AN EVALUATION OF SUPPORTIVE HOUSING: QUALITATIVE AND QUANTITATIVE PERSPECTIVES

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ABSTRACT

This paper reports the findings of an evaluation of supportive housing for people who have been hospitalized in psychiatric facilities. Both qualitative and quantitative methods were used to inquire into two key processes, social support and control in the residence, and two key outcomes, quality of life and personal growth. Interviews were conducted with 34 residents of small supportive housing programs, and staff of these settings also provided information. While residents were generally pleased with the amount of support and control they had in their residences, there were some areas in which staff exerted unilateral control (i.e., they made decisions without involving residents in the process). With respect to quality of life, residents were satisfied with their housing, but voiced some concerns over a lack of privacy, stigma, and limited opportunities for participation in the community. Residents reported showing personal growth since entering supportive housing in terms of greater independence, more instrumental role involvement, and improved self-esteem and social skills. Staff confirmed these changes. Residents indicated their increased feelings of competence were due to the social support of staff and friends, acceptance by members of their networks and the community at large, and participation in the residence and community activities. The findings expand our understanding of supportive housing in showing that such programs have beneficial effects besides reduced recidivism rates and increased work productivity for residents and in identifying program processes which contribute to residents' increased competence. Moreover, the findings illustrate the value of using qualitative data in program evaluation.

Research on supportive housing for people who have been hospitalized in psychiatric facilities has found that such programs are successful in reducing rates of rehospitalization and in increasing rates of employment (Dickey, Cannon, McGuire, & Gudeman, 1986; Fairweather, Sanders, Cressler, & Maynard, 1969; Gumruckcu, 1968; Lamb & Goertzel, 1972; Lipton, Nutt, & Sabatini, 1988;

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Wherley & Bisgaard, 1987). In their review of this literature, Nelson and Smith Fowler (1987) noted several problems with this research. One problem is that the criteria of rates of rehospitalization and work productivity are, by themselves, inadequate outcome indicators. Using these criteria, a person discharged from hospital who lives in run-down housing and who performs meaningless tasks in a sheltered workshop for little or no pay is considered a "success." Nelson and Smith Fowler (1987) suggested the use of additional outcome measures, such as individuals' level of independent functioning and perceived quality of life. The degree to which people who have been hospitalized can restore their self-sufficiency and break free of patterns of dependence from others is an important indicator of personal growth (Rappaport et al., 1985). Also, there is a need to focus more on residents' perceptions of their quality of life, since most outcome measures neglect this important dimension (Baker & Intagliata, 1982).

Another problem noted by Nelson and Smith Fowler (1987) is that existing outcome evaluations of supportive housing suffer from the "black box" phenomenon. That is, the characteristics of the programs that produce positive outcomes in participants are neither specified nor studied. Rutman (1980) has argued that evaluation research should clearly show how program activities (processes) are related to the goals for change in program participants (outcomes). Studying both process and outcome factors in supportive housing should not only help us to understand if such programs benefit residents, but also how and why such benefits occur.

Both quantitative, correlational research and qualitative research have identified several characteristics of housing environments that are related to the well-being of former psychiatric patients living in the community (Nelson & Smith Fowler, 1987). For example, the size and physical quality of the housing have been shown to be related to residents' well-being (Nelson & Smith Fowler, 1987). Since the focus of our study was on small, physically confortable settings, we decided to focus on interpersonal processes in supportive housing, rather than physical-architectural features. More specifically, we examined the processes of social support and control, as they have been shown to be important for human functioning and well-being (Holahan, 1983).

One key interpersonal process is the provision of social support. Correlational studies on social support and housing for former psychiatric patients have found that the frequency of receipt of positive social support is directly related to emotional well-being (Earls & Nelson, 1988; Nelson, Hall, Squire, & Walsh-Bowers, 1992) and community integration (Nelson et al., 1992) and inversely related to rates of rehospitalization (Holman & Shore, 1978). Similarly, qualitative studies have found that friendships and social support are very important to people who have been discharged from hospital (Herman & Smith, 1989; Kearns & Taylor, 1989; Lord, Schnarr, & Hutchison, 1987). Moreover, these findings are consistent with a large body of social science research which has shown that social support is related to well-being for a variety of different populations (House, Umberson, & Landis, 1988).

Another key interpersonal process in supportive housing is the degree to which residents have control or influence regarding decision making. Psychiatric survivors (Burstow & Weitz, 1988; Chamberlin, 1978) and qualitative researchers

(Goffman, 1961; Rosenhan, 1973) have described in vivid detail the tremendous power differential between staff and patients in psychiatric hospitals, with patients being excluded from decisions that affect their lives. Moreover, when people in hospital are subjected to what Goffman (1961) called "obedience tests," "will-breaking contests," and "deference obligations" and are encouraged to adopt the patient role, they tend to withdraw and regress.

Quantitative researchers have operationalized Goffman's (1961) concept of staff management style into scales that measure resident-oriented vs. staff-oriented management practices (e.g., King & Raynes, 1968). Research in sheltered-care facilities has found that staff-oriented management practices are related to residents' dependency (Segal & Moyles, 1979) and a lack of self-sufficiency (Kruzich & Berg, 1985). While there has yet to be research which examines the extent to which residents have influence or control in decision-making in supportive housing, research has found that opportunities for choice and control are related to the well-being of older people living in nursing homes (Langer & Rodin, 1976; Moos, 1981).

The purpose of this study is to examine processes and outcomes of supportive housing for people who have been hospitalized for psychiatric problems. The processes of social support and control in decision-making are considered. The outcomes that are examined are perceived quality of life and personal growth. The specific objectives of the research are two-fold: (a) to describe residents' experiences of support, control, quality of life, and personal growth; and (b) to analyze if and how the processes of support and control enabled residents to improve their quality of life and to achieve personal growth.

METHOD

Participants

The participants in the study were 34 residents and the staff coordinators of seven supportive housing programs located in the Waterloo and Wellington regions of southwestern Ontario. Only residents who had been in the program for at least five months were included in the study. We thought that five months were necessary for the residents to become adjusted to their new environment. The average length of stay in the program was 19.6 months for the participants.

Generally speaking, the participants were predominantly male (70.6%), single (76.5%), with partial high school education or less (70.6%). They ranged in age from 20 to 59 years with an average age of 35 years. Nearly all of the participants have been labelled as having a major psychiatric disability. Furthermore, at the time the study was conducted, approximately 85% of the participants were receiving one or more different types of psychotropic medication, and nearly all had been hospitalized at one time or another, sometimes repeatedly. Overall, 62% of the participants reported family benefits or disability pension as their major source of income, with 76% of the total sample earning between $500 and $750 per month.

Settings

The seven programs all provide accommodation for men and/or women who are 18 years of age and older, with a history of mental health problems. Five of the programs offer permanent housing, while the other two offer transitional housing (12- to 18-months' stay). Four of the programs are co-ed group homes with a capacity of eight residents. One is a group home for men only with space for 12 residents. Another is a co-ed duplex with a capacity of eight residents (four per side). The final program offers co-ed apartments (three residents per apartment); there are four apartments in total. One of the residences provides 24-hour staff support; one provides staff support only once per week or as needed; and the other five programs provide daily (8 to 12 hours per day) staff support. All of the residences are attractive, well-furnished, and comfortable.

During their stay, residents are encouraged to set goals and to follow daily individualized programs as well as joint activities with other residents, all geared toward increasing life skills and developing a more independent lifestyle. Furthermore, residents are expected to share in household chores, to attend house meetings, and to participate in house decisions, including the development of house rules.

Qualitative and Quantitative Methods

Patton (1990) has noted that qualitative research and evaluation can take many different forms. A purely naturalistic, qualitative approach (Lincoln & Guba, 1985) does not begin with a theory or hypothesis to test. Rather, it is inductive and allows the major issues to "emerge" from the data. In this approach, theory is grounded in the data and grows out of the data analysis (Strauss & Corbin, 1990). On the other hand, Patton (1990) has stated that qualitative methods can be used in conjunction with quantitative methods. This approach is more deductive in nature, employing an a priori theoretical framework and standardized open-ended questions. While the qualitative data obtained in this approach are useful on their own, they also serve the additional benefits of both "triangulation" of the quantitative findings and of clarifying the meaning of the quantitative data. The disadvantage of this combined approach is that the potential richness of a purely qualitative method is compromised by the researchers' predetermined framework and questions. In this study, we employed the strategy of using both quantitative and qualitative methods.

Interview Schedule

Residents were interviewed using a standardized interview schedule, consisting of both open-ended questions and measurement scales for four different areas: social support, control over decision making, quality of life, and personal growth. The interview schedule began with demographic questions, then moved to the measurement scales, and concluded with the open-ended questions. Questions pertaining to the four areas are as follows:

Social support.

1. Inventory of Socially Supportive Behaviours (ISSB): Residents were asked to indicate on a five-point scale ranging from "not at all" to "about every day" how often staff and fellow residents have done certain activities for them, to

them, or with them, during the past four weeks. The 24 items were taken from Barrera and Ainlay's (1983) ISSB. There are two subscales: problem-solving support (e.g., giving feedback, providing advice) and emotional support (e.g., talking about private feelings, receiving physical affection).

2. Open-ended question: Residents were asked to think back to the time just prior to entering the residence and to describe any expectations they may have had regarding the type and amount of support they would receive from housing staff. They were also asked to describe how they currently feel about the level of staff support offered by the program.

Control over decision-making. The two quantitative decision-making scales used in this study are adapted from the Resident Control and Tolerance for Deviance subscales of the Policy and Program Information Form (POLIF) (Lemke & Moos, 1980).

1. Resident Control: This scale measures the degree to which the setting provides residents with the opportunity to exercise control or influence over the program's daily operations. Residents were asked the extent to which they are involved in decision-making in 10 different areas (e.g., planning daily or weekly menus, deciding when a troublesome resident will be asked to leave). In responding to each question, residents used one of the following three categories: "staff or others basically decide by themselves" (Staff Control), "staff and residents make the decision together" (Shared Control), or "residents basically decide by themselves" (Resident Control).
2. Staff Management Style: The purpose of this scale is to measure the extent to which residents perceive that housing staff intervene with behaviour which may be seen as withdrawn, defiant, or aggressive. Three response categories reflect different styles of staff management: (a) Permissive (staff do not intervene), (b) Democratic (staff involve residents in intervention), and (c) Authoritarian (staff intervenes without involving residents). Residents were asked which management style staff would use to respond to 10 potential problems with residents.
3. Open-ended question: Residents were asked to describe the amount of control or influence they had over their living environment, and whether they felt that the residence was their home and they could do what they wanted in their home.

Quality of life.

1. Quality of Life: A revised version of Baker and Intagliata's (1982) Quality of Life scale was used. On this scale, participants subjectively rated their quality of life in several areas. Residents were asked to rate the life domain items (e.g., place of residence) on a seven-point scale ranging from "Terrible" (1) to "Delighted" (7).
2. Open-ended question: Residents were asked to describe their quality of life in the community, how they feel about their place of residence, their relationships with other people, and any other important aspect of their daily living.

Personal growth.

1. Independent functioning: We revised a scale used by Rappaport and his colleagues (1985) to assess independent functioning. Items on this scale measure

the degree to which a person is able to function independently in areas essential to living successfully in unsupervised or low-support facilities. One question, for example, asked, "Who plans and prepares the resident's meals?" The six items are rated on a four-point scale as either "no one's responsibility" (0), "other's responsibility" (1), "shared responsibility" (2), or "own responsibility" (3). This measure was completed by the residential support worker by indicating the resident's level of independent functioning at the time the resident entered the program as well as the resident's level of independent functioning at the time of the study. Total scores can range from 0 to 18.

2. Instrumental role functioning: Both residents and support staff were asked what vocational, educational, or other instrumental roles residents held, either part time or full time, at the time residents entered the program and at the time of the study.

3. Open-ended question: Each resident was asked whether he or she had changed as a person since entering the program and, if so, what particular aspects of the program might have influenced those changes. Staff members were asked to describe the ways in which residents had changed since entering the program. Both resident and staff perceptions were used for the purpose of "triangulation" of findings.

Participants were also asked if they had any suggestions for improving the programs, if there was anything else about how they had been getting along that was important for us to know, and how they felt about the content and the process of the interview.

Research Process

Preparing for the field. Meetings were held with program staff, during which the purpose and methods of the research were described and the requirements for participation were outlined. We also shared the interview schedule, and the program staff made suggestions for changes, all of which we responded to. Overall, the staff were very supportive of the research and commented on their interest in being included in the study. By the time the meetings were adjourned, the following guidelines had been established: (a) that staff would first present the study to the residents for their approval so that only interested residents were contacted, (b) that confidentiality of responses would be firmly stressed to potential participants, (c) that research involvement in the setting would not interfere with residents' daily routines, and (d) that residents would be told that a decision to not participate in the research would not jeopardize their rights to live in the residence and receive support.

Entry. Prior to entering each setting to begin the research, the first author (a woman in her mid-20s) met individually with program coordinators to reiterate the purpose of the study and to negotiate the terms or conditions for contacting potential participants. Next, an oral presentation of the study, supplemented by a letter outlining the focus of the research and copies of both the staff and resident interview schedules, were presented to the residents by the staff in order to determine who wished to participate.

Once a level of interest was expressed, the first author then visited the home to meet with the residents to introduce herself and to answer any questions or concerns. The researcher was invited for dinner or for an informal visit to all of the settings. This helped to enhance residents' comfort with the researcher and to make the data obtained more dependable and reliable. Those residents who indicated an interest in participating in the study were then contacted either by telephone or in person to arrange a time and location to conduct the interview. We do not have precise figures on rates of consent/refusal. However, we know that of the 64 people living in the seven residences, 34 participated. Moreover, not all of the 64 people were eligible to participate (some had not been in residence for at least five months), so our rate of consent was at least 50%.

Routinization of fieldwork. The majority of interviews took place in the participants' homes and lasted anywhere from 50 minutes to 2½ hours, roughly averaging around 1½ hours per resident. On a few occasions, however, interviews were conducted either at a local coffee shop or in a nearby restaurant. The interviews began with a brief description of the study as well as the methods to ensure the confidentiality of responses. The first author also reminded the participants of their right to refuse to answer any questions about which they felt uncomfortable. No one refused to answer any of the questions.

Once the first author answered any questions or concerns that the residents had regarding the interview, the participants were asked to sign a consent form to signify that they agreed to participate in the study and that they understood their rights. Residents were then interviewed. Finally, at the end of each interview, participants were asked to sign a Release of Information form which would then allow the staff support worker to give his or her perceptions of how the residents had changed since entering the housing program.

Bringing the fieldwork to a close. Shortly after completing all of the interviews in each setting, the first author sent a small note of appreciation to thank the staff and residents for their time and cooperation in the study. At the completion of the study, an executive summary was prepared and mailed out to the staff and residents of each of the housing programs. We also held individual feedback meetings with staff, residents, and board members of the programs, and made recommendations for program changes.

Qualitative Data Analysis

We followed the guidelines of Miles and Huberman (1984) for qualitative data analysis. First, responses to each open-ended question were transcribed and placed in a file for that particular question. Second, the process of coding was used to attach key words or phrases to the data. Codes or categories are descriptive and are used to reduce the data into a more manageable and meaningful form. The categories were changed and refined as the data analysis proceeded until a final set of categories was arrived at for each question. Quotes that illustrate the different codes were highlighted. Finally, a second level of analysis was employed in which unifying concepts or themes were identified which cut across all of the questions. These themes serve to link concepts or explain the relationship between concepts. The data were validated in two ways. First, when we held feedback meetings with residents and staff, they confirmed that the data reflected

their experiences. Second, the findings from the quantitative analyses were compared with the qualitative analyses to indicate the convergence or divergence of these two different types of data.

RESULTS

Responses to the Primary Questions

Social support. The average score on the problem-solving support subscale of the ISSB was 2.0, and the average score on the emotional support subscale was 2.4. The scale point of 2 signifies receiving support "once or twice per month," while the scale of 3 incidates "once a week." Thus, the average support scores were toward the lower end of the continuum. The emotional support subscale item with the highest average was "expressed concern in your well-being" (3.3); while the problem-solving support subscale item with the highest score was "gave you information on how to do something" (2.4).

Turning to the qualitative data, two categories of positive social support emerged from the data: problem-solving support and emotional support. Several residents mentioned they had expected to gain support in learning or enhancing various daily living tasks such as cooking, cleaning, and money management, whereas others mentioned they expected to receive help with social and communication skills.

When participants were asked to describe how they felt about the current level of staff support, both positive and negative responses emerged. Nearly all of those residents interviewed for the study reported they were satisfied with the current level of staff support, noting both emotional and problem-solving support as the most frequent types of support offered by the staff. For example, when one resident was asked whether the program had lived up to his expectations in terms of the level of staff support, he enthusiastically replied:

> I wasn't expecting as much as I got. I was a litle apprehensive of moving into a place like this, what kind of people would be living here, what the social life would be like, stuff like that. I'm really surprised that I get so much support! They're concerned with how I'm doing, my school work, and job hunting.

Perhaps the best illustration of how residents felt about the current level of staff support is exemplified by the following statement:

> I feel that there is a lot of support here. I get a lot of personal guidance on how to do a lot of things that I had no knowledge of, or had forgotten how to do.

Despite the highly positive perceptions by the majority of the participants regarding the level of staff support being offered at the time of the interview, a few residents expressed some degree of dissatisfaction with the support they were receiving. One resident stated that some of the attitudes of the staff were "naive" and somewhat "condescending," and referred, on at least one occasion, to the staff-resident relationship as "them and us." This same resident also noted the issue of staff turnover as being particularly troublesome with respect to the amount of support offered by the staff: "I also don't like new part-time staff coming in all the time. I find it uncomfortable to have to start over and over

again." One other resident complained that some staff showed favouritism toward some residents and were "cool" toward others.

Control over decision-making. Data from the Resident Control scale showed residents perceive that staff control predominates in the following areas: deciding on chores, making house rules, and setting mealtimes. In the other areas, shared control was most common. However, a substantial minority of the sample reported unilateral staff control regarding the following areas: deciding on decor, dealing with complaints, and deciding when a troublesome resident should leave.

Data from the Staff Management scale revealed residents perceive that democratic decision making predominates for nine of the 10 potential problem situations. Only in the case of a resident physically attacking another resident or staff member was authoritarian control expected. Authoritarian control was also expected by a sizeable minority of the sample in response to stealing, property damage, or verbal threats.

Turning to the qualitative data, there are three categories which emerged from the data: (a) perceptions of house rules and freedom, (b) personal control, and (c) involvement in decision making. While all of the residents reported that there were "rules" in the home which residents must follow, most felt these rules were not overly restrictive, and they could basically do what they want, provided that it does not interfere with the rights of the other residents. One participant explained:

> You just can't do anything you want, you have certain rules to follow, other people to consider, but you are free to do things.

For the most part, residents believed the house rules allowed them considerable freedom. This perception of freedom was manifested in several ways. For example, some residents thought they had the freedom to come and go as they pleased, while for others, this freedom meant they could have friends over whenever they wanted.

A second category regarding control referred to personal control and independence. There were many residents who defined control in this personal way, commenting on how they had gained control and independence with various daily living tasks such as cleaning, budgeting, medication monitoring, cooking, and laundry. We will expand on perceptions of control and independence later in the results section, as this category also emerged in response to another question.

The final category regarding control refers to the degree of involvement in decision making within the residence. Whether it was deciding on where to go for a group outing or selecting a new resident, participants noted the importance of having a sense of control and responsibility over what goes on within the residence.

> We have house meetings once a week to discuss recreational outings, new people coming in, changes in the residence, etc. and we all get to vote on those things. Everyone has a voice here, that's what the house meetings are for.

These quotations notwithstanding, involvement in decision making was also the only area, with respect to resident control, in which more than one participant expressed some degree of dissatisfaction. More specifically, the data suggest that

although residents are involved in decision making within the home, many thought they still lacked control over making the final decision.

> We're supposed to be able to select a new resident, but it doesn't always work out that way. One time someone was allowed in who we didn't want and the person we did want wasn't permitted.

> I feel like a lot of the time the staff does all the thinking and this is not so good. We talk about our problems during the house meetings (like chores, etc.) and then it is discussed with the staff. Then it is the staff who makes the final decision or finds out who is responsible. We should be able to do this for ourselves!

Finally, when participants were asked whether they thought the residence was their home, once again nearly all of the residents responded positively saying they were comfortable with where they were living, and they felt at home. However, there were a few participants who described their current residence as being only "temporary" or a "stepping stone," and expressed a desire eventually to be well enough and able to afford to move to their own apartment.

Quality of life. With respect to the Quality of Life scale, residents were most satisfied with the residence, the staff, and the location of the residence, while they were least satisfied with the amount of privacy in the residence, how they spend spare time, and how decisions are made in the home. Overall, the residents reported moderately high levels of satisfaction. The average score for all but one of the life domains was above 5 (i.e., toward the positive end of the scale).

Turning to the qualitative data, three categories emerged from the participants' descriptions of their quality of life: (a) housing, (b) labelling and stigma, and (c) lack of variety and choice in instrumental roles. Regarding the housing category, nearly all of the residents in the study reported they were satisfied with where they were living. Moreover, the comments indicated a favourable attitude among the residents as to the positive impact their current living environment had on their general well-being and quality of life.

There were other participants who described improvements in their quality of life by comparing how they felt about their current place of residence to that of their previous living environment. For example, one resident replied: "Before I came here I was sleeping on the streets. Since living here my quality of life has changed drastically and is very good now." Similarly, another resident who had been institutionalized for several years remarked:

> I first moved into the hospital when I was around 12 years old and was in and out till the age of 29. During that time I lived in board-and-care homes and nursing homes and I didn't like it. They would make you do a lot of housework. There was lots of drinking and very little money for ourselves. Here we don't have that. That makes me happier.

The one complaint which was made by a few residents of group homes was a lack of privacy in the residence.

"Labelling and stigma" was the second category which emerged in response to quality of life. A number of participants noted that, although they were pleased with where they were living, certain "labels" often associated with the type of people who live in group homes sometimes made it difficult for them to meet new people and to establish or maintain close relationships. To illustrate this

concern, one middle-aged man described how his son refused to visit him in the residence, because he was afraid of the kind of people that live in the home: ". . . He's young and he just doesn't understand what has happened to me and what this place is all about." Similarly, another resident recalled how her family became upset with her when she decided to leave her own home to move into a group home. Perhaps nowhere was the issue of "labels" more dominant than among the younger residents in the study. Two participants in their early twenties explain:

> It's harder (to develop friendships) when you live in a group home as opposed to other residences like the Y.W.C.A. or in apartments, because people know something is wrong with you because you live in a group home with all these other people. People are often leary of even visiting you here. I even had a friend tell me that I couldn't be their friend anymore when I moved into this place.
>
> I feel very self-conscious about living in a group home. My close friends all know where I live but some of my acquaintances that I meet through school don't. I feel self-conscious because of the stereotypical thoughts and labels about people with mental illness.

On a more positive note, several exceptions to the issue of stigmatization were also mentioned. For example, one resident commented: "People in the neighbourhood are very nice, they wave at us . . ."; while yet another participant stated: "People in the community like us. The corner store is friendly, they even give us cigarettes on credit."

Another category that emerged in response to the quality of life question is a lack of variety and choice in instrumental roles. Defined here as one's involvement in such activities as competitive work, job-training, school, sheltered workshops, or volunteering, instrumental role functioning constitutes perhaps the largest category of responses which emerged from participants' descriptions of their quality of life. Again and again residents expressed the concern that without employment or some kind of meaningful activity, one's motivation for day-to-day living becomes dramatically lowered and that one's overall quality of life deteriorates. As one frustrated resident explains:

> You need a destination to go to. Someplace to go after breakfast, or a reason to get up in the morning. When you're doing something you feel more constructive. Somedays I go to bed and think "What did I do today?" (I say) nothing! My days are not psychologically satisfying.

Personal growth. The mean scores on the Independent Functioning scale were 11.61 at the time residents entered the program and 15.42 at the time of the interview. A paired t-test showed this was a significant increase, $t(32) = 5.57$, $p < .001$. With regard to instrumental roles, 56% of the residents reported having at least one instrumental role when they entered the program, compared with 88% at the time of the study. Similarly, staff reported that 50% of the residents held at least one instrumental role when they entered the program compared with 91% at the time of the study. Most of these roles were held on a part-time basis, and few of the residents were competitively employed. Overall, residents showed increased involvement in instrumental roles after entering supportive housing.

There were two sources of qualitative data regarding residents' personal growth: staff and residents' perceptions. Positive changes were noted by staff in all but two of the 34 residents who were interviewed for the study. Three particular categories were readily identified from the staff responses: (a) social skills, (b) educational and/or vocational functioning, and (c) daily living tasks. All of the support workers in the study noted several positive changes in many of the residents' social skills and friendships since entering the housing program. Involvement in educational and/or vocational activities is the second area in which staff workers noted positive changes among many of the residents since entering the housing program. Several staff workers reported that a number of residents had found either full-time or part-time employment since entering the program. The final aspect of change as noted by the support staff refers to residents' increased functioning in daily living tasks. By far, the most noticeable increase in this area can be seen in residents' functioning in various household chores, such as cooking, cleaning, shopping, and laundry.

Analysis of the residents' data revealed that nearly all of the residents interviewed for the study thought they had made some sort of positive change since entering the housing program. Of those residents who did not report positive changes, three reported that they had made neither positive nor negative changes, while only two reported that they had experienced changes in a negative direction since entering the residence. Three categories of positive changes emerged from the data: (a) greater independence with daily living tasks, (b) improved educational and/or vocational functioning, and (c) improved self-esteem. Furthermore, several aspects of the various programs were noted as important factors which influenced these changes.

Increased ability to function independently, or at least with less support, in various daily living tasks appeared widespread throughout the data as one way that residents have changed since entering the program. For example, several residents reported that since living in the residence they were now able to do more things on their own, such as cooking, cleaning, medication monitoring, and money management.

The second category indicated becoming more active in the community in educational/vocational activities. One woman who had been hospitalized for almost two years before moving into the residence explained:

> When I first moved here I was terrified of everything . . . I couldn't even go out in the community because I was so scared. Things have improved, I ride the bus and I go shopping. I'm even going to school part time.

The final category of responses reflects a positive change in how residents are feeling about themselves. In this case, two of the most noted changes, a sense of confidence and heightened self-esteem, were described by residents in a variety of ways. For instance, a number of residents described confidence and self-esteem in the context of self-awareness or self-acceptance. "I think I've become more myself . . . I've begun to realize what my capabilities are as well as my limitations."

Themes: Linking Process and Outcome

From the description of residents' responses to the four primary questions, the reader can see that the responses did not neatly fit our predetermined distinction between process and outcome. For example, when we asked about perceptions of control (a process factor), residents talked about control both as a process (participation in decision making) and as an outcome (increased feelings of personal control). Similarly, when we asked about quality of life (an outcome factor), residents spoke of process factors which either contributed to their well-being (e.g., stable housing) or contributed to their sense of isolation (e.g., labelling and stigma). In this section, we identify the major themes that pervaded the responses and suggest how process and outcome are linked.

Competence. The theme of competence seems to sum up residents' descriptions of their personal growth and quality of life since entering the program. Competence is a multifaceted concept, with cognitive, emotional, and behavioural components. The cognitive component of competence includes perceptions of increased personal control and a more optimistic view of life and the future; the emotional component includes feelings of emotional well-being, life satisfaction, and self-esteem; and the behavioural component refer to social skills, independent functioning with tasks of daily living, and educational/vocational skills. Increased competence was a clear outcome of participation in supportive housing.

Support, acceptance, and participation. The interrelated themes of support, acceptance, and participation seem to capture the key processes in the housing programs and the community. Nearly all of the participants made some mention of the value that friendships and social support have in building their competence. Residents repeatedly described their need for someone to talk with, confide in, and give them advice on personal matters and problems in living. When residents were asked whether the program had influenced their personal growth or quality of life, the most frequently mentioned positive aspect of the program was the availability of support from staff and residents.

> The staff and my friends have helped to make these changes (in myself). When I get down, I have the staff and other residents to talk to.

The importance of problem-solving support for teaching new skills and promoting independence was mentioned by several residents.

> The staff will encourage you to do things and they will even help you, but they won't do it for you. This has helped me to get my confidence back so I can do more of these things on my own.

The struggle for acceptance from family, friends, and community members appeared throughout the qualitative data as being an ongoing issue for many residents. In this regard, perhaps the greatest barrier that ex-patients living in the community must face is stigmatization. On a number of occasions residents described how their quality of life had been affected by the "prejudice" and "ignorance" they experienced as a result of their problems, living in a group home, or previous psychiatric hospitalizations. On the other hand, when residents experienced acceptance from members of their social networks or from community members, they reported that this had a positive impact on their well-being. The concept or theme of acceptance demonstrates that although ex-patients may be

living "in" the community, many have yet to become completely "part" of that community.

The last theme that appears to be important for promoting competence is participation. Participation refers to active involvement both in the residence and in the community. Residents spoke of how particiation in democratic decision making in the residence, contributing to household chores, and opportunities for socializing with other residents all contributed to their competence. Also, participation in community activities and roles was seen as important for developing competence. However, for many residents the lack of variety and choice in instrumental roles was seen as having a negative impact on their motivation, well-being, and self-esteem.

DISCUSSION

This research has pinpointed some of the benefits and limitations of supportive group homes. With respect to outcome, the quantitative and qualitative data provided by both residents and staff strongly converged in showing increased perceived control, self-esteem, social skills, independence, and educational/vocational functioning for nearly all of the participants. Previous research on supportive housing has shown that such programs reduce rehospitalization rates and improve work participation (e.g., Fairweather et al., 1969; Lamb & Goertzel, 1972). The findings of this study add to the literature in showing that residents benefit in many other ways from their participation in such programs.

While we made an a priori distinction between perceived quality of life and personal growth as dimensions of outcome, the qualitative data analysis revealed that "competence" was an overarching theme which encompassed the cognitive, emotional, and behavioural aspects of change. This finding is similar to that obtained by Lord and Farlow (1990) in a qualitative study of people who had been marginalized by virtue of physical, developmental, or psychiatric disabilities and low-income. They found many of these people experienced personal empowerment, which included increased personal control and competence. Similarly, Walsh (1985) has argued that changes in the social functioning of ex-patients are interrelated with changes in their inner lives. Future research on supportive housing should continue to examine the subjective experiences, thoughts, and feelings of ex-patients, as well as tangible changes in work history and community tenure.

With regard to program processes, we found that the group homes provided considerable support and gave residents a measure of control in decision making. Both the quantitative data and the qualitative data showed that residents expected and received support from residential staff and friends. Moreover, many of the residents stated that the support they received from staff and friends enabled them to become more competent and healthy. In another paper on this research, we have reported the finding that social support was significantly correlated with independent functioning and some domains of quality of life (McCarthy & Nelson, 1991). Thus, both the qualitative and quantitative data converged in showing that social support is an important process that is related to outcome. This finding is consistent with previous qualitative (Lord et al., 1987; Lord & Farlow, 1990) and quantitative (Nelson et al., 1992) research.

While residents spoke primarily of supportive interactions with staff, a few residents spoke of negative interactions. Perceptions of staff favouritism toward certain residents, the characterization of staff-resident relationships as "them and us," and concerns about staff turnover were the major problems mentioned. Future research needs to look at negative as well as positive interactions with staff, since negative interactions can have quite a detrimental impact on human well-being (Rook, 1984).

On the whole, the quantitative findings on the Resident Control and Staff Management Style scales showed that a democratic, shared decision-making style predominates in these supportive housing programs. Similarly, the qualitative data suggested that residents believed they had considerable freedom and control in their residence. These findings stand in sharp contrast to the loss of power that patients experience in institutions (Burstow & Weitz, 1988); Chamberlin, 1978; Goffman, 1961; Rosenhan, 1973). Moreover, we found that the two measures of resident control were correlated with satisfaction with some domains of quality of life and independent functioning (see McCarthy & Nelson, 1991).

On the other hand, the quantitative findings showed that unilateral staff control was exercised in certain areas (e.g., deciding on chores, setting mealtimes, etc.). Similarly, the qualitative data revealed that many residents believed that while they have input into decisions, staff ultimately made the final decisions. Residents resented this "parentalistic" treatment by staff and expressed a need for more control over decision making. In particular, residents wanted more control in the selection of new residents. In our feedback meetings, we recommended that staff involve residents in a more democratic, negotiated approach to *all* decisions in the residences.

The process of control in decision making was part of a larger theme of participation, which emerged from the qualitative data. Democratic participation in decision making and in the daily routines (e.g., cooking, cleaning) of the residence and involvement in community activities and roles were seen as important for the development of competence. This finding is consistent with Walsh's (1985) assertions that ex-patients should be maximally involved in the intervention process and that active participation in actual community situations is the best way to develop competencies. In their study of personal empowerment, Lord and Farlow (1990) also found that participation was a key process in developing comptence. Similarly, Prilleltensky (in press) has argued that self-determination and democratic participation are core values which underlie an empowerment approach to intervention, which emphasizes competence development rather than deficit reduction. While generally satisfied with their level of participation in the residences, many participants complained of a lack of opportunities for instrumental role involvement in the community. Residents' perceptions reflect the reality that supported employment options are sorely lacking in the communities in which this study was conducted.

The theme of acceptance was another program and community process that was linked to the outcome of increased competence. Consistent with previous research (Goffman, 1961; Lord et al., 1987), participants spoke of their experiences of labelling, stigma, and exclusion from community life. While participants were generally satisfied with their housing, some noted ways in which

living in a group home actually contributed to stigma. Recently, there has been a shift in policy and practice away from group homes and toward apartments with flexible support (Blanch, Carling, & Ridgway, 1988). In fact, research has shown that upon discharge from hospital, most people prefer to live in an apartment, as opposed to a group home (Goering, Paduchak, & Durbin, 1990; Tanzman, Yoe, & Wilson, in press). Research on these "supported" housing alternatives is needed to determine if they can achieve the same beneficial outcomes as the group homes in this study, while providing more privacy and control and less stigma.

In addition to the substantive contributions of this research, it is also important to note the value of the qualitative component of the evaluation. Our initial assumption was that support and control are key processes in supportive housing. However, the qualitative data showed that support, acceptance, and participation were the key processes that were linked with the outcome of increased competence. Thus, inclusion of qualitative data enabled us to refine our model.

Also, the qualitative approach provided a depth and richness that was lacking in the numerical results. For instance, both the quantitative and qualitative findings showed improvement in residents' instrumental role involvement. However, the qualitative data showed residents were dissatisfied with the lack of choice and opportunities for work and other instrumental roles. Thus, the qualitative data served to qualify the positive conclusion about changes in instrumental role involvement. The depth and richness of the qualitative data permitted a better understanding of the numerical findings. For instance, the statements residents made about control in the residence showed some of the reasons and feelings underlying residents' numerical ratings of control.

One potential problem of using both quantitative and qualitative methods concerns the ordering of items in the questionnaire. In this study, all of the open-ended questions were asked at the end of the interview. It is possible that some of the quantitative items might have cued residents' responses to the open-ended questions. The high degree of convergence between the qualitative and quantitative data may be due in part to this "cueing." There is, however, evidence that certain responses were not "cued." For instance, residents did not complete a quantitative measure of independent functioning, as staff did, but they spoke of increased independent functioning in response to the question of how they had changed. In future research, we intend to ask the more general open-ended questions first and the more specific close-ended questions later in the interview.

RÉSUMÉ

Cet article présente les résultats d'évaluation d'un programme d'hébergement protégé pour des personnes ayant connu l'hospitalisation en milieu psychiatrique. Des méthodes qualitatives et quantitatives ont été utilisées pour étudier deux processus clés, le support social et le pouvoir de contrôle sur la vie en résidence et deux effets centraux, la qualité de la vie et le développement personnel. Des entrevues ont été réalisées auprès de 34 résidents participant à des programmes d'hébergement protégé et des informations ont été recueillies auprès du personnel en place. Alors que les résidents étaient satisfaits, en général, du degré de support reçu et du degré de contrôle exercé par eux sur leur vie en résidence, certains secteurs

demeuraient sous le contrôle unilatéral du personnel intervenant (qui prenait des décisions sans impliquer les résidents dans le processus). En ce qui regarde la qualité de vie, les résidents étaient satisfaits de leur vie en résidence, mais exprimaient des réserves concernant le manque d'intimité, la discrimination à leur égard, et le nombre limité d'occasions pour participer à la vie de la communauté. Les résidents ont connu un développement personnel plus grand depuis leur entrée dans le programme d'hébergement protégé, soit une plus grande autonomie, une implication plus forte dans des rôles instrumentaux, une meilleure estime de soi, et des habiletés sociales plus grandes. Le personnel a confirmé ces changements. Les résidents ont indiqué que leur sentiment accru de compétence découlait du support social fourni par le personnel et les amis, de l'acceptation reçue des membres de leurs réseaux et de ceux de la communauté plus étendue, et de leur participation aux activités communes de leur milieu résidentiel. Ces résultats ajoutent à notre compréhension des programmes d'hébergement protégé en montrant que ces programmes ont des effets bénéfiques au-delà de la seule réduction du taux de réadmission en psychiatrie ou d'une augmentation de la capacité de travail des résidents, et permettent l'identification de processus pouvant contribuer à augmenter la compétence des résidents. De plus, ces résultats montrent l'intérêt d'utiliser des données qualitatives en évaluation de programme.

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