out of the Shadows at Last, provides a solid foundation from which to build more positive views of people with mental illness, their potential for recovery, and their need for and right to income, housing, and support. The Mental Health Commission of Canada (MHCC), which grew out of the work of Senator Kirby, has funded an anti-stigma campaign called Opening Minds that will be targeted at youth and health care professionals in its first year (Mental Health Commission of Canada, n.d., “Opening minds”). In a qualitative study of three mental health organizations in the Waterloo Region of Ontario, Nelson et al. (2001) found that building a new vision and values were an important starting point for the transformative changes that each of the three organizations underwent. An alternative vision and values act as signposts to guide a process of change, so that people know where they are headed.

Education and advocacy. Education and advocacy are needed to overcome myths, misconceptions, ignorance, and inertia about the pressing social problem of housing for people with serious mental illness. There is also a need for a social movement to pressure governments to fund housing for this population. For example, housing policy in Canada for low-income citizens has eroded over the years. From 1984 to 1993 the Mulroney government cut $1.8 billion from the federal housing budget, then eliminated federal funding for housing altogether (Hulchanski & Shapcott, 2004). Under the federal Liberal government, fewer than 1,000 units of social housing
were created between 1993 and 2000, and responsibility for housing was downloaded to the provinces. In 1998, the Harris government in Ontario downloaded responsibility for housing to municipalities. Housing policy in the U.S. has followed a similar pattern, with responsibility for housing devolving to states and locales, which do not have adequate funding streams for the creation of housing for low-income citizens (Orlebeke, 2000).

To combat this erosion of public policy for housing, grassroots organizations in Canada and the U.S. have organized to educate and advocate for housing (Nelson & Saegert, 2009). Some of these efforts focus broadly on housing for low-income citizens, while others target housing for people with serious mental illness. While Nelson and Saegert (2009) have reported that some of these efforts have resulted in positive changes in the public housing sector, particularly for individuals with serious mental illness, O'Hara (2007) has noted that progress has been uneven across states in the U.S. and that federal funding for housing needs to be substantially increased to combat the housing problems faced by people with serious mental illness.

One of the recent initiatives of MHCC that came out of the work of Senator Kirby is a noteworthy exemplar of transformative change in housing and mental health. MHCC has funded the At Home/Chez Soi five-city (Vancouver, Winnipeg, Toronto, Montreal, Moncton) research demonstration project on Housing First for homeless people with serious mental illness (MHCC, n.d., At Home). More than 1,300 Canadians with serious mental illness who have been homeless will be housed under this initiative in housing of their choice. As was mentioned earlier, similar initiatives are in the planning stages in Europe. Moreover, recent reports in the U.K. (Dunn, 2008) and Australia (Edwards, Fisher, Tannous, & Robinson, 2009) have called for government support for the Housing First approach for people with serious mental illness.

Consultation. Finally, there is a need for consultation with governments, planners and policy-makers, and practitioners to change current custodial housing to supported or supportive housing. With the help of a consultant, Waterloo Regional Homes for Mental Health, Inc., in the Waterloo Region of
Ontario, shifted to a more supported housing approach, transforming existing housing and creating 100 new units of supported housing (Lord, Ochocka, Czarny, & MacGillivary, 1998). My colleagues and I consulted with the Niagara District Health Council about housing and mental health. At the time of our consultation, Niagara Region had 74 consumers living in custodial housing, 28 in supportive housing, and none in supported housing. After receiving our consultation report, Niagara Region was able to use new funding from the Phase II Mental Health Homelessness Initiative to create 86 units of supported housing (Parkinson, Nelson, & Horgan, 1998). A consultation with the Ontario Ministry of Health and Long-term Care recommended a shift towards a supported housing approach (Sylvestre et al., 2007).

Conclusion

Since the early days of deinstitutionalization, housing approaches for people with serious mental illness have evolved from custodial housing to supportive housing to supported housing. Not only is supported housing philosophically and conceptually appealing, but, as has been shown in this article, there is growing research evidence attesting to the beneficial outcomes of supported housing. Further research is needed that compares the outcomes associated with supportive and supported housing, since there is little research that evaluates the differential outcomes of these two approaches. The shift to supported housing is clearly transformative in the sense that it represents a new way of thinking about people with serious mental illness as people who are competent and capable of making choices about their lives, not as patients who are sick and need someone to take care of them, and a new way of thinking about housing as a basic entitlement of life, rather than as a therapeutic environment. While there is a long way to go in terms of making this vision a reality, there are several strategies that can be used to make this shift.
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References


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