

June 18, 2001

**AACP POSITION STATEMENT
ON
HOUSING OPTIONS FOR INDIVIDUALS WITH
SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)**

The problem of providing both housing and housing supports to individuals with serious and persistent mental illness presents significant challenges and controversies to mental health system planners and clinicians. These challenges result from several key issues:

1. Access to affordable housing is severely limited in most communities, so that consumer choice is even more severely limited. Furthermore, consumers may consequently experience housing negotiations with the mental health system as coercive, in the sense that provider imposed requirements become conditions for obtaining any housing at all.
2. There is substantial conflict between the preference of many consumers to live in independent, normative housing, integrated into the community, and the desire of mental health clinicians, family members, and the community at large to maximize safety and reduce risk of relapse and dangerous behavior by providing residential settings that are closely supervised, highly structured group living arrangements
3. There is conflict between the view that housing in the least restrictive setting is a fundamental right for individuals with disabilities, even if those individuals refuse treatment recommendations, and the view that providing housing without requiring treatment participation is at best enabling and at worst medico-legally irresponsible.
4. Finally, the problem of homelessness among individuals with serious and persistent mental illness continues to increase, most prominently among individuals with co-occurring substance use disorders. However, there is considerable controversy regarding what types of housing programs and supports should be made available to meet the needs of these difficult individuals, particularly with regard to the question of whether such supports should be offered to individuals (with SPMI) who continue active substance use.

This position statement is intended to address these controversies by identifying key philosophic principles for planning and providing housing supports to persons with SPMI, and then establishing general guidelines for the types of housing options that should be available in any system of care, and suggested methodology for planning these options to meet client needs.

Fourteen Principles

1. **Provision of safe, adequate, and appropriately supported housing for individuals with serious and persistent mental illness is a priority.** AACP believes that provision of housing and prevention of homelessness must remain a priority of all treatment systems addressing the needs of individuals with SPMI. Consequently, the range of housing options, particularly for individuals with co-occurring substance use disorders, must be developed with that priority in mind.
2. **Individuals with psychiatric disabilities should not be institutionalized because of lack of housing options.** The Olmstead decision creates a clear imperative to develop a range of housing supports to permit individuals with SPMI access to community-based housing in lieu of remaining in restrictive institutional settings in the public mental health system. AACP believes that there should be the same imperative to provide housing in lieu of inappropriate institutionalization in correctional facilities or nursing homes.
3. **Housing for individuals with SPMI is an issue for the whole community, not just for the behavioral health system.** Treatment systems must take initiative to establish relationships with public and private housing “providers” in the community (such as local housing authorities) in order to develop collaborative strategies for enhancing access to a wider range of housing options.
4. **Housing options should be designed to promote empowerment and recovery, through creating options that support consumers’ preferences for adequate assistance to achieve normative housing and full community integration.** Housing choices should not be restricted to segregated mental health “ghettos”, and consumers should neither be expected to remain indefinitely in supervised group homes or other artificial housing environments, *nor to move prematurely to more independent settings to satisfy arbitrary program requirements.*
5. **Housing options should be prioritized to be responsive to consumer choice and preference wherever possible.** Consumers are presumed to be competent to make housing choices, even if those choices are in conflict with the recommendations of their caregivers, and are entitled to access to supports in the settings of their choosing. In addition, choices regarding participation in treatment, substance use, and living companions should be respected as much as possible.
6. **Housing support options should maximize opportunities for individualization and flexibility in matching housing to consumer needs and preferences.** Housing services need to move away from attempting to fit consumers into pre-existing “slots” in pre-designed models of care, and move toward flexible wrap-around supports that can be more individually designed. In addition, housing services should be designed to maximize the consumer’s ability to maintain continuous treatment relationships in the context of housing transitions.

7. **Housing support options should be designed in a culturally competent manner, and promote integration into community environments that support consumers' cultural and linguistic preferences.** This follows directly from the prior two principles. Cultural flexibility in housing services is enhanced by emphasizing individual and small group arrangements in scattered site apartments with flexible supports, in comparison to more traditional group home models.
8. **Individuals who are transitioning from the child and adolescent system to the adult system are a particular priority population for housing services.** Specific supports are needed to promote the development of independent living skills within a safe context. Other age-based transitions (e.g., those which result from an aging and potentially medically infirm SPMI population) also require specific planning and attention.
9. **For individuals who are NOT competent to make the full range of independent choices, caregivers must proactively establish the need for protective services and provide appropriate safety and supervision in the least restrictive possible manner.** This can range from payeeships for those whose areas of lack of competence are primarily in the area of money management, to fully supervised environments for individuals with significant cognitive compromise or demonstrable likelihood of dangerous behavior in unsupervised settings.
10. **Individuals should have access to a full range of treatment options in association with housing, and treatment requirements (if any) should be individualized based upon client need and preference as much as possible.** Housing options should not routinely require arbitrary participation in pre-arranged treatment. Treatment options should include participation in stage-specific substance disorder treatment, and access to a range of options for medical care.
11. **Within the context of consumer choice, providers should proactively offer assistance to promote safety, prevent relapse, and build recovery.** Simply because consumers are not required to participate in treatment does not mean that assistance should be withheld, or offered only passively. Housing support staff can work actively to encourage consumers to make the best possible choices without rejecting them for making the wrong ones.
12. **Within the context of consumer choice, abstinence from alcohol and drugs is consistently encouraged, but housing options should not be denied because a consumer continues to use substances and/or is unwilling to accept abstinence as a goal.** For this reason, housing options should include abstinence-expected housing, abstinence-encouraged housing, and consumer choice housing. These options will be described further below.
13. **Public sector systems should develop mechanisms to encourage providers to provide the full range of housing options to consumers who continue to engage in risky behavior.** *The premise of consumer choice housing is that risk of harm will be reduced for these individuals if basic needs are met and opportunity to engage with treaters is provided. Nonetheless, providers may be exposed to significant risk of liability for individual instances of harm that*

may occur. Consequently, AACP recommends that public systems facilitate initiatives for shifting liability for such programs from individual agencies to broader risk pools.

- 14. Clinical decisions regarding housing recommendations should be based on evidence based best practice whenever possible.** More research is clearly needed to identify which housing models are most appropriately matched to consumers with particular needs or characteristics. Housing programs should therefore incorporate program evaluation efforts into program design whenever possible.

Dimensions of Housing Variability

Housing supports and housing programs can vary along multiple dimensions. **AACP recommends maximizing choices and flexibility along as many of these dimensions as possible.**

- 1. Independent vs. group living**
- 2. Wrap-around flexible support (supported housing) vs. staff model support (e.g., group home).**
- 3. Consumer lease vs. program owned**
- 4. Scatter site vs. congregate living**
- 5. Programming optional vs. required/integrated**
- 6. Loosely structured vs. highly supervised**
- 7. Medical care off site vs. VNA vs. on-site nursing care**
- 8. Self-medication vs. medication monitoring vs. med administration**
- 9. Consumer choice re: substances vs. abstinence encouraged or expected**
- 10. Permanent housing vs. transitional vs. temporary (shelter).**

Comprehensive Housing Array

The AACP position statement is as follows: In any service area or catchment area, there must be provided a full range of housing options for individuals with SPMI, including those with active co-occurring disorders.

First, a significant body of literature has established that individuals with SPMI predominantly prefer to live independently in normative, scattered site housing, with few requirements, and access to flexible supports as needed. When such supports are made available with sufficient intensity, these supported housing models produce significantly better outcomes at lower costs than more rigid group home models.

Consequently, AACP recommends maximizing availability of supported housing. Assessment of supported housing requirements begins with assessment of consumer preferences and their perceived needs for support.

Second, despite the aforementioned literature, there remains a significant minority of individuals with SPMI who **prefer** a group home, or whose level of impairment leaves them unable to care for themselves in an independent setting.

Consequently, AACP recommends that group home models remain available to the extent that the aforementioned needs assessment establishes a cadre of individuals who prefer such settings or who require such settings.

Third, psychiatric housing programs (which provide or support a place to live for individuals with psychiatric disability, in order to prevent homelessness) must be distinguished from addiction (or psychiatric) residential treatment programs (which provide episodes of treatment in a residential setting, usually with defined expectations or requirements). Both are important components of a comprehensive system of care.

In most service areas, the addiction treatment system provides a range of addiction residential treatment programs and sober housing programs (e.g., Oxford House model programs), all of which need to be abstinence-expected programs, in order to protect the integrity of the addiction recovery support provided. Individuals who enter these settings are seeking a sober recovery environment, not merely housing, and expect these requirements to be enforced. Ideally, all such individuals have a plan for housing in the event that they fail to meet program requirements and are prematurely discharged.

The mental health system, by contrast, provides mainly housing support programs for individuals with SPMI. Many of these individuals have co-occurring substance use disorders, but vary in their willingness to define substance use as a problem and/or identify sobriety as a goal, even though they may desire assistance to maintain stable housing. Some of these individuals are simply unable or unwilling to limit substance use, even when all housing supports available require such limits; these individuals frequently become homeless as a result.

Consequently, the range of housing supports and programs for individuals with SPMI (with or without co-occurring disorder) who need housing assistance due to psychiatric disability, and who are at risk of homelessness, MUST include the following choices:

- a. **Abstinence-expected (“dry”) housing:** This model is most appropriate for individuals with comorbid substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. Such models may range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than “one strike and you’re out”.
- b. **Abstinence-encouraged (“damp”) housing:** This model is most appropriate for individuals who recognize their need to limit use and are willing to live in supported setting where uncontrolled use by themselves and others is actively discouraged. However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than

substance use per se. Motivational enhancement interventions are usually built in to program design.

- c. **Consumer-choice (“wet”) housing**. This model has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (cf. Tsemberis & Eisenberg, “Pathways to Housing Program” in Psychiatric Services, April, 2000). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach.

In many systems, the latter option is unavailable, despite its potential value for preventing or ending homelessness.

Consequently, AACP specifically endorses the consumer choice housing model as a valuable component of the system of care. Consumers with psychiatric disabilities who need housing support, including those who have “failed” sober group living, should not be left homeless simply because of inability or unwillingness to maintain abstinence.

Assessment of Housing Requirements

In any system of care, a systematic process of assessment is required to determine the needed housing array.

AACP recommends utilization of a formal tool, like the LOCUS , for assessing housing “needs”, in combination with assessment of consumer competence, consumer choice, and family/caregiver choice, in order to determine the best housing option for each consumer. When the choice of a competent consumer conflicts with provider recommendations, consumer choice should be given priority, assuming necessary wraparound supports are available.

Conclusion

The AACP is hopeful that this document will prove valuable to any system attempting to design a comprehensive array of housing supports for individuals with SPMI. We welcome feedback regarding how this document can be improved or amended to more adequately accomplish its purpose.