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NARRATIVES ON DEDICATED MIXED AND INTEGRATED HOUSING

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August 1998

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This project was carried out with the assistance of a grant from Canada Mortgage and Housing Corporation under the terms of the External Research Program (CMHC File 6585-B104-1). The views expressed are those of the author and do not represent the official views of the Corporation.

This project was funded by the external research program of the Canadian Mortgage and Housing Corporation.

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DEDICATED, MIXED AND INTEGRATED HOUSING: NARRATIVES OF MENTAL HEALTH CONSUMERS* AND PROVIDERS

Abstract

It is widely acknowledged that the key components of any comprehensive community support and rehabilitative approach for consumers of psychiatric services include decent, stable housing and the availability of a wide variety of supports. There has been growing evidence that mental health consumer's perceptions of what they need in a living environment are the best predictors of success in housing. The objective of this study was to examine mental health consumer and mental health provider preferences for and perceptions of three housing types: dedicated, mixed and integrated housing. Forty-five interviews were conducted with consumers of mental health services living in each of the three types of housing and 24 interviews were conducted with mental health providers.

*Consumers are defined as people who have a mental health problem and/or people who have used mental health services.

Résumé

Il appert de plus en plus que le choix des bénéficiaires concernant les services de santé mentale et le contrôle qu'ils exercent sur le milieu dans lequel ils vivent permettent le mieux de prédire le succès des établissements résidentiels (Ridgway et Carling, 1987; Tanzman et Yoe, 1989; Baker et Douglas, 1990; Goering, Paduchak et Durbin, 1990; Srenmuck, Livingstone, Gordon et Klein, 1992). Les bénéficiaires qui éprouvent un sentiment de satisfaction et perçoivent que leur environnement domiciliaire correspond bien à leurs besoins s'adaptent mieux (Cournos, 1987). Vu l'importance du choix des bénéficiaires dans le domaine de l'habitation, plusieurs études axées sur les préférences invitaient généralement les bénéficiaires à indiquer avec qui ils voulaient vivre (Tanzman et Yoe, 1989; Everett et Steven, 1989; Texas Department of Mental Health and Mental Retardation, 1994). Malheureusement, dans la plupart des études, l'expression «vivre avec» n'est pas clairement définie. Dans le passé, l'expression évoquait le fait de partager une chambre dans un foyer ou encore de partager la cuisine ou la salle de bains avec les autres pensionnaires de la maison. Depuis l'avènement des logements aidés (apartements autonomes dans des collectifs d'habitation, services de soutien permanents ou flexibles), l'expression «vivre avec» en est venue à signifier partager le même bâtiment et non l'espace personnel. Sans cette différenciation, il est difficile d'interpréter les résultats des études axées sur les préférences.

Une récente étude consacrée à ce que pensent les bénéficiaires de services de soins mentaux des quartiers qu'ils habitent (Boydell, Gladstone, Crawford et Trainor, 1966) met en évidence certains enjeux relevés par les bénéficiaires lorsqu'ils comprennent clairement que le terme «vivre avec» désigne les voisins qui occupent le même bâtiment, mais non le même espace personnel. Ils traitent de leurs problèmes et de leurs craintes d'habiter un bâtiment où des logements sont destinés à des groupes marginalisés. Les problèmes d'occuper les mêmes bâtiments que des groupes marginaux sont exposés dans la documentation (Bredenberg, 1986). De nombreuses personnes interviewées dans le cadre de la présente étude ont déclaré «bien cadrer» avec les personnes possédant des antécédents psychiatriques, mais non avec les groupes marginalisés. Les bénéficiaires parlent de se sentir confortables et en sécurité, de partager leurs expériences respectives et leurs points en commun.

La question des logements intégrés ou spécialisés a suscité un débat animé dans le domaine de la santé mentale (Pape, 1992). À l'époque où l'étude a été menée, la politique du ministère du Logement de l'Ontario favorisait fortement les logements intégrés. Le ministère n'allait plus construire de logements spécialisés, y compris des logements destinés aux bénéficiaires de services de santé mentale. Voilà qui constituait un motif d'inquiétude pour bon nombre d'experts en santé mentale qui avaient observé qu'un certain nombre de leurs patients préféraient vivre dans des logements spécialisés. Trainor et Boydell (1986) indiquent qu'une vie sociale réussie dépend souvent de l'adhésion à des groupes d'intérêt particuliers et que la normalisation empêche la création et le développement de services spécialisés qui s'adressent aux gens s'intéressant d'abord à la santé mentale et qui sont régis par eux. L'affirmation de soi et l'accès à du soutien social sont souvent issus de groupes ou d'organismes spécialisés. Les logements spécialisés, qui mettent l'accent sur un tel «groupe d'intérêt particulier» peuvent être envisagés à la lumière de cette théorie. Que dire de la réussite sociale des bénéficiaires de services

spécialisés ou de services de soutien en milieu résidentiel? Trainor et Boydell posent comme principe que les programmes devraient peut-être avoir une nature variante plutôt que normative. Y a-t-il de la place pour des logements intégrés et spécialisés destinés aux bénéficiaires qui préfèrent choisir parmi les options?

L'objectif de la présente recherche consiste à étudier les préférences des bénéficiaires et dispensateurs de services de santé mentale à l'égard des logements intégrés, spécialisés ou de types divers, ainsi que leurs perceptions à ce propos. Trois types de milieux résidentiels ont été explorés : i) les logements spécialisés où les personnes habitent un logement individuel dans un bâtiment réservé exclusivement aux bénéficiaires de services de santé mentale; ii) les logements de types divers où les personnes habitent un logement individuel dans un bâtiment regroupant différentes catégories de gens requérant du soutien et des services variés (ex. : jeunes contrevenants, mères célibataires); iii) les logements spécialisés où les gens habitent un logement individuel dans des bâtiments sur le marché libre.

La présente étude est fondée sur quarante-cinq entrevues approfondies avec des bénéficiaires de services de santé mentale et vingt-quatre entrevues avec des experts en santé mentale. Les thèmes qui ont ressorti des transcriptions des deux groupes comportent des ressemblances frappantes. Dans leurs récits sur les logements spécialisés, tant les bénéficiaires que les experts ont indiqué que ce type de logement leur a procuré du soutien, en plus de leur permettre de partager leurs expériences et d'obtenir de la compréhension. Ils ont ainsi pu acquérir un sentiment d'appartenance à la communauté. La plupart des personnes interviewées n'avaient que de bons mots à dire au sujet des logements spécialisés. Parmi les réactions négatives, les bénéficiaires ont fait état des difficultés de vivre à proximité d'un groupe de gens dont les problèmes comportementaux et émotifs étaient souvent dérangeants. Les dispensateurs de services ont toutefois commenté à la fois le niveau de tolérance du comportement dérangeant et le caractère réciproque de cette tolérance parmi les locataires. Il est intéressant de noter que seulement quelques bénéficiaires ont indiqué que, parce qu'ils vivent dans des logements spécialisés, ils sont catégorisés à cause qu'ils souffrent d'une maladie mentale grave. Plus de dispensateurs de services traitent, par contre, de leurs préoccupations quant à la ghettoïsation directement associée aux logements spécialisés. Pour certains dispensateurs de services, les logements spécialisés leur ont facilité la tâche de soutenir un certain nombre de patients. Il s'avére plus économiquement viable pour certains organismes de soutenir un nombre plus important de patients habitant le même bâtiment.

Dans les logements de types divers, aussi bien les bénéficiaires que les dispensateurs ont signifié qu'il y avait tout lieu de sensibiliser les gens. Les bénéficiaires se sont montrés intéressés à en apprendre davantage des autres catégories de gens sur les différents besoins de soutien et de service. Les propos des dispensateurs ont porté sur leur volonté de connaître le point de vue des autres personnes habitant le bâtiment. Ils ont évoqué la possibilité que les autres locataires soient mis au courant de la présence de personnes souffrant de déficience psychiatrique. Par contre, la catégorisation constituait toujours un problème dans un tel milieu et était souvent dirigée vers les locataires venant en aide aux gens souffrant de maladie mentale et par conséquent au comportement étrange ou bizarre. Plusieurs dispensateurs de services estimaient que, aussi bien dans les logements de types divers que les logements intégrés, les sentiments de tolérance et

d'intolérance étaient l'évidence même et qu'ils dépendaient en majeure partie des types de voisins vivant dans ce milieu particulier. À ce propos, la meilleure combinaison de locataires était importante. Par exemple, les personnes âgées et les bénéficiaires peuvent faire «bon ménage» sur le plan démographique, mais pas nécessairement les jeunes contrevenants et les bénéficiaires. Lorsqu'ils ont été interrogés sur les logements de types divers, les bénéficiaires ont parlé du sentiment de vulnérabilité que suscite à leur avis la vie dans un tel milieu, surtout en ce qui concerne la sécurité. La majorité des dispensateurs de services de santé mentale indiquent que les logements de types divers regorgent de trafiquants de drogue et de prostituées. En pareils milieux, les gens éprouvant différents besoins de services constituent vraiment un groupe de personnes marginalisées réunies pour les besoins d'intégration.

Dans leurs propos sur les logements spécialisés, les bénéficiaires et les dispensateurs de services ont exprimé tour à tour les sentiments de solitude incroyable, de désaffection et de manque de soutien communautaire qu'ils y éprouvent. Les deux groupes font ressortir le sentiment accru d'être catégorisés du fait qu'ils se «distinguent» des autres locataires du bâtiment. Un bénéficiaire a cependant exprimé l'avis que vivre sous le couvert de l'anonymat dans un logement spécialisé atténue réellement quelque peu l'effet d'être catégorisé. Certains dispensateurs de services pensent cependant que leurs bénéficiaires subissent comme un renouvellement de leur personnalité puisqu'ils se perçoivent comme «normaux» et ont l'impression d'être sortis du système (santé mentale). Les bénéficiaires font spécifiquement savoir que les bâtiments intégrés qui sont mis à leur disposition sont des bâtiments regroupant des gens à faible revenu, donc des bâtiments délabrés où fourmillent les trafiquants de drogue et les prostituées. Les récits des dispensateurs de services reprennent des propos très semblables dans leur description du climat de violence et de pauvreté qui afflige de nombreux bâtiments intégrés.

Les récits issus des transcriptions de toutes les personnes interviewées abondent en situations ironiques et paradoxales qui font partie de la vie sociale. La complexité de la situation s'explique souvent par l'ironie et le paradoxe (Karp, 1994). Cette contradiction ou cette tension est évidente dans les citations extraites des récits des bénéficiaires et des dispensateurs de services. Dans les logements spécialisés, les bénéficiaires parlent du soutien et de l'esprit communautaire qu'ils acquièrent; par la même occasion, les dispensateurs indiquent que le fait que ces gens soient regroupés comme des «cinglés» les affublent déjà d'un stigmate. Dans les logements de types divers, les bénéficiaires expriment leur sentiment d'extrême vulnérabilité et de crainte pour leur sécurité personnelle, malgré qu'ils admettent par la même occasion qu'un tel milieu leur procure l'occasion de tirer parti des expériences d'autres personnes. Les bénéficiaires de logements intégrés parlent de se «réfugier» sous le couvert de l'anonymat, mais exposent aussi leur incroyable solitude, se sentant comme des étrangers parmi des gens «normaux». Pour les dispensateurs de services, il est tristement ironique que le travailleur au sein de la communauté doive protéger l'identité du client et, par conséquent, sa propre identité à titre de dispensateur de soins psychiatriques dans le but de le peindre sous les traits d'un client acceptable et «normal» et, par conséquent, comme un locataire acceptable.

Les dispensateurs de services parlent, d'une façon accablante, de l'importance à accorder aux choix en matière de logements spécialisés ou de logements intégrés. Il importe de n'admettre aucune hypothèse quant à la préférence d'un milieu par rapport à un autre, en particulier puisque

le choix du client est jugé plus important au moment d'évaluer le type de logement qui lui convient le mieux. Si les clients choisissent de vivre dans un milieu réservé aux bénéficiaires de services psychiatriques et qu'ils sont en mesure d'obtenir du soutien, d'établir des relations et de constituer des communautés, qui sommes-nous pour affirmer «qu'il ne peut en être ainsi», parce que c'est précisément ce que «nous» appellons un ghetto? Cette situation ne froisse peut-être que la susceptibilité des gens de l'extérieur.

Par ailleurs, nous ne devons pas présumer que, faute de milieu spécialisé, il doit nécessairement s'agir de milieu intégré. Le fait est que la plupart des logements offerts aux clients regroupent un mélange de gens marginalisés par leurs handicaps et souvent parce qu'ils sont simplement appauvris. Le manque de revenu suffisant des bénéficiaires continue de revêtir une importance primordiale et constitue un obstacle à l'accès à des logements de qualité convenable. La recherche doit s'attaquer aux coûts ultimes d'une telle situation autant pour les bénéficiaires que pour la société. Ces logements de types divers n'ont pas toujours correspondu à notre notion d'intégration et de normalisation auprès d'une population vaste, indépendante et saine, représentatrice de plusieurs paliers de revenu.

Les études portant sur les préférences des bénéficiaires indiquent que les gens veulent avoir leur propre logement. Ces études et la présente corroborent l'équation selon laquelle la préférence des bénéficiaires égale la réussite du milieu résidentiel. Pour admettre ne serait-ce qu'un choix limité de logements, il importe de pouvoir compter sur différentes options de logements (tant intégrés que spécialisés).

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Executive Summary

There has been growing evidence that mental health consumer choice and control over the environment they live in are the best predictors of success in housing (Ridgway and Carling, 1987; Tanzman and Yoe, 1989; Baker and Douglas, 1990; Goering, Paduchak and Durbin, 1990; Srenmuck, Livingstone, Gordon and Klein, 1992). Consumers who feel satisfied and who perceive a good fit between their needs and the home environment may make a better adjustment (Cournos, 1987). Given the significance of consumer choice in the housing field, several preference studies have been conducted in which consumers were typically asked who they wanted to live with (Tanzman and Yoe, 1989; Everett and Steven, 1989; Texas Department of Mental Health and Mental Retardation, 1994). Unfortunately, in most of these studies "living with" was not clearly defined. Historically, "living with" has meant sharing a room in a boarding home context or sharing a kitchen and bathroom with others in a rooming house. With the advent of supported housing (independent apartments in multi-unit buildings, permanence and flexible supports), "living with" has come to mean sharing a building, not personal space. Without this differentiation, it has been difficult to interpret the findings of existing preference studies.

A recent study examining what consumers of mental health services thought about the neighbourhoods they lived in (Boydell, Gladstone, Crawford and Trainor, 1996), highlighted some of the issues identified by consumers when "living with" was clearly understood to refer to their neighbours who shared their building but not their personal space. They discussed their problems and their fears of living in a building with units targeted for other marginalised groups. Problems of living in sites with other marginal groups have been documented in the literature (Bredenberg, 1986). Many

interviewees in this study stated that they "fit in" with other people who also had psychiatric histories, but not with other marginalised groups. Consumers spoke of feeling comfortable and safe, of sharing experiences and of having common understandings.

The issue of integrated/dedicated housing has sparked lively debate in the field of mental health (Pape, 1992). At the time the study was conducted the Ontario Ministry of Housing policy strongly encouraged the development of integrated buildings. The Ministry was no longer going to build dedicated housing which would include housing dedicated to consumers of mental health services. This was a concern for many mental health professionals who observed that a number of their clients preferred living in dedicated housing. Trainor and Boydell (1986) have suggested that success in social life often depends on membership in special interest groups and that normalization prevents the formation and development of specialized services which cater to and are controlled by people whose primary interest is mental health. Affirmation of identity and access to social support often come from specialized groups or organizations. Dedicated housing, with its emphasis on such a "special interest group" may be considered in light of this theory. How is social success for consumers aided by specialized services and support in housing settings? Trainor and Boydell postulate that perhaps programs should be alternative in nature rather than normative. Is there a place for dedicated and integrated housing for those consumers who would prefer to choose between the alternatives ?

The objective of this study was to examine mental health consumer and mental health provider preferences for and perceptions of integrated, mixed and dedicated housing. Three types of housing settings were explored: i) dedicated housing comprised of people living in single units in buildings

dedicated to consumers of mental health services only; ii) mixed housing comprised of people living in single units in buildings with a mix of people requiring varied supports and services (eg. young offenders, single mothers); iii) integrated housing comprised of people living in single units in buildings that are on the open market.

This study was based on forty-five in depth interviews with consumers of mental health services and twenty-four interviews with mental health professionals. The themes that emerged from the transcripts of both groups were strikingly similar. In narratives on dedicated housing, both consumers and providers identify the support, shared experience and understanding experienced in this type of housing. They also identified the sense of community that emerged as a result. Most interviewees had only positive things to say about dedicated housing. On the negative side, consumers spoke of difficulties associated with living in close proximity to a group of people whose behavioural and emotional problems were often disturbing. However, service providers remarked on both the level of tolerance of disturbing behaviour and the reciprocal nature of this tolerance amongst tenants. It is interesting to note that only a few consumers mentioned that living in dedicated housing leads to being stigmatized as a result of having a severe mental illness. More service providers, however, discussed their concerns about ghettoization directly related to dedicated housing. For some service providers dedicated housing made it easier for them to support a number of clients. It was more economically feasible for some agencies to support a larger caseload of clients located in one building.

In mixed housing, both consumers and providers mentioned the fact that there was an opportunity for some education to take place. Consumers talked about learning from other types of people with different support and service needs. Providers talked about learning from the perspective

of the others living in the building. They identified the possibility of other tenants learning about people with psychiatric disabilities. However, stigma was still an issue in this setting and this stigma was sometimes directed at tenants who befriended people identified as mentally ill and therefore perceived to be strange or odd. Several service providers felt that in both mixed and integrated settings both tolerance and intolerance were evident and that much of it depended on the types of neighbours living in that particular setting. In this respect, the best tenant mix was important. For example, while senior citizens and consumers might be a good demographic pairing, youthful offenders and consumers might not. When asked about mixed housing, consumers spoke of feeling vulnerable in such settings, particularly with respect to safety. The majority of mental health providers characterized mixed settings as replete with drug dealers and prostitutes. In these mixed settings, people with a variety of service needs are really a group of marginalised people living together under the guise of integration.

In their narratives on integrated housing, both consumers and providers referred to the incredible loneliness, alienation and lack of community support experienced in such settings. Both groups also detail increased stigmatization as a result of "standing out" in these buildings. One consumer, however, felt that the anonymity of being in integrated housing actually eased the experience of stigma somewhat. Some service providers thought that their clients experienced a renewed identity because they perceived themselves to be "normal" and experienced a sense of having graduated from the (mental health) "system". Consumers specifically spoke of the fact that the integrated buildings available to them were low-income buildings which translated into run-down buildings replete with drug dealers and prostitutes. Service providers' narratives were very similar in their depiction of the violent, poverty stricken character of many integrated settings.

The emergent narratives from the transcripts of all interviewees are rife with the ironies and paradoxes which are part of social life. It is often irony and paradox that captures the complexity of things (Karp, 1994). This contradiction or tension is evident in the quotes excerpted from consumer and service provider narratives. In dedicated housing, consumers talked about the support and sense of community they gain, at the same time providers suggested that being grouped together as "nutbars" identified them in a stigmatizing way. In mixed housing, consumers talked about feeling extremely vulnerable and fearful for their personal safety, at the same time they acknowledged that there were opportunities to learn from others in such settings. In integrated housing, consumers talked about "hiding" in anonymity, yet spoke of the incredible loneliness they experienced, feeling as an outsider in and among "normal" people. For service providers it is sadly ironic that the worker in the community must protect the identity of the client and consequently their own identity as a psychiatric service provider in order to portray the client as acceptable and "normal" and, therefore, as a desirable tenant.

Overwhelmingly service providers spoke of the importance of choice with regards to dedicated and integrated housing settings. It is important that no assumptions are made as to the desirability of one setting over another particularly as client choice is deemed most important in evaluating which housing is most suitable. If clients choose to live in settings dedicated to consumers of psychiatric services and they are able to experience support, build relationships and communities who are we to say, "no that cannot be", because that is what "we" call a ghetto? Perhaps this is only offensive to an outsiders' sensibilities.

Secondly, we must not assume that if a setting is not dedicated then it must be integrated. The

fact is that much of the housing available to clients was in reality a mix of people marginalised by their disabilities and often by the simple fact that they are impoverished. The lack of anything approaching adequate finances for consumers continues to be of critical importance and is a barrier to appropriate housing. Research must address the ultimate costs of this situation to both consumers and ultimately to society. Traditionally, then, this "mixed" housing is not what is meant when we think of integration and normalization with a much wider, independent and healthy population representative of many income levels.

Consumer preference studies indicate that consumers desire housing of their own. These studies and this current study support the fact that consumer preference is equated with residential success. In order for there to be even limited choice in housing it is important that a variety of housing options (including both integrated and dedicated) be available.

Introduction

Housing for Consumers of Psychiatric Services

Adequate housing is an integral component of the well-being of all individuals (Carling and Ridgway, 1989). More specifically, a stable home has been recognized as an important prerequisite in the mental health treatment and recovery process (Blanch, Carling and Ridgway, 1988; Ridgway and Zipple, 1990; Harp, 1990; Posey, 1990; Boydell and Everett, 1992; McCabe, Edgar, Mancuso, King, Ross and Emery, 1993). Mental health systems have recently become more focussed on assisting consumers of psychiatric services to live normal and meaningful lives in the community (Randolph, Zipple, Rowan, Ridgway, Curtis and Carling, 1989). The demand for housing alternatives

has increased as a result of the downsizing of psychiatric hospitals and the growth in community-based mental health systems (Tanzman, 1993; Trainor, Morrell-Bellai, Ballantyne and Boydell, 1993). The key components of any comprehensive community support and rehabilitative approach for people with long-term psychiatric histories include decent, stable housing and the availability of a wide variety of supports (Besio and Mahler, 1993).

In recent years, there has been a significant shift in the philosophy regarding housing for people with psychiatric histories from an "era of institutional and facility-based thinking to a transitional period where people were seen as service recipients needing a professional support system, to a world view in which people are seen as citizens with a potential for, and right to, full community participation and integration" (Carling, 1990; p.969; Ogilvie, 1997). This "paradigm shift" can be seen in the move from the residential continuum model to supported housing models. In the linear continuum of service model, housing ranges from high to low support and restrictiveness, and a resident "begins his or her progress along the continuum, moving from the most restrictive and intensely staffed setting to less restrictive alternatives" (Ridgway and Zipple, 1990; p.12). Lack of choice and individualized support, the focus on supervision rather than support, and repeated dislocation have been associated with this model (Nelson, Walsh-Bowers, Hall and Wiltshire, 1994).

The more recent supported housing* model is based on the constructs of consumer choice, permanence, normalcy, flexibility and portable supports (Posey, 1990). Consumers select the type of housing and the people they want to live with and have the support available to help them become more integrated in the community (Ontario Ministry of Housing, 1992). It is important to emphasize

*There is a distinction between supportive housing and supported housing. With supportive housing, support is tied to the housing unit itself and with supported housing, the support services are flexible and move with the individual.

that support and housing are separate and that one does not depend on the other as in the more traditional continuum model. Most supported housing consists of single unit dwellings wherein occupants enter a typical tenant relationship and no other rules or regulations govern tenure in the building. As a result, people in supported housing are viewed as tenants rather than clients or patients.

The Importance of Consumer Choice in Housing

Historically, mental health services have relied on service providers as key informants and have been slow to incorporate consumer and family perspectives (Lord, Schnarr and Hutchison, 1987; Ridgway, 1988; Yeitch, Mowbray, Bybee and Cohen, 1994). Only very recently has listening to consumers as experts and teachers been recognized as having the potential to enrich and expand both the knowledge base and the ability to provide meaningful and effective services (Wilson, Mahler and Tanzman, 1990).

There has been growing evidence that mental health consumer's perceptions of what they need in a living environment are the best predictors of success in housing (Ridgway and Carling, 1987; Tanzman and Yoe, 1989; Baker and Douglas, 1990; Goering, Paduchak and Durbin, 1990; Srebnick, Livingstone, Gordon and Klein, 1992). In fact, consumer choice and control over their environment has been posited as the single most important determinant of success and is an important principle of supported housing. These findings are supported by Cournos (1987) who cited several studies suggesting that consumers who feel satisfied and perceive a good fit between their needs and the home environment may make a better adjustment. As a result, mental health services are increasingly implementing policies that reflect consumer-driven or client-centred systems (Boydell and Everett, 1992; Tanzman, 1993). The growth of research on consumer preferences in the area of housing and

support services follows from this shift and mirrors the increased attention paid to housing issues in the mental health field in the 1990s. Following from these findings, it is critical to consult with consumers themselves about their perceptions of what they need and want in the way of housing and support in order for communities to develop appropriate plans for people with long-term mental illness (Tanzman and Yoe, 1989).

The Issue of Integration/Dedication

Given the significance of consumer choice in the housing field, several consumer preference studies have been conducted (Tanzman and Yoe, 1989; Everett and Steven, 1989; Texas Department of Mental Health and Mental Retardation, 1994). Respondents were typically asked who they wanted to live with. Unfortunately, in most of these studies, "living with" was not clearly defined. Historically, "living with" has meant a group home or boarding home context, identified by shared accommodation, and often shared bedrooms. With the advent of supported housing (independent apartments in multi-unit buildings, permanence and flexible supports) "living with" has come to mean sharing a building, not personal space. Without this differentiation, it has been difficult to interpret the findings of existing preference studies.

Clearly, this issue of integration/dedication appears to elicit varied responses from mental health consumers. It has been the investigators' experience that this topic also sparks heated debate among service providers. There is an extant paradox in the principles of supported housing; namely, the principle of consumer choice and the principle of 'normal' housing. For example, Keck (1990) states that buildings should be integrated in order to be successful. He further adds that it is inappropriate to have apartment buildings occupied solely by people who are seriously mentally ill. Consumer preference studies indicate that there are some people who desire dedicated housing. It has

been argued that buildings dedicated to those with psychiatric histories alone contributes to further ghettoization. Given that the focus on consumer goals and preferences are key ingredients of successful community living, it is important to address those consumers who have expressed the desire to live with other consumers when the larger question of preference is being explored.

A recent Canada Mortgage and Housing Corporation (CMHC) External Grant study titled: "An Exploration of the Desirability of Housing Location by Consumers of Psychiatric Services" (1995), highlighted the problems and fears of tenants when other people (non-psychiatric) with service and support needs are living in the same building (mixed building). Many tenants spoke of feeling that they "fit in" with people with psychiatric histories but not with other marginal groups. They talked about feeling comfortable and safe, of a sense of shared experiences and common understandings. Problems of living in sites with other marginal groups have been documented in the literature (Bredenberg, 1986).

Trainor and Boydell (1986) suggest that success in social life often depends on membership in special interest groups, however, normalization prevents the formation and development of specialized services which cater to and are controlled by people whose primary interest is mental health. Affirmation of identity and access to social support often come from specialized groups or organizations. The authors postulate that perhaps programs should be alternative in nature rather than normative. This report outlines emerging themes from a study of this unexplored dimension of consumer preference which allows the voice of both mental health consumers and professionals to be heard.

Methods

The objective of this study was to examine mental health consumer and mental health provider preferences for and perceptions of integrated, mixed and dedicated housing. Three types of housing settings were explored: i) dedicated housing comprised of people living in single units in buildings dedicated to consumers of mental health services only; ii) mixed housing comprised of people living in single units in buildings with a mix of people requiring varied supports and services (eg. young offenders, single mothers); iii) integrated housing comprised of people living in single units in buildings that are on the open market. Where applicable, provision of support should be understood as being off-site, flexible and consisting of a range of options for clients.

Mental Health Consumer/Service Provider Interviews

A total of forty-five interviews were conducted with consumers of mental health services and twenty-four interviews were conducted with service providers. All interviews were audio-taped and were transcribed for the purposes of analysis. Interviews with consumers of mental health services represent tenants living in dedicated, mixed and integrated settings. Interviews with service providers represent both front line workers and executive directors of community mental health agencies.

Mental Health Consumer/Service Provider Questionnaires

Two distinct questionnaires were used to conduct interviews with recipients of mental health services as well as providers (see Appendices A and B). The questions, although structured, were open-ended with probes to most effectively elicit narrative data. The final interview schedule followed from a series of focus groups with both service providers and consumers. Participants in all focus

groups commented on the semi-structured interview schedule and offered several suggestions for modification as well as the addition and deletion of certain items.

Mental health consumers were asked to speak about their experiences in their current housing particularly as it pertained to their relationships within the building. They were also asked about the benefits and drawbacks to living in that setting. Similar questions were then asked about the remaining settings (dedicated/mixed/integrated). Consumers were asked about any preferences they had for the three settings. They were also asked to give their opinion regarding the best setting for consumers to live. Three additional questions were asked relating to the issues of safety and isolation.

The questionnaire used to conduct interviews with service providers asked respondents to consider their experience when working with clients who were living in dedicated, mixed or integrated settings. They were asked to talk about how supported their clients were by other tenants in each of the settings and to discuss their own provision of support in these settings. They were questioned about which environment worked best for their clients and why. Finally they commented on the terminology itself, the meaning behind dedicated, integrated and mixed settings.

Analysis

Transcriptions from focus groups and interviews were processed using WordPerfect software and were entered as raw data files into The Ethnograph, a computer programme that facilitates analysis of qualitative text. An initial coding schedule was developed from reading transcripts and revisions were made within The Ethnograph (Seidel and Clark, 1984). The raw data files were searched and analyzed using an editing analysis style. The codes or units of meaning were explored in greater depth by applying the codes as an open-ended template which underwent several revisions

as it applied to the text. In addition to code-driven analysis, text was coded in the context of individual participants' experiences (context driven) and incorporated participants' meanings (culturally driven). The data was summarized into reports for each code across cases. In addition, quantitative data was entered into SAS (Statistical Analysis System) where simple frequencies and chi-square analyses were performed.

Results

a) Mental Health Consumer Interviews

A total of forty-five interviews were conducted with consumers of mental health services. Twenty-five (55.6%) of the interviewees were male and the remaining twenty (44.4%) were female. Seventeen of the total number of interviewees listed their age. Four clients (23.5%), were between the ages of twenty-five and thirty-five. Ten clients (58.8%) were between the ages of thirty-six and fifty and three clients (17.6%) were more than fifty years old. The age range was from twenty-six years of age to seventy-five years of age. Eighteen of the total number of interviewees listed their marital status. Eleven clients (61.1%) were single, never married, three clients (16.7%) were separated and four clients (22.2%) were divorced.

Analysis of interviews with consumers of mental health services revealed a number of themes regarding life in dedicated, mixed and integrated housing. Each individual setting will be described first, followed by a discussion of similarities and differences across the settings. (Appendix C)

Dedicated Housing

Fourteen (31.1%) of the forty-five consumers interviewed resided in dedicated housing, that is, housing wherein all tenants had a psychiatric history. Men and women were equally represented.

All tenants received formal support by the mental health system and 11 (79%) saw their housing support worker at least once every two weeks. Seventy percent indicated that they would keep their housing support worker if they moved on to a different type of housing. The majority (11 of 14) knew many or all of the other tenants in the building and the remaining three individuals knew a few others. When asked how they felt about dedicated housing, 64 percent stated that they liked living in dedicated housing, 21 percent were ambivalent and the remaining 14 percent stated that they did not like it. Forty-three percent said that they would not like living in mixed housing, and 50 percent said they would not like to live in integrated housing. Clearly, for those living in dedicated housing, most preferred that type of housing.

One outstanding feature of the consumer experience of dedicated housing was the support tenants felt they received within their own building. In addition to receiving support, people talked about the importance of being able to reciprocate and give support to others as well.

...there is an element of understanding and more support...between the tenants than there normally is in other buildings.

...in a psychiatric environment patients usually cling to each other for support....

One consumer went further by seeing this support, commonality of experience and understanding as a kind of community.

...there's more of a community where you wouldn't find where you live with other people, people in other buildings tend to stick by themselves if they have their own friends and

family and so on...naturally the whole building is a community...in a building like this [dedicated housing] people get together for coffee uh, stuff like that and they socialize more....

On the negative side of this same experience, one consumer stated that some of this close proximity to other tenants could be difficult.

...people get involved with everybody's business around here...one person turns against another...they're bumming cigarettes, I haven't got any money but I don't blame them because the money is not very much....

And yet this same tenant was able to express understanding and empathy about the root causes for some of this behaviour, the lack of money. Several tenants exemplified this same tenant attribute of compassion and understanding.

...there's an element of compassion and understanding.

Because they understand the same thing you're going through.

This common experience of psychiatric illness did not always contribute to a balanced, harmonious atmosphere in the building, nor did it always contribute to understanding others.

There can also be conflicts too because when one person's having problems, like if I'm

having problems then I'm depressed, I may sort of isolate myself from people...and I'm always afraid that if somebody's not talking it's because I've done something wrong, but 90% of the time it has nothing to do with me...So there can be conflicts in that area because there's so many problems we carry with us.

That's sort of the drawback, that you don't always have a good point of view. Maybe you're ruled by your own problem.

The issue of feeling stigmatized for having a mental illness also emerged in a few consumer transcripts as outlined in the following:

You sort of feel like you stand out, you know, like you're bright purple or something.

Mixed Housing

Mixed housing is housing wherein people with psychiatric backgrounds share tenancy with other marginalised groups. Twenty (44%) of consumer interviewees lived in mixed housing. Fifty-five percent were male. Like those living in dedicated housing, all tenants received support from the mental health system. About one half of those living in mixed housing saw their worker at least once every two weeks. The remaining saw their worker monthly or every other month. Forty-seven percent stated that their support would remain with them if they moved. More than half (55%) knew a few other tenants in their building, forty percent knew many others and the remaining five percent knew all other tenants in the building. Although fifty percent indicated that they liked living in mixed

housing, a full thirty percent stated that they did not like it, and the remaining were undecided...

In the dedicated sites having a common understanding of a psychiatric illness has its drawbacks and benefits. However, in a setting in which tenants from different backgrounds reside it is the outsider's point of view which is often seen to be beneficial.

> *...there may be some problems in the building. Somebody who isn't psychiatric can give a different assessment of what's going on where somebody else who is psychiatrically involved may not see the same things....*

Inspiration for some tenants in a mixed setting took the form of learning from others as suggested below.

> *...seeing other people working...it helps you because you want to do the same too....*

> *You could learn a lot of things. You could learn how to handle yourself a little better. What I've found especially in this area was learning patience and tolerance.*

Indeed, some tenants spoke of this tolerance of others in the mixed setting.

> *I think it's fine as long as they just behave as long as they just keep to themselves...they're (young offenders) not any worse or any better than anybody else.*

I like to give everybody at least a chance, once...I don't think I'm different than anybody else...we just learn to live together.

Simultaneously, some tenants commented on the vulnerability they felt when living with tenants who came from other support agencies, particularly with issues of safety in mind.

I wouldn't feel safe.

You get women who are really angry and abusive husbands or whatever and the young offenders and they're usually pretty angry. I think it could be potentially pretty dangerous.

It should be noted that a number of tenants talked about feeling unsafe. They had concerns around this issue regardless of the type of housing they were living in. The following tenants expressed this view from the vantage point of living in a mixed building whether the safety issues concern those with a psychiatric background or not.

If they keep to themselves like all of us but when they start going down and smashing windows and things like that. It doesn't matter who they are, whether they're young offenders or they're psychiatric, they can't stay.

I wouldn't mind anything, I think all people are entitled to...have a place where they can afford...the only thing I do mind is living in a building where there's people with criminal

backgrounds...drugs and so forth....

Another tenant attributed this vulnerable feeling to the extraordinary level of involvement with other tenants.

I would find that more difficult [mixed housing]. I intend to get involved quickly and try and help people out of situations...and I would find that harder...I would be drained...I think it could be potentially lethal.

Integrated Housing

Eleven (24%) of the consumers interviewed lived in integrated housing. Fifty-five percent were male. Once again, all tenants received support from the formal mental health system. Sixty percent saw their worker at least once every two weeks. The remaining individuals saw their worker more sporadically, sometimes only once per year. Forty-five percent stated that they could keep their supports in the event that they left their current housing. Although 63 percent knew some of the other tenants in the building, almost 20 percent knew no-one and almost 20 percent knew everyone. Although 55 percent liked living in integrated housing, the remaining 45 percent did not like living in integrated housing.

The tenant experience or perception of living in integrated housing evoked feelings of loneliness and a lack of community and support.

It was really lonely and isolating... nobody really knew anybody... it was very, very lonely....

I'd invite people over. They wouldn't come. Nobody. They just didn't do that in that building. I was there six and one half years. I can count on one hand the number of times people came in for coffee.

You wouldn't find (community) in say a building where average working people are. They usually stick to themselves and do their own thing.

It's too demanding. The support wouldn't show up there.

The lack of money available for socializing seemed to be one of the major factors contributing to loneliness. As one tenant states:

I found it very hard... because I don't always have the money where I can do this with it or do that with it... I find I don't always have the money for a social life.

While some people felt that living in an integrated building was more stigmatizing because they felt they would stand out among 'normal' tenants, others felt that living among a variety of people would have the opposite effect.

In this kind of building, everybody knows that you're paying low rent and that you need the

support.

Sometimes, I guess it's better because you don't sort of get labelled if they don't know anything about you.

I think there should be a mixture. It would give the other people an opportunity to know that psychiatric patients aren't really as bad as what everybody places them to be.

Several people recognized that living in an integrated building for them translated to living in a low income building that was run down and easily accessed by prostitutes and drug dealers.

Actually, if we went away from this uh... government thing and got into a private thing, then from what I've heard... about other apartment buildings about slum lords and things like that... well, I guess if they were as conscientious as the people here, I'd be okay. But if they're not, and I've heard a lot of bad things about slum lords and things like that... the building can really deteriorate... naturally, people give up because their residence starts to fall apart and they start giving up and it's a whole spiral downward.

There could be drawbacks too, 'cause we just recently got rid of a lot of problems... there were hookers coming in... crack dealers coming in....

Comparison of Consumers in the Three Different Settings

People living in dedicated buildings were significantly more likely (X^2=26, df=6,p<.001) to know all other tenants in the building (64%) than those living in either mixed (5%) or integrated settings (18%). Perhaps this contributes to the sense of community experienced by many of those living in dedicated settings. Consumers already living in dedicated settings were more likely to feel positively towards consumers living with other consumers exclusively. When asked whether or not they would prefer to live alone (own living unit, whether individual apartment or house), 50 percent of consumers in dedicated housing indicated a preference for living alone, 30 percent of those in mixed housing preferred to live alone and 63 percent of those in integrated settings preferred to live alone. These differences were not statistically significant. All clients in the three settings received formal support, but they differed in the frequency with which they saw their worker. Those living in dedicated housing had more contact with their worker, followed by those in integrated housing, then mixed housing. Those living in dedicated and mixed housing were significantly more likely to have other support than those living in integrated housing (X^2=6.2, df=2,p<.045). Consumers living in dedicated housing were also significantly more likely to select choice rather than a particular setting as the most important aspect of where a consumer should live (X^2=16.2, df=8, p<.040).

b) Service Provider Interviews

The service provider perspective on integrated and dedicated housing represents people working in a number of professional capacities ranging from front line workers responsible for housing and support in the community to executive directors of community mental health agencies. Mental health service providers were asked a series of open-ended questions regarding their experience

working with clients in the three different settings. They were asked to discuss the support they provided their clients in the community settings and to comment on the support or lack of support clients would attribute to relationships with other tenants in the building. They were also asked to comment on any difficulties arising out of the tenant demographic of a specific setting. Service providers were asked whether it was important to consider who else was living in a particular building when looking for housing with a client . They defined integrated and dedicated housing and were asked to reflect on the type of housing that worked best for their clients and why.

Analysis of interviews with providers of mental health services yielded themes quite similar to those expressed by mental health consumers for each of the three settings. Again, while some of these themes overlap among the dedicated, mixed and integrated settings, they will be discussed by each individual setting, followed by a discussion of similarities and differences across settings.

Dedicated Housing

One of the main themes that arose out of the service provider narratives on dedicated housing centred on the support that tenants provide one another. One type of support observed was the forming of friendships that helped to ease feelings of isolation and loneliness. Some providers felt that their clients had a much greater opportunity to form friendships and receive informal support in this setting and attributed successful community tenure to the success of these relationships.

Most of our tenants stay a long time... there are some fairly solid friendships that develop and a lot of them are instrumental supports most of the time.

The loneliness part, they talk it out... they meet and talk... they help each other out.

They say... it helps to deal with the isolation to have other people that have a common illness.

Peer support is really conducive to people managing well.

Service providers believed that sharing the experience of a psychiatric illness enabled tenants in dedicated buildings to recognize and support others whose illness was beginning to manifest itself. This informal support often enabled tenants to intervene on behalf of their neighbours. One respondent also speaks to the underlying tolerance of behaviours they witness in clients who have empathic understanding of others' symptoms.

People have rallied around to incredible degrees to where I've thought this person's not going to make it you know. And uh...the resident...uh tenant group has brought them around. People who have been just stinkingly drunk and screaming and running into the middle of the street naked. And the rest of the group like brings them in, sits them down, calls the police, goes down to the hospital with them...brings them back and stays with them overnight...I really stop and think, geez, would I do that, you know?

If someone gets sick now, they're very supportive... the manifestation of the illness doesn't frighten them... they have become much more skilled at recognizing that someone really

needs the care.

They [tenants of the building] know each other and support each other. When they don't see somebody, they know that she's sick.

They [tenants] help each other out when they're ill. They accompany people to hospital. They accompany them to appointments.

One consumer said to me, 'When I'm ill and I'm walking down the hall and I'm pacing and I talk to myself, I feel like I can do that where I live in dedicated housing. I'm not so sure that I could do that in an integrated building. They might think I'm too weird or they might not understand. They might call the police on me. Here, at least, I feel like I can be ill and still not lose my housing.'

Many respondents commented on the tolerance of particularly difficult behaviour that they had observed in dedicated housing. Sometimes this behaviour was extremely distressing for clients. Service providers expressed their amazement at the client's ability to cope with this behaviour and speculated that this was often the result of expecting and needing that same understanding when they were ill. Service providers often commented on the reciprocal nature of the tolerance exhibited by tenants which often included the unwillingness to reject fellow tenants for abusive behaviours through procedures as drastic as eviction.

They say, you know, I can't cope with so and so's behaviour but that's more of an exception rather than a rule...and this group many of which have very significant problems and behaviour problems that can range from simply just really annoying to security risks...I'm often surprised by the level of tolerance of the people who live there. It's often greater than the staff. Where the staff are ready to say let's bounce this bird. And part of that's motivated by the fact that they look at this and say, I could get off the rails and be bounced...but also out of genuine concern.

Some of the service providers talked about the sense of community that they believed consumers in dedicated housing experienced.

None of them were enthusiastic about the integrated model. They were very adamant. They wanted to stay in their own community.

I'm constantly amazed at how well they are able to work things out... infrequently they do have staff involvement. But even more interesting is when someone has a real problem, often there are lots of complaints. But when we start to suggest maybe the person can't live there anymore, there is an enormous amount of resistance from the rest of the tenants.

People say, 'Hey, let's hang out and have a barbecue.' and 'Let's get together and have something together at Christmas time. ' I know that they share turkey dinners with each

other.

The development of informal support through friendships with other tenants, the ability to intervene and exhibit tolerance when someone was unwell and the development of community within the dedicated buildings was formally undertaken by some community agencies who were committed to the use of a *peer support model* in buildings where they hoped to eventually lessen the degree of professional presence.

> *We have a mission statement that primarily states that we want to help people with mental health problems live within the community...and to do that with progressively fewer...or rely on fewer and fewer professionals...the hope is that eventually if you're that kind of peer support model, people will become more reliant on each other to develop relationships ...and not need staff ....*

Although most of the service providers had many positive things to say about dedicated housing, one provider did talk about the stigma associated with a dedicated building.

> *People will say, 'I mean, I just walk into the front door and the whole neighbourhood knows that I am a nutbar. I am identified and marginalised in this community because of where I live.'*

There was a certain percentage of people that felt that it was ghettoizing and stigmatizing and they didn't want to be thought of as a nutbar among a bunch of other nutbars.

However, one service provider, who also self-identified as a consumer/survivor, wryly pointed out that the term ghettoizing could be applied to other settings that we wouldn't normally question and implied that this was called a ghetto only because people were already stigmatized as disabled or poor.

It always intrigued me that nobody ever talked about the rich living together was a ghetto...it's only if you have some kind of disability or you're poor that living together is wrong. Not if you're wealthy.

Respondents discussed the practical need for housing dedicated to consumers of psychiatric services because they felt that they were always the last to be considered for decent affordable housing in other sectors.

If you don't set aside these flats then it's harder and harder to compete for them in this market and our people suffer because they get shuffled to the bottom of the deck, they don't have...it's hard for them to follow through , it's hard for them to be aggressive about getting housing...they get the lousiest housing.

For some workers dedicated housing made it easier for them to support a number of clients.

It was more economically feasible for some agencies to support clients who were situated in one location.

Sometimes it's a little easier to give support in a dedicated setting. You know, than to have people in a lot of isolated individual housing.

It's much easier from our perspective to serve...oversee, if you like, liaise with our clients when they're sort of together.

People expressed other practical concerns regarding dedicated housing and the difficulty of getting on long waiting lists for this housing. They also talked about the difficulty of working with exclusionary criteria, particularly around past histories of violence and arson in dedicated settings.

Mixed Housing

When talking about tenants who lived in a mixed building, service providers spoke largely about the pervasiveness of drugs and violence. The vulnerability of their clients to these elements heightened the potential dangers these tenants face.

The drug use, the people just moving and taking over your apartment and you are virtually forced out... the terrorizing and taking your money from you... women are absolutely scared out of the their trees and there is theft that happens... attacks where people

are literally left in critical condition.

I can think of a number of cases where people have had a very, very hard time dealing with the drug culture in public housing.

The tenants in the building have been a source of difficulty, especially in relation to drugs and also for female clients... when they're in environments where there is violence, it is a very distressing situation, so... safety issues are a concern.

The consumer/survivors tend to be victimized more than the victimizers.

One service provider identified the potential for some tenants who did not have a mental illness to learn about the illness which subsequently dispelled some of their fears and misconceptions.

There was a lot of fear on the part of seniors because of their perception of mental illness... the fear of who was moving in... who was at risk and that sort of thing. So, there was a training program and out of that there has been a lot more seniors involving some of the mental health consumers in their programs.

Conversely, stigma, especially that arising from behaviour perceived to be odd and difficult, was pervasive in many of these buildings. Tolerance which was exhibited in the dedicated sites was less obvious in settings where tenants came from a variety of mixed backgrounds. In these last two

examples supportive, non-stigmatizing relationships seem to depend a lot on who the neighbouring tenants are.

It all depends...it all depends, you know on how tolerant they are of the behaviour and how problematic the behaviour of the client is...people can be afraid of bizarre behaviour and kind of shun people. I've been in buildings where kids have made fun if somebody is mentally ill but I've had just as many experiences where people are supportive...it really depends on the neighbours.

Added to this perception of a difference about the tenants with mental illness in mixed settings was what one service provider observed as resentment amongst the "other" tenant population because they felt the "mentally ill" received special treatment.

Some of the people who are not in the mental health world felt there were a whole different set of rules by which people were judged. And the people with the mental health problem were excused for some behaviours because they were mentally ill and the others were held responsible for the things that they'd do.

Integrated Housing

A sense of loneliness and alienation was one of the main effects that mental health providers observed among consumers living in an integrated building.

People who tend to live in their own apartments and who are not supported by or sponsored by an agency tend to have more difficulty socializing and meeting people and having friends.... There is no contact with the other tenants in the building.

They had even felt more alienated and isolated... that is the main one (theme) that they felt ostracized and even more alienated living in integrated buildings.

This sense of alienation was reinforced by the stigma the consumers of mental health felt from the other tenants. As one service provider observed:

They do not understand what psychiatric patients are going through... they are very intolerant... they are afraid of our patients and therefore they voice a lot of complaints against our patients. It's basically due to fear and lack of knowledge.

Even when other tenants were willing to befriend consumers they were often stigmatized or ostracized as a result.

She forgets to eat so this tenant used to bring her food...and people started calling her names..."friend of the crazy" and ya know, now like she started getting in trouble for helping out.

Service providers spoke of the stigma having an effect on their ability to find decent, affordable

housing for their clients in integrated settings.

There is a lot of prejudice. They don't um...come right out and say no, we won't rent to you because you are a consumer/survivor or whatever, but um...you know, they will say, "we'll put you on the list and..."there's a lot of ignorance, a lot of trouble getting somebody into market rental. One fellow had a difficult look about him...nobody would rent to him and one of the nurses upstairs knew somebody who had an apartment and that's where he is.

The stigma is so pervasive that many clients must hide their identity in the psychiatric culture and their workers understand the need to collude with this secret identity themselves.

The landlord knew him and he felt sorry for him so he gave him a place...so it was easy you didn't have to hide or lie. 'Cause a lot of our folks feel pretty sensitive about the landlord knowing they've got a psych history or not. So you've got to try to figure out who you are to the landlord, you try not to tell the landlord who you really are.

However some respondents indicated that not all experiences in integrated housing were necessarily stigmatizing and that some people experienced success in moving out into the world. This helped them regain a more positive identity.

They feel really good about it. They're off the system. They know they've got support if they need it. They feel more confident and uh, by and large it's been really positive. But they had

to go through some things in order to get to that point. Had to learn some things and uh, sort of grow out of the system, in a way....some of them feel really good about that. "I'm paying market rent".

Again, as with the mixed building, safety was an issue for people living in integrated buildings.

And in market rent they would sometimes remark that they felt a little vulnerable if they had to choose a building that even for market rent was a little down trodden and not all that safe.

They are terrified, terrified if they don't get a decent building or anything like that, they are preyed upon, they are used...like people will move in, drug dealers will move into their apartments and will use it as a crack house or to deal from and they are, seem very powerless to be able to make any way of protecting themselves in the face of that kind of thing.

Problems such as loneliness, isolation, stigma and safety were compounded by the fact that affordability was often the single biggest issue for clients who were living without the financial means to live in truly integrated settings. Long waiting lists were also cited as being a problem. For some of the service providers it is an ideal choice for housing but often an unrealistic one.

Integrated housing is an ideal, I don't think it can be a reality.

You know the ideal situation of integrating people with a whole range of not only problems and people who are impoverished, the dream being that you have a community where you are

supporting and caring for each other um...although it's a dream.

Comparison of the Three Settings by Service Providers

Having discussed dedicated, integrated and mixed housing, service providers were asked to comment on the type of housing setting that worked best for their clients. All participants agreed that the most important element was choice in the housing setting and that there was a role for both dedicated and integrated housing. They did not feel that mixed settings were an appropriate choice for clients. Many service providers lamented the fact that there was not enough choice and that clients often agreed to take what they could get. One respondent commented that in both dedicated and integrated settings the "real" goal was integration into the wider community.

There's a role for both. I think choice is, is important. I still don't think there's enough choice...my experience would be that most people don't get housing based on what their choice is but what's available. There needs to be more choice.

For both, for both dedicated and integrated because different people have different needs. There need to be options...but whatever the model (we) need to be working towards helping the person to integrate into the community regardless of the nature of the particular setting.

There is no one kind of type and I've seen uh, the entire spectrum work well for individuals. Um, I think there is a toxic combination, for example the vulnerable client who has a history

of substance abuse who can't say no to living in a drug infested housing...that is a toxic combination and I think the field isn't active enough in recognizing that and getting people out of those environments....What I think is the most important is the match between the person and the environment.

Following on this last comment one respondent questioned if choice was really available to clients. She postulated that in order to define real choice one had to understand what is meant by "integrated" housing and, perhaps, the difference between the definition of integration in theory and in practice. In practice the differences and similarities between dedicated and integrated housing were summed up in the following words for this respondent.

*Our experience is the majority come from abusive backgrounds and their main difficulty is relationships and we place them into housing where they have to negotiate the most complex of relationships possible and they fight like cats and dogs from morning to night...but they are kind of ...not as frightening as what can happen in (*names a well known public housing) *buildings when they start to get into guns and knives.*

However, the underlying difficulties of integrated housing are more than the degree of difference in how safe tenants actually are. This respondent points out the disparity between our definitions of integrated housing and the reality of that housing for tenants .

I think integration is a word that requires very serious definition because any integration on

the basis of a variety of disabilities and disadvantages but everybody is poor, I mean everybody is poor. I mean MTHA and Regent Park is integrated housing as far as I can tell from the Ministry of Health and the Ministry of Housing perspective but we consider that from the outside looking in a distant ghetto, a ghetto of frightening people.

It (integration) *doesn't mean beans frankly and what it means is that you put a bunch of poor people together...they lump all people that are disadvantaged or marginalised are put together and then it's called integrated. Integrated housing, that is what it means to me.*

Service provider narratives indicate that choice is the most important factor in deciding where it is best for consumers of psychiatric services to live and that the choice should be theirs to live in either dedicated or integrated settings. However, many of the respondents interviewed also talked about the importance of building size and neighbourhood location as complementary factors in the search for decent housing . A couple of service providers concluded their thoughts about the issue of integrated and dedicated housing this way:

To try and feed themselves, uh...in an apartment of one's own, however that is achieved, is a prized possession.

People want a home, a real nice home and a decent neighbourhood and they don't care who their neighbours are as long as they treat them decently, they don't care if they can't hear or if they can't see, or if they are old.

Summary and Discussion

This study is based on forty-five in-depth interviews with consumers of mental health services and twenty-four interviews with mental health professionals. The themes that have emerged from transcripts of both groups were strikingly similar. In narratives on dedicated housing, both consumers and providers identify the support, shared experience and understanding experienced in this type of housing. They also identified the sense of community that emerged as a result. Most interviewees had only positive things to say about dedicated housing. On the negative side, consumers spoke of difficulties due to the close proximity to a group of people whose behavioural and emotional problems were often problematic. However, service providers remarked on the level of tolerance of disturbing behaviour and the reciprocal nature of this tolerance amongst tenants. It is interesting to note that only a few consumers mentioned that living in dedicated housing leads to being stigmatized as a result of having a severe mental illness. More service providers, however, talked about their concerns about ghettoization directly related to dedicated housing.

In mixed housing, both consumers and providers mentioned the fact that there was an opportunity for some education to take place. Consumers talked about learning from other types of people with different support and service needs. Providers talked about learning from the perspective of the others living in the building. They identified the possibility of other tenants learning about people with psychiatric disabilities. However, stigma was still an issue in this setting and this stigma was sometimes directed at tenants who befriended people identified as mentally ill and therefore perceived as strange or odd. Several service providers felt that in both mixed and integrated settings both tolerance and intolerance were evident and that much of it depended on the types of neighbours living in that particular setting. In this respect, the best tenant mix was important. For example, while

senior citizens and consumers might be a good demographic pairing, youthful offenders and consumers might not. When asked about mixed housing, consumers spoke of feeling vulnerable in such settings, particularly with respect to safety. The majority of mental health providers characterized mixed settings as replete with drug dealers and prostitutes. People with a variety of service and support needs are really a group of marginalised people living together under the guise of integration.

In their narratives on integrated housing, both consumers and providers referred to the incredible loneliness, alienation and lack of community support experienced in such settings. Both groups also detailed increased stigmatization as a result of "standing out" in such buildings. One consumer, however, felt that the anonymity of being in integrated housing actually eased the experience of stigma somewhat. Some service providers thought that their clients experienced a renewed identity because they perceived themselves to be "normal" and experienced a sense of having graduated from the (mental health) "system". Consumers specifically spoke of the fact that the integrated buildings available to them were low-income buildings which translated into run-down buildings replete with drug dealers and prostitutes. Service provider narratives were very similar in their depiction of the violent, poverty stricken character of many integrated settings.

The emergent narratives from the transcripts of all interviewees are rife with the ironies and paradoxes which are part of social life. It is often irony and paradox that capture the complexity of things (Karp, 1994). This contradiction or tension is evident in the quotes excerpted from consumer and service provider narratives. In dedicated housing, consumers talked about the support and sense of community they gain, yet at the same time providers suggested that being grouped together as "nutbars" identified them in a stigmatizing way. In mixed housing, consumers talked about feeling extremely vulnerable and fearful for their personal safety, yet at the same time acknowledged that

there were opportunities to learn from others in such settings. In integrated housing, consumers talked about "hiding" in anonymity, yet spoke of the incredible loneliness they experienced, feeling as an outsider in and among 'normal' people. For service providers it is sadly ironic that the worker must protect the identity of the client and consequently their own identity as a psychiatric service provider in order to portray them as acceptable and 'normal' and therefore desirable tenants.

Overwhelmingly, service providers spoke of the importance of choice with regards to dedicated and integrated housing settings. It is important that no assumptions are made as to the desirability of one setting over another particularly as client choice is deemed most important in evaluating which housing is most suitable. If clients choose to live in settings dedicated to consumers of psychiatric services and they are able to experience support, build relationships and communities who are we to say no, that cannot be, because that is what we call a ghetto? Perhaps this is only offensive to an outsiders' sensibilities.

Secondly, we must not assume that if a setting is not dedicated then it must be integrated. The fact is that much of the housing available to clients is in reality a mix of people marginalised by their disabilities and often by the simple fact that they are impoverished. The lack of anything approaching adequate finances for consumers continues to be of critical importance and is a barrier to appropriate housing. Research must address the ultimate costs of this situation to both consumers and ultimately to society. Traditionally, then, this "mixed" housing is not what is meant when we think of integration and normalization with a much wider, independent and healthy population representative of many income levels.

Consumer preference studies indicate that consumers desire housing of their own. These studies and this current study support the fact that consumer preference is equated with residential

success. In order for there to be even limited choice in housing it is important that a variety of housing options be available. These housing options should include group as well as independent living and should include both dedicated and integrated settings. Mixed housing settings as defined in this report are clearly less than desirable and should be avoided if at all possible.

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APPENDIX A

MENTAL HEALTH CONSUMER EXPERIENCE OF DEDICATED/INTEGRATED HOUSING QUESTIONNAIRE

Respondent ID Number:

Type of Setting (Dedicated/Integrated/Mixed):

Consumer Characteristics:

Age (in years):

Sex:

Marital Status:

Type of Housing (bachelor, one bedroom, basement apartment...):

Income Source:

Support Agency (if applicable):

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1. How long have you lived in the building you are in now? (Years and months)

2. Do you know any of the other tenants in your building?

   If yes, how many and can you tell me a little about your relationship with them? (Probe for type of relationship, acquaintance, friends, type of support/instrumental or emotional)

   If no, is this your preference?

3. How (do you/did you/would you) feel about living in a building with other consumers of psychiatric services only? (What are the benefits? Drawbacks?)

4. How (do you/did you/would you) feel about living in a building that contained a mix of people with varied support needs? (Eg. Abused women, young offenders) (What are the benefits? Drawbacks?)

5. How (do you/did you/would you) feel about living in a building that was available to anyone who was able to rent an apartment? (What are the benefits? Drawbacks?)

6. Do you have a preference for dedicated/integrated/mixed housing? Please explain.

7. Please describe your ideal living situation. Where would you live? Would you live alone? Who else would share the building with you?

8. If you received support from an agency, could you describe that support? (How often do you see your worker?)

9. Do you think that you could keep this support if you moved away from this building?

10. In your opinion, where do you think it is best for consumers of psychiatric services to live?

APPENDIX B

SERVICE PROVIDER PERCEPTION OF DEDICATED/INTEGRATED QUESTIONNAIRE

Id Number: _____

Professional position: _____

Employer/Agency : _____

Length of time in this field: _____

What is the mandate/goal of your organization/agency/department? (personal goal?)
(kind of agency, type of support)

During our interview, please think of clients who you are currently working with (if applicable):

1. How many of your clients are living in buildings with other consumers/survivors exclusively? Please describe your experience of supporting clients in this setting.

2. How many are living in buildings with tenants from other social service agencies (example, single mothers, young offenders)?
Please describe your experience of supporting clients in this setting.

3. How many are living in open market buildings, open to people from all backgrounds.
Please describe your experience of supporting clients in this setting.

4. In your opinion, do any of your clients receive support (what kind of support?) from other tenants in the building? Please elaborate.

5. In your opinion, would you say that the tenants in those settings are a source of difficulty for your clients? Please elaborate.

6. What does the term integrated housing mean to you?

7. What does the term dedicated housing mean to you?

8. Please comment on the kind/type of housing you think works for your clients and why?

9. Talk about your own experience of supporting people in these settings/working on housing policy in this area (feelings, thoughts)?

10. Do you believe that there is a role for integrated and/or dedicated housing?

APPENDIX C

SUMMARY TABLE COMPARING THREE SETTINGS
CONSUMER PERSPECTIVE

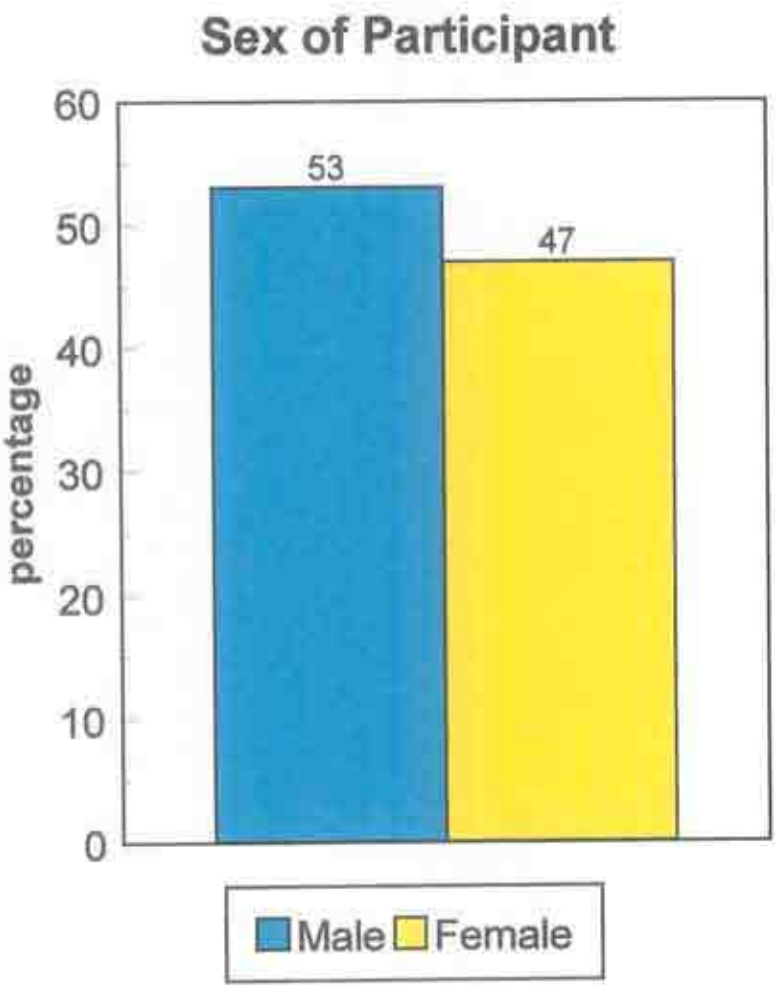
N=45

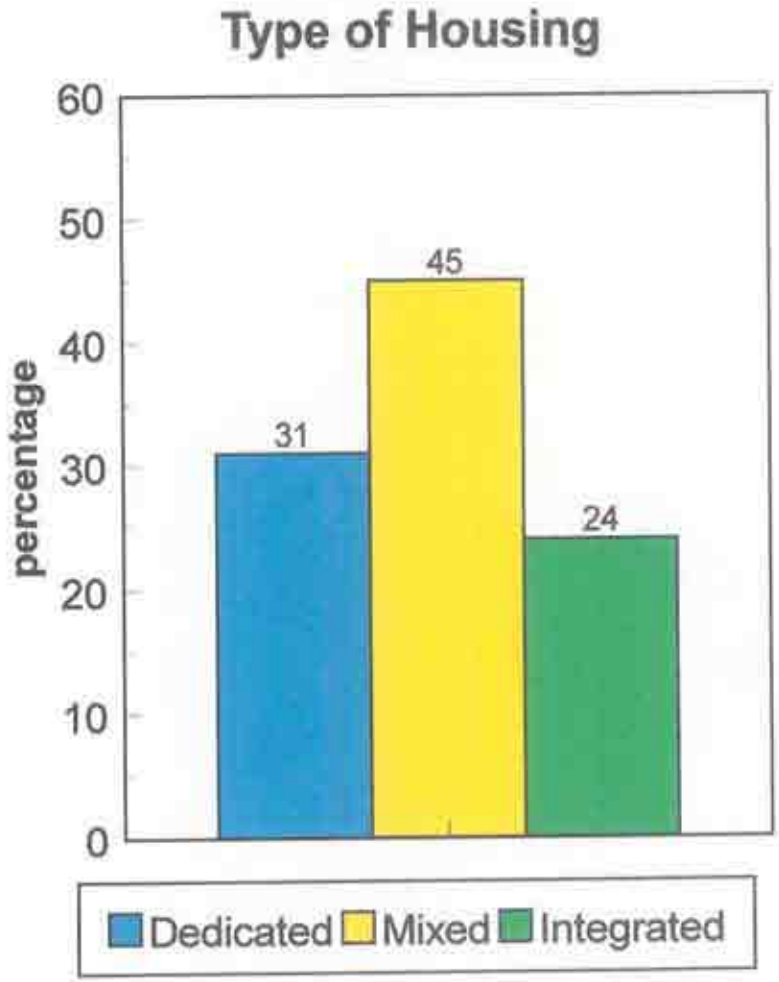
FEATURE	DEDICATED HOUSING	MIXED HOUSING	INTEGRATED HOUSING
Basic Demographics	-31.1% of interviewees live in dedicated -equal number of men and women	-44% of interviewees live in mixed -55% were male -45% were female	-24% of interviewees live in integrated -55% were male -45% were female
Support Received	-all tenants receive support from mental health system -79% see worker every two weeks	-all tenants receive support from mental health system -50% see worker every two weeks	-all tenants received support from the mental health system -60% see worker every two weeks
Knowledge of Other Tenants	-78.6% know many or all the tenants in their building -the remaining consumers know a few tenants	-55% know a few tenants in their building -40% know many and 5% know all the tenants	-63% know some of the tenants in their building - almost 20% know no one -20% know all tenants
Housing Preference	-64% like living in dedicated -14% did not like dedicated (21% were undecided)	-50% like living in mixed -30% did not like mixed (20% undecided)	-55% like living in integrated -45% did not like integrated
Likes and Dislikes of Setting	-received support and gave support to one another -little perceived stigma -behaviour of others disturbing	-benefit of outsider point of view (inspiration of others) -vulnerability to other tenants -many felt unsafe	-some say it is not as stigmatizing, for others it is more so -very lonely for some -often run down, poor places

BAR CHARTS FOR TOTAL CONSUMER INTERVIEWS

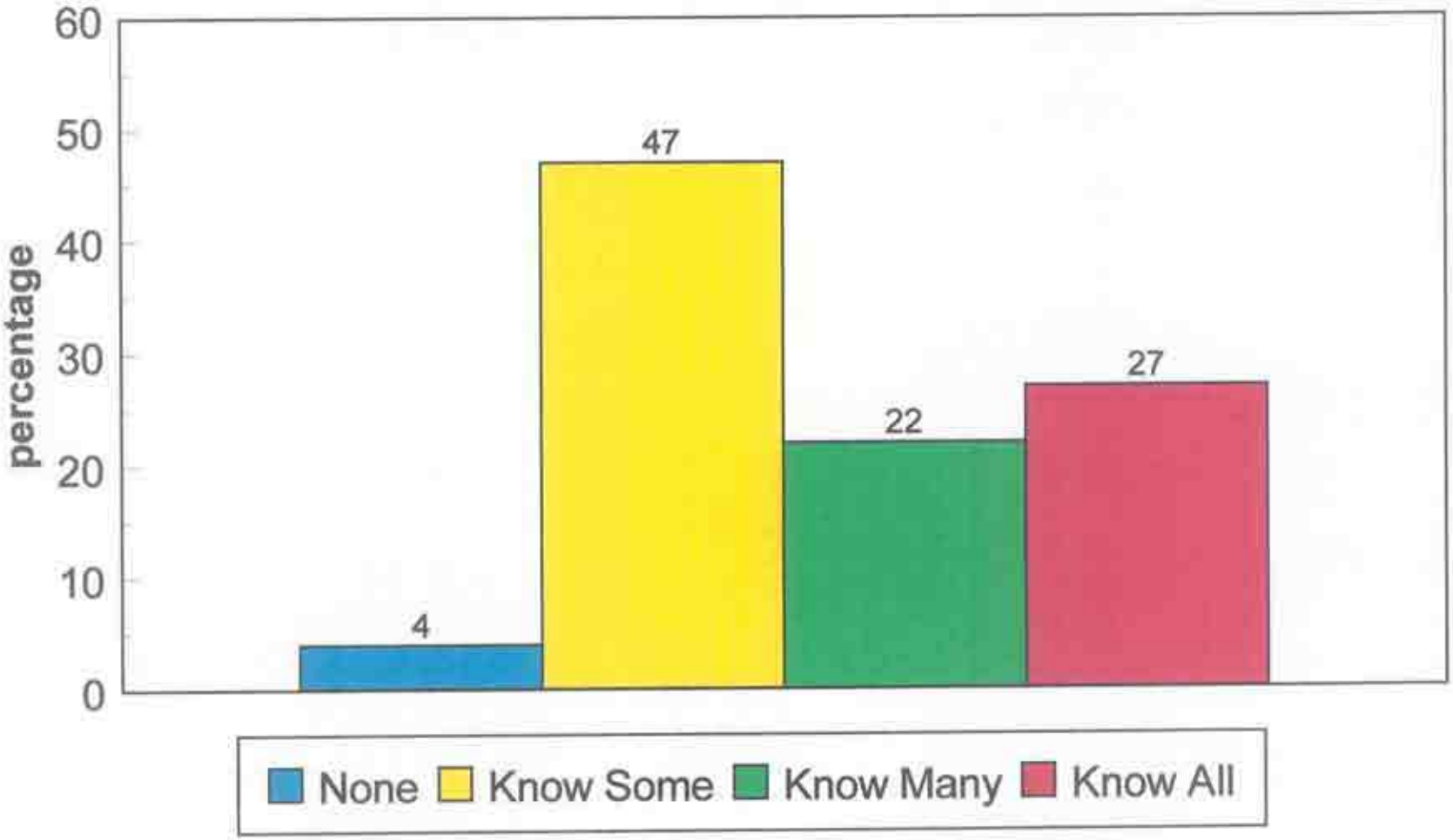
N=45

Mental Health Consumer Experience of Dedicated, Mixed and Integrated Housing

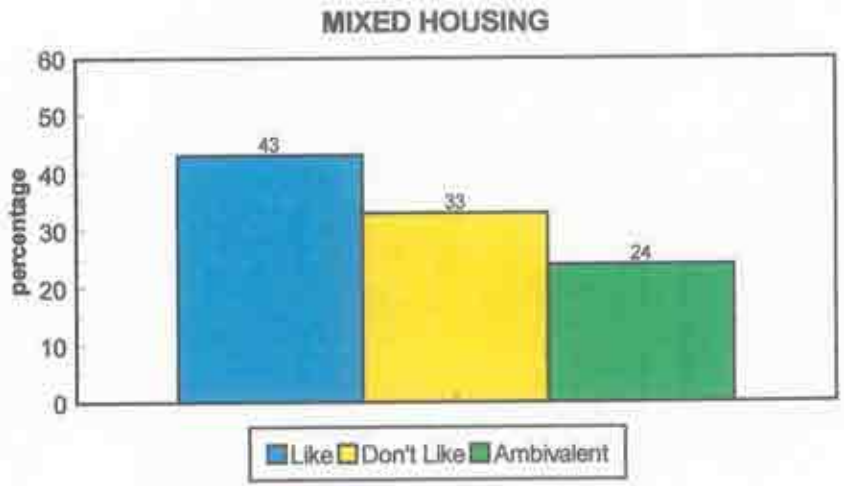


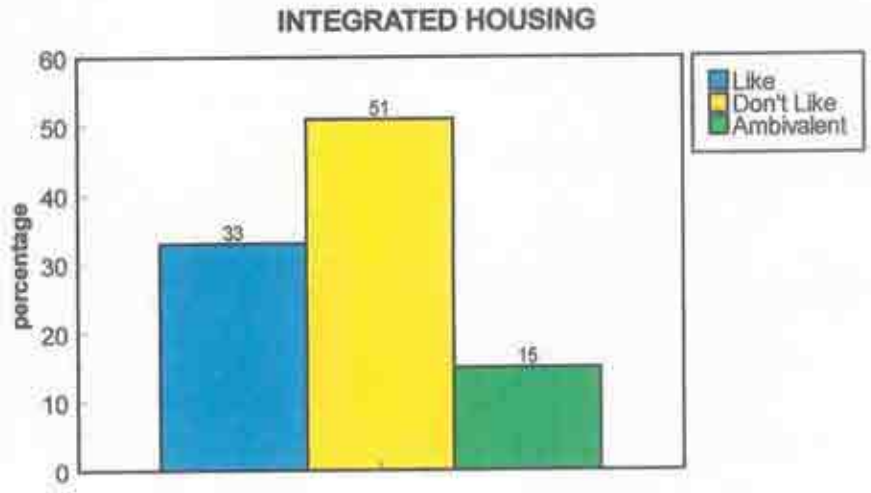


Knowledge of other Tenants in Building (Dedicated, Mixed and Integrated)

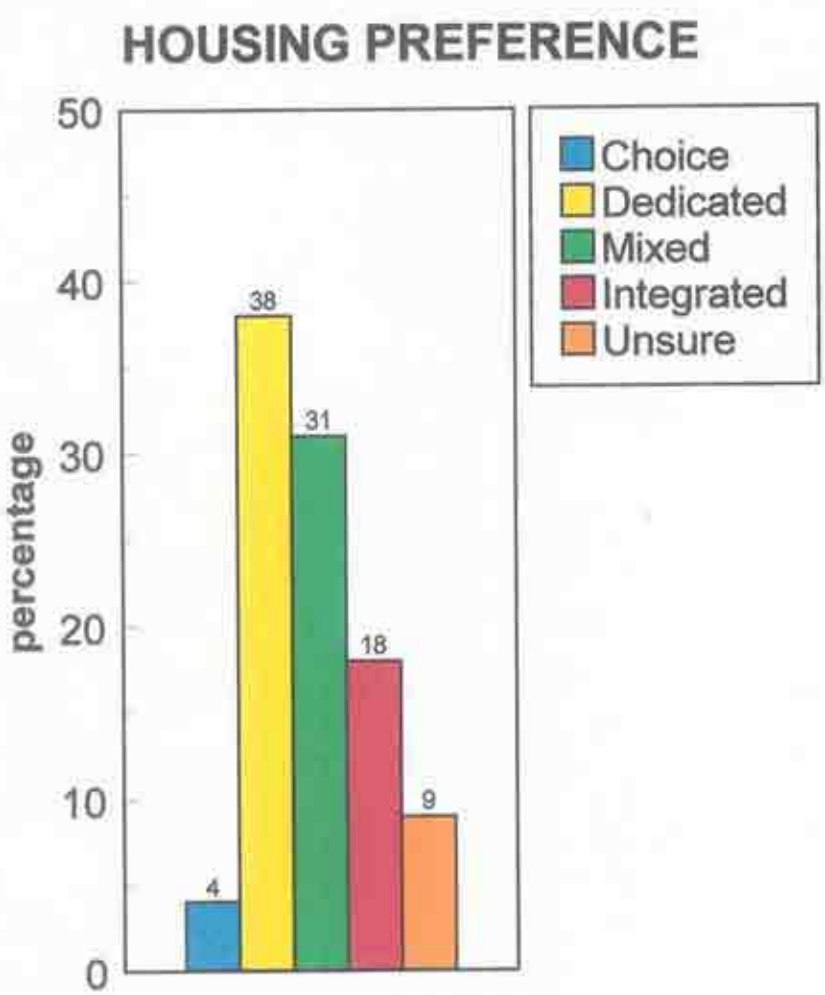


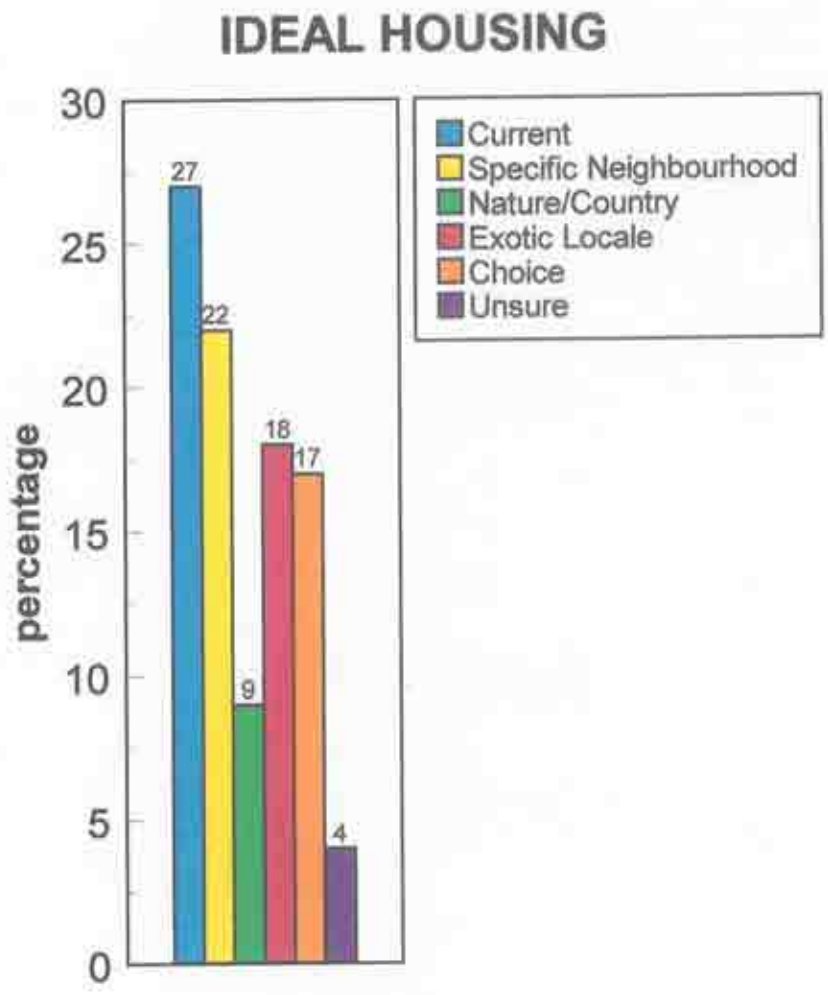
Consumer Feelings about Different Housing Types



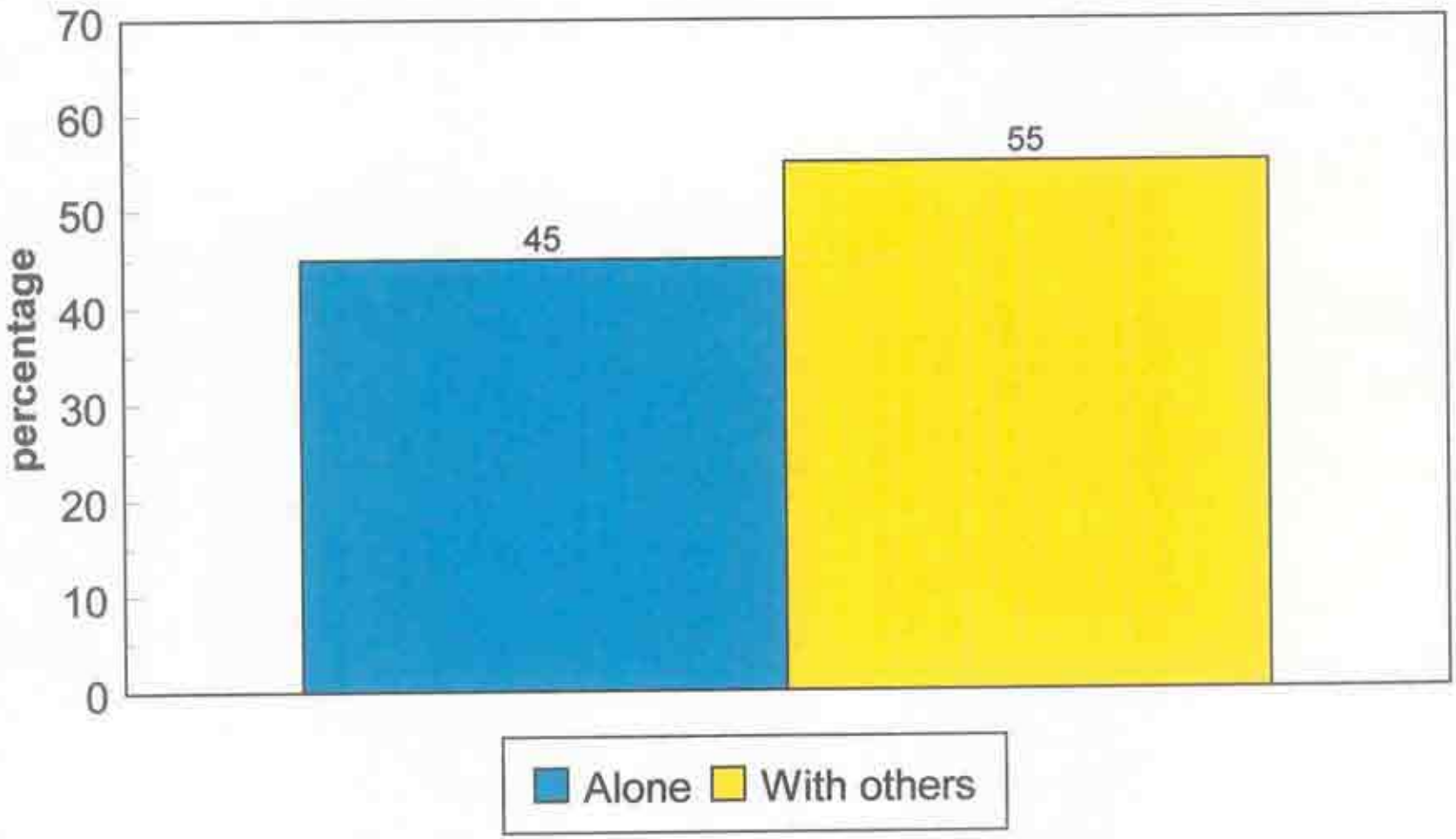


Consumer Housing Preferences and Ideals

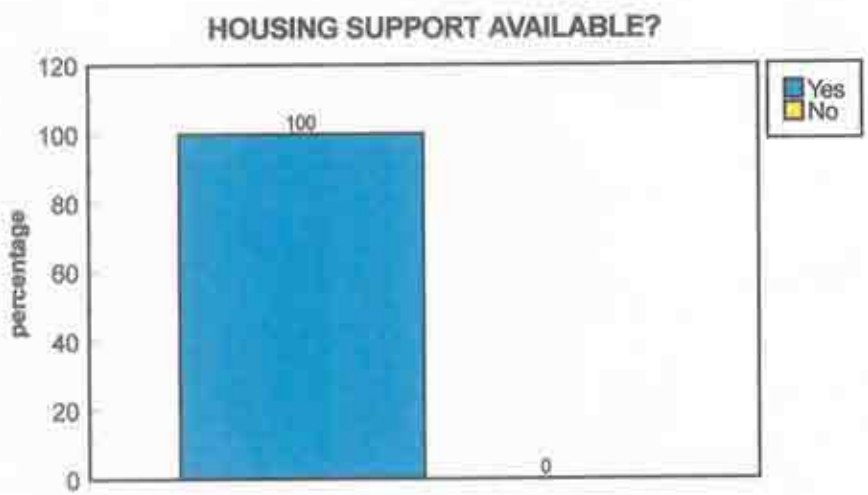


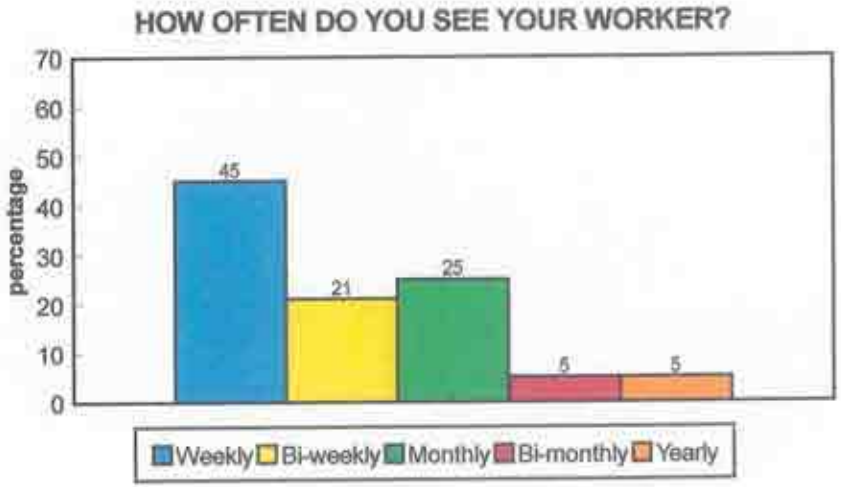


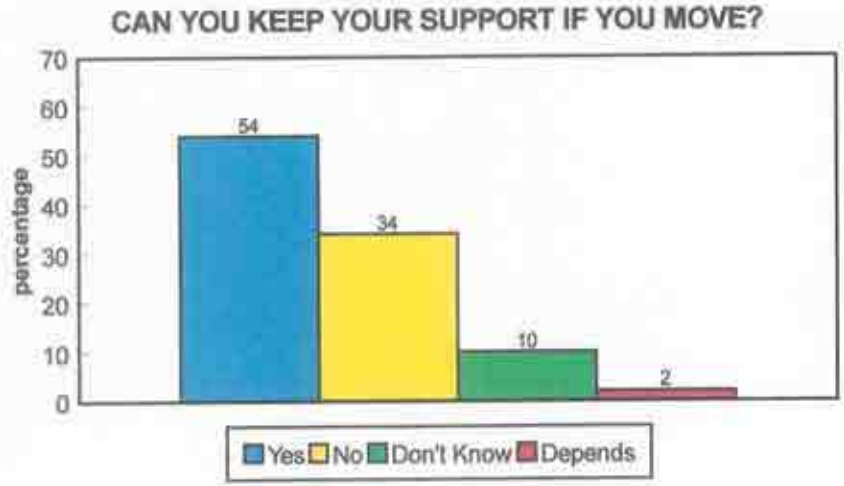
Consumer Living Preference

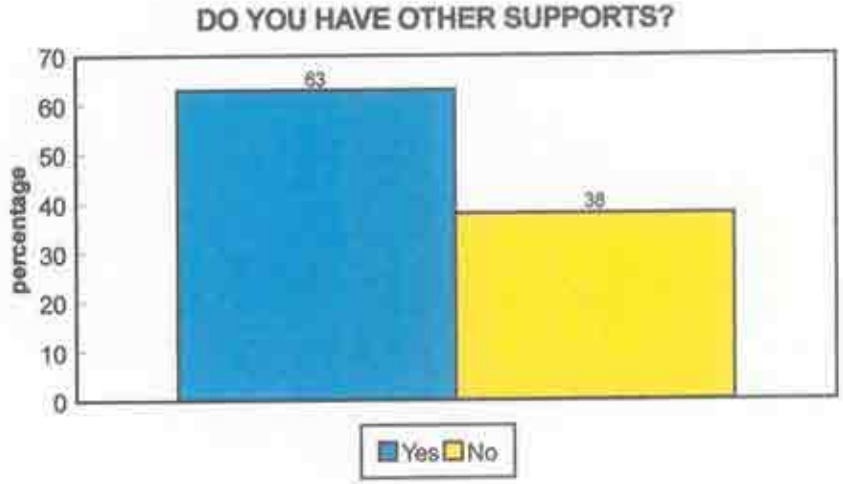


Housing Support (Dedicated, Mixed and Integrated)

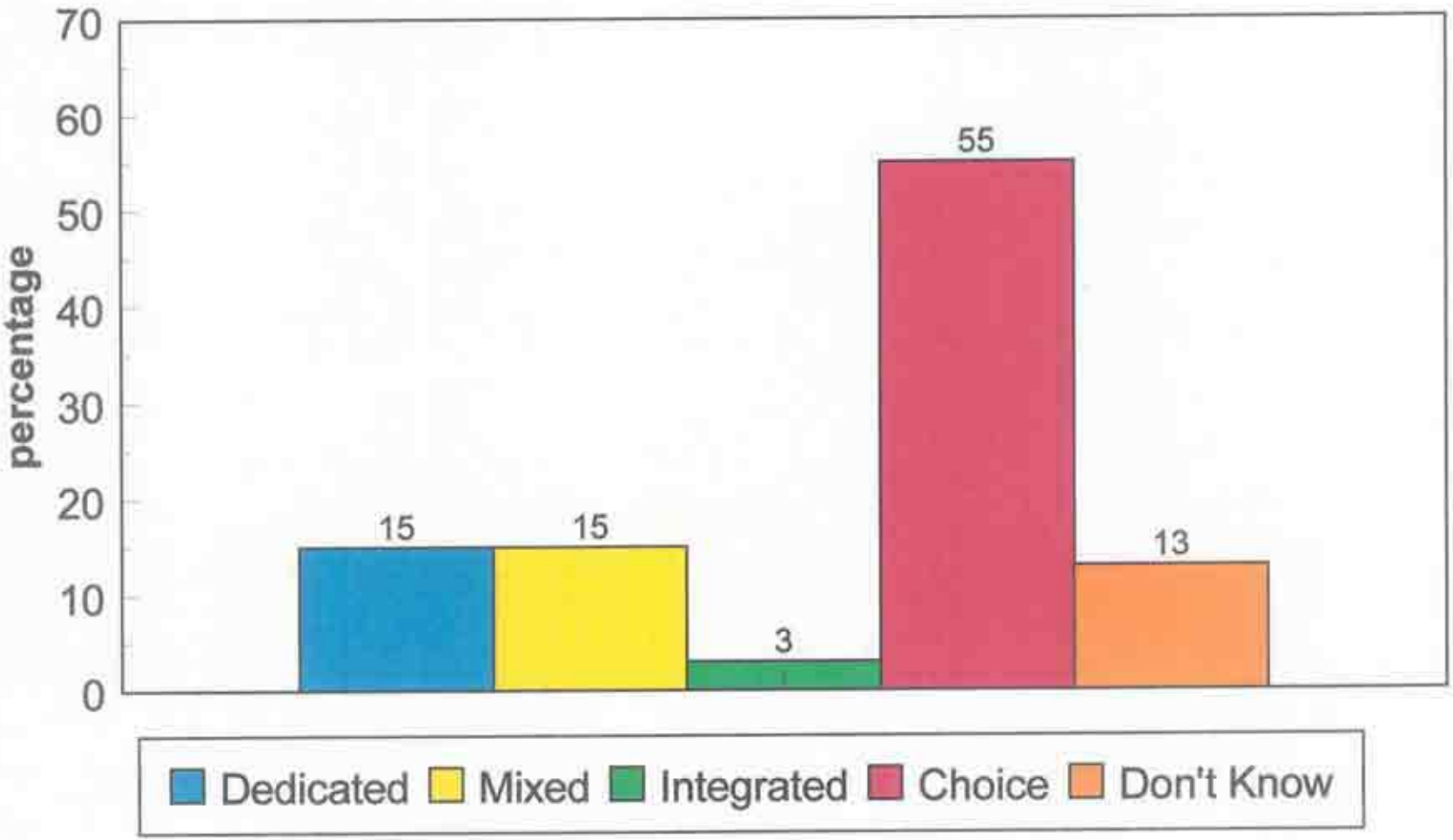






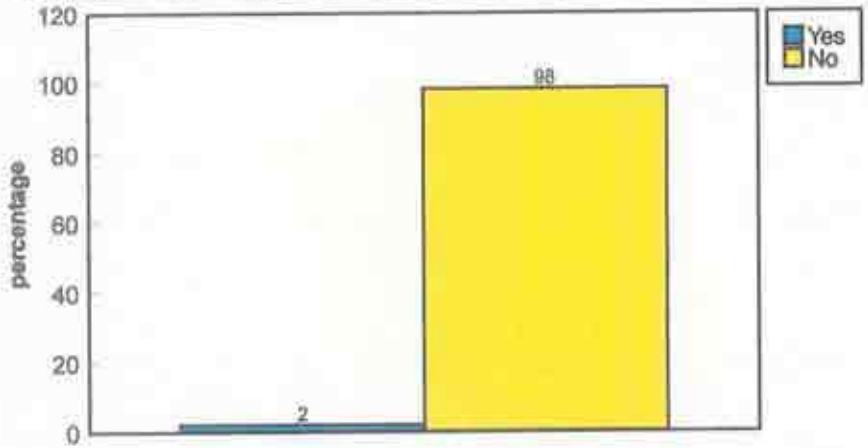


Where do you think is best for Consumers to live? (staff response)

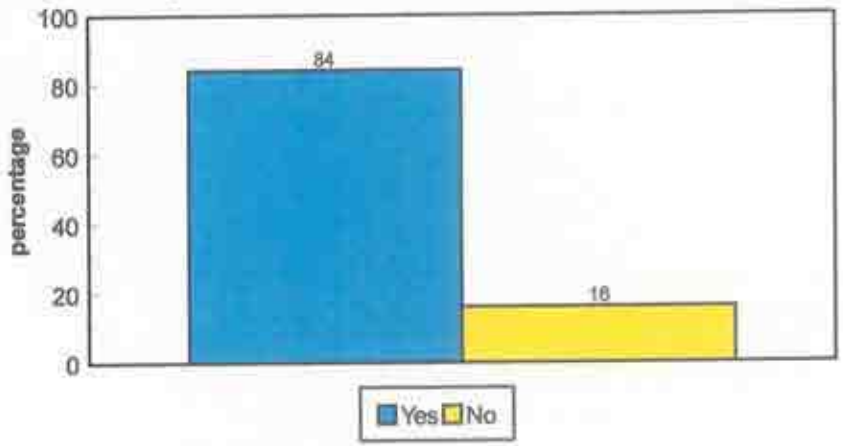


Consumer Housing Preferences (Dedicated, Mixed and Integrated)

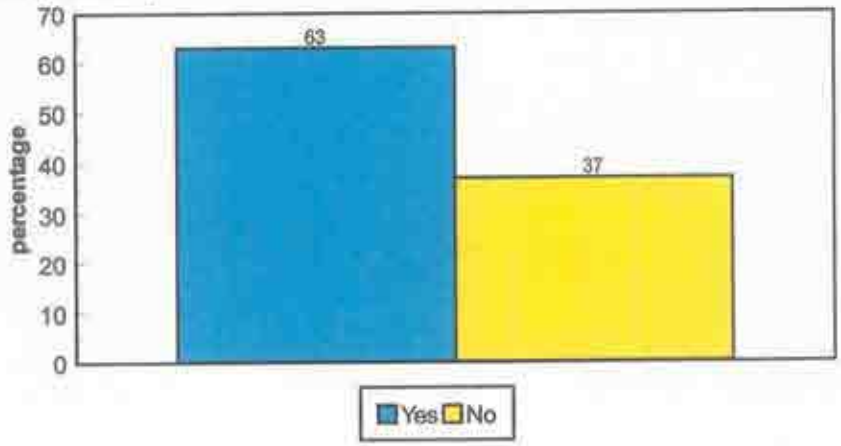
Do you prefer a particular housing type because you are a man or woman?



Do you base your decision on where to live with safety issues in mind?



Do you base your decision on where to live with isolation/loneliness in mind?



Length of Time in Current Housing

- Range: 1 -120 months
- Mean: 37 months (more than 3 years)
- Standard deviation: 31 months