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Exploring the experience of people with schizophrenia who live in boarding houses or private homes: A grounded theory study

ABSTRACT

Housing has been identified as a crucial component of successful community living for people with schizophrenia. Unfortunately, many mental health services only focus on acute care and drug solutions for their clients. This grounded theory study aimed to develop a theoretical understanding of the impact of housing on the mental health of people with schizophrenia. Data were collected from thirteen people with schizophrenia who were living in boarding houses (considered the least suitable housing) or living in their own home (considered the most suitable housing). Semi-structured, in-depth interviews were conducted to explore the participants' experiences and views of the impact of their housing on their mental health.

Findings indicated that participants living in their own homes have access to more opportunities and resources for staying well than people with schizophrenia living in boarding houses. Findings also indicated a strong desire amongst all participants to live in their own home. When they do have this opportunity they make choices that enhance their ability to stay well.

KEY WORDS

community care; mental health; schizophrenia; own homes; boarding houses; health choices; quality of life

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INTRODUCTION

Historically, society has restricted the ability of people with a mental illness to make decisions about their lives, including where they live and who they live with. Institutions took care of them and made choices for them (Screbnik et al., 1995). Mental health care services are now more focused on community care and supporting consumers to live independently (Rudman, 1996).

According to the National Mental Health Strategy (1994, 1998 & 2002), housing is considered the most crucial community support service necessary to achieve the success of community-based care for people with a mental illness. There is substantial support for this view in Australia (Burdekin et al., 1993; Queensland Health, 1996) and internationally (World Health Organization, 1990). Without the availability of quality affordable housing other treatment and rehabilitation approaches are jeopardised (Anthony & Blanch, 1989; Baker & Douglas, 1990; Moxam & Pegg, 2000; Rosenfield, 1990; Stroul, 1989).

Housing is not taken seriously as a contributor to outcomes for people attempting to recover from a mental illness (Quinn, 1994). Mental health services tend to be crisis-based and see themselves as not having the resources for long-term maintenance (Jablensky et al., 1999). This means the focus of mental health services is on quickly stabilising the acute psychosis at the expense of the quality of their clients' lives.

A study conducted in the United States (US) examined the relative contribution of housing versus psychiatric services and rates of hospital readmission among 69 chronic psychiatric patients in two communities. Results indicated that when people need both housing and psychiatric care, services for housing are a better predictor of success (determined by non-hospitalisation) than the existence of a mental health service (Rosenfield, 1990). In a much larger study undertaken by Baker and Douglas (1990) that included 729 participants, similar conclusions emerged. A causal relationship was found between the quality of housing and the global functioning and quality of life. Participants who remained in adequate and appropriate housing (as assessed by case managers) improved, while those in poor housing remained the same or deteriorated in their level of functioning and quality of life. Two groups moved and changed the quality of their housing during the study. The first group moved from poor quality housing to better housing and they improved on all measures; including global level of functioning, degree of maladaptive behaviour, and quality of life. By contrast, those participants who moved from good to poor quality housing were found to have deteriorated on all measures (Baker & Douglas, 1990).

People with schizophrenia, type of housing and quality of life

People with schizophrenia are the largest diagnostic group serviced by public mental health services in Australia (Jablensky et al., 1999). A total of 38% of people receiving mental health care in the community from specialised mental health services had a principal diagnosis of schizophrenia (MH-CASC, 1996). Due to their illness, people with a diagnosis of schizophrenia have difficulty maintaining satisfactory, stable, independent housing; this impacts seriously on their mental health (American Psychiatric Association, 2000).

People with schizophrenia have a better quality of life if they live in the community (Kirkpatrick et al, 1996). However, a 1997 Australian study found that many people with schizophrenia were living in substandard and often unstable accommodation (Berger et al., 1997). The authors concluded that a key determinant for the high rates of re-admission for people with schizophrenia was the type of accommodation to which they are discharged.

A Swedish study investigated the relationships between the characteristics of the living

situation in the community and the subjective quality of life and social networks among community-based individuals with schizophrenia. A group of 418 participants from 10 sites were interviewed about their quality of life, psychopathology, social network and need for care. Results indicated that independent housing (living in their own home) was related to a better quality of life. An independent housing situation was associated with a better social network and the availability of emotionally satisfying relationships. This better quality of life was associated with favourable perceptions of independence, feelings of empowerment and privacy (Hansson et al., 1999).

In Taiwan, a quasi-experimental longitudinal study explored people with schizophrenias' experience of housing (Shu et al., 2001). The authors examined the differences in the quality of life experienced in a government hospital, funded halfway houses and in the homes (the person's own home) of 60 people diagnosed with chronic (sic) schizophrenia. The authors applied a quality of life scale to each person at two monthly intervals for eight-months. The results showed that the quality of life of participants living in their own home was significantly higher than those in halfway houses. The dimensions of independence and social activity also showed significant differences between these two groups, with the participants in their own home scoring better in both domains.

Ninety-nine participants with schizophrenia took part in a longitudinal study into discharges from an acute inpatient psychiatric facility in inner city Sydney. The study followed the relapse of the participants' illness (Berger et al., 1997) and investigated the course and consequence of the relapse on admission, at two months and six months. Amongst other findings, the authors noted that many of the people were living in substandard accommodation that was often unstable. They concluded that a key determinant for the high rates of readmission for people with schizophrenia was the type of accommodation to which they were discharged.

Although there is a limited research in this area, there is a body of literature from developed countries that argues that people with schizophrenia living in good quality accommodation perform better on measures of mental health and than people in poor quality accommodation. The literature varies on the definition of quality accommodation but overall the message is clear – the quality of accommodation contributes significantly to the mental health of people with schizophrenia (Berger et al. 1997; Carlsson et al., 1998; Hansson et al., 1999; Kirkpatrick et al., 1996). There is also limited research that addresses the issue of why living in quality accommodation makes such a difference to people with schizophrenia. Therefore, it was timely that a study was conducted that attempted to develop a theoretical understanding of this topic.

There are a number of types of housing available to people with schizophrenia. These include living in hospitals, boarding houses, hostels and group homes with varying degrees of supervision; living with parents; and independent living in the person's own home with their choice of house mates/partners. There is consensus in the literature that, outside hospital, the most desirable accommodation is independent housing whilst the least desirable is boarding houses (Anthony & Blanch, 1989; Baker & Douglas, 1990; Carling, 1989, 1990 & 1993; Cleary et al., 1998; Health Care Complaints Commission, 1996; Howie the Harp, 1990; Linhorst, 1991; Moxam & Pegg, 2000; Posey, 1990; Strong, 1995; Trieman, 1997).

Aim of the study

Previous work by the authors of this paper have demonstrated that people with schizophrenia are more likely to be re-admitted to hospital when discharged to a boarding house, than if they are discharged to their own home – even

though there is no evidence of them being any more seriously disabled by their illness (Browne et al., 2004). Also, when living in the community, people with schizophrenia living in boarding houses and independently in their own homes had similar scores on a psychiatric symptom rating scale. People living in boarding houses, however functioned at a lower level in their activities of daily living (Browne & Courtney, 2004).

This study further explored the impact of housing type on the mental health of people with schizophrenia by examining the experience of those living independently in private homes and those living in a boarding house. The study aimed to use the experiences of the participants to develop a theoretical understanding of the consequence of different types of housing on the mental health of people with schizophrenia.

Method

This study used a grounded theory approach to explore the impact of housing on the mental health of people with schizophrenia. In-depth interviews were used to explore the comparative experiences of people with schizophrenia of living in two different types of housing, specifically private homes and boarding houses. Previous work by the researcher (Browne et al 2004, & Browne & Courtney 2004) indicated that, for people with schizophrenia, maintenance of mental health is an interactive and interpersonal process that lends itself to a constructivist grounded theory approach.

The grounded theory method specifies that it would be inappropriate to carry out a review of the literature prior to commencing data collection (Glaser, 1978, 1992; Glaser & Strauss, 1967). However, having undertaken previous studies that investigated the impact of housing on people with schizophrenia and having had extensive clinical experience as a community mental health nurse working with people with schizophrenia, the researcher was already familiar with the literature and consumers experience in this area, and it would not have been possible to unlearn the knowledge that existed.

The researcher entered the field informed by the previous studies and clinical experience. This seems consistent with Glaser and Straus's (1967) partial framework of local concepts that designate a few gross features of the structure of the substantive area to be studied. The method was driven by Glaser and Strauss' (1967) seminal work, and Glaser's on-going works regarding the development and refinement of grounded theory methodology (Glaser, 1978 & 1992).

Definitions

For the purpose of this study the following definitions were used:

- Boarding house refers to privately operated 'for-profit' public accommodation. These venues consist of sometimes shared, but normally single, bedroom accommodation with shared facilities such as bathroom, kitchen and living areas.
- Private home means: any privately owned or rented accommodation, usually a house or flat, where the participant lives alone or with family or friends of his/her choosing.

Recruitment of participants

A purposive sampling strategy was used to select 13 participants for the study. Six participants lived in a boarding house (3 female and 3 male) and seven lived in their own home (5 female and 2 male). Eligibility criteria for the study included:

- self-identification of a diagnosis of schizophrenia;
- more than one admission to a psychiatric inpatient unit reported;
- living in a boarding house or private home;
- not acutely psychotic at the time of interview;
- having been informed of the purpose of the study and signed a consent form.

In order to recruit participants the researcher attended community-based consumer group meetings and living skills programs. At these meetings the researcher delivered presentations about the study. Those who were interested were given a detailed information sheet and a consent form. Any questions were answered and the volunteer participants were asked to sign the consent.

Data collection procedures

Participants were given the option of having the interview in their own home/boarding house or to be taken to a local coffee shop for a free cup of coffee. Seven participants took up the offer of a cup of coffee; the remaining six were interviewed in their homes or boarding houses. The in-depth semi-structured interviews began with formal questions and initially encouraged the participant to share their experiences and views. The interviews lasted between one and two hours. Interviews were taped and transcribed verbatim. Field notes were taken after interviews.

Data analysis

In keeping with Glaser and Strauss' (1967) directions for sample selection, the author began with two participants. Both individuals lived in boarding houses. As categories began to emerge from interviews, the researcher broadened the sample to include individuals living in there own homes and living in other boarding houses. As data collection and analysis progressed the interviews became more focused until emerging categories were saturated, that is, further interviews added nothing to the categories. Although the interviews progressively became more focused the participants were still encouraged to express their views with questions such as "Are there any issues about your housing that are important that I haven't asked about?"

It is important to note, that the stages of data collection and data analysis did not occur in a linear sequence, but were cyclic in nature. However, for the purposes of reporting the research, the process of analysis is described in stages.

The first stage of coding involved transcribing each interview. Following this, Glaser and Strauss' (1967) process of open coding was applied. This entails examining the data/text line by line and identifying the processes in the data. This process of coding is termed "substantive coding" since the groupings or labels codify the substance of the data, often using the language of the participants.

Next, in the second stage of coding, the researcher attempted to discover the key processes, from the point of view of the participants. This level is more abstract and represents a synthesis of the first level codes. During second level coding each label was then compared with each other label and assigned to categories according to fit. This allowed a tentative conceptual framework to be generated from the categorization of the data. The researcher then devised a tentative heading for each of the categories by examining common themes and concepts evident in each of the categories, or, alternatively, by identifying if there was an underpinning process or theme.

The third stage of the analysis saw the development of hypothesized relationships between the categories and the development of the provisional framework. The researcher examined the provisional categories and perceived links and discovered umbrella terms under which several categories fitted, as a result of comparing each category with other categories to see how they clustered or connected. The umbrella term or core-category can thus be seen to encompass several initial provisional categories. As discussed above this is not a linear process but a process of constant comparison. The core-categories emerged and the process continued until saturation was reached.

The final stage in the data analysis included theoretical coding and selective sampling of

(and comparison with) the literature. Constant comparison ensured rigor for the study, and the resulting grounded theory (Glaser, 1998). It also ensured the theory would fit and work "that is, be relevant to the area it purports to study" (Glaser & Straus, 1967, p 261).

RESULTS

Thirteen categories emerged from the data and from these six core categories were synthesised. The core categories included: "A place of my own", "A space of my own", "Atmosphere", "Activities related to the housing", "Stability" and "Cost of housing" (see table 1).

A place of my own

Nine participants valued or dreamed of having a place of their own. For those living in their own home it gave them a sense of belonging and feeling that they were in charge of their lives. For those living in boarding houses, it was a dream they hoped to achieve one day. The sense of empowerment identified in the first sub-category *In charge of my life* seemed to impact on all the other categories. A female participant who lived in her own home with her family captured the sentiments of a number of her fellow participants 'You invest yourself into your own place ... you feel you belong and it is yours. Where you run your own life'. Participants valued the ability to choose with whom they lived and the opportunity to live alone if they wished. They valued the stability and security offered by having their own home. Four sub-categories emerged from this category and included: In charge of my life, *Familiarity, This is my space I feel comfortable here*, and *I dream of a place of my own*.

In charge of my life

Participants living in their own homes reported that they enjoyed and valued being in charge of their own lives and thought it contributed positively to their mental health. This feeling of empowerment came from having security and stability in their housing, as well as not being answerable to anyone and coming and going as they pleased.

A woman who lived alone with her dog reported, 'It's important because the nature of this illness is you feel like you're a bit out of control, you can't, you can't sort of, do things, and um, and, to be in as much control as you can is important ... they're like, freedom, you have freedom to make those choices'.

TABLE 1 CATEGORIES AND CORE CATEGORIES

Categories	Core categories
In charge of my life Familiarity This is my space I feel comfortable here, *and* I dream of a place of my own	A place of my own
Need to get away, *and* Under the doona	A space of my own
Living with others, *and* Knowing it is there	Atmosphere
At home activities, *and* Outside activities	Activities related to the housing
Stability and friends *and* Stability and hospital	Stability
Cost of housing	Cost of housing

Familiarity

Having your own home means it is familiar and you can collect things around you that are valuable to you and those things can add to the feeling of safety and belonging. A male participant living in his own home with his mother said, 'I've got the swimming pool, if I feel a bit seedy, I've got the TV and my video, which I like to sit down and watch videos. I've got the dining table, a nice kitchen ... I've got my bedroom so I can do my stamp collecting in there and, I've got a stereo in there, and CDs and I can play my CDs'.

None of the participants living in boarding houses reported positive feelings of familiarity or that they belonged in their housing. Many of them dreamed of one day having a home of their own.

This is my space I feel comfortable here

Participants highly valued having their own place, it helped them to feel safe and as though they belonged. One female participant living in her own home reported, 'But I think one of the things that have helped me, like I've been pretty up in the last few months and I think it's because I stay at home a lot, and I know if I've been away too long I've got to race back there'. One male participant living in his own flat near the beach said, 'It's very important, one of the most important things, is, like a home where, everyone supports you if you need to be supported, you know, so that's the main thing'. Interestingly, this man lived alone but his home was a meeting place for him and his friends.

I dream of a place of my own

Participants living in boarding houses dreamed of having their own home. They saw the boarding houses they lived in as serving a purpose. Some saw living in their own home as a possibility in the future, others saw it as an impossible dream.

The participants who were optimistic about eventually achieving their dream of their own home realised that cost would be an issue and that they would need support from the housing department and mental health services. 'Yeah, Kingscliff's really a beautiful place because it's on the beach ... I'd love a housing department place at the Tweed, a nice little housing department place', reported one female participant.

Another woman shared her predicament about living in a boarding house, 'It's just that here, it serves its purpose, sometimes you stay in a place and it serves its purpose, but you either out wear your welcome, or you say well, it's time to move on. Sometimes options and alternatives start to change and you feel you have to get into a housing department or a flat then living here. I wouldn't mind a flat even but I know I can't afford a flat for myself'.

A space of my own

Having a special safe space in their accommodation was identified by eleven of the participants as an important contributor to their mental health. This special space could be used as a sanctuary, a place to feel secure, and a place to go when they felt vulnerable. Participants living in their own homes observed that when they had a place of their own they were free to create a safe space. This freedom was often not available to people living in boarding houses. There were two sub-categories identified under this category, the *Need to get away* and *Under the doona*.

Need to get away

A need to get away from others and from the world was identified as a contributor to mental health. One participant in a boarding house complained, 'Um, yeah. But we can't go anywhere that's the trouble'.

Under the doona

One 36-year-old woman who had problems with hallucinations and anxiety described a place she valued as her bed and doona. 'Inside

your safe place (your house) you need an even safer place, an extra safe place. Like a bed or a doona ... you're completely cushioned from everything, and you're just cuddled up, nothing can get to you when you're in your bed under your doona, I think. You're completely covered, you're completely protected? ... like you've got that big feather doona around you, it's, a bit like being in your mother's arms'. Although this woman was the only one to identify a doona as being special, others identified a special chair, close proximity to the beach, and a home office as their special place. One male participant living in a boarding house identified a tree in the park, close to his accommodation, as a place he liked to go to.

Atmosphere

Twelve participants identified factors that contributed to the atmosphere of the housing. Two sub-categories emerged under this category *Living with others* and *Knowing it is there*. The first, *Living with others*, seemed to have the greatest impact. The second category was difficult to quantify, just knowing it (the home) was there contributed positively to the mental health of participants.

Living with others

Sometimes those sharing the housing contributed positively to the atmosphere: a female participant living in a boarding house said, 'It's very important, one of the most important things, is, like a home where, everyone supports you if you need to be supported, you know, so that's the main thing'.

Occasionally, housemates contributed negatively to the atmosphere but this was only reported by people living in the boarding houses. Residents of boarding houses complained about the drug use of other residents and other upsetting behaviours. A male participant living in a boarding house complained, 'Greggie's (a pseudonym) the one you want to watch because at night he chucks a mental because he's not watching his show you know, doesn't share the TV that's the trouble with him, geez he goes off, really screams at ya, doesn't matter how good you are to him, he goes off'.

Knowing it is there

There were also non-specific factors identified that seemed to contribute significantly to the wellbeing of some participants who lived in their own homes. These factors were described concisely by a 53-year-old male participant, who said, 'Being here (in my own flat) just makes me feel better'. One woman who, for family reasons, had to go to Brisbane regularly said, 'I think, in a way that I know if I, have to go to Brisbane say for a few days ... I, get quite um, really jangled and depressed and that can sometimes swing, into like a psychotic episode if I'm up there for an extended period I don't feel good in a mental health way, but if I'm back at home, or if I'm, how can I describe it, I can usually not leave the house for more than about three or four hours at a time, and that's where I have to go back to it, so I feel like that's a good place for my soul to be in, it's like a, I feel like it's home'.

Activities related to the housing

Twelve participants identified activities that were related to being in their housing as contributing to their mental health. Two sub categories emerged under this category *At home activities* and *Outside activities*. One participant explained the reason that activities were important to him 'If I fill my day up then, the schizophrenia isn't as bad. If you've got time to yourself then you start to think and the paranoia feelings come, and, it's really, you've got to keep yourself busy.'

At-home activities

It was notable that people living in their own home all mentioned home-related activities in which they participated; for example, mowing the lawn, playing guitar, and having friends

around. One of the participants had a party and we both laughed as he told this story, 'Good Friday ... and I had 15 around, we had a sauna and swum in the pool. We had a bean bag with those little white things in them and anyway somebody sat on it and the whole, the entire pool was full of balls'.

Two of the participants living in their own homes had written books. One of the books, at the time of the interview, was being published in limited supply by the local living skills centre. None of the people in boarding houses described at home activities other than housework. They complained about being bored at home, 'Ah, um, don't like, um, oh sometimes it gets a bit same, monotonous you know, that's the trouble'. Others complained the monotony made 'things worse.' The main at-home activities were housework and this sometimes caused friction. 'Yeah, they mightn't pull their weight and that affects all of us, you know, individually, when their weight's not pulled around properly, so, so it affects us individually, yeah'.

Outside activities

Both groups enjoyed outside activity, for example to going to Connections or Young ARAFMI (life skills/social programs), meeting friends or just going up to the shops. These social activities offered the opportunity to connect with others, take their mind off their difficulties and have fun.

Stability

Stability of their housing was valued by all of the participants and they thought it was valuable to live in the same place permanently. Two sub-categories emerged under this category, *Stability and friends* and *Stability and hospital*. Participants living in their own homes were better able to maintain the same housing over time. A 53-year-old male participant who lived in his own flat described the value of stability, 'I think it helps me stay stable, 'cause I've have moved around a fair bit, and ah, it gets quite dreadful when you're not, when you haven't actually got a, ah, a, ah – a good house to live in, and, I have moved around, oh – from Tasmania through Northern Queensland'.

Stability and friendships

'If I can get to know my surroundings I feel more comfortable with them', one female participant who lived in her own home explained. She went on to describe the importance of the stability of her housing, 'See if you haven't got a stable home environment, every time you move you lose those friends, there might be a couple that are becoming good for you'.

One male participant reported, 'Yeah because you just lose friends all the time, I'd go into hospital and I'd forget about everybody or lose them or something, and, or they'd lose me, and ah, I would just be, that was like in the early '80s that was a suicidal thing of mine, I haven't got any friends. I could sit down and think to myself I haven't got any friends, and I was, I was just go really down with suicidal thoughts. I was like that for a while come to think of it, I haven't thought about that for a long time'.

Stability and hospital

Having stable housing also meant a 'home' to go to when discharged from hospital. Participants reported this was helpful as they felt vulnerable when discharged from hospital. A male participant who, early in his illness, had a very nomadic life said 'I moved a lot before 1987, ... that's 15 years of moving, that's hell, cause you're really vulnerable when you move'. Having a place of his own now meant when he went into hospital he had somewhere to come home to.

Cost of housing

For participants living in their own home and those living in boarding houses the cost of housing was identified as being a contributor to their mental health. For participants living in boarding houses the cost of setting up a flat was

an obstacle to achieving their dream of living in their own home.

Often the decision to live in reasonable accommodation meant not having enough money to buy the basic necessities. For some, living in a boarding house meant that having food and board included in the rent was an advantage.

For one female participant, living alone in a flat, the cost of housing meant she did not have enough money to feed her dog; 'It, it houses me, but it's very expensive, 130 a week is just too expensive for me, but it's the only place I could to go with my dog ... the cost, I can't even begin to think how much that affects my um, my feelings and that over, I just find that it's, it's extremely stressful to have to pay that sort of rent'.

Having the resources in the family to be able to afford to live in their own home was seen as a great advantage and significant contributor to staying well for one woman, 'Well I guess, if my parents didn't have the money, I don't know where I'd be. It's that important to have stability, it accounts for 90% of your recovery'.

For others, there was the frustration of not having enough money (or not being able to handle money) to live where they wanted. They said things like: 'Where I am is less than ideal but it is all I can afford' and 'I wouldn't mind a flat, but I know I can't afford a flat for myself'.

A male participant who resided in a boarding house complained that after rent and board, he had little money for extra food: 'Yeah and um, oh I get a bit hungry at night times and cause we have dinner at 5 o'clock and by the time 8 o'clock comes well I'm hungry again ... that's the only thing I don't really like about it really. We have some afternoon tea to tie us over you know, but still, oh I don't know it's all right I suppose, we still have toast at night I suppose. No, oh, it's just the bloody wait for bloody, oh, what is it? You know pension day'.

Discussion

The aim of this study was to explore the impact of different types of housing, specifically boarding houses and the participants' own homes, on the mental health of people with schizophrenia.

The results of this study helped in the development of a grounded theory explanation of why people with schizophrenia living in boarding houses are more likely to be re-admitted to hospital. They are more likely to be re-admitted, even though their symptoms are comparable to people with a similar diagnosis living in their own homes.

Most people living in Australia make choices about where they live and with whom they live – people with schizophrenia are no different. Unfortunately maintenance of suitable housing can be difficult for this group (Jablensky et al., 1999).

In this study, participants who lived independently in their own home said it contributed positively to their mental health. Several studies have shown that independent living contributes positively to the mental health of people with schizophrenia (Gupta et al., 2003; Hansson et al., 1999; Seilheimer & Doyal, 1996; Shu et al., 2001). To the participants, independent living meant being in charge of their lives and living in familiar surroundings. They reported that this helped them to feel comfortable and as though they belonged.

For participants living in boarding houses, having their own home was a dream some believed was achievable. Although they reported being satisfied with the boarding houses, most dreamt that one day they would have their own home and live with family and friends or alone. Choice in housing is also reported in the literature as having a positive impact on the mental health of people with schizophrenia (Hansson et al., 1999).

The participants highly valued a place where they felt safe – a 'special place'. They used their special safe place to get away from everything. This offered them the opportunity to collect

themselves before they went back out into the world. Their special place helped them to be better able to deal with their illness and the world around them. This seemed to be an extension of having their own home, in that when they had their own home they had the opportunity to create a special place. This special place was used as a sanctuary when they were not feeling well and was crucial to the maintenance of mental health.

Living with others was a two-edged sword. Housemates could be supportive but they can also create problems and difficulties, especially when drugs and alcohol were involved. This has been reported by other authors such as Blanchard et al. (2000), Dixon (1999), and Siris et al. (2001). Participants also reported they appreciated knowing their home was there and this added a positive supportive aspect to their lives.

People with schizophrenia can have difficulty engaging in activities. This is a consequence of the avolition associated with their illness and its treatment, as well as the stigma of having a mental illness. Studies have shown being involved in community activities contributes positively to the mental health of people with a mental illness (Davidson & Stayner 1997; Jablensky et al., 1999)

Participants in the study reported that they enjoyed activities by themselves and with others, and that these activities were an important part of their mental health. The main difference between activities reported by the two groups in the study, was that only people living in their own home undertook social and fun activities at home. Participants living in boarding houses only reported doing housework at home, they needed to go out to engage in pleasurable activities. Productive activities in and outside the home have been reported to impact positively on the mental health of people with schizophrenia (Dickerson et al., 1999; Honkonen et al., 1999)

Having a stable home, whether it was a boarding house or their own home, contributed significantly to participants' ability to stay well. Familiarity with surroundings, as well as social networks that are able to develop when living in stable housing, were valued by participants. This contributed significantly to the mental health and the ability to stay out of hospital. This has also been reported elsewhere (Hansson et al., 1999; Kirkpatrick et al., 1996; Seilheimer & Doyal, 1996)

When they were hospitalised, having a home to come back to and an established support network, were also highly valued. It made the transition from hospital to community life easier if they could go to a home they knew.

The cost of housing was an issue for all participants, although some were lucky enough to have family financial support. They recognised how lucky they were and were grateful their family had helped them with the finances that made it possible to live in their own homes. The others had to make a decision about what to give up to maintain a reasonable standard of living. Clearly, the cost of housing can impact negatively on the mental health of people with schizophrenia and this has been reported in Australia (Berger et al., 1997), and in Europe (Carlsson et al., 2002).

People with schizophrenia living in their own home have many more opportunities to structure their lifestyles so that it contributes positively to their mental health. When people with schizophrenia live in housing of their choice that suits their needs, they tend to stay longer. With this stability comes the opportunity to develop relationships with family, colleagues with a mental illness, friends and partners. These relationships help people with schizophrenia to stay well and avoid relapses.

Conclusions

Schizophrenia has a great financial cost to the community and personal cost to individuals and their families. If mental health service providers are to assist people with schizophrenia in their

recovery they need to take into consideration more than just the symptoms of their illness.

Historically, there has been an assumption in mental health services that people with schizophrenia living in boarding houses were more disabled than people living in their own home and were therefore more likely to be re-admitted. This study questioned that assumption. If people with schizophrenia living in boarding houses were offered the same opportunities and resources as people with schizophrenia living independently in their own home they would certainly do better in terms of quality-of-life and re-admissions to hospital.

People with schizophrenia who live in marginal accommodation represent a group with special needs. Many of them have limited regular contact with specialist mental health services. Jablensky et al. (1999) argues that many of the services for people with a psychotic disorder tend to be crisis response-based and only a minority of these consumers attain a level of functioning and well being that is commensurate with a good quality of life.

This study has shown that, at least with this group of 13 people, those living independently in their own homes have greater advantages in their efforts to stay well and to stay out of hospital. Participants living in their own homes felt empowered and had the freedom to make choices and decisions about their lives. Being empowered, they made positive choices and found ways to use resources to help themselves to stay well. Participants with schizophrenia living in boarding houses did not have the same opportunities and therefore could not as easily maintain their mental health.

A focus of mental health services on cost cutting and finding new drugs to combat schizophrenia is misplaced. The cost cutting will mean a long-term increase in costs of care for people with schizophrenia. Depending on drugs alone to solve the problems associated with schizophrenia is reductionist and will not succeed. Adequately meeting the multiple needs, including housing, is likely to have a much greater impact on the course of our clients' symptoms and social adjustment than the present service provision.

As nurses, we could focus our attention more on helping our clients with schizophrenia to live independently in housing of their own choice. This could empower our clients to make choices that enhance their ability to stay well.

Service providers in general could focus more attention on housing. At present housing is not a high priority issue in mental health services. State and federal governments, whilst acknowledging that housing is a critical element in the provision of service to people with schizophrenia, do little to encourage the development of suitable housing options (Browne & Courtney 2004).

This study has demonstrated that understanding the experience of people with schizophrenia can make a valuable contribution to the formulation of mental health policy. As researchers we need to rise to the challenge, to lead the agenda for the future of mental health services. This requires us to place social issues such as housing firmly on the agenda alongside, and with equal status, to the newest drug. Only then will people with schizophrenia begin to receive the quality of services that they deserve.

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