THE GEOGRAPHY OF MENTAL HEALTH: HOUSING EX-PSYCHIATRIC PATIENTS

THE GEOGRAPHY OF MENTAL HEALTH: HOUSING EX-PSYCHIATRIC PATIENTS

BY

SUSAN J. ELLIOTT, B.A. (HONS)

A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree

Master of Arts

McMaster University

April 1987

MASTER OF ARTS (1987) McMaster University
(Geography) Hamilton, Ontario

TITLE: The Geography of Mental Health: Housing Ex-Psychiatric Patients

AUTHOR: Susan J. Elliott, B.A. (Hons) (Brock University)

SUPERVISOR: DR. S.M. TAYLOR

NUMBER OF PAGES: ix, 154

ABSTRACT

As a result of deinstitutionalization in the 1960s and 1970s, a great many chronically mentally ill psychiatric patients were released into an ill-prepared community. One of the major problems facing the discharged patient is housing. This thesis focuses on the housing situation and experience of the chronically mentally ill, which is recognized as one of several sets of interrelated environmental factors affecting their ability to cope in the community. The housing situations of a sample of 66 chronically mentally ill individuals in Hamilton were examined by way of cross- sectional and longitudinal survey data collected as part of a larger study of the community environment factors affecting the quality of everyday life among the chronically mentally ill. The specific objectives of the research were: (a) a description of the housing experience of the chronically mentally ill in Hamilton; (b) an analysis of the residential mobility of the research sample; (c) a description of the expressed housing need of the chronically mentally ill individual in the community; and, (d) a comparison of the need expressed by the sample

with the normative housing need espoused in the literature in order to gauge the 'fit' between the two.

The data show the sample clustered in the inner-city of Hamilton in lodging-home types of accommodation. An analysis of residential mobility reveals two trends. First, the sample have little control over their living situation. Second, there are two sub-groups within the sample: one which is relatively residentially stable and one which is excessively mobile. A logit analysis shows the factors affecting mobility to be level of education and preference for an independent living situation. Knowledge of these factors could aid in the task of matching client needs to appropriate living situations.

An analysis of the expressed housing need of the sample reveals that the long-term housing goal expressed by the sample is not dissimilar to the normative housing need defined in the literature: independent community living. However, there appear to be substantive (infrastructural) and procedural (lack of advocacy housing placement) gaps between the housing need as defined and the current housing stock.

ACKNOWLEDGEMENTS

Many people have contributed, directly and indirectly, to the writing of this thesis. I would like to thank them all. I would especially like to thank my departmental friends and colleagues for sharing my ideas, questions, doubts and fears. I would also like to say a special thank-you to Glenda and to Jane for their encouragement, patience and the good example they set for me.

Thank-you, John, for your never-ending patience and encouragement and thank-you, Heloise, for feeding me.

I am also very grateful to Robin Kearns for allowing me to participate in the research. I would also like to express my gratitude to Drs Michael Dear, Vera Chouinard and Lee Liaw for taking time out of their busy schedules to comment upon and examine this thesis. Their input is very much appreciated. I would especially like to thank Michael not only for all the reference letters but also for his contribution of the marginal dollar hypothesis.

Many thanks are also due to the individuals at the Canadian Mental Health Association and St. Joseph's Hospital Community Psychiatry Services for their cooperation with the research as well as help and kindness. Financial support for the research was provided by the Social Sciences and Humanities Research Council of Canada, grant #410-86-0700.

Last, but most certainly not least, I would like to express my most sincere thanks to my academic supervisor, Dr. Martin Taylor, for absolutely everything.

Without all of these people, this work could never have been accomplished.

Our table of contents would be page iii if it takes 2 pages then change page # for table of tables

Just simply follow this pattern or something similar to it

14pt bold center ↑ top line

TABLE OF CONTENTS

we would write 1.0 not

Don't write the pages for the appendix but leave room in the table of contents

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

1.1 The Research Problem

The advent of deinstitutionalization in the 1960s and 1970s was a result of a policy decision to change the primary locus of care for the mentally ill from an institutional setting (for instance, a provincial hospital) to a community- based treatment setting (Bachrach, 1984; Halpern et al, 1980; Marshall, 1982). A great many chronically mentally ill patients were released into the community as a result of this process. To illustrate, there has been a 66 per cent drop in the resident population of state mental hospitals over the past two decades (Bachrach, 1976). In Ontario, the number of patients on the books (that is, those in hospital at a given time) in 1960 was 19,507; by 1976, this had been reduced to 5,030 (Dear et al, 1980). A similar trend occurred in the city of Hamilton.

Despite the supposed therapeutic benefits of deinstitutionalization, some negative unintended consequences have resulted. Many feel this is because the process of deinstitutionalization occurred faster than the

establishment of community-based support systems (Bachrach, 1984; Dear et al, 1980; Marshall, 1982). As a result, the discharged patient faces many difficulties upon arrival into the community.

One of the major problems is housing (Allen, 1974; Dear et al, 1980; Marshall, 1982; Nelson and Earls, 1986; Peterson, 1982). The availability of appropriate and affordable housing for the chronically mentally ill is essential for adaptation and reintegration into the community (Hamilton- Wentworth District Health Council, 1984; Laws and Dear, 1987; Scott and Scott, 1980). And yet, several factors preclude the element of choice in location, type or quality of accommodation. For instance, approximately 2,000 patients are discharged annually in Hamilton, 600 of them chronic (Hamilton-Wentworth District Health Council, 1984). There are, however, only 598 beds available in supervised housing, with availability being severely restricted by low annual rates of turnover (Hamilton-Wentworth District Health Council, 1984). Further, the private market is generally out of the patient's price range (Allen, 1974; Bachrach, 1979; Dear et al, 1980; Hamilton-Wentworth District Health Council, 1984; Peterson, 1982).

The majority of discharged psychiatric patients

in Hamilton currently reside in the inner city housed in approved lodging homes or single rooms. These living environments have the potential to foster feelings of dependence or isolation. Clients themselves have recognized that today's lodging homes can be the equivalent of yesterday's back wards (Allen, 1974). Among service providers and social researchers, there appears concern that there is an acute shortage of housing alternatives for the chronically mentally ill in this city (Dear et al, 1980; Hamilton-Wentworth District Health Council, 1984). Further, although several authors have outlined comprehensively what the housing system for ex-psychiatric patients should look like, that is the normative need, (see, for example, Arce and Vergare, 1985; Dear and Wolch, 1979; Hamilton-Wentworth District Health Council, 1984; Ontario Social Development Council, 1983), the viewpoint of the individual patient, or the expressed housing need, is rarely heard.

Previous work within the geography of mental health has focussed upon community reaction to the deinstitutionalized mentally ill. An equally important focus for study is the reaction of the deinstitutionalized mentally ill to the community. This thesis examines the expressed need for housing of a sample of chronically mentally ill ex- psychiatric patients living in the

community in Hamilton. In so doing, this thesis has four research objectives. The first is a description of the current housing experience of the ex-psychiatric patient living in the community in Hamilton. The second is an analysis of the residential mobility of the research sample. The third is a description of the expressed housing need of the ex-psychiatric patient living in the community in Hamilton. The final research objective involves a comparison of the need expressed by the sample with the normative housing need being espoused in the literature in order to gauge the 'fit' between the two. It is anticipated that there may be some incongruence between these two definitions of need, as well as gaps or barriers in the present housing system. It is further anticipated that these gaps will be both substantive and procedural in nature.

1.2 Theoretical Orientation of the Thesis

This thesis is part of a larger research project which examines the factors influencing the quality of everyday life among the chronically mentally ill in the community. This examination is based on a socio-ecological model of coping (Kearns, Taylor and Dear, 1987) which identifies interacting sets of community and client variables as possible determinants of coping outcomes.

These variables or factors include personal background, beliefs, psychiatric services, lifestyle, social support network, and housing situation which collectively define community environment.

The larger project is informed by the socio-ecological model of health as described by Norman White (1981) whereby a health outcome is the result of the interaction of an individual with several environmental factors which are, simultaneously, interacting among themselves. Recent work in social and medical geography provides a theoretical basis for the research; more specifically, the analysis of environmental determinants of health outcomes (Eyles and Woods, 1983). In this context, environment is viewed in a broad sense, incorporating physical, social, economic and behavioural components of an individual's surroundings. Further, a relatively broad definition of health is employed which incorporates more subjective measures of well-being, such as quality of life or coping ability.

This thesis focuses on the housing situation as one particular element of the community environment. Although the current work does not attempt an explanation of the effects of the housing situation upon coping outcome, the research has clear implications for a better

understanding of this relationship.

1.3 Chapter Outline

This thesis is organized into five chapters. The review of the literature contained in chapter two provides, firstly, a brief history of the deinsitutionalization of the chronically mentally ill. This review sets the context for an examination of the housing issue. This issue is then located within the geography of mental health as well as a socioecological model of coping, which shows housing to be one of many environmental variables affecting the ex-psychiatric patient's ability to cope in the community. The review of the relevant housing literature which follows reveals that, although the problem of the provision of housing for service-dependent populations has been alluded to by several authors, the literature addressed directly to this issue is sparse (Bachrach, 1979; Laws and Dear, 1987). This is despite the important role appropriate housing plays in the achievement of the original goals of deinstitutionalization. And, while researchers have looked at the community tenure of chronically mentally ill ex-psychiatric patients, none have examined the residential stability of this population. A recurrent issue is the acute housing need of the population under study.

Manifestations of the crisis proportions that this need has reached in several locales are found in three areas. First is the increasing number of homeless mentally ill individuals in our communities. Second is the increasing number of chronically mentally ill people being found in prisons and penitentiaries. Finally, there is some evidence of a policy of reinstitutionalization. This review further reveals that the viewpoint of the individual ex-psychiatric patient is rarely accounted for in assessing residential need.

An outline of the research design and objectives is found in chapter three. Cross-sectional and longitudinal survey data were collected from a sample of 66 chronically mentally ill ex-psychiatric patients attached to three different aftercare programmes in Hamilton. These data were then used in a series of descriptive analyses aimed at addressing the research objectives.

The results of these analyses are presented in chapter four. Specifically, these results include: (a) a comprehensive description of the past and present housing experience of a sample of chronically mentally ill ex-psychiatric patients living in the community in Hamilton; (b) an analysis of the determinants of excessive residential mobility among this group; (c) a description of the

expressed housing need of the sample; and, (d) an examination of the substantive and procedural gaps between the normative and expressed housing need of this population.

The concluding chapter contains a summary of the research, its implications and contributions, as well as some suggestions for further investigation of the issue.

CHAPTER TWO

DEINSTITUTIONALIZATION, HOUSING, NEEDS ASSESSMENT

This chapter will briefly review the history of deinstitutionalization in order to set the context for the housing issue. The location of this issue within the geography of mental health leads to the examination of a systems-type model of coping which is informed by both a socioecological model of health as well as the theory of environmental determinants of health. Within this model, the housing situation is seen as one of several 'community environment' variables affecting the chronically mentally ill individual's ability to cope in the community. Particular emphasis is given to a review of the literature on housing for the chronically mentally ill as well as methods of residential needs assessment.

2.1 Deinstitutionalization: A Brief History

The advent of deinstitutionalization in the 1960s and 1970s was a result of a policy decision to change the primary locus of care for the mentally ill (as well as other service-dependent groups) from an institution to

a community-based treatment setting (Bachrach, 1984; Dear and Taylor, 1982; Marshall,1982). The basic objectives of deinstitutionalization have been to provide treatment and support services for the mentally disabled in the least restrictive setting possible at the lowest possible cost (Halpern et al, 1980). Further:

> Dependence would be replaced by independence with the intermediary help of a variety of supportive programs. These would include vocational and life-skills training, counselling, hospital follow-up contacts, recreational activities, assistance to families of the handicapped and - that absolutely vital component of community-based treatment - housing. Housing of many different kinds (Marshall, 1982; 7).

The primary goal of deinstitutionalization has been rehabilitation or the principle of normalization (Marshall, 1982). Application of this principle requires "...utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible" (Wolfensberger, 1972; 28). It is assumed that the problems of stigma and isolation associated with mental illness will be minimized if care, treatment and rehabilitation of special populations is undertaken in culturally normative community settings (Bradley, 1978).

Four sets of circumstances precipitated this change

in policy direction. Firstly, there was a vociferous castigation of the institutional treatment setting by those closest to its operation emphasizing the many unintended, yet negative, consequences of this treatment alternative. These included the failure to provide the patient with remedial care or the ability to develop the social and functional skills necessary for successful re-introduction into the community (Goodale and Wickware, 1979; Mechanic, 1980). Further, there was a strong ideology that community treatment would have significant therapeutic value.

Secondly, the rise of fiscal conservativism played a major role in the shift toward community-based treatment. Community care could be provided at only a fraction of the cost of institutionalized treatment. With the economic boom years gone, such a potential cost saving was a more than welcome one for politicians responsible for the provision of social services. Further, the monies saved in the reduction of institutional reliance were to be channelled into community mental health services, thus ameliorating any risk of the loss of quantity or quality of services. For example, when Lakeshore Psychiatric Hospital in Toronto was closed in 1979, only a percentage of the hospital's operating budget was channelled into community care. This resulted in an annual savings of $4.1 million

for the Ontario Government (Marshall, 1982).

Thirdly, the strong civil rights movement which took place in the 1960s and 1970s affected attitudes toward the mentally ill as well as many other groups in society. As history has illustrated, the organization of psychiatric care was shown once again to be responsive to the social, economic, and ideological influences of society at large (Foucault, 1973; Mechanic, 1980). For example, Grobb (1966, in Mechanic, 1980) has detailed how the social conditions accompanying the industrial revolution - the changing nature of work, family life and community tolerance for bizzare behaviour or incapacity - resulted in an increased tendency to hospitalize those who could not adapt to new circumstances. During the time of the civil liberties movement, therefore, advocacy groups, along with the mentally ill themselves, began to fight for their place in society as well as the community.

The final, and perhaps most crucial, catalyst of deinstitutionalization was the discovery, in the 1960s, of psychotropic drugs (Halpern et al, 1980; Marshall, 1982; Segal and Aviram, 1978; Talbot, 1984). These drugs were first used in North America by Dr. Heinz Lehman in 1953 at the then Verdun Protestant Hospital in Montreal, Quebec. According to Dr. Lehman, before these drugs were available,

60 to 70 per cent of schizophrenics who entered mental hospitals never again lived in the community (The Hamilton Spectator, May 31, 1986). However, results obtained with only a simple pill were miraculous: "Within days, some of the patients had stopped hallucinating and within two weeks, a few were in remission and ready to leave the hospital" (The Hamilton Spectator, May 31, 1986). These drugs do not cure schizophrenia or any other mental illness, but they do a great deal to control the illness and reduce its most disturbing symptoms (Marshall, 1982; Mechanic, 1980).

The introduction, in Canada, of a comprehensive and universal medicare programme in the late 1960s further supported the reasoning that appropriate care could be made available outside institutions by removing barriers of access to care (City of Toronto, Mayor's Office, 1984). Such programmes had been introduced in all provinces by 1971 (Richman and Harris, 1983).

A great many chronically mentally ill patients were released into the community as a result of deinstitutionalization. To illustrate, there was a 65 per cent drop in the resident population of state mental hospitals between 1955 and 1975, from a population of over 500,000 to one of 193,000 (Bachrach, 1979; Laws and Dear, 1987; Marshall,

1982).

The Canadian situation mirrored that of the United States, with the number of psychiatric hospitals declining by one-third between 1970 and 1978 while the length of stay for both affective and psychotic illnesses also decreased by one-third (City of Toronto, Mayor's Office, 1984; Government of Ontario, Ministry of Housing, 1986; Richman and Harris, 1983). In 1960, 10 per cent of the 75,000 Canadians in mental institutions had been hospitalized for more than seven years. Currently, nine out of 10 patients are hospitalized for less than one month, generally in small hospitals as opposed to large institutions (City of Toronto, Mayor's Office, 1984; Government of Ontario, Ministry of Housing, 1986; Richman and Harris, 1983).

In Ontario, from 1965 to 1976, the total number of patients in mental institutions dropped by almost 75 per cent. In 1963, Ontario maintained over 16,000 provincial psychiatric beds. By 1981, this number had dropped to approximately 4,500 (City of Toronto, Mayor's Office, 1984; Marshall, 1982).

While mental hospital admissions were being drastically reduced, many mental health facilities in Ontario were being closed down or severely cut back.

Lakeshore, Timmins' Northeastern, and Goderich Psychiatric Hospitals have been closed down while many others have experienced severe budget cuts and ward closings, especially London Psychiatric Hospital and the Royal Ottawa Hospital (Marshall, 1982).

The trends in mental health care at Hamilton Psychiatric Hospital are similar to that of the Province as a whole. Over the past approximately 20 years, the number of psychiatric beds available has been drastically reduced (from 1,730 in 1960 to 525 in 1977) and the census of hospital patients on the books (those in hospital at a given time) has declined from 2,173 to 456 (1960 to 1977) (Dear et al, 1980).

A rise in community-based mental health care accompanied the move away from hospital care. As such, the general hospital was encouraged to develop psychiatric service units (Dear et al, 1980). Indeed, in 1960, 20,058 psychiatric patients were housed in psychiatric hospitals while only 347 patients were admitted to general psychiatric units. By 1976, this trend had been virtually reversed, with 4,654 patients in psychiatric hospitals and 1,425 patients in general hospital units (City of Toronto, Mayor's Office, 1984).

Despite the supposed therapeutic benefit of deinsti-

tutionalization, some negative unintended consequences have occurred. A major contributor to these negative consequences has been that deinstitutionalization has occurred faster than the establishment of community-based support systems (Bachrach, 1984; City of Toronto, Mayor's Office, 1984; Dear et al, 1980; Halpern et al, 1980; Hamilton-Wentworth District Health Council, 1984; Marshall, 1982; Nelson and Earls, 1986). So, despite the fact that the total number of patients in Ontario mental hospitals dropped by 75 per cent between 1965 and 1976, during this same time period, admission rates doubled and discharges almost trippled; re-admissions constituted two-thirds of all admissions (City of Toronto, Mayor's Office, 1984) with approximately one-half of those released being re-admitted within one year of discharge (Marshall, 1982). This phenomenon is euphemistically called "the revolving door syndrome", for obvious reasons. There are approximately 7,000 psychiatric discharges every six months in Metropolitan Toronto alone; 30 to 40 per cent of those discharged are back in hospital in the first six months (Marshall, 1982).

Recall that, by definition, deinstitutionalization requires a comprehensive community support network in order to realize its full potential. Recall also that the

financing for this aforementioned network was to come from the monies saved from psychiatric hospital closings and cutbacks. Unfortunately, this network did not materialize, nor did the expected financing. For example, following the closure of Lakeshore Psychiatric Hospital in Toronto in 1979, only 10 per cent of the available funds were channelled into local community mental health services (Marshall, 1982).

Overall, the manifestation of deinstitutionalization has been other than what was originally intended. Criticisms of the movement range from the severe to the relatively benign. For example, the Ontario Public Service Employees Union has been very clear on its views of deinstitutionalization in Ontario:

> All indications are that what has been called deinstitutionalization, a purported dedication to the generally valid concept of treatment in the community, is in fact a neo-conservative euphemism for divestment of public responsibility as a way of saving money (Marshall, 1982;18).

Others have hinted that deinstitutionalization is nothing more than political rhetoric (Laws and Dear, 1987, forthcoming).

Deinstitutionalization has not been an entirely negative experience: "...a variety of highly successful programs in nontraditional and noninstitutional settings

have enhanced the lives of some chronic mental patients" (Bachrach, 1983; 105). Overall, however, it would appear that the objectives of the deinstitutionalization movement have not been met (Bachrach, 1983; Richman and Harris, 1983). This is primarily due to the fact that a comprehensive support network was not functioning in the community as large numbers of psychiatric patients were being released.

There are those who feel that 'deinstitutionalization' is a misnomer and should more rightly be referred to as 'trans-institutionalization'. That is, many psychiatric patients were not transferred to the community *per se* but, rather, transferred from large institutions to mini-institutions in the community: the nursing home, the boarding home, or the lodging home where simple custodial care remains the philosophy of 'treatment' (Allen, 1974; City of Toronto, Mayor's Office, 1984; Halpern *et al*, 1980; Lamb and Goertzel, 1971; Mechanic, 1980; Smith, 1975). Still other patients are now being treated in general hospitals as opposed to psychiatric hospitals, while some are literally dumped in inadequate housing in inner-city and transitional areas, often left to be victimized by criminal elements (City of Toronto, Mayor's Office, 1984; Dear *et al*, 1980; Marshall, 1982; Mechanic,

1980). This latter practice has contributed, along with other factors, to the process of ghettoization in the inner-city by the chronically mentally ill. This is particularly visible in certain areas of Toronto (Siggins, 1982) as well as Hamilton (Dear et al, 1980).

A disturbing realization is that deinstitutionalization has been a major factor leading to the increase in the number of homeless people. Many patrons of shelters for the homeless, in several North American cities, are there because of inadequate resources and aftercare for the chronically mentally ill (Baxter and Hopper, 1982; Block, 1984; Lamb, 1984; Nichols, 1987). It has been estimated that anywhere from 82 to 91 per cent of samples of homeless people sleeping in public shelters were diagnosed as mentally ill (Lamb, 1980). It is not certain, however, whether the experience of mental illness results in homelessness or vice versa. A more conservative estimate of the number of homeless people who can be considered mentally ill would be approximately 40 per cent (Dear and Wolch, 1987; The Globe and Mail, November 21, 1986, A7).

The 'revolving-door' syndrome is another of the consequences of the blatant shortage of comprehensive after-care for the ex-psychiatric patient. Anthony et al (1978, as cited in Meyerson and Herman, 1984) were not

surprised to discover that recidivism data show remarkable consistency despite differences in population, institutions and geographic area. In the 46 recidivism studies reviewed by these authors, typical results were as follows: 30 to 40 per cent recidivism at five to six months, 35 to 50 per cent after one year and 60 to 75 per cent after three to five years. Yet most recent studies reveal that the more available and comprehensive the after-care, the lower the rates of recidivism and rehospitalization, while there is a greater increase in community tenure and level of community adjustment (Meyerson and Herman, 1984).

Concomitant with this lack of after-care was a failure on the part of the institutional staff releasing the patient to arm that patient with the necessary skills and knowledge imperative for community living. For example, Halpern et al (1980) found that patients were leaving institutions so quickly that they were not adequately treated before they left, leaving no time to plan a community placement for them. Wasylanki and others suggest that as length of stay and number of residents decreases, the decreased number of institutional staff become more involved with acutely psychotic patients, precluding time for tasks such as after-care or discharge planning (as cited in Meyerson and Herman, 1984).

Despite the numerous unintended negative consequences of deinstitutionalization, many professionals as well as some of the chronically mentally ill patients themselves defend the movement, arguing that the fault lies in implementation and not the fundamental concept (City of Toronto, Mayor's Office, 1984; Dear et al, 1980; Halpern et al, 1980; Marshall, 1982; Smith, 1975; Mechanic, 1980). In order for the deinstitutionalization movement to realize its full potential, however, adequate community support systems, including appropriate housing, **must** be installed in the community to help the ex-psychiatric patient to cope in their new and oftentimes unfamiliar environment.

2.2. The Geography of Mental Health

The main focus of this literature has been the consequences, unintended or not, of deinstitutionalization (Dear, 1977; Dear and Taylor, 1982; Wolpert, Dear and Crawford, 1975). Empirical studies have focused on two main issues. The first involves the clustering or ghettoization of the deinstitutionalized mentally ill in inner city neighbourhoods (Dear, 1977; Smith, 1975; Wolpert and Wolpert, 1974). An attempt has been made to understand this ghettoization process through the notion of the 'public city', which suggests that the clustering of

service-dependent populations and the siting of service facilities are mutually reinforcing factors (Moos, 1984; Wolch, 1981). So much so that the recent dismantling of the public city as a result of inner city revitalization and gentrification has resulted in serious negative consequences for the service dependent, such as dislocation and homelessness (Wolch and Gabriel, 1985).

The second empirical issue involves community attitudes toward the mentally ill as well as community mental health facilities (Boeckh, Dear and Taylor, 1980; Dear, 1977; Dear and Taylor, 1982). For example, Dear and Taylor (1982) examined community reaction to facilities for the mentally ill in residential neighbourhoods in Metropolitan Toronto and analyzed determinants of public attitudes as well as the characteristics of 'accepting' and 'rejecting' neighbourhoods.

In general, this previous empirical work has centred upon the viewpoints of the community at large toward the community mental health movement and the deinstitutionalized mentally ill. The viewpoint of the mentally ill themselves has virtually been ignored, with one notable exception. Dear and others (1980) conducted a pilot study of former psychiatric patients within the inner city of Hamilton. They identified life areas where coping was a problem for

former patients. These areas included housing, income (jobs), medical and psychiatric services, and social needs (Dear et al, 1980; 5-7). The findings indicated the variability of coping performance and provided preliminary evidence on the factors affecting the former patient's ability to cope in the community.

These findings were used as a point of departure for a research project which examines the factors influencing the quality of everyday life among the chronically mentally ill in the community. This examination is based on a socioecological model of coping (Kearns, Taylor and Dear, 1987) which identifies interacting sets of community and client variables as possible determinants of coping outcomes. These variables include personal background and beliefs, psychiatric profile and services, lifestyle and social support network, and the housing situation, and can be referred to collectively as the 'community environment'.

The research is informed by the socioecological model of health (see figure 1) as described by Norman White (1981) whereby a health outcome (w,x,y,z) is the result of the interaction of a person or group of persons (P) with several environmental factors (e_1 through e_6) which are, simultaneously, interacting among themselves. The

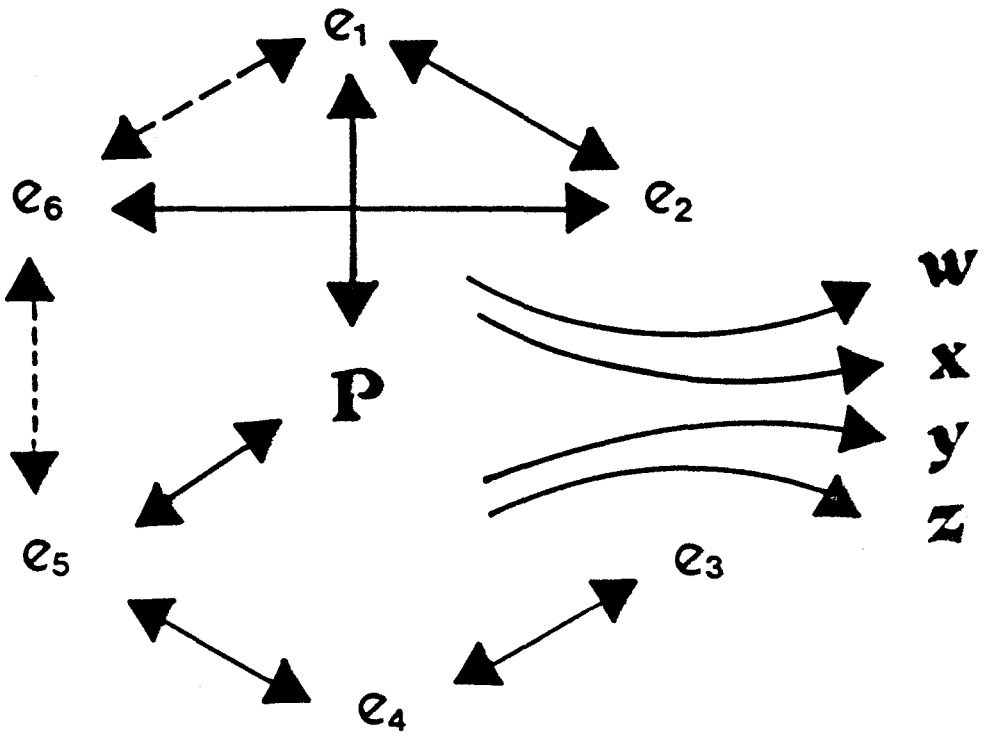

Figure 1: A socioecological model of health.

source: White(1981)

model is offered as an alternative to the prevalent Biomedical Disease Model which follows a linear sequence of illness from cause to lesion to symptom(s).

There are several facets of the interactionist perspective of the model which require comment. Firstly, because of the inter-relatedness of the environmental elements, the whole environmental impact has the potential to be greater than the sum of its parts.

Secondly, the person centred in the model is seen as a "...particularly versatile interacting element in a complicated social and physical ecosystem" (White, 1981;13). As a result, it is just as important to understand the environment that surrounds the person as it is to understand the person (White, 1981). In other words, as the research is based in a person-environment interactionist perspective, attention must be duly paid to both perspectives (that is, the person and the environment, which includes societal norms) without privileging either (Kates, 1979).

Following from this, it must be noted that while the environment impacts upon the person, the person also impacts upon the environment. And while all persons are structurally constrained in their actions, they still enjoy some measure of freedom of choice. So that while the

choices that a chronically mentally ill ex-psychiatric patient has available in terms of housing, for example, may be severely constrained by income, illness, and so on, they remain choices nonetheless (Kearns, 1986; Ley, 1983).

The concepts embedded in the socioecological model are reflected in recent work in social and medical geography; more specifically, the concept of environmental determinants of health outcomes as described by Eyles and Woods (1983). In this context, environment is viewed in a broad sense, incorporating physical, economic, socio-cultural as well as behavioural aspects of an individual's surroundings. Further, a relatively broad definition of health is employed in order to capture more subjective measures of well-being, such as quality of life or coping ability. This follows from the redefinition of health by the World Health Organization in the 1970s, when health became more than simply the absence of disease but, rather, "...a state of complete physical, emotional and social well-being" (Breslow, 1972, as cited in White, 1981).

This thesis focuses on an examination of the housing situation as one particular element of the community environment. This incorporates the type and quality of both housing and neighbourhood. The research is based upon the premise that the characteristics of the chronically

mentally ill ex-psychiatric patient's immediate environment strongly influence their ability to cope in the community and to, therefore, avoid rehospitalization. Although the current work does not attempt an explanation of the effects of the housing situation upon coping outcome, the research has clear implications for a better understanding of this relationship.

2.3 Housing Ex-Psychiatric Patients

The availability of appropriate housing for the chronically mentally ill is crucial if successful community integration is to be achieved and the original goals of deinstitutionalization are to be realized (Dear et al, 1980; Scott and Scott, 1978; Lamb and Goertzel, 1971; Laws and Dear, 1987; Segal and Aviram, 1979). As a result, it is not difficult to perceive appropriate housing to be one of the essential ecological elements within the socioecological model of health (White, 1981; see figure 1) directly affecting the ex-psychiatric patient's ability to cope in the community.

It is evident from the literature that the type of accommodation (Kruzich, 1985; Lehman et al, 1986; McCarthy et al, 1985), the architectural and locational features (Elton and Packer, 1986; Hull and Thompson, 1981;

Moos and Lemke, 1980) and the social environment of the living situation (Kruzich and Kruzich, 1985; Kunze, 1985; Linn et al, 1980; Trute, 1986) may be very important to the well-being of chronic mental patients in the community. For example, Byers et al (1978) examined the relationship between the housing needs of the chronically mentally ill and subsequent community adjustment. This research, focused on the relationship between the community support system available to 129 chronically mentally ill ex-psychiatric patients and recidivism, suggests that the living situation of the ex-psychiatric patient may be a more significant determinant of recidivism than even the receipt of traditional aftercare services (Byers et al, 1978; 33).

Further research in this vein by Smith (1978) and Smith and Smith (1979) attempted to assess the role of geographical location in the community in reintegration as well as "...test the ecological hypothesis that the environmental characteristics of the patients' residential neighbourhoods can predict recidivism in the sample" (Smith, 1978; 17). Smith's analysis demonstrated that "...spatial variations in the characteristics of residential neighbourhoods can be shown to influence a measure of well-being in former patients" (Smith, 1978; 24). Furthermore, this study showed that even without data on the

patient's diagnosis, treatment or aftercare, it was still possible to predict recidivism significantly on the basis of ecological variables alone. More specifically, Smith found that patients living in a neighbourhood classified as transient which also had a high housing and population density as well as a high percentage of commercial/industrial land use, were more likely than others to return to hospital. Such neighbourhood characteristics are typical of inner city residential areas. In rating the factors facilitating the internal integration of sheltered care residents, Segal and Aviram (1979) found "Having the facility located outside of a downtown area" very near the top of the priority list (Segal and Aviram, 1979; 505).

Smith argues that these findings have major policy implications, because a patient's living situation can be one of the most manipulable variables involved in aftercare, much more so than individual therapy (Smith, 1978). Byers et al conclude on a similar note where they claim that if appropriate housing is more effective than traditional aftercare services in contributing to the coping process, policy makers may be squandering both human and financial resources in inappropriate areas of patient aftercare (Byers et al, 1978; 34).

It would appear, therefore, that appropriate housing for the chronically mentally ill is an essential ingredient

in the coping process. There are many different facets to the housing issue, however, as well as viewpoints as to need from both the 'normative' and 'expressed' need perspectives. The most crucial aspect of the housing issue is, simply, that there is not enough appropriate housing to meet the need. In their study of housing supply for the chronically mentally ill, Scott and Scott found "...there simply is not enough room in the community to receive all of the people...for whom either deinstitutionalization and/or community care programs exist or are planned" (Scott and Scott, 1978; 219).

It is understandable that one of the greatest problems facing the psychiatric patient upon discharge from an institution is housing (City of Toronto, Mayor's Office, 1984; Dear et al, 1980; Halpern et al, 1980; Hamilton-Wentworth District Health Council, 1984; Nelson and Earls, 1986). Dispositions of ex-psychiatric patients themselves reveal that their first priority upon being released from hospital is: Where am I going to live? (Allen, 1974; Peterson, 1982). The search for housing by this population can be a very frustrating experience, however. Negative community attitudes toward this group of individuals make it very difficult for helping agencies to locate clients in residential neighbourhoods. Clients,

therefore, often end up living in more accepting, but less desirable, neighbourhoods. These neighbourhoods usually have a high proportion of non-residential land uses, are often in decline, and are potentially dangerous (Halpern et al, 1980; Dear and Wolch, 1986). As a result of financial constraints, the chronically mentally ill are usually restricted to the low-end of market rental accommodation (Dear et al, 1980; Hamilton-Wentworth District Health Council, 1984). However, Scott and Scott's study on available appropriate housing for this group found that "Much of the vacantfor-rent housing is located in neighbourhoods that may not be the best environments for clients of community-care programs" (Scott and Scott, 1978; 215). Halpern and others concur: "Normalization (is) virtually impossible in such settings" (Halpern et al, 1980; 93).

Some of the specific difficulties encountered by discharged psychiatric patients in their search for housing are detailed in Dear et al (1980; 35) in their seminal study on coping:

> "It's hard to find a place to live - people avoid me."
>
> "(There are) too many houses on the street; (there's a) factory across the street that's dirty and noisy."
>
> "I couldn't find a place to live, _____

Housing Agency turned me down three times in a row."

As a result of such difficulties, the ex-psychiatric patient may, and often does, resort to the less rejecting neighbourhoods of the inner city. This is not always a negative occurrence. Many feel that the ghettoization of this group in a single area provides an informal support network that otherwise may not be available (Dear, 1977; Cohen and Sokolovsky, 1978; Lamb, 1979; Wolch and Gabriel, 1985). Oftentimes, however, the housing avaliable in inner city areas does not constitute a therapeutic living environment (Halpern et al, 1980; Lamb and Goertzel, 1971; Smith, 1975). For example, in a sensitive account of the ghettoization of ex-psychiatric patients in the city of Toronto, Maggie Siggins describes the Parkdale neighbourhood where its huge Victorian homes have easily been turned into boarding houses. In this prime location not far from the Queen Street Mental Health Centre, more than 1,200 discharged psychiatric patients have taken up residence (Siggins, 1982). Inside the boarding houses where episodes of violence and extreme bizarre behaviour are not uncommon, four or five people are often crammed into one unkept room (Siggins, 1982).

The Supportive Housing Coalition of Toronto feels that squalid housing worsens patients' conditions

(Government of Ontario, Ministry of Housing, 1986). A former psychiatric patient, currently a resident of the Parkdale neighbourhood, had this to say at a recent public meeting:

> More than likely you are going to end up back at Queen Street (Mental Health Centre) not because of the problems that originally put you into Queen Street, but because of the problems that you have to face in a boarding house. It's just a terrifying horror story (Government of Ontario, Ministry of Housing, 1986; 17).

A non-therapeutic living environment is one of the unintended consequences of deinstitutionalization experienced by the chronically mentally ill. Recent studies have shown, however, that the lack of available and appropriate housing for this population has also resulted in a resurgence in the number of mentally ill being incarcerated in jails and penitentiaries. Lamb and Grant (1982) found that of 102 randomly selected male inmates in an American county jail, 90 per cent had experienced psychiatric hospitalizations in the past and over 75 per cent met the state criteria for involuntary hospitalization (Lamb and Grant, 1972; 17). It was in May 1986 when the Federal Solicitor-General for Canada acknowledged that the presence of large numbers of the mentally ill in the Canadian prison system was a serious problem (The Hamilton Spectator, May, 1986). Despite the progress made by the

deinstitutionalization movement, these recent events are reminiscent of the seventeenth century (Foucault, 1973).

Furthermore, it is increasingly apparent that a large proportion of the homeless people in North America are direct or indirect victims of the deinstitutionalization movement (Appleby and Desai, 1985; Bassuk, 1984; Baxter and Hopper, 1980, 1982; Block, 1984; City of Toronto, Mayor's Office, 1984; Dear and Wolch, 1987; Lamb, 1984; Nichols, 1987). In a study of the relationship between homelessness and psychiatric hospitalization, Appleby and Desai conclude that "Until various systems develop adequate responses to the problem, both the numbers and the visibility of the homeless mentally ill are likely to increase (Appleby and Desai, 1985; 732).

Recent studies in Toronto and Hamilton reveal just how acute the housing need is for the chronically mentally ill in these cities. The Mayor's Action Task Force on Discharged Psychiatric Patients in the City of Toronto (1984) reveals that supportive housing is required for the majority of discharged psychiatric patients (53-62 per cent) but "due to deficiencies in appropriate housing the discharge of 26-31 per cent of the patients may actually be delayed"[1] (City of Toronto, Mayor's Office, 1984; 32).

A similar level of need is apparent in Hamilton.

Dear et al conclude that "At base, the problem seems to be one of an acute shortage of housing alternatives for the mentally ill. The patients' need for a 'humane environment' is too frequently overlooked in the housing market" (Dear et al, 1980; 6). These observations have been more recently substantiated by similar findings contained within the Hamilton-Wentworth District Health Council's Final Report of the Mental Health Task Force (1984).

2.3.1 Alternative Residential Approaches

There are many different residential alternatives in existence for, though perhaps not available to, the chronically mentally ill in the community. These alternatives range along a continuum of living situations from those that are relatively closed (in terms of resident participation in decision making or resident's level of responsibility for self) to those that are relatively open. The living environment that can be considered the most closed, outside of the hospital, is that experienced in the nursing home. Residents in this setting are chronically psychiatrically impaired individuals whose treatment involves maintenance as opposed to rehabilitation (Hamilton-Wentworth District Health Council, 1984).

The next living environment along the continuum

in terms of degree of openness would be the half-way house. There are many different forms of this type of living situation but, at base, a half-way house is a transition-type residence which operates as a stepping-stone between an institution (for example, a psychiatric hospital) and independent community living. Emphasis is placed upon life-skills training. There are not many chronically mentally ill individuals housed in these facilities, as they are in very short supply (Hamilton-Wentworth District Health Council, 1984). For example, in their study of sheltered-care facilities in California, Segal and Aviram (1979) found that half-way houses constituted only two per cent of available facilities and served only three per cent of the population in sheltered-care (Segal and Aviram, 1979; 106). Furthermore, the nature of this living situation dictates that these are temporary, not permanent, residential placements, with length of stay averaging about seven months.

Next along the continuum would be the foster home. In this instance, 'traditional' families volunteer to board a chronically mentally ill persson in their home for a fee paid partly by the resident and partly by the state. As this residential alternative places such a strong emphasis on volunteerism, foster family care would appear to

represent a more 'normal' residential alternative than many others, and at a considerable financial saving (Appathurai et al, 1986). Despite these advantages, however, this form of residential alternative is severely under-represented among sheltered-care possibilities (Wolfensberger, 1972; Appathurai et al, 1986). For example, Segal and Aviram (1979) found that family care homes in California accounted for only 26 per cent of sheltered-care facilities and served only 14 per cent of the population (Segal and Aviram, 1979; 106). Studies have shown that ex-psychiatric patients in foster care experienced low rates of rehospitalization (Linn et al, 1980; Murphy, 1972). Despite this fact, however, foster homes have been accused of being "The New Back Wards" because "they can be as institutionalized as hospitals" (Murphy, 1972; 14).

Following foster care along the continuum is the boarding house or lodging home. These facilities serve the greatest proportion of residents in the sheltered-care population (City of Toronto, Mayor's Office, 1984; Dear et al, 1980; Hamilton-Wentworth District Health Council, 1984; Lamb, 1981; Nelson and Earls, 1986; Ontario Social Development Council, 1986; Segal and Aviram, 1979). For example, Segal and Aviram (1979; 106) found them to comprise 72 per cent of facilities in the state of California and

house 82 per cent of the sheltered-care population. Within these houses, a fee is paid for services which include, at least, a room (usually shared), three meals a day, distribution of medications and minimal to 24 hour staff supervision (Lamb, 1981). Depending upon the operator, some homes may also offer: financial management, life skills training, recreational facilities, and so on. The fee paid for service is usually quite high. For example, according to the the Social Planning Council of Metropolitan Toronto, discharged psychiatric patients moving into boarding houses can pay up to 89 per cent of their monthly income on room and board (City of Toronto, Mayor's Office, 1984; 33). Populations in these homes range anywhere from a few individuals to hundreds of individuals (Lamb, 1981). Despite the fact that these living environments are relatively open, they have the potential to foster dependence or isolation in the chronic ex-psychiatric patient, due to their lack of participation in household activities (for instance, cooking, cleaning, money management, and so on).

Following the boarding house on the continuum of living environments is co-operative living. There is an operating example of this type of housing in Toronto, Ontario. Houselink Community Homes offers inexpensive

satellite housing to the chronically mentally ill living in the community which is characterized by smallness, self-financing, minimal staff input, maximum independence, shared accommodation and support from a central source (Stark, 1982). This programme currently maintains eleven co-operative apartments and houses scattered throughout the city of Toronto. Each unit houses four or five individuals who manage their own finances, establish their own house rules and sit on the co-op's board of directors (Stark, 1982). This is the only known true co-op housing available for the chronically mentally ill in the Hamilton-Wentworth vicinity (Hamilton- Wentworth District Health Council, 1984).

The last step on the continuum is independent living in the community, which provides a completely open living environment. Interspersed at many points along the continuum, however, are experimental 'model' programmes which are very site-specific (see, for example, Armstrong, 1979; Campanelli et al, 1983; Test and Stein, 1985; Wells and Huessey, 1985).

The availability of each of these types of living environment in Hamilton is detailed in Table 2.1. There are approximately 598 residential beds specifically available to the chronically mentally ill in Hamilton. The

TABLE 2.1 EXISTING HOUSING STOCK FOR EX-PSYCHIATRIC PATIENTS (HAMILTON, ONTARIO)

HOUSING TYPE	# OF BEDS
Cooperative Living	21
Approved Homes	28
Homes for Special Care	91 residential
	147 nursing home
Second-level lodging home (contract only) [2]	279
Second-level lodging home (non-contract)	32
TOTAL	**598**

Source: Hamilton-Wentworth District Health Council, Final Report of the Mental Health Task Force. (1984)

majority of these are concentrated in second-level lodging homes. And, the overall capacity of the system to absorb new cases is restricted by low turnover rates, leaving the estimated intake capacity for a 12 month period at 155 (Hamilton-Wentworth District Health Council, 1984). Further, these are concentrated at the second-level lodging home level. A recent mental health task force estimates that 2,000 psychiatric patients are discharged annually in Hamilton, 600 of them chronic. This task force also estimates that approximately one-half of these individuals are in need of housing upon discharge, as well as some of the 1,400 acute discharged patients (Hamilton-Wentworth District Health Council, 1984). There is an obvious discrepancy, therefore, between supply and demand.

Many feel that the private housing market is well beyond the reach of the majority of the chronically mentally ill (City of Toronto, Mayor's Office, 1984; Dear et al, 1980; Hamilton-Wentworth District Health Council, 1984). This can be attributed to a variety of factors; for example, psychiatric illness/history, lack of permanent employment/ references, restricted/fixed income, negative community attitudes, and so on. Indeed, should the ex-psychiatric patient be able to overcome these hurdles, the market would still not cooperate; that is, Hamilton has a current

apartment vacancy rate of 0.4 per cent, less than one-quarter the national average (The Hamilton Spectator, November 14, 1986, D7). The Canada Mortgage and Housing Corporation feels that a vacancy rate of three to five per cent can be considered 'healthy'. Concomitant with the low vacancy rate are increasing rental rates for apartment units in Hamilton. Rents have increased at a rate higher than the general rate of inflation (Hamilton-Wentworth Region, Planning and Development Department, May 1985).

Until very recently, the ex-psychiatric patient did not have access to government assisted housing in this Province (that is, housing available through the Ontario Housing Corporation). Recent policy changes have amended this, now allowing access to this group. There are some drawbacks to this new housing option for the chronically mentally ill, however. For example, the individual must sign a one year lease. This could pose some problems if decompensation requires a return to hospital. Further, this type of living situation is also in short supply, with a waiting list for almost 600 units in the city of Hamilton alone (Conference on the Accommodation of the Psychiatrically Handicapped in Provincially Assisted Housing, January 24, 1986, Hamilton Convention Centre).

Despite the apparent gaps in the existing housing

system as well as the obvious reliance upon the boarding house as a community living environment for the ex-psychiatric patient, the recent literature appears to be supporting the view that it is quite possible, and therapeutic, to 'make do' with the current housing stock as opposed to increasing the choice and supply of housing alternatives. This literature appears to be based upon the premise that the current residential situation for the chronically mentally ill is fixed and immutable; therefore, mental health professionals, boarding home operators and clients alike should try to make the best of a bad situation by making current living environments more tolerable and/or more therapeutic.

For example, Betts et al (1981) explain that, oftentimes, residential choices for ex-psychiatric patients are very limited and that, although many board-and-care homes have received (and have deserved) some bad publicity, there are many more board-and-care homes that provide a quality of life better than their residents have ever known (Betts et al, 1981; 499). Van Putten and Spar (1979) agree that the board-and-care home does not deserve the bad press it often gets. In order to be able to differentiate between 'good' and 'bad' homes, therefore, Betts et al undertook to provide to families of ex-psychiatric patients as well

as patients themselves a checklist for selecting one of the many 'good' board-and-care homes in the state of Nebraska. Examples of checklist items include: the availability of food for those on special diets; the maximum number of residents per bedroom; and liason with mental health professionals (Betts et al, 1981, 499).

Sweeney et al (1982) provide another example of the make-do or satisficing attitude. These authors chronicle the 'exodus' of ex-psychiatric patients from the hospital to urban hotels in the poorer sections of American cities. The claim is made that mental health service agencies are fully knowledgable of the drawbacks involved yet continue to 'place' patients in these hotels because there are no alternatives and, as a result, agencies have become dependent upon these hotels over time (Sweeney et al, 1982). Further, having researched the living environments of these hotels, these authors conclude that some (although admittedly not all) can be considered therapeutic and beneficial to community reintegration (Sweeney et al, 1982; 13).

Richard Lamb and Carolyn Peterson (1983) concede that a large proportion of chronically mentally ill persons live in non-medical community residential facilities run by administrators and staff who are not specifically trained

in the management of psychiatric patients. They claim, however, that simple consultation with the staff by mental health workers can (or could) make all the difference between a therapeutic and non-therapeutic environment.

Peterson (1985) expands upon this notion by putting the onus on the mental health professional to focus on improving the understanding of the problems experienced by the community care **industry:**

> Despite the problems, community care facilities are an important resource for the mental health system. Since alternative residential resources are not available, we need to focus on improving our understanding of the problems experienced by the new community care entrepeneurs and then on designing and funding regulatory and consultative interventions that will enhance their original mission of reintegrating the mentally ill into the community (Peterson, 1985; 383).

According to Lamb (1981), in order to live amiably in a board-and-care home, one needs only to lower one's expectations:

> To be sure, living in a board-and-care home presents some problems: the constant request for cigarettes from other residents, the frequent theft of one's posessions, or the occasional insensitivity of staff. However, if one is willing to lower one's expectations and can accept a limited environment, it can be a not unsatisfactory place to live (Lamb, 1981; 28).

Despite those who feel that board-and-care homes have an important role to play in the realization of the

original goals of deinstitutionalization, still others maintain that these and other private residential facilities are in the business simply to exploit the ex-psychiatric patient and to secure a profit (Emerson, 1981; Marshall, 1982; Scull, 1981).

2.4 Residential Needs Assessment

In terms of residential needs assessment for the chronically mentally ill, it would appear that the majority of the research in this area relies upon the use of significant others (family members, social workers, therapists, psychiatrists, and so on) as key informants of need. For example, a needs assessment study was done to assess the service needs of the Los Angeles County's inpatient population through a questionnaire survey of the patients' primary therapists (Fowler, 1980). It was felt that primary therapists were both knowledgable informants about the patients' needs and potent influences, through the referral process, on the demand for alternative services, including residential placement.

A more recent needs assessment study made by Solomon and Davis (1985) used social workers cum discharge planners as sources of information. These mental health professionals filled out a 'Service Needs Assessment Form'

for each of their patients. 'Needed services' were defined as those which were considered necessary for the discharged patient to be self-sufficient, or to be working toward self-sufficiency in the community (Solomon and Davis, 1985; 12). The overall conclusion of these authors was that almost one half of the study cohort had their basic service needs met but few had their rehabilitation needs met. That is, the service needs most likely to be met were individual therapy, chemotherapy and financial assistance. These were generally the most needed services, according to this study, and were considered basic maintenance services as opposed to the more rehabilitative services; the implication of this being, of course, that the researchers are assuming housing needs to be rehabilitative as opposed to basic maintenance needs. However, the authors report that at the time of the study, the local government mental health planning body had projected a need for 2,340 residential beds in the County while there were only 258 beds available (Solomon and Davis, 1985; 15).

Misconceptions such as these are the obvious reason why some researchers feel that too much emphasis is being placed upon the viewpoint of significant others and not enough upon the perceptions of the chronically mentally ill as to their housing need (Laws and Dear, 1987; Levine

and Parrish, 1986; Segal and Aviram, 1978). Indeed, Segal and Aviram unequivocally state: "That individuals as residents of sheltered care should be used as primary source [sic] of evaluative information relating to their living arrangements" (Segal and Aviram, 1979; 505; emphasis added).

2.4.1 Expressed Housing Need

When assessing the residential needs of the chronically mentally ill in the community, the viewpoint of the individual client is rarely heard. Descriptive accounts of expressed need can be found in the writings of ex-psychiatric patients themselves. For example, Priscilla Allen (1974) is an ex-psychiatric patient now living in a board-and-care home in California. She writes of the advantages and disadvantages of life in the community versus life in the hospital. Although she never wants to go back to the hospital, she feels that there is a real possibility that the back wards of yesterday's state mental hospitals are being reincarnated into the board-and-care homes of today (Allen, 1974; 5).

Ronald Peterson is an ex-psychiatric patient living in New York City. In addressing the needs of chronic mental patients, Peterson echoes others in stating that the most important consideration upon discharge to the community

is the living situation. He expresses this need as follows:

> Many of us, with just a little help, could live with each other in a real apartment of our own. This way we could have a bedroom, a living room, our own toilet...and also a little kitchen where we could do some cooking if we wanted (Peterson, 1982; 610).

One of the most recent studies of residential needs assessment (Nelson and Earls, 1986) combines both research methods by using significant others as key informants of need as well as a survey of the chronically mentally ill themselves. While the authors claim that their study reveals agreement between long-term psychiatric clients and the people who serve them that housing is a significant problem for the chronically mentally ill living in the community, no standard unit of comparison is provided to the reader. So that while the paper states that 77 per cent of key informants felt that housing was a problem for at least half of their clients, it is unclear whether one can compare that to the statement that 48.4 per cent of the clients reported three or more housing concerns at the time of the interview (Nelson and Earls, 1986; 13-16). The social welfare literature does reveal, however, that clients have a tendency to under-estimate their needs (For a discussion of this tendency as well as a review of the literature, see Plant et al, 1980; 14-21).

2.4.2 Normative Housing Need

Normative housing need, in the context of this thesis, is the housing need of the ex-psychiatric patient in the community as defined by academics as well as mental health and associated professionals. For instance, in the former category, Dear and Wolch (1979) have developed a comprehensive theoretical framework for defining need consisting of a two-dimensional space formed by two continua - autonomy- dependence and protected-unrestricted - with the aim being an optimal assignment of client needs to treatment settings. Here, client needs range along the autonomy-dependence continuum matched with various treatment settings along the protected-unrestricted continuum. Within this framework, the sectoral or treatment progression begins with total dependence in an institutional setting. A spatial progression along the continuum to the client's new community outside of the institution involves a sectoral/treatment progression to inpatient care or a group home, where the client enjoys slightly more independence than in the institution. When the client progresses into the local community, s/he also progresses into a much less restrictive sector/treatment (for instance, independent community living). Ingress and egress are controlled by the system's gatekeeper (for example, the general practitioner)

and the yardstick used for spatial progression is the tolerable autonomy level of the client along with the degree of normalization of the physical and social environment of the sectoral/treatment progression (Dear and Wolch, 1979; see also Hull and Thompson, 1981).

The majority of academic literature (Arce and Vergare, 1985; Hull and Thompson, 1981; Nelson and Earls, 1986) as well as the professional literature (City of Toronto, Mayor's Office, 1984; Hamilton-Wentworth District Health Council, 1984; Marshall, 1982; Ontario Social Development Council, 1983) appears to agree with the model developed by Dear and Wolch (1979) in that a continuum of housing options is needed, with environments ranging from total dependence or restrictiveness to total independence or unrestriveness. This literature also seems to agree on the fact that such a housing system is not yet in place.

A recent task force of the American Psychiatric Association (Arce and Vergare, 1985; 427) established what this housing continuum should resemble in reality:

1. Nursing facility
2. Group home
3. Personal care home (a congregate care facility)
4. Foster home
5. Natural family placement
6. Satellite housing (co-op housing)
7. Independent community living

Studies calling for additional housing options for

ex-psychiatric patients in the community are recommending more group homes, half-way houses and co-operative (satellite) housing, as they feel that these are the types in shortest supply (Hamilton-Wentworth District Health Council, 1984, recommendation 5, priority 3; Nelson and Earls, 1986, 13-14).

Some call has even been made for the three-quarter way house for clients who need a less-structured transitional living situation prior to independent living. The main attraction of this alternative is that the cost is two-thirds that of half-way house placement (Campbell, 1981).

2.5 Conclusions

As a result of deinstitutionalization a great many chronic psychiatric patients were released into the community. This occurred faster than the establishment of community- based support systems. One of the major problems facing the discharged psychiatric patient is housing. The review of the housing literature contained within this chapter reveals the importance of appropriate housing to reintegration as well as the acute need for housing for the group under study. However, there appears to be an impetus within the recent literture to want to make-do with the

current housing stock as opposed to providing more housing options.

In terms of residential needs assessment, it appears that the majority of research in this area relies upon the use of significant others as key informants of need. There are no comprehensive descriptions within the literature of the housing experience as described by the chronically mentally ill themselves nor any examination of the residential stability of this group. The normative definition of housing need for the chronically mentally ill in the community involves a range of housing options to be matched with client needs along a dependence-autonomy continuum. Such a housing system is not yet in place in Hamilton. Indeed, a survey of the existing housing stock reveals a shortage of housing for the chronic ex-psychiatric patient in Hamilton as well as a concentration of housing in second-level lodging homes. How the normative definition of housing need 'fits' with expressed housing need is not yet known, as the viewpoint of the individual client is rarely heard.

The objectives of this research are aimed at addressing these gaps in the literature, concomitantly informing the relationship between housing and coping as

described in the socioecological model of coping (Kearns, Taylor and Dear, 1987).

CHAPTER THREE

RESEARCH DESIGN

This thesis is part of a larger research project designed to examine the coping ability of the chronically mentally ill in different community settings in Hamilton. Cross-sectional and longitudinal survey data were collected by way of the 'Life Management in the City Questionnaire' (see Appendices A and B) from a sample of clients participating in one of three existing mental health care programmes in Hamilton, each offering different levels of support and service to the chronically mentally ill in the community. Specifically, the project sought to examine the effects on coping ability of four sets of environmental factors: living situation, material well-being, social network and psychiatric support system. The current research focuses upon the living situation as one particular environmental factor. This thesis does not attempt an explanation of the effects of the living situation upon coping outcome, although the research has clear implications for a better understanding of this relationship.

Individuals sought for inclusion in the study sample are the chronically mentally ill. These are individuals

who have conventionally been defined in terms of their dysfunctional characteristics (Goldman et al, 1981). This definition has been charged with being partial, however, and has been replaced with a more empirically useful definition referring to those individuals 'functionally impaired for reasons of mental illness for an extended period of time' (Freedman and Moran, 1984). Hence, this definition introduces measures of diagnosis and duration to complement a measure of disability.

3.1 Research Objectives

This thesis has four research objectives. The first is a description of the current housing experience of the chronically mentallly ill living in the community in Hamilton. This involves documenting the type and location of the current living situation of the research sample. This documentation of experience is clearly an essential foundation upon which to build subsequent analyses and, with very few exceptions (for example, Dear et al, 1980) remains absent from the literature.

The second research objective involves an analysis of the residential stability of the sample. This aspect of housing for the ex-psychiatric patient is yet unexplored in the literature. Self-reported residential mobility

histories indicate the timing, type and location of residential moves as well as referral and reason(s) for move. This information can be used to determine client variations in residential mobility. The logical next step is to model the characteristics of sub-groups defined in terms of levels of mobility and thereby illuminate the determinants of excessive residential mobility among this population.

The third objective is a description of the expressed housing need of the sample. This involves documenting measures of satisfaction and coping with the living situation as well as type and location of preferred housing choice. Included in the analysis of expressed need is the 'marginal dollar' hypothesis. This hypothesis states that a **marginal** increase in dollar income **may** result in a substantial increase in 'quality of life' for the ex-psychiatric patient. The poor housing conditions currently experienced by the chronically mentally ill have already been documented (see chapter two). Should the individual be granted an increase in income, would this be put toward the increase of the quality of the living situation?

The fourth research objective involves a comparison of the housing need expressed by the sample with the

normative housing need being espoused in the literature (see section 2.4) in order to gauge the 'fit' between the two. When assessing residential need, the viewpoint of the individual patient is rarely heard. It is anticipated, therefore, that there may be some incongruence between these two definitions of need as well as gaps or barriers in the present housing system. It is further anticipated that these gaps will be both substantive and procedural in nature.

While contributing to the increasing stock of literature based within the geography of mental health, this research will also lead to a better understanding of the factors affecting coping. This is fundamental to the development of health care policies suited to the magnitude of the problems of service provision which have emerged in the wake of deinstitutionalization (see section 2.1.2).

3.2 The Sample

It is difficult to know the true population of chronically mentally ill individuals in Hamilton. Many ex-psychiatric patients are not attached to an after-care programme or care-giver, which would allow them to be counted. A recent mental health task force estimates that approximately 2,000 psychiatric patients are discharged annually from

various psychiatric institutions in Hamilton, 600 of these chronic (Hamilton-Wentworth District Health Council, 1984). This task force also estimates that over one-half of these chronic patients would be in need of housing upon discharge. In addition, some of the 1,400 'acute' discharged psychiatric patients would also be in need of housing (Hamilton-Wentworth District Health Council, 1984).

The research sample drawn from this population consists of 66 individuals chosen from three existing mental health care programmes. The intent of the study has been to select a sample of chronically mentally ill individuals which conforms to diagnosis, disability and duration characteristics. Rather than adopt strict exclusionary criteria, respondents were deemed eligible for inclusion in the sample by virtue of their participation in an after-care programme targetted at the chronically mentally ill. Approximately one-third of the sample was drawn from the 'Care Centre', an informal drop-in centre associated with the Canadian Mental Health Association which provides a social atmosphere as well as recreational programmes and client advocacy. Another approximately one-third of the sample was drawn from the Canadian Mental Health Association's 'Community Enrichment Service' (C.E.S.). This client case-management programme also offers counselling and

client advocacy. The final third of the sample was drawn from the St. Joseph's Hospital 'Community Psychiatry Service' (C.P.S.). This more clinically-based client case-management programme offers counselling, client advocacy and medications.

The individuals in the research sample were purposively selected to satisfy a four cell age-by-gender matrix. An approximately equal number of males and females were chosen (39 and 27, respectively) in order to allow comparisons of coping ability across genders. The cut-point for age was set at 35 years, thus allowing for a comparison of coping ability between younger, minimally institutionalized patients and an older group which is more likely to have experienced longer-term hospitalization (Bachrach, 1982). The result was that 31 individuals in the sample were under 35 years of age while 35 individuals were over 35 years of age. The overall mean age of the sample was 38 years with a range of 22 to 64 years.

The method of sample selection was relatively informal. Having been given the above general guidelines to work from, care-givers in the two case-management programmes selected individuals from their case loads on the basis of expected willingness to participate in the research. Individuals from the Care Centre were selected following

the same general guidelines but on a personal basis, as one of the researchers had worked as a volunteer at the Centre in the past. Survey research requires a manageable sample size. While it is difficult to know the true population from which the sample was drawn, the after-care programmes from which clients were selected are quite variable in nature. Therefore, although the sample is neither large nor representative of all chronically mentally ill individuals in the community in Hamilton, it can be considered reasonably representative of chronically mentally ill individuals attached to a local after-care programme.

The sample is predominantly schizophrenic by diagnosis (64%) with lesser representations of other disorders: 11% manic-depressive; 8% schizo-affective; 5% personality disorder. The overall sample reveals a moderate level of community tenure; that is, during the two years prior to the study, 58 per cent of the sample experienced no hospitalizations while only 12 per cent experienced two or more hospitalizations. The majority of the respondents currently have their illness stabilized by medication(s). In terms of marital status, 85 per cent of the sample are single, with a greater number of females married. This is generally true of the chronic psychiatric population.

A large proportion of the sample are currently unemp-

loyed. Of the 21 per cent who are working regularly, approximately one-half do so in sheltered workshops, for nominal remuneration. 59 per cent of the sample have either been unemployed for over two years or have never worked at all. Chronic unemployment is not unusual among this population.

Monthly income for the sample ranges from $63 to $912, with mean monthly income being, approximately, $513. This puts the average annual income of the sample ($6156) at a rate well below the poverty level for a single person as currently defined by the Government of Canada ($10,108) (Government of Canada, National Council of Welfare, 1986). The majority of the sample (78%) receive either general welfare assistance or 'family benefits allowance' (a disability pension).

42 per cent of the sample currently live in second-level lodging homes, most of which are located within the inner city of Hamilton. While one member of the sample owns a home, the balance reside in some form of rental accommodation, most often located within the inner city.

3.3 The Research Instrument

The research instrument consists of an 80-item, relatively open-ended interview schedule designed so as to approximate a conversational style as opposed to a

'formal interview'. The 'Life Management in the City Questionnaire' (see Appendix A), modelled after the 'Community Needs Questionnaire' (Dear et al, 1980), was designed to probe the hypothesized influences of four aspects of the environment on coping ability. These are: living situation, social network, psychiatric support, and material well-being (that is,income and employment conditions). Based upon a series of single and multiple item coping indices, the research instrument sought responses to both structured scales as well as open-ended questions regarding, for example, coping strategies and expressed need. In order to facilitate a comprehensive analysis of the living situation, data were recorded outlining each respondent's residential history by move; satisfaction, coping and measures of likes and dislikes regarding the living situation and the neighbourhood; as well as measures of expressed need (that is, where would you live if you could choose? with whom? and so on).

The instrument was pilot-tested with ten clients at the Care Centre during the early fall of 1985. After minor adjustments, the instrument was administered to a further 56 individuals between January and April, 1986. After the first round of interviews, the research instrument was adjusted on the basis of the interview experience as

well as recent additions to the relevant literature. The revised instrument (see Appendix B) was then administered to the same sample between July and September, 1986. In addition, care-giver assessments were completed for each individual subsequent to each round of questionnaire administration in order to allow for a comparison of self-assessed coping with care-giver assessed coping. This involved rating respondents along a structured scale as to: social situation, community life, employment status, income and money management, as well as an 'overall' category of coping assessment. Respondents were not rated as to living situation due to the fact that care-givers, in most instances, had inadequate opportunity to observe.

3.4 Administration of the Instrument

All interviews were conducted by the research team and varied in length from one-half to two hours. Care Centre clients were all interviewed on-site by the researcher who had once served the drop-in centre as a volunteer. The remaining clients were interviewed in a variety of settings, usually chosen by the client's care-giver. Care- givers in all three settings provided anecdotal evidence about the clients, and care-givers from the two case-management programmes remained present during

the interviews. In the latter instance, clients indicated being more comfortable with the researcher, while care-givers frequently remarked upon the insight they had gained into their clients as a result of being present at the interview. By the second round of interviews, it was decided that a male researcher would interview male clients while a female researcher would interview female clients. It was felt that this methodological decision would put respondents even more at ease, possibly leading to more detailed information.

The two rounds of interviews were conducted six to eight months apart. This longitudinal research design was chosen for three reasons: to allow a test-retest comparison of responses to the interview schedule; to monitor the effects of specific life-events on coping outcomes during the study period; and, to examine the effects of seasonality and related changes in environmental circumstances on the respondents' community experience.

The total sample in round one comprised 66 individuals. The follow-up rate was 88 per cent or 58 individuals. Of the eight individuals not interviewed in the second round, one was deceased, one was incarcerated, one was hospitalized, three could no longer be contacted and two declined a second interview for reasons unknown to the

researchers. Upon completion of the second interview, the respondent was presented with a small book of food vouchers for a local restaurant as a token of the research team's appreciation for their participation in the study.

CHAPTER FOUR

ANALYSIS OF THE LIVING SITUATION

The purpose of this chapter is to report on the empirical analysis of the living situation of the ex-psychiatric patient in the community in Hamilton. The analysis is based on the data gathered during both rounds of interview administration and is divided into four parts. Section 4.1 entails a descriptive analysis of the existing housing experience of the research sample. It appears that the ghettoization of ex-psychiatric patients in certain urban areas, as uncovered in other research, is also apparent in Hamilton.

Section 4.2 examines the housing experience of the sample over time by way of self-reported residential mobility histories. This facet of housing for ex-psychiatric patients is yet unexplored in the research literature. A large part of this analysis centres upon the development of a model to identify determinants of excessive residential mobility (that is, transiency) among the research sample. Section 4.3 examines the housing need of the ex-psychiatric patient living in the community as expressed by the sample themselves. Finally, section 4.4 entails a comparison of the expressed housing need of the

research sample (section 4.3) and normative housing need (as defined in section 2.4) in order to determine if, and where, any substantive and/or procedural gaps exist between these two definitions of need. It is suggested that the long-term housing goals of ex-psychiatric patients living in the community are not dissimilar to those defined on their behalf by mental health professionals but that gaps in the current housing system prevent the attainment of these goals.

4.1 The Housing Experience of the Ex-Psychiatric Patient

The initial research task involved a comprehensive description of the housing experience of ex-psychiatric patients living in the community in Hamilton. The literature surrounding the geography of mental health, in general, depicts the typical housing experience of the ex-psychiatric patient in the community as one of ghettoization in inner city areas in some board-and-care type housing (see chapter two). The results of an analysis of a sample of ex-psychiatric patients living in the community in Hamilton reveals similar findings. Table **4.1** illustrates the concentration of the research sample in Hamilton's inner city in second-level loding homes.2

For the purposes of this analysis, Hamilton's inner

TABLE 4.1 (a) LIVING SITUATION TYPE BY LOCATION, CURRENT SITUATION ONLY

TYPE	LOCATION		ROW TOTAL
	Inner City	Other	
Lodging Home	18 (27.2%)	10 (15.2%)	28 (42.4%)
Independent, Alone	10 (15.2%)	7 (10.6%)	17 (25.8%)
Other	12 (18.2%)	9 (13.6%)	21 (31.8%)
COLUMN TOTAL	40 (60.6%)	26 (39.4%)	N=66

TABLE 4.1 (b) LIVING SITUATION TYPE BY LOCATION, ALL REPORTED SITUATIONS

TYPE	LOCATION		ROW TOTAL
	Inner City	Other	
Lodging Home	38 (16.1%)	26 (11.0%)	64 (27.1%)
Independent, Alone	36 (15.3%)	28 (11.9%)	64 (27.1%)
Hospital	0 (0%)	45 (19.1%)	45 (19.1%)
Other	16 (6.8%)	47 (19.9%)	63 (26.7%)
COLUMN TOTAL	90 (38.1%)	146 (61.9%)	N=236

Notes: (1) 'Current' refers to living situation of respondent at time of latest interview.
(2) The 'Independent, Alone' living situation includes YM/YWCA, boarding and rooming house situations.

city has been defined as that area bounded by the Escarpment to the south, the harbour to the north, Highway 403 to the west, and Wentworth Street to the east. This encompasses approximately 19 of some 90 census tracts contained within the urban area boundary. As is evident in part (a) of Table **4.1**, approximately 61 per cent of the sample are currently living in the inner city, while over 27 per cent are currently living in the inner city in a second-level lodging home. Approximately 15 per cent of the sample are currently living 'independently, alone' in the inner city. This category of living situation includes boarding and rooming houses and the YM/YWCA. In subsequent analyses of expressed housing need, 'independent living' is defined as living in a private house or apartment, independently.

Part (b) of Table **4.1** reveals a similar breakdown, but for the residential mobility history reported by the sample as opposed to the current living situation. The 66 members of the sample reported 236 moves over the time period they could recall from memory. This time period ranged from nine months to 52 years and was not standardized across the sample in order to avoid constraining the data set at the outset. In subsequent analyses, data were standardized to a time period of two and one-half years. 38

per cent of all living situations reported were in the inner city and 16 per cent were in the inner city in a lodging home. Thus, the geographical concentration of the research sample is clear.

Tables **4.2** and **4.3** break the living situation down by type and by location for both the current living situation as well as residential moves made over time. In general, these tables reveal no concentrations of type or location other than those already discussed. It is interesting to note from Table **4.2**, however, that almost 20 per cent of all reported moves have been in and out of Hamilton Psychiatric Hospital. This figure represents 40 individuals, 35 of whom (53% of the sample) reported one hospitalization in their residential mobility history and 5 (8% of the sample) reported two hospitalizations.

In addition, the relatively low numbers reported for the categories 'parental family' and 'independent, conjugal' indicate how few ex-psychiatric patients return to a family situation upon discharge, for whatever reason.

Further, it is interesting to note the relatively small number of living situations experienced in a foster family/group home and that none of these were located within the city of Hamilton. This indicates further the relative lack of supervised housing in Hamilton as outlined in

TABLE 4.2 TYPES OF LIVING SITUATION EXPERIENCED BY THE SAMPLE

TYPE	CURRENT		OVER TIME	
	f	%	f	%
Hospital	-	-	45	19.1
Parental Fam.	5	7.6	23	9.7
Friends/Rel's	4	6.1	11	4.7
Foster Fam./ Group Home	-	-	4	1.7
Lodging Home	28	42.4	64	27.1
Independent, Conjugal	8	12.1	20	8.5
Independent, Alone	21	31.8	64	27.1
Homeless	-	-	4	1.7
missing	-	-	1	0.4
TOTAL	66	100%	236	100%

Notes: (1) 'Over Time' refers to that period that could be recalled from memory. This time period ranged from nine months to 52 years and was not standardized across the sample in order to avoid constraining the data set at the outset. In subsequent analyses, data were standarized to a time period of 2.5 years.

(2) The 'Independent, Alone' living situation includes YM/YWCA, boarding house and rooming house situations.

(3) 'Missing' refers to data not collected from certain respondents for particular questions. As a result of the psychiatric handicap experienced by the individuals in the sample, this situation understandably occurs at several points in the data set. Missing data is specified, therefore, simply for the sake of comprehensiveness.

TABLE 4.3 LOCATIONS OF LIVING SITUATIONS EXPERIENCED BY THE SAMPLE

LOCATION	CURRENT		OVER TIME	
	f	%	f	%
Inner City	40	60.6	90	38.1
East End	21	31.8	47	19.9
West End	1	1.5	-	-
Mountain	3	4.5	5	2.1
Ham. Psych. Hospital	-	-	45	19.1
Out of Town	1	1.5	27	11.4
missing	-	-	22	9.3
TOTAL	66	99.9%	236	99.9%

Notes: (1) 'Current' refers to living situation of respondent at time of latest interview.

(2) 'Over Time' refers to that period of residential mobility history that could be recalled from respondent's current memory. This time period ranged from nine months to 52 years was not standardized across the sample in order to avoid constraining the data set at the outset. In subsequent analyses, data were standardized to a time period of 2.5 years.

(3) 'Missing' refers to data not collected from certain respondents for particluar questions. As a result of the psychiatric handicap experienced by the individuals in the sample, this situation understandably occurs at several points in the data set. Missing data is specified, therefore, simply for the sake of comprehensiveness.

chapter two (see section 2.3.1)

Finally, it must be noted that the four homeless 'living situations' experienced by the sample were experienced by only two individuals, one of whom reported three homeless episodes. This indicates that the housing situation for the ex-psychiatric patient in Hamilton is not as desperate as implied in some of the research literature for other locales (see chapter two). Indeed, the city of Hamilton has a reputation for being "...an atypical city in the progressive manner in which it has dealt with the housing needs of such special groups as ex-patients..." (Marshall, 1982; 106). The fact that the problem of homelessness among the Hamilton sample is not of crisis proportions does not tarnish the significance of the fact, however, that the sample may be inappropriately housed.

4.2 Residential Mobility of the Ex-Psychiatric Patient

Residential mobility among this population in the period post-deinstitutionalization, with few exceptions (for example, Segal and Aviram, 1978), has not been treated in the research literature. There is, however, general acceptance of the importance of an appropriate and stable living situation for the coping ability of ex-psychiatric patients living in the community (Byers et al, 1978;

McCarthy et al, 1985; Smith and Smith, 1979; Trute, 1986). Attention is now turned to an analysis of the residential stability of the Hamilton sample.

4.2.1 Reasons for Move

The 66 individuals in the sample reported making 236 moves over time. The reasons cited for making these moves are reported in Table 4.4. Upon examination, this table reveals a striking number of involuntary residential moves. Even discounting hospital admission and discharge, 56 per cent of the moves made to the current living situation were made for involuntary reasons. Moves considered involuntary in the residential mobility literature include residential shifts implied in other decisions such as employment or marital status (Rossi, 1980), a 'forced' move such as an eviction or transfer of ownership of a tenant-occupied dwelling (Barrett, 1974), or displacement as a result of wider social forces such as gentrification (Ley, 1983). As the sample was drawn from a specific population, the definition of involuntary used here includes reasons more common to the sample: financial problems and unacceptable conditions in the home. The term 'unacceptable conditions' encompasses such circumstances as too many bugs in the house, general uncleanliness, bad food,

TABLE 4.4 REASON FOR MOVE TO CURRENT LIVING SITUATION AND FOR ALL REPORTED MOVES

REASON FOR MOVE	CURRENT SITUATION f	CURRENT SITUATION %	ALL REPORTED f	ALL REPORTED %
Hospital Admission	-	-	41	17.4
Hospital Discharge	14	21.2	44	18.6
Financial Problems	4	6.1	9	3.8
Landlord Problems	5	7.6	14	5.9
Unacceptable Conditions	15	22.7	51	21.6
'Better' Residence	6	9.1	12	5.1
Circumstances	5	7.5	13	5.5
Desired Change	11	16.7	31	13.1
Other	4	6.1	13	5.5
missing	2	3.0	10	4.2
TOTAL	66	100%	236	99.9%

Notes: (1) 'Current' refers to living situation of respondent at time of latest interview.

(2) 'Unacceptable Conditions' are as perceived by the respondent and include, for instance, complaints of bad food or poor housekeeping in a lodging home; irreconcilable differences with other residents; threats of physical violence; over crowding; and so on.

(3) 'Other' includes reasons such as: a change in conjugal circumstances, break with parental family and so on.

(4) 'Circumstances' refers to circumstances beyond the client's control such as the sale of a tenant-occupied dwelling.

(5) 'Missing' refers to data not collected from particular respondents for particular questions. As a result of the psychiatric disability experienced by the individuals in the sample, this situation understandably occurs at several points in the data set. Missing data is specified, therefore, simply for the sake of comprehensiveness.

over-crowding, irreconcilablr differences with other residents and/or staff, and threats of physical violence. Over time, 62 per cent of moves were **involuntary.**

When compared to the residential mobility literature for other populations, this figure seems even more striking. For example, Barrett's house-buyer study of Metropolitan Toronto reports that only 8.6 per cent of moves were made involuntarily (Barrett, 1974; 97). Rossi's more recent study of Philadelphia surveys tenants as well as homeowners thus, indirectly, including individuals of lower socioeconomic status. Rossi found that two out of every five households had to move involuntarily (Rossi, 1980; 223). Discounting hospital moves, three out of every five moves were made involuntarily by the Hamilton sample. Finally, Hodge's 1979 Seattle study (as cited in Ley, 1983) reports only seven per cent of sample moves being made involuntarily (Ley, 1983; 250). When Hodge examined particular 'vulnerable' groups, he found that 25 per cent of tenants, 27 per cent of low-income households and 34 per cent of elderly moved involuntarily (Ley, 1983; 250). Thus, none of these residential mobility studies report figures of involuntary moves close to the 62 per cent reported by the research sample.

This finding indicates the relative lack of control

the sample had over their living situation. One particular respondent, for example, rates herself as being very dissatisfied, and coping very poorly, with her living situation because of the 'unacceptable conditions' she feels she must tolerate. She feels this way because she is very frightened of the other residents in the lodging home in which she lives. Such emotions, obviously, are not conducive to a stable, or appropriate, living situation. Moreover, moving to a new living situation would not alleviate the problem as she claims that the incidents which frighten her occur everywhere, particularly in other lodging homes.

A final note to be made regarding Table **4.4** is that, of the 14 respondents who moved to their current living situation for reasons of hospital discharge, 64 per cent were discharged to second-level lodging homes which, with the exception of one, were all located in the inner city. Indeed, of all post discharge moves, 57 per cent were to a second-level lodging home. These figures may indicate a dependence on the lodging home system in Hamilton by hospital discharge planners.

4.2.2 Referral

Information regarding housing referral or placement

was sought in order to determine whether patients, at time of discharge, were given guidance toward appropriate living situations or if they were being left to their own devices. Unfortunately, data from the interviews regarding referral to new living situations is sketchy, at best. The original interview schedule was not designed to elicit this information. Further, it was difficult, in the second interview, to recover referral information for earlier moves. Therefore, referral to current living situation is only known for a small proportion of the sample (27 %) while referral to all situations is only known for 13 per cent. However, for those individuals for which referral data were recorded for the most recent move, over one-half (56%) showed referrals by self or another ex-psychiatric patient as opposed to, for instance, a care-giver (6%) or an after-care agency (3%). This same pattern is evident over time, with 43 per cent of all reported moves being referred by self or by another ex-psychiatric patient.

4.2.3 Stability Versus Excessive Mobility

As yet, there has been little research addressed to the issue of residential stability among ex-psychiatric patients living in the community. Segal and Aviram (1978) studied the residential mobility of ex-psychiatric patients living in the community in California but only those housed

in sheltered care facilities (that is, halfway houses, family care homes and board-and-care homes). Further, they did not obtain a detailed residential mobility history of their sample, most likely because many had only recently been discharged from hospital.

Tables 4.5 and 4.6 report residential mobility data for the Hamilton sample. Almost 40 per cent have an average length of stay in all reported previous living situations of less than one year. Compared to the residential mobility literature cited earlier, this proportion is high. For example, Barrett found that only 7.4 per cent of his Toronto sample had been in their previous residence for less than one year while 18 per cent had stayed for eight years or more (Barrett, 1974). Rossi found that only 23 per cent of the Philadelphia respondents surveyed had been in their previous residence less than two years (Rossi, 1980), while the current sample shows an average length of stay of less than two years for 62 per cent of respondents. Despite the differences in sample make-up and method of measurement, it is interesting to note from the California study of Segal and Aviram (1978) that 60 per cent of their ex-psychiatric group had lived in their current facility for greater than one year while almost the same proportion of the Hamilton sample (57%) had lived in their current

TABLE 4.5 LENGTH OF STAY IN CURRENT RESIDENCE AND AVERAGE LENGTH OF STAY IN ALL REPORTED PREVIOUS RESIDENCES

LENGTH OF STAY	CURRENT RESIDENCE			AVERAGE OVER TIME		
	f	%	cum.%	f	%	cum. %
1 week-2 mos	16	24.2	24.2	6	9.1	9.1
2.25-5.75 mos	13	19.7	43.9	10	15.2	24.3
6-11 mos	8	12.1	56.0	10	15.2	39.5
12-23 mos	7	10.6	66.6	15	22.7	62.2
2-3 yrs	11	16.7	83.3	7	10.6	72.8
4-8 yrs	7	10.6	93.9	11	16.7	89.5
8+ yrs	3	4.6	98.5	5	7.6	97.1
missing	1	1.5	100.0	2	3.0	100.1
TOTAL	66	100%		66	100%	

Notes: (1) 'Current' refers to living situation of respondent at time of latest interview.

(2) 'Over Time' refers to that period of residential mobility history that could be recalled from the respondent's current memory. This time was not standardized across the sample in order to avoid contraining the data set at the outset. In subsequent analyses, data were standardized to a time period of 2.5 years.

(3) 'Missing' refers to data not collected from certain respondents for particular questions. As a result of the psychiatric disability experienced by the individuals in the sample, this situation understandably occurs at several points in the data set. Missing data is specified, therefore, simply for the sake of comprehensiveness.

TABLE 4.6 TOTAL NUMBER MOVES MADE PER RESPONDENT DURING 2.5 YEARS PRIOR TO LATEST INTERVIEW

NUMBER OF MOVES	FREQUENCY	PERCENT	CUMULATIVE PERCENT
9	1	1.5	1.5
8	-	-	1.5
7	2	3.0	4.5
6	1	1.5	6.0
5	5	7.6	13.6
4	5	7.6	21.2
3	6	9.1	30.3
2	9	13.6	43.9
1	19	28.8	72.7
0	18	27.3	100.0
TOTAL	66	100%	

residence for **less than** one year.

In addition to having a relatively short average length of stay, Table **4.6** reveals that a substantial proportion of the sample - 30 per cent - have made a residential move more often than once per year over the last two and one-half years. This is comparable to Segal and Aviram's (1978) finding that one-third of their sample had moved within the last year.

The residential mobility literature shows that residential relocation rates are higher for tenants than for owners, unattached singles than for families, and higher in inner city districts (Ley, 1983; Rossi, 1980). Rossi went so far as to show that renters who preferred to own were the most mobile of all (Rossi, 1980). In these respects, the Hamilton sample matches the profile of highly mobile households very closely: 98.5 per cent are tenants, 85 per cent are unattached singles, and 61 per cent reside in the inner city. When the mobility characteristics of the sample are examined in more detail, two sub-groups can be identified: one which appeared to be relatively residentially stable and one which appeared to be excessively residentially mobile. [3] Segal and Aviram (1978) came to a very similar conclusion based on their group of residents in sheltered care facilities. They concluded

that people in sheltered care are generally residentially stable and that only a small group tend to be very mobile. They viewed this to be consistent with the expressed desire of sheltered care residents for a stable lifestyle.

The identification of two sub-samples in terms of mobility led the research in the direction of attempting to profile the characteristics of the two groups. This involved two immediate tasks: the selection of a cut-point in level of mobility as the basis for defining 'stable' and 'transient' sub-groups; and the selection of independent variables to be included as predictors of mobility in a statistical model.

In light of the residential mobility literature cited earlier, a person was considered excessively residentially mobile if s/he had made a residential move more often than once per year over the last two and one-half years **and** had an average length of stay in all reported previous living situations of less than one year. 16 respondents (24% of the sample) met both of these criteria and were considered excessively residentially mobile for the purposes of this analysis. By extension, the remaining approximately three-quarters of the sample were considered relatively residentially stable.

The independent variables considered for the analysis

fell into the following five categories: demographic variables, illness-related variables, income-related variables, living situation variables, and, finally, measures of satisfaction and coping with the living situation. The selection of these particular variables was informed by the residential mobility literature as well as knowledge of the sample gained through the interview experience.

Tests of association (chi-square, mann-whitney u, and student's t) were performed to determine whether or not any of these variables were related to excessive residential mobility (Table **4.7**). The following variables were significantly related ($p < 0.10$) to excessive residential mobility: age, gender, education, number of hospitalizations over the last two and one-half years, ineffective budgetting (running out of money before the end of the month), census tract location of living situation, satisfaction with current living situation, and preference for an independent living situation (that is, a house or apartment on their own). In terms of these characteristics, the more mobile respondent is generally younger, male, with a higher level of education and a greater number of hospitalizations, lives in the inner city, is not happy in their current living situation and preferred an independent

TABLE 4.7 VARIABLES ASSOCIATED WITH RESIDENTIAL MOBILITY

VARIABLES	TEST STATISTIC
Demographic Variables	
Age [1]	2.95***
Gender [2]	2.95*
Education [3]	311.5*
Illness Related Variables	
Diagnosis [2]	0.04
# of Hospitalizations [1]	-1.7*
Income Related Variables	
Ineffective Budgetting [2]	3.01*
How much more $ needed? [1]	-0.95
Living Situation Variables	
Type of Situation [2]	0.17
Census Tract Location [2]	2.32*
Own Room? [2]	1.29
Satisfaction & Coping Measures	
Satisfaction with lvg sit. [3]	249.5
Coping with living situation [3]	299.0
Housing needs met? [2]	0.65
Happy in current lvg sit.? [2]	4.90**
Prefer independent living? [2]	5.60**

Tests of Association Used:

1. T-test.
2. Chi-square.
3. Mann-Whitney.

Significance Levels:

*** $p < 0.01$
** $p < 0.05$
* $p < 0.10$

living situation. These relationships make sense. Age, gender and location of living situation are frequently discussed in the literature as factors affecting residential mobility (Barrett, 1974; Ley, 1983; Michelson, 1977; Rossi, 1980). It is not surprising that number of hospitalizations is related to mobility, as a hospitalization was also recorded as a move in this analysis. Ineffective budgetting, dissatisfaction with the living situation and preference for another are all factors that could plausibly result in mobility. The relationship between education and mobility has not yet been examined in the literature but a similar relationship has been uncovered in current research which reveals a relationship between education and rates of rehospitalization among schizophrenics in Hamilton (Dr. B. Humphrey, McMaster University, personal communication).

There was no relationship between mobility and diagnosis. Perhaps this is due to the fairly homogeneous nature of the sample in this respect (64% schizophrenic). Respondents' estimates of financial need were also not related to mobility, while ineffective budgetting was. Perhaps this is because ineffective budgetting is more an indicator of income (and therefore mobility) than estimates of financial need. There was no relationship between

mobility and living situation type or whether respondents had their own room. This may indicate the need for all types of living situation along the housing continuum, even congregate care facilities which provide highly dependent living environments. Finally, there was no relationship between mobility and ratings of satisfaction or coping with the living situation or whether respondents felt their housing needs were being met. This is surprising in light of the relationship between mobility and satisfaction with living situation and preference for another; relationships which make intuitive sense. However, mobility in this instance is related to satisfaction with all <u>past</u> living situations reported in the residential mobility history, while ratings of satisfaction and coping are for the <u>current</u> living situation only.

The next step in the analysis was to construct a logistic regression model to determine the ability of the independent variables to predict mobility. The logit model is appropriate in situations where the dependent variable is dichotomous, as in this case. This model has found its way into the geographic literature by way of discrete choice modelling in the field of economic geography, but is finding wider application due in part to the recent emphasis on the analysis of survey data. The logit is

a non-linear regression of the log of the odds of the dependent variable occurring given the independent, or explanatory, variable(s). This approach assumes that the relationship between the dependent variable and the independent variable(s) can be described by a logistic curve, asymptotic to zero and one, the endpoints of a probability function. Parameters in the model are estimated by way of an iterative algorithm and the model produces regression coefficients along with measures of standard error.

The eight independent variables found significantly related to mobility in the bivariate analyses (see Table 4.7) were reduced to four (Table 4.8), as a parsimonious set of independent variables was required for the model. 'Number of hospitalizations' was removed as it was counted both as a residential move as well as a hospitalization. Gender, ineffective budgetting and census tract location of living situation were removed on the basis of their insignificant contributions to a preliminary model. The remaining four variables were entered into a logit model using excessive residential mobility (yes/no) as the dependent variable. The results revealed that the variables most strongly influencing excessive residential mobility were: HIGH, HAPPY and INDPT (see Table 4.8). This was

TABLE 4.8 VARIABLES CHOSEN FOR INCLUSION IN A LOGIT MODEL

VARIABLE	
High	Whether or not respondent has a high school education.
Happy	Whether or not respondent is happy in current living situation or would prefer another.
Indpt independent	Whether or not client would prefer an living situation.
Years	Whether or not respondent is over or under 35 years of age.

evident from the regression coefficients as well as the t-values reported for these parameters. The variable YEARS was removed at this stage due to its insignificant contribution to the model.

A second logit analysis was conducted using HIGH, HAPPY and INDPT (Table **4.8**) as the independent variables. The model predicted a high probability of mobility for respondents with a high school education, who were unhappy in their current living situation and who would prefer to live independently in a house or apartment. However, the variables HAPPY and INDPT were measured as different responses to the same question (that is, where would you live if you could choose?). Therefore, it was felt that one of these should be removed from the model.

The final logit model included HIGH and INDPT (Table **4.8**) as the two independent variables. The results (Table **4.9**) confirm that those with high school education and expressing a preference for independent living have a higher probability of being excessively residentially mobile.

Table **4.9 (b)** illustrates the predictive power of this logit model. 31 respondents did not have a high school diploma **and** did not express a preference for independent living. The predicted probability of excessive mobility for this group is low (p=.08) and corresponds closely with

TABLE 4.9 (a) RESULTS OF LOGIT ANALYSIS

	REGRESSION COEFFICIENT	STANDARD ERROR	t
HIGH	.79482	.32910	2.41510
INDPT	.81263	.32665	2.48775

Pearson Goodnes-of-Fit Chi Square = .528
DF = 1
P = .468

TABLE 4.9 (b) OBSERVED AND EXPECTED FREQUENCIES

HIGH	INDPT	# SUBJ.	OBS.	EXP.	RESID.	PROB.
.00	.00	31.0	3.0	2.5	.552	.07898
.00	1.00	15.0	4.0	4.5	-.552	.30344
1.00	.00	12.0	3.0	3.5	-.552	.29596
1.00	1.00	8.0	6.0	5.5	.552	.68106

the proportion who were highly mobile (3/31=.10). In contrast, eight respondents had a high school diploma **and** preferred independent living. A high proportion of this group (0.75) were excessively mobile, which again matches closely with the predicted probability (0.68). For the other two groups, defined by the remaining combinations of scores on the independent variables, the correspondence of predicted and actual mobility is similarly close.

A plausible interpretation of the results relates to the life, and more specifically housing, expectations associated with a higher level of education which possibly makes one less tolerant of marginal living situations. Within the residential mobility literature, the disparity between housing expectations and experience is referred to as residential stress (Ley, 1983). Stress levels above a threshold determined by inertia factors are directly related to mobility interactions and decisions (Brummel, 1981). Given the nature of the sample as well as their housing experience, stress levels may be magnified. A case in point is the person who reported three homeless episodes. He had a Bachelor of Science (Honours) degree from a local university and felt his housing expectations so degraded within second-level lodging homes that he preferred living on the streets. When housing expectations

involve independent community living, the residential search can be impeded by factors commonly associated with mental illness such as financial or illness-related constraints, negative community attitudes toward this group, and so on. Attempting to work within these constraints may lead to a series of housing situations which do not match housing expectations and, therefore, a residential mobility history which resembles transiency.

A limitation of this analysis is due to the operational definition of the dependent variable. In order to determine the sensitivity of the results in this regard, a further analysis was performed using a less restrictive definition of excessive mobility (that is, more than **two** moves per year over the past **two** and one-half years and an average length of stay of less than two years).

The results were largely unchanged. The same two variables, HIGH and INDPT, were again the strongest predictors of excessive mobility. The predicted probability for excessive mobility remained low for the group of respondents which did not have a high school diploma and did not express a preference for independent living (p=.16) and again corresponded closely with the proportion who were highly mobile (6/31=.20). In contrast, a high proportion of the group who had a high school diploma and did prefer

independent living (0.88) were excessively mobile. This also matched closely with the predicted probability (0.77). Again, the correspondence of predicted and actual mobility is similarly close for the other two groups, defined by the remaining combinations of scores on the independent variables. The consistency between the two sets of results is a counter to the criticism that the findings are in part an artefact of the operational definition of mobility.

4.3 The Housing Need Expressed

Approximately one-quarter of the sample (24%) feel their housing needs are not being met in Hamilton. The major reasons cited for this were: 'availability of appropriate and affordable housing' (46%); ''poor conditions' in the lodging home' (31%); and, 'financial constraints' (15%). Indeed, one respondent went so far as to report that her **mental health** needs were not being met because finding appropriate housing was such a problem: "It's like beating your head against the wall."

Despite the fact that almost one-quarter of the sample feel their housing needs are not being met in Hamilton, both rounds of interview adminstration revealed a relatively high proportion of the sample being satisfied with their current living situation. That is, on a six

point scale from 'very satisfied' to 'very dissatisfied' (see Appendix B), 73 per cent and 75 per cent of the research sample, respectively, rated themselves as satisfied (either 'very', 'quite', or 'somewhat') with their current living situation. Further, an even higher proportion felt that they were coping well with their living situation (91% and 83%; measured again on a six point scale; see Appendix B). Compared to the residential mobility literature, these figures are not unusual. For instance, Barrett's Toronto home-buyer's study found that only 5.5 per cent of his sample were dissatisfied with their housing (Barrett, 1974; 102). In addition, Michelson's Toronto study of tenants and owners found only 10 per cent of the research sample dissatisfied with the type or location of their housing (Michelson, 1977; 274). Given the nature of the accommodation available to the research sample, however, one would not expect such a high degree of satsifaction with the living situation. It is interesting to note that Dear et al (1980; 43) obtained similar results in their earlier Hamilton study.

The high levels of residential satisfaction and coping are perhaps surprising in light of the fact that one-quarter of the sample feel their housing needs are **not** being met in Hamilton, that the majority of residential

moves being made by the sample are being made **involuntarily**, and that approximately one-quarter of the sample are **excessively residentially mobile**. This seeming inconsistency can probably be explained by the ex-psychiatric patient being resigned to accept adverse living conditions as typical. One respondent rated herself as being very dissatisfied with her living situation, but is resigned to it because: "It's the same in other lodging homes and everywhere". Furthermore, for those old enough to have experienced periods of institutionalization, most likely **any** living situation is perceived to be better than living in the psychiatric hospital (see Allen, 1974; Bachrach, 1982; Lamb, 1980; Peterson, 1982).

From another perspective, these responses may be disguising the true feelings of the sample. Respondents may have rated themselves high on satisfaction and coping scales in order to present themselves in a good light to the interviewer or simply because they maintain such positive attitudes as part of a coping strategy. Indirect measures of satisfaction contained within responses to another question, for example, reveal that only 40 per cent of the sample are happy in their current living situation. In addition, those who were not happy in their current living situation ranked themselves significantly lower on

the satisfaction scale (p=.0005) than those who were.

4.3.1 Preferred Living Situation

In order to elicit more detailed information regarding the expressed housing need, respondents were asked in what type of living situation they would live, if they could choose (Table **4.10**). The majority in both rounds of interviews would prefer to live independently, basically meaning an apartment or house on their own (39% and 33%, respectively). The only other response reported with any measure of frequency was 'happy as is'. Of those who responded in this manner, almost one-half were living in some form of independent living situation (47% in round one and 43% in round two). Further, a fairly high proportion were living in lodging homes (37% and 43%), indicating the importance of both these types of living situation as components along the housing continuum.

When asked about their location, the majority reported they would prefer central Hamilton (42% and 32%). This most likely reflects the importance of proximity to services as a requirement of the living situation of this and other service-dependent populations (see Wolch, 1981). In addition, the inner city has traditionally been known as an area of affordable housing.

TABLE 4.10 TYPE OF PREFERRED LIVING SITUATION

TYPE	R_1	%	R_2	%
Parental Fam.	3	4.5	2	3.0
Assisted Hsg	3	4.5	1	1.5
'Better' Apt/ House	8	12.1	7	10.6
Other Lodging Home	6	9.1	4	6.1
Independent	26	39.4	22	33.3
Happy as is	19	28.8	21	31.8
missing	1	1.5	9	13.6
TOTAL	66	99.9%	66	99.9%

Notes: (1) 'R_1' refers to the first round of interviews while 'R_2' refers to the second round.

(2) 'Missing' refers to data not collected from certain respondents for particular questions. As a result of the psychiatric handicap experienced by the individuals in the sample, this situation understandably occurs at several points in the data set. Missing data is specified, therefore, simply for the sake of comprehensiveness.

When asked if they would prefer to live on their own or with others, the response was split almost in half, with slight favour being shown to 'on own'. This most likely indicates the need for this group to finally break free of congregate living situations, such as a hospital ward or a lodging home.

Information was also collected on the factors preventing preferred housing choice (Table **4.11**). Not surprisingly, the most frequently mentioned constraint was financial (33% and 32%). As noted previously, the majority of the sample receive either general welfare assistance or family benefits allowance (between $400 and $513 per month). For those respondents living in lodging homes, all of this monthly income, except a $77 'comfort allowance', goes to the lodging home operator to pay for board and care. Thus, financial realities make it extremely difficult, if not impossible, for the ex-psychiatric patient to compete in the general rental housing market.

4.3.2 The Marginal Dollar Hypothesis

The 'marginal dollar hypothesis' states that a marginal increase in monthly income may result in a substantial increase in 'quality of life', in terms of adequate provision of basic needs, for the ex-psychiatric

TABLE 4.11 FACTORS PREVENTING PREFFERRED HOUSING CHOICE

FACTOR	R_1	%	R_2	%
Financial Constraints	22	33.3	21	31.8
Availability	9	13.6	4	6.1
Family/Care Giver Averse	5	7.6	2	3.0
Settled as is	2	3.0	2	3.0
Dont't Know/ Nothing	5	7.6	7	10.6
Not Applicable	19	28.8	21	31.8
missing	4	6.1	9	13.6
TOTAL	66	100%	66	100%

Notes: (1) 'R_1' refers to the first round of interviews while 'R_2' refers to the second round.

(2) The category 'Not Applicable' pertains to individuals who responded 'Happy as is' when asked "Where would you live if you could choose?".

(3) 'Missing' refers to data not collected from certain respondents for particular questions. As a result of the psychiatric disability experienced by the individuals in the sample, this situation understandably occurs at several points in the data set. Missing data is specified, therefore, simply for the sake of comprehensiveness.

patient. When asked "How much more money would it take every month to meet your needs?", the average response was under $100 (for both rounds of interviews), with a range of zero to $900. Although this request seems small, it represents approximately 20 per cent of the average monthly income of the sample. When asked what they would spend this modest dollar increase on, the most frequent response was clothing (shoes, boots, better clothes, etc.) while the second most, and only other, frequent response was 'a better place to live'. These data were consistent between rounds.

Although this does not strongly support the marginal dollar hypothesis, neither does it provide cause to reject it; perhaps a marginal increase in dollar income is all that is needed to upgrade the quality of the life of the ex-psychiatric patient in the community.

4.4 Normative Versus Expressed Housing Need

It is evident from section 4.3 that the housing need expressed by the sample is independent community living. Recall from section 2.4 that the normative housing need of the ex-psychiatric patient living in the community has been defined as the provision of a continuum or graduated sequence of housing options ranging from totally closed living environments to totally open living environm-

ents (Dear and Wolch, 1979). These environments are to be matched with client needs which range along a parallel continuum from total dependence to total independence. Recall also that a recent task force of the American Psychiatric Association (Arce and Vergare, 1985; 427) translates this concept of a continuum of housing options into reality thus:

1. Nursing Facility
2. Group Home
3. Personal Care Home (congregate care facility)
4. Foster Home
5. Natural Family Placement
6. Satellite Housing (co-operative housing)
7. Independent Community Living

With regard to the apparent 'fit' between these two definitions of housing need for ex-psychiatric patients living in the community in Hamilton, it would appear that both the ex-psychiatric patient and the mental health professional have the same long-term housing goal: independent community living for the deinstitutionalized mental patient. However, it has been established (see section 3.3) that many of the interim housing environments along this continuum - such as group homes, foster homes, satellite and co-operative housing - are in very short supply in the city of Hamilton. Further, of all members of the current sample, none had ever lived in satellite or co-operative housing and

only four living situations out of a total of 236 had ever been experienced in a group home or foster home, all of which were located outside the city of Hamilton. As a result, there is a bi-modal concentration of the current sample in second-level lodging homes (personal care facilities on the continuum) and independent living situations which, at present, include boarding and rooming houses and the YM/YWCA. These living situations have the potential to foster feelings of dependence and/or isolation among ex-psychiatric patients living in the community. Such feelings may be manifested in transient residential behaviour, with the deinstitutionalized mental patient moving from one inappropriate living environment to another in search of a long-term housing goal. The residential search may be further impeded by inadequate preparation for community living before discharge as well as little or no guidance from a care-giver.

The ex-psychiatric patient cannot be thrust into independent community living over-night, however, without risking a relapse. Indeed, out of 41 sample moves made to Hamilton Psychiatric Hospital for reasons of illness, 46 per cent originated in independent living situations. Unless interim living situations are provided in adequate supply, the chronically mentally ill individual will never

learn to cope in independent community living and will simply remain caught in the revolving door of recidivism or rehospitalization.

The procedural gaps in the 'fit' between normative and expressed housing need involve the lack of a close relationship between the mental health professional and the rental housing market accessible to the ex-psychiatric patient living in the community in Hamilton. Admittedly, the housing referral data gathered from the research sample are sketchy, at best. They do indicate, however, the forced autonomy of the ex-psychiatric patient in dealing with an unfamiliar, and often unfriendly, rental housing, or even supervised housing, market. Especially in light of the short supply of appropriate interim housing for this population in Hamilton, advocacy housing placement and referral is an essential step in the process of helping the ex-psychiatric patient achieve a long-term housing goal. The Supportive Housing Coalition of Metropolitan Toronto (1981) has this to say about the existing housing system for discharged mental patients:

> The present housing system is not a system. It is an unplanned uncoordinated series of separate elements (as cited in Marshall, 1982; 104).

There has been no evidence to show that the situation in Hamilton is any different. In addition, there appears

to be a dependence upon the second-level lodging home system in Hamilton by psychiatric hospital discharge planners. This may be due, in part, to the concentration of available residential beds for ex-psychiatric patients in Hamilton in this type of living situation. In addition, the lodging home is seen as a semi-independent living situation to be used as a stepping-stone to independent community living. As such, this situation plays a vital role in the housing process. Indeed, some ex-psychiatric patients will always need, and desire, the level of dependence characteristic of such a living situation. However, in the majority of cases, this living situation should be seen for what it truly is: one of several stepping-stones to independent community living for the deinstitutionalized mentally ill.

4.5 Conclusion

This chapter has examined the living situation of a sample of ex-psychiatric patients in Hamilton. The survey data show a clustering of ex-psychiatric patients in inner city second level lodging homes. Few respondents have control over their living situations; 62 per cent of the residential moves made by the sample over time were made involuntarily. In addition, there was little evidence

of a comprehensive referral or housing placement service in operation for this population. Thus, the ex-psychiatric patient is left to cope autonomously with the rental housing market.

With regard to residential stability, it would appear that there is a division between those who are relatively stable and those who are excessively mobile. Factors characterizing the latter group were determined to be: having a high school education and having a preference for independent community living in a house or apartment on one's own.

In terms of the 'fit' between normative and expressed housing need for this group, it would appear that both the sample as well as mental health professionals share a similar long-term housing goal: independent community living in a house or apartment on their own. Unfortunately, it seems that there are substantive and procedural gaps along the housing continuum which prevent this goal from being reached.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

5.1 Summary

This thesis has examined the expressed need for housing of a sample of chronically mentally ill persons living in the community in Hamilton. In so doing, the thesis had four objectives: (a) to provide a comprehensive description of the housing experience of the chronically mentally ill living in the community in Hamilton; (b) an analysis of the determinants of excessive residential mobility among this population; (c) to determine the expressed housing need of the sample; and, (d) to determine where, if any, substantive and/or procedural gaps exist in the current housing system by way of a comparison of expressed and normative housing need.

Following a brief history of the deinstitutionalization of the mentally ill, which set the context for an examination of the housing issue, the literature review revealed a number of recurring themes. Firstly, although the problem of the provision of housing for service-dependent populations is alluded to by several authors, the literature addressed directly to this issue is

sparse (Bachrach, 1979; Laws and Dear, 1987). This is despite the important role appropriate housing plays in the achievement of the original goals of deinstitutionalization (Dear et al, 1980; Lehman et al, 1986; Segal and Aviram, 1979; Smith and Smith, 1979). Secondly, while researchers have looked at the community tenure of the chronically mentally ill, none have examined the factors affecting the residential stability of this population. Thirdly, there appears to be an acute need for housing for the chronically mentally ill in the community (City of Toronto, Mayor's Office, 1984; Dear et al, 1980; Hamilton-Wentworth District Health Council, 1984; Ontario Social Development Council, 1983). Finally, this review revealed that the viewpoint of the individual chronically mentally ill person is rarely accounted for in the assessment of residential need.

In order to address these research objectives, cross-sectional and longitudinal survey data were gathered from a sample of chronically mentally ill persons attached to one of three local aftercare programmes by way of the 'Life Management in the City' questionnaire (see Appendices A and B). A description of the current and past housing experience of the research sample reveals that, as in other cities, the chronically mentally ill are clustered in the inner city of Hamilton in lodging home types of

accommodation. An examination of the residential mobility of the sample revealed that the proportion of involuntary moves being made by the sample (over 60%) is substantially higher than the proportion reported for other populations (see, for example, Ley, 1983). This finding indicates the lack of control the Hamilton sample have over their living situation. This analysis further revealed that there was a division within the sample between individuals who are relatively residentially stable and those who are excessively residentially mobile. Further, by way of logit analysis, it was determined that individual characteristics most strongly related to excessive residential mobility among the chronically mentally ill living in the community in Hamilton are level of education and preference for an independent living situation. As some researchers have suggested (Smith, 1978, for example), housing is probably the most manipulable variable involved in after-care, more so than individual therapy. Awareness of the determinants of mobility could therefore aid mental health professionals in the task of matching client needs to appropriate living situations.

A description of the housing need as expressed by the group under study revealed that it is not dissimilar to the normative housing need as defined by academics as

well as mental health professionals; that is, a long-term goal of independent community living. However, there appear to be substantive (infrastructural) and procedural (lack of advocacy housing placement) gaps between the housing need as defined and the current housing stock.

5.2 Conclusions

It would appear, therefore, that, despite the similarity between normative and expressed housing need, the optimal housing arrangement for the chronically mentally ill does not exist in Hamilton. In fact, there are many gaps in the current housing system. Furthermore, it would seem that a policy-driven inertia exists which prevents the realization of a housing system closely approximating the optimum. For instance, current hospital discharge patterns belie the relative dependence of mental health professionals upon the second-level lodging home system in Hamilton. Although this seeming dependence may be a result of available supply, it would appear that this housing component is being employed as an end in itself as opposed to a means to an end, as it is meant to be.

This inertia is further buttressed by the lobbying power of the local lodging-home operators association. The political 'power' of this group is presumed to be a

function of the dependence upon this housing component by the local mental health system.

The second-level lodging home system is also legitimated by local government. That is, these homes are licensed by city of Hamilton licensing by-laws with respect to fire and safety regulations. Although this licensing does not deem these homes appropriate living environments, this legitimation certainly protects these establishments from undue, but perhaps necessary, criticism.

Client knowledge also aids in the perpetuation of the lodging home system in Hamilton. In the absence of a comprehensive housing placement/referral service, the chronically mentally ill have become quite knowledgable of the lodging home 'system'; they know which operators will tolerate certain behaviours as well as clients.

Finally, government policy at the Provincial level further perpetuates the lodging-home system in Hamilton. That is, one-quarter of one million dollars has recently been allocated to the Canadian Mental Health Association/ Hamilton office to begin a programme of life-skills training to take place within the lodging home itself, subject to certain conditions being agreed to by the home's operator. The result of this policy, in essence, is to perpetuate the existing housing system as opposed to developing appro-

private alternatives.

As long as the lodging home system continues to be perpetuated by way of the policy arena, the original goals of deinstitutionalization cannot be realized, without at least a concomitant dedication to the provision of alternatives. For individuals do not behave independently of their physical and social environments, and these environments contribute greatly to shaping adaptive responses.

The research in this thesis makes several contributions both to issues related to the provision of housing for the chronically mentally ill as well as to the growing literature within social and medical geography on the environmental determinants of health. This thesis did not attempt an explanation of the effects of the housing system upon coping outcome but has obvious implications for a clearer understanding of this relationship. In particular, this research has implications for understanding, and hopefully avoiding, a mis-match between client needs and living situations.

This study has been able to fill some of the gaps in the literature around the issue of housing for the chronically mentally ill by extending previous work in this area. For example, Dear et al (1980) established that

housing was one of five life areas where coping was a problem for the discharged mental patient in Hamilton. This thesis used this finding as a point of departure for an examination of three specific aspects of housing; a description of experience and expressed need along with an analysis of mobility.

In addition, Nelson and Earls (1986) examined the housing and social support needs of long-term psychiatric patients in Waterloo, Ontario. These researchers employed a combination of both expressed and normative definitions of need. While making a significant contribution to research, this study did not go beyond an assessment of need to look at an assessment of experience or factors affecting mobility.

Finally, Segal and Aviram (1978) made a prelimary attempt to examine residential mobility among clients of residential care facilities in California. These authors looked at mobility during the year prior to data collection as well as the respondents' most recent move. This thesis extends Segal and Aviram's work by examining a more detailed residential mobility history of the sample; by sampling from a variety of housing situations, not just residential care facilities; and by going beyond description to an analysis of the factors affecting mobility among this popul-

ation.

5.3 Analytical Considerations

The sample employed in this research may be questioned as to its representativeness of the chronically mentally ill population in Hamilton. Although the sample can be considered representative of chronically mentally ill individuals attached to local aftercare programmes, it may not be representative of ex-psychiatric patients **not** attached to an aftercare programme. Unfortunately, it is impossible to know the true population. There were, however, no significant differences between results of analyses across programmes. For example, there were no significant programme differences between type or location of living situation, likes and dislikes about the living situation or the neighbourhood, measures of satisfaction with the living situation, length of stay or number of moves, or even measures of mobility. We can, therefore, remain secure in the sample's representativeness of chronically mentally ill persons attached to a local aftercare programme. Although the sample may be considered small, it is anticipated that the level of detail provided by respondents would have been restricted by a larger sample size.

The sample may also be questioned on the basis of its composition. Essentially, can these data be considered valid considering that their source is a group of chronically mentally ill individuals, primarily diagnosed as schizophrenic? Unfortunately, this simply cannot be known. The concern can be dispelled, however, by recalling that client care- givers for two of the three programmes were present during both rounds of interview administration and were willing - and indeed did - correct any response known to be a fabrication. This practice was not deemed necessary for the third programme as the interviewer had developed a personal relationship with clients. In addition, client ratings of satisfaction and coping in all life areaa were found to be highly consistent across rounds (Kearns, 1987).

5.4 Directions for Further Research

There is ample room in the research literature for a deeper and more comprehensive examination of the relationship between housing and the coping ability of the chronically mentally ill in the community. Firstly, it is apparent that the relevant literature (including this thesis) suggests that the housing network for this population is functioning relatively well at the 'protected' end of the service spectrum while there appear to be gaps at

the 'autonomous' end of the spectrum (Dear et al, 1980). As a result, recommendations are being made to fill in these gaps. It is not yet known, however, what proportion of the population under study can be accommodated, appropriately, in more autonomous living situations. An interesting, and innovative, combination of research techniques using **both** expressed and normative definitions of need (see, for example, Nelson and Earls, 1986) could be employed in an attempt to address this question.

There is an obvious need, however, for more work in this area which would document the effects of **particular aspects** of the living environment upon coping ability. Indeed, behavioural researchers as well as practitioners are beginning to realize the importance of the investigation of the living situation as part of the treatment of health problems. An examination of the living situation of the ex-psychiatric patient would indeed add to the stock of knowledge in this area. Particular aspects of the living situation which could be examined include measures of clients' perceptions of the physical and psychological comfort of the situation (for example, do they have enough space and privacy? do they feel at home?), levels of resident involvement in house government or household chores/activities, and presence or absence of social support

within the situation.

It is the intent of these suggestions for further research to add to a more comprehensive understanding of the factors affecting coping. This understanding is essential to the development of health care policies suited to the magnitude of the problems of service provision post-deinstitutionalization. The urgency of the issue is based in two realizations: the alarming increase in the number of homeless mentally ill individuals in our communities and the possibility of reinstitutionalization in response to the unintended consequences of the commmunity-based treatment alternative.

ENDNOTES

1. This Task Force reports that 7,000 psychiatric patients are discharged every six months in Metropolitan Toronto (City of Toronto, Mayor's Office, 1984; 31).

2. 'Second-level lodging home' is a City of Hamilton licensing designation and is defined in the by-law as a House:
   - which accommodates 4 or more residents;
   - where, for a fee, the Operator offers to residents guidance in the activities of daily living and advice and information; and,
   - where, 24 hours per day, at least the Operator or one adult employee of the Operator is on duty in the house and able to furnish such guidance (Hamilton-Wentworth District Health Council, 1984).

   The majority of these homes have entered into a contract with Hamilton-Wentworth Regional Social Services who subsidize the accommodation of individuals with little or no financial means on a per diem basis in return for 24 hour supervision and certain standards of care for the residents.

3. Note must be made of the fact that there are three members of the research sample who have a relatively short 'average length of stay in all reported previous living situations' while concomitantly having a relatively long 'length of stay in current residence'.

APPENDIX A

The Life Management in the City Questionnaire:

Round One

I.D. # _____

LIFE MANAGEMENT IN THE CITY QUESTIONNAIRE

INTRODUCTION

Agency Director/ Social Worker: This is _____ who's from McMaster University. S/He's interested in what life's like in Hamilton for people who've had mental illness.

Researcher: I wonder if you'd be willing to spare some time and answer some questions? This sheet outlines what my study is about. If you're happy to participate perhpas you could sign this consent form. Thank-you.

I'm interested to know what your days are like. What do you like and dislike about everyday life right now?

I SOCIAL SUPPORT

1. Tell me about your family.

2. Where does your family live? (What city? or, if Hamilton, just the street name).

3. (Q 3-5, only if not living with family) How often do you see your family?

4. Are you happy with this frequency?

5. Would you like to be living with your family?

6. Are there any groups or organizations you belong to?

   eg Church
      Recreation
      Political

7. Do you meet with groups of friends sometimes?

8. Who else do you spend time with?

	1	2	3	etc
First Name				
Relationship				
Where/How met				
How long have you known each other?				
How often do you see each other?				

Given all you've told me, how satisfied are you with your social situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your social situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

II LIVING SITUATION

9. Tell me about the place you live in right now. Is it:

   with family
   indpendent
   hostel
   lodging home
   other

10. Do you have your own room?

11. How many people do you live with?

12. What exactly do you like about your living situation?

13. Dislike?

14. Do you participate in household activities?

cooking	_____
cleaning	_____
laundry	_____
shopping	_____
buying your own clothes	_____
doing your own baking	_____
making doc's app'ts	_____

15. If no, why not?

16. Would you like to be able to do more around the house?

17. What do you like about the house you live in now?

18. Dislike?

19. What about the neighbourhood you live in. What do you like about that?

20. Dislike?

21. Tell me about any difficulties you've had finding a suitable place to live.

22. Have you moved recently; say, in the last year or two? If so, tell me about the moves you've made.

	date	type	moved to...	because...
1.				
2.				
3.				
etc.				

23. Where would you live if you could choose?

24. What sorts of things prevent this?

Given all you've told me, how satisfied are you with your present living situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your living situation, how do you feel you are coping?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

III THE COMMUNITY

25. What do you enjoy doing most in your spare time?

26. Is this on your own or with others?

27. Do you have enough to do in your spare time?

28. What sorts of things would you do, if you had the opportunity?

29. What prevents you from doing these things?

30. How do you travel around Hamilton?

31. How often in a week do you take the bus?

32. How often do you get out of Hamilton?

33. How did you travel to do this?

34. Do you find people in shops and offices friendly to you?

35. If not, how do you handle this situation?

Given all you've said, how satisfied are you with the kind of community you're living in right now?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to living in the community, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

IV PERSONAL HISTORY

36. What year were you born?

37. What year did you leave school?

38. What kind of psychiatric problems have you had?

39. When did you start having these problems?

40. Could you tell me about the times you've been in hospital over the past few years?

Year	Location	Duration

41. What sort of treatment (if any) are you currently receiving?

42. Are you satisfied your mental health needs are being met?

If no, why not?

43. Do you experience any difficulties in living in Hamilton that you think are related to mental illness?

eg to do with where you live?
to do with money?
to do with your safety?

44. What sort of help do you receive in these difficulties?

45. Have there been any particular happenings that have recently changed your life for better or for worse?

46. Do you have a police record?

47. Have you ever been harassed by the police? By other people?

48. How do you tend to feel about the day ahead when you wake each morning?

V INCOME/EMPLOYMENT

49. Tell me about the jobs you've had in the past few years.

50. Are you currently employed? (if no, go to Q 62)

51. Do you work:

full time	_____
part time	_____
seasonally	_____
other	_____

52. Where do you work?

53. What do you do there?

54. How long have you worked there?

55. Did you have trouble finding a job?

56. (If 'yes' to above) What type of problems did you have?

57. Did anyone help you find a job?

If 'yes', who helped?

58. Do you feel you 'fit in' where you work?

59. What do you like about your job?

60. Dislike?

61. Are you thinking of changing jobs? If 'yes', why?

If Unemployed:

62. Are you looking for a job?

63. What sort of difficulties are you having, if you are looking?

64. Is anyone helping you find a job?

65. How long have you been unemployed?

Given all you've told me, how satisfied are you with your employment status?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your employment status, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

All Respondents

66. How much money do you receive every month?

67. Where does this come from?

68. Do you manage your own money?

69. What do you spend your money on?

Type of Spending	Amount Each Month

70. Do you have enough money to meet your needs?

71. What would you do if you had more money?

72. How many more dollars each month would it take to meet your needs?

Given all you've told me, how satisfied are you with your income situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your money situation, how do you feel you are coping?

very well	quite well	fairly well	fairly well	quite well	very well

Taking into account all we've talked about, what helps you to cope with everyday life?

What makes it difficult to cope?

THANK-YOU

APPENDIX B

The Life Management in the City Questionnaire:

Round Two

LIFE MANAGEMENT IN THE CITY QUESTIONNAIRE

I.D. # _____

Date _____

Interview Site _____

Primary Caregiver _____

1. Tell me what you like about everyday life right now?

2. Dislike?

SOCIAL SITUATION

3. Whom in your family have you seen lately?

   How often?

4. Are you happy with this frequency?

5. What groups and organizations are you now involved in?

6. How often have you been meeting with groups of friends recently?

7. Who are the most important people for you right now?

	1	2	3
RELATIONSHIP			
DURATION OF RELATIONSHIP			
CIRCUMSTANCES			
REGULARITY OF CONTACT			
WHERE DO YOU USUALLY MEET?			

8. Who bothers you most?

   How do they do that?

   How often do you see them?

9. Who notices when you're having a hard time?

   Who do you worry about?

Given all you've told me, how satisfied are you with your social situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your social situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

LIVING SITUATION

12. Are you still living at _____?

If not, what moves have you made since the last interview?

Have there been any difficulties finding a suitable place to live?

13. Do you have your own room?

14. Do you feel your housing needs are being met?

If no, why not?

15. What exactly do you like about your living situation?

16. Dislike?

17. What about the neighbourhood you live in; What do you like about it?

18. Dislike?

19. Where would you live right now if you could choose?

20. Would this be on your own or with others?

21. What prevents this?

Given all you've told me, how satisfied are you with your present living situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your living situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

THE COMMUNITY

24. Tell me about how you've been spending your spare time lately.

25. Do you have enough to do in your spare time?

26. Tell me about where you spend most of your spare time.

27. How often in the last month have you:

Been to a shopping mall? _____

Taken the bus? _____

Gone out for coffee? _____

Gone out for a meal? _____

Seen a movie? _____

Been to a bar? _____

Visited a friend? _____

Been to the bank? _____

Been to a post office? _____

Talked to neighbours? _____

Been to a doctor? _____

Seen your social worker? _____

Been out of Hamilton? _____

28. What are the most important places in Hamilton for you right now?

	1	2	3
PLACE			
WHY DO YOU GO THERE?			
HOW LONG HAVE YOU BEEN GOING THERE?			
HOW DID YOU FIRST GET TO KNOW ABOUT THIS PLACE?			
DO YOU GO ON YOUR OWN OR WITH OTHERS?			
HOW OFTEN DO YOU GO THERE?			
HOW DO YOU FEEL WHEN YOU ARE THERE?			

Given all you've said, how satisfied are you with the kind of community you're living in right now?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to living in the community, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

PERSONAL HISTORY

31. Have you been in hospital since we last talked?

32. How did you come to be involved in CPS/CES/Care Centre?

    How long have you been involved?

33. Tell me about this programme/place; what do you like about it?

34. Is there anything you dislike about it?

35. What other mental health services are you receiving?

36. Are you satisfied your mental health needs are being met in Hamilton?

    Why?

37. What other services do you think should be available?

38. Have there been any important events that have changed your life since the last interview?

EMPLOYMENT

39. Are you still (un)employed?

(If newly employed), Details of employment:

What do you do?

How did you find the job?

Do you feel you 'fit in'?

What do you like/dislike about the job?

40. If still unemployed:

Are you looking for a job?

What sorts of difficulties are you having?

Is anyone helping you find a job?

When was your last job? Why did you leave?

Given all you've told me, how satisfied are you with your employment situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your employment situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

INCOME

44. How much income do you receive every month?

45. Where does this come from?

46. Do you have enough money to meet your needs?

47. Do you tend to run out of money before the end of the month?

If so, how do you cope with this situation?

48. What would you do if you had more money?

49. How many more $ per month would it take to meet your needs?

Given all you've told me, how satisfied are you with your income situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to your money situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly

53. Taking into account all we've talked about, what helps you to cope with everyday life right now?

54. What makes it difficult to cope?

THANK-YOU

BIBLIOGRAPHY

Allen, P (1974) "A Consumer's View of California's Mental Health Care System", Psychiatric Quarterly. 48(1), 1-13.

Appathurai, C., G. Lowery and T. Sullivan (1986) "An Expanded Role for Foster Care?", Canada's Mental Health. 34(3), 6-12.

Appleby, L. and P.N. Desai (1985) "Documenting the Relationship Between Homelessness and Psychiatric Hospitalization", Hospital and Community Psychiatry. 36(7), 732-737.

Arce, A.A. and M. Vergare (1985) "An Overview of Community Residences as Alternatives to Hospitalization", Psychiatric Clinics of North America. 8(3), 423-436.

Armstrong, B. (1979) "Conference report. The Community Lodge: Helping the Chronically Mentally Ill Help Each Other", Hospital and Community Psychiatry. 30(10), 705-708.

Aviram, U. and S.P. Segal (1973) "Exclusion of the Mentally Ill: Reflection on an Old Problem in a New Context", Archives of General Psychiatry. 29, 126-131.

Bachrach, L.L. (1979) "Planning Mental Health Services for Chronic Patients", Hospital and Community Psychiatry. 30(6), 387-392.

_____. (1982) "Young Adult Chronic Patients: An Analytical Review of the Literature", Hospital and Community Psychiatry. 33(3), 189-97.

_____. (1983) "Evaluating the Consequences of Deinstitutionalization", Hospital and Community Psychiatry. 34(2), 105.

_____. (1984) "Asylum and Chronically Ill Psychiatric Patients", American Journal of Psychiatry. 141(8), 975-978.

Barrett, F. (1974) Residential Search Behaviour. Geographical Monographs Number 1, York University, Department of Geography, Toronto, Ontario.

Baxter, Ellen and Kim Hopper (1982) "The New Mendicancy: Homeless in New York City", American Journal of Orthopsychiatry. 52(3), 393-408.

_____. (1984) "Troubled on the Streets: The Mentally Disabled Homeless Poor", in J.A. Talbot (ed) (1984) The Chronic Mental Patient Five Years Later. Orlando, Florida: Grune and Stratton.

Betts, J., S.L. Moore and P. Reynolds (1981) "A Checklist for Selecting Board-and-Care Homes for Chronic Patients", Hospital and Community Psychiatry. 32(7), 498-500.

Blake, R. (1986) "Normalization and Boarding Homes: An Examination of Paradoxes", Social Work in Health Care. 11(2), 75-86.

Block, Robert (1984) "The Tragedy of Freedom", Maclean's. October 8.

Boeckh, J.L., M.J. Dear and S.M. Taylor (1980) "Property Values and Mental Health Facilities in Metropolitan Toronto", Canadian Geographer. 24(3), 270-285.

Bradley, V.J. (1978) Deinstitutionalization of Developmentally Disabled Persons: A Conceptual Analysis and Guide. Baltimore: University Park Press.

Brummel, A.C. (1981) "A Method of Measuring Residential Stress", Geographical Analysis. 13, 248-261.

Byers, S., S. Cohen and D.D. Harshbarger (1978) "Impact of Aftercare Services on Recidivism of Mental Hospital Patients", Community Mental Health Journal. 14(1), 26-34.

Campanelli, P.C., H.J. Lieberman and M. Trujillo (1983) "Creating Residential Alternatives for the Chronically Mentally Ill", Hospital and Community Psychiatry. 34(2), 166-167.

Campbell, M.E. (1981) "The Three-Quarterway House: A Step Beyond Halfway House Toward Independent Community Living", Hospital and Community Psychiatry. 32(7), 500-501.

Caplan. R.D. (1979) "Social Support, Person-Environment Fit, and Coping", in L.A. Ferman and J.P. Gardus (eds) (1979) Mental Health and the Economy. W.E. Upjohn Institute for Employment Research, Kalamazoo, Michigan.

City of Toronto, Mayor's Office (1984) Final Report of the Mayor's Action Task Force on Discharged Psychiatric Patients. Dr. Reva Gerstein, Chairman.

Cohen, C.I. and J. Sokolovsky (1978) "Schizophrenia and Social Networks: Ex-Patients and the Inner City", Schizophrenia Bulletin. 4, 546-560.

Coulton, C.J., V. Fitch and T.P. Holland (1985) "A Typology of Social Environments in Community Care Homes", Hospital and Community Psychiatry. 36(4), 373-377.

Cutler, David L. (1986) "Community Residential Options for the Chronically Mentally Ill", Community Mental Health Journal. 22(1), 61-73.

Dear, M. (1977) "Psychiatric Patients and the Inner City", Annals of the Association of American Geographers. 67, 588-594.

_____, L. Bayne, G. Boyd, E. Callaghan and E. Goldstein (1980) Coping in the Community: The Needs of Ex-Psychiatric Patients. A Mental Health/Hamilton Project, Funded by Young Canada Works.

_____ and S.M. Taylor (1982) Not On Our Street. London: Pion Books.

_____ and J. Wolch (1979) "The Optimal Assignment of Human Service Clients to Treatment Settings" in S.M. Golant (ed) Location and Environmental Context of the Elderly Population. New York: Halsted Press.

_____ (1987) Landscapes of Despair: From Deinstitutionalization to Homelessness. New York: Allen and Unwin.

Elton, P.J. and J.M Packer (1986) "A Prospective Randomised Trial of the Value of Rehousing on the Grounds of Mental Ill-Health", Journal of Chronic Diseases. 39(3), 221-227.

Emerson, R.M., E. Rochford Jr. and Linda Shaw (1981) "Economics and Enterprise in Board and Care Homes for the Mentally Ill", American Behavioural Scientist. 24(6), 771-785.

Eyles, J. and K.J. Woods (1983) The Social Geography of Medicine and Health. London: Croom-Helm.

Falloon, I. R. and G. N. Marshall (1983) "Residential Care and Social Behaviour: A Study of Rehabilitation Needs", Psychological Medicine. 13(2), 341-347.

Foucault, M. (1973) Madness and Civilization: A History of Madness in the Age of Reason. New York: Vintage Books.

Fowler, G. (1980) "A Needs Assessment Method for Planning Alternatives to Hospitalization", Hospital and Community Psychiatry. 31(1), 41-45.

Freedman, R.I. and A. Moran (1984) "Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization", Medical Care. 22(12), Supplement.

Goldman, H., A. Gattozi and C. Taube (1981) "Defining and Counting the Chronically Mentally Ill", Hospital and Community Psychiatry. 32(1), 21-27.

Goldstein, J.M. and C.L. Caton (1983) "The Effects of the Community Environment on Chronic Psychiatric Patients", Psychological Medicine. 13(1), 193-199.

Goodale, T. and S. Wickware (1979) "Group Homes and Property Values in Residential Areas", Plan Canada. 19, 154-163.

Government of Canada, National Council of Welfare (1986) 1986 Poverty Lines: Estimates by the National Council of Welfare.

Government of Ontario, Ministry of Housing (1986) Housing for Roomers, Boarders and Lodgers: The "State of Knowledge". Task Force on Roomers, Boarders and

Lodgers.

Haberman, S.J. (1978) Analysis of Qualitative Data, Volume 1. New York: Academic Press.

Halpern, J., K. Sackett, P. Binner and C. Mohr (1980) The Myths of Deinstitutionalization Policies for the Mentally Disabled. Boulder, Col.: Westview Press.

Hamilton-Wentworth District Health Council (1984) Final Report of the Mental Health Task Force.

Hamilton-Wentworth Region, Planning and Development Department (1985) Housing and Population Monitoring Report. Hamilton, Ontario.

Hull, J.C. and J.T. Thompson (1981) "Factors Which Contributeto Normalization in Residential Facilities for the Mentally Ill", Community Mental Health Journal. 17, 107-113.

James, Terry (1986) "Improving a Local Condition", Hamilton Style. March 20-April 2; 4.

Kaminoff, R.D. and H.M. Proshansky (1981) "Stress as a Consequence of the Urban Physical Environment" in L. Goldberger and S. Breznitz (eds) The Handbook of Stress: Theoretical and Clinical Aspects. New York: The Free Press, 380-409.

Kearns, R.A. (1986) "Unravelling the Web: The Influence of Environment over Coping Ability of Chronic Psychiatric Patients", Paper Presented at the 2nd International Symposium of Medical Geography, Rutgers University, New Jersey.

_____. (1987) Ph.D. in Progress.

_____, S. Martin Taylor and Michael Dear (1987) "Coping and Satisfaction Among the Chronically Mentally Ill", forthcoming.

Kruzich, J.M. (1985) "Community Integration of the Mentally Ill in Residential Facilities", American Journal of Community Psychology. 13, 553-564.

_____ and S.J. Kruzich (1985) "Milieu Factors Influencing Patients' Integration into Community Residential

Facilities", Hospital and Community Psychiatry. 36(4), 378-382.

Kunze, H. (1985) "Rehabilitation and Institutionalization in Community Care in West Germany", British Journal of Psychiatry. 147, 261-264.

Lamb, H.R. (1979) "The New Asylums in the Community", Archives of General Psychiatry. 36, 129-134.

_____. (1981) "Maximizing the Potential of Board and Care Homes", New Directions for Mental Health Services. Number 11, 19-34.

_____. (1984) "Deinstitutionalization and the Homeless Mentally Ill", in H.R. Lamb (ed) The Homeless Mentally Ill. Washington, D.C.: American Psychiatric Association, 55-74.

Lamb, H.R. and Goertzel, V. (1971) "Discharged Mental Patients: Are They Really in the Community?", Archives of General Psychiatry. 24, 29-34.

_____ and R.W. Grant (1982) "The Mentally Ill in an Urban County Jail", Archives of General Psychiatry. 39, 17-22.

_____ and C.L. Peterson (1983) "The New Community Consultation", Hospital and Community Psychiatry.34(1), 59-64.

Laws, G. and M.J. Dear (1987) "Coping in the Community: A Review of the Factors Influencing the Lives of Deinstitutionalized Ex-Psychiatric Patients", forthcoming.

Lehman, A.F. (1983) "The Well-Being of Chronic Mental Patients", Archives of General Psychiatry. 40(4), 369-373.

_____ and L.S. Linn (1984) "Crimes Against Discharged Mental Patients in Board-and-Care Homes", American Journal of Psychiatry. 141(2), 271-274.

_____, S. Possidente and F. Hawker (1986) "The Quality of Life of Chronic Patients in a State Hospital and in Community Residences", Hospital and Community Psychiatry. 37(9), 901-907.

Levine, I.S. and J. Parrish (1986) "Comments on Residential Facilities for the Mentally Ill: Needs Assessment and Community Planning", Community Mental Health Journal. 22(2), 90-93.

Ley, David (1983) A Social Geography of the City. New York: Harper and Row.

Linn, M.W., J. Klett and E.M. Caffey (1980) "Foster Home Characteristics and Psychiatric Patient Outcome: The Wisdom of Gheel Confirmed ", Archives of General Psychiatry. 37, 129-132.

Marshall, John (1982) Madness: An Indictment of the Mental Health Care System in Ontario. Ontario Public Service Employees Union.

McCarthy, P., D. Byrne, S. Harrison and J. Keithly (1985) "Housing Type, Housing Location, and Mental Health", Social Psychiatry. 20, 125-130.

Mechanic, D. (1980) Mental Health and Social Policy. Englewood Cliffs, New Jersey: Prentice-Hall, Second Edition.

Meyerson, A.T. and G.S. Herman (1984) "Aftercare: Current Status", in J.A. Talbott (ed) The Chronic Mental Patient: Five Years Later. Orlando, Florida: Grune and Stratton.

Michelson, William (1977) Environmental Choice, Human Behavior, and Residential Satisfaction. New York: Oxford University Press.

Moos, Adam I. (1984) Structuration Theory and the Ghettoization of Ex-Psychiatric Patients. Master's Thesis, McMaster University, Hamilton, Ontario

Moos, R.H. and S. Lemke (1980) "Assessing the Physical and Architectural Features of Sheltered Care Settings", Journal of Gerontology. 35, 571-583.

Murphy, H.B.M. (1972) "Foster Homes: The New Back Wards?", Canada's Mental Health. Suppl. 71, 1-17.

Nelson, G. and M. Earls (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.

Nichols, M. (1987) "Canada's Homeless: The Search for a Future", Maclean's. February 16, 34-43.

Ontario Social Development Council (1983) Adult Residential Facilities: A Provincial Perspective. Prepared on behalf of the Committee of Social Planning Councils.

Pearlin, L.I. and C. Schooler (1978) "The Structure of Coping", Journal of Health and Social Behaviour. 19, 2-21.

Peterson, C.L. (1985) "Regulation and Consultation in Community Care Facilities", Hospital and Community Psychiatry. 36(4), 383-388.

Peterson, R. (1982) "What Are the Needs of Chronic Mental Patients?", Schizophrenia Bulletin. 8(4), 610-616.

Plant, R., H. Lesser and P. Taylor-Gooby (1980) Political Philosophy and Social Welfare. London: Routledge and Kegan Paul.

Randolph, F.L., R.E. Lindenberg and A.Z. Menn (1986) "Residential Facilities for the Mentally Ill: Needs Assessment and Community Planning", Community Mental Health Journal. 22(2), 77-89.

Richman, A. and P. Harris (1983) "Mental Hospital Deinstitutionalization in Canada", International Journal of Mental Health. 11(4), 64-83.

Rossi, P. (1980) Why Families Move. Beverly Hills: Sage Publications, Second Edition.

Scott, N.J. and R.A. Scott (1980) "The Impact of Housing Markets on Deinstitutionalization", Administration in Mental Health. 7(3), 210-222.

Scull, A. (1981) "A New Trade in Lunacy: The Recommodification of the Mental Patient", American Behavioural Scientist. 24(6), 741-754.

Segal, S.P. and U. Aviram (1978) The Mentally Ill in

Community-Based Sheltered Care. New York: Wiley and Sons.

_____ (1979) "Reintegrating the Mentally Ill in the Community" International Journal of Rehabilitation Research. 2(4), 499-506.

Shern, D.L., N.Z. Wilson, R.H. Ellis, D.A. Bartsch and A.S. Coen (1986) "Planning a Continuum of Residential/ Service Settings for the Chronically Mentally Ill: The Colorado Experience", Community Mental Health Journal. 22(3), 190-202.

Siggins, Maggie (1982) "Madness in South Parkdale", The Hamilton Spectator. March 6.

Smith, C.J. (1975) "Being Mentally Ill in the Asylum or the Ghetto", Antipode. 7(2), 53-59.

_____. (1978) "Recidivism and Community Adjustment Amongst Former Mental Patients", Social Science and Medicine. 12, 17-27.

_____ and C.A. Smith (1979) "Evaluating Outcome Measures for Deinstitutionalization Programs", Social Work Research and Abstracts. 23-30.

Smith, S.J. (1984) "Practicing Humanistic Geography", Annals of the Association of American Geographers. 74, 353-374.

Solomon, P. and J. Davis (1985) "Meeting Community Service Needs of Discharged Psychiatric Patients", Psychiatric Quarterly. 57(1), 11-17.

Stark, Yvonne (1982) "Alternative Housing for Ex-Psychiatric Patients", Habitat. 25(1), 40-44.

Stein, L.I. and M. Test (eds) (1985) The Training in Community Living Model: A Decade of Experience. San Francisco, California: Jossey-Brass Inc.

Sweeney, D., J. Garrison, C. Dabrowski and P. McGettigan (1982) "Mapping Urban Hotels: Life Space of the Chronic Mental Patient", Journal of Psychosocial Nursing and Mental Health Services. 20(5), 9-14.

Talbot, J.A. (ed) (1984) The Chronic Mental Patient Five

Years Later. Orlando, Florida: Grune and Stratton.

Trute, B. (1986) "Sheltered Housing for the Chronic Psychiatric Patient: The Influence of Operators of Board and Care Facilities on Community Participation of Their Residents", Canadian Journal of Community Mental Health. 5(1), 31-38.

Turk, D.C. (1979) "Factors Influencing the Adaptive Process With Chronic Illness: Duplications for Intervention", in I.E. Sarason and C.D. Spielberger (eds) Stress and Anxiety, Volume 6. New York: Hemisphere, 291-311.

Van Putten, T. and J.E. Spar (1979) "The Board-and-Care Home: Does it Deserve a Bad Press?", Hospital and Community Psychiatry. 30, 461-464.

Weils, M.H. and H.R. Huessey (1985) "A Unique Approach: Spring Lake Ranch", Psychiatry Clinics of North America. 8(3), 597-608.

Weisman, G.K. (1985) "Crisis-Oriented Residential Treatment as an Alternative to Hospitalization", Hospital and Community Psychiatry. 36(12), 1302-1305.

White, N. (1981) "Modern Health Concepts", in The Health Conundrum. 5-18, T.V. Ontario, Toronto.

Wolch, J.R. (1981) "Residential Location of the Service-Dependent Poor", Annals of the Association of American Geographers. 70(3), 330-341.

_____ and S.A. Gabriel (1985) "Dismantling the Community-Based Human Service System", Journal of the American Planning Association. 51(1), 53-62.

Wolfensberger, W. (1972) The Principle of Normalization in Human Services. Toronto, Ontario: National Institute on Mental Retardation.

Wolpert, J., M. Dear and R. Crawford (1975) "Satellite Mental Health Facilities", Annals of the Association of American Geographers. 65, 24-35.

_____ and E. Wolpert (1974) "From Asylum to Ghetto", Antipode. 6, 63-76.

NEWSPAPERS CITED

The Globe and Mail. Toronto, Ontario.

The Hamilton Spectator. Hamilton, Ontario.