“Who Believes Most in Me and in My Recovery”: The Importance of Families for Persons With Serious Mental Illness Living in Structured Community Housing

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Abstract

In this article, the authors report on qualitative findings on the role of family in supporting recovery for mental health consumers living in structured, community housing in a large Canadian city. Despite living separately from families and relying heavily on formal services, residents identified their families more often than mental health professionals, friends, and residential caregivers as those who most believe in them and their recovery. Families supported recovery by providing affection and belonging, offering emotional and instrumental support, and by staying actively involved with residents. Families are a vital, untapped resource for social workers in promoting independent living.

Keywords

community housing; mental health; qualitative research; recovery; rehabilitation; serious mental illness

Families, as primary caregivers for persons with psychiatric disability, are increasingly recognized for their potential role in fostering mental health and well-being (Mental Health Commission of Canada, 2009). The recovery paradigm in mental health acknowledges

families as important players in the recovery process. Families are often at the center of people's social worlds, providing them with primary support networks. However, most research on the role of families in recovery has focused on persons living at home, or independently in the community. There has been little concern with the role of families in the recovery journey of persons living in structured residential care. Over the past 50 years, a continuum of housing under the supervision of mental health professionals has been developed for people with psychiatric disabilities in several countries, including Canada and the United States. This ranges from highly structured, professionally staffed housing, such as hostels and group homes, to more autonomous arrangements, including foster homes and supervised apartments.

LITERATURE REVIEW

Mental health recovery is described as a transformational process leading to a more fulfilling, satisfying, contributing life despite the presence of symptoms (Anthony, 1993; Deegan, 1988, 1996a). Two major perspectives have emerged on the meaning of recovery in mental health: clinical recovery and personal recovery (Davidson & Roe, 2007; Slade, 2009). Clinical recovery derives from traditional outcome research (Lieberman, Kopelowicz, Ventura, & Gutkind, 2002; Silverstein & Bellack, 2008), and longitudinal studies establishing that most people show substantial clinical improvement over time (Ciompi, 1980; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b; McGlashan, 1988; Pevalin & Goldberg, 2003). Clinical recovery involves diagnosis, objective measures of symptom management and remission, and psychosocial functioning, as rated by mental health professionals.

By contrast, personal recovery is described as an ongoing, lifelong, and highly subjective process (Davidson et al., 2005; Piat et al., 2009; Smith, 2000; Spaniol, Wewiorski, Gagne, & Anthony, 2002; Young & Ensing, 1999). Personal recovery has its origins in the lived experience and writings of "psychiatric survivors," ex-patients of psychiatric hospitals who organized around their shared experiences of neglect and poverty in the community (Chamberlin, 1978; Deegan, 1996a, 1996b; O'Hagan, 1991). Personal recovery, as a process, starts with redefinition of the self or personal identity (Davidson & Strauss, 1992; Kelly & Gamble, 2005), and might include negotiating internal and external dimensions of recovery (Jacobson, 2001; Ochocka, Nelson, & Janzen, 2005). Key concepts in the recovery process include hope (Deegan, 1996a); personal responsibility, self-advocacy, and wellness (Mead & Copeland, 2000); empowerment and self-determination (Ahern & Fisher, 1999, 2001; Fisher, 1999; Frese & Davis, 1997); and acceptance (Spaniol, 1997).

Recovery is also about "connection." Young and Ensing (1999) described connecting with friends, family, professionals, and community as an indication that the person has returned to basic functioning. Jacobson and Greenley (2001) and Schon (2009) underlined the importance of social relationships in the recovery process. Davidson et al. (2005) identified "being supported by others" as a critical aspect of recovery among those trying to live interdependently in the community. Other studies focus on the social support provided specifically by families (Moos & Moos, 2007; Pernice-Duca, 2010; Skarsater & Willman, 2006). Corrigan and Phelan (2004) reported a positive correlation between the size of the

family support network and recovery. The Padgett, Henwood, Abrams, and Drake (2008) study of homeless mental health consumers provides further support for the importance of family in recovery, as the volatility of family relationships constituted an important missing element in people's recovery.

Several studies focus on how the family's belief in the person's capacity to recover is a vital source of hope for recovery (Fisher, 1997; Kelly & Gamble, 2005). Families in the Mancini, Hardiman, and Lawson (2005) study expressed unwavering and steadfast belief in the affected person's ability to recover, and did not view the person through the lens of disability. Ridgway (2001) reported that consumers actively chose people who believed in, and showed affection for them as their "real family." It is Deegan (1988), however, who best described the unconditional belief of family in recovery for the person engulfed in the despair of mental illness. Deegan underlined the critical factor of "suffering with" the person, calling on the person to rise above the circumstances and remain hopeful despite the odds.

Families often play a central role in protecting the person's sense of self, countering negative messages experienced in treatment settings, and building the person's confidence. Mancini et al. (2005) and Topor et al. (2006) described how family members, from years of "standing alongside the person," possess a deep knowledge of the person, and maintain continuity with the preillness self. As such, families prevent the person from adopting a stigmatized self-image.

Families also provide material and practical support, which reduces stress and enhances a sense of security among recovering consumers. Sixty-seven percent of respondents in a study by Murray-Swank et al. (2007) favored family participation in psychiatric treatment. Families often helped by lending money (Schon, Denhov, & Topor, 2009). Baxter and Diehl's (1998) study on recovery as a shared process between consumers and their families, identified advocacy as a primary activity of families who have learned to cope after the initial shock of diagnosis.

Recovery demands that mental health consumers have an opportunity to "give back" through interpersonal relationships. Building healthy interdependence within families, and being helpful to others, are important aspects of recovery (Baxter & Diehl, 1998). As Topor et al. (2006) argued, helpers must step down from their one-sided roles, and prepare themselves to receive the recovered person's concern and advice. Most of the literature deals with the role of families for people with serious mental illness living with their family or independently in the community. Little research exists on the family role in the recovery process for people living apart, as in the case of those living in structured community housing.

PURPOSES OF THE STUDY

This large, multisite study explored the role of housing in the recovery of persons with serious mental illness.¹ The aim was to better understand how mental health consumers

¹Findings presented in this article are part of a larger study funded by the Canadian Institutes of Health Research, Project #81110.

living in different types of structured community housing experience recovery. This article is based on results from the qualitative phase of the study, and reports on the role of family in recovery for a group of mental health consumers who live separately from their families and depend on formal services for most of their needs.

METHOD

The study was conducted in a large Canadian city, a major urban center with almost 2 million inhabitants. At the time of the research, there were 3,920 persons with serious mental illness living in different types of structured community housing, such as hostels and group homes, as well as foster homes and supervised apartments (Agence de la Santé et des Services Sociaux, 2003). In this city, housing is organized according to three basic categories with diminishing levels of supervision: (a) short-term transitional housing with intensive supervision—high supervision; (b) long-term housing with moderate supervision—medium supervision; and (c) autonomous housing with ongoing support or supervision—low supervision (Ministère de la Santé et des Services sociaux, 2005, p. 91). Mental health professionals from three university-affiliated psychiatric hospitals supervise these residences. They are operated by either rotating 24/7 professional staff, nonprofessional caregivers, or off-site staff.

Participants

To be included in the study, residents had to (1) have a *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [DSM-IV]; American Psychiatric Association, 2004) diagnosis of serious mental illness (schizophrenia, bipolar disorders, major depression); (b) live in structured community housing for a minimum of 6 months; (c) be between 18 and 64 years of age; and (d) not have an intellectual impairment as the primary diagnosis. In all, 40 consumers participated, and 57.5% were male. The average age was 46. Ninety percent had never married, and 7.5% were divorced. One participant was living in a common-law union. Sixty percent had a diagnosis of schizophrenia, 15% had major depression, 10% had a bipolar disorder, and the rest reported multiple diagnoses. In terms of education, 65% had completed some high school or less, and 20% had their high school diploma. Ten percent had a university degree. The rest had less than high school or did not respond.

Residents living in structured community housing come through the hospital system, and are followed by multidisciplinary teams. Study participants lived between 1 and 7 years in their current housing, with an average tenure just under 4 years. The average number of residents in each home was between eight and nine. Although the great majority of residents (87.5%) had a single room, the remainder shared with one or two roommates. Seventy-eight percent of residents would recommend their current housing as a good place to live, but responses were split on whether residents would want to make their current living situation permanent (40% yes, 48% no).

Procedure

The research team obtained the lists of all housing situations from the supervising psychiatric hospitals. The lists were divided into three categories as described earlier. In all,

there were 302 residences, including 63 high-level supervision, 195 medium-level supervision, and 44 low-level supervision. Methods to recruit participants included: (a) posting of written announcements in lobbies or common areas of the residences; (b) distributing pamphlets in individual mailboxes inviting people to participate; and (c) publicizing the study among residents by staff.

Participation was voluntary. Those interested in participating in the study telephoned the investigators directly. A research assistant screened each person for eligibility, knowledge of recovery, and willingness to undergo the interview. In all, 164 consumers contacted the research team. Twenty-five did not meet the eligibility criteria, 22 were eliminated due to difficulties with comprehension or oral expression at the time of the screening, 10 could not be reached subsequently, and 13 declined to participate for lack of interest. Of 94 eligible participants, a purposeful sample of 40 was selected (Patton, 1990).² To ensure a maximum variation sample, the final selection took into account the following variables: sex, age, diagnosis, number of years in current housing, and number of years the home was in operation. Only one person from each residence was selected to participate.

A qualitative interview guide covering eight topics, each with subquestions, was developed by the research team. The topics covered included: the meaning of recovery, present housing and recovery, meaningful relationships, caregivers and mental health professionals, and recovery and best home for recovery. Administrators from the three supervising hospitals validated the interview guide for content and language. The interview guide was pretested with four residents, and minor changes were made. Findings for this article emerge from two related questions in the interview guide on the topic of “meaningful relationships.” These are: “Who is the person who believes most in you and your recovery?” and “How does this person help you recover?”

The principal investigator and one research assistant conducted interviews between March and October 2009. Interviews were conducted in the residences, or in other settings offering privacy and quiet. Interviews were audiotaped, and lasted between 45 and 90 minutes. Sociodemographic questionnaires were administered following the interviews, and all interviews were transcribed verbatim. All participants signed and received a copy of the consent form. To ensure confidentiality and anonymity, participants were identified by pseudonyms, and any potentially identifying information was obscured in writing up the results. Study participants are thus anonymous to the reader, but not to the research team.

Analysis

Qualitative data analysis was inductive and ongoing over a 5-month period, and involved four stages. First, to become familiar with the data and to identify any striking patterns or commonalities, team members read each transcript several times (Morse & Field, 1995). Second, all the verbatim was extracted around responses to the question identifying “who believes in you most and in your recovery.” Third, all the verbatim related to family was extracted from the entire corpus. Fourth, two members of the research team coded each segment of verbatim into the smallest units of meaning, using substantive or open coding

²As one transcript was unintelligible, the results include data for 39 participants.

(Glaser & Strauss, 1967). Two hundred and ninety (290) initial units of meaning were identified. These codes were then regrouped into 21 categories, and, through further data reduction, regrouped into three overall themes, which are presented in this article.

Specific efforts were made to ensure the trustworthiness of the study. Data analysis was a shared process, involving constant discussion and feed-back between the principal investigator and a research assistant. Co-investigators on the project met as a group, and reviewed the methodology and emerging findings at key stages. A detailed audit trail was kept over the course of the study, including raw materials (questionnaires/transcriptions), and data reduction and analysis materials (interview summaries, codebooks, and memos).

RESULTS

The majority of residents identified their families as those who most believe in them and their recovery.³ The findings reveal how this is so and how families translated their belief into concrete action: by providing affection and a sense of belonging, by offering emotional and instrumental support, and by staying actively involved in the person's life.

My Family Believes Most in My Recovery

Table 1 presents resident responses to the question "Who believes most in you and in your recovery?" Thirty-nine percent of residents identified family members as those who most believe in them and in their recovery. Responses were highly consistent across the three residential categories. Residents described their family as their primary source of strength. At times, families expressed more hope than professionals in recovery, and envisaged a future where their loved ones would be "completely recovered" and even able to work.

Residents spoke about the unwavering conviction of their families that they would recover from mental illness. A number of residents used the word *trust* to describe their family's belief in them. Families were confident that their loved one was capable of recovery, insisting that recovery is up to the person. For example, Rémi insisted, "Listen, it's my parents who trust me; they know I'm capable, and that I am going to be capable. They aren't afraid." Michael identified his grandfather as the person who most believes in his recovery, and who also kept the family together. Michael tells the story of how the need to restore his uncle's trust helped him get through therapy and overcome an addiction:

He did not say anything, but he said "I thought you had stopped," you know I told him I had stopped but I had started again ... and after I came out of desintox I went to see my grandfather, and he was really happy, you know, and I gave him the card so that he would believe in me, and he did, and you know it did something ... it touch[es] your heart.

Families recognized the qualities and accomplishments of their loved ones beyond the illness from which they were struggling to recover. Hugo's brother considers him "an artist, or singer, someone who has not yet realized his destiny to succeed." "That's how he sees

³Family members included members of the immediate family of origin: parents and siblings. One grandfather was identified as the mainstay of the family.

me,” Hugo added, “not as someone who is sick.” David reported how his sister appreciates his qualities:

She finds that I am very courageous, that I have a very strong will ... that I am the strongest (laugh). She tells me this often. She says, “I have never known anyone who has such a strong will as you ... “ when she sees how I’m moving along.

Families were able to strike a realistic balance between encouraging progress, but also accepting the person and respecting the person’s need to live for the moment. Blandine and Liam both expressed feeling accepted by their families as they are, even with my “ups and downs.” When Hugo makes mistakes, his brother gives him the benefit of the doubt, saying “Normally you wouldn’t do this.” Rémi stated that his parents want him to do his best, without worrying about what he cannot do.

My Family Shows That They Believe in Me

Three themes emerged in which residents described how their family members harnessed, and translated into action, their unwavering belief in recovery. These themes are providing affection and a sense of belonging to the family, offering emotional and instrumental support, and staying actively involved in the person’s life.

My family gives me affection and a sense of belonging—For all residents who described family as their primary support, affection and family ties were crucial to their recovery. Myriam emphasized the importance of her family’s close presence for her recovery. Even after many years of illness and separation, residents remained confident that their family members still loved and cared about them. Félix spoke about his family, and especially one brother whom he loves very much, as a great source of comfort:

I have trouble explaining myself, and being myself ... I glue myself to my brothers and sisters because I am the youngest ... and when I am able to concentrate, I think about people in my family, like my brother who is my idol and who wants the best for me, and I feel good.

Hugo described recovery as feeling surrounded by love; that the love of his family “fills him completely.” Marc spoke about his family as “loving people who care for me,” emphasizing his assurance: “I just assume they do ...,” because his family never forgot about him in the years he was hospitalized.

Family ties ran deep for residents. “We are very close in my family,” Valerie commented, echoed by Liam, who stated that sometimes his mother and girlfriend know him better than he knows himself. Explaining why his mother is the most important person in his recovery, Marc said, “We’re all our mother’s children, right? It’s the same thing for everybody, you know.” Florence talked about being from a large family, all of whom are involved in her recovery. Hugo listed the members of his extended family—his girl-friend and son and his sister, brother, nephews, and nieces, both in Canada and abroad. He explained: “You understand, we don’t live together but we communicate,” he explained; “we are together.” David talked about his sister’s beautiful children, how she made him godfather to one, and

“uncle” to the other. Having no children of his own, David was grateful to have these children in his life.

Others spoke about how easy it is to share moments of their lives with those who are close. Félix emphasized that his siblings know how to talk to him, and that nothing changes over time because of their shared experience growing up in their parents’ home. Félix further asserted that being a member of an accomplished family makes him “somebody.” As he put it:

My sister is a neurologist, and I am second-year CEGEP. But I think that if my sister is a neurologist, and I am her brother; she has an important job, and all my family works, and my father worked, then I am also someone important ... even though I am poor, it doesn’t mean that I am only a sick person.

Families reinforced residents’ sense of belonging through the care and concern they extended over the long term. Francis said his mother is a real “mother hen.” Marc said that his mother continues to take care of him, as she did when he was young. Florence had the same sense that her family cared for her, and were happy when she was doing well.

All residents described ways in which they maintained contact with their families. Some had developed certain routines with different family members. For example, Marc’s sister, who called his residence a “home away from home,” takes Marc out to restaurants every weekend. Guillaume also sees his parents every week. Félix said that he has no friends outside of his residence, but described a sister as his important social contact; he goes regularly to her house. David’s mother lives far, but he speaks with her by telephone daily, as does Blandine with her aging parents. Michael emphasized that his grandfather, now 78, is still part of his life; Michael visits him once a month. Valerie explained that family members are an important social network, providing good conversations and preventing her from closing in on herself.

Family activities were another means of reinforcing the residents’ sense of belonging. Valerie and her sisters play cards, go to films, and listen to music at one of their houses. Florence and her sisters enjoy shopping and going to movies. Marc’s weekly outings with his sister and her family promise “good conversation and ... a good time. She buys me a hamburger, and french fries and a chocolate sundae and so that’s the way it goes.” Valerie mentioned the stimulation she receives from family, which is also true for Guillaume who works with his father on Wednesdays. Sometimes family activities provide opportunities for trips, or weekends in the country. David looks forward to spending time at his mother’s place up North where he “eats like a king and does what he wants.”

My family gives me emotional and practical support—Residents described how receiving both emotional and practical support from their families helped them recover. Several used the word *encouragement* to describe this kind of help. Valerie spoke of her need to feel her family’s psychological and moral support, of how *proud* her mother is of her progress. Florence talked about all the critical support her family offered when she was depressed. She had lived with one of her sisters, and knows that she could always return

there if the residence does not work out for her. Marc described a situation where he was very down, but his mother was there to cheer him up.

Valerie acknowledged receiving instrumental support from her family: Her sister helps with the housework, and her mother does her banking. David's father sends letters and gifts. The father helped David quit smoking, even though they only meet once or twice a year, and otherwise communicate by telephone. Liam gets *tangible* support from his mother and girlfriend, including financial support and help to keep his things in order.

Others spoke about how they used their parents' houses to get some respite from their residences. For Blandine, going home was a "right" that she found very important, especially in her early days at the residence. Isabelle has the key to her mother's apartment in the city, and loves to spend week-ends there alone, "away from the house, because there's seventeen patients."

My family stays actively involved in my life—Family members made their presence felt and stayed actively involved in the lives of their loved ones. Family members were "there for me" or "never gave up" in crises or difficulties. Hugo described how his brother has been with him since the beginning, as the reason why this brother is the most important person in his recovery:

I was giving them problems; I couldn't stay in one place; I was running all over town and somebody had to be always behind me. Down there it's not like you can go to the police and say: "Go look for so-and-so who has disappeared" and they will trace the person. It's like you have to have a friend, or a member of your family who has to look for you everywhere, find you, convince you to go back, and that's why I think that my brother did a lot. Because this went on for a long time and he just kept on; he never gave up.

Hugo insisted that, although he might be able to live alone, he has learned that recovery means to be surrounded by others. Michael had a very different story, yet with a similar hero in his grandfather who "never gave up on me ... he never gave up on any of us in the family" as Michael and his brother battled drug addiction and mental illness.

Family members also stayed involved by giving advice, participating in decision making, keeping up informal surveillance over the residences, and by advocating on behalf of residents with mental health providers. Families gave advice in a number of areas. Florence's family thought that she could use her time better by taking up art. Gabrielle had to promise her mother and sister that she would stop listening to her voices, which she is now able to do at least during the day. As Liam stated, he feels influenced by his mother, but at least is not alone: "Well, I have frequent visits from my mother; so for sure she influences me a lot, and I end up following her advice. I'm not left to myself; I have an entourage and all that."

Families also offered advice about medication. Francis's family believes that the worst is over, and that, with medication, he will continue to go forward. Rémi's parents spoke as true recovery experts in giving this advice: "You do what you can and if things don't work out—

it's easy to say—but you try something else and try to forget what didn't work out, or you begin again if you can.”

Residents stated that their families would likely be involved in making major decisions about their lives. Some spoke in terms of mutual decision making between themselves and their families. For example, decisions involving Félix are a family affair:

With my family around, I don't have many important things to do. If something important happens, then the entire family reflects with me, as they are in the habit of doing because I am sick. I have an illness called schizophrenia.

Families also found ways to keep an eye on things in the residences. Marc's mother comes regularly to the residence to “see his model airplanes, and dust them off.” Liam speculated that his family visits “to see how I'm organizing myself; if I'm living in a dirty apartment or ... to make sure I'm changing my clothes, I don't know.” As Liam states, visits by his mother influence him, but at least he is not alone: “Well, I have frequent visits from my mother; so for sure she influences me a lot, and I end up following her advice. I'm not left to myself; I have an entourage and all that.” Guillaume reported that his father worries about him constantly, and asks questions.

Finally, residents talked about how their families' roles in advocating for them vis-à-vis the mental health system. One of Florence's sisters had been instrumental in obtaining a place for Florence in her current residence. Florence was certain that her sisters would intervene again to protect her, if her housing were somehow jeopardized. Blandine asserted that her family would be the first to get involved if she was not happy in her residence. Félix stated that members of his family are in contact with his caregiver. Kelly's brother thought that she could be receiving better mental health services, and made his own appointment for a consultation with her psychiatrist.

DISCUSSION

The majority of residents living in structured community housing in this study identified their families as those who most believe in them and their recovery. Families ranked higher than mental health professionals, friends, and nonprofessional caregivers. This is an unexpected finding. Most people move into structured community housing because of a need to live apart from their family, due to family burden or conflict, or because they have not succeeded in living on their own. Given that participants had lived up to 7 years in their current residences, we anticipated them to identify nonprofessional caregivers, or mental health professionals, as those who most believed in them and their recovery because of residents' frequent interaction with them. Caregivers are expected to be acquainted with recovery, as a key principle in the current Quebec Mental Health Action Plan (Ministère de la Santé et des Services sociaux, 2005), and to promote a recovery perspective through their involvement in implementing individual treatment plans for their residents. Alternatively, we would have anticipated that residents would look to mental health professionals as primarily involved in promoting their recovery. By living in structured community housing, residents are provided with a complete package of treatment and rehabilitative services directed by mental health professionals, and based on individual need. Within this context, we expected

that residents would locate their primary sources of support for recovery within the mental health system.

Instead, these findings tell an important story about the positive influence of families on the recovery process of people living in structured community housing. Residents described drawing primary strength from their families, with a richness of detail and emotional depth not conveyed in previous research. Families led the recovery process by envisioning their loved ones as already recovered, and by encouraging them in much the same way that Deegan described the constant invitation of her family "... to be more than (she) was" (cited in Ridgway, 2001). Similar to findings in the Mancini et al. (2005) study, families in this study viewed their loved ones as capable, whole persons with good qualities and a promising future. Families further demonstrated a balance between optimism and realism, patience and perseverance. Like Deegan's (1996a, 1996b) significant others, families in this study had learned that they could not "climb the mountain" for residents, but could "suffer with" them. Families never gave up on their loved ones, even in the most difficult moments or crises. Residents' descriptions of relationships with their families bore little resemblance to the negative portrayal of families in earlier research (Bebbington & Kuipers, 1994; Dixon, 2000; Drapalski, Leith, & Dixon, 2009; Vaughn & Leff, 1981).

One of the most interesting findings emerging from this study was the efforts of residents and families to stay united, and to maintain a sense of belonging despite the years residents had lived apart from their families. Residents retained a strong identification with their families, and sense of belonging; affective ties had remained intact. They described ways in which they kept in close contact with their families, through visiting rituals and shared activities that ensured a rich and continuous family life. The emotional and practical support provided by family members also helped sustain close relationships. It might be that physical separation from their families had actually strengthened family ties due to the specific efforts required to maintain close relationships and a family identity.

Families with members who experience psychiatric disability are largely excluded from the formal mental health system and have little voice. Yet, when their close involvement with their loved ones is positive, families become the primary external source of support for those who might otherwise remain passive recipients of services. Residents described a high level of family involvement in terms of giving advice and advocacy, which was also the major activity of families in the Baxter and Diehl (1998) study. The insights of Topor et al. (2006) and Mancini et al. (2005) on the role of families in preventing the person from internalizing messages of hopelessness, or adopting a stigmatized self-image seem highly relevant in our study.

The recent interest in families as major supporters of recovery should come as no surprise to social workers, for whom family is traditionally the overriding situational context for practice. Even so, it must be pointed out that mental health providers, including social workers, have often left families aside in planning and decision making around housing for persons with serious mental illness. Although families are committed to recovery, they could perhaps benefit from further education regarding the importance of housing for recovery. For social workers charged with moving residents toward more independent living, stable

families are perhaps their best resource and an additional bridge to the larger community. Social workers are in the best position to harness the interest and commitment of families. Social workers need to develop broader strategies that acknowledge family concerns, facilitate communication between families and the mental health system, and involve them in planning for independent community living in collaboration with their loved ones. With the consent of adult residents, the movement toward more autonomous housing in the community should reflect a working partnership among social workers, residents, and interested family members. This study has a number of strengths and limitations. It is one of few studies to elicit the views of residents in structured housing on how their housing relates to recovery from serious mental illness. Participants included persons with serious mental illness living in every type of structured housing available in the city studied. An important limitation of the study is that the analysis did not include other groups supportive of recovery (professionals, caregivers, friends). The resident sample was small, and biases of social desirability must be acknowledged. The findings might not be generalized beyond this study, and, as such, do not represent a portrait of residents living in structured housing across Canada. Future research might focus on how people with psychiatric disabilities, living in their family homes or on their own, experience recovery.

CONCLUSIONS

Families are invested in, and highly influential, in the recovery process of persons with serious mental illness living in structured community housing. Yet they have been excluded from consideration in the planning and delivery of housing services for this population. Social workers have a major role to play in incorporating families into the planning of housing services if the recovery process toward independent living is to succeed.

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TABLE 1

Who Believes Most in Me and in My Recovery?

Responses by level of supervision provided in residences									
	High		Medium		Low		Totals		
	N	%	N	%	N	%	N	%	N
Family members	8	12.9	8	12.9	8	12.9	24	38.7	
Professionals	4	6.5	3	4.8	6	9.7	13	21.0	
Friends	0	0	4	6.5	7	11.3	11	17.8	
Residence caregivers	3	4.8	6	9.7	0	0	9	14.5	
Self	2	3.2	2	3.2	1	1.6	5	8.0	
Totals	17	27.4	23	37.1	22	35.5	62 ^a	100.0	

^aMultiple responses were allowed, yielding a total of 62 responses for 39 participants.