Housing and Support for People Who Have Experienced Serious Mental Illness: Value Base and Research Evidence

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Geoffrey Nelson and Sarah Peddle
Department of Psychology
Wilfrid Laurier University

The purpose of this paper is three-fold. First, we review past and current trends in housing and support for people with serious mental illness. Second, we propose a value-based approach to housing and support for people with serious mental illness. Finally, the bulk of the paper is devoted to a review of evidence related to the core values that we believe should underlie housing and support for people with serious mental illness. We begin with a brief review of past and current trends in housing for this population.

Past and Current Trends in Housing and Support

Past Approaches to Housing and Support

When the era of deinstitutionalization began in Ontario in the 1960s, the main approach to housing people with serious mental illness in the community was **custodial housing** (Parkinson, Nelson, & Horgan, 1999; Trainor, Morrell-Bellai, Ballantyne, & Boydell, 1993). Many individuals were placed in often times large, congregate housing, operated by private landlords for profit. These settings, which include lodging homes, approved homes, board-and-care homes, domiciliary care, Homes for Special Care, and single-room occupancy hotels, typically provide custodial care rather than active rehabilitation programs. Custodial housing replicates many of the problems of mental hospitalization, and there is no evidence to suggest that such housing leads to an improved quality of life for people with serious mental illness (Parkinson et al., 1999). For example, in a 10-year follow-up study of more than 300 people with serious mental illness residing in sheltered care facilities in California, Segal and Kotler (1993) found that while days spent in hospital decreased over time, participants also reported more health problems and psychiatric symptoms and lower levels of independent functioning and family contact over time.

Beginning in the 1970s in Ontario, non-profit community mental health and housing agencies began to develop **supportive housing** as an alternative to custodial housing. In supportive housing, staff provides case management, support, or rehabilitation in a variety of different types of housing, including halfway houses, group homes, and supervised apartments. In some communities, supportive housing programs were organized along a residential continuum, ranging from high support group settings to lower support apartments (Ridgway & Zipple, 1990). The idea underlying this approach was to *match the needs of the consumer with the appropriate housing type, which was linked to the amount of support*. While several studies have shown that people with serious mental illness who live in supportive housing show improved outcomes, problems with supportive housing and the residential continuum approach

became apparent in the 1980s. These problems include: the fact that consumer survivors do not have choice over where they live or with whom they live; they are often concentrated in one setting, thus inhibiting rather than promoting community integration; and they may be forced to move into a less supportive residential setting when they show improvement, thus disrupting relationships that they have developed with living companions and staff (Carling, 1993; Ridgway & Zipple, 1990).

The Shift to Supported Housing

It was in this context that Paul Carling and colleagues imported the concept of **supported housing** (Carling, 1993, 1995; Ridgway & Zipple, 1990), which had its roots in independent living for people with physical and developmental disabilities, into the field of community mental health. There are several key values of supported housing. One is that people with serious mental illness should have choice and control over where they live and with whom they live. In this regard, the supported housing approach works from a disability rights perspective rather than a medical model. Second, supported housing emphasizes community integration. Rather than creating separate facilities for people with mental health problems, the supported housing approach advocates integration into housing that is available to anyone in a community. Third, to have realistic choices about housing, the supported housing approach recognizes that consumer/ survivors need financial and social support to enable them to operate in a normal housing market context. *The central idea underlying supported housing is to help individuals "choose, get, and keep" the type of housing that they want.* It is the third of these principles that poses a significant practical barrier to achieving implementation of supported housing in many communities. For the most part, consumers do not have the financial resources to obtain the type of housing that they desire. Moreover, support from the community mental health professionals is often linked with certain types of housing rather than being flexible and portable.

Several Canadian supportive housing programs have made the shift to a supported housing approach. In Winnipeg, the Canadian Mental Health Association (CMHA) began a change process with its Supportive Housing Program in 1989 (Parkinson, 1999; Strutt, Maurakis, & Evenson, 1993). At that time, the program consisted of six houses (not owned by the CMHA) that emphasized cooperative, group living for consumers with staff support linked to the housing programs. The CMHA/ National's emerging Framework for Support (Trainor, Pomeroy, & Pape, 1999) was used as the vision for change, and Dr. Paul Carling was brought in as an external consultant to help facilitate the change process. An implementation committee of staff and consumers was used to guide the change process. A highly participatory and value-based approach to change was used to move the organization towards a supported housing model (Parkinson, 1999; Strutt et al., 1993). The six houses were closed down and consumers were moved to independent housing. An entirely new program approach, now called Options in Support and Housing Program, was created and the number of consumers housed expanded from 25 to 125. While some consumers struggled with the new emphasis on independence, staff were able to implement a more individualized, flexible, and recovery-oriented approach to rehabilitation that benefitted consumers (Parkinson & Nelson, 2003). The change process was not easy for the stakeholders. It was lengthy (over two years) and stressful because of the uncertainty that was omnipresent. The staff identified three key process issues: a) everything is

up for grabs; b) getting comfortable with feeling stupid; and c) nothing to fear but fear itself. Clarifying the values underlying the new approach to housing was an important part of the change process, but implementing those values into service principles and concrete actions was challenging for all.

In an article entitled "Supporting People, Not Structures," Pyke and Lowe (1996) described the change process within Regeneraton House, Inc., a supportive housing program in Toronto. At the time of the beginning of the change process in 1990, Regeneration House operated five group housing programs, all with linked staff support, ranging from weekly visits to 24-hour staff coverage. There were between five and 10 residents in the programs. A value-based organizational review was undertaken with the full participation of staff and consumers. The following changes were planned and implemented: a) separating the agency's landlord and support role, b) meeting the unique needs of each tenant, and c) effecting a partnership between consumers and support staff. While people remain in the five housing sites, support was shifted form a "level system" whereby support is linked with a particular site to an individualized approach. Moreover, new housing that was obtained in 1996 consisted of 40 independent apartment units. Both staff and tenants reported many benefits resulting from this shift, and tenants continued to identify problems related to related to group living.

Lord, Ochocka, Czarny, and MacGillivary (1998) analyzed a process of change within Waterloo Regional Homes for Mental Health, Inc. in the Waterloo region of Ontario. Waterloo Regional Homes operated nine separate housing sites, ranging from high support group living to independent apartments. In 1991, the Executive Director and the board of directors began to embark on a change process within the organization. The change process was guided by an external consultant, Dr. John Lord, and involved other external change agents, including Dr. Paul Carling and evaluation consultants, Dr. Joanna Ochocka and Ms. Heather MacGillivary. Like the previously described change processes, a highly participatory and value-based approach was used with consumers, staff, board members, and community members. The change occurred over a period of several years and led to the following outcomes: a) a more individualized approach to staff support (staff support was "de-linked" to housing settings), b) a more broad ownership over the change process, and c) a shift to more consumer power and control. As with the Regeneration House experience, consumers continued to live in settings owned by Waterloo Regional Homes, but support was extended to consumers living in independent housing. Moreover, 80 new units of housing created under the provincial government's Phase II Mental Health Homelessness Initiative in 2001 were independent apartments.

These three initiatives demonstrate that supportive housing programs can be shifted toward a supported housing approach. While not all aspects of the supported housing approach were achieved in two of these cases (e.g., consumers continue to live in group settings that may not be their preference), support and housing were successfully de-linked and power was shifted towards consumers in all three case examples. While consumers welcomed these changes, at least one study of older consumers living in nursing homes has shown that some consumers may be afraid of and resistant to more independent living (Sohng, 1996). Key organizational change processes that were common across the three case studies included developing a vision and values to guide the change process, a highly participatory approach with all stakeholders, a

commitment to shifting power to consumers, expecting the change process to be challenging for everyone, and allowing adequate time to ensure a good process while continually moving forward towards the desired changes.

Towards a Value-based Approach

Today, the distinction between supportive housing and supported housing has become blurred. This is due to the fact that some supportive housing programs have made the shift towards more of a supported housing approach, as we noted above (Lord et al., 1998; Ochocka, Nelson, & Lord, 1999; Pyke & Lowe, 1996). Few supportive housing programs today have limits on how long residents can live in the setting; some have eliminated the "levels of support" system and moved to an individualized support approach in which housing and support are de-linked; and some have strived to maximize consumer choice and control within the constraints of a group housing setting.

In view of this blurring of approaches to housing, we believe that the terms "supportive" and "supportive" housing may have outlived their usefulness. Alternatively, we suggest that for the future development of housing and support for people with mental illness that it is more useful to speak of a value-based approach to housing and support. The key values mentioned earlier that we believe should guide housing and support are:

1. Consumer empowerment - People with serious mental illness should have choice, control, and independence with respect to their housing and supports. Moxham and Pegg (2000) take the philosophy of supported housing a step further by suggesting that supports and housing options should facilitate ownership and control by the consumer.

2. Access to valued resources - People with serious mental illness need to have financial, professional, housing, and social resources to support them in realizing their choices (Nelson, Lord, & Ochocka, 2001).

3. Community integration - Housing and support should enable the consumer to move beyond the service system and professional support so that they can enjoy supportive relationships with peers, friends, co-workers, and family and participate in community activities and settings that are available to anyone in a community (Wong & Solomon, 2002). In our value-based framework, consumers move from being "clients" to "citizens" who are engaged in, supported by, and contributing to their communities.

These values have been articulated in several sources (Nelson et al., 2001), including the CMHA/National's Framework for Support (Trainor et al., 1999), which was adopted by the government of Ontario as the framework for a reformed mental health system in its 1993 policy document, *Putting People First.* The essence of this value-based approach is that it is consumer-directed. We believe that it is important to speak of consumer control and choice rather than consumer "needs." As McKnight (1995) has pointed out, the language of needs focuses on deficits rather than strengths, clients rather than citizens, and professional control rather than consumer choice and control. A variety of housing choices should be available to consumers, but

not organized along a residential continuum with service-providers matching client needs with housing settings that vary in terms of the intensity of professional support.

We suggest that consumer choice and control over resources is the overarching value that should guide housing and support for people with serious mental illness. Moreover, we suggest that there are four main types of resources that are essential to housing and support for people with serious mental illness: a) financial resources, b) professional resources, c) housing resources, and d) social resources. We describe each of these types of resources below.

Financial Resources

Consumers should have adequate financial resources to pay the rent for the type of housing they wish to live in; consumers should have control over those financial resources; and consumers should have the potential for supported employment should they wish to work to increase their incomes without the penalty of losing all disability benefits.

Professional Resources

Consumers should have access to professional supports; housing and professional support should be de-linked (no on-site staff); support should be consumer-directed; support should be oriented towards consumer independence and growth; and support should be individualized.

Housing Resources

Key features of housing include choice over type of housing, control over decision-making within the housing, safety (of both the housing and the neighbourhood), privacy (having one's own room or apartment), physical comfort and cleanliness, proximity to professional support services, informal sources of support, and community services and settings, and integration with non-consumer citizens.

Social Resources

Consumers should have choice over living companions in their housing, support from neighbours and landlords, meaningful daily activity, and broader integration into communities and society through valued social roles (e.g., volunteer, student, worker).

A Review of Research on Housing and Support for People with Serious Mental Illness

In this section, we review evidence related to this value-based framework, focusing on research relevant to these four different types of resources. This review updates previous literature reviews by Nelson and Smith Fowler (1987) and Parkinson et al. (1999), focusing primarily on studies published since 1998 (i.e., after the Parkinson et al. review). We note conclusions from the earlier review in our updates of the different sections of this review. In addition to reviewing primary studies, we also draw on several literature reviews published within the last five years (Chilvers, MacDonald, & Hayes, 2003; Fakhoury, Murray, & Shepherd,

2002; Nelson, LaFrance, & Aubry, in progress; Newman, 2001; Rosenheck, 2000). We have organized the review according to the four main types of resources described in the previous section.

Financial Resources

A major barrier to finding independent housing for people with serious mental illness is the poverty in which many consumers live (Wilton, 2003). In the U.S., a federal policy has been developed whereby people with serious mental illness can apply to the Department of Housing and Urban Development for Section 8 certificates. These certificates enable people "to pay a fixed 30% of their income for a private rental unit" (Hurlburt, Wood, & Hough, 1996, p. 310). This policy provides consumers with the financial resources to access typical rental unit housing with their communities, rather than specialized housing programs. Most people who use this program rent private apartments. The Section 8 certificate program is consistent with the philosophy of supported housing that consumers should be able to access whatever housing they wish and removes the financial barrier to accessing normal housing.

There are now several controlled, longitudinal studies of supported housing, particularly for those who have been homeless and who have experienced mental illness (Dickey, Gonzalez, Latimer, Powers, Schutt, & Goldfinger, 1996; Dickey, Latimer, Powers, Gonzalez, & Goldfinger, 1997; Goldfinger et al., 1997; Goldfinger, Schutt, Tolomiczenko, Seidman, Penk, Turner, & Caplan, 1999; Hurlburt et al., 1996; Rog & Randolph, 2002; Rosenheck, Kasprow, Frisman, & Liu-Mares, 2003; Newman, Reschovsky, Kaneda,& Hendrick, 1994; Shern et al., 1997; Tsemberis, 1999; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003). These studies, all of which have been conducted in the U.S., evaluate the impacts Section 8 certificates or some other rent-geared-to-income scheme that enables consumers to live in private apartments. The most clear-cut outcome reported in these studies is that consumers are able to maintain more stable housing and reduce homelessness and psychiatric hospitalization to a significantly greater extent than participants in comparison groups who received standard care or case management alone (Nelson, LaFrance, & Aubry, in progress). There is also some evidence that those living in supported housing show greater improvement on measures of symptomatology, quality of life, and social networks.

Two Canadian studies of supported housing have utilized a qualitative approach to evaluation (Parkinson & Nelson, 2003; Walker & Seasons, 2002). Parkinson and Nelson (2003) reported positive impacts of supported housing in terms of personal empowerment (i.e., stable mental health, power and control, developing and fulfilling dreams), community integration (i.e., involvement in the community, improved relationships), and acquisition of valued resources (i.e., having a "home"). Parkinson and Nelson (2003) also found that tenants of supported housing wanted paid employment. On the other hand, Walker and Seasons (2002) reported that those living in independent apartments reported feelings of isolation and loneliness (a finding that was noted in Parkinson et al.'s (1999) earlier review of this literature), a desire for others to better understand their mental health issues, and a desire for more interaction with people in the community other than low-income tenants in their apartments.

Another approach to housing is the creation of congregate or group living arrangements (Hopper & Barrow, 2003). While this approach has been tied to the philosophy of supportive housing described earlier, group housing and support can be de-linked to more closely approximate the philosophy of supported housing. In earlier reviews (Nelson & Smith Fowler, 1987; Parkinson et al., 1999), it has been reported that controlled, longitudinal studies of supportive group living have achieved the same positive benefits as have been found for supported housing. That is, supportive group living has been found to lead to increased housing stability, decreased rates of hospitalization, and improvements in independence, social skills, social networks, quality of life, symptomatology, and participation in the community. More recent controlled, quantitative studies (Conrad, Hultman, Pope, Lyons, Baxter, Daghestani, Lisiecks, Elbaum, McCarthy, & Manheim, 1998; Metraux, & Culhane, 2003) and qualitative studies (Nelson, Clarke, Febbraro, & Hatzipantelis, under review) of supportive group living have found similar positive outcomes.

Two studies comparing independent supported housing with supportive group living have found similar positive outcomes for both approaches (Dickey et al., 1996; Dickey et al.,1997; Goldfinger et al., 1997; Goldfinger et al., 1999; Nelson, Hall, & Walsh-Bowers, 1997). On the other hand, two separate studies in New York City reported that those living in supported housing achieved greater levels of housing stability than those in supportive group living (Tsemberis, 1999; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004).

In summary, rent supplements, such as Section 8 certificates, or rent-geared-to-income housing (either independent apartments or supportive group living) are different strategies that have been used to provide consumers with the financial resources that they need to access desirable housing in the community. Outcome studies have found that not only do different types of housing increase consumers' housing stability, but that they also help to improve consumers' well-being and quality of life. Thus, the financial resources to access housing play a vital role in the well-being of mental health consumers living in the community.

Professional Resources

People with serious mental illness also need access to professional resources. However, some professional resources are clearly more helpful than others. Mental health professionals who operate from a medical model emphasizing the expert role of the professional and the patient or client role of the person with serious mental illness perpetuate a power imbalance that is unhelpful. Also, settings that operate from a custodial care model in which the professional role is one of "taking care of" people with serious mental illness are also unhelpful. Both the medical and custodial models promote passivity and dependency. In contrast, what is helpful are professionals who operate from a framework of psychosocial rehabilitation and recovery. The rehabilitation and recovery approach is consumer-directed, individualized, and oriented towards personal growth, independence, recovery, and empowerment (Nelson et al., 2001; Parkinson et al., 1999; Parkinson & Nelson, 2003), which is consistent with the value-based approach that we are promoting.

There are a variety of different approaches to case management or support coordination based on a rehabilitation and recovery framework that have been used to help consumers access and maintain housing (Nelson, LaFrance, & Aubry, in progress). In the supported housing approach, professional support is "de-linked" from the housing. In other words, the support is connected to the person rather than the person's housing, so that there are typically not staff on-site in the person's housing. Several controlled, longitudinal outcome studies of support coordination have been conducted with people with serious mental illness who have been homeless (see Nelson, LaFrance, & Aubry [in progress] for a review of these studies). The evidence from these studies is that relative to consumers receiving "standard care," those receiving Intensive Case Management (ICM) or Assertive Community Treatment (ACT) have increased housing stability and decreased rates of psychiatric hospitalization (Calsyn, Morse, Klinkenberg, Trusty, & Allen, 1998; Calsyn, Winter, & Morse, 2000; Hurlburt et al., 1996; Korr & Joseph, 1995; Lehman, Dixon, Hock, Deforge, Kernan, & Frank, 1999; Lehman, Dixon, Kernan, Deforge, & Postrado, 1997; Morse, Calsyn, Allen, Tempelhoff, & Smith, 1992; Morse, Calsyn, Klinkenberg, Trusty, Gerber, Smith, Tempelhoff, & Ahman, 1997; Rosenheck et al., 2003; Wolff, Helminiak, Morse, Calsyn, Klinkenberg, & Trusty, 1997). Additional findings from these studies suggests improvements in mental health, quality of life, well-being, and coping in the community for those who participate in ICM or ACT.

In summary, access to rehabilitation and recovery-oriented case management or support coordination leads to the same beneficial outcomes as was found for studies of independent and supportive group living approaches to housing. Moreover, two studies have suggested that the combination of housing and support coordination produces superior outcomes than either approach alone (Clark & Rich, 2003; Rosenheck et al., 2003).

Housing Resources

Housing resources can be conceptualized as the qualities of housing that consumers find desirable and that research has shown to be beneficial to the well-being of consumers. Previous reviews of this literature (Nelson & Smith Fowler, 1987; Newman, 2001; Parkinson et al., 1999) have identified several key qualities of housing: a) resident choice and control, b) physical quality/habitability, c) privacy, d) the concentration of consumers in the housing, and e) location.

Resident choice and control. Research on consumer choice and control has followed two distinct paths. One line of research examines consumer preferences for housing and support, while the second examines consumers' perceptions of choice and control within their current housing.

There is a great deal of research regarding the housing and support preferences of people with serious mental illness. In a review of 26 studies, Tanzman (1993) found clear evidence that consumers want to live in their own apartment or house, prefer to live alone, or with a spouse/ partner or a friend rather than with other mental health consumers, to have staff support available as needed, and to have access to material and financial supports, such as rent subsidies, telephone, and transportation. Research published since Tanzman's (1993) review has yielded similar results (Friedrich, Hollingsworth, Hradek, Friedrich, & Culp, 1999; Goldfinger & Schutt,

1996; Massey & Wu, 1993; Minsky, Riesser, & Duffy, 1995; Nelson, Hall, & Forchuk, in press; Rogers, Danley, Anthony, Martin, & Walsh, 1994; Schutt & Goldfinger, 1996). This research has also shown that consumers prefer more independent housing than what treatment staff (Goldfinger & Schutt, 1996; Massey & Wu, 1993; Minsky et al., 1995; Schutt & Goldfinger, 1996) or family members recommend for them (Friedrich et al., 1999; Rogers et al., 1994). Goldfinger et al. (1999) reported that consumers' preferences for independent housing predicted more days homeless, while clinician recommendations for group living predicted more days homeless. This finding casts some doubt on a basic premise of supported housing that consumer preferences are related to positive outcomes. However, this study examined consumer preferences and clinician recommendations independently. A collaborative process between clinician and consumer might have yielded a different outcome.

There is considerably less research on consumers' perceptions of choice and control within their housing. In their review of this literature, Parkinson et al. (1999) found some evidence that resident perceptions of choice and control and a democratic management style were positively related to residents' satisfaction with their housing. For example, it has been reported that consumers who were not living in the housing of their choice reported higher levels of depression than residents who had choice over housing location (Taylor, Elliot, & Kearns, 1989). Srebnik, Livingston, Gordon and King (1995) found that the majority of the 115 consumers in supported housing had very little choice in the type of housing in which they lived. Despite having few options, they were generally satisfied with their housing option(s). It was also discovered that housing choice was positively related to housing satisfaction, residential stability, and psychological stability. Similarly, Tsemberis, Rogers, Rodis, Dushuttle, and Shryha (2003) surveyed 300 individuals with severe mental illness in various residential settings ranging from community housing, supportive housing and supported housing across seven U.S. states. Those living in supported housing were found to be significantly more satisfied overall with their housing and were more satisfied with the amount of choice they had over housing.

In a study of formerly homeless people with serious mental illness in three Ontario cities, Sylvestre et al. (2004) found a significant increase on a measure of choice and control over housing and professional support from previous residence to their current residence in one of the housing programs offered through the government's Phase I homelessness initiative. Moreover, those who were housed in apartments had significantly higher levels of choice and control than those living in group settings. Similarly, in randomized controlled trial of individuals with dual diagnosis (mental illness and substance abuse) who had been homeless, those who were assigned to independent supported housing had significantly higher levels of control than those living in group settings that were part of a residential continuum (Tsemberis et al., 2004; Yanos et al., 2004).

Housing choice has been found to be related to a number of treatment outcomes. For example, in a study conducted by Calsyn, Winter, and Morse (2000), consumers who were homeless at baseline and who were then enrolled in a modified ACT program were randomly assigned to choice and no choice conditions. Those in the choice condition had choice over five different treatment programs, while those in the no choice condition participated in ACT. They found that consumers in the choice condition visited staff at the ACT office more frequently but

they did not find that consumers differed by condition on any of the other outcome measures (stable housing, psychotic symptoms, depression and substance abuse). Yanos et al. (2004) found that housing choice was positively correlated with a positive reaction to one's housing.

In an examination of an experimental group housing program for adults with serious mental illness, Ware (1999) stated that true empowerment is impossible unless consumers are given choices. Consumers were given more choices over their day-to-day activities within the residence, had the option to attend or not attend outings or house meetings, collaboratively decided with staff what the house money was to be spent on, defined their own treatment goals, and were involved in the selection of new roommates and staff. Although the consumers had choices regarding participation in activities within their housing, they did not have choice over the type of housing in which they would live (Ware, 1999).

Similarities between the elderly and the consumer population have been drawn in that there is an identified need for more independent housing with support services for both of these groups (Park & Robertson, 1999). Providing people with options outside of the realm of institutionalized care, nursing homes or group living, can result in a number of positive changes, such as: a reduction in fear, overall betterment in health status, a cost effective method of care, and support outside of a hospitalized setting. Piat, Perreault, Lacasse, Loannou, Pawliuk, and Bloom, (2004) found that something as small as having their own key to a residence in group living situations can make consumers feel more in control of their living situation.

Physical quality/habitability. When speaking of the "quality" of a person's housing, a plethora of factors come into play. Here we are talking not only about the physical quality (e.g., the state of the floors, walls, and furniture, the height of the ceilings, etc.), but also the habitability of the residence (e.g., the noise level, odors, etc.) (Parkinson et al., 1999). In an earlier review of the literature (Parkinson et al., 1999), it was reported that a few studies have found that consumer concerns about housing quality are negatively correlated with satisfaction with housing and positively correlated with negative affect and symptom distress (e.g., Nelson, Wiltshire, Peirson & Walsh-Bowers, 1995). Similar findings have been reported in a review of the literature on housing quality and mental health for non-clinical populations (Evans, Wells, & Moch, 2003). For example, in a longitudinal study of a non-mental health consumer population, Evans, Wells, Chan, and Saltzman (2000) found that housing quality was inversely related to symptom distress, after controlling for income. Moreover, studies of housing improvements have shown modest gains in mental health by those living in improved accommodations (Evans et al., 2000; Evans et al., 2003). One exception to this overall pattern of relationship between the physical quality/habitiability of housing and consumers' well-being is a study of board-and-care homes by Mares, Young, McGuire, and Rosenheck (2002), in which a measure of the physical quality of the homes was found to be unrelated to consumers' well-being. In a study of physical housing quality, Jarbrink, Hallam, and Knapp (2001) compared multiple types of housing along 12 physical quality dimensions and found that 10 out of the 11 highest scores were recorded for group/residential homes. The difference was notably significant for two items, "cleanliness" and "comfort of furniture" with group homes rating higher than both general and supported housing.

Privacy. In the literature, privacy as a housing concern has not been studied exclusively but rather as one of the many factors under investigation when looking at housing satisfaction. Lack of privacy, as a dimension of housing quality, has been found to be predictive of negative affect, especially in group living situations (Nelson et al., 1998; Parkinson et al., 1999). In three qualitative studies in Ontario (Forchuk, Nelson, & Hall, under review; Nelson, Clarke, et al., under review; Wilton, 2003), it was found that privacy or lack thereof was a primary concern of consumers in group living situations where rooms have to be shared. Consumers who have to share a bedroom with others have identified privacy as a primary housing concern (Wilton, 2003). Tsemberis, Rogers, et al. (2003) found that consumers living in supported housing were more satisfied with their level of privacy than consumers living in community residences.

Research has revealed that consumers living in different types of housing experience a trade-off between privacy and support (Forchuk et al., under review, Johnson, 2001; Tsemberis, Rogers, et al., 2003). For example, Tsemberis, Rogers, et al. (2003) found that consumers living in supported housing were more satisfied with their level of privacy than consumers living in community residences. However, as was noted earlier, consumers living in supported housing (i.e., individual apartments) often report feelings of loneliness and isolation (Parkinson et al., 1999; Walker & Seasons, 2002), a finding that we discuss further in a subsequent section on social resources. Consumers have recommended housing that provides both common space for social interaction and separate apartments for privacy (Johnson, 2001).

Concentration of consumers . The number of consumers living in a residence can have an impact on quality of life variables. As Wong and Solomon (2002) state, the extent to which a housing setting is normalized depends largely upon the density of other consumers in that same location. Some consumers are against living in housing exclusively for people with mental health difficulties because they would like to fit into the larger community (Walker & Seasons, 2002). For example, Mares et al. (2002) found that in comparing larger board-and-care homes with smaller board-and-care homes that there were a number of significant differences between the two. One finding was that those living in larger board-and-care homes reported that they were in more frequent contact with friends and family outside of the residence than were those from smaller homes. Mares at al. (2002) hypothesized that this is because smaller residences provide a more naturalistic family environment than the larger homes, so that consumers feel less of a need to reach out to their families.

Location. In their earlier review of this literature, Parkinson et al. (1999) reported that housing that is physically integrated in the community, so that one cannot distinguish that mental health consumers live in the residence, has been found to increase the likelihood of social integration, likely the result of reduced stigma and isolation. Interestingly, Mares at al. (2002) stated that consumers living in low-income neighbourhoods may experience less social stigma than those living in high-income areas, because their neighbours are more disenfranchised. Location can also be assessed based on how close a consumer's home is to needed community resources like a grocery store, public transportation, etc. In one study, it was found that consumers who live in community residential facilities that are close to community resources were more integrated into their community than those living further away from such resources (Wong & Solomon, 2002).

The U.S. Department of Housing and Urban Development has included housing location as an essential element of their housing program. However, as Guhathakurta and Mushkatel (2000) point out, little has been to test the effectiveness of this policy. Even with the best intentions, different housing groups may be targeting the same, often low economic areas for housing, thus resulting in a concentration of subsidized housing. Guhathakurta and Mushkatel (2000) examined the locational patterns of three types of subsidized housing: a) conventional project-based housing, b) supported housing (Section 8 assisted rent and shelter plus care support), and c) shelters for homeless people. They found that all of these housing types reinforce concentrations of subsidized housing in some neighbourhoods in Phoenix, Arizona. The central finding of this study was that the voucher or certificate program, originally designed to desegregate the low-income population, is not reaching its goal.

One other aspect of housing that has emerged from qualitative research with consumers is that of safety (Forchuk et al., under review; Nelson, Clarke, et al., under review; Yanos, Barrow, & Tsemberis, 2004). When consumers do not have enough privacy or the physical quality of the residence is lacking (e.g., there are no locks on doors), consumers feel that their physical and psychological safety is threatened. Tsemberis, Rogers, et al. (2003) found that those living in community residences were the least satisfied with their privacy but were the most satisfied with their safety, while Yanos et al. (2004) found that the majority of formerly homeless individuals with a dual diagnosis (mental illness and substance abuse) who lived in either independent apartments or group living reported an increased sense of safety in their new housing. Further research is needed to examine this issue of safety more fully

Social Resources

According to the earlier review by Parkinson et al. (2003), the size of consumers' social networks and the amount of social support that consumers receive is important for mental health and well-being. As Wilton (2003) pointed out, having a serious mental illness can lead to impairments in social functioning. This ties into the fact that the size of a consumer's social network is generally small. Reduced network size has been liked to a number of factors, including poverty, degree of community integration, and mental health service use (Anderson, Lyons, & West,2001; Wilton, 2003). Anderson et al. (2001) found that consumers living in psychiatric nursing homes who had social and family contact were more likely to use mental health services. In a study conducted in the Netherlands, Depla, de Graaf, van Busschbach and Heeren (2003) compared two living arrangements for elderly long-term psychiatric consumers. They looked at the impacts of the resident's involvement in social activities, social network size, and the frequency of visits from members of residents' social networks. Residents were either in a specialized care unit, "concentrated housing," or dispersed throughout the facility, "dispersed housing." In concentrated housing the residents were housed in apartments in a separate unit in the facility while in dispersed housing, residents were located throughout the facility. These two types of residential homes were then compared with psychiatric hospitals. It was found that those in concentrated housing had smaller social networks than other groups, but the three groups did not differ significantly in the frequency of visits from members of their social networks. Generally speaking, only the dispersed housing models were an improvement over psychiatric

hospitals. In Sweden, Brunt and Hansson (2002b) found that social network size was positively related to consumers' quality of life and inversely related to psychiatric symptoms.

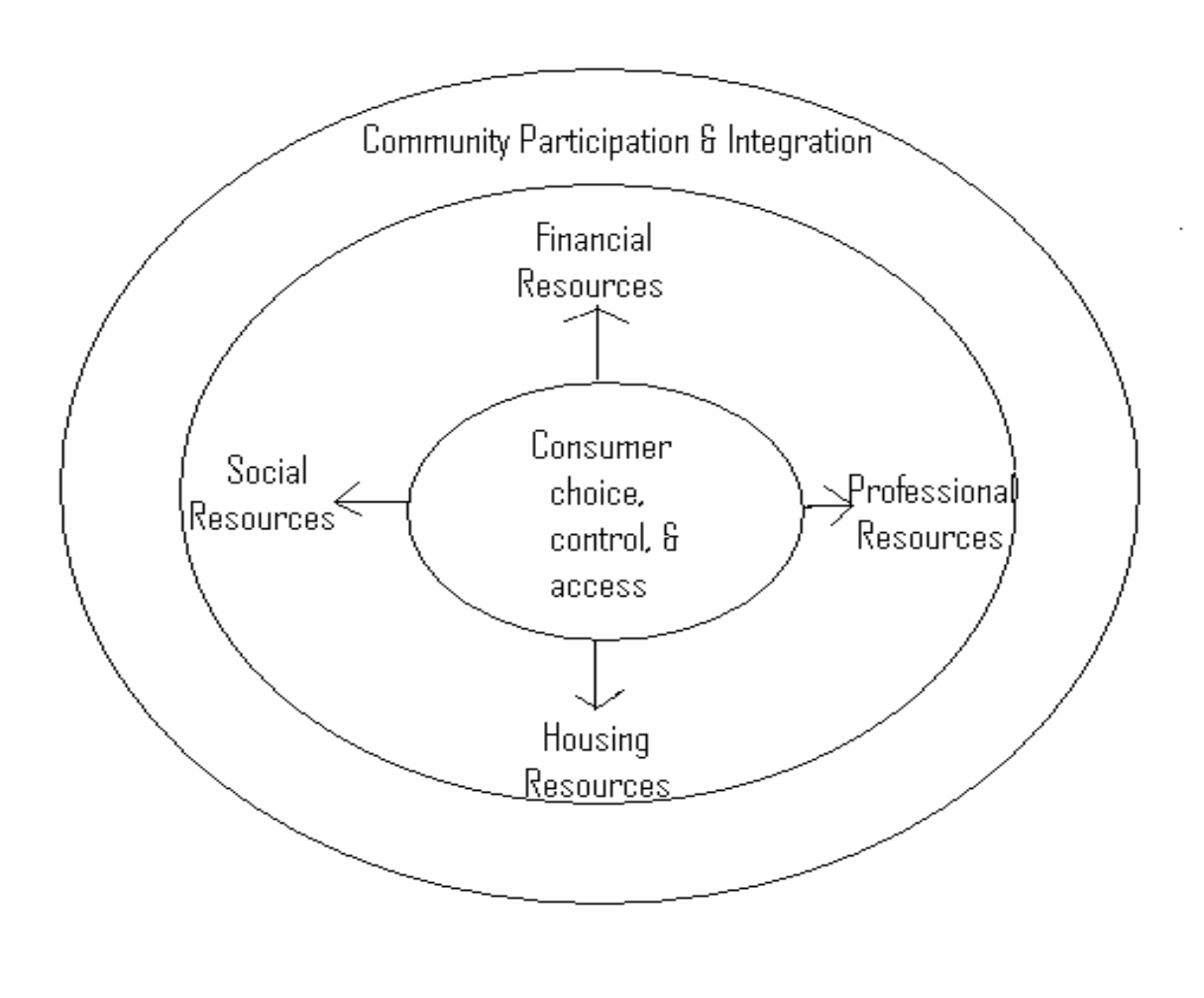
For more than 40 years in Montréal, Québec, residents of psychiatric hospitals have been released into foster homes upon discharge (Piat et al., 2004). The primary rationale for this type of housing is that often consumers who have been in psychiatric hospitals have had little contact with those outside of their immediate environment and family connections are often lost. The foster home provides them with an opportunity to get back into the community. Piat et al. (2004) conducted focus groups with multiple stakeholders and examined four main areas: the foster home environment, characteristics of the foster home caregiver, community integration and stakeholder relationships. They found that caregivers could feel isolated even with the existence of support groups, which can thus negatively impact on their relationships with the residents. This finding indicates that attention needs to able be paid to the caregivers because they play an important role in the community integration of residents.

Loneliness can occur for any number of reasons, but for consumers in supported housing and living alone, there is often a desire for more social interaction (Walker & Seasons, 2002). This feeling of loneliness is a common criticism of the supported housing model (Parkinson et al. 1999). For this reason it has been argued that more attention needs to be paid to the strength of a person's social support network (Nelson et al., 1998; Walker & Seasons, 2002). Social network size has been found to be associated with a number of factors such as psychotic symptoms, social skills, use of psychiatric symptoms, and quality of life (Goldberg, Rollins, & Lehman, 2003). Demographic variables may also play a role in network size. For example, those who have graduated from high school have reported having larger social networks than those who did not (Goldberg et al., 2003). Goldberg et al. (2003) also found that a larger social network was related to a greater satisfaction with activities, health, social relations and safety. Those with high self-esteem also tended to have larger social networks.

Conclusion

With the shift in values towards a supported housing approach came an emphasis on increased community participation and integration for consumers. Based on this review, we propose that the values of consumer choice and control, access to valued resources work, and community participation and integration should underlie housing and support. In Figure 1, consumer choice and control take centre stage. First, to be empowered, consumers must have choice and control. This is the overarching value of our framework. Secondly, choice and control should enable consumers to access the financial, professional resources, housing, and social resources that they desire. Third, when consumers have choice and control and are able to access valued resources, their integration and participation in the community is enhanced.

Figure 1.



Resources are the critical bridge between consumer choice and community integration. Consumers must have resources from which to choose in order to make empowerment and community integration a reality (Nelson et al., 2001). If people do not have access to financial resources, they will likely not be able to afford to partake in social activities with others resulting in more isolation than integration. The closer that consumers live to available community resources, the more accessible these services will be. This is supported but the finding of Wong and Solomon (2002) that the consumers who were living in community residential facilities that are close to community resources were more integrated into their community than those living further away from such resources (Wong & Solomon, 2002). Professional support resources are often instrumental in helping consumers to access a variety of other resources. In terms of housing resources, having a choice over the housing type and location can help to reduce stigma and the concentration of consumers in low-income communities. Supported and/or subsidized housing that is physically integrated in the community to the point that it is indistinguishable from other residences increases the likelihood of social integration, likely the result of reduced

stigma and isolation (Parkinson et al., 1999; Wong & Solomon, 2002). In order for community integration and participation to be attained, consumers must have choice, control and access to financial, professional, social, and housing resources.

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