

in community

Innovations in Housing and Support for People with Psychiatric Disabilities

From the Editors

This issue of *In Community* is dedicated to the discussion of supported housing services and supports which are being offered through Clubhouse programs. The lead article discusses the potential benefits and challenges of linking these two approaches to supporting people with psychiatric disabilities. *In Practice* describes three clubhouse programs providing housing supports, including one clubhouse that is completely operated by consumers. The *In Person* article summarizes the comments of two Clubhouse members who have been participating in Genesis Club's supported housing program.

This issue's *In Research* is a special article which summarizes some of the major findings of 26 studies on consumers' preferences for housing and supports, collected and analyzed by Beth Tanzman.

Finally, we hope you will read our *In the Future* on page 7. Our next issue, which will be the last under this project, will address critical staffing issues, including the hiring of consumers and managing blended staffs.

Clubhouse-Based Supported Housing: The Fifth Right?

By Laurie C. Curtis, M.A.,
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The Clubhouse model of rehabilitation services is based on the principles of self-determination, membership, opportunity, and on-going support. Through a Clubhouse program, persons with psychiatric disabilities have an opportunity to come together in supportive communities for help to meet personal, social, vocational, and educational goals. The Clubhouse philosophy states that members have the following rights:

- 1) To belong;
- 2) To have meaningful work;
- 3) To have meaningful relationships; and
- 4) To return.

Should housing be considered a fifth right? If a strong Clubhouse emphasizes an individual's right to work at gainful employment, should it not also guarantee its membership a right to live in safe, decent, and affordable housing? These questions are actively being raised within the international Clubhouse movement.

Clubhouses have traditionally been concerned about the housing needs of their members. A number of clubhouse agencies have developed residential programs, including congregate living arrangements and scattered site apartments; however, the majority of members live in non-club operated residential settings. The need of members for decent housing and the Clubs' desire for philosophical congruence between the Club and housing services have spurred the development of supported housing services within many clubs.

The Marriage

The Clubhouse model has pioneered many aspects of rehabilitation which are currently gaining momentum in the field; empowerment, peer support and self-help, dignity, the importance of community and connections, the healing power of meaningful work, and blended relationships between members and staff. The Club environment nurtures non-hierarchical, "peer" relationships between members and staff. Members choose their level of involvement with the club based on their own needs at different points in time. Members are actively involved in daily program operations and decision making, and are often hired as paid staff.

Clubhouses have typically developed supports which are based on members preferences and which are organized around normal adult work and social patterns (e.g. work "units" in the Club which function like departments of a business, shared meals, adult education, banking services, and part-time employment outside the Club).

Current Clubhouse standards (Probst, 1992) outline the following expectations which are synchronous with the supported housing approach. "The Clubhouse is committed to securing a range of choices of safe, decent, and affordable housing for all members. In Clubhouse housing:

- a. Members and staff manage the program together;
- b. Members who live there do so by choice;
- c. Members choose the location of their housing and their housemates;
- d. Policies and procedures are developed in a manner congruent with the rest of the Clubhouse culture;

- e. The level of support increases or decreases in response to the changing needs of the members;
- f. Members and staff actively reach out to help members keep their housing, especially during periods of hospitalization.”

The Challenges

In Home Support Services

A clubhouse is not typically organized to provide in-home assistance with practical activities such as cooking, home maintenance, or neighbor relationships. “Outreach” tends to refer to the responsibility of members of a work unit to contact other members of the unit if they have not been seen for a while. Individuals involved in supported housing may or may not be actively connected to the Clubhouse units. Therefore, a special challenge of Clubhouse-based supported housing is determining out how to “unleash” support from the Clubhouse and to develop mechanisms for delivering a variety of supports to individuals in their own homes. This means going to the individual – rather than expecting the individual to come to the Clubhouse – and developing strategies to ensure intensive in-home support to persons with high needs (Curtis, 1993).

Crisis Support. Clubhouses do not typically provide after-hour availability or crisis intervention. These services are usually provided by other agencies or other components of the mental health system. Individuals in apartments talk about the importance of having access to a support person (staff or peer) any time of day or night. This helps people to handle difficult feelings before they become unmanageable.

Community Integration. The Clubhouse approach is one formal mental health service that clearly understands and operationalizes peer support, including outreach by members, social and leisure activities, and connections formed through active participation in the Clubhouse. However, peer support is a primary function of the Club, and there is little systematic effort to help individuals develop connections with the community outside of the Clubhouse membership. Many individuals living in their own homes are asking for assistance in building stronger networks in the community. Supported housing philosophy emphasizes the importance of community integration and helping individuals to make connections with persons with and without psychiatric disabilities, including neighbors, church members, community organizations, co-workers and others. There can be tension in Clubhouses between keeping members closely connected with the Club community and nurturing their connections with the outside community.

Housing Activities

Few Clubhouses have taken on the challenge to develop a clear vision or strategic plan relating to the Club's role in housing for their members. There is often confusion as to whether housing should be a place to live or a treatment setting, and little has been done to determine the housing preferences of Club membership. In a recent survey of 43 studies of consumer housing and support preferences (Tanzman, 1993), none were conducted by Clubhouses of their membership. Such surveys can be an important tool to inform local housing planning and advocacy activities. (See *In Research* page 6.)

Housing activities within the Clubhouse are typically done by a "housing unit." The unit's responsibilities vary from Club to Club, but may include: providing information on housing, apartment location assistance, managing overall apartment maintenance, rental collections, sight of rental subsidies or contingency funds, and screening and placement. Often the Clubhouse leases units of housing from community landlords and then subleases them to members. Since it is the housing unit which also typically assumes the supported housing services in a Clubhouse setting, it may potentially be in the position of both providing in-home support services and collecting rentals at the same time. This can place the staff and unit members in awkward role conflict and covertly make housing tenure contingent upon treatment compliance.

Risk and Safety

Who decides the issues of risk and safety? An approach of staff and members working together with ongoing psychiatric, family, and case management consultation may be called for to clarify ways to provide support and minimize risks, given individualized needs and concerns, urban and rural challenges, high risk neighborhoods, and other challenges.

Clubhouse Organization

Program or Unit? Since the Clubhouse is based on work units, the Club needs to clarify whether supported housing is a discrete service offered to a few members within the Club or an integral part of the Clubhouse. Funding sources may dictate that the program be discrete which may cause conflict with the work unit structure and "generalist" orientation of the staff. Since each unit is charged with outreach to its own unit members, should the unit also provide the in-home outreach to its members or is that service provided elsewhere in the Club?

Who is served? There is a tendency to reserve supported housing resources for "higher functioning" members who may need less supports. In transitional employment programs, the major criteria is a desire and willingness to work – not functioning level. The challenge is for Clubs to operationalize this concept in supported housing.

Conclusion

The development of clubhouse and supported housing approaches is “co-evolutionary.” There is a natural philosophical affinity between the two approaches and enough difference to stimulate reflection, cross-fertilization, and creative synergy. While there are both advantages and challenges to blending supported housing and clubhouse approaches, the greatest challenge is to remain focused on the common goal: to remain open and responsive to the expressed needs of persons with psychiatric disabilities in a field more often driven by funding, personnel, and political needs.

Acknowledgements:

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References:

- Curtis, L.C., (1993). Personal Correspondence with Kevin Bradley, Executive Director, Genesis Club.
- Probst, R.N., (1992). Standards for Clubhouse Programs: Why and How They Were Developed. Psychosocial Rehabilitation Journal, 16:2, 25-30.
- Tanzman, B., (1993). An Overview of Surveys of Mental health Consumers’ Preferences for Housing and Support Services. Hospital and Community Psychiatry, 44:5, 450-455.

in person

The following are comments made in interviews with Yeteive (“T”) Clark and Christopher M. Smith, both members of Genesis Club, Inc. in Worcester, Massachusetts. They work with the Housing Unit at the Club and participate in the Club’s Supported Housing Program.

Please tell me about your involvement with the Supported Housing program at Genesis.

Yeteive: I’ve been involved in the program for about 2 years – right from the start. I was in a residential program before and had been feeling that I was ready to do it on my own for awhile...I have my own lease. I had a rental subsidy from Genesis at first, but now I have a Section 8 Certificate. I was fortunate and got a subsidy within 4 months. I applied while I was still in my last residential placement. I am also involved in the housing unit which helps people find apartments and gives out information on housing. It’s more than cutting coupons.

Christopher: I was in the right place at the right time. I was looking to leave the residential program I was living in at the time. I have a yearly lease. I have moved once

since January, 1992, because I wanted to; I'd never had that luxury before! I live in a nice neighborhood. Nobody dictated to me where I could live. I get a Genesis rent subsidy, and I am on the waiting list for a Section 8 Certificate. I live alone. Sometimes it gets lonely, but most of the time I really like it.

Why did you choose to get involved in this program?

Yeteive: I liked the whole idea of having my own place and having someone there in case I needed help. I want to cook when I want to cook, and clean when I want to clean. When I realized that someone would be there when I wanted, it just sounded so great. [Although] I wondered, "Will they be there to do all the things they say they will?" And, they were.

Christopher: Well, I needed a place to live. I wanted to take charge of myself and not really have to answer to anyone (except for how people normally answer to each other). There isn't as much of a hierarchy in this program as in other residential programs where I felt controlled much of the time. I don't have to worry about privilege levels or jumping through hoops. Don't get me wrong. I was in a good residential program, but even a gilded cage is still a cage. Now, I'm the one making the choices and taking responsibility for them. There is no one else to blame if things don't go well.

Are there any differences between supported housing, and other programs you've been involved in?

Yeteive: I was in adolescent group homes and adult group homes. The staff was constantly there, sometimes way too much. In the adult home, the staff said you had choices, but they still had rules they wanted you to go by. For example, they would say "You don't have to be out of the house at a set time," but if you came from your room at 10:30 a.m., they would ask "Don't you have someplace you have to be? Don't you have a day program?" In this program, when I need help, I know how to come and ask for it. I know they'll be there when I ask for help.

Christopher: A clubhouse has a different attitude than many programs. It's based more on peer relationships than on staff-patient relationships. It's more genuine.

What aspects of the program have been the most helpful to you?

Yeteive: The 24-hour beeper coverage. When I was having a very difficult time, it was great. There is an amazing amount of support for me – I've certainly tested it. Just knowing someone is always there either in the middle of the night or during the day has helped me get through some difficult times. I need help constantly with budgeting, and I can go in and say, "this is what I'm having trouble with." They help me understand that I'm not the only one in the world with budgeting problems – lots of people need help!

Christopher: The beeper system has been very helpful. At 11:30 p.m., when I've had a hard day, things have come up; and most of the people I know are in bed or are not accessible. The beeper is always there. They always call me back; and they're not judgmental. They know that if you call, you need the help.

Is there anything that you would change about the program?

Yeteive: No, not really. I'm not saying it's perfect, but it is close. I do think they should increase the availability of the program and get more people involved. I hope people continue to have an interest in supported housing and that it continues to grow. It helps people get along farther than we can ever imagine. It makes a significant difference in peoples' lives. Just getting an apartment helped me move on to other things. It has given me back hope in my life, god knows.

Christopher: I would try to get more money to have more slots for people. There are 50 people on the waiting list. I would also have all the people in supported housing get to know each other a bit better, to be more of a group. All of us live alone, or most of us do. It would be nice to have more of a sense of community within the program itself, get together monthly or do things together. Peer support often goes unused.

Any last comments?

Christopher: Supported housing is cost efficient, compared to other residential programs or the hospital. I'm getting services, but I'm also out on my own. It's not widely recognized yet, but it really can work for people. It's worked for me, and I'm pretty skeptical.

in practice

Clubhouse programs have always been concerned about the housing needs of their members. Recently, there has been a strong shift in these programs toward supported housing approaches to housing. This article describes the supported housing services being developed by three clubhouse programs.

Genesis Club, Inc.
Worcester, MA
Kevin Bradley, Executive Director

Genesis Club began providing supported housing services in early 1991. The Club received a grant from the Massachusetts Department of Mental Health to develop a pilot supported housing program for 29 persons with long term and severe mental illness. The major objectives of this project were to:

1. Provide an alternative to the existing residential programs in the area;

2. Reduce the rate of frequency and duration of overall psychiatric hospitalizations for members in supported housing;
3. Have members in key decision making roles regarding the operation and implementation of the housing component.

Over half of the tenants came into the program directly from the state hospital; the majority of the remainder moved from a community residential program. As a pilot project, the overall Clubhouse community (members, staff, landlords and Board of Directors) identified the following areas as key program components:

1. Members choose their own location and type of housing including selection of roommates;
2. Members and staff manage the housing program together. There are no separate residential components or staff meetings to set policy;
3. Participation is voluntary in all housing and Clubhouse services.

A twenty-four hour on-call support network (a beeper system) was also developed, staffed with consumers and Genesis members. A mobile outreach capacity was also created to augment the supports of the Clubhouse. This included an in-home respite system also staffed by members and consumers. A respite apartment was initially established, but was discontinued after one year of operation due to low utilization. A bridge subsidy is also provided until federal or state subsidies are received. Members also have participated in all hiring and review of Housing, respite and on-call staff. During the two years that the program has been operational, its initial objectives were met and then exceeded. After eighteen (18) months of operation, the program has documented some dramatic results in decreased rates of hospitalization and increased rates of employment and education. For example, 90% of the total members in supported housing have maintained their own apartments without eviction. Only four members have been re-hospitalized at the State Hospital for short periods of time. Two-thirds of the members have returned to work or education. Plus, two housing members have become parents and are the major caretakers of their child.

Fountain House
New York City, New York
Kenn Dudek, Executive Director

Fountain House has been involved in offering housing to its members since 1958, when the agency began renting apartments and subleasing them to groups of members. The housing was unstaffed and its purpose was to guarantee availability of affordable housing in a highly competitive market. In the past decade, the agency has gradually expanded its housing capacity to serve 350 persons. The agency is currently in the process of converting 250 of these slots to supported housing, including two 24-hour staffed residences and the existing scattered-site “graduate” housing program. The goal

is to get an apartment support system in place that can take people straight out of hospital or off the streets, and into apartments, with less emphasis on members earning graduate apartments by successfully moving through a continuum of housing options. This shift entails changes in the character and delivery of supports available in the housing, as well as some changes in the Clubhouse units' function.

Housing Unit. The Housing Unit is responsible for all 250 persons in the program and is divided into two teams. A Housing Support Team provides practical in-home assistance focused on transition, apartment maintenance, and periodic "check in" visits. This team also helps monitor the condition of the apartment and provide management or preventive support as needed. A Response Team goes to people's apartments in crisis situations and times of distress. It is available daily, but emphasizes evening and weekend outreach.

Clubhouse Base. The Clubhouse provides a welcoming place for people to be, day to day support, social connections, and work opportunities. The Clubhouse requires that participants in the residential programs be Club members, but is very flexible about their level of participation. Members in supported housing dictate the frequency and intensity of in-home support activities. The Clubhouse work units continue to provide active telephone outreach when individuals do not come into the Club. The Housing Unit will follow-up the work unit telephone outreach with in-home outreach to supported housing members.

Education Unit. This unit provides adult education workshops designed to help adults learn to live successfully in their own apartments, including topics such as cooking for one, living with housemates, and home maintenance. Many classes are offered in the evening.

New Services. Plans are underway to develop a "warm line" which would be operated by members and would provide informal telephone support; and a "hot line" which would provide telephone support (e.g. information, supportive counseling, and referrals to other support resources) to persons in crisis situations.

Members' Role. Members play an involved role in the planning process, and in developing and implementing new services. Members have been hired to be staff of the Housing Support Team and the Response Team.

**Capital Clubhouse
Olympia, Washington
Lee Mosely, Executive Director**

Capital Clubhouse, located in Olympia, Washington, is operated and staffed entirely by consumers and ex-patients. The Clubhouse opened December 1989, through a grant provided by the National Institute of Mental Health. Funding has since been provided by

the Thurston/Mason Regional Support Network to serve a two county area. The Clubhouse has served an estimated total of 150 adults with psychiatric disability since 1989. Currently, there are about 20 active members, and another 70 inactive or partially active consumers, averaging about 25 members visiting each day. The Clubhouse does not limit its membership to persons who are linked with the community mental health system. Not all members fit the “chronic” criteria.

The Clubhouse has a total of eight staff, five full-time and three part-time, who provide leadership in a variety of areas and who also back each other up as needed. Lee Mosely, Executive Director, and Cheryl Crist, Clubhouse Manager, fulfill administrative and management functions. There is a full time Advocate and a full time Education and Employment Specialist who provide a great deal of direct support to members. There is also a Clerical Unit Leader, who coordinates the publication of a newsletter; a Kitchen unit Leader, who supervises kitchen unit functions and work training in cooking, serving and cleaning related to the daily meal provided by the clubhouse; a Social and Recreation Leader, who supervises member activities and teaches leisure skills to members; and the Capital Players Leader who lead a popular group of members who perform throughout the state to inform the public about mental illness and decrease the effects of stigma in the community.

Advocate, Debbie Harding, is dedicated to providing a variety of supports to members. “People are so busy focusing on their basic needs, how can they focus on growth? Learning to understand their illness and manage their symptoms even loses priority to their basic needs for food, clothing, shelter, transportation, etc.” Debbie provides information, referral, transportation, and support to link members with resources in the community. She assists with obtaining housing applications, subsidies, bus passes, locating clothing, locating apartments, moving, going to the food bank, getting to medical appointments; they even helped repair one member’s car. Staff and members will visit a member who is temporarily in the hospital, bringing them personal belongings, offering support, and helping them to maintain the connections they need to return to their home in the community. They also provide support to members who are involved with the legal system, referring them to attorneys and the human rights commission, visiting members in jail, supporting them in court, and advocating with law officials.

The Clubhouse is very proud of the work of their Education and Employment Specialist, Bill Arensmeyer, a former teacher who collects information on local employment opportunities, provides job counseling, helps assess job goals and abilities, teaches job finding skills, and provides transportation to employment and training programs. In addition, the Clubhouse offers numerous classes for members, using resources from within the community, on a wide variety of topics including, medication, symptom management, communication skills, self defense, HIV/AIDS awareness and prevention, crisis response, the criminal justice system, client rights, and vocational and rehabilitation services. Members are trained as if they are to be case aides and are

awarded certificates of completion; so that they may not only help themselves, but help to support other members as well.

Debbie noted, “It’s people helping people! People are cautious of mental health professionals; they’re frightened of being hospitalized...Persons with mental illness can help each other and work together. They can be productive, and they have so much to contribute.” Likewise, Cheryl added, “For me, having a place to go where you could talk about your illness and not be rejected (was most helpful). It’s different for each individual. For some it’s jobs; others it’s advocacy or an address; and for some it’s having a good hot meal once a day.”

Lee Mosely also commented on the importance and uniqueness of the consumer operated alternative: “Most importantly, it’s a safe and welcoming place where people are encouraged and comfortable to share their experience without being interrupted or judged by mental health standards. The level of acceptance is one that may not be experienced in other environments. Staff here is perceived differently than a mental health professional would be. It allows us to be a healthy alternative and supplement to the mental health system.”

Resources

For further information about supported housing in Clubhouses contact:

Atlantic House
338 Washington Street
Quincy, MA 02169
Contact: Belinda Ellison

Baybridge
278 Main Street
Hyannis, MA 02601
Contact: Laurie Tranchell

Beach House
3143 Magic Hollow Road, Suite 100
Virginia Beach, VA 23456
Contact: Amy Darden

Capital Clubhouse
618 Seventh Avenue S.E.
Olympia, WA 98501
Contact: Sue Allen

Fountain House
425 West 47th Street
New York, NY 10036
Contact: Kenneth Dudek

Genesis Club, Inc.
274 Lincoln Street
Worcester, MA 01605
Contact: Kevin Bradley

Vail Place
1412 W. 36th Street
Minneapolis, MN 55408
Contact: Kathie Prieve

in research

Mental Health Consumers' Preferences for Housing and Support Services

By Beth Tanzman, M.S.W.

Increasingly, mental health services are implementing policies that reflect “consumer-driven” or “client-centered” systems. The growth of research on consumers’ preferences in the areas of housing and support services echoes this shift. In 1992, at least 43 studies on consumers’ housing and support preferences were completed in 24 states and two Canadian provinces (Tanzman, 1993). Almost all of the studies, 40 of 43, drew their samples from among people who were receiving mental health services from a variety of out-patient programs, including residential and day programs and medication management programs. The research methods and instruments used in 26 studies were similar enough that their findings could be compared. These 26 studies surveyed a total of 4,438 adults with psychiatric disabilities.

Housing. The most frequently reported current housing arrangement was independent living or living in the respondent’s own house or apartment. The exceptions to this trend were six studies that targeted people who were hospitalized or homeless or who lived in board-and-care homes or other group facilities. The second most frequently reported current housing arrangement was living with family. Despite the variety of target populations, sampling strategies, implementation methods, and geographic regions, strikingly little variation in respondents’ housing preferences existed among studies. The most preferred housing arrangement in every study was independent living in a house or apartment. In 20 of the studies, at least 70 percent of the sample mentioned this preference.

Housemates. In 16 of 22 studies in which this issue was addressed, the majority of respondents preferred to live alone. Sixteen of the studies asked respondents if they would prefer to live with other consumers. In 14 studies, most consumers reported that they would prefer not to live with other consumers.

Staff support. Respondents were asked to identify what supports they would need to succeed in their preferred housing arrangement. In 22 studies, the two most frequently cited staff-related supports were the ability to reach staff any time of the day or night and help in dealing with emotional upsets and crises. Between 64 and 96 percent of respondents in each study reported needing these two supports.

The next most frequently cited supports in all 26 studies were the availability of staff to come to the respondents’ home any time of the day or night and help in budgeting money. In addition, thirty to 55 percent of respondents from each study reported needing regular home visits from staff, and 16 to 47 percent reported needing help managing

medications. Relatively fewer respondents reported that they would need help with cooking and shopping. The least cited support in each study was live-in staff, named by 26 percent of respondents.

Material supports. In every study the most frequently cited material supports were more income and benefits and money for a deposit on housing. Fifty to 95 percent of respondents in the 26 studies said they would need more financial resources to succeed in their preferred housing arrangement. The second most frequently identified supports were telephones and transportation, cited by more than 50 percent of the respondents in each study.

Conclusions

Findings from recent studies on consumers' housing and support preferences show that a majority of consumers of mental health services prefer to live in their own apartments or houses and not in residential mental health programs or facilities. Most respondents would prefer to live alone or with a spouse or romantic partner or friends. This reflects a desire for social integration and participation in typical social roles such as spouse and parent.

Consumers preferred not to live with other mental health consumers, indicating a desire not to be grouped in living situations on basis of disability. This finding may also reflect a reaction against the practices of traditional residential services, which tend to offer consumers too little choice in decisions about where and with whom they will live.

Three themes emerge from the findings on supports. First, although consumers strongly prefer independent living arrangements, such arrangements are not construed by respondents as living without support from mental health staff, friends, and family members. The second theme is a consistently strong preference for supports that are available on an as-needed basis, rather than supports that are constantly available. The third theme emerging from the findings on support preferences is the importance of material supports such as more income, housing subsidies, transportation, and telephones. Consumers' success in housing arrangement of their choice may be as much an economic issue as a clinical issue.

in fact

- The single most frequently preferred arrangement reported in 43 different consumer housing preference surveys is “my own house or apartment”.
- The least preferred housing options were a psychiatric hospital or being homeless.
- When asked, nearly two thirds of consumers would prefer not to live with other mental health consumers.
- In order to succeed in the housing of their choice, most consumers report that they would need “help dealing with emotional upsets and crisis” and “to be able to reach staff any time of the day or night”.
- Two of the material supports that consumers most frequently cited needing were telephones, and money for rental deposit on housing.

References:

Tanzman, B. (1993). Researching the Preferences for Housing and Supports: An Overview of Consumer Preference Surveys. Hospital and Community Psychiatry, 44 (5), 450-455.