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From Housing to Homes: A Review of the Literature on Housing Approaches for Psychiatric Consumers/Survivors

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FROM HOUSING TO HOMES: A REVIEW OF THE LITERATURE ON HOUSING APPROACHES FOR PSYCHIATRIC CONSUMER/SURVIVORS

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ABSTRACT

In this paper, we review the literature on housing for psychiatric consumer/survivors since the publication of the Nelson and Smith Fowler (1987) review more than a decade ago. First, we review research and propose a definition to contrast key features of three approaches to housing: (a) custodial, (b) supportive, and (c) supported. Second, we examine studies of the relationships between the characteristics of housing and adaptational outcomes for residents (e.g., personal empowerment). Third, we review studies which have examined out-comes for residents for these three different housing approaches. We conclude by critically reflecting on the values and research of the different approaches to housing, to make recommendations for future policy and planning, practice, and research.

Since the 1960s, there has been a gradual shift in housing ideology from a *custodial* approach to a *supportive* approach and, most recently, to a *supported* approach (Trainor, Morrell-Bellai, Ballantyne, & Boydell, 1993). However, much of the literature that has been produced regarding housing for psychiatric consumer/survivors has lacked clear practical definitions of the different housing approaches. Therefore, this review, which is an update of the literature published since the Nelson and Smith Fowler (1987) review just over 10 years ago, has four objectives: (a) to identify the underlying values and defining characteristics of custodial, supportive, and supported housing approaches, (b) to determine the relationships between the characteristics of housing and adaptational outcomes for residents, (c) to review studies which have examined outcomes for residents for these three different housing approaches, and (d) to make recommendations for future policy and planning, practice, and research.

THREE APPROACHES TO HOUSING FOR CONSUMER/SURVIVORS

The literature on housing has described the historical development and the characteristics of the three approaches. These key qualities are outlined in Table 1.

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TABLE 1

Key Qualities of the Three Approaches to Housing

Key dimensions	Type of housing		
	Custodial	**Supportive**	**Supported**
Underlying values	• Custodial care	• Rehabilitation	• Empowerment and community integration
Typical settings	• Board-and-care homes • Foster families	• Small group homes • Clustered apartments	• Cooperatives • Apartments
Location	• Predominantly inner-city	• Predominantly inner-city	• Anywhere
Characteristics of Residents	• All mental health consumer/survivors or people with disabilities • Residents are often quite dependent and have a lengthy history of mental health problems	• All mental health consumer/survivors • Residents are often oriented towards personal growth and have a short history of mental health problems	• Anyone, but often people with low-income • Residents vary in terms of their orientation towards personal growth and their history of mental health problems
Number of people living in setting	• Varies from small to large number of people with disabilities	• Typically small to medium number of consumer/survivors	• Typically a small number of people
Role of consumer/ survivor	• Patient/client	• Resident	• Tenant/citizen
Role of staff	• Care provider	• Rehabilitation agent	• Facilitator
Intervention orientation	• Deficit focus	• Focus on deficits and strengths	• Strengths focus
Potential for consumer/survivor empowerment	• Little choice over housing, living companions, and daily activities • Restrictive rules • Staff control	• Some choice over housing, living companions, and daily activities • Some rules • Shared control	• Considerable choice over housing, living companions, and daily activities • Few or no rules • Tenant control
Nature of support	• In-house staff support • Oriented toward care and dependency	• In-house staff and peer support • Oriented toward independence	• Staff support from outside • Support process controlled by tenant
Internal vs. external integration	• Internal integration	• Internal and external integration	• External integration
Stability	• Long-term	• Can be long-term, but is usually used for short term	• Long-term

Custodial Housing: The Medical Model in the Community

In the initial phases of deinstitutionalization, the predominant approach to housing for individuals with severe mental illness was custodial housing. The custodial approach was implemented through board-and-care homes, Homes for Special Care, foster families, single-room occupancy hotels, and nursing homes (Nelson & Smith Fowler, 1987; Trainor et al., 1993), which are mostly located in inner-city core areas (Taylor, Elliot, & Kearns, 1989) due to zoning regulations (Hall, Nelson, & Smith Fowler, 1987). Nelson and Earls (1986) found these settings to have twice as many housing concerns (i.e., odour, poor lighting, and condition of furniture) as supportive housing settings, although this was not confirmed in a subsequent study (Nelson, Hall, & Walsh-Bowers, 1997).

Wilson and Kouzi (1990) found the average size of board-and-care homes to be 17 residents, and Nelson et al. (1997) reported a similar number. However, some homes can be as small as four residents (Taylor et al., 1989). Additionally, quite often, the majority of residents of custodial settings have experienced a more severe and complicated history of mental illness that has resulted in more hospitalizations, higher levels of symptomatology, and lower functioning levels than residents of group homes or supportive apartments in the community (Goldstein, Dziobek, Clark, & Bassuk, 1990; Lehman, Possidente, & Hawker, 1986; Lehman, Slaughter, & Myers, 1991; Nelson, Hall, Squire, & Walsh-Bowers, 1992; Nelson et al., 1997, 1999; Segal & Kotler, 1993).

Consumer/survivors in custodial settings often have few instrumental roles. They are not involved in activities, chores, or rehabilitation, and they are expected to remain in the setting long-term. The role could be described as one of a "patient for life," because individuals are seen as too sick to contribute and only services to meet basic needs are provided (i.e., food, shelter, medication) (Trainor et al., 1993). The characteristics of support are truly custodial in nature, as they are usually limited to meals and shelter (Capponi, 1992; Nelson & Smith Fowler, 1987; Wilson & Kouzi, 1990). Staff may also be responsible for medication management and controlling and administering consumer/survivors' finances (Jacobson, 1992; Taylor et al., 1989; Trainor et al., 1993). Staff typically lack training in mental health rehabilitation and place very little emphasis on skills training or independence. The support provided to individuals in custodial settings is on-site, and depending on the facility, may be 24-hour care (Nagey, Fisher, & Tessler, 1988).

The intervention orientation in these settings focuses on deficits rather than strengths and, consequently, dependency is fostered (Capponi, 1992; Taylor et al., 1989; Trainor et al., 1993). Consumer/survivors cannot choose their housing or their roommates; they have little power or privacy; and they have fewer activities in which to participate, which is not conducive to empowerment (Nagey et al., 1988; Nelson et al., 1997; Trainor et al., 1993). Nelson et al. (1997) reported that residents of board-and-care homes live with many rules (regarding issues such as smoking, drinking, or visitors). The integration focus of the residences can be described as either internal or external. Segal and Aviram (1978) defined internal integration as the degree to which an individual accesses or participates in activities

within the residence, while external integration is the extent to which an individual accesses or participates in activities in the community. As Trainor et al. (1993) explained, residents in custodial settings are not assisted to learn to live outside the setting; therefore, the integration focus is internal. Aubry and Myner (1996) compared consumer/survivors (the majority of whom lived in board-and-care facilities) with non-consumer/survivor neighbours on measures of integration and found that the two groups differed on external integration (neighbours were more integrated externally), but not on internal integration. Acceptance into a custodial setting is typically for a long-term or permanent residence (Nagey et al., 1988; Segal & Liese, 1991).

Supportive Housing: The Residential Continuum Approach

The community treatment and rehabilitation school of thought began to emerge in the late 1960s out of a need for increased community services for individuals with serious mental illness (Anthony & Liberman, 1986), and it influenced the development of supportive housing. The supportive housing model is aimed at assisting individuals with serious mental illness to live in the community by providing life-skill development through community treatment and rehabilitation (Nelson, Walsh-Bowers, & Hall, 1998).

Supportive housing offers a continuum of residential facilities that provide supports ranging in staff support (i.e., high-support group homes, medium-support group homes, low-support supportive apartments) (Nelson, Hall, & Walsh-Bowers, 1995; Ridgway & Zipple, 1990b). Individuals are placed in the residential program at a level of support consistent with their current level of social functioning. As an individual's level of functioning changes, she/he moves on to other facilities that offer supports consistent with her/his current functioning level. Individuals are expected to graduate and stay in each setting for a time-limited period or until they improve functioning levels (Goldstein et al., 1990; Nelson, Hall, & Walsh-Bowers, 1995; Pyke & Lowe, 1996; Ridgway & Zipple, 1990b). However, some supportive organizations have shifted policy to allow residents to stay in the setting of their choice for as long as they want. A typical continuum may consist of a group home, half-way house, supportive apartments, and independent living (Nelson, Hall, & Walsh-Bowers, 1995). While a residential continuum may have a number of group homes with varying degrees of support, this diversity is rare (Ridgway & Zipple, 1990b). Group living settings are often restricted by zoning regulations to inner-city areas (Hall, Nelson, & Smith Fowler, 1987), while supportive apartments can be dispersed throughout the community (Ridgway & Zipple, 1990b).

Supportive housing environments limit services to individuals with a history of mental illness; moreover, individuals in a home usually exhibit similar levels of need for services (Ridgway & Zipple, 1990b). Residents often have to receive some type of out-patient treatment or rehabilitation to be admitted (Hodgins, Cyr, & Gaston, 1990). However, consumer/survivors in supportive apartments are more independent than individuals in group homes (Nelson et al., 1992; Nelson et al., 1997). A supportive group home may have an average of 6 to 12 residents (Goldstein et al., 1990; Nelson et al., 1997). Supportive apartments are smaller and may have only two or three residents (Nelson, Hall, & Walsh-Bowers, 1995). However, supportive apartments are often clustered together in one building, so that there

may be several apartments housing exclusively consumer/survivors in one building (Boydell & Everett, 1992; Hodgins et al., 1990; Nelson, Hall, & Walsh-Bowers, 1995). The number of house mates that an individual lives with decreases in accordance with increases in functioning. The goal of supportive housing is to reach the optimal level of independence whereby an individual will be able to live in her/his own apartment, or with one other person and receive flexible supports based upon individual need.

In supportive housing settings, the consumer/survivor has responsibilities (i.e., chores, activities), and he/she is seen as a resident needing supervision (Ridgway & Zipple, 1990b). The staff in supportive settings often play a rehabilitation role (Carling, 1993; Jacobson, 1992; Nelson, Walsh-Bowers, & Hall, 1998); however, staff training may be limited (Carling, 1993; Jacobson, 1992). Included in the rehabilitation role, staff may be responsible for supportive counselling, case management, social and life skills training, and a variety of other activities (Carling, 1993; Jacobson, 1992; McCarthy & Nelson, 1993). Staff and residents often share in the decision-making process (McCarthy & Nelson, 1993; Mowbray, Greenfield, & Freddolino, 1992). Placements of consumer/survivors in housing settings are made by staff as well (Ridgway & Zipple, 1990b). The possibility of moving to an independent setting, skill building, and staff consultation with consumer/survivors on some decisions provides opportunities to develop empowerment. The most restrictive settings provide the fewest opportunities for these positive experiences (Mowbray et al., 1992; Nelson, Hall, & Walsh-Bowers, 1995), whereas the least restrictive settings provide more freedom and control (McCarthy & Nelson, 1993; Ridgway & Zipple, 1990b).

Supportive housing settings vary in the intensity of support. Flexible support may be negotiated with individuals in more independent settings (Nelson, Hall, & Walsh-Bowers, 1995) to learn independent skills and become involved in outside activities (Nelson & Smith Fowler, 1987). However, the trend is to have standardized levels of assistance within group homes (Mowbray et al., 1992; Ridgway & Zipple, 1990b). Typically, support is provided in-house, but staff may be on call and not be present at the homes (Lord, Ochocka, Czarny, & MacGillivary, 1998). There is an intentional decrease in formal support as an individual progresses through the continuum, which is designed to foster independence (Carling, 1993; Nelson, Hall, & Walsh-Bowers, 1995; Ridgway & Zipple, 1990b). Given the group structure of the environments, peer support is encouraged as well (Boydell & Everett, 1992; Carling, 1993; Nelson, Hall, & Walsh-Bowers, 1995). Nelson et al. (1992) found consumer/survivors in group homes and supportive apartments had more friends and professionals providing support than individuals in board-and-care homes. Also, there is some evidence that individuals living in group homes have more support than individuals living independently or in supportive apartments (Nelson et al., 1992; Nelson et al., 1997; Pomeroy, Cook, & Benjafield, 1992).

Supported Housing: An Emerging Paradigm in Community Mental Health

Carling (1995) has proposed a new paradigm in housing in the 1990s in which there exists a person-centered focus of support, emphasizing self-help and natural supports and de-emphasizing professional services. With the use of this approach,

individuals can become settled and comfortable in their own homes, which they choose, and supportive relationships assist them to participate in their communities and access resources they desire (Nelson, Walsh-Bowers, & Hall, 1998). Empowerment is facilitated as consumer/survivors are assisted to "choose, get, and keep" non-segregated, stable, quality housing and supports that they want in the community (Carling, 1993; Nelson, Walsh-Bowers, & Hall, 1998; Ridgway & Zipple, 1990a, 1990b). Consumer/survivor control over decisions and involvement in management and organizational activities also encourages empowerment (Carling, 1993; Pyke & Lowe, 1996; Ridgway & Zipple, 1990b; Srebnik, Livingston, Gordon, & King, 1995).

The homes that consumer/survivors can afford are typically apartments, housing co-ops, or other government-funded social housing for low-income people (Church & Reville, 1989; Ridgway & Zipple, 1990b). However, because the consumer/survivor has choice, an individual may decide to live in a setting that is more characteristic of the supportive or custodial approaches (Ridgway & Zipple, 1990b). Homes can be widely dispersed in the community, so that consumer/survivors may choose locations that are close to friends, family, activities, stores, services, school, or work (Hogan & Carling, 1992; Ridgway & Zipple, 1990b). Chosen locations are usually close to community resources and they blend into neighborhoods that are accepting (Carling, 1990, 1993; Sohng, 1996). Individuals typically choose to live on their own or in pairs (Carling, 1990, 1995). Consistent with consumer preferences, support-providers should attempt to provide options for apartments where the number of consumer/survivors does not exceed a normal ratio of consumer/survivors to other tenants (Hogan & Carling, 1992). The supported housing approach makes a shift from resident to community member with normal tenant and social roles and with rights for community participation (Carling, 1993; Ridgway & Zipple, 1990b).

Individuals who vary in functioning level, illness, and resources can acquire homes through supported housing, and receiving treatment is not a requirement (Carling, 1993; Ridgway & Zipple, 1990a). Although supports often assist someone to stay in her/his home, individuals vary in their desire and request for support (Carling, 1993). The staff in supported housing organizations act as facilitators to help individuals choose, acquire, and maintain their homes (Ridgway & Zipple, 1990b). The roles of landlord and support provider have to be separated (Pyke & Lowe, 1996). In addition to requested support and rehabilitation provision, staff also typically play the roles of advocate, community educator, resource developer, community organizer, and networker (Carling, 1993; Hogan & Carling, 1992; Ridgway & Zipple, 1990a).

The supported housing approach is oriented to strengths (Ridgway & Zipple, 1990a). Staff have shifted their attitudes from "I know what's best" to "How can I best assist?" (Pyke & Lowe, 1996, p. 8). Services are not forced on consumer/survivors if they do not feel they require them. As housing and support are "delinked" in supported housing, the individual can choose to receive support in the home or community (Ridgway & Zipple, 1990a, 1990b).

Support is individualized and flexible, as determined by the consumer/survivor, and available for as long as requested (Hogan & Carling, 1992; Ridgway

& Zipple, 1990a, 1990b; Sohng, 1996). However, the support available is often less than in group home or custodial settings, which can lead to feelings of isolation (Carling, 1993; Nelson et al., 1997; Sohng, 1996). When providing individual support, staff try to facilitate connections with generic services in the community (in vivo learning environments, self-help groups, and informal supports) which, coupled with normal housing, contribute to external integration (Ridgway & Zipple, 1990a, 1990b; Sohng, 1996). The staff are trained to formulate options, encourage decision-making, and most of all, value the choices of the consumer/survivors. At times, staff may not agree with consumer/survivors' decisions and they may help individuals weigh consequences, but staff cannot make decisions for consumer/survivors (Srebnik et al., 1995). A supported housing program may also make flexible funds available to support moving and start-up costs (Carling, 1993). The length of time a tenant stays in a home obtained through supported housing is determined by the consumer/survivor (Carling, 1990). As well, the services or supports are not time limited so, if needed and requested, individuals can continue to receive supports even if they relocate (Hogan & Carling, 1992).

Summary and Proposed Definition of the Three Types of Housing

Although a descriptive outline has been given for each approach, a practical definition is still required in order to allow for accurate categorization of each housing approach. In the literature, there exists considerable confusion about what constitutes supported housing (Ogilvie, 1998). The practical definition that we are proposing to differentiate the three different types of housing approaches consists of three basic criteria: (a) the profit orientation of the support-provider, (b) the nature and terms of support provided, and (c) the degree of consumer/survivor empowerment (choice and decision-making control). While the three types of housing *may* differ in terms of the qualities outlined in Table 1, the criteria outlined in Table 2 are the key defining characteristics of the three types of housing.

First, the profit orientation of the support-provider refers to whether the support-provider is in the private market. For-profit situations include those in which the landlord and/or staff are in the private market. Non-profit situations include those in which the staff are paid by a non-profit agency, which is typically government-funded. Custodial housing is in the private market, while supportive and supported housing are not for-profit.

Second, support refers to the services that are provided to consumer/survivors and how the services are provided. We make a distinction between *care services* and *rehabilitation services*. Care services involve "doing for" consumer/survivors to meet their basic needs. Such services include maintenance and household issues such as meals, cleaning, and dispensing medications. Rehabilitation services, in contrast, involve "doing with" consumer/survivors and are designed to promote the personal empowerment and community integration of consumer/survivors. Such services include supportive counselling, life and social skills training, crisis intervention, etc. In custodial housing, care services are provided, while rehabilitation services may be provided by some organization from outside of the setting. In supportive housing, residents accept rehabilitation services from staff, either from inside or outside of the setting, as a basic condition of residence. However, in

supported housing, residents choose the nature and frequency of support from outside staff.

The third component, the degree of consumer/survivor empowerment, refers to the degree of choice and control that consumer/survivors have over the type of housing, who their living companions are, the support they receive, and decision-making within their housing. In custodial housing, consumer/survivors have little control; in supportive housing, consumer/survivors and staff make most decisions together; and in supported housing, consumer/survivors have complete control over all decisions and issues regarding their housing.

TABLE 2
Defining Characteristics of the Three Approaches to Housing

	Type of housing		
Defining characteristics	**Custodial**	**Supportive**	**Supported**
Profit orientation of the support-provider	• Support-provider offers housing as a for-profit business	• Support is provided by a non-profit agency	• Support is provided by a non-profit agency
Nature and terms of support provided	• In-house staff provides care services (e.g., meals, cleaning, medication) • Rehabilitation services (e.g., life-skills training, social-skills training, supportive counselling, encouragement of outside activities) may be provided by staff from outside the setting	• Consumer/survivors accept rehabilitation services (e.g., life-skills training, social-skills training, supportive counselling, encouragement of outside activities) as a condition of housing • Rehabilitation services may be provided by in-house staff or staff from outside the setting	• Staff from outside the setting may provide rehabilitation services (e.g., life-skills training, social-skills training, supportive counselling, encouragement of outside activities) as requested or chosen by individual residents • Rehabilitation services provided are individualized and tailored to each person
Degree of consumer/survivor empowerment (choice and decision-making)	• Consumer/survivors have little choice over the type of housing, who their living companions are, or the support they receive • Staff have control over most of the decisions in the residence	• Consumer/survivors have little choice over the type of housing, who their living compaions are, or the support they receive • Staff and consumer/survivors make most decisions together	• Consumer/survivors have complete control over the type of housing, who their living companions are, and the support they receive • Consumer/survivors have control over all decisions regarding their housing

RELATIONSHIP OF HOUSING AND SUPPORT CHARACTERISTICS TO ADAPTATIONAL OUTCOMES FOR CONSUMER/SERVIVORS

The literature on housing for psychiatric consumer/survivors includes correlational research, which examines the links between housing and support characteristics with adaptational outcomes for consumer/survivors (e.g., personal empowerment, community integration). Our focus is on research published since the Nelson and Smith Fowler (1987) review. The findings in the following section are from research conducted primarily in the United States and Canada (mostly Ontario).

Social Networks and Social Support

According to Hall and Nelson (1996), a social network refers "to the structural aspects of a person's support system, such as the number and type of network members, while 'social support' refers to the functional aspects of a network, including the various types of support that are received and given" (p. 1743). Early research reviewed by Nelson and Smith Fowler (1987) suggested that social networks and social support may be important qualities of community living for the adaptation of consumer/survivors. More recent studies of the social networks of consumer/survivors residing in supportive housing have found that, while total network size is unrelated to well-being (Earls & Nelson, 1988) and support satisfaction (Goering, Durbin, Foster, Boyles, Babiak, & Lancee, 1992), the sizes of one's peer, friendship, and living companion networks are directly related to well-being (Hall & Nelson, 1996; Nelson, Hall, & Walsh-Bowers, 1998) and support satisfaction (Goering et al., 1992). Having peers or friends may provide opportunities for mutual support and socialization, which may promote well-being.

Several studies of the social support of consumer/survivors in supportive housing have consistently found that the frequency of receipt of emotional and problem-solving support are directly related to emotional well-being (Earls & Nelson, 1988; Hall & Nelson, 1996; Kennedy, 1989; Nelson et al., 1992; Nelson et al., 1999; Nelson, Wiltshire, Hall, Peirson, & Walsh-Bowers, 1995), life satisfaction (McCarthy & Nelson, 1991; Nelson, Wiltshire et al., 1995), community integration (Hall & Nelson, 1996; Kennedy, 1989; Moxley, 1988; Nelson et al., 1992), and perceptions of personal control (Nelson et al., 1999; Nelson, Wiltshire et al., 1995). Also, measures of negative social interactions (e.g., emotional abuse, advice to avoid problems) have been found to be directly related to measures of negative affect (Hall & Nelson, 1996; Nelson, Wiltshire et al., 1995; Nelson et al., 1992; Nelson et al., 1999).

The aforementioned findings describing the relationship between social support and adaptational outcomes are examples of main effects that have been replicated several times. According to the stress-buffering hypothesis, social support can also interact with life stressors to buffer the impact of such stressors on well-being. In this regard, Earls and Nelson (1988) examined the interaction between housing concerns and social support on well-being in a sample of consumer/survivors. Consistent with the stress-buffering hypothesis, they found significant interactions between housing concerns and support on well-being.

Physical Qualities of the Housing

There is abundant variation in the physical qualities of housing for psychiatric consumer/survivors. Consistent with the earlier review by Nelson and Smith Fowler (1987), recent large, multi-site research projects have found that the larger and less individualized the setting, the lower the level of consumer/survivor independence (Nagey et al., 1988; Nelson, Hall, & Walsh-Bowers, 1998).

The housing concerns that may be present in the homes of consumer/survivors are many (e.g., odour, noise, condition of furniture) (Earls & Nelson, 1988). Such housing concerns reflect the physical qualities and aesthetic appeal of housing. Capponi's (1992) personal story of life in a boarding home describes these problems in vivid detail. Several studies consistently have found that housing concerns are negatively correlated with satisfaction with housing, satisfaction of basic needs, and total life satisfaction (Lehman, Possidente, & Hawker, 1986; Nelson, Wiltshire et al., 1995), and are positively correlated with negative affect (Earls & Nelson, 1988). In addition to these cross-sectional studies, longitudinal research has found that housing concerns predicted consumer/survivors' negative affect one year later (Nelson, Hall, & Walsh-Bowers, 1998), and that housing problems were associated with an increase in maladaptive behaviour nine months later (Baker & Douglas, 1990).

Privacy is another important dimension of the physical quality of housing. In the previously mentioned longitudinal study, Nelson, Hall, and Walsh-Bowers (1998) found that having to share a room was directly related to negative affect one year later. Qualitative studies also have found that lack of privacy is a concern expressed by consumer/survivors in group living conditions (McCarthy & Nelson, 1993; Nelson, Wiltshire et al., 1995).

Location

The location of a residence or home has been found to be related to the adaptation of consumer/survivors in two cross-sectional studies (Aubry & Myner, 1996; Goldstein et al., 1990) and one longitudinal study (Taylor et al., 1989). Housing settings that were physically integrated in the community so that they were not identifiable as residences for consumer/survivors were directly associated with social integration, which was likely due to decreased stigma and social isolation (Aubry & Myner, 1996). Goldstein et al. (1990) reported a direct link between stable, permanent housing scattered in the community with meaningful performance accomplishments or successes in independent living. As well, locations that are not consumer/survivors' choice because they preferred to be living independently in the community have been found to be positively related to mobility (Taylor et al., 1989). The same study reported depression due to residents living in locations they did not prefer.

Resident Control and Choice

Several studies have examined the impact of resident control over decision-making within housing settings and staff management style on adaptational outcomes. Resident control has been found to be directly associated with various domains of life satisfaction (McCarthy & Nelson, 1991), independent functioning

(McCarthy & Nelson, 1991; Nelson, Hall, & Walsh-Bowers, 1998), and perceptions of control (Nelson et al., 1999). Similarly, a democratic management style, not authoritarian and permissive styles, was directly associated with various domains of life satisfaction (McCarthy & Nelson, 1991) and perceptions of control (Nelson, Wiltshire et al., 1995; Nelson et al., 1999), while a permissive management style has been found to be inversely related to independent functioning (Nelson, Hall, & Walsh-Bowers, 1995).

Research on resident choice is limited. A longitudinal study found that having a range of housing options was positively related to housing satisfaction and appropriateness of housing match with consumer/survivor needs (Srebnik et al., 1995). Individuals who were not pressured from others and had more information regarding choices had better housing stability and higher ratings of happiness and life satisfaction (Srebnik et al., 1995).

Summary

One of the limitations of the correlational research reviewed in this section is that it cannot establish causal relationships between housing qualities and outcomes for consumer/survivors. However, longitudinal studies which control for demographic variables and initial levels of adaptation (e.g., Baker & Douglas, 1990; Nelson, Hall, & Walsh-Bowers, 1998) can suggest possible causal relationships. In the next section, we review recent experimental and quasi-experimental studies of different types of housing, which examine changes in consumer/survivor outcomes over time. Such studies can provide evidence of causal relationships.

OUTCOME RESEARCH: THE EFFECTIVENESS OF THE THREE HOUSING APPROACHES

In this section, we briefly review outcome research completed subsequent to the earlier review by Nelson and Smith Fowler (1987). Studies using experimental or quasi-experimental longitudinal designs are reviewed for custodial settings, group living situations, supportive apartments, and supported housing. We also reviewed some longitudinal studies, which did not employ any type of comparison group.

Custodial Housing

In their earlier review, Nelson and Smith Fowler (1987) did not report research demonstrating beneficial impacts of custodial housing on the adaptation of consumer/survivors. In the decade since their review, there has not been a great deal of outcome research on custodial facilities for consumer/survivors. While such facilities are still numerous, they have generally fallen out of favour with mental health professionals and consumer/survivors. This may account for the lack of research on such settings.

The only outcome study on such facilities that we located included a 10-year follow-up of 360 residents of sheltered care in the United States (Segal & Holschuh, 1991; Segal & Kotler, 1993). While this study did not use a control or comparison group, it is quite impressive in terms of the large sample size and the

fact that there was an attrition rate of only 8% over the 10-year follow-up period. Segal and Kotler (1993) found the number of days residents spent in hospitals had decreased compared to prior years, but they experienced poorer health and more symptoms, had reduced levels of independent social functioning and family contact, and they reported no significant changes in external or assisted social interactions. Moreover, compared to the general population, the mortality rate of the individuals in these settings was 2.85 times higher and 3.9 times higher for young residents.

Supportive Housing

Group living situations. Nelson and Smith Fowler (1987) reported studies that found halfway houses and group treatment facilities to foster reduced rehospitalization rates and increased employment in their residents as compared to hospital or board-and-care control groups. They also found some evidence of increased participation, self-respect, self-concept, independent functioning, social support, and involvement in leisure activities, as well as decreased medication use and treatment use for consumer/survivors living in such settings. Subsequent studies on group living situations have replicated these results and identified additional positive outcomes.

In the past decade, there have been a few studies of group living facilities that assessed individuals at different times, but which did not employ a control or comparison group (Hawthorne, Fals-Stewart, & Lohr, 1994; Leff, Thornicroft, Coxhead, & Crawford, 1994; Leff, Trieman, & Gooch, 1996; McCarthy & Nelson, 1991, 1993; Okin, Borus, Baer, & Jones, 1995; Okin & Pearsall, 1993) and a few studies that did employ some type of control or comparison group (Bond et al., 1989; Lipton, Nutt, & Sabatani, 1988; Nelson et al., 1997; Wherley & Bisgaard, 1987). Although there are quite a few methodologically weak studies with no comparison group and no randomized designs, the results of these studies have replicated findings of studies which have used control or comparison groups. This research has been conducted in Canada, Great Britain, and the United States.

These studies indicated that residents of group living situations have experienced increases in housing and financial stability (Bond et al., 1989), instrumental roles, independent functioning (Hawthorne et al., 1994; McCarthy & Nelson, 1991; Nelson et al., 1997), self-esteem, social skills, competence in daily living skills (McCarthy & Nelson, 1993), vocational functioning (Wherley & Bisgaard, 1987), social networks, capacity to meet basic needs (Leff et al., 1994; Leff et al., 1996; Okin & Pearsall, 1993), cognitive and social functioning (Hawthorne et al., 1994; Okin et al., 1995), quality of life (Lipton et al., 1988; Okin & Pearsall, 1993), reduced numbers of days spent in hospitals, reduced hospitalization rates, and fewer symptoms (Bond et al., 1989; Hawthorne et al., 1994; Leff et al., 1994; Leff et al., 1996; Lipton et al., 1988; McCarthy & Nelson, 1991). Lipton et al. (1988) also reported that significant numbers of participants discharged to group living had increased likelihood of moving on to permanent housing and reduced numbers of nights spent homeless.

Supportive apartments. Outcome research on supportive apartments is relatively new, as Nelson and Smith Fowler (1987) reported only one evaluation in

their review. Two longitudinal studies without a comparison group (Boydell & Everett, 1992; Nelson, Hall, & Walsh-Bowers, 1995) and two longitudinal studies with a comparison group (Hodgins et al., 1990; Nelson et al., 1997), all conducted in Canada, have examined the impacts of supportive apartments. Except for the study by Hodgins et al. (1990), each of these studies has small sample sizes and only one employed a comparison group (Nelson et al., 1997). Moreover, in the Hodgins et al. study, it is not clear that individuals in supportive apartments had any better situations than people in the comparison group.

Living in a supportive apartment has been found to lead to increases in independent functioning (Boydell & Everett, 1992; Nelson, Hall, & Walsh-Bowers, 1995; Nelson et al., 1997), practical skills (Boydell & Everett, 1992), instrumental roles in the community (Nelson, Hall, & Walsh-Bowers, 1995; Nelson et al., 1997), health, positive emotions, self-esteem (Nelson, Hall, & Walsh-Bowers, 1995), and understanding of feelings and personal problems (Boydell & Everett, 1992), and decreases in needs for staff services (Boydell & Everett, 1992). On the other hand, Hodgins et al. (1990) discovered increased thought disorder in participants in supportive apartments. However, compared to a group of participants living independently, apartment residents did not differ in hospitalizations, stress, social support, employment, or use of health and social services. Studies of consumer/survivors residing in supportive apartments have reported changed relationships with family and both positive and negative experiences in relationships with roommates (Nelson, Hall, & Walsh-Bowers, 1995; Nelson et al., 1997).

Supported Housing

Outcome studies of supported housing are relatively new (Ridgway & Rapp, 1997), as there were no evaluations of this approach that were covered in the earlier review by Nelson and Smith Fowler (1987). Each of the studies reviewed in this section was conducted in the United States. The most common findings are that supported housing programs increase resident stability and independent living (Depp et al., 1986; Dixon, Friedman, & Lehman, 1993; Hurlburt, Wood, & Hough, 1996; Newman, Reschovsky, Kaneda, & Hendrick, 1994). The stability of supported housing has contributed to reduced homelessness (Dixon et al., 1993; Hurlburt et al., 1996). Hurlburt et al. (1996) conducted the most sophisticated study of supported housing in terms of research design. A total of 362 homeless mentally ill persons were randomly assigned to one of four conditions in a completely crossed design (case management and a housing subsidy were the independent variables). Several other supported housing studies also utilized comparison groups (Brown, Ridgway, Anthony, & Rogers, 1991; Depp et al., 1986; Dixon, Krauss, Myers, & Lehman, 1994; Champney & Dzurec, 1992).

Living in a home found through supported housing has been shown to lead to reductions in hospitalization rates (Brown et al., 1991; Burek, Toprac, & Olsen, 1996) and symptoms (Dixon et al., 1994). Reports of changes in other adaptational outcomes have been mixed. Depp et al. (1986) found no differences between supported housing participants and non-participants on measures of housing satisfaction, social network composition, and community integration. However, Champney and Dzurec (1992) found resident satisfaction to increase after 10

months in the housing and residents were more satisfied if they had a housing subsidy. As well, Newman et al. (1994) found service gaps and neighbourhood problems decreased over time.

Satisfaction with and stability in housing are associated with access to housing subsidies (Champney & Dzurec, 1992; Hurlburt et al., 1996; Newman et al., 1994) and consumer/survivor choice and control (Newman et al., 1994). These ingredients allow consumer/survivors to select affordable housing with better physical conditions (Newman et al., 1994). The use of effective case management (which includes small caseloads and thus consistent availability of support workers to directly assist consumer/survivors) has not been shown to affect residential stability (Champney & Dzurec, 1992; Hurlburt et al., 1996).

There are two limitations to the supported housing approach that have been identified. One pertains to problems of isolation and loneliness (Champney & Dzurec, 1992; Depp et al., 1986; Pulice, McCormick, & Dewees, 1995). The second is that there is currently more evidence of increased employment for individuals involved in supportive housing than supported housing. In the supported housing studies reviewed, only Burek et al. (1996) examined employment, and they found that the majority of residents wanted work upon entry to supported housing, but only a minority obtained employment. Thus, although there are several benefits to supported housing, there needs to be further attention to the employment and social support needs of consumer/survivors involved in supported housing.

CRITICAL REFLECTIONS ON THE LITERATURE AND RECOMMENDATIONS FOR POLICY AND PLANNING, PRACTICE, AND RESEARCH

In this section, we critically reflect on the state of the literature and make recommendations for future policy and planning, practice, and research.

Policy and Planning

While some of the research on housing is methodologically weak, the best controlled studies tell us that providing homes through the supported housing approach is the best strategy (Brown et al., 1991; Dixon et al., 1994; Champney & Dzurec, 1992; Hurlburt et al., 1996). Each level of government should take responsibility to create policies that support housing as a basic human right with the stipulation that all individuals should have permanent "homes" (Carling, 1995), not simply shelter or housing programs. This trend is consistent with innovations in housing for people with other disabilities, such as the independent living movement for people with physical disabilities (Hutchison et al., 1997). Permanent housing options are an investment community advocates should be presenting to funding agencies and government to increase as an alternative to custodial care, as no evidence exists that custodial options offer any benefits to consumer/survivors. In fact, Segal and Kotler (1993) found that adaptation actually deteriorated for residents who had lived in custodial settings for 10 years. Custodial housing, which now constitutes much of the housing for consumer/survivors, should be phased out and replaced with more beneficial supported housing options.

Different stakeholder groups should be pushing governments to increase access to permanent homes through rent supplements for all consumer/survivors. Methodologically strong research on supported housing has reported decreased housing problems and increased residential stability and satisfaction for individuals with housing subsidies (Hurlbert et al., 1996; Newman et al., 1994). Although supportive apartments restrict consumer/survivors' choice over living companions (they must live with other consumer/survivors) and they can be segregating, they represent a close approximation to supported housing in most respects (Nelson, Hall, & Walsh-Bowers, 1995). Moreover, while the research on supportive apartments is scant and what is available suffers from methodological weaknesses, favourable outcomes have been reported thus far (Boydell & Everett, 1992; Nelson, Hall, & Walsh-Bowers, 1995; Nelson et al., 1997). Finally, the return of government support for resources for social housing is required to increase the amount of housing options for all low-income groups. The resources should be allotted to the development of more co-ops and independent settings.

Correlational research points to the importance of ensuring that any funding that is invested for housing by government, foundations, or communities should include policy guidelines that homes are small and unsegregated (Nagey et al., 1988; Nelson, Hall, & Walsh-Bowers, 1998), have flexible, off-site support (Ridgway & Zipple, 1990b), and maximize consumer/survivors' control and choice (Srebnik et al., 1995). As well, these policies should include requirements for organizations to include consumer/survivors at all levels of policy, planning, implementation, and evaluation (Carling, 1993; Pyke & Lowe, 1996).

The recommended emphasis for permanent homes with the aforementioned priorities should represent the majority of housing in the community, but some short-term rehabilitation settings may be needed for some individuals. Currently, most crisis intervention and short-term care are provided by hospital psychiatric services when an individual is in the acute stages of a mental illness. As far back as Kiesler's (1982) review of alternatives to hospitalization, research has shown that a variety of community-based alternatives are more cost-effective than hospitalization and these settings can be viable alternatives to hospitalization for crisis intervention and short-term rehabilitation.

Several of the methodologically stronger studies on group living situations that we reviewed showed that the beneficial impacts of such rehabilitation-oriented settings can be achieved in the short-term (from a few months to a year) (Bond et al., 1989; Lipton et al., 1988; Nelson et al., 1997; Wherley & Bisgaard, 1987). We think short-term group living could be one option for consumer/survivors, but we make this recommendation with two stipulations. First, support providers should ensure that consumer/survivors are able to choose whether or not they want group living; it should not be presented as the only choice. Second, the support and housing in group living should be de-linked, just as it is in the supported housing approach; staff should not be permanently stationed on-site. This requires governments to shift to a policy of de-linking housing and support. We make these stipulations because of our concern about the self-perpetuating nature of group settings and the importance of consumer/survivor control shown in the research (McCarthy & Nelson, 1991; Nelson et al., 1999; Srebnik et al., 1995).

Practice

In practice, supported housing and supportive apartments have achieved positive results, including increased health, empowerment, independence, instrumental roles, and community integration (Boydell & Everett, 1992; Nelson, Hall, & Walsh-Bowers, 1995; Nelson et al., 1997; Newman et al., 1994; Ridgway & Rapp, 1997). As well, correlational findings support unsegregated settings and use of generic community resources promoting interaction with neighbours and community integration (Aubry & Myner, 1996; Ridgway & Zipple, 1990a, 1990b). However, concerns have emerged about isolation and the lack of social relationships for people living in apartments (Champney & Dzurec, 1992; Depp et al., 1986; Pulice et al., 1995). Therefore, staff must be vigilant about the "support" part of supported housing to help alleviate isolation and to promote employment, education, and other life goals that consumer/survivors may have.

To implement supported housing, organizational change and staff training are needed. Mental health organizations must value, encourage, and actualize the philosophy of the supported housing paradigm into all activities. Experiences in other housing organizations have demonstrated that making a shift from the supportive to the supported paradigm is challenging (Lord et al., 1998; Pyke & Lowe, 1996). A highly participatory process with a focus on establishing the values and vision of the organization and developing program approaches consistent with the values and vision are necessary to promote ownership and reduce the resistance of different stakeholders (staff, residents, family members) to such changes (Lord et al., 1998; Pyke & Lowe, 1996). In practice, another hurdle is promoting access to different types of affordable housing for consumer/survivors. Community workers need to advocate for subsidies, provide information about options, work with landlords, and form partnerships with housing-providers that enhance opportunities for consumer/survivors to live in homes that they choose (Carling, 1995). Staff training in these areas is needed.

Research

As most of the research remains focused on traditional rehabilitation alternatives, the literature on supported housing alternatives is limited. Much of the research on supported housing and supportive apartments describes consumer/survivor preferences (e.g., Tanzman, 1993). More research is required on the processes and outcomes of supported housing and supportive apartments. Research on group living and custodial settings in the past decade generally confirms the findings reported in the review by Nelson and Smith Fowler (1987). Thus, research should concentrate on the newer approaches to housing (supported), rather than more traditional approaches (group living).

Another recommendation is to have a research and evaluation component built in to the development of supported housing (Carling, 1993). Research on these settings would encourage the organization and its stakeholders to engage in a process of continuous learning about and improvement of such alternatives. As well, research from different geographic locations would provide information on the impact of diverse communities, urban and rural landscapes, government policies, housing stock options, and climate. A practical definition of supported

housing was developed as part of this review and the use of this definition is recommended in future research. By using this definition to establish what type of program is being examined, comparisons of process and outcome results can be made between the different types of housing.

The recommendations outlined focus the emphasis in policy and planning, practice, and research on the values of the emerging paradigm of supported housing. In the last 10 years, the advancement of supported housing and its filtration into the housing field has improved opportunities for consumer/survivors. According to the literature reviewed, consumer/survivor preferences are fulfilled and the most beneficial results are achieved with this approach. Therefore, increased information sharing and development of this approach is necessary to reduce barriers to consumer/survivors finding homes.

RÉSUMÉ

Ce travail présente une recension des écrits dans le domaine du logement des «consumer/survivors» depuis la publication de la recension de Nelson et Smith Fowler (1987). En premier lieu, nous présentons un aperçu global de la documentation et nous proposons une définition pour souligner les caractéristiques importantes de trois approches conceptuelles au logement: (a) «custodial» (b) «supportive» et (c) «supported». Deuxièmement, nous examinons les projets de recherche qui traitent de la relation entre les caractéristiques du logement et les résultats pour l'adaptation des résidents (ex: prise en charge). Par la suite, nous présentons les résultats des études qui ont examiné l'impact de ces trois approches au logement sur la vie des résidents. En guise de conclusion, nous nous interrogeons de façon critique sur les valeurs et la recherche dans le domaine des différentes approches au logement, afin de faire des recommendations pour l'avenir de la politique, de la planification, de la pratique, et de la recherche.

REFERENCES

Anthony, W.A., & Liberman, R.P. (1986). The practice of psychiatric rehabilitation: Historical, conceptual, and research base. *Schizophrenia Bulletin, 12*, 542-559.

Aubry, T., & Myner, J. (1996). Community integration and quality of life: A comparison of persons with psychiatric disabilities in housing programs and community residents who are neighbours. *Canadian Journal of Community Mental Health, 15*(1), 5-20.

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

Bond, G.R., Witheridge, T.F., Wasmer, D., Dincin, J., McRae, S.A., Mayes, J., & Ward, R.S. (1989). A comparison of two crisis housing alternatives to psychiatric hospitalization. *Hospital and Community Psychiatry, 40*, 177-183.

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

Brown, M.A., Ridgway, P., Anthony, W.A., & Rogers, E.S. (1991). Comparison of outcomes for clients seeking and assigned to supported housing services. *Hospital and Community Psychiatry, 42*, 1150-1153.

Burek, S., Toprac, M., & Olsen, M. (1996, February). *Third-year outcomes of supported housing in Texas: Measuring the long-term effects of system change*. Paper presented at the 6th Annual National Conference on State Mental Health Agency Research and Program Evaluation, Arlington, VA.

Capponi, P. (1992). *Upstairs in the crazy house: The life of a psychiatric survivor*. Toronto: Penguin Books.

Carling, P.J. (1990). Supported housing: An evaluation agenda. *Psychosocial Rehabilitation Journal, 13*, 95-104.

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

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

Champney, T.F., & Dzurec, L.C. (1992). Involvement in productive activities and satisfaction with living situation among severely mentally disabled adults. *Hospital and Community Psychiatry, 43*, 899-903.

Church, K., & Reville, D. (1989). User involvement in the mental health field in Canada. *Canada's Mental Health, June*, 22-25.

Depp, F.C., Dawkins, J.E., Selzer, N., Briggs, C., Howe, R., & Toth, G. (1986). Subsidized housing for the mentally ill. *Social Work Research and Abstracts*, 3-7.

Dixon, L., Friedman, N., & Lehman, A. (1993). Housing patterns of homeless mentally ill persons receiving assertive community treatment. *Hospital and Community Psychiatry, 44*, 286-288.

Dixon, L., Krauss, N., Myers, P., & Lehman, A. (1994). Clinical and treatment correlates of access to Section 8 certificates for homeless mentally ill persons. *Hospital and Community Psychiatry, 45*, 1196-1200.

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

Goering, P., Durbin, J., Foster, R., Boyles, S., Babiak, T., & Lancee, B. (1992). Social networks of residents in supportive housing. *Community Mental Health Journal, 28*, 199-214.

Goldstein, J.M., Dziobek, J.F., Clark, R., & Bassuk, E.L. (1990). Supportive housing for the chronically mentally ill: Matching clients with community environments. *The Journal of Nervous and Mental Disease, 178*, 415-422.

Hall, G.B., & Nelson, G. (1996). Social networks, social support, personal empowerment, and the adaptation of psychiatric consumers/survivors: Path analytic models. *Social Science and Medicine, 49*, 1743-1754.

Hall, G.B., Nelson, G., & Smith Fowler, H. (1987). Housing for the chronically mentally disabled: Part I: Conceptual framework and social context. *Canadian Journal of Community Mental Health, 6*(2), 65-78.

Hawthorne, W.B., Fals-Stewart, W., & Lohr, J.B. (1994). A treatment outcome study of community-based residential care. *Hospital and Community Psychiatry, 45*, 152-155.

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

Hogan, M.F., & Carling, P.J. (1992). Normal housing: A key element of a supported housing approach for people with psychiatric disabilities. *Community Mental Health Journal, 28*, 215-225.

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

Hutchison, P., Pedlar, A., Lord, J., Dunn, P., McGeown, M., Taylor, A., & Vanditelli, C. (1997). The impact of independent living resource centres in Canada on people with disabilities. *Canadian Journal of Rehabilitation, 10*(2), 99-112.

Jacobson, J.W. (1992). The social history and character of mental health group homes. *Adult Residential Care Journal, 6*, 75-86.

Kennedy, C. (1989). Community integration and well-being: Toward the goals of community care. *Journal of Social Issues, 45*, 65-77.

Kiesler, C.A. (1982). Mental hospitals and alternative care: Noninstitutionalization as potential public policy for mental patients. *American Psychologist, 37*, 349-360.

Leff, J., Thornicroft, G., Coxhead, N., & Crawford, C. (1994). The TAPS Project. 22: A five-year follow-up of long-stay psychiatric patients discharged to the community. *British Journal of Psychiatry, 165*(Supplement 25), 13-17.

Leff, J., Trieman, N., & Gooch, C. (1996). Team for the assessment of psychiatric services (TAPS) Project 33: Prospective follow-up study of long-stay patients discharged from two psychiatric hospitals. *American Journal of Psychiatry, 153*, 1318-1324.

Lehman, A.F., Possidente, S., & Hawker, F. (1986). The quality of life of chronic patients in a state hospital and in community residents. *Hospital and Community Psychiatry, 37*, 901-907.

Lehman, A.F., Slaughter, J.G., & Myers, C.P. (1991). Quality of life in alternative residential settings. *Psychiatric Quarterly, 62*, 35-49.

Lipton, F.R., Nutt, S., & Sabatani, A. (1988). Housing the homeless mentally ill: A longitudinal study of a treatment approach. *Hospital and Community Psychiatry, 39*, 40-45.

Lord, J., Ochocka, J., Czarny, W., & MacGillivary, H. (1998). Analysis of change within a mental health organization: A participatory process. *Psychiatric Rehabilitation Journal, 21*, 327-339.

McCarthy, J., & Nelson, G. (1991). An evaluation of supportive housing for current and former psychiatric patients. *Hospital and Community Psychiatry, 42*, 1254-1256.

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

Mowbray, C.T., Greenfield, A., & Freddolino, P.P. (1992). An analysis of treatment services provided in group homes of adults labelled mentally ill. *The Journal of Nervous and Mental Disease, 180*, 551-559.

Moxley, D.P. (1988). Exploring the validity of social network indicators for use in psychosocial rehabilitation. *Psychosocial Rehabilitation Journal, 11*, 3-10.

Nagey, M.P., Fisher, G.A., & Tessler, R.C. (1988). Effects of facility characteristics on the social adjustment of mentally ill residents of board-and-care homes. *Hospital and Community Psychiatry, 39*, 1281-1286.

Nelson, G., & Earls, M. (1986). An action-oriented assessment of the housing and social support needs of long-term psychiatric clients. *Canadian Journal of Community Mental Health, 5*(1), 19-30.

Nelson, G., Hall, G.B., Squire, D., & Walsh-Bowers, R. (1992). Social network transactions of psychiatric patients. *Social Science and Medicine, 34*, 433-445.

Nelson, G., Hall, G.B., & Walsh-Bowers, R. (1995). An evaluation of supportive apartments for psychiatric consumers/survivors. *Canada's Mental Health, 43*, 9-16.

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

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

Nelson, G., Hall, G.B., & Walsh-Bowers, R. (1999). Predictors of the adaptation of people with psychiatric disabilities residing in group homes, supportive apartments, and board-and-care homes. *Psychiatric Rehabilitation Journal, 22*, 381-389.

Nelson, G., & Smith Fowler, H. (1987). Housing for the chronically mentally disabled: Part II: Process and outcome. *Canadian Journal of Community Mental Health, 6*(2), 79-91.

Nelson, G., Walsh-Bowers, R., & Hall, G.B. (1998). Housing for psychiatric survivors: Values, policy, and research. *Administration and Policy in Mental Health, 25*, 455-462.

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

Newman, S.J., Reschovsky, J.D., Kaneda, K., & Hendrick, A.M. (1994). The effects of independent living on persons with chronic mental illness: An assessment of the Section 8 Certificate Program. *The Milbank Quarterly, 72*, 171-198.

Ogilvie, R.J. (1998). The state of supported housing for mental health consumers: A literature review. *Psychiatric Rehabilitation Journal, 21*, 122-131.

Okin, R.L., Borus, J.F., Baer, L.B., & Jones, A.L. (1995). Long-term outcome of state hospital patients discharged into structured community residential settings. *Psychiatric Services, 46*, 73-78.

Okin, R.L., & Pearsall, D. (1993). Patients' perceptions of their quality of life 11 years after discharge from a state hospital. *Hospital and Community Psychiatry, 44*, 236-240.

Pomeroy, E., Cook, B., & Benjafield, J. (1992). Perceived social support in three residential contexts. *Canadian Journal of Community Mental Health, 11*(1), 101-107.

Pulice, R.T., McCormick, L.L., & Dewees, M. (1995). A qualitative approach to assessing the effects of system change on consumers, families, and providers. *Psychiatric Services, 46*, 575-579.

Pyke, J., & Lowe, J. (1996). Supporting people, not structures: Changes in the provision of housing support. *Psychiatric Rehabilitation Journal, 19*, 6-12.

Ridgway, P., & Rapp, C.A. (1997). *The active ingredients of effective supported housing: A research synthesis*. Lawrence, KA: The University of Kansas School of Social Welfare.

Ridgway, P., & Zipple, A.M. (1990a). Challenges and strategies for implementing supported housing. *Psychosocial Rehabilitation Journal, 13*, 115-120.

Ridgway, P., & Zipple, A.M. (1990b). The paradigm shift in residential services: From the linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal, 13*, 11-31.

Segal, S.P., & Aviram, U. (1978). *The mentally ill in community-based sheltered care: A study of community care and social integration*. New York: John Wiley and Sons.

Segal, S.P., & Holschuh, J. (1991). Effects of sheltered care environments and resident characteristics on the development of social networks. *Hospital and Community Psychiatry, 42*, 1125-1131.

Segal, S.P., & Kotler, P.L. (1993). Sheltered care residence: Ten-year personal outcomes. *American Journal of Orthopsychiatry, 63*, 80-91.

Segal, S.P., & Liese, L.H. (1991). A ten-year perspective on three models of sheltered care. *Hospital and Community Psychiatry, 42*, 1120-1124.

Sohng, S.S.L. (1996). Supported housing for the mentally ill elderly: Implementation and consumer choice. *Community Mental Health Journal, 32*, 135-148.

Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal, 31*, 139-151.

Tanzman, B.H. (1993). Researching the preferences for housing and supports: An overview of consumer preference surveys. *Hospital and Community Psychiatry, 44*, 450-455.

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

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

Wherley, M., & Bisgaard, S. (1987). Beyond model programs: Evaluation of a countywide system of residential treatment programs. *Hospital and Community Psychiatry, 38*, 852-857.

Wilson, J., & Kouzi, A. (1990). Quality of the residential environment in board-and-care homes for mentally and developmentally disabled persons. *Hospital and Community Psychiatry, 41*, 314-318.