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Conceptualizing community: A comparison of neighborhood characteristics of supportive housing for persons with psychiatric and developmental disabilities

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ABSTRACT

Housing and services for persons with developmental disabilities (DD) have been shaped by the normalization approach, a commitment to full integration within the general community. In contrast, housing and services for persons with psychiatric disabilities (PD) have had various and sometimes conflicting goals, including provision of custodial care, promotion of therapeutic community, and community integration. This cross-field study compares the neighborhood characteristics of publicly-funded housing for the PD and DD populations in a metropolitan community. The aim of the study was to examine whether the contrasting housing approaches are reflected at an ecological level and to consider how these findings relate to the goal of community integration for people with PD and DD. Administrative databases provided residential addresses of 1932 residents with PD living in 297 locations and 1716 residents with DD living in 749 locations in the city of Philadelphia. The 2000 U.S. Census and city's police department database provided information on neighborhood characteristics. Geographic information system (GIS) methodology generated maps displaying the distribution of housing locations in relation to spatial dispersion, distress, stability, safety, and race/ethnic diversity. Statistical analyses compared neighborhood characteristics of the DD and PD populations. Findings indicated that the DD population in supportive housing was more spatially dispersed, and lived in less distressed, less unstable, more secure, but equally racially/ethnically diverse neighborhoods when compared to the PD population in supportive housing.

Greater geographic dispersal among persons with DD may be the result of more emphasis on normalization within policies and programs determining the location of their housing. The higher funding levels for housing and residential support for persons with DD also provided programs with the option of placing people in higher income neighborhoods. Given that community integration has emerged as an organizing principle within mental health services over other models, policymakers in the field of psychiatric disabilities may have much to learn from the normalization movement for people with developmental disabilities.

Introduction

The impact of deinstitutionalization on the lives of people with disabilities has been a central concern for policymakers and researchers throughout Europe and North America (Emerson, 2004; Mechanic & Rochefort, 1990). Given the emergence of community integration as a key goal and guiding principle of public policy (Racino, 1995) and the findings that housing and neighborhood characteristics are critical in affecting the quality of community living (Baker & Douglas, 1990; Harkness, Newman, & Salkever, 2004; Newman, Harkness, Galster, & Reschovsky, 2001), the extent to which people with disabilities have been integrated into the community and the conditions of their neighborhoods are important indicators for whether policies pertaining to deinstitutionalization have been successful. Community integration refers to the degree to which people with disabilities have the opportunity to live, work, and recreate in the same manner as peers without disabilities.

In the fields of developmental disabilities (DD) and psychiatric disabilities (PD) in the United States, deinstitutionalization commenced at about the same time, but two distinct service systems have developed to meet the multi-faceted needs of the two populations. Despite commonality in the desired goal of improving the quality of community living in general and promoting

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integration in particular, little research has been conducted on comparing the neighborhood conditions of DD and PD populations. This study integrated management information system data from a local social services system with data from the U.S. Census and an academic research center for cartographic modeling. Based un this data, we examine two dimensions of community integration: spatial dispersal and the conditions of neighborhoods where persons with DD and PD reside in a large metropolitan area. The study focuses on supportive housing, which refers to a collection of publicly-funded programs that couple provision of housing with supportive services that enable individuals with disabilities to maintain tenure in the community. By comparing the neighborhood characteristics of supportive housing for people with DD and PD, we analyze the extent to which public policy is effective in meeting its goal of providing a living environment for people with disabilities that is conducive to their participation in community life.

Background

Deinstitutionalization in the United States for persons with psychiatric and developmental disabilities commenced in the 1950s and has continued to date, influenced by an array of technological, cultural, legal, and financial factors (Mechanic & Aiken, 1987). The residential service systems for the two populations have evolved separately, responding to different philosophies and separate funding streams. Also, people with developmental disabilities and those with psychiatric disabilities have different service and community support needs. In response, the housing provision for people with DD has offered more permanency, while the housing provision for people with PD is more transitional with the end goal of people graduating to independent housing.

Development of housing for persons with developmental disabilities

Care in the community for persons with DD has largely been guided by Wolfensberger's normalization principle, which was further developed in Europe by Nirje's work on social role valorization (Flynn & Aubry, 1999). The principle states that individuals must be integrated into culturally normative settings and given every opportunity to pursue socially valued roles and activities. Wolfensberger argued that institutional settings are harmful because they segregate people with disabilities, thereby perpetuating the public perception of deviance (Wolfensberger, 1983). By living and participating in mainstream society, persons with disabilities would be able to maximize their sense of personal competence and self-esteem. In order to realize the goal of normalization, Wolfensberger developed the Program of Analysis of Service Systems (PASS), a system of evaluation assessing the extent to which human services achieve normalization, social integration, and dignity for its clients (Flynn & Aubry, 1999). PASS made normalization a measurable goal, enabling states to shape their residential care systems according to the normalization framework.

Residential settings for persons with DD vary by size and intensity of support provided to their residents and can be divided into the following categories: (1) supervised therapeutic care facilities providing intensive treatment and rehabilitation; (2) small group living situations facilitating peer relations and community participation; (3) family living situations with a surrogate family; and (4) residents' own homes with flexible support services (Janicki, Krauss, & Seltzer, 1988). The first residential alternative to institutions for persons with DD was surrogate family care designed to assist individuals with mild to moderate disabilities make the transition to independent living. With the acceleration of deinstitutionalization in the 1970s, a second model was developed: group homes offering long-term care with a continuum of supervision and structured care (Janicki et al., 1988). Originally group homes were designed to serve individuals with milder disabilities but currently the group home model has expanded to include persons with severe disabilities. More recently, supportive living arrangements and home based supports have enabled residents to stay in their own or surrogate homes and receive an array of services including assistance with activities of daily living, therapy, and respite care. Services are usually only located on site in the more intensive therapeutic care settings; otherwise, residents attend clinics or have providers visit them in the community.

In the United States, there has been significant increase in persons with DD living in smaller residential settings during the last two decades. Such increase is attributable to legal challenges to institutional arrangements, active lobbying by parents of persons with DD, and legislation providing financial incentives for states to render care in less restrictive settings (Trent, 1994). Legal actions, such as *Pennhurst State School v. Halderman (1981)*, ordered the closure of all large institutions based on the finding that they violated residents' fundamental and constitutional rights. Funding mechanisms for residential services have also played an instrumental role in determining alternative types of housing. In 1971, Medicaid funding was for the first time made available for institutions providing intensive treatment and rehabilitation for persons with DD through the Intermediate Care Facilities/Mental Retardation (ICF/MR) program. Designed primarily to improve the quality of facilities, the program permitted small or "community" facilities of 4–15 people to be classified as ICF/MRs. In 1981, the Home and Community Based Services Waiver further allowed Medicaid funding for non-institutional services with the specific intention of diverting people from Medicaid funded nursing facilities or ICF/MRs (Hill, Lakin, & Bruininks, 1988). With these fiscal incentives, states halved the number of people with DD living in large facilities (with 16 or more residents). Nationally, by 2004, 83.5% of all residents with developmental disabilities were living in settings of 15 or less, 70.2% in settings with six or less, and 46.2% in settings with 3 or less (Prouty, Smith, & Lakin, 2005).

Development of housing for persons with psychiatric disabilities

With the increasing presence of persons with severe mental illnesses in the community since the 1960s, the community support system (CSS) has been adopted as a framework for community care. The CSS, designed in the 1970s by the National Institute of Mental Health in collaboration with state mental health officials, researchers, consumer and family groups, and citizen advocacy groups, refers to "an organized network of caring and responsible people committed to assisting persons with long-term mental illness to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Stroul, 1984, p. 8).

Housing is considered an essential component of the community support system (Stroul, 1989), affecting the quality of life and community adaptation of psychiatric consumers (Wong & Solomon, 2002). In the 50-year span of deinstitutionalization, three major housing approaches have evolved, predicated on the prevailing care ideologies of the times (Parkinson, Nelson, & Horgan, 1999). The three distinct approaches are (1) the "medical model in the community" for providing custodial care; (2) the "rehabilitation model" for developing a residential continuum with facilities varying in intensity of care and levels of restrictiveness to match with consumers' service needs and psychiatric impairment; and (3) the "empowerment/integration model" emphasizing normalized