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Housing Preferences among Adults with Dual Diagnoses in Different Stages of Treatment and Housing Types

Jack Tsai, Ph.D.^a, Gary R. Bond, Ph.D.^{b,c}, and Kristin E. Davis, Ph.D.^d

^aDepartment of Psychiatry, Yale University, New Haven, CT 06516

^bDepartment of Psychology, Indiana University-Purdue University Indianapolis, Indianapolis, IN 46202

^cDepartment of Psychiatry, Dartmouth Psychiatric Research Center, Lebanon, NH 03766

^dThresholds Institute, Chicago, IL 60613

Abstract

Housing is an essential component of psychiatric rehabilitation, particularly for consumers with dual diagnoses. Research has not clearly examined why and when consumers prefer different types of housing. This exploratory study examined 1) whether housing preferences differ between stage of treatment for substance abuse, 2) whether consumers who prefer certain housing types have preferences for certain characteristics, and 3) whether consumers living in different types of housing report differences in social support, choice, and housing satisfaction. A total of 103 participants living in supervised housing (n= 65), independent apartment housing (n= 22), single room occupancy hotels (n= 11), and with family (n= 5) completed self-report questionnaires. Results showed that 1) the majority of participants preferred their own apartment or house across different stages of treatment, 2) preference for supervised housing was associated with on-site staff and peer support while preference for apartment housing was associated with autonomy and privacy, and 3) consumers in single room occupancies reported the least choice and lowest satisfaction. These findings contribute to the understanding of consumers' housing preferences and the differences consumers perceive between certain housing types.

Keywords

Housing Preferences; Supported Housing; Residential Programs; Dual Diagnosis

Adequate and appropriate housing is a necessary foundation for treatment and recovery from severe mental illness. Adults with dual diagnoses, i.e., a severe mental illness with a co-occurring substance use disorder, constitute a subgroup susceptible to housing instability (Drake & Mueser, 2000). Many dual diagnosis programs now incorporate the stages of treatment model (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1995). The stages of treatment conceptualizes health behavior change as a progression through a series of stages and studies have demonstrated that individuals can be classified into these stages (Prochaska & Norcross, 2001). However, the stages of treatment model is not commonly used in providing housing services to consumers with dual diagnoses, nor is much attention paid to housing preferences that may change. Although some clinicians have used a "linear continuum" model of transitioning consumers from restrictive housing settings to increasingly independent settings, this has not explicitly been done in the context of the

stages of treatment model (Bebout, Drake, McHugo, & Harris, 1997; Ridgway & Zippile, 1990).

No prior study found has examined housing preferences of dual diagnosis clients by their stage of treatment. There are several interesting possibilities. Clients may have an increasing preference for independent housing as they progress through stages of treatment, clients may have a high preference for independent housing regardless of stage of treatment, or clients may have a high preference for supervised housing in the active treatment stage. There is some evidence suggesting the latter. Many homeless dual diagnosis consumers in the early stages of treatment do not want to live in a highly structured, restrictive environment after living on the streets (Blankertz & White, 1990). It might be expected that consumers in the early stages of treatment would prefer independent housing, but as consumers enter the active treatment stage and make the determination to recover, they may seek the structure, on-site staff, and peer support available in residential programs.

A correlation between stage of treatment and housing outcomes has been suggested by two studies that found consumers who entered residential programs near the active treatment stage were more engaged and successful in their recovery than those who entered during earlier or later stages (Davis, et al., 2006; McCoy, et al., 2003). However, these studies were observational and did not assess housing preferences. Certainly, more evidence of possible causality is needed as this may have important implications on how assessments and housing services are provided.

Numerous surveys (Owen, et al., 1996; Piat, et al., 2008; Tanzman, 1993) have found that the general majority of consumers, 44 to 70%, prefer to live independently in their own house or apartment. Second most preferred housing was group homes (7 to 29% of consumers), living with family (4 to 19%), and board-and-care homes (5 to 10%). However, a literature search did not uncover any study that has examined whether housing preferences differ by stage of treatment.

In general, psychiatric consumers prefer housing that is safe, affordable, in good repair, and with convenient access to transportation so that they can lead normal lives (Forchuk, Nelson, & Hall, 2006; O'Connell, Rosenheck, Kasprow, & Frisman, 2006). However, which housing characteristics are associated with which housing types has not been clearly delineated (Newman, 2001). Independent housing, described as housing in the open rental market, can offer more autonomy, privacy, and normality than group housing (Nelson, Sylvestre, Aubry, George, & Trainor, 2007; Parkinson, Nelson, & Horgan, 1999; Warren & Bell, 2000). Supervised housing, defined as housing with congregate living and on-site mental health staff, may offer social support as consumers living independently often report feelings of isolation and loneliness (Friedrich, Hollingsworth, Hradek, Friedrich, & Culp, 1999; Meltzer & Kemp, 1994; Nelson, Hall, Squire, & Walsh-Bower, 1992; Siegel, et al., 2006).

Studies that have examined differences in satisfaction between supervised and independent living have resulted in mixed findings (Nelson, Hall, & Walsh-Bowers, 1997; Newman, 2001; Schutt, Goldfinger, & Penk, 1992). A few potential factors may account for this. First, consumers living in SROs have reported lower satisfaction than those living in apartments (Levstek & Bond, 1993; Tanzman, Wilson, & Yoe, 1992). Yet, single room occupancies (SROs) are often classified as independent housing (e.g., Seidman, et al., 2003), and perhaps some studies have ignored differences between apartments and SROs (e.g., Siegel, et al., 2006). A second factor may be that what determines housing satisfaction is not the type of housing *per se*, but whether the housing choice fits the consumers' preferences. Consumers living in their preferred housing report the highest levels of housing satisfaction (Nelson, Hall, & Forchuk, 2003) and some studies have examined satisfaction without regard to

consumer preferences (Newman, 2001). Thirdly, these studies described above included consumers with various diagnoses who may have different needs, and did not only focus on consumers with dual diagnoses. These factors aforementioned were examined in the current study.

Three research questions are explored in this study. First, do consumers' housing preferences differ by stage of treatment for consumers with a dual diagnosis of co-occurring substance abuse and severe mental illness? No previous known study has examined this question, but as described above, research in this area has suggested this possibility. Thus, it is hypothesized that independent housing will be the most preferred option across stages, but that those consumers in the active stage of treatment will report a higher preference for supervised housing than those in the earlier and later stages. Second, do dual diagnosis consumers who prefer certain types of housing have preferences for specific housing characteristics? It is hypothesized that preference for supervised housing will be associated with preferences for structure and rules, on-site mental health staff, and peer support while preference for independent housing will be associated with preferences for autonomy, privacy, and normality. Third, are there differences between dual diagnosis consumers living in supervised and independent housing on perceived social support, choice, and residential satisfaction? It is hypothesized that supervised housing will provide more social support than independent housing because of its on-site staff and tenant peers, but that those consumers living in supervised housing will report less choice in their everyday living because of its structure and rules. It is also hypothesized that those consumers living in their preferred housing will be more satisfied than those who are not.

Methods

A packet of self-report questionnaires was distributed to consumers served by a large psychosocial rehabilitation agency in Chicago. Inclusion criteria for participation were a history of homelessness and a dual diagnosis, as determined by the agency data management staff. Participants were offered \$5 compensation and their diagnoses and stage of treatment for substance abuse were obtained from electronic medical records by agency staff. As part of care services, the agency required clinicians to conduct bi-annual assessments of consumers' stage of treatment for substance abuse using the Substance Abuse Treatment Scale (McHugo, Drake, Burton, & Ackerson, 1995). This study was initiated in 2008, all participants gave informed consent for their participation, and all procedures were approved by the appropriate institutional review boards.

The supervised housing sample consisted of consumers from two residential programs, Rowan Trees and Grais Apartments. Both residential programs offer individual units that include a private bath and kitchen. Residents are offered integrated substance abuse and mental health treatment, but there is no requirement to attend. Further details of these two programs have been described elsewhere (Davis, et al., 2006; Mayes & Handley, 2005; McCoy, et al., 2003). The independent housing sample consisted of a random sample of consumers living in independent housing arrangements, including apartments and SROs, who were receiving intensive case management services. However, apartments and SROs were not analyzed together as independent housing, but were treated as separate types of housing as detailed below.

Sampling

All 89 consumers living in two residential programs and a random sample of 160 consumers living in independent housing arrangements were asked to participate. Consumers living in supervised housing had questionnaires distributed to them by residential staff, while those living in independent housing had questionnaires mailed to them with self-addressed prepaid

envelopes; reminder letters were sent one month later. Sixty-five consumers in supervised housing (73.0% response rate), and 38 consumers (22 in apartments, 11 in SROs, and 5 living with family) living in the community (23.8% response rate) completed the questionnaires for a total of 103 participants.

Measures

Current physical housing quality—The Housing Environment Survey-Physical Quality Scale (HES-PQ; Wright & Kloos, 2007) contains 14 items which ask consumers to rate how much they agree with statements about the physical quality of their housing, such as its cleanliness and plumbing, on a 5-point scale Likert-scale from 1 (Strongly Disagree) to 5 (Strongly Agree). A previous study found this scale had adequate internal consistency and test-retest reliability (Wright & Kloos, 2007). The current sample found adequate internal consistency with an alpha of .78 ($n = 84$).

Housing preferences—Goldman, Rachuba, and Tosh (1995) found that studies on consumer housing preferences have typically only used one or two of the following approaches: 1) a simple satisfaction question, e.g., “How satisfied are you with your current living situation?”; 2) a single forced-choice response, e.g., “Which one of the following places do you want to live in?”; or 3) a multiple-choice question asking preferences for different characteristics of housing, e.g., “How do you feel about the following housing supports?”. The current study assessed housing preferences using all three approaches using a scale created for the study. First, items from Tanzman’s national survey (1993) were taken to create two items in a force-choice format asking participants their first and second housing preference from a list of 8 housing options (e.g., group homes, own apartment, SROs). Second, 8 items were created asking participants to rate the strength of their preference on a 5-point scale from -2 (strongly do not want)^a to 2 (strongly want) for each housing option. Lastly, 10 items were created listing various characteristics of housing (e.g., autonomy, privacy, etc.) and participants were asked to rate their preference on a 5-point scale from -2 (strongly do not want) to 2 (strongly want). Preference for a group home/residential program or community care home (e.g, board-and-care home) was collapsed into the category of supervised housing.

Social support—An adapted version of the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) was used, consisting of 12 items with three subscales: staff, other consumers, and significant other. Several items were reworded from the original MSPSS by replacing “friends” with “other consumers” and “family” with “staff.” Respondents rated items on a 7-point Likert scale ranging from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree) for statements like “I can count on other consumers when things go wrong”. The original MSPSS has demonstrated good reliability and validity among groups with psychopathology (Eker & Arkar, 1995; Zimet, et al., 1988). This study found excellent internal consistency with an overall alpha of .95 ($n = 93$) and alphas of .91, .94, and .91 on the significant other, staff, and consumer subscales.

Perceived choice—The Housing Choice Measure (Srebnik, Livingston, Gordon, & King, 1995) includes 16 items asking respondents to rate the degree of choice they have on various issues related to housing (e.g., the place where you live, decoration). Respondents answered on a 5-point scale from 1 (no choice at all) to 5 (completely my choice). The scale was developed for people with severe mental illness and has shown adequate internal

^aAnchor points that were -2 (strongly do not want) or -1 (do not want) were given negative values to reflect the valence of the response.

consistency and test-retest reliability (Srebnik, et al., 1995). This study found good internal consistency, yielding an alpha of .91 ($n = 79$).

Residential satisfaction—The Substance Abuse and Mental Health Services Administration Housing Satisfaction scale (Tsemberis, Rogers, Rodis, Dushuttle, & Skryha, 2003) consists of 19 items that consumers rate on a 5-point scale from 1 (very dissatisfied) to 5 (very satisfied) on 4 subscales, namely, choice, safety, privacy, and proximity. Choice refers to satisfaction about the amount of choice over where and with whom they live. Safety refers to satisfaction about how safe they feel in their living space and neighborhood. Privacy refers to satisfaction about how much privacy they feel they have in their dwelling. Proximity refers to satisfaction about their proximity to community amenities. This scale has been field tested in various settings and demonstrated good reliability and validity (Tsemberis, et al., 2003). The current study found good internal consistency with an overall alpha of .93 ($n = 87$) and alphas of .87, .81, .88, and .65 on the choice, safety, privacy, and proximity subscales, respectively.

Stage of treatment—Clinicians used the Substance Abuse Treatment Scale (SATS; McHugo, et al., 1995) to assess consumers' stage of treatment for their substance abuse in the last 6 months. The SATS was rated on a 8-point scale: 1 or 2 represent the engagement stage, 3 or 4 the persuasion stage, 5 or 6 the active treatment stage, and 7 or 8 the relapse prevention stage. This instrument has been widely used and shown high inter-rater and test-retest reliability (Drake, Xie, McHugo, & Shumway, 2004; McHugo, et al., 1995).

Data Analysis

Background differences between participants were tested with one-way analyses of variance (ANOVA) and Pearson's Chi-square. Fisher's least squares difference (LSD) test was used to test specific group comparisons. Pearson's chi-square and one-way ANOVA was used to test for differences in housing preferences by stage of treatment. Pearson correlations were used to examine the associations between preferences for housing types and characteristics. Finally, independent t-tests and one-way ANOVA were conducted to compare consumers in different housing types on perceived choice, social support, and satisfaction. Independent t-tests were also conducted to compare consumers who were currently in their preferred housing to those who were not on choice, social support, and housing satisfaction measures. Levene's test for equality of variances was used to test for homogeneity of variance and adjustments to t-tests were made accordingly.

Results

As noted earlier, a total of 103 participants responded to questionnaires, 65 in the supervised housing sample, 22 in apartments, 11 in SROs, and 5 living with family. The 5 consumers living with family were excluded from analyses comparing supervised housing, apartments, and SROs, but were included in analyses involving housing preferences.

Background characteristics are summarized in Table 1. Consumers living in SROs reported the highest rent and the lowest physical housing quality. Comparing participants based on their first housing preference, there were no significant background differences.

Table 2 shows that on categorical measure of first housing preference, the majority of participants indicated that having their own apartment or house was their first preference, and the next highest first choice preference was supervised housing. On a strength-of-preference measure, participants also indicated the strongest preference for their own apartment or house followed by living with family, and supervised housing. A paired t-test of all participants found that the strength of preference for a person living in their own

apartment or home was significantly greater than the strength of preference for a group home/residential program ($t= 11.91$, $p<.001$).

For the first research question, Table 3 shows housing preference by stage of treatment. No statistical differences were found in preferences between stage of treatment using either the categorical measure of first preference ($X^2= 7.83$) or the strength-of-preference measure for each housing type as shown in the table.

For the second research question, Table 4 shows that the preference for a person to live in their apartment or house is significantly correlated with preference for autonomy, privacy, safety, access to transportation, and affordability. Preference for residence in a group home/residential programs is significantly correlated with preference for peer support and on-site mental health staff.

For the third research question, Table 5 shows consumers living in SROs reported significantly less choice and lower satisfaction than the two other housing types. The difference between the three housing types on the total social support scale approached significance ($p= 0.06$). A post-hoc analysis using Fisher's LSD showed consumers in supervised housing reported significantly greater peer support on the consumer subscale than those living in SROs ($p<.05$).

Then, participants who were living in their preferred housing were compared to those who were not. Thirty-five (36.5%) participants were living in their first housing preference, including 17 (81.0%) in their own apartment, 13 (22.0%) in supervised housing, and 3 (60.0%) in their family's home. It was found that consumers living in their preferred housing reported significantly more choice in their everyday living than those who were not in their preferred housing type ($t= 3.64$, $p<.001$), but they did not differ on perceived social support or satisfaction.

Discussion

Results show that the majority of dual diagnosis consumers prefer living in their own apartment or house, regardless of their stage of treatment. However, the small sample size in the active treatment stage limited the analyses to be exploratory and further study is needed. Preference for living in supervised housing is associated with preference for on-site mental health staff and peer support, while preference for an apartment or house is associated with preference for autonomy and privacy. This supports the hypothesis that consumers base their preferences for each housing type on what researchers have identified as the key differences (Parkinson, et al., 1999).

Although there was only a small number of participants living in SROs, it is clear that they held this housing type in low regard. Consumers living in SROs reported having the least choice, the lowest satisfaction, the lowest physical housing quality, and the highest rent compared to those living in residential programs and apartments. These differences may have been due to a combination of factors, including the small spaces, short-term leases, and transient neighbors that are characteristic of SROs. There has been little research specifically on SROs and mental health, but two older studies (Levstek & Bond, 1993; Tanzman, et al., 1992) also found low satisfaction with SROs consistent with our findings. Studies on drug use and risky sex behaviors have also commonly reported the low housing quality of SROs (Minkler, Frantz, & Wechsler, 2006; Shannon, Ishida, Lai, & Tyndall, 2006).

Besides participants living in supervised housing reporting lower rent, there were no statistically significant differences found between consumers living in supervised housing and apartments. This finding fails to support the widely-held contention that group homes

are perceived by consumers as overly restrictive and undesirable as places to live in (Warren & Bell, 2000). It is especially surprising, given the finding that consumers associate supervised and apartment housing with different housing characteristics. These results suggest that consumers with dual diagnoses have different impressions and expectations about supervised and apartment housing, but there may be fewer differences between the two types than expected.

Contrary to the study hypothesis, consumers who live in their preferred housing type do not report significantly greater satisfaction than those who are living in other types of housing. This may be explained by the finding that although the majority of participants expressed a preference for apartment housing, those living in supervised housing were just as satisfied. Participants living in their preferred housing type did report greater choice over their housing and activities. Hence, consumers that live where they want tend to report a greater sense of control and choice.

This study has several study limitations. There were a surprisingly small number of participants in the active treatment stage and a low response rate from those living in independent housing. This may have resulted in low statistical power to detect differences. There was also a possible response bias because participants in independent housing had to return surveys by mail, whereas participants in supervised housing handed surveys to staff. Unfortunately, we were unable to compare respondents and non-respondents to rule out potentially influential differences. Although participants in supervised housing were informed their responses would be confidential, some may have been reluctant to provide negative responses for fear staff may read their responses after receiving them. There may have been other influential factors not accounted for because they were unmeasured or not the focus of the study, e.g., the effect of employment on housing preferences. Lastly, generalizability may be limited because the supervised housing in the study was “damp” housing where abstinence was not necessarily a requirement of housing (as in “dry” housing), and each consumer had their own room. Results may not generalize to other supervised housing or housing outside of Chicago. Nonetheless, many of the findings point to areas for further research in other contexts.

This study focused exclusively on individuals with dual diagnoses and whether these results generalize to consumers without a substance use disorder has yet to be determined. Further investigation is needed on how housing preferences develop and why some consumers prefer living in non-independent housing. Differences in more objective outcomes, such as treatment progress, between clients in different types of housing certainly need to be assessed. Research needs to look at how to develop supported housing models in accordance with resident preferences and what type of housing is best for them, especially because the type of housing treatment providers recommend is often at variance with what consumers want (Schutt, Weinstein, & Penk, 2005). As the majority (63.5%) of consumers in this study was not living in their preferred housing, mental health staff may need to devise better ways to accommodate consumer preferences in housing services.

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Table 1

Demographic and Background Differences

	Supervised Housing (N= 65) ^a	Apartment (N= 22)	Single Room Occupancy (N= 11)	Test of Difference	Group Comparisons p<.05
Age (sd)	45.4 (9.7)	48.6 (9.7)	40.7 (9.9)	F= 2.32	n/a
Gender					
Male	49 (75.4%)	18 (81.8%)	10 (90.9%)	X ² = 1.52	n/a
Female	16 (24.6%)	4 (18.2%)	1 (9.1%)		
Race					
Black	34 (56.7%)	14 (66.7%)	6 (54.5%)	X ² = 3.96	n/a
White	19 (31.7%)	6 (28.5%)	2 (18.2%)		
Other	7 (11.7%)	1 (4.8%)	3 (27.3%)		
Primary Diagnosis					
Schizophrenia-spectrum	29 (45.3%)	14 (77.8%)	4 (44.4%)	X ² = 2.08	n/a
Bipolar	16 (25.0%)	4 (22.2%)	4 (44.4%)		
Other	19 (29.7%)	0 (0.0%)	1 (11.1%)		
Secondary Diagnosis					
Alcohol Abuse/Dependence	18 (35.3%)	9 (50.0%)	3 (33.3%)	X ² = 1.33	n/a
Drug Abuse/Dependence	33 (64.7%)	9 (50.0%)	6 (66.7%)		
SATS score	5.8 (2.1)	5.2 (2.5)	5.5 (1.9)	F= 0.51	n/a
Employment Status					
Not working/Volunteer	51 (78.5%)	14 (70.0%)	8 (72.7%)	X ² = 0.68	n/a
Part-time/Full-time	14 (21.5%)	6 (30.0%)	3 (27.3%)		
Monthly Income (\$)	661.6 (287.0)	856.8 (387.3)	698.4 (365.9)	F= 2.66	n/a
Monthly Rent Average (\$)	203.2 (99.2)	392.8 (178.7)	435.7 (141.5)	F= 22.85**	SH<APT<SRO ^b
Lifetime hospitalizations	10.4 (12.0)	9.8 (8.4)	15.5 (17.6)	F= 0.96	n/a

	Supervised Housing (N= 65) ^a	Apartment (N= 22)	Single Room Occupancy (N= 11)	Test of Difference	Group Comparisons p<.05
Lifetime arrests	5.2 (7.2)	3.1 (2.8)	10.6 (16.8)	F= 3.03	n/a
Residential tenure (months)	39.2 (31.8)	37.0 (55.4)	29.6 (42.4)	F= 0.26	n/a
Physical Housing Quality ^c	3.8 (0.6)	3.9 (0.7)	2.6 (0.9)	F= 17.73**	SH, APT>SRO

* p<.05,

** p<.001

^a Individual N's for each category ranged from 55 to 65 for supervised housing, 18 to 22 for apartment, and 6 to 11 for single room occupancy.

^b SH= Supervised Housing, APT= Apartment, SRO= Single Room Occupancy

^c Housing quality was rated on a 5-point scale with higher scores denoting higher quality.

Table 2

Summary of Housing Preferences for Different Housing Types

	First Housing Preference (n=96) ^a	Second Housing Preference (n=86)	Strength of Preference ^b (n= 102)
Mental Hospital/Inpatient Unit	2 (2.1%)	2 (2.3%)	1.7 (1.1)
Group Home/Residential Program	14 (14.6%)	21 (24.4%)	2.6 (1.3)
Community Care Home	1 (1.0%)	5 (5.8%)	1.9 (1.0)
Single Room Occupancy	4 (4.2%)	22 (25.6%)	2.4 (1.3)
Own Apartment or House	66 (68.8%)	21 (24.4%)	4.5 (1.0)
Family's Home	9 (9.4)	12 (14.0%)	2.7 (1.4)
On the Streets	0 (0.0%)	3 (3.5%)	1.4 (0.8)

^aSeven participants were missing their first housing preference, and 17 were missing second housing preference.

^bStrength of preference was rated on a 5-point scale with higher scores indicating greater preference.

Table 3

Housing Preferences by Stage of Treatment

	Engagement/Persuasion Stages (n= 34)	Active Treatment Stage (n= 10)	Relapse Prevention Stage (n= 40)	Total	Test of Difference ^a F=
Prefer Own Apartment or House					
<i>Strength of Preference^b</i>	26 (76.5%) ^c 4.3 (1.2)	8 (80.0%) 4.4 (1.0)	24 (60.0%) 4.7 (0.8)	58	1.10
Prefer Supervised Housing					
<i>Strength of Preference</i>	4 (11.8%) 2.7 (1.2)	2 (20.0%) 3.0 (1.3)	9 (22.5%) 2.7 (1.4)	15	0.25
Prefer SRO					
<i>Strength of Preference</i>	1 (2.9%) 2.1 (1.2)	0 (0.0%) 2.8 (1.0)	3 (7.5%) 2.6 (1.4)	4	1.70
Prefer Living With Family					
<i>Strength of Preference</i>	3 (8.8%) 2.8 (1.5)	0 (0.0%) 2.5 (0.7)	3 (7.5%) 2.7 (1.4)	6	0.12
Prefer Mental Hospital/Inpatient Unit					
<i>Strength of Preference</i>	0 (0.0%) 1.4 (0.7)	0 (0.0%) 1.6 (0.8)	1 (2.5%) 1.9 (1.2)	1	2.03

^a ANOVAs compared the strength of preference for each housing type across stages of treatment

^b Strength of preference was rated on a 5-point scale with higher scores indicating greater preference.

^c Percentages shown are the proportion of participants in that stage of treatment

Table 4
Correlations between Strength of Preference for Different Housing Types and Housing Characteristics

Strength of Preference for:	Strength of Preference for:					
	Mental Hospital/ Inpatient Unit	Group Home/ Residential Program	Community Care Home	Single Room Occupancy	Own Apartment or House	Family's Home
Autonomy	-.36**	.06	-.21*	-.22*	.37**	.09
Structure and Rules	-.03	.13	.09	-.04	.11	.11
Privacy	-.29**	-.06	-.19	-.19	.43**	-.03
On-Site Mental Health Staff	.06	.36**	.26**	.04	.12	-.04
Normality	-.09	.08	.10	-.05	.09	.08
Peer Support	-.02	.28**	.12	.04	.06	.07
Safety	-.12	.15	.02	-.13	.29**	.03
Easy Access to Transportation	-.12	.21*	-.02	-.05	.36**	-.11
Affordable	-.11	.13	-.04	.01	.47**	-.04
Beauty	-.10	.10	-.08	-.08	.41**	-.06

*
p<.05,

**
p<.01

Table 5

Differences between Housing Type on Choice, Social Support, and Satisfaction

	Supervised Housing (n= 65) ^a	Apartment (n= 22)	Single Room Occupancy (n=11)	ANOVA F=	Group Comparisons ^b p<.05
Choice scale mean (sd)^c	3.8 (0.7)	4.0 (0.6)	2.8 (1.1)	10.1***	SH, APT>SRO
Social Support scale^d					
Staff mean (sd)	5.3 (1.7)	5.0 (1.9)	4.6 (2.3)	0.74	n/a
Significant Other mean (sd)	4.9 (1.8)	4.4 (1.9)	4.8 (1.5)	0.56	n/a
Consumer mean (sd)	4.6 (1.6)	4.2 (1.6)	3.4 (2.0)	2.93	n/a
Total mean (sd)	4.9 (1.5)	4.6 (1.7)	4.2 (1.5)	1.19	n/a
Housing Satisfaction scale^e					
Choice mean (sd)	4.1 (0.6)	4.0 (1.0)	3.2 (1.1)	5.74**	SH, APT>SRO
Safety mean (sd)	3.8 (0.8)	3.7 (0.9)	3.0 (1.0)	4.25*	SH, APT>SRO
Privacy mean (sd)	3.9 (0.7)	4.0 (1.1)	2.9 (1.2)	6.54**	SH, APT>SRO
Proximity mean (sd)	3.8 (0.7)	3.9 (0.8)	3.8 (0.6)	0.24	n/a
Total mean (sd)	3.9 (0.6)	3.9 (0.9)	3.1 (1.0)	5.42**	SH, APT>SRO

* p<.05,

** p<.01,

*** p<.001

^a N's ranged from 63 to 65 for supervised housing, 21 to 22 for apartment, and 10 to 11 for single room occupancy.

^b SH= Supervised Housing, APT= Apartment, SRO= Single Room Occupancy

^c Choice was rated on a 5-point scale with higher scores denoting greater choice.

^d Social support was rated on a 7-point scale with higher scores denoting greater social support.

^e Satisfaction was rated on a 5-point scale with higher scores denoting greater satisfaction.