

CURRENT AND PREFERRED HOUSING OF PSYCHIATRIC CONSUMERS/SURVIVORS

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ABSTRACT

As part of a participatory action research project, we surveyed 300 psychiatric consumers/survivors from southwestern Ontario regarding their housing preferences and housing satisfaction. We found that, while 79% of the sample preferred independent living, 76% were living in some other type of setting (e.g., temporary shelter, supportive housing, sheltered care). Those living in temporary shelters reported the lowest levels of housing satisfaction, and those who were living in the type of housing that they preferred had the highest levels of housing satisfaction. This information is being used by stakeholder groups involved in the project to help build the capacity of the community to provide the types of housing that are preferred by consumers/survivors.

INTRODUCTION

When the era of deinstitutionalization began in Canada in 1960s, the main approach to housing people with serious mental illness in the community was custodial housing (Parkinson, Nelson, & Horgan, 1999; Trainor, Morrell-Bellai, Ballantyne, & Boydell, 1993). Custodial housing usually consists of large, congregate facilities (mini-institutions in the community), operated by private landlords for profit. These settings, which include lodging homes and single-room occupancy hotels, typically provide custodial care rather than active rehabilitation programs. After the 1976 formation of the Community Mental Health Branch of the Ministry of Health and Long-term Care in Ontario, the provincial government began to provide funding to non-profit community mental health and housing agencies to develop supportive housing as an alternative to custodial housing. In supportive housing, staff provides support or rehabilitation in a variety of different housing types, including half-way houses, group homes, and supervised apartments. In some communities, supportive housing programs initially were organized along a residential continuum, ranging from high-support group settings to lower-support apartments (Ridgway & Zippel, 1990). For example, the Supportive Housing Coalition of Toronto, which created 800 units of supportive housing during the 1980s, initially emphasized groups

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homes that were organized according to levels of support (Trainor, Lurie, Ballantyne, & Long, 1987; Trainor et al., 1993). The idea underlying this approach was to match the needs of the consumer with the appropriate housing type and amount of support.

By the late 1980s, problems with supportive housing and the residential continuum approach were recognized. With this approach: (a) consumers/survivors do not have choice over where or with whom they live; (b) they are often concentrated in one setting, thus inhibiting rather than promoting broader community integration; and (c) they may be forced to move into a less-supportive residential setting when they show improvement, thus disrupting relationships that they have developed with living companions and staff (Hogan & Carling, 1992; Ridgway & Zippel, 1990). Such forced relocation can have the effect of disassembling social networks, which other research has shown to be centrally important to fostering the adaptation of psychiatric consumers/survivors to life in the community (Hall & Nelson, 1996; Nelson, Hall, Squire, & Walsh, 1992).

In this context, Paul Carling and his colleagues promoted the concept of "supported housing" (which had already taken root in the fields of developmental and physical disabilities under the rubric of "independent living") to the field of mental health as a response to deficiencies in the available alternatives (Carling, 1995; Hogan & Carling, 1992; Ridgway & Zippel, 1990). There are three key principles of supported housing:

1. Mental health consumers/survivors should have choice and control over where and with whom they live. In this regard, the supported housing approach works from a disability rights rather than a medical model perspective.
2. Supported housing emphasizes community integration. Rather than creating separate facilities for people with mental health problems, the supported housing approach advocates integration into housing that is available to anyone in a community.
3. To have realistic choices about housing, consumers/survivors need financial and social support to enable them to operate in a normal housing market context. The goal of supported housing is to help individuals "choose, get, and keep" the type of housing that they want. Thus, it is this third principle which, in many communities, poses a significant practical barrier to achieving the implementation of supported housing.

In the 1990s, some mental health housing organizations in Ontario began to shift their orientation from that of supportive housing to the supported housing philosophy (Lord, Ochocka, Czarny, & MacGillivray, 1998; Pyke & Lowe, 1996). Today supportive and supported approaches have been blended in many of the province's community mental health housing agencies. While housing programs continue to have congregate or group living settings, most do not employ a "levels" system or have time limits on residency. Some programs do not have staff specifically attached to the setting; rather, staff members work with individuals, whatever their place of residence. Also, many housing agencies have developed individual apartments, some of which are scattered and some of which are concentrated in one apartment block, and provided portable staff support to residents of these apartments. Consumer choice and portable support services are the common elements of these different types of housing. Moreover, this mix of types of housing is supported by research that has found positive impacts for both supportive and supported housing on the well-being of consumers/survivors (Health Canada, 1997; Parkinson et al., 1999).

An important component of the supported housing approach has been research on consumer preferences for housing and support. Tanzman (1993) reviewed the

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findings of 26 of these studies. She reported that consumers consistently reported: (a) wanting to live in their own apartment or house; (b) preferring to live alone or with a spouse/partner or friend rather than other mental health consumers; (c) wanting to have staff support available as needed; and (d) needing access to material and financial supports, such as rent subsidies, telephone, and transportation. Research published since Tanzman's (1993) review has yielded similar results (Friedrich, Hollingsworth, Hradek, Friedrich, & Culp, 1999; Goldfinger & Schutt, 1996; Massey & Wu, 1993; Minsky, Riesser, & Duffy, 1995; Rogers, Danley, Anthony, Martin, & Walsh, 1994; Schutt & Goldfinger, 1996). This research also has shown that consumers prefer more independent housing than what treatment staff (Goldfinger & Schutt, 1996; Massey & Wu, 1993; Minsky et al., 1995; Schutt & Goldfinger, 1996) or family members recommend for them (Friedrich et al., 1999; Rogers et al., 1994).

One of the limitations of the existing literature on consumer preferences for housing and support is that few studies have compared where consumers currently live with where they would like to live. One exception to this is a study conducted in Iowa City by Friedrich and colleagues (1999). They compared the housing preferences of consumers currently living in three types of settings: (a) congregate facilities with on-site support, (b) supported housing with on-site visits, and (c) apartments or houses with no on-site staff. In each type of setting, the majority of consumers indicated that they were currently living in the type of housing that they preferred.

Another issue that has not received much attention is how consumers' satisfaction with housing is related to current or preferred housing. Lehman and colleagues (Lehman, Possidente, & Hawker, 1986; Lehman, Slaughter, & Myers, 1991) found that consumers living in hospitals or custodial housing had lower levels of housing satisfaction than those living in supportive housing settings. Similar ratings of satisfaction with different types of supportive housing were found in a study by Hanrahan, Luchins, Savage, and Goldman (2001). In an Australian study, Horan, Muller, Winocur, and Barling (2001) compared the satisfaction of consumers diagnosed with schizophrenia living in either boarding homes or hostels. The boarding homes in this study more closely resemble what we would call group homes in Canada: they are large houses with private bedrooms and more personal space, and residents are actively involved in meal preparation. Hostels, on the other hand, more closely resemble Canadian boarding homes: they are large facilities; they lack privacy and personal space; and staff provide meals, dispense medications, and dole out spending money. Horan and colleagues (2001) found that residents of boarding homes had significantly higher scores on general life satisfaction and satisfaction with living situation than did residents of hostels. Overall, these findings indicate that consumers who live in supportive housing report higher levels of life satisfaction than consumers living in hospital or custodial housing.

One other important limitation of extant research is that, with the exception of one study of the housing preferences of homeless women in Toronto (Goering, Paduchak, & Durbin, 1990), the vast majority of the research on consumer preferences for housing has been conducted in the United States. The policy context and political climate of the U.S. are quite different from those in Canada in general and in Ontario in particular. Thus, the extent to which studies in the U.S. can be generalized to Canada is unknown. In the U.S., there is a federal government policy whereby people with serious mental illness can apply to the Department of Housing and Urban Development for Section 8 certificates that enable individuals with low-income to rent market housing at an affordable rate. This policy is congruent with the supported

housing approach because it provides consumers with choice about where they want to live, avoids congregate living facilities, and substantially removes or reduces financial barriers to accessing "normal" housing in the community.

In contrast, Canada has no such social policy. Moreover, the federal and Ontario governments (the latter refers to where the current study was conducted) have retreated in the past two decades from their role in supporting social housing for low-income citizens (Hulchanski, 1998; Shapscott, 2001). Since 1980, when nearly 25,000 units of affordable housing were created nationwide, there has been a steady decline in government-funded social housing. From 1994 to 2000, fewer than 1000 new units of social housing were created per year across Canada. Only recently in Ontario have the consequences of the lack of a national or provincial housing policy and funding for affordable housing for psychiatric consumers/survivors been recognized. Since 2000, the Ontario government is in the process of creating 3500 units of supportive and supported housing under the Phase I and Phase II Mental Health Homelessness Initiative.

In this study we are interested in knowing not only if housing satisfaction is related to the current housing of mental health consumers/survivors, but also whether or not there is a discrepancy between where consumers are currently living relative to where they want to live. We expect that those who are living in their preferred type of housing should have higher levels of housing satisfaction than those not living in their preferred housing type.

Four specific objectives are addressed: (a) to compare consumer preferences for housing with their current living situation, (b) to examine housing satisfaction by type of housing, (c) to compare the housing satisfaction of those living in their preferred type of housing with those not living in their preferred type of housing, and (d) to illustrate a participatory action research approach to the study of consumer preferences for housing and supports.

METHODOLOGY

Community Context

This project is part of a program of research on housing and mental health developed by a SSHRC-funded Community-University Research Alliance (CURA), entitled "Partnerships in Capacity Building: Housing, Community Economic Development, and Psychiatric Consumers/Survivors." The alliance seeks to promote understanding of the housing situation for psychiatric consumers/survivors on individual, community, and societal levels. The purpose is to improve the capacity for appropriate housing by using a participatory action research approach that includes both qualitative and quantitative methods (Nelson, Ochocka, Griffin, & Lord, 1998) to take into account current housing conditions and consumer preferences.

The City of London, which is located in Middlesex County, Ontario, is the focus of our research, although data also were collected from residents of Homes for Special Care in several other nearby communities in southwestern Ontario. London had a population of 337,300 in 2001. Until recently, the city had a large provincial psychiatric hospital that served the city and the surrounding region. In 2001, the hospital had its governance moved to a community hospital as part of provincial mental health reform. This transfer was one aspect of a general plan that called for a large reduction in psychiatric beds and redeployment of mental health resources to the communities served by the former provincial hospital. The reduction in hospital

beds and movement of people and resources to the community provided a need and opportunity to examine housing issues related to psychiatric consumers/survivors.

Housing Settings and Sampling

A major focus of the research was a survey of 300 psychiatric consumers/survivors, stratified by gender (150 of each) and by type of housing (described below). Each relevant housing agency was asked to provide the number of available units/beds occupied within the past year, and the percentages occupied by males/females. The sample frame was designed to maintain the same male/female ratio. The inclusion criteria were that the participants had a history of mental illness for at least one year, were 16 years of age or older, had sufficient proficiency in English to complete an interview, and did not have an organic brain disorder that would have interfered with their ability to complete the interview.

The types of community-based housing included: (a) 18 Homes for Special Care (large houses operated for profit, with private or shared bedrooms for 4-20 people per house, meals provided, and 24-hour staffing); (b) 3 temporary shelters (primarily large dormitory-style rooms with up to 20 people, set up as emergency housing for the homeless); (c) 18 supportive housing units (group homes or individual apartments within one apartment block with support staff available provided by 2 non-profit agencies); and (d) 78 independent living settings (apartments or houses).

Sample quotas were set according to the proportion of beds/units per housing type relative to all beds. The number of people to include in the sample from independent housing was calculated by asking two community mental health agencies for the number of clients that they served. Numbered lists of participants from the Homes for Special Care, shelters, and supportive housing programs constituted the sampling frame for participants from these three types of settings. Participants were randomly selected from these lists until the quota for each setting was achieved. In case of refusal, a substitute was selected for inclusion from the same type of housing.

Signs advertising the study were posted in community agencies to recruit participants from those living independently. For some of the types of housing (shelter, independent living), fewer potential women participants were available than hoped and therefore all potential women participants were included. Only 7 people who were invited refused to participate in the study. The reasons for refusal were related to concerns about the length of the interview.

Interview Process

Study participants were interviewed about demographic variables, psychiatric history and diagnosis, housing preferences, housing history, and quality of life. The interviewers were research staff and graduate students participating in the CURA project who underwent a two-day interview training process. New students/staff added to the interview team would observe an actual interview and be observed doing a second interview before independently interviewing participants. Interviewers carried cell phones in case they needed support or clarification, but for this study no one required using the phone during the interviews. Participants were paid \$20 CAD as compensation for their time in the interview (one to two hours). Interviews were done in a mutually agreeable location, most often in the participants' current housing.

Measures

To assess preferences for housing, living companions, and supports, we used the short version of the Consumer Housing Preference Survey Instrument. This instrument was developed by Beth Tanzman (1990) of the Centre for Community Change Through Housing and Support (now the Centre for Community Change International). The survey instrument, which has been used in numerous studies (e.g., Tanzman, 1993), includes questions about demographic information, current housing, preferred housing, preferred living companions, and supports needed. The format for most of the items is that of fixed-choice alternatives, which yield categorical data. For example, the question used to assess preferred living situation is "Ideally, what kind of place would you like to live in?" Consumers respond to this question by choosing one of 11 fixed-choice options (e.g., in a group home run by a community mental health center, in an apartment, in my family's home, in a shelter) or by indicating some other choice. In addition to these fixed-choice questions, there are also a few open-ended questions (e.g., "What is it about that place that would be most important to you?", "What kinds of supports or services do you think you might need in order to be able to live where you want?").

Housing history was measured through a form developed for this study. All moves within the past five years were listed by participants. Participants reported the length of time spent in each residence and whether the move was a desired or undesired change. Finally, we used a three-item measure of satisfaction with living situation ($\alpha = .81$), taken from the Lehman Quality of Life scale (Lehman, Postrado, Roth, McNary, & Goldman, 1994). Scores on individual items ranged from 1 ("terrible") to 7 ("delighted").

Characteristics of the Sample

As can be seen in Table 1, participants living in different types of housing differ with respect to demographic background and psychiatric history. While the participants did not differ significantly in terms of age, those living in shelters changed residences the most within the past five years, while those living in supportive housing report the fewest number of residential changes. There are proportionately more women than men living in Homes for Special Care or in their own apartment/house, while men predominate in shelters and supportive housing. Those living in their own apartments or houses are more likely to be married or to have been married at some point, and are least likely to be employed. Participants who live in supportive housing and in their own apartments or houses have the highest levels of education, and those living in supportive housing are most likely to be employed full-time or part-time. Those living in Homes for Special Care and supportive housing are most likely to have a self-reported primary diagnosis of schizophrenia. Those living in shelters are most likely to have a primary diagnosis of mood disorder and not to be taking psychiatric medication.

Feedback Process

As part of the participatory action approach to the project, a written summary of the results was provided to all participants who indicated interest in receiving it. All participants also were invited to participate in an annual search conference, which served to feed back research results and seek further input from community stakeholders on priorities for the CURA for the next year. Participation in the search conferences was at no cost to participants, and transportation and babysitting costs

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TABLE 1
Comparison of Residents of Different Types of Housing on Demographic Variables and Measures of Psychological Functioning

Demographic Variables and Psychiatric History	Type of Housing				Statistic
	Homes for Special Care	Shelter	Supportive Housing	Own apartment/house	
<i>Demographic variables</i>					
Age	43.1 (12.5)	41.3 (11.7)	41.1 (14.1)	38.6 (13.4)	not significant $F(3,279) = 4.4^*$ $\chi^2(3) = 19.5^*$
Number of housing moves in past 5 years	2.2 (4.1)	3.4 (4.5)	.8 (1.4)	2.4 (3.0)	
Gender					
Men	38 (42%)	54 (66%)	25 (60%)	27 (35%)	
Women	53 (58%)	28 (34%)	17 (40%)	51 (65%)	
Marital status					
Married/widowed	7 (8%)	4 (5%)	1 (2%)	12 (15%)	$\chi^2(6) = 18.5^*$
Separated/divorced	17 (19%)	21 (26%)	11 (26%)	29 (37%)	
Single never married	67 (73%)	57 (69%)	30 (72%)	37 (48%)	
Education					
University or college	13 (14%)	14 (17%)	13 (30%)	30 (38%)	$\chi^2(6) = 30.5^*$
High school	53 (58%)	60 (73%)	25 (60%)	42 (54%)	
Elementary school	25 (28%)	8 (10%)	4 (10%)	6 (8%)	
Employment status					
Employed part-time or full-time	19 (21%)	13 (16%)	13 (31%)	6 (8%)	$\chi^2(6) = 16.5^*$
Not employed	72 (79%)	67 (84%)	29 (69%)	72 (92%)	
Psychiatric history					
Primary psychiatric diagnosis (self-reported)					
Schizophrenia	51 (56%)	9 (11%)	20 (48%)	26 (33%)	$\chi^2(9) = 58.4^*$
Mood disorder	15 (17%)	40 (49%)	9 (21%)	29 (37%)	
Other	20 (22%)	19 (23%)	13 (31%)	20 (26%)	
Unknown	5 (5%)	14 (17%)	0 (0%)	3 (4%)	
Currently taking psychiatric medication					
Yes	85 (93%)	46 (56%)	40 (95%)	66 (85%)	$\chi^2(3) = 48.1^*$
No	6 (7%)	36 (44%)	2 (5%)	12 (15%)	

^a $p < .01$. Note that for age and number of housing moves, means and standard deviations are reported, while for the categorical variables, frequencies and percentages are reported.

* $p < .01$. Note that for age and number of housing moves, means and standard deviations are reported, while for the categorical variables, frequencies and percentages are reported.

were reimbursed. Approximately 40 consumers/survivors participated each year in the conference. This process ensures that results are quickly fed back to the consumer/survivor community and used to increase the level of information that the community has about housing preferences relative to the current housing available to them.

FINDINGS

Comparison of Housing Preferences with Current Living Situation

A total of 238 people in the sample (79.3%) stated they prefer to live in their own apartment or house (see Table 2). Across all different types of current housing, living in an apartment or house is the clear preference. In response to an open-ended question about the most important qualities of their preferred living situation, the qualities most often mentioned by participants are privacy, freedom, independence, and ownership. Other important qualities mentioned are safety and security, having more space, cleanliness, peace and quiet, access to public transportation and services, comfort, decent furnishings and appliances, and having a yard or garden. A few participants also indicated that they want a place suitable for children or one in which they could have a pet. Nearly half of the sample (46.5%) indicated that they prefer to live alone, with the remainder preferring to live with friends (21%), other mental health consumers (23%), or family or spouse (17%).

TABLE 2
Current Housing by Preferred Housing

Preferred Housing	Current Housing					Total— Preferred housing
	Homes for Special Care	Shelter	Supportive housing	Own apartment/ house	Other (transitional housing, AIDS home)	
Homes for Special Care	28		2			30 (10.0%)
Shelter		1				1 (.3%)
Supportive housing	8		10	1		19 (6.3%)
Own apartment/house	51	78	28	74	7	238 (79.3%)
Other	4	3	2	3		12 (4.0%)
Total— Current housing	91 (30.3%)	82 (27.3%)	42 (14.0%)	78 (26.0%)	7 (2.3%)	300 (100%)

Many of the most important supports needed to obtain preferred housing are tangible: transportation (mentioned by 83% of participants), more income/benefits (82%), a telephone (82%), money for a security deposit (78%), and help getting benefits (74%) (see Table 3). Access to staff support around the clock is also important (70%). The most difficult areas for which more support is needed pertain to emotional upsets and budgeting (see Table 4).

Comparing participants' preferred housing with their current housing, we found that a total of 113 people (37.7%) in the sample (those in the diagonal cells of Table 2) are currently living in their preferred housing type. Thus, the majority of

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participants are not living in the type of housing that they prefer. This discrepancy is magnified by the fact that only one of the 82 people currently residing in a shelter prefers to live there. Nevertheless, the majority of participants living in Homes for Special Care and supportive housing also want to live in their own apartments. It is also important to note that, while 37.7% of the sample lives in their preferred *type* of housing, they are not necessarily living in housing that they are comfortable with. In other words, a person may be living in an apartment and wish to live in an apartment, but that person may or may not find the particular apartment they are living in to be satisfactory.

TABLE 3
Supports Needed to Obtain Preferred Housing

Type of Support Needed	<i>n</i> (%)
Transportation	250 (83.3%)
More income/benefits	247 (82.3%)
Telephone	245 (81.7%)
Money for deposit	234 (78.0%)
Help getting benefits	222 (74.0%)
Being able to reach staff by telephone by any time of the day or night	211 (70.3%)
Help finding a place to live	192 (64.0%)
Household supplies	186 (62.0%)
Furniture	182 (60.7%)
Being able to ask staff to come to my home any time of the day or night	176 (58.7%)
Roommates or housemates	118 (39.3%)
Having staff regularly coming to my home during the day	100 (33.3%)
Help in finding roommates or housemates	58 (19.3%)
Having staff live with me	31 (10.3%)

TABLE 4
Areas of Difficulty and Help Needed

Area of Difficulty	A Lot of Help Needed <i>n</i> (%)	Some Help Needed <i>n</i> (%)	No Help Needed <i>n</i> (%)
Dealing with emotional upsets	72 (24.2%)	152 (51.0%)	74 (24.8%)
Budgeting money	63 (21.0%)	115 (38.3%)	122 (40.7%)
Avoiding emotional upsets	60 (20.0%)	144 (48.0%)	96 (32.0%)
Managing medications	37 (12.5%)	72 (24.3%)	187 (63.2%)
Making friends	31 (10.4%)	65 (21.7%)	203 (67.9%)
Cooking	25 (8.3%)	67 (22.3%)	208 (69.3%)
Getting along with others	22 (7.3%)	78 (26.0%)	200 (66.7%)
Keeping the house clean	21 (7.0%)	82 (27.3%)	197 (65.7%)
Shopping	18 (6.0%)	98 (32.7%)	184 (61.3%)
Laundry	12 (4.0%)	45 (15.0%)	243 (81.0%)

Satisfaction with Living Situation by Type of Housing

The residents of the four main types of housing (those living in housing categorized as "other" were excluded from this analysis, $n = 7$) were compared on the three-item measure of satisfaction with living situation (Lehman et al., 1994). Participants living in shelters have a lower mean score (3.2, $SD = 1.3$) than participants

living in Homes for Special Care (4.8, SD = 1.3), supportive housing (5.1, SD = 1.4), and own house/apartment (5.0, SD = 1.1). A comparison was used to test the difference in scores between participants living in shelters and those living in all of the other three types of housing. This comparison was statistically significant, $t(291) = 10.58, p < .001$. To determine the magnitude of this difference, an effect size (ES) was calculated by subtracting the mean of shelter group from the mean of the other three groups combined and dividing by the pooled SD. The ES was found to be 1.3, which, according to Cohen (1988), is a very large effect size in social and health science research. Hence, on average, the satisfaction with living situation for those living in shelters is 1.3 standard deviations lower than those living in other types of housing.

Satisfaction with Living Situation by Living in Preferred Housing

We also compared the scores on housing satisfaction with living situation measure for two groups: those who were living in their preferred type of housing (those on the diagonal in Table 2) and those not living in their preferred type of housing (those off the diagonal in Table 2). Those living in the type of housing which they preferred had a significantly higher mean score on satisfaction with living situation (5.2, SD = 1.1) than those not living in their preferred housing (4.0, SD = 1.5), $t(298) = 7.1, p < .001$. The ES for this difference was found to be .9, which is also a large effect size (Cohen, 1988).

DISCUSSION AND IMPLICATIONS FOR ACTION

We had four objectives in this research: (a) to compare consumer preferences for housing with their current living situation, (b) to examine housing satisfaction by type of housing, (c) to compare the housing satisfaction of those living in their preferred type of housing, and (d) to illustrate the value of a participatory action research approach to the study of consumer preferences for housing and supports. In this section we discuss findings relevant to each of these objectives, as well as discussing the implications of the findings for action.

Comparing Consumer Preferences with Current Situations

Our results are consistent with previous studies that have found that individuals who have been diagnosed with psychiatric illnesses, like most other people, prefer to live in their own house or apartment (e.g., Friedrich et al., 1999; Rogers et al., 1994; Tanzman, 1993). To the best of our knowledge, this is the first large-scale study of consumer preferences for housing in Canada. Like consumers in the U.S., consumers in Canada prefer independent living.

The results of this study also extend previous research by showing that preferences for independent housing options are consistent across a variety of different types of current housing situations. Friedrich et al. (1999) found that participants in their study in Iowa tended to prefer the types of housing in which they were currently residing. Our findings stand in sharp contrast: nearly 80% of the participants, including those living in large congregate facilities, shelters, and supportive housing, want to live in their own house or apartment. It is unclear why the findings from the Friedrich et al. (1999) study are inconsistent with those of this study and the many other studies of consumer preferences (Tanzman, 1993), which show that people want to live independently, not in the types of housing in which they currently reside.

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As in previous studies (e.g., Tanzman, 1993), we found that the majority of participants identified numerous barriers to obtaining the type of housing they prefer and the supports that they wish to have available to them. For the most part, the barriers to independent living are, not surprisingly, financial in nature. The list of concrete supports required to achieve preferred housing reflects concerns about poverty and isolation. Transportation was the most prevalent need, despite the fact that London has a well-developed public transportation system. Similarly, over 80% of respondents indicated the need for a telephone. Clearly, if consumers/survivors' budgets are so constrained that busses or telephones pose problems, then it is likely that many other basic resources will be equally inaccessible. Greater financial benefits to access independent living was also underscored by participants (see Table 3). These financial concerns reflect the inadequacy of current social policies in Ontario for disadvantaged, low-income people, including those who have experienced mental illness.

As for the "support" component of supported housing, participants noted the need for staff support to help them deal with a variety of day-to-day challenges for living independently in the community. Participants did not want the intrusiveness of live-in staff, but they did want to be able to access staff support at any time of the day or night. In particular, participants noted the need for help in dealing with emotional upsets. Having support staff available to help handle difficult situations as they arise is important for ensuring that consumers can maintain their housing and quality of life in the community (Parkinson et al., 1999).

Examining Satisfaction by Type of Housing

We found that participants who lived in shelters had much lower levels of housing satisfaction than participants living in all of the other types of housing. While previous research has examined satisfaction and quality of life of consumers/survivors residing in different types of housing (e.g., Lehman et al., 1986; Lehman et al., 1991), no previous research has compared the housing satisfaction of people living in shelters with people living in other types of housing. There is sometimes a public myth that individuals in shelters or on the street live there because that is where they want to be. It is important to note that, in this study, not only are levels of housing satisfaction low for those living in shelters, but only one individual in this sample actually wanted to live in the shelter system. Clearly, shelters are not an appropriate solution to the housing challenges faced by psychiatric consumers/survivors and proffering this type of housing as a viable form of community living does not have support from consumers/survivors.

Comparing Satisfaction of People Living in their Preferred Housing Type

We found that those people living in their preferred housing type had much higher levels of quality of life related to housing compared with people not living in their preferred type of housing. Srebnik, Livingston, Gordon, and King (1995) found that the more control that mental health consumers/survivors have over their housing, the higher is their level of housing satisfaction, residential stability, and psychological well-being. These findings suggest the need for the development of more independent living arrangements than are currently available in communities such as London. This finding also is supported by qualitative data from focus group interviews conducted with mental health consumers/survivors from the CURA research program, in which individuals have stated that they sometimes have to make a choice between the services they want or the housing they want. Clearly, with increased

opportunity for independent living, psychiatric consumers/survivors also should have ongoing access to available supportive mental health services.

Assessing Participatory Action Research

The last objective of this research was to illustrate the value of a participatory action research approach to the study of consumer preferences for housing and supports. The consumer preference survey reported in this paper, along with focus groups with consumers/survivors and family members, is the first step in a participatory action research process designed to enhance the capacity of the London community to meet the needs of consumers/survivors. The research has not only documented the need for independent living, but it has also served to raise the awareness of the community about this issue. Service-providers at the local level and policy-makers at the local, provincial, and federal levels of government need to understand both consumer preferences and the tangible necessities which would facilitate independent living for this group. Previous action research has shown that needs assessment is an important building-block for mobilizing the community around issues of affordable housing for people with serious mental health issues.

In another Ontario community, one outcome of a needs assessment study was the formation of a mental health housing coalition, consisting of housing providers, mental health service-providers, consumers/survivors, family members, and other concerned citizens (Nelson & Earls, 1986). From 1984 to 1990, this coalition lobbied successfully for the creation of nearly 100 units of affordable housing for this population in one region (Nelson, 1994). It is important to note that the success of this coalition can be attributed, at least in part, to the favorable political climate and policy context of the time (Nelson, Lord, & Ochocka, 2001). During this time, the reigning Liberal government substantially increased funding for community mental health and housing programs in Ontario (Nelson, 1994; Nelson et al., 2001).

The more recent political context has been less friendly to social issues, including the creation of affordable housing. Since the early 1990s, funding for community mental health in Ontario has been frozen, and no new mental health housing was created for nearly 10 years. However, in 2001, the Canadian government did promise to spend \$680 million dollars on affordable housing over 5 years, with the provinces agreeing to provide matching funds (National Housing and Homelessness Network, 2003). Within this context, the Progressive Conservative government of Ontario did fund 3500 units of housing for people with serious mental illness who were homeless or at risk of being homeless.

Consistent with a participatory action approach to research (Nelson et al., 1998), the overarching goal of the CURA project is to improve community capacity to provide independent living for people with serious mental illnesses. At the time of the writing of this article, the province of Ontario is in the midst of a provincial election campaign. CURA members have developed a summary bulletin and fact sheet with the findings of the research reported in this article and related CURA research, as well as recommendations for the development of housing policy, funding for housing, increases in income supports for consumers/survivors, funding for community mental health services, the development of a program to eliminate stigma, and opportunities for the participation of consumers/survivors in making needed policy changes. This information is being widely distributed in the community, including to all those who are running for office in the London area. Moreover, CURA has hosted an "all candidates" meeting on the topic of housing and mental health. The goal of these

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initiatives is to get the issue of housing and mental health on the political agenda of this campaign and with whatever party is elected. To this end, CURA and its research and action programs provide a forum for public education, community development, and advocacy—all of which are necessary ingredients to make the dreams of consumers/survivors in London a reality.

We conclude this article with a poem written by one of the community members who has actively contributed her artistic talents and streetwise sensitivities to CURA since its inception. This poem was written after hearing the authors summarize the research reported in this article at a CURA dissemination conference held in October, 2003. Poetry provides another form for expressing experiences of poverty and homelessness in community, social, and political contexts. We appreciate the author's willingness to include her poetry in this article. It is to be read as spoken word poetry.

Sundown, bittersweet month's end half way,
 Folks outta food again.
 Hard to breathe hope once life's wounds go Social Assistance.
 Madame Citoyen Avec Culotte, save us from depraved socialized indifference?
 October rains a cold, too tired to revel in life's joy.
 Yes, sleeps the harsh knowings of dreamt direness.
 Awake, awake four walls 2:38 am, hunger.
 Buried alive in penalty after the fact of injury is the hour's chill.
 And the little birds I know say paupers can't be choosers, but folks fight to sing,
 all the same.
 Bones hurt to move/ OntarioWorks? No, no and no.
 Then, in a faithful moment a burger may become the good mental health of a
 small comfort.
 Yet, the hut you crash iz likely be done according to Hoyle.
 Yes, sicker-by-the-day desiccates the unfortified.
 Ontario Disability Support is a legislated lament.
 Nine years Machiavellian-Altruism ruined us in untold ways.
 Cupboards bare, Kraft-Dinner and do-more-with-less ain't no goodness to be
 named healthy.
 O'Mercy, wounds upon wounds—Dignity as misery?
 Sad, the anxious suffrage of Survivors is the measure of "Our" society's worth.
 Poverty, it's a wicked business—Scurrilous, yes?
 Guess, it's the scrooge in each, that's the custodian of making crazy.
 So, now some work late to build equity in the Ontario of 2003.
 And there in civility stands "Injury, Privation, Neglect and Disservice,"
 They are the daughters and sons of much misrepresentation.
 Poverty's Survivor, the End and the Beginning it's a 24-7 act of courage!
 And the umbrella's rat carried on playing in the rain,
 Singing: "*Aucune crédibilité sans qualité de la vie*—No credibility without
 quality of the life!"
 ("Having Survived Life East of Equity, Kinda" ©2003 LiBbey Joplin, all
 rights reserved. Blue Note Poetry)

RÉSUMÉ

Dans le cadre d'un projet de recherche d'action participative, nous avons mené une étude auprès de 300 personnes qui présentent un diagnostic psychiatrique et qui demeurent dans le sud-ouest de l'Ontario afin de connaître leurs

préférences et leur niveau de satisfaction en matière de logement. Nos résultats indiquent que 79% des participantes et participants préfèrent la vie autonome, mais que 76% d'entre eux vivent présentement dans un logement non autonome (ex: abri temporaire ou logement adapté, soit en milieu intégré soit en unités spéciales). Les personnes qui vivent dans un abri temporaire rapportent le taux de satisfaction le moins élevé, tandis que celles qui vivent dans un logement de leur choix rapportent le taux de satisfaction le plus élevé. En ce qui concerne les groupes communautaires participant à notre projet, ces résultats appuient leurs initiatives en vue de travailler avec la communauté à mettre en place les formes de logement préférées par les personnes présentant un diagnostic psychiatrique.

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