Housing characteristics and stability in a rural sample of people with mental illness

Gordon Lambert
Illawarra Institute for Mental Health, Wollongong, glambert@uow.edu.au

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HOUSING CHARACTERISTICS AND STABILITY IN A RURAL SAMPLE OF PEOPLE WITH MENTAL ILLNESS

A thesis submitted in partial fulfillment of requirements for the award of the degree of

MASTER OF SCIENCE (HONOURS)

UNIVERSITY OF WOLLONGONG

By

William Gordon Lambert

Graduate School of Public Health
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ABSTRACT

Housing has been identified as a crucial component of recovery from mental illness yet very little research has been undertaken in rural areas that compares the housing circumstances of mentally ill populations with that of the community at large. Similarly, there have been a large number of studies of homeless people with mental illness but relatively few that examine factors that may be used to predict housing instability. The aims of the present study were to address both of these issues. Firstly, the study compares the housing characteristics of individuals being managed by a rural mental health service with those of the Australian population. Secondly, it explores the extent the factors satisfaction, quality and choice of housing predict different measures of housing instability. The survey and structured interview was based on the 1994 Australian Housing Survey and the Boarding House Survey developed by the Australian Bureau of Statistics. The survey was administered to a sample of 101 individuals being managed by a rural mental health service in a community and an acute inpatient setting. The results suggested that respondents generally had adequate access to community services and social supports. However, the study group was four times over represented in the lowest income quintile with over three-quarters of respondents reliant on some form of government benefit and less than 8% in fulltime employment. The low income of respondents appeared to be reflected in the type of dwelling occupied which, when compared with other Australians, was less likely to be a separate house and more likely to be a semi-detached house, flat or boarding house. Rates of housing stability of respondents varied widely according to the definition of stability or instability used. In terms of the prediction of housing instability the measures of satisfaction, quality and choice and predict stability well but not instability. The implications of these findings for clinical practice are discussed together with recommendations for future research.
CHAPTER 1

BACKGROUND AND INTRODUCTION TO THE PROJECT

Introduction

This thesis describes an inquiry into the housing needs of a group of mentally ill people receiving support from a regional public mental health service. The survey was conducted in the Mid Western Region of New South Wales which has an area of 63,262 square kilometres and a population of 172,660 (McLennan & Flannigan, 1994, 1995a, 1995b).

The "Australian Dream" is to own one's own home (Forrest & Mutie, 1995) so it is not surprising that Australia has one of the highest levels of home ownership in the developed world (Castles, 1992). In New South Wales it is estimated that 70% of 2.2 million households own, or are buying, their home while 20% of households rent privately and 6% rent public housing (Knowles, 1995). In rural Australia the level of home purchase or ownership is higher at 77% and public and private rented accommodation is correspondingly lower at 15% (ABS, 1992).

The National Housing Strategy (1992, p. 2) states that “appropriate housing is essential if people are to participate fully in society”. The ‘home’ is the place where we spend most of our time. It is the centre for domestic production and it is where we undertake most of
our leisure activities. It also provides us with a form of identity and a sense of local belonging (Badcock, 1995), and importantly, it is a place of security and protection from a sometimes hostile world (Paris, 1993). The maxim that a person's house is their castle has been popular through the ages, Dryden exclaimed “my lodging, as long as I rent it, is my castle” and William Pitt believed “The poorest man in his cottage may bid defiance to all the forces of the Crown” (cited in Paris, 1993, p. 6). A home, then, is not just a configuration of building materials, not simply a dwelling place, it has a more symbolic meaning which denotes family or group living, growing together and of individuals enjoying the dignity of personal space. Adequate housing is essential for both our physical and psychological well being (Castles, 1992).

These functions of housing have implications for individuals who suffer from a serious mental illness. The Report of the Human Rights and Equal Opportunity Commission’s National Inquiry into the Human Rights of People with Mental Illness (1992) states emphatically that “Living with a mental illness - recovering from it - is difficult even in the best of circumstances. Without a decent place to live it is virtually impossible” (p. 337).

Statement of the Problem

There is evidence that treatment outcomes for people suffering from a mental illness are limited by social and structural issues such as housing and poverty (Goldman, Rachuba & Van Tosh, 1995; Yeich, Bybee, Mowbray & Cohen, 1994). Yet there is very little
research which compares the housing and income status of the mentally ill with that of the general community (Lambert, Ricci, Harris & Deane, 1999, see Appendix 1). In addition, most research in housing has focussed on the factors that predict homelessness in mentally ill populations rather than factors associated with housing stability of people who are already housed. Evidence suggests that many people with a mental illness who cannot be classified as homeless “live in stressful, substandard and transient circumstance that can be considered unstable” (Drake, Wallach, Teague, Freeman, Paskus & Clark, 1991, p. 330). The impact of housing instability has major implications for mental health services. For example, people with a mental illness are ten times more at risk of homelessness than the general population (Susser, Lin & Conover, 1991) and are twice as likely to be re-hospitalized as those with stable housing (Drake, Wallach & Hoffman, 1989).

Aims of Study

The study has two broad aims: firstly, to describe and compare housing variables of a sample of rural mental health users with those of the Australian population. Secondly, to examine the relationship of factors that may predict housing instability in mentally ill populations.
Specific Objectives

The objectives of the project are:

- To compare the type of housing utilized by people with serious mental illness with that of the Australian population
- To compare the income characteristics of respondents with that of the Australian population
- To compare the housing cost characteristics of respondents with those of the Australian population
- To compare the characteristics of housing tenure of respondents with those of the Australian population
- To describe the relationship between different definitions of housing stability in a sample of rural people with a mental illness
- To describe the level of housing stability of respondents according to differing definitions of stability
- To examine the relationship between satisfaction, quality and choice and housing stability
- To examine the extent to which satisfaction, quality and choice can be used to predict the risk of instability
- To make recommendations about factors that should be considered by case managers in their assessment of the housing status of clients
Significance of Study

The housing needs of people with mental illness represent a challenge for health planners whose goal is to provide a mix of hospital and community accommodation options that meet the needs of consumers. The provision of appropriate housing for the mentally ill is a significant factor in community adjustment outcomes (Baker & Douglas, 1990). It is also crucial to the devolution of hospital services and the redirection of funding for the development of alternative community services (National Mental Health Plan, 1992, 1997). The risk of housing instability and homelessness in mentally ill populations is a significant problem and associated with poor mental health outcomes (Drake, et al., 1991). It is therefore important to identify factors that may compromise housing stability for people who suffer from a mental illness in order to reduce the risk of homelessness.
CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

To understand the importance of housing in recovery from mental illness it is first necessary to explore the broader social context in which mental illness is treated. Engels (1977) argues that psychiatry can no longer adhere to an understanding of mental illness based on a disease model. The assumption that mental illness can be explained by measuring biological variables discounts the impact of its social, psychological and behavioural dimensions. As Kety (1974) points out “experiential factors and their interaction with biological vulnerability make it possible or prevent the development of schizophrenia” (p. 961). For example, Zubin and Spring’s (1977) stress-vulnerability model of schizophrenia compels us to consider not only the management of an individual’s clinical symptoms, that is the treatment of their biological needs, but also the extent to which the environment in which the person lives acts as a stressor and thus contributes to relapse into illness. The dangers of over reliance on biological measures can also lead to serious iatrogenic effects which act as a barrier to recovery from mental illness (Anthony, 1993). It will be argued that in this biopsychosocial model of mental illness, stable housing is a important factor in the process of recovery.

The relationship between stable housing and treatment outcome is a major contemporary issue and the last decade has seen a burgeoning literature about where individuals with a mental illness wish to live and the level of support they desire (Carling, 1993; Leonard &
Devereau, 1992; Owen et al., 1996; Tanzman, 1993). However, while a great deal has been written about factors that predict homelessness for people with a mentally illness, there is a paucity of information about predictors of housing stability. In addition, most housing studies have been conducted in metropolitan areas and much less is known about rural areas. This literature review considers housing issues for mentally ill people within a biopsychosocial model of mental illness that recognizes that the social milieu in which treatment takes place may be as important as clinical intervention. In this context it examines the relationship of factors thought to be associated with stable housing that may be used to predict risk of instability.

**DEINSTITUTIONALIZATION**

Changes to public mental health policy in the UK, USA and Australia from the late 1950’s onwards moved the locus of care for people suffering from a mental illness from the hospital to the community (Carling, 1990; Edwards, 1988; Thornicroft & Bebbington (1989). To understand the topic of this study, it is first necessary to examine the background to deinstitutionalization and its implications for the community management of the mentally ill.

The movement away from institutions as the locus of care for mentally ill people began to gather momentum at the end of WWII and has been attributed to changes in community attitudes to mental illness (Busfield, 1986) and the availability of work during periods of economic prosperity (Warner, 1985). Also critical to the deinstitutionalization
process was the development of powerful neuroleptic drugs in the 1950's such as chlorpromazine which provided improved symptom control in psychosis (Edwards, 1988; Thornicroft & Bebbington, 1989). This, however, must be considered in the context of evidence that up to 50% of people with schizophrenia did not benefit from these drugs and their unwanted effects made adherence a major problem in long-term therapy (Bellach & Meuser, 1986). Nonetheless, the availability of these new drugs facilitated the development of alternative approaches to treatment including the therapeutic community (Edwards, 1988); the use of assertive approaches to community care (Hoult, Reynolds, Charbonneau-Powis, Weekes & Briggs, 1983; Thompson, Griffith & Leaf, 1990) and a focus on the role of families (Brown, Burley & Wing, 1972) which lead to the development of psychoeducational family treatments (Falloon & Pederson, 1985; Hogarty, Anderson & Reiss, 1991; McFarlane, Link, Dushay, Deakins, Newmark, Dunne, Horan & Toran, 1995). This, together with social welfare changes that for the first time provided income maintenance for people with psychiatric disabilities, allowed a level of economic independence not previously possible (Busfield, 1986) and facilitated care in the community.

The impact of deinstitutionalization was profound. In New South Wales the number of people with mental illness being treated as inpatients per 100,000 population fell from 225 in 1962 to 55 in 1984 in the absence of a formal policy of deinstitutionalization (Andrews, Teeson, Stewart & Hoult, 1990). The Richmond Report (1983) recommended a raft of changes to support the deinstitutionalization process in New South Wales including the release of 'seeding funds' for the development of community based
residential and support programs. It also recommended a concerted effort to close or reduce the size of public mental hospitals and reallocate funds to under-served rural and remote areas of the State. Evidence of the success of the ‘Richmond Program’ was reported by Andrews and colleagues (1990) who followed up 208 longstay hospital patients discharged to supported community housing. The study found that 78% of respondents preferred to live in the community compared to 7% who preferred to be in hospital. Of the 195 respondents contacted, 118 were still living in supported accommodation, 22 had returned to hospital, 16 had moved on to a boarding house, 21 were living with their families or in other private accommodation and only two were homeless.

However, it needs to be recognized that this group benefited from a coordinated and well-funded program of deinstitutionalization. While similar programs such as the Madison Model in Wisconsin (Thompson, Griffith & Leaf, 1990) have achieved good outcomes, in other cases patients have been discharged into the community with only minimal support. In the United States, it has been reported that after 25 years of deinstitutionalization, people with long term mental illness were receiving fewer services and were provided with less care than when they were in institutions (Kraus, 1989). This can be explained to some extent by the absence of services but, Minkoff (1987) suggested that the ideology of deinstitutionalization failed to predict that people with a mental illness may not readily wish to assume the identity of the ‘chronic patient’ and may be reluctant to use available treatment programs. He pointed to the dilemma of the ‘good patient’ who is passive, compliant, dependent and with limited goals yet to be ‘adults’
they must become independent, risk taking, adventurous and intimate. He suggests a new ideology in which people need to adapt to long-term mental illness irrespective of where that treatment takes place. For staff this may require an examination of paternalistic notions of the needs of people with mental illness.

There has also been concern about the inadequate consideration given to the supply of housing for the deinstitutionalized mentally ill and a lack of consultation between the health and housing sectors (Australian Housing Research Council, 1990). Ford, Rohner and Obermeyer (1992) noted that there was a lack of policy concerning development of accommodation options for patients who were deinstitutionalized. The result was that individuals were offered limited choices and forced to accept 'placement' in group living programs because they lacked the skills to live independently in the community (Ridgeway, 1988). In fact, many patients were transferred to settings that were clearly more restrictive than the hospitals they came from (Ridgway & Zipple, 1990).

Cohen (1993) believed that deinstitutionalization transformed what had been predominantly a mental health problem into a social welfare problem which is consistent with the contention of Anthony (1993) that clinical care alone is not enough. Mental health services, therefore, cannot meet these broader vocational, educational and housing needs without the development of linkages with government, non-government and private service providers (Australian Health Ministers, 1992, Australian Health Ministers, 1998).
HOUSING - THE AUSTRALIAN CONTEXT

The point has been made that adequate and appropriate housing is an essential part of recovery from mental illness (Human Rights and Equal Opportunity Commission, 1993). At its most basic level housing can be viewed as simply meeting the need for shelter (Maslow, 1987). However, within a complex society such as Australia, home ownership may represent, for example, an intergenerational asset or may confer social status (Forrest & Mutie, 1995). It may also represent an unfulfilled or unachievable aspiration. Therefore, in order to understand the housing needs of people with mental illness it is first necessary to understand the broader context of housing in Australia

Home Ownership

Government policy in Australia has consistently encouraged home ownership and ‘The Great Australian Dream’ of owning one’s home has been a dominant factor in post colonial Australia (Castles, 1992). The success of this policy can be found in evidence which demonstrates that almost 90% of Australians have been owner occupiers at some stage in their life (Badcock, 1995). In the aftermath of the Great Depression and World War II, home ownership became an important strategy of Australian governments as the country strove to return to stability (ABS, 1992). The Commonwealth government negotiated the first Commonwealth State Housing Agreement in 1945, which put housing ownership within the grasp of low and moderate-income earners with the provision of low interest loans over long periods. Consistent with its policy to facilitate home
ownership, in 1954 the Commonwealth Government encouraged the sale of public rental property. The Home Savings Grant Act, 1964-5 provided further encouragement to first home buyers with the provision of a tax free grant. While the Housing Loans Insurance Act, 1965 facilitated home purchase for low-income groups (Castles, 1992). The impact of these strategies was dramatic with home ownership growing from 52.6% in 1947 to peak at 71% in 1966 (Badcock, 1995). The level of home ownership for rural areas is even higher at 77% compared to 70% in the capital cities (Badcock, 1995). However, for people suffering from a mental illness, home ownership may be as low as nine percent (Owen et al., 1996). This level of under-representation as home owners has major implications for public policy if disadvantaged groups, such as the mentally ill, are to have access to readily available and affordable accommodation. In particular it places a greater burden on the public and private rental market.

**Public Rental**

The first public rental housing in Australia was provided in NSW following the proclamation of the *Housing Act 1912* and the establishment of a Housing Board with the powers to build a public rental housing estate and reduce slums (Castles, 1992). In NSW the *Housing Act 1941* (NSW) created the New South Wales Housing Commission which, as with the earlier legislation, had responsibility for slum clearance and public housing. More recently, the Commonwealth government has placed a greater emphasis in the provision of public housing. The Commonwealth State Housing Agreement 1973 focussed on public rental housing and placed limitations on the sale of existing public
rental stock. Revision of the Agreement in 1978 provided rental subsidies and further discouraged the sale of public rental housing. In 1984 it included a clause broadening eligibility to any group in the community requiring housing including people with disabilities. Another important feature of the agreement was a costs-rent principle that was based on cost recovery rather than market rates as the basis for setting minimum rents. The NSW Government Green Paper on Housing (Knowles, 1995) identified the need to increase expenditure on maintaining and improving existing public housing stock and to make use of private sector funds to provide additional subsidized housing.

Private Rental

State and Commonwealth governments have cooperated over the issue of rent control in the private rental market since the early 1940’s. Responsibility for rent control now rests with the State government following a national referendum in 1946. Since that time the Commonwealth’s role has been limited to encouraging investment in private rental dwelling construction. In 1985 the Commonwealth Government introduced a four percent depreciation provision for new properties and simultaneously a taxation provision for rental property investment (negative gearing) was taken away. This caused a slump in the private rental market and the provision was quickly reintroduced (Castles, 1992).
MENTAL ILLNESS AND HOUSING

Carling, (1990) states “Historically the mental health field has seen housing as a social welfare problem and has defined its role as treatment” (p. 970). The focus of mental health care provision solely on the delivery of clinical services minimises the importance of issues such as housing. For example, Kiesler (1991) believes that public policy must address stable housing, income enhancement and stabilization if we are to overcome the problems of at risk groups such as homeless mentally ill people. However, this will require a reversal of public policies wedded to the notion of the undeserving poor (Cohen, 1993).

Strategies that can be used by mental health services to address these problems include: building relationships with the public and private housing sector with a focus on policy, funding and regulations (Carling, 1990); taking an active role in local housing markets through membership of planning and development groups (Ridgeway & Zipple, 1990); support for disabilities legislation which includes the voice of consumers, expands consumer choice and places people with mental illness in the social and economic mainstream (Srebnick, Livingston, Gordon & King, 1995); and in rural areas developing partnerships with local government (Australian National Housing Strategy, 1992).

Some examples of efforts to address these issues in North America include a move on the eastern seaboard of the USA for states to facilitate the development of supported housing options with a focus on affordability, flexible support and consumer involvement
(Knisely & Fleming, 1993; Livingston & Srebnick, 1991). There was also the introduction of subsidized rental approaches such as the Section 8 certificate program to help the poor obtain safe, decent, affordable housing (Newman, Reschovski & Hendicks, 1994). In Ontario, Canada, where amendments have been made to the Human Rights Code to include ‘mental handicap’ to ensure that people with a mental illness have the same rights to housing as that of the general population (Weisberg, 1994). In particular, the right to security of tenure is a critical issue. The Australian National Housing Strategy (1992) defines this as “...the right to continued occupation of a home.” (p. 37) which is associated with home ownership or security in the form of a long-term lease.

This suggests that if the housing needs of people with mental illness are to be met, a range of individual, public policy and treatment issues must be addressed. These include individual preferences for housing, availability and access to housing alternatives, their location and quality, and the barriers to becoming housed, such as, affordability, stigma and community opposition.

**HOUSING NEEDS**

The Indicative Planning Council for the Housing Industry states “[housing] needs will frequently vary depending on population group and location. Needs vary over time as the characteristics of populations change” (Department of Housing and Regional Development, 1994, p. 17). For individuals with a mental illness, issues of satisfaction, quality, choice, affordability, accessibility, safety, security of tenure (including protection
if temporary hospitalization is necessary), privacy, compatible social milieu, support, consumer involvement, and satisfaction are all seen as important elements of housing (Australian Housing Research Council, 1990; Susnick, 1993; Ridgeway & Zipple, 1990). The normative nature of these needs is underscored by Hogan and Carling (1992) who argue ‘... the overriding considerations in housing selection by persons with a psychiatric disability are no different than by individuals who do not have a psychiatric disability’ (p. 219). Correspondingly, the community adjustment of the individual will be compromised if housing is not of a suitable quality and appropriateness (Baker & Douglas, 1990). What is also critical is the level of support an individual requires to exercise their choice of housing (Carling, 1990; 1993; Ridgeway & Zipple, 1990). Hogan and Carling (1992) have developed some guiding principles relating to housing need:

- Housing must be chosen by consumers
- Neighbourhoods should be chosen based on their likely ability to assimilate and support consumers
- The number of labeled or stigmatized residents in relation to the total number of residents in the overall housing unit is critical and should be limited consistent with community norms
- The appearance of housing should be consistent with community norms
- Housing should be selected which keeps levels of stress manageable
- Housing should enhance stability not be time limited
- Housing should enhance opportunities for control over the environment
Carling (1993) puts it succinctly when he states that people with a mental illness require, "homes not residential treatment; choice not placement; client not staff control; physical and social integration not congregate living; in vivo learning not preparatory learning in transitional settings; most facilitative not least restrictive; interdependence not independence" (p. 443).

HOUSING PREFERENCES

Donison and Ungerson (1982) make the point that housing preferences are neither simple nor self-evident. Schlay (1985) debunks the notion of the monolithic 'dream' of home ownership in a study that found that preferences in the general population are highly individualized. Similarly, there is evidence that the choice of housing for people with a mental illness is also a highly idiosyncratic and complex process of understanding one's needs, exploring options, examining contingencies and prioritizing preferences (Carling & Ridgeway, 1988). This process may also be influenced by an individual's prior experience of group and independent living (Schutt & Goldfinger, 1996).

The question of whether the housing preferences of people with a mental illness are related to individual traits or if they simply reflect a normative response pattern, that is, reflect the housing preferences characteristic of the general population is addressed in a study by Yeich et al., (1994). The study found that the majority of respondents preferred to live in an apartment or house. It also found that those with lower functional abilities wanted more help with management and housing issues which suggested they were aware
of their limitations. Participants living in a treatment setting were least satisfied with their environment.

These results have been replicated in other studies which consistently report that consumers preferred: independent living to living in communal or group settings (Owen et al., 1996; Carling, 1993; Schutt & Goldfinger; Tait, 1985); in an environment of low behavioural demand (Owen et al., 1996), living with a spouse or romantic partner (Tanzman, 1993) and practical assistance when needed (Keck, 1990). According to an Australian study by Owen et al. (1996) consumers least prefer long term hospitalization or homelessness and ‘for profit’ boarding houses were preferred to psychiatric group homes. This may reflect the level of behavioural expectation of the respective facilities and levels of staff intrusiveness (Hodgkins, Cyr & Gaston, 1990). However, some consumer’s have stated they would prefer homelessness to rigidly structured residential facilities (Howie the Harp, 1990).

If housing preferences are so individualized, the involvement of consumers in the decision making process is of critical importance (Howie the Harp; 1990, 1993; Owen et al., 1996). Carling and Ridgeway (1989) noted the discrepancies between consumer preferences for housing and the views of mental health workers. An unpublished survey of the housing preferences of a group of hospitalized clients with a long-term mental illness by Lambert (1992) found that staff believed clients needed more restricted and supervised forms of accommodation than did the client themselves. This anomaly has been reported in other studies including one in which staff requested that the survey
results should be checked because they believed data reporting that 15% of clients owned their home was a gross over-estimation (Pandiani, Edgar & Pierce, 1994). Massey and Wu (1993) found consumers and case managers agreed on some issues such as safety, comfort and privacy. However, consumers considered independence, personal choice, convenient location, access to mental health services to be significantly more important than did their case managers.

**HOUSING OPTIONS**

There was a rapid growth of community residential options for people with mental illness in the 1980’s but the lack of a uniform nomenclature on housing types made data collection difficult (Randolph, Ridgeway & Carling, 1991). The Australian Housing Research Council (1990) identifies the following options: living with a family member; private accommodation; partially supervised private accommodation (e.g. boarding houses); targeted accommodation in the public, private and non-government sector; hospital or residential care; and homelessness. Bachrach (1992) has pointed to the need for a wide spectrum of residential services and cautions that the notion that one size fits all should be avoided. She regards flexibility in housing arrangements tailored to client needs as paramount. Yet studies show that few agencies offered more than one housing alternative (Carling, 1990).
Public Housing

Public housing is often not seen as an option for people with a mental illness because of beliefs that there are long waiting times, little choice and poor support. Mentally ill clients often have limited knowledge and skills to obtain public housing and generally fear bureaucracies (Barling, 1997). This disadvantage may be magnified if the individual is symptomatic or has deficits with literacy skills. It also highlights the importance of government policies aimed at improving co-operation between mental health services and public housing providers (Refshauge, 1995).

Ward in a House

The concept of “Ward in a House” attempts to combine the best features of high quality hospital care with a setting which is homely and domestic in scale and operation with access to the community and normal expectations of the resident in terms of cleaning cooking and involvement in decision making (Shepherd, King & Fowler, 1994; Shepherd, 1995). Outcome data from a study of two such units (n = 67) suggest that residents spent more time in community-based activities, had an increased level of social interaction and a reduction in abnormal behaviour (Shepherd et al., 1994).
Group Homes

Geller and Fisher (1993) reported that in the USA group homes form the most common type of program and commonly operate with live-in staff or the provision of 24-hour support. Core and cluster developments such as the Satellite Housing Integrated Program System (SHIPS) which formed part of this study provide a ‘core’ house staffed 24 hours a day and a ‘cluster’ of group homes which receive differing support according to need (Sainsbury, 1987). The Way Station approach reported by O’Rear and O’Rear (1989) provides a similar integrated housing approach with much greater consumer involvement through a ‘core’, which functions as a Club House.

Carling (1992) has criticized group homes as being reflective of past practices in which power resides with the mental health staff to ‘place’ a mentally ill person. There is also evidence that the client’s identity as a ‘psychiatric patient’ endures independent of length of community tenure (Robey, 1994) which may impede the extent of a client’s community participation and integration - the very raison d’être of such services. Alternatively, Kavanagh and Fares (1995) argue that group homes do not replicate the institutions they have replaced and caution against oversimplification.

This caveat is important because while there is evidence which supports criticism of group homes, there is another side to the story. For example, McCarthy and Nelson (1993) found that residents of supported group homes were satisfied with their housing but expressed dissatisfaction with issues such as lack of privacy, stigma and limited
opportunities to participate in community activities. And, while residents reported greater independence, more instrumental role involvement, increased self-esteem and social skills, they were dissatisfied in areas where staff exerted unilateral control such as in the allocation of household chores. In another study Lessage and Morrissett (1993) concluded that group home residents enjoyed high levels of autonomy but were reliant on skills of staff.

This suggests the critical nature of staff support that must ensure that the basic needs of residents are met within an environment that promotes individual choice and autonomy. One anticipated outcome of this would be that residents would move on to more independent forms of accommodation. However, research, demonstrates that this progression tends not to occur (Geller & Fisher, 1993; Pandiani, Edgar & Pierce, 1994)

**Supervised Apartments**

A study by Hodgkins *et al.* (1990) compared people living in supervised apartments with a matched control group that lived on their own. The results showed no differences in relapse rates, as measured by re-hospitalization. However, the group living in supervised apartments reported greater levels of stress, drug and alcohol use, violence and medication refusal. These services have been described as mini institutions and may be subject to many of the institutional practices found in hospitals (Lewis, Doherty & Craig, 1993). Alternatively, Mandiberg and Telles (1990) describe a clustered apartment project
in which clients are expected to provide support for one another and staff assume the role of consultant rather than therapist.

**Boarding Houses and Hostels**

Licensed privately owned boarding houses often accommodate 20-30 individuals and feature dormitory style bedrooms, meals provided and very little else in the way of meaningful activity or skills acquisition (Australian Housing Research Council, 1990). The relevance of this form of accommodation to a system of mental health care based on principles of normalization has been challenged by Kearns and Taylor (1989) who state “... an adult living with up to 25 unrelated others recognizes the situation is abnormal” (p. 3).

Hostels average 10 - 20 beds, but some may be considerably larger. They are usually operated by government or non government organizations with often a very institutional character (Australian Housing Research Council, 1990).
Kendig, Paris and Anderton (1987) state that “... homelessness is an especially likely prospect for those who are excluded from the Australian mainstream by mental illness” (p. 3). Evidence from Western countries suggests that levels of homelessness among the mentally ill are 10 to 100 times higher than the general population (Cohen, 1993). Kraus (1989) reports that in the United States between 25% and 40% of homeless individuals managed by the Robert Wood Johnson Foundation have psychiatric symptoms or have been admitted to a mental hospital. A Scottish study found that levels of mental illness in a hostel population had actually fallen from 25% in 1966 to 9% in 1992 (Geddes, Newton, Young, Bailey, Freeman & Priest, 1994).

The impact of homelessness can be profound. Living on the streets places enormous stress on physical health which may be already compromised by the iatrogenic effects of treatment (Webster, 1988). It may also lead to involvement in petty crime. A study of 96 individuals with a diagnosis of schizophrenia found an association between homelessness and arrest history although the direction of the relationship was not clear (Draine & Solomon, 1992).

It has been proposed that homelessness may, for some people, represent a choice not to accept what is on offer and to withdraw from the strictures of a settled life (Hopper & Baumhl, 1994, Howie the Harp, 1991). These views tend to be anecdotal and were not supported in a study which found that 92% of users of homeless shelters would choose to
live in permanent housing even if it meant taking regular medication (Schutt & Goldfinger, 1996).

Whether homelessness should be addressed as a medical or social welfare problem is not clear. Proponents of a social welfare approach argue that changing the ratio of low-income housing is more important than focussing on treatment services alone (Aviram, 1990; Kiesler, 1991). This viewpoint is supported by Hurlburt, Hough and Wood (1996) who found that homeless people suffering from mental illness and substance abuse with access to a form of State subsidized housing (Section 8 Certificates) were more likely to achieve stable housing than those receiving only case management. This outcome is supported in a study by Rosenfield (1991) which concluded that when an individual needs both clinical care and housing, housing is more important for prolonging community tenure.

It may be that a combination of treatment and social welfare intervention is indicated. A large four year follow up of inner city homeless mentally ill people in Sydney found that hospital admissions significantly decreased for those people treated in the outreach program whereas those who failed to attend showed no such decrease (Buhrich & Teeson, 1996).
MODELS OF HOUSING PROVISION

Geller and Fisher (1993) suggest that “Residential programs are in the midst of an uneven revolution and a stormy debate” (p. 1070). Similarly, Carling (1990) described a paradigm shift from an era of institutional and facility-based thinking to one in which service recipients are seen as people in need of professional support. What that support should be and where it should be provided has been a focus of debate (Shepherd et al., 1994). However, the discussion has been handicapped by the lack of scientific study of the efficacy of different models of housing provision (Cournos, 1987).

During the first stage of deinstitutionalization between 1960 and 1980 there was no formal policy for the provision of housing alternatives (Ford, et al., 1992). Residential services at that time tended to be poorly staffed by people with little mental health training; follow up was informal and inconsistent; and only one third of the population served could be classified as severely mentally ill. In the second stage of deinstitutionalization which began in the early 1980’s the ‘continuum’ or ‘supportive’ housing model became the preferred approach to housing provision with the development of the concepts of ‘least restrictive’ environment and ‘transitional housing’ where clients move through a series of graded supportive accommodation facilities based on their level of function (Geller & Fisher, 1993; Pyke & Lowe, 1996; Richmond, 1983).

The ‘continuum’ or supportive housing approach has been described as “...... an ill-fitting and restrictive state of permanent transition, with the goal of ‘graduating to the
community’ largely illusory” (Goering, Sylph, Boyles & Babiak, 1992, p.107). It has been widely criticized on the basis that larger more restrictive environments do not prepare people for less restrictive settings. For example, Deegan (1992) has argued, learning to cook spaghetti for 20 people as a preparation for independent living is inappropriate. Other arguments against this approach include: the trauma of multiple moves (Carling, 1992); zoning and neighbourhood resistance (Wenocur & Belcher 1990); marginal integration into the community (Cometa, Morrison & Ziskoren, 1979); minimal impact on hospital readmissions (Cometa et al., 1979; Hodgkins et al., 1990); increase in deviant behaviour, stigma and stress (Ridgeway & Zipple, 1990); poor generalization of skills from one setting to another (Carling & Ridgeway, 1989; Carling, 1992) consumer dissatisfaction and gridlock –(nobody moves), (Gates & Nagy, 1990; Ridgeway & Zipple, 1990); needs of the individual are subsumed by the service providers stereotypical assumptions of need (Pyke & Lowe, 1996) and ‘institutional’ practices (Lewis et al., 1993). There is also the paradox of both ‘success’ (individual reaches rehabilitation goals) and ‘failure’ (individual does not reach rehabilitation goals within a prescribed time frame) both requiring transfer to another setting (Blanch, Carling & Ridgeway, 1989; Carling, 1990; Pyke & Lowe, 1996; Ridgeway & Zipple, 1990).

A study of transitional housing by Gates and Nagy (1990) found that residents did not move along the continuum which they attributed to dependence on staff relationships at the expense of community integration. Geller and Fisher (1993) have also questioned the extent to which transitional housing models have been successful in meeting the objective of moving people with mental illness who were formerly institutionalized into more
independent housing. In a study of 393 individuals discharged from a state psychiatric hospital to community residential facilities during a four-year period from 1987 to 1991, changes in the place of residence were monitored. The results for supervised residential settings found that only 7.9% of participants had moved to a less restrictive setting.

The third and most recent stage of deinstitutionalization saw the development of 'supported housing' options which were seen primarily as the place the client lives and not a location for treatment. It represented a movement away from staff knowing what was best for clients to asking consumers how could staff best assist them (Pyke & Lowe, 1996). This was done by introducing an element of choice of where the client wishes to live and with what support. As Test and Stein (1977) stated: “a support system should assure that a person’s unmet needs are met; and should not meet the needs the person is able to meet himself” (p. 609). This distinguishes continuum or supportive housing practice from supported housing where clients are regarded as full citizens, holding amongst other things, the right to lease their own house (Carling, 1993; Tanzman, 1993).

The growth of supported housing is reported in a Canadian study which found that during the 1980’s there was a 393% increase in the number of supported houses while the average number of beds in each residence had fallen from 4.7 to 3.4 (i.e. in the direction of normal size), (Trainor, Morrell-Bellai, Ballantyne & Boydell, 1993). Hatfield (1993) stated the move from transitional to permanent housing was long overdue.
Supportive versus Supported Housing

During the first stage of deinstitutionalization boarding houses mushroomed as large numbers of people with mental illness were often ‘dumped’ into the community and although most have now disappeared, vestiges still remain. It seems clear from the criticism of the continuum model that supportive housing which developed during the second wave of deinstitutionalization often militated against individualized care and that the development of supported housing models can be seen as an attempt to redress this problem. Clearly, housing is an important issue in the recovery process but in the absence of empirical evidence about its efficacy (Lehman, 1995) it makes sense to adopt a pluralistic approach to housing provision (Ridgeway & Zipple, 1990) such that it targets: those most in need (Carling, 1990); offers a combination of independence and support from trained staff (Crayden, 1994; Madeo, 1990; Schutt & Goldfinger, 1996) and is provided by a range of public and not-for-profit agencies (Cohen & Somers, 1990; Chipperfield & Aubry, 1990).

LOCATION

Donison and Ungerson (1982) state that housing is more than a configuration of bricks and mortar but rather complex packages which include the neighbours, the reputation of the neighbourhood as well as access to work, schools, doctors, shops and other opportunities. They make the point that:
'a house which offers everything a man or woman could desire when considered as a building may be uninhabitable when considered as a location’ (p.12).

The general findings of an Australian study conducted by the National Housing Strategy (1992) found that relatively few respondents believed that access to community services was a problem. The groups that encountered most problems tended to be those with life cycle related problems such as the aged, sole parents and couples with children. The study makes the point that:

‘Where people live affects their access to community services and employment, the mode of transport they use and the duration of journeys, the type and quality of their dwellings, and the nature and extent of their social networks’ (p.6).

For a person with a mental illness location is strongly linked to access (walking distance) to buses, shopping, recreational facilities, community services and social networks (Crayden, 1994; Madeo, 1990).

In summary, the mentally ill now have access to a broad range of housing options located in the community. However, they also face a number of barriers that may limit individuals from obtaining the housing of their choice. Some of these barriers are structural, for example, the inflexibility of public housing policy to accommodate the needs of people with a mental illness (Australian Housing Research Council, 1990). Others, such as poverty and unemployment, relate to the disability associated with
illnesses such as schizophrenia and depression and contribute to social disadvantage and stigma (Anthony, 1993). These factors may also have a direct economic effect which further limits access to mainstream housing. In the case of home purchase, Kendig, Paris and Anderton (1987) state that housing ‘shares’ are primarily determined by the distribution of income and the other bases of social advantage and power. Consequently, whether purchasing or renting, when these criteria are applied the mentally ill are seriously disadvantaged.

BARRIERS TO HOUSING FOR PEOPLE WITH MENTAL ILLNESS

Public Housing Policy

The Australian Housing Research Council (1990) has identified a number of structural barriers to the mentally ill having equal access to public housing. These include a lack of policy and clear practice guidelines; difficulty in qualifying for priority housing; previous tenancy records; question marks about ability to live independently and lack of appropriate advocacy. This creates lengthy waiting times and may means longer stays in hospital or the use of temporary accommodation with a risk of being lost in the system. Inflexible conditions such as the ‘one offer only’ rule which, if refused, places the client back at the bottom of the waiting list and a 48 hour period for acceptance which can compound an already difficult situation (Barling, 1997). Alchin (1994) presents a vivid case study of the kind of problems that arise from this inflexibility. A woman suffering from schizophrenia and her elderly husband applied for public housing. In their
application they requested a unit that was near a shopping centre, preferably in the inner city where they had lived most of their lives, and where they could keep their dog that was an important companion. When their housing allocation was made it was in a high rise block several kilometres from the nearest shops in outer western Sydney on the seventh floor in a unit where pets were not allowed. Their choice was to accept the allocation with the risk of compromising their mental health, or go to the bottom of the waiting list again.

It is argued that these situations arise because mentally ill people have been marginalized in the health and welfare system and the mental health sector has developed poor intersectoral links with services such as public housing providers (Aviram, 1990; Macklin, 1993). As Benson (1993) suggests, people with a mental disability are confronted with a series of financial, statutory and bureaucratic obstacles which make it difficult to get on public housing lists or, once there, find they have been removed because of a failure to respond to written communication or the inability to provide written documentation.

Once housed, there are a number of difficulties that may emerge to threaten continued tenure in public housing. These include finding the money to pay rental bonds, meeting rental payments, maintenance of the property, relapse into illness and consequent behavioural problems and exploitation by unwanted guests (Australian Housing Research Council, 1990: Howie the Harp, 1991). Carling (1995) believes there are unique conditions demanded of individuals suffering from a mental illness:
“To retain access to housing, many mental health agencies will in turn impose program requirements on tenants as conditions of living there - required use of medication, required attendance at day treatment programs, required participation in case management services, and so forth. Often special clause leases impose requirements and responsibilities on clients with psychiatric disability that are not imposed on any other tenants” (p. 208).

Clearly, the lack of expertise within mental health services in supporting the housing needs of their clients must be addressed (National Housing Strategy 1992). To this end the need to develop collaborative relationships between mental health services and public housing providers is paramount (Aronson & Fitzpatrick, 1990; Knowles, 1995). Strategies to overcome some of these intersectoral difficulties include the use of a pilot or head license which allows the mental health service to obtain a lease which they can then sublet. This provides the service with the flexibility to increase client access to accommodation by, for example, waiving rental bonds, and increasing security of tenure by not requiring the payment of rent during periods of hospitalization (Carling, 1993; Madeo, 1990).
Stigma

The psychosocial sequelae of mental illness which include poverty, unemployment and limited social networks create negative public attitudes (Kearns & Taylor, 1989) particularly when individuals exhibit high levels of symptomatic behaviour (Shepherd, 1995). The social stigma which results also creates barriers which give rise to the belief that the mentally ill are too disabled to manage in the community (Carling & Ridgway, 1988). The Report of the Human Rights and Equal Opportunities Commission (1993) concludes that such stigmatising beliefs include that “anything will do” for people with a mental illness.

Acceptance by the community at large is a crucial factor in community integration (Nelson & Fowler, 1987). The NIMBY (not in my back yard) phenomenon has been commonly reported during periods when governments actively pursued deinstitutionalization policies (Benson, 1993; Carling 1993; Wenocur & Belcher 1990). Fears from local residents that mentally ill persons living in an area would reduce property values (Boydell, Trainor & Pierri, 1989) and pose a safety risk to the community have been widely reported. In Orange, NSW where the current study was conducted, the water supply to a local group home for the mentally ill was poisoned in what was believed to be some form of protest. It was an event that received national publicity.

However, despite reported public angst, a number of studies have found that the establishment of facilities such as group homes has no effect on indicators such as
housing turnover, average selling price, annual rate of appreciation and number of days that properties were listed for sale (Goodale & Wickware, 1981), or volume of sales and selling price (Boydell, et al., 1989; Dear & Taylor, 1982). This suggests that community attitudes appear to be based on prejudice rather than empirical evidence.

Nevertheless, the stigma of mental illness remains a major obstacle to obtaining community housing for both consumers and professionals often borne by ignorance and fear of the mentally ill (Mayer & Barry, 1992). Carling (1993) suggests that low income and stigma are the major barriers to housing rather than psychiatric disability itself. A telephone survey of landlords who had advertised rooms for rent found that callers were significantly more likely to receive a positive response if no reference was made to mental illness (Page, 1983). Alisky and Iczkowski (1990) found that 40% of landlords immediately rejected people with known psychiatric disabilities even though they were otherwise suitable candidates. This has implications for a group which is competing for a limited resource against other low income groups, most of whom the community views as more suitable tenants (Carling, 1990).

Poverty

Most people suffering from a serious mental illness live in poverty (Carling & Ridgeway, 1988; Carling, 1990; Polak & Warner, 1996; Tanzman,1993) and are dependent on some form of social assistance payment (Baker & Douglas, 1990). In the USA, for example, welfare payments dropped by a third in real dollar terms in the 1980’s.
The association between schizophrenia and lower socioeconomic status is well recognized with clients from lower socioeconomic groups experiencing worse outcome (Cohen, 1993). However, poverty has been largely ignored as a focus for research (Keisler, 1991). Cohen (1993) links the role of poverty with the stress vulnerability model of schizophrenia (Zubin & Spring, 1977) and draws comparisons between the consequences of poverty and the symptoms of the illness. He points out that the risk of schizophrenia is eight times greater in the lower quartile of socioeconomic status.

Poverty is a central factor for people with a mental illness (Wasow, 1987). It limits their access to community services and contributes to a reduction in the availability of meaningful activity (Kearns & Taylor, 1989; Lafave, de Sousa, Prince Atchison & Gerber). Cohen (1993) makes the point that the characteristic behaviours of poverty including apathy, resignation, low self-esteem, alienation and distrust are also descriptors of people with long-term mental illness. He also suggests that being poor also contributes disproportionately to stressful life events, such as homelessness and physical illness, increasing the risk of relapse (Holmes & Rahe, 1966; Falloon & Shanahan, 1988).

Kiesler (1991) recommends a focus on economic policies, such as income enhancement, to address these problems. Paradoxically, he believes the focus of mental health interventions has been on the provision of expensive treatment rather than addressing issues such as poverty. However, simply providing people with a mental illness with
supplementary income that raises them above the poverty line may not improve their quality of life (Lafave *et al*., 1995).

**Unemployment**

Research by Warner (1985) found higher rates of recovery from mental illness during times of labour shortage such as in the post WWII period, when Western economies were growing. He suggested that this phenomenon could be explained by the increased demand for labour and the opportunity for people with a mental illness to obtain competitive employment. There is also evidence of improved outcome for schizophrenia in developing countries which may, in part, be attributable to the need for even the most disabled members of the community to contribute to the work effort (Warner, 1985).

Work is a major source of self-esteem and plays an important role in the process of recovery from mental illness (Cohen, 1993). Kearns and Taylor (1989) report that users of mental health services view full time employment as a yardstick for the measurement of self-worth. However, those who accept social assistance on the basis of psychiatric disability are exposed to what they see as the tokenism of sheltered workshop activity when what they want real employment not “Mickey Mouse work” (Kearns & Taylor, 1989, p. 2). For those who receive social security benefits, there are also disincentives for work including the marginal benefit of part time work where as income increases, there is a corresponding reduction in social security payment (Polak & Warner, 1996).
The extent to which individuals suffering from a mental illness are under-represented in the fulltime workforce is significant. Cohen (1993) estimates that people with schizophrenia are 4.5 times more likely to have been partly employed or unemployed than people with no mental illness and 3 to 5 times more like to receive social welfare benefits than the general population. This view is strongly supported by evidence that over 80% of people with schizophrenia are unemployed (Davies & Drummond, 1994; Anthony & Dion, 1986). A South Australian study by Barber (1985) found that 88% of mentally ill leave hospital to be unemployed. Pandiani, et al. (1994) found that 6% of people being managed by a community mental health team were in full-time employment and a further 16% were employed part time. This low level of workforce participation is supported by Yeich et al., (1994) who estimates that a few as 10% of people suffering from a mental illness receive any income from employment. As a consequence, employment and access to an adequate income directly affect the affordability of housing.

**AFFORDABILITY**

For individuals suffering from a mental illness housing affordability is a major issue (Aronson & Fitzpatrick, 1990; Carling, 1990; Carling, 1993; Carling & Ridgeway, 1988; Crayden, 1994; Ridgeway & Zipple, 1990). This view is supported by the Human Rights and Equal Opportunities Commission (1993) which found that most accommodation for people with mental illness is both expensive and substandard. Newman et al., (1994) found a significant relationship between housing affordability and time spent in hospital
which may be explained by the stress of maintaining high rental payments (Smith, Kearns & Abbott, 1992). For example, it has been reported that people with mental illness expend 50-80% of their income on rent (Carling 1990, 1993; Benson, 1993) which exceeds the maximum ratio of cost to income of 30% suggested by Newman et al., (1994).

A study conducted in Australia found that the lowest income quintile of households paying off a home expend 30% on housing and for households owning their residence outright the proportion is 20% (ABS, 1989). By contrast, the lowest quintile of private rental households, on average, pay more than 50% of their weekly earnings for housing while public renters contribute about half of that. In rural Australia, housing is generally more affordable based on the cost of purchase, but this must be traded off against access to jobs, unemployment and access to services and transportation (National Housing Strategy, 1992).

The present study will calculate the affordability of housing as a percentage of income to cost and will compare the results with the findings of similar studies.

**ACCESS TO HOUSING**

The affordability of housing places limits on access for individuals with a disability and, therefore, competition for housing resource distribution among the diverse groups that compete for them is a critical issue (Kendig, et. al. 1987). Macklin (1993) states that
access to appropriate housing for people with a mental illness has strong influence on clinical and social outcomes and argues that little or no resources have been reallocated for accommodation. Where housing is available, as is the case of public housing in New South Wales, 1 in 5 applications for public housing are from people with a disability (Knowles, 1995) but only 1.3% of those on public housing waiting lists report a mental illness (Office of Disability, 1993). This may support the view of Benson (1993) that individuals are reluctant to label themselves as mentally ill even if it may mean their application may receive favourable treatment.

Part of the effects of this disadvantage can be seen in studies of shelters for the homeless. A five year follow up study by Teeson and Buhrich (1990) of an inner Sydney refuge found that the prevalence of schizophrenia amongst residents rose from 14-16% in 1983 to between 21-26% five years later. If we assume that the point prevalence of schizophrenia is 0.5% (Andrews, 1994), this is a massive over representation of this subgroup among the homeless. Teeson and Buhrich’s (1990) analysis of these trends reflect problems of access to housing rather than simply an artifact of deinstitutionalization. A majority of the cohort studied (86%) had a history short-term hospitalization and only 14% had experienced prolonged periods of institutional care. The authors point out that the study by Andrews et al (1990) of 208 long-stay mentally ill patients reported that none had moved to refuges for the homeless.

If the cause of this increase of mentally ill in refuges is not deinstitutionalization then what is it? A study by Burke, Hancock and Newton (1984) found that inner city public
housing was extremely well placed for access to facilities such as medical care, shopping and public transport but this was not the case for people living in suburban public housing estates. This suggests that people with mental illness may be drawn to the inner city because these areas best meet their needs. However, when the availability of affordable housing changes, many individuals may be thrown into a life of homelessness. For example, in Sydney in the period 1983-88 the number of council registered boarding houses fell by 27% and in a three month period the average rent for a one bedroom flat rose by 21% (Teesson & Buhrich, 1990).

To summarize it can be argued that while factors such as public housing policy and the stigma of mental illness can act as barriers to housing for people with a mental illness, one of the most significant barriers is economic. The evidence presented demonstrates that the mentally ill in general have low incomes and high levels of unemployment. This in turn impacts on the type of accommodation an individual sufferer can afford to purchase and thus limits their options.

**HOUSING MOBILITY**

The issue of housing mobility appears crucial to our understanding of housing stability. For example, the number of times an individual with a mental illness moves home in a specific period of time has been used as a measure of housing stability in a number of studies (Bebout et al., 1997; Srebnick et al., 1995). The National Housing Strategy (1992) reported that 39% of households had moved in the previous five years. Of this
group 84% of private renters, 48% of public renters and 44% of purchasers had moved compared to only 14% of homeowners. While private renters represented only 20% of households they represent 42% of movers. The study noted that the propensity to move corresponded with increases in income with higher income groups more likely to move with the exception of the lowest income group where a high level of mobility was attributed to young people on fixed or marginal incomes. Most moves were voluntary in nature and represented a desire to adjust consumption, however, one sixth of private renters were forced to move.

Amongst people with a mental illness, Yeich et al., (1994) found that individuals who moved most frequently were least satisfied with their accommodation and suggest this is conceptually consistent with a client group which moves frequently because of dissatisfaction with their housing or who are dissatisfied because they are moving so frequently.

**HOUSING STABILITY**

Research on the impact of homelessness on people suffering from a mental illness suggests that homelessness represents only the extreme end of a continuum of housing instability. Many people who cannot be classified as homeless “live in stressful, substandard and transient circumstance that can be considered unstable” (Drake et al., 1991). The impact of housing instability has major implications for mental health services. For example, people with a mental illness are ten times more at risk of
homelessness than the general population (Süsser et al., 1991) and are twice as likely to be rehospitalized as those with stable housing (Drake et al., 1989).

Unfortunately, most research has focussed on risk factors that predict homelessness in psychiatrically ill populations rather than on those factors which predict housing stability. For example, an association between elevated psychiatric symptoms when the client is discharged from hospital and risk of homelessness has been reported (Olfson, Mechanic, Hansell, Boyer & Walkup, 1999) although some other studies have failed to find an association between housing stability and psychiatric symptoms (e.g. Bebout et al., 1997). Drake et al. (1991), in a study of a rural population found no association between housing instability and psychiatric symptoms (with the exception of suicide ideation).

However, the focus on homelessness as an indicator of housing instability is akin to shutting the stable door after the horse has bolted. There is a clear need to develop predictors that can be used to alert clinicians and carers of the risk of housing instability for someone with a mental illness. The predictors could then be used to develop a measure that might identify the risk of housing instability and facilitate early intervention to ameliorate stress and reduce the risk of future homelessness. In addition, most studies have been undertaken in urban centres and there is a paucity of research in rural areas. Problems with the availability of mental health services in rural areas means that people with mentally illness are more likely to use alternative services than their urban counterparts (Sullivan et al. 1996) particularly crisis and supportive housing (Sommers, 1989).
How is housing instability defined?

The term "housing instability" is often used synonymously with homelessness. However, using this definition a client's residential status is either stable (housed) or unstable (homeless). The problem with this dichotomy is that it does not allow an examination of levels of housing stability that fit between these two points. Others have developed definitions based on the number of moves made by the client during a six or twelve month period (Bebout et al., 1997; Srebnick, et al. 1995). While it seems self-evident that the number of times a person changes residence can be used as a proxy for stability, it can be argued that at least for some people changing residence may reflect a move into better circumstances (National Housing Strategy, 1990). The Family Resource Centres Network (1999) has developed a housing matrix for the general population based on security, safety and stability of housing over time, condition of housing and income. Five levels of stability are operationally defined based on these criteria - thriving, safe/self sufficient, stable, at risk and in crisis. For example, the criteria for stable housing includes: living in permanent housing, or temporary situation that will last for at least six months; able to pay rent each month; housing is not hazardous, unhealthy, overcrowded; some savings or resources to draw on in emergency (p. 1). The advantage of this approach is that it attempts to develop a continuum of housing stability. However, the matrix does not include client satisfaction or choice and it was not possible to determine if the model had been tested empirically. In contrast to this, a review of the mental health literature found few consistencies in the definition of housing stability.
The absence of a clear operational definition of housing stability for mentally ill populations has implications for how it is measured. Few studies of the residential needs of people with a mental illness use instruments that specifically measure housing stability. A majority of the measures examine risk factors that may correlate with housing stability. Drake et al. (1989) measured the “stability of patients’ living arrangements in the community” by examining the level of support the client received which was rated on a continuum from highly supportive to highly stressful (p. 331). However, although support is considered a crucial variable in the provision of housing for people with a mental illness (Carling, 1993), it could be argued that this instrument measures environmental stress which may be unrelated to housing status. In addition, the provision of clinical support in itself may be a stressor (Hodgkins et al., 1989; Owen et al., 1997).

In the absence of an accepted definition of housing instability, it is useful to examine the strengths and limitations of specific measures that may play a useful role in predicting housing instability. It can be argued that for individuals that are currently housed, one measure of stability is the length of time an individual has lived in their current dwelling with those with the shortest length of tenure (eg < one year) classified as the least stable (Srebnick et al., 1995). A second measure for this group might be those individuals who do not want to move from their current dwelling and have not considered moving. A third level could include individuals with a general desire to move but who have no plans to move and could be considered as being at relatively low risk of instability. For
an individual who expresses an intention to move within a specific time frame, the risk of instability is clearly more immediate and therefore is higher.

The next group are those who insecure accommodation and includes those with no lease or other form of secure tenure, individuals who have been refused accommodation in the past, and/or expect to be thrown out of their current dwelling. Finally, those who are homeless or have highly insecure accommodation (e.g. living in a squat or inner city hostel) and can be classified as “virtually homeless” (Drake et al., 1989) can be considered as being at the extreme end of instability.

However, none of the measures account for an individual’s motivation for moving which may be driven by personal choice (i.e. a move from satisfactory accommodation to even better circumstance), because the standard of accommodation is so poor, or finally that the reasons are not rational but rather a function of some form of delusional belief. However, while any move may be stressful (see Holmes & Rahe, 1967), if the move is forced because of unsatisfactory circumstances or a relapse into illness, it is likely to be relatively more stressful than one that is planned and involves a change to better circumstances (Evans et al., 2000).

It appears that the foregoing measures are unlikely capture a single underlying construct of instability because they apply to different populations. It might be anticipated that some measures in closer proximity along the continuum are more likely
to be related than those that are more distant rather than each representing independent proxies of stability. For example, desire and intention to move might be expected to relate to each other because they represent a group of individuals who are currently housed and have greater control of their circumstances. Alternatively, individuals with no lease or other form of secure tenure, those who have been refused accommodation in the past, and/or expect to be thrown out of their current dwelling may represent a group whose control over housing is governed by external factors (eg. the behaviour of an unsupportive landlord).

It is therefore important to begin to examine potential predictors or “reasons” for instability that have been found in prior research. The present study compares three potential predictors of housing stability namely, satisfaction with housing, quality of housing and housing choice, with factors thought to be associated with the risk of housing instability.

**SATISFACTION WITH HOUSING**

*A priori*, it could be argued that satisfaction with one’s house and neighbourhood might have an important effect on housing stability. That is a person who is dissatisfied with where they live may move home and hence meet one of the criteria for instability discussed previously with the potential for a negative outcome (eg. homelessness). Yet very little research has been conducted into the relationship between satisfaction with housing and mental health outcome although there is some evidence that people with a mental illness have higher levels of satisfaction than the general population (Tempier,
Carón, Mercier & Leouffre, 1998). To some extent this may be an artifact of the perceived alternatives and not surprisingly, the lowest levels of satisfaction have been associated with long-term accommodation in an institutional setting (Shepherd, Muijen, Dean & Cooney, 1996). Conversely, Seilheimer and Doyal (1996) report that less restrictive housing and greater self-efficacy was associated with increased client satisfaction.

A number of studies have found that satisfaction with housing is associated with concerns about the physical qualities and conditions of the residence (Nelson et al., 1996; Sukorska, 1999), neighborhood characteristics (Lord & Rent, 1991), convenient location, safety and comfort, privacy and proximity to mental health services (Massey & Wu, 1993), and coping ability (Elliot, Taylor, Martin & Kearns, 1990). Finally, Srebnick, et al. (1995) studied consumer housing choice in a mentally ill population and reported that respondents expressed satisfaction even where they perceived they had very little choice in where they lived which was attributed to either community housing being preferred to institutional care or a form of learned helplessness.

Despite an absence of major studies examining the impact of satisfaction with housing in mentally ill populations, a logical case can be mounted that satisfaction with one’s dwelling, location, environment and access to community activities and services are important determinants of housing stability and are therefore worthy of further investigation.
A number of studies have shown that a client’s perceived level of choice over their living environment has an important effect on psychological well-being (Srebnick, et al., 1995). However, as discussed previously the choice of housing for people with a mental illness is a highly idiosyncratic and complex process (Carling & Ridgeway, 1988). There is evidence that mental health consumers prefer to live independently in an apartment or house (Yeich, et al., 1994) and least prefer living in communal or group settings (Carling, 1993; Schutt & Goldfinger, 1996; Tait, 1985). The extent to which consumers are beginning to exercise choice may be reflected in a trend away from supervised care settings towards independent living. (Pandiani, et al., 1994).

To what extent are mental health consumers able to exercise choice over their housing? Srebnick et al. (1995) found that individuals discharged from psychiatric hospitals had limited housing options and that service providers exerted a strong influence over housing choice. The study found that over two thirds of respondents were given only one choice of house and the remaining third little or no choice. However, there was a significant relationship between amount of choice and residential stability as measured by number times respondents moved ($r = -.29$).

The latter study suggests that client choice may play an important mediating role in the maintenance of housing stability. Choice is an important contemporary issue with a growing literature on the active rather than passive participation of mentally ill
individuals in their recovery process. The assertion that factors such as a lack of opportunities for self-determination militate against the process of recovery (Anthony, 1993) supports the further examination of the role of choice in the prediction of housing stability.

QUALITY OF HOUSING

The quality of housing that people with a mental illness can afford appears crucial to housing stability. Housing quality is represented by a combination of factors that include the ratio of cost to income, physical adequacy, safety and comfort, privacy and convenience (Massey & Wu, 1993; Newman & Ridgely, 1994; Tanzman, 1993). As noted previously, there seems to be some general agreement, that housing costs should not exceed 30% of client income (Hurlburt, et al., 1996; Newman & Ridgely, 1994). For example Newman and Ridgely (1994) also found that greater housing affordability was associated with a reduction in hospital bed days. Paradoxically the study found that less affordable rents were associated with greater housing stability which the authors attribute to the availability of a rental subsidy that allowed clients to obtain better quality accommodation.

However, very few studies have examined the relationship between housing quality and mental health outcome in either the general population or indicated populations such as those with a mentally illness. A number of methodological difficulties have been identified which make it difficult to conduct this type of research. Evans, Wells, Chan
and Saltzman (2000) have identified two major issues. Firstly, they argue that individuals choose where they want to live and it is difficult to control for confounding variables such as socio-economic status and base-line mental health status. Secondly, existing measures of housing quality were developed to measure either threats to public health (eg. disease) or the physical adequacy of housing construction through building codes. Hence the impact of environmental factors such as safety and privacy, which are linked conceptually to mental health, are not taken into account.

Several longitudinal studies which have examined the physical quality of housing in the general population have reported modest gains in mental health among groups that receive improved housing (Elton & Packer, 1986; Halpern, 1995; Wilner, Wackley, Pinkerton & Tayback, 1962). Recently, in a cross-sectional study of 207 women living in a rural area it was reported that, after controlling for income, housing quality was a significant predictor of psychological distress (Evans et al., 2000). In a second part of the same study a cross-sectional sample of 31 women living in an urban area were assessed before and after their relocation to a new, purpose-built residence. It found that an improvement in housing quality was significantly related to psychological health and was associated with a reduction in psychological distress (Evans et al., 2000).

There are no reports of similar studies being conducted for populations with a mental illness although Baker and Douglas (1990) reported a large study (n = 844) which demonstrated that clients rated by their case managers as living in adequate housing had significantly less mental health service needs and increased functional ability than those
whose housing was rated as inadequate. While the study supports a relationship between mental health outcome and quality of housing the study was subject to confounding variables such as economic status and base-line symptoms (see Evans et al., 2000).

Studies by Owen et al. (1996) and Rosenfield (1991) support the contention that good housing outcome is related to the client’s perception of the housing program rather than their individual characteristics or level of psychiatric care. However, there appears to be a relationship between poor quality of housing conditions and stress and the onset of psychiatric symptoms (Nelson et al., 1998). This relationship does not seem to be mitigated by the level of psychiatric support the client receives from mental health services (Baker & Douglas, 1990).

CLIENT-RELATED FACTORS

An association between elevated psychiatric symptoms at index discharge and risk of homelessness has been reported (Olfson et al. 1999) while other studies failed to find an association between housing stability and psychiatric symptoms (e.g. Bebout et al., 1997; Wallach et al., 1991). A number of other individual factors related to client functioning have been identified as being associated with housing instability. For example, the relationship between housing stability and specific psychosocial variables such as ability to prepare meals, manage financial matters, engagement in social activities has been established (Drake et al., 1989, 1991). Studies have also found housing stability was associated with alcohol and drug use, medication adherence (Drake al. 1989, 1991;
Olfson, et al., 1999) and quality of life and self-efficacy (Srebnick et al., 1995; Seilheimer & Doyal, 1996). However, while these factors may be related to housing instability, it was beyond the scope of the study to take comprehensive measures of clients mental health and social functioning.

METHODOLOGICAL ISSUES

Clearly there are a range of definitions of housing stability which makes comparison across studies difficult. The variability of rates of housing stability across studies may therefore be a function of different definitions of stability. There is a need for research that compares across a range of different definitions.

The historical measurement of housing stability has also been based largely on clinician judgement. For example in the studies by Drake et al. (1989, 1991) ratings were undertaken entirely by case managers who were required to complete a semi structured questionnaire to identify the number of times the client changed accommodation, causes of housing problems and supports needed to maintain housing. There are a number of methodological concerns associated with such measures (Susnick, 1993; Goering et al., 1992). For example, there is evidence that case managers are not well informed about the housing status of clients. In a large field trial (n = 2137) of the Health of the Nation Outcome Scales it was found that the highest percentage of "not known" ratings were associated with the item which measured accommodation status (Trauer, 1999, personal communication). In addition, the reliability of housing status measures used by direct
care staff may be affected by the highly variable sources of data that they use in making such judgements. The use of approaches to data collection which explore the clients first hand views about satisfaction with housing may therefore provide more reliable data (Pyke & Lowe, 1996). One aim of the present study is to get the first hand views of consumers about their current housing status.

CONCLUSIONS

There is evidence that the mentally ill suffer from serious economic disadvantage. They are more likely to be unemployed and, as a corollary, are more likely to be dependent on some form of social security payment. This limits access to housing in terms of its quality and affordability. In turn poor housing appears to be related to increased levels of dissatisfaction with housing and in at least one third of cases, there is evidence people with a mental illness have been “placed” in accommodation rather than been given a choice about where they wish to live. These issues have important implications for housing stability.

It has been argued that maintaining stable housing provides an important buffer for people with a mental illness that may mitigate the risk of relapse. It is therefore important that case managers remain mindful of, and monitor, the housing stability of their clients. Some evidence has been presented that housing stability can be viewed on a continuum from currently housed to not currently housed (homeless). Factors that appear to be associated with housing stability include security of tenure and length of tenure while
factors that may compromise housing stability include a sufferer’s desire to move or their intention to move from their current dwelling.

The present study attempts to provide a general description of a sample of people being treated by a rural mental health service and compares them with a sample of the Australian population. It goes on to describe the “housing stability” of the mentally ill sample. Finally, it examines the relationship between different measures of housing stability and explores the relationship between housing stability and satisfaction, choice, and quality of current housing.
CHAPTER 3

METHODOLOGY

PARTICIPANTS

A list of outpatient clients and clients from a community residential program who were registered at the time of the survey, was obtained from the Mid Western Area Mental Health Service database. Fifteen percent of this group was randomly selected from the register using a table of random numbers. Clients who did not have contact details recorded on the database were excluded from the study. The name, address and telephone number of each client selected was then recorded in order of selection, with the appropriate ethical safeguards (refer to Appendix 2). The survey was conducted between December 1995 and February 1996. The hospitalized sample was also included and comprised clients who volunteered to participate in the study and who attended a discharge planning group at the regional acute admission unit during the period of the study. The total number of clients in treatment during the period of the study was 688 comprising outpatient clients (n = 578), clients in a residential program (n = 78) and hospitalised clients (n = 32)

To ensure informed consent all participants were given the following information:

- an explanation of the purpose of the study;
- explanation of how the study was to be conducted;
- explanation of what was expected of participants involved in the study;
• the right to refuse to participate in the study without any prejudice to the treatment they receive;
• the right to withdraw from the study at any time without any prejudice to the treatment they receive (refer to Appendix 3);

Clients were given sufficient time to make a decision about participation in the study. A total of 224 clients were approached to participate (outpatients n = 192, inpatients n = 32) and 110 surveys were completed (outpatients n = 91, inpatients n = 19). However, 9 of the community clients surveyed were under the age of 18 and were subsequently excluded from the final sample leaving a final sample of 101 and a response rate of 45.1% (see Table 3.1).

Table 3.1: Housing survey response rate by client group

<table>
<thead>
<tr>
<th>Client Sub Group</th>
<th>Completed surveys</th>
<th>Client not at home</th>
<th>Client refused to participate</th>
<th>Client had moved address</th>
<th>Sample Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Clients</td>
<td>68</td>
<td>72</td>
<td>36</td>
<td>20</td>
<td>38.6%</td>
</tr>
<tr>
<td>Clients in Residential Services</td>
<td>14</td>
<td>NA</td>
<td>2</td>
<td>NA</td>
<td>87.5%</td>
</tr>
<tr>
<td>Inpatients about to be discharged</td>
<td>19</td>
<td>NA</td>
<td>13</td>
<td>NA</td>
<td>59.4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>101</td>
<td>72</td>
<td>51</td>
<td>20</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

NA = Not Applicable
Of the 123 clients who did not participate 51 refused (37 outpatients and 14 inpatients) and research assistants could not contact 72 at their place of residence after three visits. The refusal rate of 34% (51/152) of those actually surveyed is consistent with other research in samples with similar characteristics. For example, self-report surveys response rates between 25% and 45% have been found to be demographically representative of hospital and general populations (e.g. Press & Ganey, 1989).

However, a lack of knowledge about why 32% (72/224) of the randomly selected sample were not at home limits the ability to generalize the findings to the larger rural mentally ill population.

The mean age of respondents was 39.6 years (SD = 14.5 years) and slightly more than half were male (53.5%). Only 7.9% of respondents were born overseas (n = 8) and 3.0% described themselves as Aboriginal (n = 3). Almost half of those interviewed reported they had never married (n = 50), 27.7% were either married (n = 27) or living in a de facto relationship (n = 1) and 22.8% were either divorced (n = 15), widowed (n = 5) or separated (n = 3). Fifty four percent of respondents had completed four years or more of secondary education while only one person reported that had never attended school. Almost half (49.0%) had completed some form of tertiary qualification including a TAFE program (n = 41), undergraduate degree or diploma (n = 7) or postgraduate diploma (n = 1).

Over three-quarters of respondents agreed they had a diagnosis of mental illness while 12.9% stated they had no mental illness. Of those indicating they had a mental illness
36.6% stated the diagnosis as schizophrenia and 29.7% understood their diagnosis to be depression or bipolar illness.

**Representativeness of Sample**

The study is cross-sectional, and thus does not measure change over time. It is descriptive and there were no interventions that could have affected the results. The sample size represents 14.68% of the population (101/688 x 100) which is acceptable under a simple random sample design ($\alpha = 0.05$) to within 10% of the population value.

**MEASURES**

**Limitations of previous housing measures**

There are several methodological issues to be considered when addressing the objectives of this research. With respect to survey instruments, Goldman *et al.*, (1995) reviewed 21 studies assessing the housing needs of people with a mental illness and found that most consumer preference questionnaires were designed by mental health professionals or consumers without reference to experts in housing. Carling (1993) points out that few studies of residential programs are based on a probabilistic sample. Furthermore, in prior questionnaire studies, two of the most frequent aims were to focus on whether community care was superior to hospital treatment and what level of mental health support was required by consumers, rather than focusing on consumer satisfaction with housing.
Some studies of consumer housing preferences have relied on the views of staff or the interpretation of raters engaged to conduct client interviews, rather than seeking the views of the consumer. Others have sought consumer preferences for hypothetical types of housing, a construct that may idealize benefits and de-emphasize or ignore disadvantages. Therefore, studies that explore satisfaction with housing directly with clients have the potential to provide more reliable information. Finally, Goldman et al. (1995), point out that many surveys of housing need do not take into account the constraints of income, the availability and accessibility of support services, medical practitioners and mental health services.

The first part of the present study consists of the comparative analysis of the housing needs and preferences of people treated for mental illness. In order to address the first broad goal of the research the housing status of rural mentally ill were compared with the Australian population. Thus it was necessary to use the same measures and procedures as used in studies conducted by the Australian Bureau of Statistics. Therefore the main questionnaire in the study was adapted from two survey instruments of the Australian Bureau of Statistics for the Australian Housing Survey (ABS, 1994) and the Boarding House Survey (ABS, unpublished). In addition 23 supplementary questions were also developed to test the findings of a review of the needs of people with a mental illness conducted by Tanzman (1993). These included the following items related to choice about housing: “People with a mental illness are able to choose where they live”, “There are enough housing choices for people with a mental illness”, and “I live here because it is my choice” (refer to Appendix 4). Thus, a balance between replicability to allow
comparison with prior surveys (i.e. ABS) and the ability to extend prior housing research with new items was required.

The questions were presented in two main forms: those which sought demographic information and those which required the respondent to rate specific variables on a Likert-type scale. Flash cards were used where an item required the respondent to consider a number of categories such as income group or housing choice (refer to Appendix 5). The questionnaire was reviewed and modified in consultation with the Australian Bureau of Statistics and piloted on a small group of clients. It was administered in accordance with the guidelines developed for prior ABS surveys and took 30 minutes to complete.

Diagnosis

Diagnosis was established by asking respondents “Do/did you have a diagnosis of mental illness?” and “If yes, what is the name of that illness?” A formal diagnostic assessment was not undertaken because it was considered unnecessarily intrusive and time consuming and beyond the scope and focus of the study.

Income

Respondents were asked a series of questions about their source of income, how much income they received each week before tax, their main source of income, whether they
were in receipt of a pension or other benefit, the length of time they had been in receipt of these benefits, receipt of additional benefits such as family payments, Austudy or a disability pension through the Department of Veteran’s Affairs and, finally, the receipt and amount of any form of rental assistance. The total income of respondents was distributed according to the quintile ranges reported in the 1994 Australian Housing Survey. Unweighted data from the 1994 Australian Housing Survey was obtained from the ABS to enable comparison. To eliminate the effect of differences in sample size (94 v 14457) and the skewed distribution of income in the study sample, the first and second and third to fifth income quintiles were grouped and Chi square analysis was undertaken on the percentage of income in each cell.

**Rental Costs and Affordability**

The cost of rent was determined by asking respondents “How much rent do you (or your spouse/partner pay and what period does it cover (weeks)?” Weekly rental cost was then calculated by dividing total cost by the number of weeks. In order to assess perceived affordability respondents were also asked about their level of agreement with the statement “The rent, board, mortgage I pay is affordable?” on a five point Likert scale from (1) strongly agree to (5) strongly disagree. Finally, housing affordability was calculated as a percentage of housing costs over total income including housing subsidies (eg. Newman et al., 1994).
Tenure Type

Respondents were asked if the dwelling they were living in was owned, being purchased or rented by themselves, their spouse/partner, or parents/family member, or if they lived in a boarding house or hostel. Renters were asked to specify whether they were renting public or private housing or if they were living rent-free. To allow comparisons to made with unweighted data from the Australian Housing Survey (ABS, 1994), tenure type was grouped into owned, being purchased, rented - public, rented - private, rent-free or other.

Dwelling Type

Interviewers were instructed to note the type of dwelling according to the schedule used in the Australian Housing Survey (ABS, 1994). The dwelling categories were: separate house; semi-detached, row or terrace house, town house; flat attached to house; other flat, unit or apartment; caravan, tent, cabin in a caravan park, house boat in a marina; house or flat attached to a shop or office; boarding house or hostel and; other.

Access

Respondents were asked to rate their access to a range of places in the community including the residences of family and friends in terms of importance of access and difficulty of access. Importance of access was rated on a four point scale from “Very
Important" to “Not Important at All” and difficulty of access on a similar scale from “Very Easy” to “Very Difficult”.

Housing Instability

The second part of the study tests the relationship between measures of housing stability and the factors of satisfaction, quality and choice which have been identified in the literature as having an association with housing stability. Specifically, the ability of these measures to predict individuals at risk of housing instability.

Security of Tenure

Security of tenure was measured in four ways: type of tenure, length of tenure, a composite measure of factors associated with security of tenure and the respondent’s desire and intention to move to another dwelling.

The first item relating to tenure type sought information about whether the respondent’s dwelling was owned, being paid off or rented by themselves or a family member or whether they lived in a boarding house or hostel (ABS, 1994). For this item renters with no lease and no other form of secure tenure were classified as unstable.

Length of tenure was measured by two items that asked if the respondent had lived in their current dwelling for greater than, or less than 10 years and if not, to specify how
long they had been living in their current dwelling. Consistent with the criteria used by Srebnick et al., (1995) respondents with less than one year of tenure were classified as unstable.

In the case of renters, a Composite Measure of Housing Stability (CMHS) was formed by combining three items relating to security of tenure. The items used included (a) “do you have a lease or other form of secure tenure”; (b) “have you ever been refused rental accommodation” both coded yes = 0, no = 1; and (c) “I do not expect to be thrown out of where I am living” rated on a 5-point scale from 1, “strongly agree” to 5, “strongly disagree”. The distribution of the last item was highly skewed and hence it was recoded into a categorical variable with “strongly agree”, “agree” and “neither” coded 0 (stable) and “strongly disagree” and “disagree” coded 1 (unstable). All three items were added to form a total which ranged from 0 – 3. A score of “3” reflected a high level of instability indicating the respondent had no lease or secure tenure, had previously been refused rental accommodation, and had some level of expectation they may be thrown out of their current dwelling.

*Desire/Intentions to Move*

Desire/intention to move was measured by two items that asked respondents (a) if they would like to move out of their dwelling (desire to move), and (b) if they intended to move home in the next twelve months (intention to move). Respondents who answered
“yes” to these items were considered to have higher levels of housing instability. These two items were then treated as independent categorical variables.

Satisfaction

Satisfaction items assessed the respondent’s satisfaction with the environment in which they lived (3 items), access to activities and services (calculated as the mean of 9 items), location of the dwelling (1 item), and overall satisfaction with the dwelling itself (1 item). Satisfaction with environmental characteristics were measured by asking the respondent, “are you satisfied with the following aspects of this dwelling?”, the amount of natural light, noise from neighbours and safety and security (rated yes = 1 or no = 0). The items relating to activities and services required respondents to rate satisfaction with access to work, shops, public transport, doctors, dentists and other health services, hospital, recreational facilities, schools, childcare and entertainment. These items were rated on a five point scale from 5, “excellent” to 1, “very poor”. A number of items in this group, which are of great relevance to the general population such as getting to work and access to childcare, were of less relevance to a sample in which 82.2% were currently not employed and 53% had never married. Where there was missing data for these items a mean of the remaining available items was calculated. The final score was calculated as a mean of all nine items. The last two items related to satisfaction with location and dwelling type and were also rated on a five point scale described above. The mean of the access items were then summed with the other items to provide a total satisfaction score with a possible range of 3 to 18. Cronbach’s alpha for the items related to satisfaction
with environment was $r = .44$. This value is quite low but this is likely to be a function of the number items. However, the item total correlations were all above .2 indicating some evidence of inter-relatedness. In the case of the items that comprise satisfaction with access, Cronbach’s alpha was $r = .92$. Spearman’s correlation was then conducted between the sum of satisfaction with noise, light and safety and the mean of satisfaction with access. The results indicate a moderate correlation $r = .27$ (p = .01, 2 tailed). These correlations provide support for the combination of the two items. Finally, Cronbach’s alpha for all measures of satisfaction was $r = .62$ indicating that they may be measuring different aspects of satisfaction and is satisfactory for research purposes.

**Quality of Housing**

Quality of housing was measured by counting the number of rooms in the dwelling (excluding bathrooms, toilets and laundries), whether bedroom areas were shared (rated yes = 0, no = 1), and eight items relating to the availability of amenities including safe storage of valuables, storage for clothing, cooking facilities, adequate bench space, a refrigerator and bathroom and toilet facilities (rated yes = 1, no = 0). All items were summed to provide a total quality score which ranged from 1 (a single, shared room with no amenities) to a maximum of 9. The number of rooms in dwelling was then added to this score.
Choice of Housing

Choice of housing was measured by two questions that addressed whether the respondent exercised choice in the location and type of residence. Respondents who indicated they had “no choice” were rated zero and alternative responses rated one. In addition, respondents were asked to rate their answer to the question “I live here because it is my choice” rated on a five-point scale from 5, “strongly agree” to 1, “strongly disagree”. Ratings for each item were summed. The range of possible scores on this measure was 1 to 7. Spearman’s correlation was conducted between the scores for choice of location and type of residence and “I live here because it is my choice”. The results indicate a moderate correlation of $r = .45$ and $r = .38$ ($p = .01$, 2 tailed) respectively. These correlations provide support for the combination of these items. Cronbach’s alpha for all items was $r = .66$. This value is moderate but suggests the overall measure is satisfactory for research purposes.

PROCEDURE

Research assistants first attempted to contact clients by telephone to determine whether they were willing to participate. If the client could not be contacted by telephone or did not have a telephone, they were visited at the address on three occasions at different times of the day. Clients were excluded from the study if: if the address on the data base was incorrect, they had moved out of the area; or if they were not at home on three consecutive visits. A total of 110 questionnaires were completed.
The research assistants were third year health science students who all undertook a training program in standardized administration of the questionnaire and the use of flash cards to facilitate the administration of questions where a choice needed to be made from an extensive list of variables.
CHAPTER 4

RESULTS

This chapter reports the results of the analyses previously outlined in Chapter 3. It begins by reporting a comparison between respondents in this study and the general Australian population based on the Australian Housing Study (ABS, 1994). Specifically, the two samples are compared along the variables of income, dwelling type and tenure. The analysis then examines the relationship between different measures of stability and finally the extent to which measures of quality, satisfaction and choice are related to indices of housing stability. Data analysis was conducted using the Statistical Package for the Social Sciences (Version 9).

ACCESS, AFFORDABILITY AND TENURE

Transport and Community Access

Over two thirds of respondents used a motor vehicle as their most frequent means of transport (n = 68) while only 5.9% used a bus (n = 6) and 25.7% relied on walking or the use of a bicycle (n = 26). In the group that used a motor vehicle, 70.6% drove themselves (n = 48) and the remainder were driven by a spouse (n = 4), family member or friend (n = 8), a mental health worker (n = 2) or used a taxi (n = 6). Finally, for one third of respondents who relied on walking or bicycle, this represented their only form of transport.
Table 4.1 provides a comparison of respondents’ rating of the importance of access and ease of access to specific community services and support networks. Respondents whose rating of importance of access to community facilities, family, friends and public transport was high also reported corresponding levels of ease of access to these supports.

In particular, access to doctors and other health care facilities, shops and the houses of family and friends were rated “very important” to “important” by almost three-quarters of respondents (see Phi coefficients in Table 4.1). Finally, a majority of respondents strongly agreed/agreed with the statement “I like where I am living at present” (75.2%, n = 76) and believed that they were receiving the support services they needed (80.2%, n = 81).

Table 4.1: Respondents’ rating of the importance of access and the ease of access to: health care facilities, transport, family and friends and community facilities

<table>
<thead>
<tr>
<th>Access to:</th>
<th>Very important/important %</th>
<th>Very easy/easy %</th>
<th>Phi coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors, dentist or other health facilities</td>
<td>83.0</td>
<td>83.2</td>
<td>.43 *</td>
</tr>
<tr>
<td>Shops</td>
<td>78.2</td>
<td>82.2</td>
<td>.42 *</td>
</tr>
<tr>
<td>Hospitals</td>
<td>73.3</td>
<td>81.2</td>
<td>.43 *</td>
</tr>
<tr>
<td>House of relative or friend</td>
<td>68.0</td>
<td>71.4</td>
<td>.68**</td>
</tr>
<tr>
<td>Open countryside</td>
<td>53.5</td>
<td>63.4</td>
<td>.39</td>
</tr>
<tr>
<td>Parks, lakes, public open space</td>
<td>47.0</td>
<td>65.4</td>
<td>.42</td>
</tr>
<tr>
<td>Entertainment, cinemas, restaurants, theatres</td>
<td>33.3</td>
<td>54.5</td>
<td>.49 *</td>
</tr>
<tr>
<td>Public transport</td>
<td>29.0</td>
<td>39.6</td>
<td>.51</td>
</tr>
<tr>
<td>Place of employment</td>
<td>25.8</td>
<td>21.8</td>
<td>.81 *</td>
</tr>
<tr>
<td>Sports facilities</td>
<td>25.7</td>
<td>43.6</td>
<td>.37</td>
</tr>
<tr>
<td>Tertiary institutions</td>
<td>20.0</td>
<td>27.7</td>
<td>.31</td>
</tr>
<tr>
<td>Children’s play areas</td>
<td>14.1</td>
<td>18.8</td>
<td>.83 *</td>
</tr>
<tr>
<td>Primary schools</td>
<td>12.1</td>
<td>15.8</td>
<td>.58</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .001
Housing Costs

The cost of housing varied considerably according to type of tenure and the services provided. Home buyers had the highest weekly costs with a mean mortgage repayment of $132.25 (range 43.25 – 300.00, SD = 81.64) followed by residents of hostels $126.67 (range 78 – 173.50, SD = 31.61), renters $75.63 (range 14 – 180, SD = 39.67) and those paying board $66.10 (range 40 – 120, SD = 27.80). The calculations exclude respondents who received free rent (n = 10) and free board (n = 7). In terms of the cost of rent, mortgage or board, 76.2% of respondents in the sample strongly agreed or agreed that their housing-related payments were affordable.

Income

The income distribution of respondents was positively skewed and is clearly different to that of the general Australian population ($\chi^2 = 21.78, \text{df} = 1, p < .001$) (see Table 4.2). A majority of respondents (75.2%) reported they received some form of government benefit as their primary source of income and 93.6% were in the lowest two income quintiles compared to 39.1% of respondents in the Australian Housing Survey (ABS, 1994b; Table 4.2). Only 7.9% (n = 8) of respondents stated they were in full-time paid employment and a further 9.9% (n = 10) were in part-time paid employment.
Table 4.2: Income of respondents compared to Australian family income

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Income Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First and Second</td>
</tr>
<tr>
<td>NSW Mentally ill sample</td>
<td>88</td>
</tr>
<tr>
<td>%</td>
<td>(93.6)</td>
</tr>
<tr>
<td>ABS(^1)</td>
<td>5659</td>
</tr>
<tr>
<td>%</td>
<td>(39.1)</td>
</tr>
</tbody>
</table>

\(^1\) 1994 Australian Housing Survey.

Rental Cost and Affordability

The median weekly rent of respondents was half that of Sydney and was also below the median for renters in New South Wales excluding Sydney, and for Australia (Table 4.3).

Rent payments represented 35% of total income in the mentally ill sample. This is considerably higher than the rental payments for Australians in the lowest income quintile which constitute 25% of income (ABS, 1994).

Table 4.3: Median weekly rent of respondents compared to median weekly rent of households in Australia\(^1\) and New South Wales\(^1\)

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Median weekly rent ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentally Ill Sample</td>
<td>75</td>
</tr>
<tr>
<td>New South Wales</td>
<td>131</td>
</tr>
<tr>
<td>Sydney</td>
<td>152</td>
</tr>
<tr>
<td>Rest of State</td>
<td>100</td>
</tr>
<tr>
<td>Australia</td>
<td>119</td>
</tr>
</tbody>
</table>

\(^1\) 1994 Australian Housing Survey.
Tenure Type

The survey also showed a significant difference in the tenure type of respondents compared to Australians. Less than one third of respondents (28.8%) were living in accommodation that they either owned or were purchasing. According to the ABS Housing Survey almost three-quarters of Australian families (70.5%) own or are purchasing their own home. Furthermore, 41.6% of respondents surveyed were living in rented accommodation, compared to 29.5% of Australian families who rent. Table 4.4 provides a more detailed comparison of housing tenure type between the sample of people with mental illness and the ABS Housing Survey. Chi-square analysis confirmed that these differences were statistically significant ($\chi^2 = 41.76$, df = 5, p < .001).

However, these results need to be viewed with some caution because it is not clear to what extent the differences are due to living in a rural community or having a mental illness.

Table 4.4: Tenure type of respondents compared to tenure data from Australian Housing Survey 1994

<table>
<thead>
<tr>
<th>Tenure Type</th>
<th>Mentally Ill Sample n</th>
<th>Mentally Ill Sample %</th>
<th>ABS n</th>
<th>ABS %</th>
<th>Expected Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned by self</td>
<td>15 (14.85)</td>
<td>5965 (42.30)</td>
<td>42.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being purchased by self</td>
<td>14 (13.86)</td>
<td>4246 (30.12)</td>
<td>30.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented - Public</td>
<td>17 (16.83)</td>
<td>976 (9.92)</td>
<td>6.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented - Private</td>
<td>25 (24.75)</td>
<td>2583 (18.32)</td>
<td>18.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent free</td>
<td>10 (9.90)</td>
<td>243 (1.72)</td>
<td>1.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>20 (19.80)</td>
<td>87 (0.62)</td>
<td>0.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>101 (100.0)</td>
<td>14100 (100.0)</td>
<td>101.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dwelling Type

The lower median rental payment of respondents reported above is also reflected in their type of dwelling. For example, respondents were less likely to live in a separate house than other Australians (54.5% v 79.3%). They were also more likely to live in a semi-detached or terrace house (18.8 v 8.1%), flat, unit or apartment (17.9% v 12.5%) or caravan, boarding house or hostel (9.0% v 0.2%).

HOUSING STABILITY

The analysis of the housing stability data is divided into three sections. The first describes the measures of housing stability used in the study and the frequency of respondents who could be considered “unstable” according to these different definitions. The second section examines the relationship between the different measures of housing stability. Finally, the third section examines the relationship between different measures of housing stability and satisfaction, quality, and choice.

Measures of Housing Stability

The number of people who could be classified as living in unstable housing varied widely according to the definition used. Applying the definitions of housing instability adopted for this study, between 1% (a single respondent who rated a maximum score of three on the Composite Measure of Housing Stability) and 42.6% (n = 43 respondents who had lived in their current dwelling for less than one year) met one or more of the criteria.
Table 4.5 shows the percentage of respondents classified as unstable using the different measures of stability.

Table 4.5: Level of housing stability of respondents according to different definitions

<table>
<thead>
<tr>
<th>Definition of stability</th>
<th>Stable n</th>
<th>Stable (%)</th>
<th>Unstable n</th>
<th>Unstable (%)</th>
<th>Missing data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of tenure (&lt;1 year, &gt;1 year)</td>
<td>57</td>
<td>(57.0)</td>
<td>43</td>
<td>(43.0)</td>
<td>1</td>
</tr>
<tr>
<td>Desire to move from current dwelling</td>
<td>65</td>
<td>(65.7)</td>
<td>34</td>
<td>(34.3)</td>
<td>2</td>
</tr>
<tr>
<td>Some form of secure tenure (e.g. Lease)(^1)</td>
<td>80</td>
<td>(79.2)</td>
<td>21</td>
<td>(20.8)</td>
<td></td>
</tr>
<tr>
<td>Intention to move from current dwelling</td>
<td>87</td>
<td>(87.0)</td>
<td>13</td>
<td>(13.0)</td>
<td>1</td>
</tr>
<tr>
<td>Do not expect to thrown out of dwelling(^1)</td>
<td>93</td>
<td>(92.1)</td>
<td>8</td>
<td>(7.9)</td>
<td></td>
</tr>
<tr>
<td>Refused accommodation in past(^1)</td>
<td>96</td>
<td>(95.0)</td>
<td>5</td>
<td>(5.0)</td>
<td></td>
</tr>
<tr>
<td>CMHS (highest possible score)</td>
<td>100</td>
<td>(99.0)</td>
<td>1</td>
<td>(1.0)</td>
<td></td>
</tr>
</tbody>
</table>

Note: CMHS = Composite Measure of Housing Stability, highest possible score is “3” \(^1\) = all 3 variables with superscript are summed to comprise the CMHS

**Length of tenure**

One-third of the respondents had lived in their current residence for less than one year, one-third had lived in their current residence for between one year and less than 10 years, while the remaining one third of respondents had occupied their current residence for more than 10 years.

**Composite Measure of Housing Stability**

The Composite Measure of Housing Stability (CMHS) comprised three items: (a) no lease or other form of secure tenure; (b) “I do not expect to be thrown out of my current
"dwelling" and; (c) had been refused rental accommodation in the past. Using these items the number of respondents who could be classified as unstable varied in descending order from no lease or other form of secure tenure (n = 17), [I] expect to be thrown out of my current dwelling (n = 9) and those who had been refused rental accommodation in the past (n = 4). Of the 25 respondents who had a score of one or more on this measure a majority (n = 21) scored 1, three scored 2 and only one respondent had a maximum score of three.

Respondents were classified as unstable if they obtained a score of one or more on the CMHS. Chi square analysis revealed a significant relationship between CMHS and desire to move ($\chi^2 = 9.76$, df = 1, $p < .01$) but not intention to move in the next 12 months (Table 4.6). Further analysis of the relationship between desire to move and the CMHS indicated a modest level of overall agreement between the two measures (Phi coefficient $= -0.31$). However, the correspondence of the variability for those in the stable category was high with 84.6% of respondents rated as stable on the CMHS also rated as stable within desire to move and conversely 73.3% rated stable by desire to move also rated as stable within the CMHS.
Table 4.6: Chi square analysis of respondents who expressed a desire to move and the Composite Measure of Housing Stability

<table>
<thead>
<tr>
<th></th>
<th>Composite Measure of Housing Stability</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score = 1-3 (Unstable)</td>
<td>Score = 0 (Stable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (Unstable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>15</td>
<td>19</td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>% within desire to move</td>
<td>(44.1)</td>
<td>(55.9)</td>
<td></td>
<td>(100.0)</td>
</tr>
<tr>
<td>% within CMHS</td>
<td>(60.0)</td>
<td>(25.7)</td>
<td></td>
<td>(34.3)</td>
</tr>
<tr>
<td>No (stable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>10</td>
<td>55</td>
<td></td>
<td>65</td>
</tr>
<tr>
<td>% within desire to move</td>
<td>(15.4)</td>
<td>(84.6)</td>
<td></td>
<td>(100.0)</td>
</tr>
<tr>
<td>% within CMHS</td>
<td>(40.0)</td>
<td>(74.3)</td>
<td></td>
<td>(65.7)</td>
</tr>
<tr>
<td>Total:</td>
<td>25</td>
<td>74</td>
<td></td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>(25.3)</td>
<td>(74.7)</td>
<td></td>
<td>(100.0)</td>
</tr>
</tbody>
</table>

Missing data = 2

Comparison of Desire and Intention to Move

One third of respondents expressed a desire to move from their current dwelling (n = 34). However, less than half of that number stated that they intended to move in the next twelve months (n = 13). The group of respondents who expressed a desire to move from their current dwelling was significantly related to those who stated they intended to move in the next 12 months ($\chi^2 = 29.52$, df = 1, p < .001). Further analysis between the two measures revealed a moderate level of agreement (Phi coefficient = .55). This is largely accounted for by the complete correspondence between respondents rated unstable using intend to move and desire to move (Table 4.7).
Table 4.7: Chi square analysis of respondents who express a desire to move and intention to move in the next 12 months

<table>
<thead>
<tr>
<th>Desire to move</th>
<th>Intend to move in next 12 months</th>
<th>Yes (Unstable)</th>
<th>No (Stable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (Unstable)</td>
<td>Count</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>% within desire to move</td>
<td>(39.4)</td>
<td>(60.6)</td>
</tr>
<tr>
<td></td>
<td>% within intend to move</td>
<td>(100.0)</td>
<td>(23.5)</td>
</tr>
<tr>
<td>No (Stable)</td>
<td>Count</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>% within desire to move</td>
<td>(100.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% within intend to move</td>
<td>(76.5)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>13</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>% within desire to move</td>
<td>(13.3)</td>
<td>(86.7)</td>
</tr>
<tr>
<td></td>
<td>% within intend to move</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Missing data = 3

The results of Chi square analyses of the relationship between length of tenure and desire to move, intention to move and the CMHS were not significant.

In general these analyses suggest that the diverse measures of housing stability appear to have some relationship with each other. The next section aims to clarify the extent to which these variables contribute to the predictor variables of satisfaction, quality and choice.

**PREDICTION OF HOUSING STABILITY**

The final section of the analysis examines the relationship between housing choice, satisfaction with housing and quality of housing and desire to move, intention to move and the Composite Measure of Housing Stability. The mean score for the housing
satisfaction measure was 12.68 (range 5.5 – 16.71, SD = 1.92). The relatively high mean and low standard deviation suggests that respondents were satisfied with the dwelling, its location and access to community resources.

Overall, the quality of housing of respondents in terms of dwelling type was significantly poorer than that of Australians in general (see Lambert et al. 1999). However, once again the mean score and low standard deviation for the housing quality measure of 13.11 (range 6 – 17, SD = 1.95) suggests that in terms of internal space and the availability of amenities, the quality of the dwelling was relatively good.

The mean score for choice of housing was 5.22 (range 1 – 7, SD = 1.61) indicating that a majority respondents believed they had high levels of choice over where they lived. However, an internal validity check revealed seemingly contradictory data regarding respondent’s views about their level of choice. In response to two items to where the respondent lived, 24.5% (n = 24) stated they had no choice in the selection of the dwelling and 26% (n = 26) believed they had no choice in the selection of the area. However, 41.7% (n = 10) of those who stated they had no choice in the selection of their dwelling and 46.2% (n = 12) who had no choice in the selection of the area also agreed with the statement “I live here because it is my choice”. This suggests a discrepancy between the respondent’s level of involvement in the initial decision making process (note that one third of respondents reported they had no choice), and a decision to “stay” where they are out of choice. It appears that this measure may be capturing aspects of both of these issues.
Satisfaction, Quality and Choice as Predictors of Housing Stability

In the present study satisfaction was significantly correlated with both choice (r = .31, p < .005) and quality (r = .31, p < .005), but quality and choice were not significantly related (r = .09, p > .05).

It was predicted that those who were considered to be in “unstable” housing circumstances would be significantly less satisfied with their housing, have lower overall quality of housing and have lower levels of choice over that housing. Using the housing stability measures of desire to move, intention to move, and the CMHS, those in the stable group were compared to those in the unstable group using independent sample t-tests. Tables 4.8, 4.9 and 4.10 show the results of this analysis which indicate a significant difference between groups on satisfaction (t = -3.37, p < .001), and choice (t = -4.3, p < .001) when using desire to move as the stability measure. When using intention to move as the measure of stability there was a significant difference between groups for choice (t = -3.4, p < .001). When using the CMHS as the stability measure there were significant differences for satisfaction (t = 3.09, p < .01) and quality (t = 3.23, p < .05).
Table 4.8: Mean and standard deviation for satisfaction, quality and choice by desire to move

<table>
<thead>
<tr>
<th>Variable</th>
<th>Desire to move</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (Unstable)</td>
<td>No (Stable)</td>
<td>t</td>
<td>p</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n = 34</td>
<td>n = 65</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>11.81</td>
<td>2.51</td>
<td>13.14</td>
<td>1.38</td>
<td>-3.37</td>
</tr>
<tr>
<td>Quality</td>
<td>12.97</td>
<td>1.99</td>
<td>13.14</td>
<td>1.69</td>
<td>-0.79</td>
</tr>
<tr>
<td>Choice</td>
<td>4.36</td>
<td>1.97</td>
<td>5.73</td>
<td>1.15</td>
<td>-4.30</td>
</tr>
</tbody>
</table>

Table 4.9: Mean and standard deviation for satisfaction, quality and choice by intention to move

<table>
<thead>
<tr>
<th>Variable</th>
<th>Intention to move</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (Unstable)</td>
<td>No (Stable)</td>
<td>t</td>
<td>p</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n = 13</td>
<td>n = 87</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>12.50</td>
<td>2.71</td>
<td>12.77</td>
<td>1.68</td>
<td>-0.50</td>
</tr>
<tr>
<td>Quality</td>
<td>13.69</td>
<td>1.75</td>
<td>13.01</td>
<td>1.97</td>
<td>1.17</td>
</tr>
<tr>
<td>Choice</td>
<td>3.85</td>
<td>2.27</td>
<td>5.44</td>
<td>1.44</td>
<td>-3.40</td>
</tr>
</tbody>
</table>
Table 4.10: Mean and standard deviation for satisfaction, quality and choice by CMHS

<table>
<thead>
<tr>
<th>Variable</th>
<th>CMHS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (Unstable)</td>
<td>No (Stable)</td>
<td>t</td>
</tr>
<tr>
<td>n = 25</td>
<td>n = 76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>11.67</td>
<td>13.00</td>
<td>3.09</td>
</tr>
<tr>
<td>SD</td>
<td>2.51</td>
<td>1.57</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>12.00</td>
<td>13.46</td>
<td>3.23</td>
</tr>
<tr>
<td>Quality</td>
<td>4.96</td>
<td>5.31</td>
<td>0.91</td>
</tr>
<tr>
<td>Choice</td>
<td>1.83</td>
<td>1.60</td>
<td></td>
</tr>
</tbody>
</table>

In summary, these analyses indicate that satisfaction and choice appear to be most consistently related to stability (2/3 measures). The relationship between quality and the CMHS was also significant and may indicate that respondents with least security of tenure also have the poorest quality of dwelling.

In order to establish the direction and predictive value of the above relationships, three binary logistic regressions were performed on desire to move, intention to move and the CHSM as measures of housing stability with the three predictor variables of quality, satisfaction and choice in each logistic regression.

Desire to Move

For desire to move after the deletion of 14 cases for missing values, data from 87 respondents was available. Missing data appeared to be randomly scattered across categories of stability and the predictors decreasing the possibility of any systematic loss.
A test of the full model with all three predictors against a constant only model was reliable $\chi^2 = 17.21$, df = 3, $p < .001$ which represents a significant improvement from the Null model. Overall, the model correctly predicts 78.16% of the cases (see Table 4.11) but it is better at predicting stability (93.0%) than instability (50.0%). Adjusting for skewness in the group membership did not alter the results. Table 4.12 shows Wald statistics and odds ratios of the three predictors. According to the Wald criterion, only Choice ($z = 7.81$, $p < .01$) reliably predicted housing stability measured by desire to move and the Satisfaction variable approached significance ($z = 3.13$, $p < .08$).

### Table 4.11: Prediction classification table for desire to move

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted</th>
<th>Percent correct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stable</td>
<td>Unstable</td>
</tr>
<tr>
<td>Stable</td>
<td>53</td>
<td>4</td>
</tr>
<tr>
<td>Unstable</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.12: Logistic regression analysis of satisfaction, quality and choice as a function of stability measured by desire to move

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>Standard Error</th>
<th>Wald test (z - ratio)</th>
<th>df</th>
<th>p</th>
<th>Odds/ ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction</td>
<td>-0.31</td>
<td>0.17</td>
<td>3.13</td>
<td>1</td>
<td>.08</td>
<td>1.35</td>
</tr>
<tr>
<td>Quality</td>
<td>-0.02</td>
<td>0.15</td>
<td>0.02</td>
<td>1</td>
<td>.88</td>
<td>1.02</td>
</tr>
<tr>
<td>Choice</td>
<td>0.46</td>
<td>0.17</td>
<td>7.81</td>
<td>1</td>
<td>.01</td>
<td>1.58</td>
</tr>
<tr>
<td>Constant</td>
<td>5.93</td>
<td>2.72</td>
<td>4.77</td>
<td>1</td>
<td>.05</td>
<td></td>
</tr>
</tbody>
</table>

**Intention to Move**

For intention to move after the deletion of 12 cases for missing values, data from 87 respondents was available. Missing data appeared to be randomly scattered across categories of stability and the predictors decreasing the possibility of any systematic loss. A test of the full model with all three predictors against a constant only model was reliable $\chi^2 = 10.73$, $df = 3$, $p < .05$ which represents a significant improvement from the Null model. Overall, the model correctly predicts 85.39% of the cases (see Table 4.13) but it is better at predicting stability (97.37%) than instability (15.37%). Adjusting for skewness in the group membership did not alter the results. Table 4.14 shows Wald statistics and odds ratios of the three predictors. According to the Wald criterion, only Choice ($z = 7.49$, $p < .01$) reliably predicted housing stability measured by intention to move.
Table 4.13: Prediction classification table for intention to move

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted</th>
<th>Percent correct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stable</td>
<td>Unstable</td>
</tr>
<tr>
<td>Stable</td>
<td>74</td>
<td>2</td>
</tr>
<tr>
<td>Unstable</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Overall %</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.14: Logistic regression analysis of satisfaction, quality and choice as a function of stability measured by intention to move

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>Standard Error</th>
<th>Wald test (z - ratio)</th>
<th>df</th>
<th>p</th>
<th>Odds/ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction</td>
<td>0.01</td>
<td>0.18</td>
<td>.01</td>
<td>1</td>
<td>.95</td>
<td>1.01</td>
</tr>
<tr>
<td>Quality</td>
<td>-0.26</td>
<td>0.18</td>
<td>2.14</td>
<td>1</td>
<td>.14</td>
<td>0.77</td>
</tr>
<tr>
<td>Choice</td>
<td>0.50</td>
<td>0.18</td>
<td>7.49</td>
<td>1</td>
<td>.01</td>
<td>1.64</td>
</tr>
<tr>
<td>Constant</td>
<td>2.74</td>
<td>2.61</td>
<td>1.10</td>
<td>1</td>
<td>.29</td>
<td></td>
</tr>
</tbody>
</table>

Composite Measure of Housing Stability

For the CMHS after the deletion of 12 cases for missing values, data from 89 respondents was available. Missing data appeared to be randomly scattered across categories of stability and the predictors decreasing the possibility of any systematic loss. A test of the full model with all three predictors against a constant only model was reliable $\chi^2 = 13.22$, df = 3, p < .01 which represents a significant improvement from the Null model. Overall, the model correctly predicts 76.4% of the cases (see Table 4.15) but it is better at
predicting stability (95.5%) than instability (18.2%). Adjusting for skewness in the group membership did not alter the results. Table 4.16 shows Wald statistics and odds ratios of the three predictors. According to the Wald criterion, quality ($z = 4.5, p < .05$) and satisfaction ($z = 3.71, p < .05$) reliably predicted housing stability measured by the CMHS.

Table 4.15: Prediction classification table for Composite Housing Stability Measure

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted</th>
<th>Percent correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>Stable</td>
<td>Unstable</td>
</tr>
<tr>
<td>64</td>
<td>3</td>
<td>95.52</td>
</tr>
<tr>
<td>Unstable</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Overall %</td>
<td>76.4</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.16: Logistic Regression Analysis of Quality, Satisfaction and Choice as a Function of Stability Measured by the Composite Measure of Housing Stability

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>Standard Error</th>
<th>Wald test (z - ratio)</th>
<th>df</th>
<th>p</th>
<th>Odds/ ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction</td>
<td>- 0.33</td>
<td>0.17</td>
<td>3.71</td>
<td>1</td>
<td>.05</td>
<td>0.72</td>
</tr>
<tr>
<td>Quality</td>
<td>- 0.31</td>
<td>0.15</td>
<td>4.50</td>
<td>1</td>
<td>.03</td>
<td>0.73</td>
</tr>
<tr>
<td>Choice</td>
<td>0.07</td>
<td>0.18</td>
<td>0.50</td>
<td>1</td>
<td>.70</td>
<td>1.07</td>
</tr>
<tr>
<td>Constant</td>
<td>6.66</td>
<td>2.50</td>
<td>7.10</td>
<td>1</td>
<td>.008</td>
<td></td>
</tr>
</tbody>
</table>
In summary, all three regressions were significant with two out of three having choice as a predictor and one satisfaction and quality. In the case of choice the results indicate that greater levels of choice were associated with greater risk of instability.
CHAPTER 5

DISCUSSION

One of the main thrusts of the Australian National Mental Health Plan (1992) upholds the right of consumers of mental health services to have “access to the services and opportunities available to others” (p. 15). Results of the study suggest that this objective has been at least partially achieved for people with a mental illness living in a rural community. The correlation between respondents ratings of the importance of access and their ease of access to social networks and community services was high for health services including hospitals, shops, entertainment facilities, place of employment and children’s play areas. The strongest correlation was between importance and ease of access to the house of relatives and friends.

The overall finding supporting access to services appears to contradict the views of Kearns et al. (1989) and Lafave et al. (1995) who found that the mentally ill have limited access to community services. There are at least two possible explanations for this finding. The first is that it may relate to differences in sampling. The study group was from a rural area where housing is less expensive, towns are smaller and accessibility to community services, at least in theory, is better. A second, and more general, explanation is the finding can be understood as a characteristic of a group which has been disenfranchised by the stigma of mental illness resulting in apathy, low self-esteem and resignation that in turn has created a lowering of expectations (Cohen, 1993). However, further research is necessary to determine the factors associated with this finding.
As might be expected of a group of people suffering from a disabling condition and significant social and economic disadvantage, respondents gave their highest priority to access to health care services, shops and family and friends and the lowest priority give to services which were affected by factors such as discretionary expenditure (ie. entertainment, cinemas, restaurants); employment status (ie. access to places of employment, tertiary education institutions); and marital status (ie. primary schools, children’s play areas). Overall, respondents believed that they received the support services they needed. However, while these data lend support to the community management of people with a mental illness they also underscore the social disadvantage brought about by limited income.

The study confirms previous research findings that people with a mental illness suffer from economic disadvantage and that a majority rely on some form of social assistance payment (Baker & Douglas, 1990; Cohen, 1993). The income distribution of respondents was significantly different to that of the Australian population with 93.6% represented in the lowest two income quintiles. Respondents were four times more likely to be in the lowest income quintile which supports the findings of a large number of studies that have identified poverty as a major issue for people suffering from a mental illness (Carling, 1990; Carling & Ridgeway, 1988; Kearns et al., 1989; Lafave et al., 1995; Polak & Warner; 1996; Tanzman, 1993). A corollary of low levels of income is the reliance of respondents on social services benefits (Baker & Douglas, 1990) and their low participation rate in the full-time and part-time workforce. These data are consistent with the results of other studies (Anthony & Dion, 1986; Barber, 1988; Davies & Drummond,
1994; Pandiani et al., 1994; Yeitch et al., 1994). Low net income is also reflected in housing choice, where almost one-half of respondents nominated the cost of housing as a reason for selecting their current place of residence. This is despite the fact that the cost of rental accommodation, for example, in the study was significantly lower than other regions in Australia.

The cost of housing varied considerably according to type of tenure. The highest weekly mean cost was associated with home purchase ($132.25) followed by hostel residents ($126.67), renters ($75.63) and board and lodgings ($66.10). In terms of rental costs, respondents reported median weekly rental payments of $75.00 which was half that of Sydney renters and three quarters that of NSW renters excluding Sydney (ABS, 1994). Given the sample was most similar to Australians in the lowest income quintile, rent as a proportion of income was compared with this group. It demonstrated that respondents expended ten percent more of their income on rental payments than the comparison group (35% v 25%). Paradoxically, over three-quarters of respondents agreed that their housing costs were affordable. One explanation for this is the view that housing choice is related to a combination of characteristics rather than to a single factor such as rental cost or other form of payment for housing (Shlay, 1985). Hence individuals may include the benefits of housing location (already described in terms of access to shopping centres, health care facilities etc.) in their judgements. However, for those respondents who wished to move from their current accommodation, cost was identified as a major constraint.
Lower rental payments were reflected in the type of dwelling occupied. Dwelling types were significantly different to that of other Australians with respondents less likely to live in a separate house (54.5% v 79.3%) and more likely to live in a semi-detached or terrace house (18.8% v 8.1%); a flat unit or apartment (17.9% v 12.5%); or boarding house or hostel (9.0% v 0.2%). These data support evidence that the limited income of respondents means they are unable to afford the same standard of housing to that of the community at large. Yet despite this relative economic disadvantage, two thirds of respondents were living independently in a house or apartment (Owen et al., 1996; Pandiani et al.; Yeitch et al., 1994). Only a small group of respondents were residing in accommodation such as boarding houses and hostels.

As predicted, the number of respondents who could be classified as being in stable housing varied widely according to the definition of stability or instability adopted. Using the criterion of stability used by Srebnick et al. (1995) 43% of the group who had been resident in their current dwelling for less than 12 months could be classified as unstable. This is similar but slightly lower than the proportion reported in the Srebnick et al. (1995) study (51.4%). The next group who could be considered unstable were those who expressed a desire to move, that is there was some likelihood they might move. Thirty four percent of respondents could be considered unstable using this criterion, however, less than half of this group expressed an actual intention to move in the next 12 months. The analysis demonstrated that all of the clients who expressed an intention to move also stated a desire to move (see Table 4.8), suggesting that these measures differ by degree of risk of instability rather than representing independent measures of risk. It also suggests
that different measures of stability may be on a continuum with the largest group being contemplators (desire to move) followed by a smaller group who are planning to move (intention) and finally those who demonstrate the behaviour (actual move). The extent to which desire and intention to move predicts behaviour was not addressed in this study and represents an area for future investigation.

Housing stability measured by the index of security of tenure revealed that 22% of respondents could be considered unstable. While it was not possible to make a direct comparisons with other groups, this level of instability can be considered greater than for Australians in general where higher levels of home ownership represent an important index of security of tenure (National Housing Strategy, 1992). Those at greatest risk of instability using the measures from the survey were respondents who expected to be evicted from their current dwelling (7.9%, n = 8) or had been refused rental accommodation in the past (5.0%, n = 5). When these measures were combined to form the Composite Measure of Housing Stability only one respondent was rated unstable on all three measures and as a consequence could be classified as being in extremely unstable housing conditions.

Testing the relationship of the above measures suggests a level of ambiguity. For example, while analyses of the relationship between the CMHS and desire to move indicated a low level of overall agreement it also showed a high level of correspondence in the stable category. So while the measures reliably identify those respondents who
could be considered stable, this is not the case for instability suggesting the measure may be tapping different aspects of the housing stability variable.

**Prediction of Housing Stability**

As discussed earlier, despite the relative economic disadvantage of respondents which places limits on the type of housing they can afford, respondents reported high levels of satisfaction with the environment in which they lived, the location of their dwelling and access to community services. One explanation for this is that community tenure for many people with a mental illness, although not ideal, is better than alternatives such as institutional care (Srebnick *et al.*, 1995).

There are a number of methodological problems in measuring the quality of housing which creates difficulties in establishing benchmarks for what constitutes a suitable quality of housing. For example, while quality can be measured in terms of compliance with building codes, there is also a subjective element of personal choice which may render such objective criteria redundant (see Evans *et al.*, 2000). If quality of housing is measured by the type of dwelling, then as discussed above, there were significant differences between the study group and Australians in general (Lambert *et al.*, 1999). However, most respondents scored highly on the quality measure based on the Australian Housing Survey (ABS, 1994) which calculated the amount of internal space, whether bedrooms were shared and the availability of amenities respondents.
In relation to choice, two thirds of respondents reported they chose their current dwelling and neighbourhood based on a range of characteristics including cost, location and general characteristics of the dwelling. The remaining one third of respondents who reported they had no choice in the decision making process which is consistent with the study by Srebnick et al. (1995) who found that 39.3% of people surveyed believed they had little or no choice over their housing. Yet paradoxically almost half of the latter group also agreed with the statement “I live here because it is my choice”. This apparent contradiction may be explained by the fact that although the respondent may have been denied initial choice in the selection of their dwelling and neighbourhood, the decision to continue to live there was perceived as being within their control.

**Satisfaction, Quality and Choice as Predictors of Housing Stability**

The ability to choose where one lives is an important issue for mental health consumers (Tanzman, 1993). Choice of housing also has an important influence on housing stability in mentally ill populations (Srebnick et al., 1995). However, with the exception of the Srebnick et al. study, no other studies which have examined this relationship could be found. Similarly, for satisfaction and quality, there was also a paucity of research examining the impact of these variables on housing stability. Yet, it has been argued that quality of housing is an important constructs in terms of mental health outcomes (see Evans et al., 1999). Finally, there is some evidence that greater levels of satisfaction may be linked to housing that was less restrictive (Seilheimer & Doyal, 1996).
In the present study the analysis of the relationship between the predictors and measures of stability suggested that different predictors may be important for different measures of stability. As expected, the study found differences in the relationship between the predictor variable of satisfaction, quality and choice and the measures of housing stability used in the study.

Generally, there were significant differences between stable and unstable groups for satisfaction and choice but less reliably for quality. When these data were subjected to binary logistic regression only choice remained significant indicating that respondents who exercised choice in selecting their dwelling and location were more likely to express a desire to move. This seems to indicate that respondents who selected their own housing in the first place now feel they have subsequent choice and are therefore more inclined to want to move (ie. desire). In other words, the more choice they feel they have, the more likely they are to exercise that choice.

In the case of intentions to move independent sample t-tests also revealed a relationship between choice but not satisfaction or quality. As with desire to move, binary logistic regression confirmed that greater levels of choice were associated with an intention to move in the next 12 months. These findings contradict those of Srebnick et al. (1995) who reported a weak relationship between perceived choice over living environment and greater residential stability. However, the cross-sectional survey methodology used in the current study did not allow examination of whether those respondents who expressed a desire to move actually moved in the period after the survey was completed. Nevertheless
it is interesting to consider implications of this finding from the point of view of risk factors for relapse. It may be that individuals who had no choice in the selection of their accommodation are the group most dependent on mental health services. The priorities of this group may be to strive to have their basic needs for accommodation and social support met; a task that may take up most of their energies. The greatest risk of relapse may come from issues such as symptom management and basic coping skills. Hence, the availability of support, even if it reduces choice over matters such as accommodation needs, may be preferable to some of the alternatives such as institutional care or homelessness. In this context self-determination may be a lower order issue.

However, self-determination is clearly one of the goals of psychosocial rehabilitation and has an important influence on recovery from mental illness (Anthony, 1993). In this context having choice and exercising that choice over where one lives may, in some instances, increase the risk of psychological instability. Alternatively it may mean the individual is moving into better circumstances such as a better quality of housing, more desirable neighbourhood, or closer to family and other support networks which may counter balance any negative impact of moving. In any event it is neither possible nor useful to cocoon individuals from the uncertain impact of change whether it is for better or worse. There is a need for balance between individuals having high levels of perceived choice over their housing and the effects this may have on housing stability, stress and mental health indicators.
Analysis of the relationship between the predictor variables and the CMHS using independent sample t-tests demonstrated a significant relationship between satisfaction and quality but not choice. These relationships were confirmed using binary logistic regression and showed an inverse relationship between the stability measure and the predictor variables. Thus, lower levels of satisfaction and quality were related to greater risk of instability. One explanation for this finding is that the CMHS identifies a group of respondents most at risk to instability because they are renters with no lease, may have been refused rental accommodation in the past, and/or expect to be evicted from their current dwelling. Correspondingly it may be that these groups have the poorest quality accommodation and are hence most likely to be dissatisfied.
Limitations of Study

The study has a number of limitations associated with its design. Firstly, the survey design is subject to mono method bias. Secondly, it did not attempt to assess the impact of the effects the symptoms of mental illness may have had on the responses of participants. Two thirds of the study group reported they suffered from a serious mental illness such as schizophrenia, depression or bi-polar disorder and is possible that the effects of symptoms of illness such as delusional believes or paranoia may influenced the objectivity of some of the data collected.

The survey included people with a mental illness who were registered with the mental health service but it provides no information about those not registered at the time of the survey which could represent up to 50% of the target population (Andrews, 1995). In terms of comparison with other studies, most researchers have utilized different measures so that uniform comparison to other research is either difficult or not possible.

In addition, a lack of knowledge about the reasons 72 (32%) of the randomly selected outpatients were not at home limits the ability to further clarify the representativeness of the sample. Non-responders could not be further followed up (ie. beyond three visits). However, it could be postulated that the timing of the survey might have contributed to the size of this group. The survey was conducted during summer when a number of businesses close down allowing their employees to take annual leave. It is therefore possible that the study under-reports clients who were employed and as a consequence
excluded a group whose income might exceed the modal income of responders. However, the findings of our study are similar to those of others with respect to unemployment (Barber, 1985), income (Tanzman, 1993; Kearns & Taylor, 1989) and accommodation (Human Rights and Equal Opportunities Commission, 1993).

The demographic profile of the study group is similar to that of comparable housing studies in terms of age, gender, marital status, high school-level education and employment (eg. Shutt & Goldfinger, 1995; Srebnick et al., 1994). However, the number of clients with a diagnosis of schizophrenia was a little more than half that of these studies. It is unclear whether this difference is due to the less rigorous approach to establishing a diagnosis used in the current study (asking clients) or because the study group was in fact a less chronic population.

Whilst using ABS survey forms allowed comparison of data with the general Australian population on housing factors, it also limited the ability to assess factors especially those related to choice and satisfaction with housing. In addition, the comparison between the rural mentally ill sample and the Australian Housing Survey (1994) should be treated with some caution because it was not possible to determine if the differences stem from being mentally ill or from living in a rural area.

Despite these limitations the present study does provide one of the few studies of housing issues for people with a mental illness in rural Australia. In addition, it begins to explore the relationship between different measures of housing stability and predictors of housing
stability. Even this preliminary research has potential implications for addressing housing issues in clinical practice.
Implications for Clinical Practice

The argument has been made that decent, affordable housing is an essential condition of recovery from mental illness (Human Rights & Equal Opportunities Commission, 1993). A house provides a buffer from the intrusion of the outside world (Paris, 1993) and living independently with a friend or loved one is an ubiquitous aspiration for people with a mental illness (Tanzman, 1993). There is a burgeoning literature on the plight of the homeless mentally ill and the factors associated with becoming homeless (eg. Drake et al. 1989, 1991). However, while a great deal of research has been undertaken about the causes of homelessness very little research has addressed factors which contribute to stability of housing. In this context, remaining adequately housed in a dwelling of your choice represents an important mental health outcome (Evans, et al., 2000; Srebnick, et al., 1995).

It is therefore important for case managers to monitor housing stability so that they can pick up as early as possible those clients who are at risk to negative outcomes such as homelessness. The three predictor variables of satisfaction, quality and choice used in this study all showed some promise in terms of identifying respondents at risk of becoming unstable. In the case of respondents who expressed a desire or intention to move, higher levels of choice in selecting the dwelling and neighbourhood was the best predictor of risk. This finding was to some extent counter-intuitive. That is, it could be argued that a lack of choice might lead to higher levels of dissatisfaction which might in turn increase the desire and intention to move (ie. instability). Clearly these complex relationships
require further study and longitudinal research to determine the extent to which desire or intention to move predicts actual future moves. Nevertheless, involving consumers as equal partners in decision making is now clearly acknowledged as a national priority (National Mental Health Policy, 1992) but unless partnerships are real (ie. the consumer is given more than one viable option), the consumer may feel they have been given no choice at all (Meagher, 1995). Correspondingly, if a mental health consumer later wishes to move elsewhere (increasing housing instability) they should be allowed to be exposed to the dignity of that risk and supported by their case manager throughout the process.

The variables of satisfaction and quality were significant predictors of the Composite Measure of Housing Stability. This has some face validity in that the measure captures those with the least secure form of tenure and arguably the least desirable housing conditions. From the point of view of clinical management it is important to ensure that issues such as housing quality and satisfaction are monitored. Descriptive data from the present study provide some criteria and comparisons of quality which might be used by case managers with their clients when considering housing options. Future research should be directed at the development of an easily administered measure that can be used routinely by case managers to identify those at risk of housing instability as early as possible.

In summary, there appears to be some advantages associated with rural residency despite the mentally ill still being disadvantaged when compared to the general Australian population. This study provides some qualified evidence that people with a mental illness
living in a rural area have lower housing payments and have relatively good access to community services and family supports. To counter balance this, they live on marginal incomes and experience unacceptable levels of unemployment.

Finally, this is one of the first studies which attempts to compare measures of stability which might in the future be used to better predict very high risk housing instability such as homelessness. Further work is needed to refine these measures so that they can become part of routine clinical practice to facilitate early intervention (ie. action can be implemented to prevent instability or ameliorate the consequences). There is also a need to expand the investigation of potential predictors of instability in order to clarify further when moving may be detrimental versus beneficial for a client’s mental health. Choice as a predictor of instability is something of a double-edged sword in that whilst more choice reflects a desirable level of independence and self-determination there are also potential risks related to increased stress associated with frequent moves. Case manager need to balance these consideration in a process which includes clients participation.
The study suggests that despite the fact that a large majority of respondents have low incomes, they are more likely to be renters than owners, and live in an inferior dwelling to that of Australians in general. Over three-quarters of the sample liked where they lived and believed they had access to the support services they needed. Respondents valued privacy, safety and security provided by community tenure in common with other Australians. Their high level of satisfaction with current housing supports evidence that people with a mental illness prefer community living to being in hospital or homelessness (Carling, 1993; Owen et al., 1996). However, these findings confirm the need for government policies that address the housing needs of the mentally ill and in particular the level of economic disadvantage that they bear. The development of interdepartmental relationships such as now exists between NSWHealth and the NSW Department of Housing is essential if this disadvantage is to be addressed. In addition, mental health case managers need to be well informed about public housing policy to ensure that clients who are eligible for public housing get their proper entitlement.

The study found that measures of satisfaction, quality and choice appear to tap different aspects of the housing stability – instability continuum. Choice and to a lesser extent, satisfaction, were useful in predicting respondents classified as stable using the criteria of desire to move in the next 12 months and actual intention to move. However, choice and satisfaction did not reliably predict the group classified as unstable. While it is useful to
identify individuals that are currently in stable accommodation, further refinement of the measures is needed in terms of their ability to be used as early predictors of housing instability. When using the Composite Measure of Housing Stability that tapped security of tenure, satisfaction and quality of housing were better predictors.

The study did not establish a single index that predicted housing instability across all groups. However, it should be noted that the group in the least secure accommodation (i.e., highest risk of housing instability) as measured by the CMHS applied to less than 10% of those surveyed. Membership of this group could be determined by addressing a simple measure such as security of tenure that may reflect more immediate concerns or risk of instability. If factors such as security of tenure were not problematic then one could review quality and choice as other predictors. While the measure of housing choice used in the study identified respondents classified a stable, the important mediating role of self-determination in recovery from mental illness suggests that it will play a crucial role in contemporary policy development. The role of choice should also be the focus of continuing investigation to further understand its relationship to housing stability.

Limitations in the design of the current study associated with the confounding influence of mental illness and rural residence should also be addressed. The use of a measure of mental status such as the Brief Psychiatric Rating Scale (Overall & Gorham, 1962) could be used to further investigate the impact of symptoms on respondent’s perceived housing needs. This would help to address the extent to which the differences identified between
the study group and the comparison group (ABS, 1994) are associated with rural residence alone.

Finally, this is one of the first studies that attempt to address the development of measures that can be used to predict the risk of housing instability. However, the cross-sectional nature of the study has only allowed for only a preliminary investigation of the relationship of measures of housing stability and the predictor variables of satisfaction, choice and quality. It has not established whether these measures are robust enough be used in clinical practice. This will require further refinement of the measures and a longitudinal study to test their reliability and validity. The negative mental health outcomes associated with unstable housing including the risk of homelessness make this an important area for future research.
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Trauer, T. Personal communication.


APPENDIX 1

HOUSING NEEDS OF CONSUMERS OF MENTAL HEALTH SERVICES IN RURAL NEW SOUTH WALES, AUSTRALIA

GORDON LAMBERT, PAOLO RICCI, ROSS HARRIS & FRANK DEANE

SUMMARY
A survey of the housing needs of 101 people with mentally illness treated by the Central Western Area Mental Health Service were compared with data from the 1994 Australian Housing Study (Australian Bureau of Statistics). The results indicate that people with mental illness want housing similar to Australians in general. However, unemployment or very low incomes may affect their ability to realise their housing choices. Despite very low incomes most in the survey felt their rent was affordable. Preferences for housing types and factors relating to housing choice are described. The results are discussed in relation to the importance of housing in maintaining mental health.

INTRODUCTION
The "Australian Dream" is to own one's own home so it is not surprising that Australia has one of the highest levels of home ownership in the developed world. In New South Wales it is estimated that 70% of 2.2 million households own, or are buying, their home while 20% of households rent privately and 6% rent public housing (Knowles, 1995). In rural Australia the level of home purchase or ownership is higher at 77% and public and private rented accommodation correspondingly lower at 15% (Family Survey, ABS, 1992).

The National Housing Strategy Issue Paper No 6 (1992, p. 2) states that "appropriate housing is essential if people are to participate fully in society". The "home" is the place where we will spend most of our time (Paris, 1993). Home is not only the place where we were born and the centre for domestic production, but it is also where we undertake most of our leisure activities. It is a place of security and protection from a sometimes hostile world (Paris, 1993). A home, then, is not just a configuration of building materials, not simply a dwelling place, it has a more symbolic meaning which denotes a family or group living and growing together and individuals enjoying the dignity of personal space.

Housing has equally important implications for individuals who suffer from mental illness. The assumption that mental illness can be explained in biological terms discounts the impact of its social, psychological and behavioural dimensions (Engels, 1977). As Kety (1974, p. 961) points out in the case of schizophrenia we need to examine "how experiential factors and their interaction with biological vulnerability make it possible or prevent the development of schizophrenia". Zubin and Spring's (1977) stress vulnerability model of schizophrenia compels us to consider not only the management of an individual's clinical
symptoms, that is the treatment of their biological needs, but also the extent to which the environment in which the person lives may act as a stressor and thus may contribute to relapse. As Harrison et al. (1994) state ‘Schizophrenia does not have a natural history that unfolds independent of its culture and social milieu’. Earls and Nelson (1988) support this view by suggesting that quality of housing may be a mitigating factor allowing the mentally ill individual to devote their energy to meeting other needs. Newman et al. (1994) postulate that those who experience the greatest improvement in housing should display the greatest improvement in treatment outcome. In reference to housing the Report of the Human Rights and Equal Opportunity Commission’s National Enquiry into the Human Rights of People with Mental Illness (1993) puts it bluntly. ‘Living with a mental illness – recovering from it – is difficult even in the best of circumstances. Without a decent place to live it is virtually impossible’ (p. 337).

This last statement reflects professional opinion on the central role of housing for people with mental illness during their recovery. The literature on where people with a mental illness wish to live is growing (Carling, 1993; Owen et al. 1996). For example, Carling (1993) believes mental health consumers prefer to live independently in their ‘home’ with a friend or loved one, rather than in a ‘therapeutic’ facility. Tanzman (1993), in a review of 43 studies of mental health consumer preferences, supports this viewpoint, but notes that consumers must have some form of income, access to rental subsidies, a telephone, access to transportation and 24 hour availability of outreach staff. She adds that consumers do not want to live with others who are mentally ill; and that they want the support of mental health workers only when it is needed.

Others have conducted that there is a need for a range of accommodation options (Carling, 1993), including highly supervised permanent accommodation, such as the ‘ward in house’ (Shepherd, 1995) and 24 hour supervised hostels for individuals with a history of long term hospitalisation (Gibbons & Butler, 1987). However, Hodgkins et al. (1990), compared a group of mental health consumers living in supervised apartments with a group living in their own homes and found that life in supervised apartments was more stressful because of the high expectations and intrusiveness of staff. An Australian study by Owen et al. (1996) on the housing preferences of a group of clients attending a community treatment service reinforces this view. This study found that most respondents preferred to live alone in an environment of low behavioural expectation or in their own home. The least preferred option was being homeless or in long term hospitalisation. ‘For profit’ boarding houses were preferred to psychiatric group homes, a preference that may reflect the behavioural expectation of the respective facilities on the residents.

Being housed is necessary for successful adjustment to community living for people with a mental illness; but the affordability of housing is a major barrier (Carling, 1993; Keck, 1990; Carling & Ridgeway, 1989; Carling, 1990; Aronson & Fitzpatrick, 1990). Affordability has two aspects, namely, the cost of housing and an individual’s ability to meet those costs within a limited budget. The Human Rights and Equal Opportunities Commission (1993) found that most accommodation, in Australia, for people with a mental illness is expensive and substandard. Furthermore, it is often unavailable. Added to this mix are findings from a South Australian study that found 88% of people discharged from a psychiatric hospital remained unemployed (Barber, 1985). This helps to develop a link between mental illness and poverty (Lafave et al. 1995; Kearns & Taylor, 1989) and in this context, it is not
surprising that people with a mental illness expend 50–80% of their income on rent (Carling, 1993, 1990; Benson, 1989). The 1988–89 Australian Household Expenditure Survey found that the households in the lowest income quintile, who occupy private rental accommodation, on average pay more than 50% of their weekly earnings for housing (Benson, 1989; ABS, 1989) and there is evidence that the mentally ill are over-represented in this income group (Tanzman, 1993). In the case of rural dwellers housing is generally more affordable because mortgage repayments and rentals are lower (due to generally cheaper housing). However, this must be traded off against higher rates of unemployment and more limited access to services, jobs and transportation (National Housing Strategy, 1992).

The research context for this paper is that housing availability, affordability and tenure are critical socio-economic factors and have important theoretical and practical implications for the well-being of individuals who suffer from mental illness. Consideration of these factors is vital to any analysis of psychosocial rehabilitation particularly with respect to recovery from mental illness.

However, prior studies have suffered from methodological limitations. Goldman et al. (1995) reviewed 21 studies that assessed the housing needs of people with a mental illness. They found that most consumer preference questionnaires were designed by mental health professionals or consumers without reference to expenses in housing. In addition, Carling (1993) noted that few studies of residential programs were based on a probabilistic sample. Furthermore, two of the most frequent questions used in these measures attempted to determine whether community care was superior to hospital treatment and the level of mental health support required by consumers, rather than focusing on consumer satisfaction with housing.

Some studies of consumer housing preferences rely on the views of staff or the interpretation of raters engaged to conduct client interviews, rather than directly seeking the views of the consumer (Susnick, 1993; Goering et al. 1992). Other studies seek consumer preferences for hypothetical types of housing, a construct that may idealise benefits and de-emphasise or ignore disadvantages (Shlay, 1985). Finally, Goldman et al. (1995) point out that many surveys of housing need do not take into account the constraints of income, the availability and accessibility of support services, medical practitioners and mental health services.

The present study aimed to address a number of these methodological limitations in assessing the housing preferences and needs of a group of mentally ill people supported by a rural health service in New South Wales. Our findings are qualitatively compared with the results obtained by the Australian Bureau of Statistics (ABS) from the Australian Housing Survey (1994a).

METHOD

The survey assessed the housing preferences of a group of mentally ill people supported by three Rural Health Districts in New South Wales, which comprised an area of 63,262 square kilometres and a population of 172,660 (McLennan & Flannagan, 1994, 1995a, 1995b). The group surveyed was randomly selected from a client population registered with the Central Western Area Mental Health Service. In order to be included in the survey, each individual client must have been a registered client of that Mental Health Service.
Measures
The questionnaire used in the present study was adapted from two instruments, the Australian Bureau of Statistics for the Australian Housing Survey (1994a) and the Boarding House Survey (unpublished). These instruments were used to measure respondent's satisfaction with housing, access to services and income. The final questionnaire comprised 133 items of which 110 were taken directly from the ABS questionnaires. The remaining 23 supplementary questions were developed from a review of the literature and sought information specific to the needs of people with a mental illness. The questions were presented in two main forms: those which sought demographic information and those which required the respondent to rate specific variables on a five point scale. Flash cards were used where an item required the respondent to consider a number of categories such as income group or housing choice. The questionnaire was reviewed and modified in consultation with the Australian Bureau of Statistics and piloted on a small group of clients. It was administered in accordance with the guidelines developed for prior ABS surveys and took 30 minutes to complete.

Participants
A list of outpatient clinics, who were registered at the time of the survey, was obtained from the Central West Mental Health Service Data Base for each of the three health districts surveyed (i.e.: Evans, Lachlan and Central West Health Districts) and a supported housing program which formed part of the community mental health service. Ten percent of each sub group was randomly selected from the register. Clients who did not have contact details recorded were excluded from the study. The name, address and telephone number of each client selected was recorded in order of selection with the appropriate ethical safeguards. The survey was conducted between December 1995 and February 1996. The hospitalised sample comprised clients who volunteered to participate in the study and who attended a discharge planning group at the regional acute admission unit during the period of the study.

A total of 224 clients were approached to participate (outpatients n = 186, inpatients n = 38) and 101 surveys were completed (outpatients n = 77, inpatients n = 24) providing a response rate of 45.1%. Of the 123 clients who did not participate 51 refused (37 outpatients and 14 inpatients) and research assistants could not contact 72 at their place of residence after three visits. We believe the refusal rate of 34% (51/152) of those actually surveyed is satisfactory for this sample. However, our lack of knowledge about why 32% (72/224) of the randomly selected sample were not at home limits our ability to generalise the findings to the larger rural mentally ill population. Despite this, for some self-report surveys response rates between 25% and 45% have been found to be demographically representative of hospital and general populations (e.g. Press & Ganey, 1989).

Of the 101 clients who completed the questionnaire 53.5% were male and 49.5% had never married. The mean age of respondents was 39.6 years (standard deviation = 14.5 years). Over three-quarters of respondents stated they had a diagnosis of mental illness and 13.9% stated they had no mental illness: 36.6% of respondents named their illness as schizophrenia and 29.7% understood their diagnosis to be depression or bipolar illness.

Procedure
Research assistants first attempted to contact clients by telephone to determine whether they were willing to participate. If the client could not be contacted by telephone or did not have
a telephone, they were visited at the address listed on the data base. Clients were excluded from the study if: they were not at home on three consecutive visits, if the address on the data base was incorrect, or they had moved out of the area. A total of 110 questionnaires were completed. However, nine of the clients surveyed were under the age of 18 and were subsequently excluded from the final sample. The remaining 101 clients were drawn from the State hospital (n = 24), a community satellite housing program (n = 9) and a community mental health service (n = 68).

The research assistants were third year health science students who all undertook a training program in standardised administration of the questionnaire and the use of flash cards to facilitate the administration of questions where a choice needed to be made from an extensive list of variables.

RESULTS

Income
The income distribution of respondents was positively skewed and is clearly different to that of the general Australian population. A majority of respondents (75.2%) reported they received some form of government benefit as their primary source of income and 87.1% were in the lowest two income quintiles whereas ABS statistics indicated that 36% of the Australian general population fell into these two lower quintiles (ABS, 1994b: see Table 1). Less than 10% of respondents were in full-time or part-time paid employment and only 4.5% listed some form of employment as their main source of income.

Housing needs
Less than one third of respondents (28.8%) were living in accommodation that they owned or were purchasing. According to the ABS Housing Survey almost three-quarters of Australian families (70.5%) own or were purchasing their home. Furthermore, 41.6% of respondents in the mental health survey were living in rented accommodation. whereas the ABS Housing Survey found 29.5% of Australian families rent. Table 2 provides a more detailed comparison of housing tenure type between this sample of people with mental illness and the ABS Housing Survey. Chi-square analysis confirmed that these differences were statistically significant ($\chi^2 = 570.63, df = 5, p < .001$).

Table 1

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Income Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First and Second</td>
</tr>
<tr>
<td>NSW Mentally Ill Sample</td>
<td>88</td>
</tr>
<tr>
<td>%</td>
<td>(87.1)</td>
</tr>
<tr>
<td>ABS</td>
<td>5658</td>
</tr>
<tr>
<td>%</td>
<td>(36.0)</td>
</tr>
</tbody>
</table>

Note. ABS = Australian Bureau of Statistics (1994) sample statistics obtained from Australian Housing Survey
### Table 2
Tenure of respondents compared to tenure data from Australian Housing Survey 1994

<table>
<thead>
<tr>
<th>Tenure Type</th>
<th>Mentally Ill Sample</th>
<th>ABS</th>
<th>Expected Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Owned by self</td>
<td>15</td>
<td>(14.85)</td>
<td>5965</td>
</tr>
<tr>
<td>Being purchased by self</td>
<td>14</td>
<td>(13.86)</td>
<td>4246</td>
</tr>
<tr>
<td>Rented – Public</td>
<td>17</td>
<td>(16.83)</td>
<td>976</td>
</tr>
<tr>
<td>Rented – Private</td>
<td>25</td>
<td>(24.75)</td>
<td>2583</td>
</tr>
<tr>
<td>Rent free</td>
<td>10</td>
<td>(9.90)</td>
<td>243</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>(19.8)</td>
<td>87</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>(100.0)</td>
<td>14100</td>
</tr>
</tbody>
</table>

Note. ABS = Australian Bureau of Statistics (1994) sample statistics obtained from Australian Housing Survey

The median weekly rent of respondents was A$75, which falls below the median for Sydney A$152, for renters in New South Wales excluding Sydney (A$100), and for the rest of Australia (A$119). The lower median rental payment of respondents is also reflected in their type of dwelling. For example, these respondents are less likely to live in a separate house than other Australians (54.5% v. 79.3%); and more likely to live in a semi-detached or terrace house (18.7% v. 8.1%), flat, unit or apartment (17.8% v. 12.5%) or in a group home (9.0% v. 0.2%). In terms of the cost of rent, mortgage or board, 70% of the sample with mental illness stated that their housing-related payments were affordable.

One-third of the respondents had lived in their current residence for less than one year or more, one-third had lived in their current residence for between one year and less than 10 years, while the remaining one-third of respondents had occupied their current residence for more than 10 years. Slightly more than one-half of the respondents wanted to remain in their present accommodation (55.6%), one-third wished to move from where they were living (34.3%), and a small group (10.1%) stated they did not know what they wanted to do. For those respondents who wanted to move, the main reasons which prevented them from doing so were essentially economic, namely, the cost of moving, the inability to meet rental payments, unemployment, or that there was nowhere else for them to go.

Table 3 provides a comparison of respondents’ rating of the importance of access and ease of access to specific community services. Respondents stated that cost and proximity to family and friends were the main reasons for choosing their current area of residence. Other reasons given by respondents for choosing the area in which they lived included descriptions such as ‘nice area’ or ‘familiar area’ and access to shops and health care facilities. Cost and the availability of space were the major reasons given by half of the respondents for choosing their place of residence, with privacy and the quality of the dwelling also considered to be important. One-third of respondents stated they had no choice in selecting their home.

Where importance of access to community facilities, family, friends and public transport was high respondents reported corresponding levels of satisfaction with their ease of access to these supports. In particular, access to doctors, dentists and health care facilities, hospitals, shops and the houses of family and friends were rated as very important to important by
Table 3
Percentage of respondents who rated access to health care facilities, transport, community services, family and friends as very easy to easy and their importance of access as very important to important

<table>
<thead>
<tr>
<th>Ease of access</th>
<th>Importance of access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shops</td>
<td>83 91</td>
</tr>
<tr>
<td>Place of employment</td>
<td>26 22</td>
</tr>
<tr>
<td>Primary schools</td>
<td>16 21</td>
</tr>
<tr>
<td>Public transport</td>
<td>32 46</td>
</tr>
<tr>
<td>Hospitals</td>
<td>79 90</td>
</tr>
<tr>
<td>Doctors, dentist or other health facilities</td>
<td>89 91</td>
</tr>
<tr>
<td>Entertainment, cinemas, restaurants, theatres</td>
<td>37 61</td>
</tr>
<tr>
<td>Parks, lakes, public open space</td>
<td>51 73</td>
</tr>
<tr>
<td>Sports facilities</td>
<td>29 52</td>
</tr>
<tr>
<td>Houses of friends or relatives</td>
<td>73 76</td>
</tr>
<tr>
<td>Open countryside</td>
<td>59 70</td>
</tr>
</tbody>
</table>

three-quarters of respondents (Table 3). Finally, a majority of respondents stated they liked where they lived (76%) and that they received the support services they needed (81%).

DISCUSSION

The present study surveyed 101 respondents who were being treated by a regional mental health service in rural New South Wales, Australia to investigate housing tenure, income, cost of housing, satisfaction with housing and issues of access to social and community networks. The results support the proposition that the housing needs of people with a mental illness are similar to those of the Australian community, considering affordability, access to community services and access to social support networks (Carling, 1993; Tanzman, 1993).

However, it also reveals that housing profile of consumers of mental health services is significantly different from the housing profile of the general Australian population. Respondents were under-represented as family or individual home purchasers or owners when compared to the Australian population (28.7% v. 70.5%). Moreover, the proportion of public renters in our study group was more than twice that of public renters in the Australian population (16.8% v. 6.9%).

The most striking finding of our study is that 87.1% of respondents were in the lowest two income quintiles, with the majority in the lowest quintile (76.2%). This is consistent with the results of Lafave et al. (1995), and Kears & Taylor (1989), that poverty is a major issue for people suffering from a mental illness. This is also reflected in housing choice, where almost one-half of the respondents nominated the cost of housing as a reason for selecting their current place of residence. The median rental payment of respondents ($75) was substantially less than other Australian renters ($119). However, this result needs to be viewed in the context of the income of respondents and the type of housing they can afford.

The rental payments of respondents represents 40% of median income of the sample.
which is double that of other Australians (ABS, 1994), and thus leaves the respondents with less discretionary income. However, rental payment as a proportion of income for respondents in this study were similar to those reported in the 1988–89 Australian Household Expenditure Survey for individuals in the lowest income quintile.

Paradoxically, over three-quarters of our respondents agreed that their rent, board or mortgage was affordable (n = 77) and that they liked where they lived (n = 76). This may be explained by trade-offs for some of the benefits of housing location, already discussed in terms of access to shopping centres, health care facilities and social networks and by issues of privacy, safety, security of tenure and choice. Our findings support the view that housing choice is related to a combination of characteristics rather than to a single factor such as rental cost or other form of payment for housing (Shlay, 1985). However, for those respondents who wished to move from their current accommodation, economic factors were identified as a major constraint.

A limitation of the study was our lack of knowledge of the reasons 72 (32%) of randomly selected outpatients were not at home. Non-responders were not followed up, however, it could be postulated that the timing of the survey may have contributed to the size of this group. The survey was conducted during summer when a number of businesses close down allowing their employees to take annual leave. It is therefore possible that the study under-reports clients who were employed and as a consequence excluded a group whose income might exceed the modal income of responders. However, the findings of our study are similar to those of others with respect to unemployment (Barber, 1985), income (Tanzman, 1993; Kears & Taylor, 1989) and accommodation (Human Rights and Equal Opportunities Commission, 1993).

In conclusion, the study suggests that despite the fact that a large majority of respondents have low incomes, are more likely to be renters than owners, and live in an inferior dwelling to that of Australians in general, over three-quarters of the sample liked where they lived and believed they had access to the support services they needed. Respondents valued privacy, safety and security provided by community tenure in common with other Australians. Their high level of satisfaction with current housing supports evidence that people with a mental illness prefer community living to being in hospital or homelessness (Carling, 1993; Owen et al. 1996). However, the question of whether this high level of satisfaction is a response to the unattractiveness of perceived alternatives, such as hospitalisation, or that respondents simply do not aspire to improving their housing status or have given up hope of change, is a subject for further investigation. Similarly, the present findings should be contrasted with the housing needs of those living in inner city or metropolitan areas where housing costs may further limit options.

ACKNOWLEDGEMENTS

The authors wish to thank The NSW Department of Health for funding the project and the Central Western Region Mental Health Service for its support in the administration of the survey. We are also grateful to Lyn Beattie for her help with the project. We would also like to thank David Groube and his staff from the Housing Statistics Unit, Australian Bureau of Statistics for his advice in the development of the survey questionnaire and in the analysis
of the results. Finally, we would like to thank the Illawarra Institute for Mental Health for its contribution to the project.

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Gordon Lambert, Department of Public Health and Illawarra Institute for Mental Health, University of Wollongong
Paolo Ricci, University of California. Survey Research Center. Berkeley, CA. USA
Ross Harris, Center for Pain Management Research, University of Sydney
Frank P. Deane, Department of Psychology, University of Wollongong

Correspondence to Gordon Lambert, Department of Public Health and Illawarra Institute for Mental Health, University of Wollongong, Northfields Avenue, Wollongong 2522, Australia
APPENDIX 2

University of Wollongong Human Research Ethics Committee Approval Letter
29 August 1995

Mr W. Lambert,
Department of Public Health & Nutrition
University of Wollongong

Dear Mr Lambert,

I am pleased to advise that the following Human Research Ethics application has been approved:

Ethics Number: HE95/166
Project Title: The housing needs of consumers of mental health services in the Evans, Central West and Lachlan Health Districts
Name of Researcher: W.G. Lambert
Approval Date: 22 August 1995
Duration of Clearance: 21 August 1996

This certificate relates to the research protocol submitted in your application of 1 August 1995. It will be necessary to inform the Committee of any changes to the research protocol and seek clearance in such an event.

Please note that experiments of long duration must be reviewed annually by the Committee and it will be necessary for you to apply for renewal of this application if experimentation is to continue beyond one year.

Chairperson
Human Research Ethics Committee

cc. Head, Department of Public Health & Nutrition
The housing needs of consumers of mental health services in the Evans, Central West and Lachlan Health Districts.

William Gordon Lambert

This research project is being conducted for the Central West Mental Health Service supported by funding from the New South Wales Department of Health. The study will also be used to complete an Honours Master of Science degree supervised by Professor Ross D Harris of the Department of Public Health and Nutrition at the University of Wollongong.

The purpose of this study is to gather information on the housing needs of consumers of mental health services in the Central West of New South Wales. The study will address consumer preferences for housing within the constraints of housing availability, social support networks, income, geography, and functional ability.

The information obtained from the study will be used by the Central Western Region Mental Health Service to plan for better housing options for the future.

If you wish to participate in the study it will involve meeting with the researcher or a research assistant and answering a number of questions about your housing needs. The interview will take about 30 minutes to complete.

The confidentiality of everyone who participates in the study will be protected at all times and all confidential information will be kept under lock.

If you wish to cease your involvement in the study at any time you are free to leave without any penalty or prejudice to your future treatment.
If you have any inquiries regarding the conduct of the research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on (042) 213079.

I understand that the data collected will be used to evaluate the outcome of the study and I consent for the data to be used in that manner.

If you wish to take part in this research please sign below:

............................................. .../.../......
APPENDIX 4

Housing Needs Survey Questionnaire
HOUSING NEEDS SURVEY

The purpose of this study is to gather information on the housing needs of consumers of mental health services in the Central West of New South Wales. Information from the study will be used to plan for better housing options for the future.

ALL INFORMATION WILL BE KEPT IN STRICTEST CONFIDENCE.

First, some questions about you:

1. SEX
   Male . . . . . . [ ]
   Female . . . . . . [ ]

2. AGE
   Years .............

3. MARITAL STATUS
   Married [ ]
   De facto [ ]
   Separated [ ]
   Divorced [ ]
   Widowed [ ]
   Never married [ ]

4. ARE YOU AN ABORIGINAL OR TSI AUSTRALIAN?
   No [ ]
   Aboriginal [ ]
   Torres Strait Islander [ ]

5. WHAT IS YOUR COUNTRY OF BIRTH?
   Australia [ ]
   UK and Ireland [ ]
   Italy [ ]
   Greece [ ]
   Netherlands [ ]
   Germany [ ]
   Viet Nam [ ]
   Other (specify) [ ]

Housing Needs Survey
Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
IN WHAT YEAR DID YOU ARRIVE IN AUSTRALIA?

19

DO/DID YOU HAVE A DIAGNOSIS OF MENTAL ILLNESS?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Yes</td>
<td>[ ]</td>
</tr>
<tr>
<td>No</td>
<td>[ ]</td>
</tr>
<tr>
<td>Unsure</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

IF YES, WHAT IS THE NAME OF THE ILLNESS?


HAVE YOU EVER BEEN ADMITTED TO HOSPITAL FOR YOUR MENTAL ILLNESS?

<p>| | |</p>
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<th></th>
<th></th>
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<tbody>
<tr>
<td>Yes</td>
<td>[ ]</td>
</tr>
<tr>
<td>No</td>
<td>[ ]</td>
</tr>
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</table>

IF YES HOW MANY TIMES?


HOW LONG OVERALL (IN WEEKS) HAVE YOU SPENT IN HOSPITAL?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Number of weeks</td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Now some questions about your present accommodation:

INTERVIEWER SHOW PROMPT CARD 1

IS THIS (SPECIFY DWELLING TYPE)

BEING PAID OFF BY YOU OR YOUR SPOUSE/PARTNER?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 1</td>
<td>Q.14</td>
</tr>
</tbody>
</table>

OWNED OUTRIGHT BY YOU OR YOUR SPOUSE/PARTNER?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 2</td>
<td>Q.14</td>
</tr>
</tbody>
</table>

RENTED BY YOU OR YOUR SPOUSE/PARTNER?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 3</td>
<td>Q.13</td>
</tr>
</tbody>
</table>

BEING PAID OFF BY PARENTS/FAMILY MEMBER?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 4</td>
<td>Q.13</td>
</tr>
</tbody>
</table>

OWNED OUTRIGHT BY PARENTS/FAMILY MEMBER?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 5</td>
<td>Q.13</td>
</tr>
</tbody>
</table>

RENTED BY PARENTS/FAMILY MEMBER?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 6</td>
<td>Q.13</td>
</tr>
</tbody>
</table>

A BOARDING HOUSE/HOSTEL?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 7</td>
<td>Q.13</td>
</tr>
</tbody>
</table>

OTHER (SPECIFY DWELLING TYPE)


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Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
13. DO YOU OR YOUR SPOUSE/PARTNER:-

PAY RENT TO LIVE HERE? [ ]
PAY BOARD TO LIVE HERE? [ ]
LIVE HERE RENT FREE? [ ]
OTHER (specify)

14. HAVE YOU OR YOUR SPOUSE OR PARTNER LIVED IN THIS (specify dwelling type) FOR MORE THAN 10 YEARS?

Yes ............. [ ] ➔ Q.16
No ............. [ ]

15. HOW LONG HAVE YOU LIVED IN THIS (specify dwelling type)

Years ............
Less than 1 year [ ]


Separate house [ ]
Semi-detached / row or terrace house / town house
- one storey [ ]
- two or more storeys [ ]
Flat attached to house [ ]
Other flat / unit / apartment
- In one or two storey block [ ]
- In a three storey or more block [ ]
Caravan / tent /cabin in a caravan park, houseboat in a marina, etc [ ]
Caravan not in a caravan park, houseboat not in a marina, etc [ ]
House or flat attached to a shop or office, etc [ ]
Boarding house or hostel [ ]
Other (specify) .................
........................................ [ ]
17. **HOW MANY OF THE FOLLOWING ROOMS ARE IN THIS (specify dwelling type)?:**

<table>
<thead>
<tr>
<th>a) BEDROOMS?</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Interviewer:</em> Exclude bedsits.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) KITCHENS?</th>
<th>[ ]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>c) SEPARATE TOILETS NOT INCLUDED IN A BATHROOM OR ENSUITE?</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Interviewer:</em> If separate toilet(s) identified probe:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d) (IS THERE AN OUTSIDE TOILET?)</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ..................................</td>
<td>[ ]</td>
</tr>
<tr>
<td>No ..................................</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>e) BATHROOMS AND ENSUITES?</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Interviewer:</em> Do not include separate toilets.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>f) LAUNDRIES?</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Interviewer:</em> Do not include laundries incorporated into other rooms eg bathrooms</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>g) FAMILY, LOUNGE, DINING AND COMBINED LOUNGE / DINING ROOMS?</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Interviewer:</em> Include bedsits</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>h) STUDIES AND SUNROOMS?</th>
<th>[ ]</th>
</tr>
</thead>
</table>

| i) OTHER ROOMS? | (Specify) .................................................. |

18. **DOES YOUR (specify dwelling type) HAVE THE FOLLOWING AMENITIES?:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

- **SAFE STORAGE SPACE FOR YOUR PERSONAL VALUABLES?**

| ![ ] | ![ ] |

- **STORAGE FOR CLOTHING OTHER POSSESSIONS?**

| ![ ] | ![ ] |

- **WORKING COOKING FACILITIES?**

| ![ ] | ![ ] |

- **ADEQUATE COOKING/BENCH SPACE?**

| ![ ] | ![ ] |

- **SINK OR BASIN WITH WORKING TAPS?**

| ![ ] | ![ ] |

- **A WORKING BATH OR SHOWER CONNECTION?**

| ![ ] | ![ ] |

- **A WORKING TOILET?**

| ![ ] | ![ ] |

- **A WORKING REFRIGERATOR?**

| ![ ] | ![ ] |

- **None of these**

19. **ARE YOU SATISFIED WITH THE FOLLOWING ASPECTS OF THIS (specify dwelling type):**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

- **THE AMOUNT OF NATURAL LIGHT?**

| ![ ] | ![ ] |

- **THE NOISE LEVELS FROM NEIGHBOURS?**

| ![ ] | ![ ] |

- **THE SAFETY AND SECURITY OF THE (BUILDING / PROPERTY)?**

| ![ ] | ![ ] |
20. *Interviewer show prompt card 2*

**USING THIS SCALE, HOW WOULD YOU RATE SATISFACTION WITH GETTING TO:**

<table>
<thead>
<tr>
<th>WORK?</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very poor</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>SHOPS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**DOCTORS, DENTISTS AND OTHER HEALTH SERVICES?**

<table>
<thead>
<tr>
<th>d</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very poor</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>HOSPITAL?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**PUBLIC TRANSPORT?**

<table>
<thead>
<tr>
<th>c</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very poor</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**PARKS AND OTHER PUBLIC GARDENS OR RECREATIONAL FACILITIES?**

<table>
<thead>
<tr>
<th>f</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very poor</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
21. USING THIS SCALE, HOW WOULD YOU RATE YOUR SATISFACTION WITH THE LOCATION OF THIS (specify dwelling type)?

- Excellent
- Good
- Fair
- Poor
- Very poor
- Not applicable

22. ON THE SAME SCALE, HOW WOULD YOU RATE YOUR OVERALL SATISFACTION WITH (specify dwelling type)

- Excellent
- Good
- Fair
- Poor
- Very poor
- Not applicable

23. DO YOU (MEMBERS OF THIS HOUSEHOLD/YOU) OWN A MOTOR VEHICLE

- Yes
- No
24. WHAT FORM OF TRANSPORT DO YOU MOST FREQUENTLY USE TO GET TO SHOPS, SERVICES, VISIT FRIENDS ETC?

Drive a motor vehicle [ ]
Driven by spouse /partner [ ]
Driven by family / friends [ ]
Driven by mental health worker [ ]
Taxi [ ]
Bus [ ]
Train [ ]
Motor cycle [ ]
Walk / Bicycle [ ]
Never go out [ ]
Other (specify) [ ]

GO TO ➔ Q26

25. DO YOU HAVE REGULAR ACCESS TO TRANSPORT OTHER THAN WALKING OR BICYCLE?

Yes [ ]
No [ ]

Sequence Guide

If a home buyer ('1' in Q12) ➔ Q26
If a home owner ('2' in Q12) ➔ Q26
If a renter ('3' in Q12) ➔ Q28
If living with parents/family member(s) ('4', '5' or '6' in Q12) ➔ Q35
If living in a boarding house/hostel ➔ Q37
If hospitalised ➔ Q46

26. IS THIS (specify type of dwelling) THE FIRST HOUSE THAT YOU (OR YOUR SPOUSE/PARTNER) (HAS/HAVE) PURCHASED?

Yes [ ]
No [ ]

27. HOW MUCH WAS THE LAST PAYMENT ON YOUR HOUSING LOAN MORTGAGE AND WHAT PERIOD DID IT COVER?

Amount $…………..
Weeks ………… ➔ Q48

28. DO YOU (OR YOUR SPOUSE/PARTNER) HAVE A LEASE OR OTHER FORM OF SECURE TENURE?

Yes [ ]
No [ ] ➔ Q30

Housing Needs Survey
Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
### 29. HOW MANY MONTHS ARE LEFT ON THE LEASE TENURE?

<table>
<thead>
<tr>
<th>Months</th>
<th>..........</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indefinite</td>
<td>[ ]</td>
</tr>
<tr>
<td>Don’t know</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 30. HOW MUCH RENT DO YOU (OR YOUR SPOUSE/PARTNER) CURRENTLY PAY AND WHAT PERIOD DOES IT COVER?

<table>
<thead>
<tr>
<th>Amount</th>
<th>..........</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks</td>
<td>..........</td>
</tr>
</tbody>
</table>

### 31. Interviewer: Show prompt Card 3

**WHO DO YOU (OR YOUR SPOUSE/PARTNER) PAY RENT OR BOARD TO?**

- Real estate agent [ ] 01
- State housing commission/trust [ ] 02

#### Person not in the same household:

- Parent/other relative [ ] 03
- Other person [ ] 04

#### Person in the same household:

- Parent/other relative [ ] 05
- Other person [ ] 06
- Owner/manager Caravan park [ ] 07

### 32. IS THE (specify part of dwelling) PROVIDED FURNISHED OR UNFURNISHED?

- Furnished [ ]
- Part furnished [ ]
- Unfurnished [ ]

### 33. HAVE YOU EVER BEEN REFUSED RENTAL ACCOMMODATION?

- Yes .......... [ ] 1
- No .......... [ ] 2 → Q48
34. WHY WERE YOU REFUSED RENTAL ACCOMMODATION?

- Ethnicity/race
- Family type
- No references
- No pets
- No groups
- Family too large
- Unable to pay bond/rent in advance
- Disabled (mental illness)
- Age
- Unemployed
- Students
- Don’t know
- Other (specify) ................................

GO TO ➔ Q48

35. HOW MUCH BOARD DO YOU (OR YOUR SPOUSE/PARTNER) CURRENTLY PAY AND WHAT PERIOD DOES IT COVER?

- Amount $ ............
- Weeks ...............
38. WHICH OF THESE DESCRIBES THE PART OF THE (specify dwelling type) IN WHICH YOU BOARD OR LODGE?

- A room in this dwelling [ ]
- Shared room [ ]
- A self contained flat [ ]
- A sleepout [ ]
- A bungalow [ ]
- A granny flat [ ]
- A garage in the grounds [ ]
- A caravan in the grounds [ ]
- Other (specify) .................................

39. ARE ANY OF THE FOLLOWING FACILITIES SHARED BY YOU?

<table>
<thead>
<tr>
<th>Facility</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kitchen?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Laundry?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Bathroom?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Toilet?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Recreation/TV Room?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Any other facilities?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

(Specify)

.................................

None of the above [ ]

40. WHICH OF THESE SERVICES, IF ANY DOES THIS BOARDING HOUSE/HOSTEL OFFER?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision and dispensing of medication</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Doctors appointments made for you</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Your money is looked after by the management of the boarding house/hostel</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Your linen is washed for you</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Clean linen is provided</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Clothes are washed for you</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Recreational facilities</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Morning meal</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Midday meal</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Evening meal</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>None of these ....</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Q44

Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
41. WHICH OF THESE SERVICES, IF ANY DO YOU USE?

- Supervision and dispensing of medication [ ]
- Doctors appointments made for you [ ]
- Your money is looked after by the management of the boarding house/hostel [ ]
- Your linen is washed for you [ ]
- Clean linen is provided [ ]
- Clothes are washed for you [ ]
- Recreational facilities [ ]
- Morning meal [ ]
- Midday meal [ ]
- Evening meal [ ]
- None of these ..... ➔ Q44

42. IS THE COST OF ANY OF THESE SERVICES INCLUDED IN YOUR BOARD?

- All .......... .... [ ] ➔ Q44
- Some [ ]
- None [ ]

43. HOW MUCH EXTRA DO YOU HAVE TO PAY IN TOTAL FOR THESE SERVICES EACH WEEK?

- Amount $................
- Don't know [ ]

44. HAVE YOU EVER BEEN REFUSED RENTAL ACCOMMODATION?

- Yes ................. [ ] 1
- No ........ ➔ Q48 [ ] 2

45. WHY WERE YOU REFUSED RENTAL ACCOMMODATION?

- Ethnicity/race [ ]
- Family type [ ]
- No references [ ]
- No pets [ ]
- No groups [ ]
- Family too large [ ]
- Unable to pay bond/rent in advance [ ]
- Disabled (mental illness) [ ]
- Age [ ]
- Unemployed [ ]
- Students [ ]
- Don't know [ ]
- Other (specify) [ ]

GO TO ➔ Q48
46. CAN YOU TELL ME ABOUT THE DWELLING YOU LIVED IN BEFORE YOU WERE ADMITTED TO HOSPITAL?

Separate house [ ]

Semi-detached / row or terrace house / town house
- one storey [ ]
- two or more storeys [ ]

Flat attached to house [ ]

Other flat / unit / apartment
- In one or two storey block [ ]
- In a three storey or more block [ ]

Caravan / tent / cabin in a caravan park, houseboat in a marina, etc [ ]

Caravan not in a caravan park, houseboat not in a marina, etc [ ]

House or flat attached to a shop or office, etc [ ]

Boarding house or hostel [ ]

Other (specify) ......................... [ ]

47. WAS THAT (Specify dwelling type)

RENTED BY YOU OR YOUR SPOUSE? [ ] 1

BEING PAID OFF OR OWNED OUTRIGHT BY YOU (OR YOUR SPOUSE/PARTNER)? [ ] 2

RENTED BY YOU PARENTS/ FAMILY? [ ] 3

BEING PAID OFF OR OWNED OUTRIGHT BY YOUR PARENTS? [ ] 4

None of these [ ] 5

GO TO ➔ Q51

48. WOULD YOU LIKE TO MOVE OUT OF THIS DWELLING?

Yes [ ] 1 ➔Q51

No [ ] 2 ➔Q51

Don't know [ ] 3 ➔Q51
49. WHAT, IF ANYTHING, IS STOPPING YOU FROM MOVING OUT OF THIS DWELLING?

<table>
<thead>
<tr>
<th>Option</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nowhere to go</td>
<td></td>
</tr>
<tr>
<td>Can't afford to move</td>
<td></td>
</tr>
<tr>
<td>Rent's too expensive</td>
<td></td>
</tr>
<tr>
<td>Wouldn't allow pets</td>
<td></td>
</tr>
<tr>
<td>Wouldn't allow children</td>
<td></td>
</tr>
<tr>
<td>Wouldn't allow groups</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
<tr>
<td>Nothing</td>
<td></td>
</tr>
</tbody>
</table>

50. HOW LONG DO YOU INTEND TO STAY IN THIS DWELLING?

<table>
<thead>
<tr>
<th>Option</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td></td>
</tr>
<tr>
<td>1 up to 2 years</td>
<td></td>
</tr>
<tr>
<td>2 up to 3 years</td>
<td></td>
</tr>
<tr>
<td>3 up to 4 years</td>
<td></td>
</tr>
<tr>
<td>4 up to 10 years</td>
<td></td>
</tr>
<tr>
<td>10 years or more</td>
<td></td>
</tr>
<tr>
<td>Don't know/ indefinite</td>
<td></td>
</tr>
</tbody>
</table>

51. Interviewer use prompt card 4

WHAT DO YOU CONSIDER IS THE MAIN ADVANTAGE OF LIVING IN THIS / THAT AREA?

Interviewer:
If respondent is currently in hospital, the area in which they lived before admission.

<table>
<thead>
<tr>
<th>Advantage</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close to nearest city/town</td>
<td></td>
</tr>
<tr>
<td>Close to work</td>
<td></td>
</tr>
<tr>
<td>Close to schools/colleges</td>
<td></td>
</tr>
<tr>
<td>Close to shops/services/recreation areas</td>
<td></td>
</tr>
<tr>
<td>Convenient to public transport</td>
<td></td>
</tr>
<tr>
<td>Close to family/friends</td>
<td></td>
</tr>
<tr>
<td>Quiet location</td>
<td></td>
</tr>
<tr>
<td>Price</td>
<td></td>
</tr>
<tr>
<td>No advantage</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
52. Interviewer use prompt card 5

WHAT DO YOU CONSIDER IS THE MAIN ADVANTAGE OF LIVING IN THIS DWELLING?

Interviewer:
If respondent is currently in hospital, the dwelling in which they lived before admission.

<table>
<thead>
<tr>
<th>Option</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large dwelling</td>
<td></td>
</tr>
<tr>
<td>Small dwelling</td>
<td></td>
</tr>
<tr>
<td>Owning own home</td>
<td></td>
</tr>
<tr>
<td>Privacy</td>
<td></td>
</tr>
<tr>
<td>Large yard</td>
<td></td>
</tr>
<tr>
<td>Small yard</td>
<td></td>
</tr>
<tr>
<td>Pleasant appearance /character</td>
<td></td>
</tr>
<tr>
<td>Safety security</td>
<td></td>
</tr>
<tr>
<td>Low maintenance</td>
<td></td>
</tr>
<tr>
<td>No advantage</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

I would now like to ask you about the week starting Monday the ....... and ending last Sunday the ....... that is last week.

53. LAST WEEK DID YOU DO ANY WORK AT ALL IN A JOB, BUSINESS OR FARM?

<table>
<thead>
<tr>
<th>Option</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Permanently unable to work</td>
<td></td>
</tr>
</tbody>
</table>

54. (IN THAT JOB) DO YOU WORK:-

<table>
<thead>
<tr>
<th>Option</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOR AN EMPLOYER FOR WAGES OR A SALARY?</td>
<td></td>
</tr>
<tr>
<td>IN YOUR OWN BUSINESS WITH:-</td>
<td></td>
</tr>
<tr>
<td>- EMPLOYEES?</td>
<td></td>
</tr>
<tr>
<td>- NO EMPLOYEES?</td>
<td></td>
</tr>
<tr>
<td>WITHOUT PAY IN A FAMILY BUSINESS?</td>
<td></td>
</tr>
</tbody>
</table>

55. HOW MANY HOURS A WEEK DO YOU USUALLY WORK?

<table>
<thead>
<tr>
<th>Option</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 hours or more</td>
<td></td>
</tr>
<tr>
<td>1 to 34 hours</td>
<td></td>
</tr>
<tr>
<td>Less than 1 hour/ no hours</td>
<td></td>
</tr>
</tbody>
</table>
56. HOW LONG AGO SINCE YOU LAST WORKED FULL-TIME FOR TWO WEEKS OR MORE?

Enter date ....../....../19.....

Under 2 years (no. of weeks) ............

Never worked full-time for two weeks or more but has worked [ ]

Has never worked [ ]

57. Interviewer show prompt card 6

DO YOU CURRENTLY RECEIVE INCOME FROM ANY OF THESE SOURCES?

Yes [ ]

No [ ]  ➤ Q.64

58. WHICH ONES?

A wage or salary from an employer [ ] 1

A wage or salary for your own limited liability company [ ] 2

Family payment [ ] 3

Any other government pension or cash benefit [ ] 4

Maintenance / child support [ ] 5

Superannuation/annuity [ ] 6

Worker’s Compensation

59. Interviewer use prompt card 7

BEFORE TAX IS TAKEN OUT, HOW MUCH DO YOU USUALLY RECEIVE FROM (THIS/THOSE) SOURCE(S) IN TOTAL EACH WEEK?

$  

Group 1: 1 - 57 [ ]

Group 2: 58 - 96 [ ]

Group 3: 97 - 154 [ ]

Group 4: 155 - 230 [ ]

Group 5: 231 - 308 [ ]

Group 6: 309 - 385 [ ]

Group 7: 386 - 481 [ ]

Group 8: 482 - 577 [ ]

Group 9: 578 - 673 [ ]

Group 10: 674 - 769 [ ]

Group 11: 770 - 961 [ ]

Group 12: 962 - 1,154 [ ]

Group 13: 1,155 - 1,346 [ ]

Group 14: 1,347 + [ ]

Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
60. **Interviewer use prompt card 8**

**WHAT IS YOUR MAIN SOURCE OF INCOME?**

- Profit or loss from own business (excluding limited liability company(s) or share in a partnership) [ ]
- Profit or loss from rental investment properties [ ]
- Dividends [ ]
- Interest [ ]
- A wage or salary from an employer [ ]
- A wage or salary from own limited liability company [ ]
- Family Payment [ ]
- Any Government pension or cash benefit [ ]
- Maintenance/child support [ ]
- Worker’s Compensation / Accident or Sickness Insurance [ ]
- Any other regular income [ ]

**Sequence guide**

If receives government pension/benefit Code ‘3’ or ‘4’ in Q58

Otherwise

61. **Interviewer show prompt card 9**

**DO YOU CURRENTLY RECEIVE ANY OF THESE PENSIONS OR BENEFITS?**

- Age pension [ ]
- Service pension (DVA) [ ]
- Disability support pension (Invalid pension) (DSS) [ ]
- Wives pension [ ]
- Carer’s pension [ ]
- Sole parent’s pension [ ]
- Sickness allowance/sickness benefit [ ]
- New start allowance/job search allowance/mature age allowance/unemployment benefit [ ]
- Special benefit [ ]
- Partner allowance [ ]
- None of these [ ] 🔄 Q63

62. **HOW LONG HAVE YOU BEEN RECEIVING THIS ASSISTANCE?**

- Less than 2 years (Record no. weeks) .................
- 2 to 5 years [ ]
- More than 5 years [ ]

Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
63. **Interviewer show prompt card 10**

**DO YOU CURRENTLY RECEIVE ANY OF THESE?**

- Additional family payment [ ]
- Austudy/Abstudy [ ]
- Austudy/Abstudy supplement [ ]
- Disability pension (DVA) [ ]
- War widows pension (DVA) [ ]
- Child disability allowance [ ]
- Home child care allowance [ ]
- Overseas benefit or benefit [ ]
- Other pension/benefit [ ]
- None of these [ ]

64. **DO YOU (OR YOUR SPOUSE/PARTNER) CURRENTLY RECEIVE ANY FORM OF RENT ASSISTANCE?**

- Yes ................ [ ]
- No ................ [ ] ➔ Q67

65. **WHO DO YOU (OR YOUR SPOUSE/PARTNER) RECEIVE THIS RENT ASSISTANCE FROM?**

<table>
<thead>
<tr>
<th>Source</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS</td>
<td>[ ]</td>
</tr>
<tr>
<td>Housing Authority</td>
<td>[ ]</td>
</tr>
<tr>
<td>Veteran’s Affairs</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other <em>(specify)</em></td>
<td></td>
</tr>
</tbody>
</table>

66. **HOW MUCH WAS YOUR LAST RENT ASSISTANCE AND WHAT PERIOD DID IT COVER?**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$...........</td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

Now I’d like to ask you some questions about your health care

67. **DO YOU HAVE ANY OF THE FOLLOWING PEOPLE VISITING YOU?**

- REGISTERED NURSES? [ ]
- MEDICAL PRACTITIONERS? [ ]
- PHYSIOTHERAPISTS? [ ]
- CLINICAL PSYCHOLOGISTS OR PSYCHIATRISTS? [ ]
- SOCIAL WORKERS? [ ]
- OTHER SUPPORT WORKERS *(Specify)*

None of the above [ ] ➔ Q69
68. **Interviewer:** Show prompt card 11

**HOW OFTEN DO THE (Specify each type of professional worker) VISIT YOU AT (Specify dwelling type)**

**(REGISTERED NURSES?)**

Live/work at boarding house/hostel [ ]
Daily [ ]
Weekly [ ]
Monthly [ ]
When required called [ ]

**(MEDICAL PRACTITIONERS?)**

Live/work at boarding house/hostel [ ]
Daily [ ]
Weekly [ ]
Monthly [ ]
When required called [ ]

**(PHYSIOTHERAPISTS?)**

Live/work at boarding house/hostel [ ]
Daily [ ]
Weekly [ ]
Monthly [ ]
When required called [ ]

**(CLINICAL PSYCHOLOGIST/PSYCHIATRISTS?)**

Live/work at boarding house/hostel [ ]
Daily [ ]
Weekly [ ]
Monthly [ ]
When required called [ ]

**(SOCIAL WORKERS?)**

Live/work at boarding house/hostel [ ]
Daily [ ]
Weekly [ ]
Monthly [ ]
When required called [ ]

**(OTHER SUPPORT WORKERS?)**

Live/workboarding house/hostel [ ]
Daily [ ]
Weekly [ ]
Monthly [ ]
When required called [ ]

---

Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
I would like to ask you some questions about your bedroom.

69. HOW MANY PEOPLE SHARE THE BEDROOM WITH YOU.

Number  ..................  
None  [  ]

I would now like to ask about your education.

70. AT WHAT AGE DID YOU LEAVE SCHOOL?

Still at school .....  ➔ Q73
Never went to school [  ]
Under 14 years [  ]
14 years [  ]
15 years [  ]
16 years [  ]
17 years [  ]
18 years [  ]
19 years [  ]
20 years [  ]
21 years and over [  ]

71. SINCE LEAVING SCHOOL HAVE YOU COMPLETED A TRADE CERTIFICATE, DIPLOMA, DEGREE, OR ANY OTHER EDUCATIONAL QUALIFICATION?

Yes  [  ]
No  [  ] ➔ Q73

72. Interviewer show prompt card 12

WHICH OF THESE BEST DESCRIBES THE HIGHEST QUALIFICATION YOU HAVE COMPLETED?

Primary School completed [  ]
Secondary School Qualification [  ]
Teaching Qualification [  ]
Trade Certificate Apprenticeship [  ]
Technician's Certificate / Advanced Certificate [  ]
Certificate other than above [  ]
Associate Diploma [  ]
Undergraduate Diploma [  ]
Bachelor Degree [  ]
Postgraduate Diploma [  ]
Masters Degree / Doctorate [  ]
Other (Specify)  ........................................ [  ]
I would like to ask you some questions about why you chose to live in the area in which you currently reside.

73. **Interviewer show prompt card 13**

WHAT WERE ALL THE REASONS YOU CHOSE TO LIVE IN THIS AREA?

<table>
<thead>
<tr>
<th>No Choice</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Someone else chose it for me</td>
<td>01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Could Afford</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing is in my price range</td>
<td>02</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proximity to Work</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>It's handy to where I work</td>
<td>03</td>
</tr>
<tr>
<td>It's handy to my spouse/partner's work</td>
<td>04</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neighbourhood Services (cont)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Has good access to public transport</td>
<td>05</td>
</tr>
<tr>
<td>Has good access to health and/or medical services</td>
<td>06</td>
</tr>
<tr>
<td>It is close to shopping facilities</td>
<td>07</td>
</tr>
<tr>
<td>There is a good choice and availability of recreational/cultural facilities</td>
<td>08</td>
</tr>
<tr>
<td>Has good access to child care facilities</td>
<td>09</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neighbourhood Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is a scenic / environmentally attractive area</td>
<td>11</td>
</tr>
<tr>
<td>Has a close community feel</td>
<td>12</td>
</tr>
<tr>
<td>Am familiar with area</td>
<td>13</td>
</tr>
<tr>
<td>It is an area with houses of good quality</td>
<td>14</td>
</tr>
<tr>
<td>It is an area with people of similar age and/or background</td>
<td>15</td>
</tr>
<tr>
<td>It's a safe area</td>
<td>16</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family / Social Contacts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Handy to friends or family</td>
<td>18</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>19</td>
</tr>
</tbody>
</table>

**Sequence Guide**

If more than one code ticked in Q73 go to Q74

74. WHICH OF THESE REASONS WAS THE MAIN REASON YOU CHOSE TO LIVE IN THIS AREA?

Enter code from Q73

Don't know / no main reason
### 75. Interviewer show prompt card 14

I WOULD NOW LIKE TO ASK YOU ABOUT WHY YOU CHOSE TO LIVE IN YOUR CURRENT DWELLING?

<table>
<thead>
<tr>
<th>Choice</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No choice</td>
<td>[ ] 01</td>
</tr>
<tr>
<td>Someone else chose it for me</td>
<td></td>
</tr>
<tr>
<td>Price</td>
<td>[ ] 02</td>
</tr>
<tr>
<td>It was in my price range</td>
<td></td>
</tr>
<tr>
<td>Investment</td>
<td>[ ] 03</td>
</tr>
<tr>
<td>It looked like a good investment</td>
<td></td>
</tr>
</tbody>
</table>

**General Features of Dwelling**

- Liked the architectural style of the dwelling [ ] 04
- The dwelling is very private [ ] 05
- There is plenty of scope for renovation/remodelling and redecoration [ ] 06
- It is not attached to another house (separate house) [ ] 07
- It has a garage/carport [ ] 08

**Particular Features of Dwelling**

- It is a dwelling with high quality fixtures and fittings [ ] 09
- There is lots of room in the house [ ] 10
- The upkeep and maintenance looked easy [ ] 11
- It is physically secure [ ] 12

**Outdoor Features**

- There is plenty of outdoor space [ ] 13
- It has a private garden area [ ] 14
- Has a compact and easy to maintain garden [ ] 15
- It has no garden to maintain [ ] 16
- Other (specify) [ ] 17

**Sequence Guide**

*If more than one code ticked in Q75 go to Q76*

### 76. WHICH OF THESE REASONS WAS THE MAIN REASON YOU CHOSE TO LIVE IN THIS DWELLING?

Enter code from Q75

- Don’t know / no main reason [ ]

### 77. OVERALL, WHAT WAS THE MOST IMPORTANT CONSIDERATION IN SELECTING YOUR PRESENT HOME: THE NEIGHBOURHOOD OR THE DWELLING ITSELF?

- Neighbourhood [ ]
- Dwelling [ ]
- Equally important [ ]
- Neither [ ]
**78. **Interviewer show prompt card 15

**DO YOU INTEND TO MOVE HOME IN THE NEXT 12 MONTHS?**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>[ ]</td>
<td>⇔ Q86</td>
</tr>
<tr>
<td>Don't Know</td>
<td>[ ]</td>
<td>⇔ Q86</td>
</tr>
</tbody>
</table>

**79. **WHY DO YOU INTEND TO MOVE?

**Investment**

Increase level of investment [ ] 01

**Size / Quality of Home**

To upgrade standard of residence [ ] 02
This residence is too small [ ] 03
This residence is too big [ ] 04
To live in a more secure residence [ ] 05

**Family / Social Contact**

To be closer to family / friends [ ] 06
To be further away from family / friends [ ] 07
Getting married or commence defacto / Breakdown of marriage or partnership [ ] 08
Moving away from parent's home [ ] 09
Change in household size [ ] 10

---

**Neighbourhood Services**

Dissatisfied with level of services/shops [ ] 11
Dissatisfied with recreational and/or cultural facilities [ ] 12
Dissatisfied with public transport arrangements [ ] 13

**Proximity to Work**

To move closer to work [ ] 14
To move further away from work [ ] 15
Going to change jobs / retire / be transferred [ ] 16

**Neighbourhood Characteristics**

Too much traffic / industrial noise [ ] 17
Move to a scenic environmentally attractive area [ ] 18
Dissatisfaction with the quality of the surrounding dwellings [ ] 19
To live in a safer neighbourhood [ ] 20

**Outside Personal Control**

Going to be evicted [ ] 21
This dwelling will be no longer available [ ] 22
Move with a job [ ] 23
Public Housing Authority responsible for move [ ] 24
### Personal Reasons

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dislike neighbours</td>
<td>[ ] 25</td>
</tr>
<tr>
<td>For health or disability reasons</td>
<td>[ ] 26</td>
</tr>
<tr>
<td>To move to a nursing home / supervised care</td>
<td>[ ] 27</td>
</tr>
</tbody>
</table>

**Sequence Guide**

*If more than one code ticked in Q79 go to Q80*

80. **WHAT IS THE MAIN REASON FOR MOVING?**

*Enter code from Q79 .................*

81. **Interviewer show prompt card 16**

**WHAT FACTORS WOULD YOU TAKE INTO ACCOUNT IN CHOOSING THE AREA IN WHICH YOU WOULD MOST LIKE TO LIVE?**

- No choice [ ] 01
- Housing is in my price range in this area [ ] 02
- It's handy to where I work [ ] 03
- It's handy to my spouse / partner's work [ ] 04
- It has good access to public transport [ ] 05
- It has good access to health / medical services [ ] 06
- It is close to shopping facilities [ ] 07
- It has a good choice of sporting / recreational facilities [ ] 08
- It is close to schools [ ] 09
- It is familiar to me [ ] 10
- It is an area with houses of good quality [ ] 11
- It is an area with other people of similar age and / or background to me [ ] 12
- It has a close community feel [ ] 13
- It is scenic / environmentally attractive area [ ] 14
- It is a safe neighbourhood [ ] 15
- It is handy to friends and / or family [ ] 16
- Other (specify) .................. 17

**Sequence Guide**

*If more than one code ticked in Q81 go to Q82*

82. **WHICH IS THE MOST IMPORTANT FACTOR YOU WOULD TAKE INTO ACCOUNT?**

*Enter code from Q81 .................*
83. **Interviewer show prompt card 17**

**WHAT CHARACTERISTICS OF THE DWELLING WOULD BE IMPORTANT IN YOUR CHOICE?**

- The architectural style of the dwelling
- A high degree of privacy
- A house with plenty of scope for renovation / remodelling and redecoration
- A house that is not attached to another house (separate house)
- Lots of room in the house
- Easy upkeep and maintenance
- It is physically secure
- Plenty of outdoor space
- A compact, easily maintained garden
- Have a private garden
- A house with no garden to maintain

**Other (specify)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>The architectural style of the dwelling</td>
</tr>
<tr>
<td>02</td>
<td>A high degree of privacy</td>
</tr>
<tr>
<td>03</td>
<td>A house with plenty of scope for renovation / remodelling and redecoration</td>
</tr>
<tr>
<td>04</td>
<td>A house that is not attached to another house (separate house)</td>
</tr>
<tr>
<td>05</td>
<td>Lots of room in the house</td>
</tr>
<tr>
<td>06</td>
<td>Easy upkeep and maintenance</td>
</tr>
<tr>
<td>07</td>
<td>It is physically secure</td>
</tr>
<tr>
<td>08</td>
<td>Plenty of outdoor space</td>
</tr>
<tr>
<td>09</td>
<td>A compact, easily maintained garden</td>
</tr>
<tr>
<td>10</td>
<td>Have a private garden</td>
</tr>
<tr>
<td>11</td>
<td>A house with no garden to maintain</td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

**Sequence Guide**

*If more than one code ticked in Q83 go to Q84*

84. **WHICH IS THE MOST IMPORTANT CHARACTERISTIC?**

Enter code from Q83 ...............  
Don’t know         [ ]

85. **OVERALL, WHICH WOULD BE MORE IMPORTANT TO YOU IN SELECTING THIS HOME: THE AREA IN WHICH THE DWELLING IS LOCATED OR THE DWELLING ITSELF?**

- Locality [ ]
- Dwelling [ ]
- Equally important [ ]

---

Housing Needs Survey  
Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
The following questions are about getting to places from your home.

PLEASE INDICATE HOW IMPORTANT IT IS FOR YOU TO BE ABLE TO GET FROM YOUR HOME TO EACH OF THE FOLLOWING PLACES.

*Interviewer show prompt card 18*

<table>
<thead>
<tr>
<th>Place</th>
<th>Very Important</th>
<th>Important</th>
<th>Somewhat Important</th>
<th>Not Important at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>86. SHOPS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>87. PLACE OF EMPLOYMENT</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>88. PRIMARY SCHOOLS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>89. PUBLIC TRANSPORT</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>90. HOSPITALS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>91. DOCTORS, DENTIST OR OTHER HEALTH</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>FACILITIES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92. ENTERTAINMENT, CINEMAS, RESTAURANTS,</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>THEATRES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>93. PARKS, LAKES PUBLIC OPEN SPACE</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>94. CHILDREN'S PLAY AREAS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>95. SPORTS FACILITIES</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>96. HOUSES OF FRIENDS OR RELATIVES</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>97. TERTIARY INSTITUTIONS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>98. OPEN COUNTRYSIDE OR SCENIC AREA</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
USING THE RESPONSES OUTLINED ON THE SHEET, HOW DIFFICULT IS IT TO GET TO EACH OF THESE PLACES?

*Interviewer show prompt card 19*

<table>
<thead>
<tr>
<th>Place</th>
<th>Very Easy</th>
<th>Easy</th>
<th>Difficult</th>
<th>Very Difficult</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>99. SHOPS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>100. PLACE OF EMPLOYMENT</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>101. PRIMARY SCHOOLS</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>102. PUBLIC TRANSPORT</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>103. HOSPITALS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>104. DOCTORS, DENTIST OR OTHER HEALTH FACILITIES</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>105. ENTERTAINMENT, CINEMAS, RESTAURANTS, THEATRES</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>106. PARKS, LAKES PUBLIC OPEN SPACE</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>107. CHILDREN’S PLAY AREAS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>108. SPORTS FACILITIES</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>109. HOUSES OF FRIENDS OR RELATIVES</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>110. TERTIARY INSTITUTIONS</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>111. OPEN COUNTRYSIDE OR SCENIC AREA</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
I WOULD LIKE YOU TO TELL ME WHETHER YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS USING THE RESPONSES OUTLINED ON THE SHEET.

**Interviewer show prompt sheet 20**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>112. I would prefer to live with people who do not have mental illness</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>113. I would prefer my mental health worker to visit me at home only at my request</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>114. My mental health worker can drop in whenever s/he wants to</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>115. People with a mental illness are able to choose where they live</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>116. People with a mental illness are able to choose whom they live with</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>117. People with a mental illness have access to the same housing as anyone else</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>118. I get help for my mental illness when I think I need it</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>119. There are times when I need help but don’t know what to do</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>120. There are enough housing choices for people with a mental illness</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>121. Getting the housing I need is a major problem for me</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
The following questions are about what you think about where you live now.

I WOULD LIKE YOU TO TELL ME WHETHER YOU AGREE OR DISAGREE WITH EACH STATEMENT USING THE RESPONSES OUTLINED ON THE SHEET.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>122. I like where I am living at present</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>123. I get the support services I need</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>124. I have access to the services I need</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>125. I have the level of privacy I need</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>126. I have at least one room of my own</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>127. I have a telephone</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>128. The rent/mortgage/board I pay is affordable</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>129. I like the neighbourhood I live in</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>130. I live close to my family and friends</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>131. The neighbourhood I live in is safe</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>132. I do not expect to be thrown out of where I am living</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>133. I live here because it is my choice</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

THANK RESPONDENTS FOR THEIR PARTICIPATION IN THE STUDY AND ASK THEM IF THEY HAVE ANY QUESTIONS THEY WOULD LIKE TO ASK.

Housing Needs Survey

Questionnaire developed with the assistance of the Housing Unit, ABS, Canberra
APPENDIX 5

Flash Cards
**PROMPT CARD 1**

1. Being paid off by you or your spouse/partner?
2. Owned outright by you or your spouse or partner?
3. Rented by you or your spouse or partner?
4. Being paid off by parents or family member?
5. Owned outright by parent or family member?
6. Rented by parents or family member?
7. Live in a boarding house or hostel?
8. Other?

**PROMPT CARD 2**

1. Excellent
2. Good
3. Fair
4. Poor
5. Very poor
6. Not applicable
### PROMPT CARD 3

1. Real estate agent
2. State housing department

**Person not in the same household:**
3. Parent or other relative
4. Other person

**Person in the same household:**
5. Parent or other relative
6. Other person
7. Owner/manager of caravan park

**Employer:**
8. Government Authority
9. Other employer
10. Housing co-operative/community church group
11. Other

### PROMPT CARD 4

1. Close to nearest city/town
2. Close to work
3. Close to schools/colleges
4. Close to shops/services/recreation areas
5. Convenient to public transport
6. Close to family/friends
7. Quiet location
8. Price
9. No advantage
10. Other
### PROMPT CARD 5

1. Large dwelling  
2. Small dwelling  
3. Owning own home  
4. Privacy  
5. Large yard  
6. Small yard  
7. Pleasant appearance or character  
8. Safety security  
9. Low maintenance  
10. No advantage  
11. Other

### PROMPT CARD 6

1. A wage or salary from an employer  
2. A wage or salary for your own limited liability company  
3. Family payment  
4. Any other government pension or cash benefit  
5. Maintenance / child support  
6. Superannuation or annuity  
7. Worker’s Compensation / Accident or Sickness Insurance  
8. Any other regular income
PROMPT CARD 7

<table>
<thead>
<tr>
<th>Group 1:</th>
<th>1 - 57</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 2:</td>
<td>58 - 96</td>
</tr>
<tr>
<td>Group 3:</td>
<td>97 - 154</td>
</tr>
<tr>
<td>Group 4:</td>
<td>155 - 230</td>
</tr>
<tr>
<td>Group 5:</td>
<td>231 - 308</td>
</tr>
<tr>
<td>Group 6:</td>
<td>309 - 385</td>
</tr>
<tr>
<td>Group 7:</td>
<td>386 - 481</td>
</tr>
<tr>
<td>Group 8:</td>
<td>482 - 577</td>
</tr>
<tr>
<td>Group 9:</td>
<td>578 - 673</td>
</tr>
<tr>
<td>Group 10:</td>
<td>674 - 769</td>
</tr>
<tr>
<td>Group 11:</td>
<td>770 - 961</td>
</tr>
<tr>
<td>Group 12:</td>
<td>962 - 1,154</td>
</tr>
<tr>
<td>Group 13:</td>
<td>1,155 - 1,346</td>
</tr>
<tr>
<td>Group 14:</td>
<td>1,347 +</td>
</tr>
</tbody>
</table>

PROMPT CARD 8

1. Profit or loss from own business (excluding limited liability company(s) or share a partnership)
2. Profit or loss from rental investment properties
3. Dividends
4. Interest
5. A wage or salary from an employer
6. A wage or salary from own limited liability company
7. Family Payment
8. Any Government pension or cash benefit
9. Maintenance/child support
10. Worker's Compensation or Accident or Sickness Insurance
11. Any other regular income
**PROMPT CARD 9**

1. Age pension
2. Service pension (DVA)
3. Disability support pension (Invalid pension) (DSS)
4. Wives pension
5. Carer's pension
6. Sole parent’s pension
7. Sickness allowance or sickness benefit
8. New start allowance/job search allowance/mature age allowance/unemployment benefit
9. Special benefit
10. Partner allowance
11. None of these

**PROMPT CARD 10**

1. Additional family payment
2. Austudy or Abstudy
3. Austudy/Abstudy supplement
4. Disability pension (DVA)
5. War widows pension (DVA)
6. Child disability allowance
7. Home child care allowance
8. Overseas benefit or benefit
9. Other pension/benefit
10. None of these

**PROMPT CARD 11**

1. Resident of boarding house or hostel
2. Daily
3. Weekly
4. Monthly
5. When required called
### PROMPT CARD 12

1. Secondary School Qualification
2. Teaching Qualification
3. Trade Certificate
   Apprenticeship
4. Technical Certificate or
   Advanced Certificate
5. Certificate other than above
6. Associate Diploma
7. Undergraduate Diploma
8. Bachelor Degree
9. Postgraduate Diploma
10. Masters Degree or Doctorate
11. Other

### PROMPT CARD 13

**No Choice**

1. Someone else chose it for me

**Could Afford**

2. Housing is in my price range

**Proximity to Work**

3. It's handy to where I work
4. It's handy to my spouse/partner's work

**Neighbourhood Services**

5. Has good access to public transport
6. Has good access to health and/or medical services
7. It is close to shopping facilities
8. There is a good choice and availability of recreational/cultural facilities
9. Has good access to childcare facilities
10. Other (*Please specify*)

**Neighbourhood Characteristics**

11. It is a scenic /environmentally attractive area
12. Has a close community feel
13. Am familiar with area
14. It is an area with houses of good quality
15. It is an area with people of similar age and/or background
16. It's a safe area
17. Other (*Please specify*)

**Family / Social Contacts**

18. Handy to friends or family
19. Other (*Please specify*)
**PROMPT CARD 14**

<table>
<thead>
<tr>
<th>No Choice</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Someone else chose it for me</td>
</tr>
<tr>
<td>Price</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>It was in my price range</td>
</tr>
<tr>
<td>Investment</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>It looked like a good investment</td>
</tr>
<tr>
<td>General Features of Dwelling</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Liked the architectural style of the dwelling</td>
</tr>
<tr>
<td>5.</td>
<td>The dwelling is very private</td>
</tr>
<tr>
<td>6.</td>
<td>There is plenty of scope for renovation/ remodelling and redecoration</td>
</tr>
<tr>
<td>7.</td>
<td>It is not attached to another house (separate house)</td>
</tr>
<tr>
<td>8.</td>
<td>It has a garage/ carport</td>
</tr>
<tr>
<td>Particular Features of Dwelling</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>It is a dwelling with high quality fixtures and fittings</td>
</tr>
<tr>
<td>10.</td>
<td>There is lots of room in the house</td>
</tr>
<tr>
<td>11.</td>
<td>The upkeep and maintenance looked easy</td>
</tr>
<tr>
<td>12.</td>
<td>It is physically secure</td>
</tr>
<tr>
<td>Outdoor Features</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>There is plenty of outdoor space</td>
</tr>
<tr>
<td>14.</td>
<td>It has a private garden area</td>
</tr>
<tr>
<td>15.</td>
<td>Has a compact and easy to maintain garden</td>
</tr>
<tr>
<td>16.</td>
<td>It has no garden to maintain</td>
</tr>
<tr>
<td>17.</td>
<td><strong>Other (Please specify)</strong></td>
</tr>
</tbody>
</table>

**PROMPT CARD 15**

| Investment                      |                           |
| 1.                             | Increase level of investment |
| Size / Quality of Home         |                           |
| 2.                             | To upgrade standard of residence |
| 3.                             | This residence is too small |
| 4.                             | This residence is too big   |
| 5.                             | To live in a more secure residence |
| Family / Social Contact        |                           |
| 6.                             | To be closer to family/friends |
| 7.                             | To be further away from family/friends |
| 8.                             | Getting married or commence defacto/ breakdown of marriage or partnership |
| 9.                             | Moving away from parent’s home |
| 10.                            | Change in household size    |
| Neighbourhood Services         |                           |
| 11.                            | Dissatisfied with level of services/shops |
| 12.                            | Dissatisfied with recreational and/or cultural facilities |
| 13.                            | Dissatisfied with public transport arrangements |
PROMPT CARD 15 (cont)

Proximity to Work
14. To move closer to work
15. To move further away from work
16. Going to change jobs/retire/be transferred

Neighbourhood Characteristics
17. Too much traffic/industrial noise
18. Move to a scenic environmentally attractive area
19. Dissatisfaction with the quality of the surrounding dwellings
20. To live in a safer neighbourhood

Outside Personal Control
21. Going to be evicted
22. This dwelling will be no longer available
23. Move with a job
24. Public Housing Authority responsible for move

Personal Reasons
25. Dislike neighbours
26. To move to a nursing home/supervised care
27. For health or disability reasons

PROMPT CARD 16

1. No choice
2. Housing is in my price range in this area
3. It's handy to where I work
4. It's handy to my spouse/partner's work
5. It has good access to public transport
6. It has good access to health/medical services
7. It is close to shopping facilities
8. It has a good choice of sporting/recreational facilities
9. It is close to schools
10. It is familiar to me
11. It is an area with houses of good quality
12. It is an area with other people of similar age and/or background to me
13. It has a close community feel
14. It is scenic/environmentally attractive area
15. It is a safe neighbourhood
16. It is handy to friends and/or family
17. Other (Please specify)
PROMPT CARD 17

1. The architectural style of the dwelling
2. A high degree of privacy
3. A house with plenty of scope for renovation/remodelling and redecoration
4. A house that is not attached to another house (separate house)
5. Lots of room in the house
6. Easy upkeep and maintenance
7. It is physically secure
8. Plenty of outdoor space
9. A compact, easily maintained garden
10. Have a private garden
11. A house with no garden to maintain
12. Other (Please specify)

PROMPT CARD 18

1. Very Important
2. Important
3. Somewhat Important
4. Not important at all

PROMPT CARD 19

1. Very Easy
2. Easy
3. Difficult
4. Very Difficult
5. Don’t Know or Not Applicable

PROMPT CARD 20

1. Strongly Agree
2. Agree
3. Neither Agree nor Disagree
4. Disagree
5. Strongly Disagree