SUPPORTED HOUSING FOR PEOPLE WITH SERIOUS MENTAL ILLNESS: RESIDENT PERSPECTIVES ON HOUSING

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ABSTRACT

Supported housing involves integrated housing that is adequate and affordable, paired with flexible, individualized mental health support services. In this qualitative study, interviews were conducted with supported housing residents in cities and towns in southwestern Ontario to examine their housing experience. Ques-tions were organized around 4 dimensions of housing: (a) physical environment, (b) social environment, (c) affordability and choice, and (d) residential history. The inquiry, which occurred at neighbourhood and dwelling-unit levels, revealed 4 themes: (a) loneliness, (b) making do with socially and structurally inferior housing, (c) a desire for more understanding, and (d) a concern with an individual's sense of integration into a community.

BACKGROUND

Supported housing has emerged during the 1990s as the most popular model of housing and support among people with serious mental illness (Clarke Institute of Psychiatry, 1997). It is also a central component of mental health reform in jurisdictions across Canada (e.g., Ontario, 1999; Alberta, 1996; British Columbia, 1998). Supported housing involves normal, integrated housing that is adequate and affordable, paired with flexible and individualized mental health support services. This model focuses on person-centred support, self-help, and natural supports, and de-emphasizes the role of professional services (Carling, 1995). Another distinguishing characteristic of supported housing is that the roles of landlord and mental health service provider are separated. The basic premise of supported housing is that, rather than congregating in mental health agency-owned housing, people are empowered to

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choose, get, and keep the housing and support services they want, and thus are able to experience their residence as a *home* rather than as *housing* (Carling, 1993; Boydell & Everett, 1992).

There have, however, been some well-documented drawbacks to the supported housing model. One of the greatest barriers to implementing the model is the lack of affordable rental units (Hogan & Carling, 1992; Ogilvie, 1997). While most people with serious mental illness earn low incomes and require subsidized housing, a recent study in southwestern Ontario has shown that most supported housing residents live in market-rent housing which they cannot afford, rather than in rent-geared-to-income places (Walker, 2000). A second problem with the supported housing model is its potential to contribute to loneliness and isolation (Parkinson, Nelson, & Horgan, 1999; Ogilvie, 1997). Residents in a single-bedroom apartment, for example, may experience loneliness and miss the informal support present in group living arrange-ments (Johnson, 2001).

Housing for people with serious mental illness has been the focus of much research, although most studies have looked at rehabilitative settings such as group homes and supportive apartments (McCarthy & Nelson, 1993; Nelson, Hall, & Walsh-Bowers, 1995), or at the housing and support environment in custodial board-and-care homes (Lehman, 1983; Nelson, Hall, & Walsh-Bowers, 1997). Four dimen-sions of mental health housing have appeared frequently in the literature: (a) the *physical housing environment,* (b) the *social housing environment*, both in the neighbourhood and the dwelling (Earls & Nelson, 1988; Newman, 1994; Nelson, Wiltshire, Hall, Peirson, & Walsh-Bowers, 1995), (c) *housing affordability and choice* (Srebnik, Livingston, Gordon, & King, 1995), and (d) *housing history*, including resi-dential mobility and the reasons why people move from one dwelling or neighbour-hood to another (Taylor, Elliott, & Kearns, 1989; Hurlburt, Wood, & Hough, 1996).

Most of this research has been based upon a quantitative methodology, with qualitative techniques only being used to flesh out the quantitative results. However, researchers are increasingly pointing to the value of using qualitative techniques to reflect resident perspectives on housing (Nelson, Walsh-Bowers, Hall, & Wiltshire, 1994; Doyle, Burnside, & Scott, 1996; Johnson, 2001; Boydell, Gladstone, Crawford, & Trainor, 1999), and mental health housing researchers are focusing their inquiry on qualitative research programs more frequently than in the past (Johnson, 2001; Boydell et al., 1999).

At the culmination of an extensive review of literature on housing approaches for people with serious mental illness, Parkinson et al. (1999) called for more research that examines the supported housing model. In a thorough review of existing literature on supported housing, Ogilvie (1997) emphasized the need for more qualitative re-search that listens to supported housing residents and develops a better understanding of their housing experience. The purpose of our research was to examine, using a qualitative approach, the overall housing experience of residents in supported housing.

METHOD

A qualitative research design was used in this study to elicit from participants their views and experiences. Qualitative research relies heavily on the narratives of participants, which allows them to voice their experiences rather than have them sum-

marized by objective measures such as statistics. Obtaining and communicating narratives from marginalized groups of people is an effective way to give them a voice (Richardson, 1990; Boydell et al., 1999). In this study, the goal was to understand the specific circumstances of the participants (how and why things actually happen in their lives) and to acknowledge that experiences are situational and conditional (Rubin & Rubin, 1995).

Study Area and Participants

Our research occurred in southwestern Ontario, within the catchment area of the Waterloo Region—Wellington-Dufferin District Health Council (District). The District comprises the Regional Municipality of Waterloo and the counties of Wellington and Dufferin. Thirty-one semi-structured interviews were conducted with supported housing residents in the cities and small towns of the District. Parkinson et al.'s (1999) definition of supported housing as a model in which: (a) support is provided by a non-profit agency, (b) residents choose the nature and frequency of support from outside staff, and (c) residents have complete control over all decisions and issues regarding their housing (Parkinson et al., 1999) was used to define the study population.

In this study, participants were chosen through maximum variety sampling, a non-probabilistic method suggested by Morse (1994). This method emphasizes sam-pling for diversity instead of for the typical respondent that is sought with random sampling. In this study, where the goals were to represent the diversity of the study population and to uncover both the variety of human experience among residents and some of the commonalities across different socio-demographic and locational (i.e., urban/rural) groups, maximum variety sampling was particularly useful.

Prospective interview participants were approached through mental health support co-ordinators from the five mental health support agencies in the District. Support co-ordinators circulated letters of information and consent forms to pros-pective participants with whom they worked. If a prospective participant agreed to participate, the support co-ordinator would forward the completed consent form to us by mail or FAX. Participants were then contacted by telephone to schedule an interview time and location suitable to them. Most interviews occurred in participants' homes.

Interviews were conducted with 14 single men, 14 single women, and 3 couples. The age of participants ranged from 22 to 56, with an average age of 41 years (SD = 9.60). Four of the single women lived with their children on a day-to-day basis. Two of the single women had children who spent a considerable amount of time at their home (e.g., every second weekend). Four men and three women lived in small towns in Wellington-Dufferin, with town populations ranging from 3,300 to 8,900 people. The others were residents in small and mid-size cities in the District. Eight people were living in subsidized, non-profit housing. Two of those were living in co-opera-tive housing, five were in developments dedicated to low-income households, and the other person was in a subsidized unit integrated into a building of predominantly market-rent units. Twenty-three participants were residing in market-rent apartments. Although it was initially intended that half of the participants would be from small towns and half from cities, there were not enough prospective participants in small towns within the District to achieve this balance. For this reason, our findings are a better indication of the similarities between the urban and rural experience than of the differences.

Data Collection

Rubin and Rubin (1995) distinguish between two broad types of qualitative interviewing: cultural and topical. In cultural interviews, the style of questioning is relaxed and the questions focus on the norms, values, rules of behaviour, and understandings of the group. Topical interviews, on the other hand, are more narrowly focused and are based on a set of linked questions prompted by preliminary observation, literature review, or preliminary interviews. In topical interviews, questions are worded broadly enough to encourage participants to express their knowledge and ideas (Rubin & Rubin, 1995; Palys, 1997), but narrowly enough to provide the interviewer with the data required for meeting the objectives of the study. The interviews conducted in this study were topical, and consisted of a combination of directed and exploratory open-ended questions that enabled the expression of the participants' ideas and knowledge.

Interviews ranged from 45 minutes to two hours; most lasted just over one hour. A $10 stipend was given to participants for their assistance. The interview schedule was organized around the four dimensions of mental health housing research—physical environment, social environment, housing affordability and choice, and housing history—and investigated residential experience at the level of neighbourhood and dwelling. Many of the questions were adapted from other qualitative research schedules (i.e., Boydell, Gladstone, Crawford, & Trainor, 1996; Clarke Consulting Group, 1995; Taylor et al., 1989), while the rest were original to this study.

The semi-structured design of the interview schedule was such that a set of questions were worked out in advance and modified slightly depending upon the flow of conversation with residents. The structure was sufficiently flexible to encourage significant deviation from the schedule of questions. During the interviews, respondents clearly had a story to tell, and they told it before the interview was through. A small number of fixed-response questions were used as summary questions at various times throughout the interviews. If responses to open-ended questions within a section of the interview were at odds with the fixed-response at the end of that section, the discrepancy could be explored. In most cases, there were no discrepancies. This tactic was used to strengthen the credibility and confirmability of results (Lincoln & Guba, 1985).

Data Analysis

In most cases, interviews with residents were recorded on micro-cassette. In cases where residents did not want to be recorded, notes were taken instead. All interviews were transcribed. Using the analysis techniques outlined by Rubin and Rubin (1995), three general steps were followed: (a) categorizing interview data according to theme or concept, (b) comparing material within categories to search for variations and nuances in meaning, and (c) comparing across categories to discover integrative themes that demonstrate the relationships between different variables. While the dimensions examined and questions asked during interviews were the "best guesses" at what might be important to residents, the integrative themes provided a better reflection of what really mattered to participants.

Following the interviews, summaries of the results were mailed to participants and their feedback was invited. Feedback was received directly from three participants and

indirectly from several others through their support co-ordinators. The feedback was helpful for clarifying the presentation of results. None of the feedback received was aimed at changing the substantive content of the results.

RESULTS

The narrative responses to all open-ended questions from the interview schedule revealed four integrative themes: (a) loneliness, (b) making do, (c) a desire for understanding, and (d) fitting-out (as opposed to fitting-in). These themes were based on and threaded through most interview transcripts. To complement the narrative responses in our discussion of the theme making do, quantitative data were used to describe the conditions of housing affordability among respondents.

Loneliness

Loneliness is a complicated issue, involving a tension between a desire for privacy and a desire for social interaction. Lack of privacy was not a prevalent issue among participants; when it was, it was associated with nosy or gossipy neighbours more so than with penetrating noise from neighbours.

> You don't get privacy here. There's sometimes when I just want to sit outside on my front step by myself with my tea and just veg, you know. Then you get on with other people. "Hi, hello, how are you," that's OK. But I mean then they want to talk about, "well gee, Betty just did this. . . ." I don't care. I don't want to know about it. It's their life not mine. And I find that I've got to tell people more than once. Like excuse me, mind your business. More than once, and I don't really think you should have to do that, but unfortunately a lot of people are hard-headed in that respect and especially around here when it comes to privacy. You don't get it. Living here is not the place to live if you want to continue being a private person. They won't allow you.

> Privacy, there is no such thing. Everybody's looking at everybody in my build-ing.

Some participants were concerned that they had too much privacy and expressed feelings of loneliness.

> Yeah, I do [have enough privacy]. And that's something that's very important to me. I need to have my privacy. I'm glad I'm living in the unit I'm living in on a fairly quiet floor. Maybe even too much privacy sometimes. Because living alone can be challenging. It can be lonely. . . .

Participants stated that they did not know the other people in their building. A recurrent concept was that of participants and their neighbours keeping to themselves.

> Most of them [other tenants] leave me alone and keep to themselves.

> They keep to themselves; I keep to myself. It's how I like it.

> I'm a rather solitary individual now. Because of all the slights I've received, both from family and friends, I'm finding a solitary existence the most profitable one.

Participants used the concept of others keeping to themselves in a way that suggested a desire for more social interaction with neighbours.

> I think people just stay in their homes and don't come out, or come out only when they have to. The neighbourhood could be a little friendlier.

> They [other residents] like to mind their own business around here. I mean they'll talk to you but they won't go too far, you know. They just go so far. There's sort of a barrier I guess.

One prominent theme that emerged in interviews with participants who live alone and experience loneliness was that, even in nice apartment units, loneliness could make the apartment undesirable.

> I like it here but I don't. It's very lonely here.
>
> I feel lonely because I don't have much companionship with other people. I feel a lot of disconnection from the community, you know. I mean if there were more activities I could go to in town and help with mental health. But I just wish I had more company. . . . If there were someone sharing the apartment I would feel much better, someone that I could trust. Otherwise I like the apartment. It's very nice. It makes you dislike the apartment, because of the loneliness, you know. So companionship is the main thing I'm missing.

Some experienced enough social interaction in their place of residence to suit their wants. Those that expressed this point of view were typically people with part-ners or people living in co-operative housing.

> It is nice to sit outside and just chit-chat. That's nice here and you do get that. Everybody that's moved has missed that. Or talking to the kids. The kids will sit down and talk to you. So that is a really nice thing about the summer here, or even in the winter, when somebody will come out and help you shovel. You know, so that is a nice thing here. And everybody that's moved has missed that, that going out into the parking lot and talking to somebody, or sitting out on your porch and talking to somebody. I think the up-side of co-operative housing is really good. It's really an up-side. It's worth it. . . . I can feel useful here. Like I've met friends and I've babysat my friends' kids. It's a place where somebody with a mental illness can feel useful.

In general, participants would have liked more social interaction in their homes and neighbourhoods, beyond simply saying hello to neighbours.

> I'd like to have someone in for coffee every once in a while. I'd like to have a friend. I had a friend in the building but she moved.
>
> I'd like to maybe talk to them [others in the building], have them in the apart-ment, have a coffee with them or something, you know.

Making Do

In their study of the perceptions of people with serious mental illness about their neighbourhoods and their neighbourhood experiences, Boydell et al. (1999) identified the concept of making do—a process of accommodation in which tenants tolerate a variety of deleterious conditions within their immediate environments and within the broader neighbourhood, while still expressing gratitude for their living situations.

This concept of making do was prevalent throughout our analysis of the residential experience of tenants in supported housing. This prevalence demonstrates a relationship between a number of variables, particularly housing affordability and the social and structural conditions of housing, which were paired with a general sense of satisfaction with or gratitude for housing.

Eight out of 31 interview participants reported living in subsidized housing where they pay roughly 30 percent of their income on rent. Twenty-three participants reported living in market-rent housing, and their proportion of monthly income spent on rent (including utilities) ranged from 34 to 60 percent, with the average proportion at 48 percent ($SD = 7.96$). The woman paying 60 percent of her monthly income on rent has four school-age children in her care. The woman paying 34 percent of her

income on rent is one of three participants doing paid work supplemental to her disability pension earnings. When the rent paid for housing is in excess of 30 percent of household income, housing tenure is considered precarious (Canada Mortgage and Housing Corporation, 1992).

As discussed earlier, residents often were coping with loneliness and a desire for more social interaction. Residents also coped with structural inadequacies. One resident, commenting on the apartment's structural condition, reported that:

> There's a wall falling down. I think it can almost be condemned, you know. An animal can crawl through the wall in the basement, on this side, right into the basement. . . . They've got jacks holding the main beams up and stuff like that. . . . you can see cracks in the wall, you know. You can see a bit of light coming through.

Concerns of poor insulation and cold winters also were raised. On a number of occasions, participants expressed an inability to afford to heat their already poorly insulated apartments in the winter. After expressing general satisfaction with his apartment, one resident noted:

> I would like to see the place a little warmer in the winter somehow, without causing me any further expense. But I have conquered that in one way. I have an electric blanket. They're great to have in the winter. I guess for $375.00 a month and the old building it is, I'll just have to grin and bear it. I feel that since I've got an electric blanket in the bedroom, I can shut off the heat in the bedroom and sleep with the electric blanket at night. It costs less hydro than it does for the electric baseboard to be running. It could be warmer in the winter; that's one thing.

Another resident noted that he wore warm clothes around his apartment in the winter and only turned the heat on if he was expecting visitors, in which case he turned it on for a couple of hours before they arrived and for the duration of their visit.

Apartment size was another common structural concern.

> The living room is the bedroom. Over three people in the apartment and it's crowded. It's just too small. But for the price, when you're on disability it's hard to move into places that are more expensive, unless you go in with someone.
>
> If it [the building] was owned by one person with a family, it would be great. So all those apartments would be rooms, with other rooms leading up to them, and it would be real nice. For apartments, it's a little small.

Mothers who were interviewed raised the concern of insufficient space for their children. In a couple of instances, children were sharing bedrooms with each other or with their mother. In other instances, mothers with joint custody of their children or who had children who visit frequently did not have enough space for them.

> The problem is, I have five children. I wouldn't be able to have them all over at one time and that bothers me. Plus, I have my daughter coming every other weekend to visit overnight, so the place isn't big enough.

That residents were satisfied with or grateful for their home was a pronounced theme during interviews.

> Well, this ain't the best looking house in town. But you know, I have a roof over my head and for the government to give me money to help me out, to live, I'm very happy and grateful for it.

Speaking optimistically about a walk-up apartment described earlier in the interview as run-down, one tenant said:

> I think I should be happy with what I've got. I think the building is not too bad. It's the inside that counts. The only thing that I'm concerned about that the land-lord does is fix this wall (large crack), because it's starting to affect another wall on this side, you know. So that's getting kind of dangerous, you know. That's the main concern that I have.

The affordability problems faced by participants and the high frequency with which social and structural concerns were raised, paired with the fact that participants expressed that they were satisfied with or grateful for their home, provided evidence that many are simply making do with their housing.

Desire for Understanding

Participants expressed a general desire to develop understanding—particularly of mental health issues—with landlords, other tenants, and the community at large. Residents pointed out that the stigma associated with having a mental illness caused them to feel apart from the other residents and community members.

> No [I don't feel like I fit in], because of my mental problems. There's such a stigma attached. You feel singled out. It's the same wherever I go though. I don't tell people about it. People tend to just turn away from you when they find out.

> It's like a jigsaw puzzle and a piece that doesn't fit right. You feel like you just don't fit in with them because you're sick.

One resident of co-operative housing, who had earlier expressed a high level of satisfaction with the social environment at her co-op, pointed nonetheless to a lack of understanding of mental health issues.

> Well, I've been accepted although there are people that don't understand me. They think I'm lazy and live off the government. Because you can't see it [mental illness]. I don't have a wheelchair.

Having an understanding landlord was important to participants and contributed to a sense of security in their tenure, as well as general satisfaction with their housing. In summarizing his satisfaction with his current home, this resident made note of his understanding landlord:

> It's cosy, it's comfortable and it's close to downtown. The rent is reasonable and the landlord understands [mental illness].

Although the discussion about participants' experiences with their landlords was generally positive, the most notable negative trait of landlords was that some were not understanding about mental health issues. One resident, when asked how she would change her relationship with her landlord if she could, said:

> I'd have her ease up and understand that if someone does have an issue, if they suffer from depression, be a little more understanding and not so hard on them. You know, work with them, not against them. Be a support without patronizing.

The management of general public housing also were targeted for their lack of understanding of mental health issues.

> Subsidized housing is good because it's geared to your income. But they kicked me out because I got sick, you know. I think it was mainly the elderly people in the building that were complaining. I think they should have staff on duty or something to deal with people that are getting sick, because I have ups and downs. I started a relationship with someone, it ended, and I got sick. And I lost my subsidized housing just because I got sick.

This resident moved from an affordable subsidized apartment to a market-rent apartment, where at the time of the interview he was paying 55 percent of his income on rent.

The desire to develop understanding of mental health issues among other residents and in the community at large was well articulated throughout the interviews.

> I think I'd like them [other residents] to understand where I come from, that I'm not just lazy and living off the government, but that I have a major mental illness. You don't get on CPP Disability for nothing you know. And I would educate people that we're [people with mental illness are] human beings. It's an illness that we didn't ask for. Like I didn't think when I was a teenager, oh, I'd like to get schizophrenia and alcoholism and mood disorder. I didn't wish that on myself. So education, definitely education.

> There's a need for integration in the community, where the community accepts you and understands that you have a disability or an illness, but that it's being controlled by medication. That way you can try and live a full life, you know, which is not possible right now because of the stigma, social status, and income level.

Fitting-Out

A prominent theme was that residents of housing which is almost exclusively occupied by low-income households did not identify with their communities. Time and again, residents spoke against living in housing that is dedicated to people with serious mental illness. Overall, there was a strong desire to fit-in with the community at large, in apartment buildings and neighbourhoods that exhibit diversity.

In low-income housing developments, participants complained that other tenants were negligent in maintaining their building.

> The corridor up to the apartment, they [management] make an effort to maintain it; however, the people that live here don't care. It's neglected by the tenants. The outdoors are beautiful. It's very nicely maintained. And then there's the tenants who litter excessively. I've lived in high rent apartments and the tenants pitch in to keep the place nice. Here, there's no respect, no consideration.

> People spit on the floor. People put cigarettes out on the floor. They put garbage beside the dumpster. Trash is littered everywhere.

Participants also expressed a social distance from other tenants in low-income housing developments, stating that they would like more social interaction in their lives, but with people away from their building.

> I wouldn't mind having more [social interaction]. Not with people in my building but with people away from my building.

> I wish there were more people in this building that I wanted to interact socially with.

Notably, participants who were earning a long-term disability pension and living in low-income housing developments did not identify with other residents on other forms of social assistance.

> I kind of feel like I fit-out. Like I feel as though I'm pretty ambitious and sort of a bit out of sync with people here in the building. Like I'm trying to do whatever I can to get off social assistance. I don't know if and when I'll be able to accomplish this but that would be a nice long-term goal for me. And I think there are people here who will be on it forever.

> I'm trying to rebuild my life. Except for a few people, they're [other tenants are] at a just getting by stage and happy to stay like that. Or they're the type of people that are looking to be cared for by someone else, like a free ticket.

There was also concern raised over the impressions held in the community at large about low-income housing developments and the people living in them.

> Other people [in the neighbourhood] look at this residence as being basic low-life. If you have a high esteem or fairly healthy self-esteem before you come here, you'll lose it quickly as a result of the way other people treat you and look down on you because you're living here.

Participants stressed that they enjoy or desire the diversity of the broader community and living in regular housing. Some also raised the alarm of discrimination when asked about how they would feel living in dedicated mental health housing. Many had experience living in housing dedicated to people with mental health issues and, time and again, they reported that living in group homes or apartments where everyone has a mental illness can be very stressful.

> It's too taxing, too hard to deal with. Your home should be a place where you retreat to and feel comfortable. It shouldn't be a place of stress, or as little stress as possible. And I've done that before too, tried living in situations where I'm with other consumers-survivors, and it's never worked out for me. I've always wanted to get out of there.

Acknowledging the prevalence of this sentiment, however, a sizeable minority expressed a desire to live in housing that is dedicated to people with mental illness or at least where a significant proportion of residents were dealing with mental health issues. The main reason for this desire was that there would be more understanding and positive social interaction in these housing developments.

> It would be better [living in a building with others experiencing mental illness] because I find them very, very friendly, and it helps you out in a way if you're having a rough time or something. They wouldn't figure, oh, you're just crazy or whatever. They wouldn't just call the police right away and get them to come and get you and send you to the psychiatric ward at the hospital. They would sit and talk if somebody's having a problem or upset or whatever.

DISCUSSION

The purpose of this research was to examine the overall housing experience of residents in supported housing. To this end, the analysis coalesced around four integrative themes: loneliness, making do, desire for understanding, and fitting-out.

Loneliness

The tension around acquiring privacy without loneliness was well pronounced. In mental health housing studies, privacy typically has been discussed in terms of people having their own bedrooms instead of shared rooms (e.g., Nelson et al., 1994). This study showed that once this basic spatial aspect of privacy is satisfied, nosy or gossipy neighbours can become the forces working against privacy.

Participants also were concerned about having "too much privacy" and discussed feelings of loneliness. This experience of loneliness suggests a notable criticism of the supported housing model generally (Parkinson et al., 1999; Ogilvie 1997; Johnson 2001). While people's basic pain avoidance needs can be met through the physical

qualities of housing, personal growth needs can only be met through social characteristics, particularly the strength of social and peer support networks (Nelson, Hall, & Walsh-Bowers, 1998). Although the supported housing model appeals to most people (Clarke Institute of Psychiatry, 1997), many want help from their support co-ordinators to make friends (Ogilvie, 1997). Lindheim and Syme (1983) stressed the importance of considering social environment in a discussion of environments and health, and noted that a lack of meaningful social contacts results in higher rates of schizophrenia, alcoholism, and suicide. This trend was confirmed by an author with schizophrenia (Peterson, 1982), who stressed that loneliness and a lack of meaningful social activity leads to a deterioration in mental health. In a study of the housing environment of single parents (Doyle et al., 1996), the social environment of housing was found to be the second most important contributor to personal well-being (the most important being those macro-level factors which determine socio-economic status).

Participants often used the concept of keeping to themselves to describe relations with other tenants. Boydell et al. (1999) noted that tenants who participated in their study adopted passive strategies, such as keeping to themselves, as a fundamental way of coping with everyday life in their communities. Reclusive behaviour contributes to loneliness and only complicates the struggle for more social interaction. Difficulty making and keeping friends is one of the most frequently cited effects of stigma on people experiencing mental illness (Wahl & Harman, 1989). Loneliness was expressed in many ways by participants and it became clear that, even when the physical characteristics of an apartment are satisfactory, loneliness can work to negate any sense of home and belonging.

Making Do

Apart from concerns over the social environment in supported housing, residents also voiced concern over structural deterioration in their homes and a general lack of space—factors which bear a relationship to poor community adaptation (Baker & Douglas, 1990). These concerns were clearly expressed, particularly by residents of small towns and residents living in low-income housing developments. In the latter case, structural concerns were mostly tied to the negligent behaviour of other tenants. When residents' basic pain avoidance needs for stable housing are not met due to poor housing conditions, they experience emotional stress and possibly psychiatric symptoms (Nelson et al., 1998). It is important to recognize, however, that the deleterious effects on mental and physical health of the physical characteristics of housing are marginal when compared to more widespread social and economic deprivation (Duvall & Booth, 1978; Lindheim & Syme, 1983; Kearns, Smith, & Abbott, 1991; Dunn, 1998; Dunn, 2000).

Faced with a scarcity of subsidized housing, a lack of affordable market rental stock, tight rental markets, and shelter allowances that are not indexed to rent increases (Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada, 1999; Ontario Federation of Community Mental Health and Addiction Services and Canadian Mental Health Association, 1998), residents of supported housing are finding it difficult to afford adequate housing. When residents are required to move because of forces beyond their control (such as rising rents), their personal well-being is jeopardized (Kearns & Smith, 1994).

Prevalent throughout our analysis of the residential experience of tenants in

supported housing was their gratitude for their housing and their general sense of satisfaction and optimism—in spite of social and structural concerns with housing that was often not affordable. The decision by residents to make do with their housing situation may be attributable to their low housing expectations, habituation to inferior living conditions, or simply a lack of alternatives (Newman, 1994; Boydell et al., 1999).

Desire for Understanding

A desire for understanding among landlords, other tenants, and the community at large was well evidenced in this study. There is an important role to be played here by mental health agencies and social housing groups. Education programs can be instrumental in developing understanding among private and public sector landlords (Weisberg, 1996), and can progress into formal or informal partnerships between mental health support providers and landlords to create supported housing (Walker & Seasons, 2001; Walker & Seasons, 2002; Clarke Institute of Psychiatry, 1997). Education programs also raise awareness and understanding in the community at large (Weisberg, 1996).

Fitting-Out

Participants valued integration. Residents in low-income housing developments were not happy with their relationships with others in the building, expressing that they essentially fit-out. Boydell et al. (1996) also found that many tenants felt uncomfortable in housing with other marginalized groups. Participants also noted that living in housing where all residents have a mental health issue is very stressful, corroborating findings by Hodgins, Cyr, and Gaston (1990) that the congregation of many residents with mental health issues into one housing development contributes to a stressful living environment. Some participants nonetheless expressed a desire to live in housing where there were more people experiencing mental illness. Again, Boydell et al. (1996) found that several of their participants would have preferred to live among others with a common psychiatric history. These findings support the idea that residents must have choice, as no living arrangement will satisfy all aspirations (Trainor, Morrell-Bellai, Ballantyne, & Boydell, 1993).

CONCLUSION

Further research investigating supported housing in small towns and rural areas would help to clarify the impact of these settings on residents' housing experience. This study examined supported housing in small and mid-size cities and small towns; however, a solid comparison of the city and small town experience was not undertaken. In this study and others, a small but significant number of people have expressed the desire to live in housing with others suffering from similar mental health issues. Research that explores both the reasons for this preference and the distin-guishing characteristics of the group of people who hold them would be useful in planning for a range of housing choices. Most importantly, research is needed that demonstrates how supported housing can be implemented in ways which address residents' concerns, and that include collaboration with residents, to whatever extent they desire.

RÉSUMÉ

Le logement adapté est une forme de logement intégeré qui est passable et abordable, ainsi que lié à des services de santé mentale flexibles et individualisés. Cette étude qualitative consiste en une série d'interviews avec des résidents et résidentes vivant dans des logements adaptés situés dans des grandes et petites villes du sud-ouest ontarien. Le but de cette recherche est de comprendre les conditions de vie de ces résidents et résidentes en ce qui concerne le logement. Les questions se penchent sur 4 aspects de ces conditions: (a) l'environnement physique, (b) l'environnement social, (c) le coût et le choix, et (d) l'expérience passée des résidents et résidentes en matière de logement. La recherche, qui se déroulait tant au niveau du quartier qu'à celui des unités de logement, décèle 4 thèmes: (a) l'isolement, (b) des logements qui laissent à désirer aux plans sociaux et structuraux, (c) le désir d'être mieux compris et (d) une préoccupation quant à l'intégration de l'individu dans une communauté.

REFERENCES

Alberta. (1996). *Final report of the housing ad hoc task group*. Edmonton: Provincial Mental Health Board.

Baker, F., & Douglas, C. (1990). Housing environments and community adjustment of severely mentally ill persons. *Community Mental Health Journal*, *26*(6), 497-505.

Boydell, K.M., & Everett, B. (1992). What makes a house a home? An evaluation of a sup-ported housing project for individuals with long-term psychiatric backgrounds. *Canadian Journal of Community Mental Health*, *10*(1), 109-123.

Boydell, K.M., Gladstone, B.M., Crawford, E.S., & Trainor, J.N. (1996). *An exploration of the desirability of housing location by consumers of psychiatric services*. Ottawa, ON: Canada Mortgage and Housing Corporation.

Boydell, K.M., Gladstone, B.M., Crawford, E.S., & Trainor, J.N. (1999). Making do on the outside: Everyday life in the neighborhoods of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, *23*(1), 11-18.

British Columbia. (1998). *Revitalizing and rebalancing British Columbia's mental health system: The 1998 Mental Health Plan*. Victoria: Ministry of Health and Ministry Responsible for Seniors.

Canada Mortgage and Housing Corporation. (1992). A comparison of housing needs measures used in Canada, the United States, and England. *Research and Development Highlights, CMHC Socio-Economic Series*, 7.

Carling, P.J. (1993). Housing and supports for persons with mental illness: Emerging ap-proaches to research and practice. *Hospital and Community Psychiatry*, *44*, 439-450.

Carling, P.J. (1995). *Return to community: Building support systems for people with psychiatric disabilities*. New York: The Guilford Press.

Clarke Consulting Group. (1995). *Houselink Program Evaluation Project: Final report*. Toronto: Clarke Consulting Group.

Clarke Institute of Psychiatry, Health Systems Research Unit. (1997). *Review of best practices in mental health reform*. Ottawa: Minister of Public Works and Government Services Canada.

Doyle, V., Burnside, B., & Scott, S. (1996). *The Single Parents' Housing Study: The effect of housing governance on the health and wellbeing of single parent families in Vancouver*. Vancouver: Author.

Dunn, J.R. (1998). *Social inequality, population health, and housing: Towards a social geography of health*. Unpublished Ph.D. thesis, Department of Geography, Burnaby, BC: Simon Fraser University.

Dunn, J.R. (2000). Housing and health inequalities: Review and prospects for research. *Housing Studies*, *15*(3), 341-366.

Duvall, D., & Booth, A. (1978). The housing environment and women's health. *Journal of Health and Social Behavior*, *19*, 410-417.

Earls, M., & Nelson, G. (1988). The relationship between long-term psychiatric clients' psychological well-being and their perceptions of housing and social support. *American Journal of Community Psychology*, *16*(2), 279-293.

Hodgins, S., Cyr, M., & Gaston, L. (1990). Impact of supervised apartments on the functioning of mentally disordered adults. *Community Mental Health Journal*, *26*(6), 507-516.

Hogan, M.F., & Carling, P.J. (1992). Normal housing: A key element of a supported housing approach for people with psychiatric disabilities. *Community Mental Health Journal*, *28*(3), 215-226.

Hurlburt, M.S., Wood, P.A., & Hough, R.L. (1996). Providing independent housing for the homeless mentally ill: A novel approach to evaluating long-term longitudinal housing patterns. *Journal of Community Psychology*, *24*(3), 291-310.

Johnson, L.C. (2001). The community/privacy trade-off in supportive housing: Consumer/survivor preferences. *Canadian Journal of Community Mental Health, 20*(1), 123-133..

Kearns, R.A., & Smith, C.J. (1994). The residential mobility experiences of marginalized populations. *Tijdschrift voor Economische en Sociale Geografie*, *85*(2), 114-129.

Kearns, R.A., Smith, C.J., & Abbott, M.W. (1991). Another day in paradise? Life on the margins in urban New Zealand. *Social Science and Medicine*, *33*(4), 369-379.

Lehman, A. (1983). The effects of psychiatric symptoms on quality of life assessments among the chronic mentally ill. *Evaluation and Program Planning*, *6*, 143-151.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. London, UK: Sage Publications.

Lindheim, R., & Syme, S.L. (1983). Environments, people, and health. *Annual Review of Public Health*, *4*, 335-359.

McCarthy, J., & Nelson, G. (1993). An evaluation of supportive housing: Qualitative and quantitative perspectives. *Canadian Journal of Community Mental Health*, *12*(1), 157-175.

Morse, J.M. (1994). Designing funded qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). London, UK: Sage Publications.

Nelson, G., Hall, G.B., & Walsh-Bowers, R. (1995). An evaluation of supportive apartments for psychiatric consumers/survivors. *Canada's Mental Health*, *43*(2), 10-16.

Nelson, G., Hall, G.B., & Walsh-Bowers, R. (1997). A comparative evaluation of supportive apartments, group homes, and board-and-care homes for psychiatric consumer/survivors. *Journal of Community Psychology*, *25*(2), 167-188.

Nelson, G., Hall, G.B., & Walsh-Bowers, R. (1998). The relationship between housing characteristics, emotional well-being and the personal empowerment of psychiatric consumer/ survivors. *Community Mental Health Journal*, *34*(1), 57-69.

Nelson, G., Walsh-Bowers, R., Hall, G.B., & Wiltshire, C. (1994). *A comparative evaluation of supportive apartments, group homes, and board-and-care homes for psychiatric consumer/ survivors*. Working Paper Series #36, Urban and Regional Planning, Waterloo, ON: University of Waterloo.

Nelson, G., Wiltshire, C., Hall, G.B., Peirson, L., & Walsh-Bowers, R. (1995). Psychiatric consumer/survivors' quality of life: Quantitative and qualitative perspectives. *Journal of Community Psychology*, *23*, 216-233.

Newman, S.J. (1994). The housing and neighbourhood conditions of persons with severe mental illness. *Hospital and Community Psychiatry*, *45*(4), 338-343.

Ogilvie, R. (1997). The state of supported housing for mental health consumers: A literature review. *Psychiatric Rehabilitation Journal*, *21*(2), 122-131.

Ontario Federation of Community Mental Health and Addiction Services and Canadian Mental Health Association, Ontario Division. (1998). *Joint advocacy paper to the Ontario Ministry of Health regarding housing for people with serious mental health problems*. Toronto: Author.

Ontario. (1999). *Making it happen: Implementation plan for the reformed mental health system*. Toronto: Ministry of Health.

Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada. (1999). *Where's home? A picture of housing needs in Ontario*. Toronto: Carlton Printers.

Palys, T. (1997). *Research decisions: Quantitative and qualitative perspectives*, 2nd edition.

Toronto: Harcourt Brace & Company.

Parkinson, S., Nelson, G. & Horgan, S. (1999). From housing to homes: A review of the literature on housing approaches for psychiatric consumer/survivors. *Canadian Journal of Community Mental Health*, *18*(1), 145-164.

Peterson, R. (1982). What are the needs of chronic mental patients? *Schizophrenia Bulletin*, *8*(4), 610-616.

Richardson, L. (1990). Narrative and sociology. *Journal of Contemporary Ethnography*, *19*(1), 116-135.

Rubin, H.J., & Rubin, I.S. (1995). *Qualitative interviewing: The art of hearing data*. London, UK: Sage Publications.

Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal*, *31*(2), 139-152.

Taylor, S.M., Elliott, S., & Kearns, R.A. (1989). The housing experience of chronically mentally disabled clients in Hamilton, Ontario. *The Canadian Geographer*, *33*(2), 146-155.

Trainor, J.N., Morrell-Bellai, T.L., Ballantyne, R., & Boydell, K.M. (1993). Housing for people with mental illnesses: A comparison of models and an examination of the growth of alternative housing in Canada. *Canadian Journal of Psychiatry*, *38*(7), 494-500.

Wahl, O.F., & Harman, C.R. (1989). Family views of stigma. *Schizophrenia Bulletin*, *15*(1), 131-139.

Walker, R.C. (2000). *Housing for people with serious mental health issues in Waterloo Region and Wellington-Dufferin*. Guelph, ON: Waterloo Region—Wellington-Dufferin District Health Council.

Walker, R.C., & Seasons, M.L. (2001). Partnerships for supported housing: Transformations in housing for people with serious mental illness. In *Proceedings of the Canadian Institute of Planners and Ontario Professional Planners Institute Annual Conference* (held in Ottawa, ON, July 2001). Ottawa: Canadian Institute of Planners.

Walker, R.C., & Seasons, M.L. (2002). Planning supported housing: A new orientation in housing for people with serious mental illness. *Journal of Planning Education and Research*, *21*(3), 313-319.

Weisberg, S. (1996). Increasing the effectiveness of frontline workers through a model mental health training program. *Community Mental Health Journal*, *32*(4), 363-370.