"Reengineering" Residential Care Facilities: A Case Study of Hamilton, Ontario

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ABSTRACT

Residential care facilities are an enduring feature of Ontario's community mental health system. While these facilities offer affordable housing, they are also custodial environments that are poorly suited to goals of recovery and rehabilitation. This paper examines the extent to which facilities can be "reengineered" to improve tenants' daily lives using a case study of facilities in Hamilton, Ontario. Data from a 2005 survey of 50 people with psychiatric disabilities living in residential care facilities were used to assess quality of life and the extent to which operators have implemented newly revised municipal regulations. The findings are compared with those of earlier researchers (Taylor, Elliott, & Kearns, 1989) who conducted a similar survey in 1986 in Hamilton. While the two surveys differ with regard to specific items, broad comparison suggests little has changed, raising questions about the extent to which such facilities should continue to play a central role in housing for people with psychiatric disabilities.

In late 2005, a coalition of mental health consumers in Hamilton, Ontario, celebrated its 10th anniversary. From the outset, the coalition has advocated for improvements to the city's privately owned residential care facilities, which provide housing for several hundred mental health consumers as well as for low-income elderly persons and people living with developmental and physical disabilities. The coalition's mandate is to work to improve living conditions and quality of life in residential care facilities, but the job has not been an easy one. Efforts to bring about change have been frustrated by multiple factors including state funding cuts, an absence of political will, and the vested interests of private facility owners. In this paper, we reflect on the character of Hamilton's residential care facilities, and the implications for the lives of tenants. We draw on data from a survey of facility residents conducted collaboratively with the tenants' coalition. The similarities between these data and those reported in research conducted almost 20 years earlier underscore the need for concrete change to facilities as well as the barriers that frustrate such change. We discuss the implications of this work in relation to the literature on housing and community mental health.

HOUSING FOR PERSONS WITH PSYCHIATRIC DISABILITIES

Access to affordable and appropriate housing has been recognized as a key factor shaping the quality of life of people with psychiatric disabilities and their chances for success in the community (Aubry & Myner, 1996; Carling & Curtis, 1997; Sylvestre et al., 2007). Research has demonstrated several ways in which the character of accommodation can exert a significant influence on daily living. An overarching theme of this work has been the extent to which housing increases (or diminishes) community integration and quality of life. Studies have raised concerns that while people with psychiatric disabilities living in the community may be physically integrated, they remain socially isolated (Kloos, Zimmerman, Scrimenti, & Crusto, 2002). One reason for the continuing absence of social integration is that housing options have historically taken the form of segregated, custodial residential settings like board-and-care homes. This type of housing has persisted despite evidence that many people with psychiatric disabilities would prefer smaller, less restrictive housing choices that are better integrated into surrounding communities (Nelson, Hall, & Walsh-Bowers, 1998).

Research has shed considerable light on the significance of a number of housing-related factors in the lives of people with psychiatric disabilities. The physical quality and comfort of housing has a significant influence on individuals' well-being (Nelson, Wiltshire, Hall, Peirson, & Walsh-Bowers, 1995). Privacy also emerges as an important influence. Nelson et al. (1998) found that several factors, including not having one's own room, were related significantly to poorer emotional well-being among people with psychiatric disabilities (Horan, Muller, Winocur, & Barling, 2001).

The ability to exercise control within residential environments is another important factor. Nelson et al. (1995) found that a democratic management style and the residents' perceived quality of life were closely related: the less democratic the style in board-and-care settings, the lower the subjective quality of life. In a comparison of board-and-care homes, group homes, and supported apartments, Nelson, Hall, and Walsh-Bowers (1999) found that residents of board-and-care homes reported lower levels of control. The extent to which residents are able to exert control over housing conditions (e.g., having a key to the front door or being able to use kitchen facilities) has implications for their ability to develop greater independence. The authors contend that for-profit board-and-care homes often operate using a "philosophy of containment" that leaves little room for rehabilitation.

Safety issues have also been identified as significant. Horan et al. (2001) found that hostel residents were more likely to report being victims of crime than boarding home residents (which also relates to facility size and control over space). Elsewhere, Lehman, Rachuba, and Postrado (1995) found significant gender differences in subjective and objective quality of life among residents of board-and-care homes, with men reporting fewer concerns about safety. Men also tended to be better off financially and more satisfied with daily activities.

Other work identifies in-house rehabilitation programs as a factor influencing residents' social integration (Aubry & Myner, 1996). The presence or absence of in-house programming, as well as the provision of single rooms and greater choice for residents, is influenced by whether housing is provided on a for-profit basis. The profit motive of private board-and-care operators can work against the

interests of residents, making it less likely that they will have their own room and reducing flexibility around meal times (Linney, Arns, Chinman, & Frank, 1995; Nagy, Fisher, & Tessler, 1988).

Finally, the extent to which people with psychiatric disabilities have choice in their selection of housing has been examined. Srebnik, Livingston, Gordon, and King (1995) found that greater choice was associated with residential stability and psychological well-being. At the same time, most of their sample reported few housing options in practice, and about one third felt they had little or no choice.

Other research has explored the potential to move beyond the limitations of segregated, custodial housing. Elliott, Taylor, and Kearns (1990) have argued for a "housing continuum" to reflect and respond to people's changing needs and preferences. Carling and Curtis (1997) have explored a "supported housing" model, which emphasizes integrated housing options, choice, and flexible/portable support services. However, the availability of such housing choices remains limited in many contexts (Rog, 2004; Sylvestre et al., 2007). The creation of new housing requires a commitment of significant funds. Sylvestre et al. (2007, p. 92) suggest that in the current fiscal climate it is unrealistic to expect a broad reworking of the housing system and that "a more pragmatic approach requires the identification of particular recommendations that could proceed expeditiously." In this context, questions arise about practical strategies that could produce positive change in housing, as well as the potential barriers to the implementation of such strategies. Pulier and Hubbard (2001) have argued that board-and-care homes remain an important source of housing given the scarcity of other options. They contend that such homes can be "reengineered" with physical upgrades, and provision of home-like amenities and in-house programming. However, they say little about how facility operators can be "encouraged" to effect such changes in practice. In this paper, we examine some of the practical difficulties involved in efforts to improve the conditions of board-and-care housing in one urban centre.

CONTEXT

Hamilton's "Service-Dependent Ghetto"

As the site of a provincial psychiatric institution, Hamilton witnessed first-hand the process of deinstitutionalization in the postwar period. Hamilton's psychiatric hospital saw significant reductions in its inpatient capacity, with the number of beds falling from 1,730 in 1960 to just over 500 by the late 1970s (Dear & Wolch, 1987). The transfer of patients from the hospital created a demand for affordable housing that was met in large part by privately owned lodging homes—now known as residential care facilities. As a result, the number of these facilities increased from 33 in 1976 to 89 by 1984 (Dear & Wolch, 1987). Many of these facilities were (and are) located in the central city where older residential properties were available for conversion. The number of facilities receiving public subsidies for housing declined from 89 in 1984 to 70 in 2003, but these settings still represent almost three quarters of designated affordable housing for people with psychiatric disabilities (Hamilton District Health Council, 2001).

Facilities range in capacity from 8 beds to 40 or more, and they are required to provide food, accommodation, and rehabilitation services. This latter requirement reflects the fact that facilities were

initially intended to be transitional, with people moving on to more independent residential arrangements. Facility operators are paid a per diem rate for each tenant, while tenants receive a monthly personal needs allowance to pay for toiletries, clothing, and other basic needs (Wilton, 2004). The tenant population is composed of men and women with psychiatric disabilities but also includes the low-income elderly and people with physical and developmental disabilities.

Residential care facilities can be interpreted in different ways. As Pulier and Hubbard (2001) have observed, this type of accommodation remains an important source of affordable housing in proximity to professional services and peer supports. At the same time, as was noted earlier, concerns about the quality of this type of accommodation as well as its failure to provide effective in-home services are longstanding. In the 1980s, researchers in Hamilton examined the housing conditions of people with psychiatric disabilities (Elliott et al., 1990; Taylor, Elliott, & Kearns, 1989). This research found that respondents had few options other than custodial facilities or private-market boarding and rooming houses. Moreover, respondents identified multiple concerns with conditions inside facilities (see below).

In 2000/01, the municipal government undertook a review of the regulations governing the city's residential care facilities, in light of new thinking about housing for people with psychiatric disabilities. City staff consulted with stakeholders, including the tenants' coalition and the facility operators' association. Council approved a new set of regulations in late 2001. The tenants' coalition was disappointed with the lack of substantive change. However, some important revisions were made; for example, facility operators were required to sign tenancy agreements with residents to reflect the latter's status as legal tenants. In 2005, the tenants' coalition, in collaboration with the researchers, decided that a survey of facility tenants would be a useful vehicle to assess whether facility operators had implemented the regulations and to offer fresh insight on residents' experiences of housing.

METHOD

The Earlier Research

In 1986, researchers surveyed 66 people with psychiatric disabilities at three programs operating in the community (Elliott et al., 1990; Taylor et al., 1989). The survey focused on four aspects of the social and physical environment (living situation, social network, psychiatric support, and income/employment). The 80-item questionnaire included a mix of open-ended questions and structured scales. A number of items measured respondents' satisfaction with their living situations. For example, respondents were asked to rate their current housing on a 6-point scale from *very satisfied* to *very dissatisfied*. They were also asked to assess whether their housing met their current needs, describe their ideal living arrangement, and identify specific housing problems. The sample was stratified by gender and age to include both women and men, and younger and older clients. As the authors noted, the sample was not representative of the larger population with psychiatric disabilities since those attending the community programs may have had different needs and characteristics than those who were not. Just under half of the respondents were living in residential care facilities at the time of the study, while the remaining respondents were concentrated in other rental accommodation (mainly rooming and boarding houses).[1] This mix of residential arrangements complicates comparison with

respondents in the current study. However, the analysis did report a number of findings specific to residents of residential care facilities (e.g., housing satisfaction, preferred living arrangement) that are used here for comparison.

Current Participants

In our study, 50 respondents were surveyed about living conditions in residential care facilities. The sample included 41 men and 9 women, ranging in age from 23 to 64 years old, with an average age of 43. Respondents lived in 29 different residential care facilities across the city that accommodated between 5 and 40 tenants,[2] with an average of 17. Respondents had lived at their current facility for an average of 4.5 years, although there was significant variation, with 10 people reporting residency of 1 year or less, and 7 people having lived at the same facility for 10 years or more. Length of stay for these respondents differed significantly from the 1980s study participants. Taylor et al. (1989) reported that 62% of respondents had been at their current address for less than 2 years.[3] Among the 2005 respondents, this figure was 24%.

Survey Measures

The current study was *not* intended to be an exact replica of the earlier study. The researchers worked with coalition members to design a survey to assess the implementation of regulations by facility operators (e.g., meals, bedrooms, bathroom facilities, tenancy agreements, complaints process, social relations, rehabilitation services), and to measure the residents' quality of life and satisfaction with their housing situation (e.g., bedroom, other people in the home, privacy, control over life, social activities, home overall). Both closed and open-ended questions were included. The questions about quality of life and satisfaction were drawn from Lehman's (1996) Quality of Life instrument, using the "delighted-terrible" scale to gauge responses. Similar to the earlier study, people were asked where they would prefer to live given a choice.

Survey Procedure

It was decided not to conduct the survey within the facilities. Past experience suggested facility owners would be reluctant to grant admission to researchers asking about the quality of the residential environment, while coalition members worried that tenants would be afraid to speak openly about their experiences. Instead, we approached five community organizations providing services to facility tenants and asked if we could use their sites to recruit participants and administer surveys. We recognized that this approach (which was also used in the earlier study) would not give a representative sample of all facility tenants. At each organization, a coalition member and a researcher introduced the study and obtained informed consent by explaining the nature of the survey, the uses to which the data would be put, and the fact that participation was anonymous and voluntary.

Quantitative data from the surveys were entered into SPSS for analysis. Qualitative data were derived from a series of open-ended questions (e.g., What types of safety concerns do you have? What do you like most/least about where you live?). Some people wrote responses themselves, while others

received help from the researchers. Some people shared a lot of information—engaging the researcher in discussion after completing the survey—while others were brief. Where additional information was offered after the formal survey, the researcher asked permission to record the insights for use in the analysis. All qualitative responses were transcribed and reviewed by both authors separately. Subsequently, the authors worked together to organize responses to each open-ended survey item into a series of thematic categories that reflected the principal concerns and opinions of respondents. For the most part, the data were organized by survey item (e.g., What do you like most about where you live?), while subcodes were developed to reflect the principal themes that emerged (e.g., meals, kindness).

Additional Qualitative Data

After the survey had been completed and some initial analysis had taken place, the researchers conducted six key informant interviews with local service providers to help interpret the results.[4] Informed consent was obtained by explaining the nature of the interview questions and emphasizing that the interviews were voluntary and confidential. Interviews were taped and transcribed. These interviews were coded manually and were used in the analysis as an additional source of insight alongside tenants' input. In the remainder of this paper, we present findings from the survey, where possible comparing data with the earlier Hamilton research.

RESULTS

The survey produced a number of findings in relation to compliance with municipal guidelines and the broader question of tenants' satisfaction with their housing. With regard to compliance, for example, a majority (68%) of people said that they either had not signed a legal tenancy agreement or were unsure if they had signed such an agreement. This suggests that many facility operators either are not providing tenancy agreements or are not explaining the documents they require tenants to sign upon admission. This finding has implications for respondents' understanding of their rights as tenants (e.g., in relation to eviction from a facility). Similarly, municipal regulations require facility operators to provide tenants with a Care Home Information Package containing information about facility rules, staff regulations, and complaints procedures. Almost half of respondents (46%) said they had not received this information, and another third were unsure.

More broadly, tenants raised a number of concerns about their housing. The most frequently cited concerns from the current and earlier studies are presented in Table 1. Although the wording varies, many of the concerns identified in the 1980s were also present in 2005. In both surveys, for example, lack of privacy and overcrowding surfaced as concerns. Many people are required to share bedrooms with one or more other tenants. While the municipal regulations issued in 2001 require tenants to be given their own bedrooms, pressure from the facility operators meant the requirement only applied to facilities licensed *after* the regulations came into effect. Among the 2005 respondents, 60% were still sharing rooms. As a compromise, the regulations stipulated that partitions should be installed in shared rooms to provide some privacy. Among respondents who were sharing rooms, a majority (62%) indicated that they did *not* have a partition. This situation has obvious implications for privacy, particularly for those sharing bedrooms with two or three other people.

Table 1

Comparing Tenants' Perspectives

Problems cited/reasons for moving (Taylor et al., 1989)[a]	What do you like *least* about your home? (2005)[b]	What do you like *most* about your home? (2005)
• Presence of rodents • General uncleanness • Poor food • Overcrowding • Irreconcilable differences with other residents • Arguments with staff • Threats of physical violence	• Staff members (yelling, unpleasant, mad) (5) • Other residents fighting, arguing, bullying (5) • Too hot, no fans, air conditioning (3) • Unsafe, theft, no lock on bathroom door (3) • Too many people in home, lack of privacy (3) • Nothing to do in home (3) • Staff inconsistencies (3) • Lack of cleanliness, presence of rodents (2)	• Meals ("spaghetti and meatballs!") (8) • Reasonable degree of freedom (4) • Staff generally positive (4) • Get coffee, smokes, and good sleep (3) • No curfew (2) • Kindness and concern shown (1) • You have someone to talk to (1) • Better to be in community than an institution (1)

Note.

[a] In the Taylor et al. (1989) study, respondents identified a variety of unacceptable and inadequate housing conditions. The combination of these problems was identified as the most frequently cited reason for moving. The problems were not ranked individually in the paper.

[b] We used an open-ended question to ask respondents what they liked most and least about their housing (multiple responses were allowed). The responses were coded, and those presented here are the most frequently cited likes and dislikes. The numbers in parentheses indicate the frequency of mention.

Alongside privacy, concerns about verbal harassment from staff and other residents, theft, and the threat of physical violence surfaced in both surveys. Commenting on staff-tenant relations, one man said:

> You get some staff, I guess they get so sick of doing the same jobs all the time and the same people bothering them that they start talking down to them. They start screaming at them. It brings you down.

With regard to security, the absence of secure storage for personal possessions has long been a concern. In consultations informing the revisions to municipal regulations, the tenants' coalition had strongly urged municipal staff to mandate the provision of lockable storage units for all facility tenants. However, pressure from facility owners again meant that this recommendation was not included in the final document approved by city council.

When asked about personal safety in the facility, one third of the 2005 respondents said they had safety concerns (Table 2). There is an important gender dimension to this issue, with two thirds of women expressing concerns about safety in the facilities. Although the survey sample is small, this result is worrisome, especially since little explicit attention has been given to the differential experiences of women and men in board-and-care living arrangements. In Hamilton, only one lodging home currently offers a women-only environment.

Table 2

What Types of Safety Concerns Do You Have?

Women[a]	Men[a]
• One of the men that live there is violent, try to avoid him • There is no lock on the washroom (people sometimes look in) • Male resident was intimidating • Assault • Watch my room out • There was a fire alarm for the fireman to come, there was a bad chimney block, the landlord the next day said it was nothing • Smoking in rooms (fire hazard)	• Money being cheated (landlord withholds my money, sometimes I never receive it) • Theft • Intimidation by a particular male resident, uses size to get smokes and money from other tenants • Fights between tenants all of the time (gets physical) • Once attacked by resident with a butter knife • Drugs and booze in the home

Note.
[a]These are verbatim statements from individual respondents. All of the women and 6 of the 10 men who expressed a concern about safety responded to this open-ended follow-up question.

Alongside the identification of specific concerns, both surveys asked tenants about the extent to which they felt their housing needs were being met. In the earlier study, 75% of respondents living in residential care facilities felt that their housing needs were being met. To gauge subjective quality of life and housing satisfaction in 2005, respondents were asked how they felt about their bedrooms, sense of privacy and control in the home, other people in the home, social activities provided, and the home overall. These questions used a 7-point "delighted-terrible" scale to rate responses. A majority of people indicated high levels of satisfaction for each item. For example, 80% of people said they were mostly satisfied, satisfied, or delighted with their current housing overall. Respondents were least positive about the other people in the home, but even here 60% still said they were mostly satisfied or better. Reflecting concerns about safety, women gave lower ratings for privacy, other people, and the home overall than did men.[5]

At first glance the positive nature of responses to questions about housing satisfaction is puzzling in light of concerns presented in Tables 1 and 2. Elliott et al. (1990) suggested that high levels of satisfaction could be as much a product of tenants' diminished expectation for housing as a reflection of the actual living conditions in facilities. Moreover, studies commonly report a disjuncture between objective conditions and subjective states when measuring quality of life (Lehman, 1996). In key informant interviews, none of the service providers were surprised by the high levels of reported satisfaction, and many viewed these ratings as a product of diminished expectations. However, they also offered two other explanations. Some suggested tenants were afraid to express dissatisfaction with facilities for fear of being evicted. This fear was evident in the concerns expressed by respondents during the survey administration. As one tenant commented, "You don't want to make too many waves because it's either this or you're out on the street." At the same time, service providers noted that expressed satisfaction could also reflect the positive environments found in *some* facilities.

However, tenants' satisfaction with facilities may reflect a dependency on an environment that meets basic needs. In the 1980s, an absence of sustained rehabilitation and life-skills programming led some tenants to characterize the facilities as mini-institutions (Elliott et al., 1990). While two thirds of the 2005 respondents said they received some encouragement from facility staff/operators to take part in programs outside the home, key informants commented that tenants were often unable to apply what they had learned. For example, a tenant might attend a cooking workshop but return to a facility where he or she has no access to the kitchen. More broadly, an inability to take an active role in daily living can impact on people's aspirations for more independent living. As one tenant recognized,

> There's some good people here, but you know the word *institutionalized*. This is the problem. They get people in here and they get them hooked up on three meals per day, and their medication given to them, and false security . . . hiding away in this place.

Again, there is variation among facilities with some operators helping tenants to undertake tasks such as laundry. A majority (62%) of respondents said their facilities required residents to be in by a certain time at night. While some saw the curfew in positive terms—as a way to ensure safety—its use raises questions about control over daily life and the tendency of facilities to foster dependency.

Finally, both studies asked tenants where they would like to live if given a choice. Among residential care facility residents in the earlier survey, 40% said they were "happy as is," with independent living identified as the most preferred alternative. In the current study, 35% said they were "happy as is," but 60% of respondents indicated a desire for more independent living arrangements such as an apartment with or without support staff on site, or "my own house" (the remaining 5% preferred "another lodging home"). These responses are significant, not least because they conflict with the sentiments about housing satisfaction presented earlier. While a majority of people said they were mostly satisfied or better with their current housing, when offered a choice a majority wanted something different. There was also an age gradient, with respondents in their 20s most likely to express a desire for more independent living (80%), in comparison with people over 30 (69%), 40 (68%), and 50 years of age (47%). This finding parallels earlier work (Nelson et al., 1999).

DISCUSSION

The present study examined the housing experiences of people with psychiatric disabilities living in residential care facilities in Hamilton, Ontario. The research has a number of limitations, not least a small sample size that makes it difficult to establish statistical significance for results presented in the previous section. Nevertheless, the survey does offer some insight in relation to earlier Hamilton research and the broader literature on housing for people with psychiatric disabilities.

In relation to the earlier Hamilton study, the current research suggests that conditions within facilities have not changed appreciably. Many of the concerns cited by tenants in 2005 mirror issues noted by respondents almost two decades earlier. Most residential care facilities meet basic needs in terms of food and shelter, and some operators work hard to offer what they believe to be supportive environments. Nevertheless, facilities are essentially providing custodial care, and many operators lack resources and/or incentives to adopt an approach that is more conducive to rehabilitation and

recovery. "Higher order" services directed toward consumer empowerment and skills training are not consistently available. The findings that a majority of respondents had not signed a lease, or were uncertain whether they had, and that most had not been provided with required information on the rules and operations of their facilities speak directly to this point.

The results of this study also connect with existing research on board-and-care accommodation. Earlier work had identified the lack of privacy as a consistent problem in custodial facilities, and this had implications for people's quality of life and emotional well-being (Horan et al., 2001). Lack of privacy continues to be a problem, with the majority of respondents to the 2005 survey sharing rooms. Related to this is the issue of people's ability to exert control over residential space. Nelson et al. (1999) found that residents reported lower levels of control in board-and-care homes than in other living arrangements, with implications for independence in daily living. In Hamilton, tenants' groups lobbied unsuccessfully for lockable storage in all facilities. In the absence of single rooms, such storage would have at least given tenants some ability to control access to personal possessions.

Relationships within facilities emerged as an important issue. Problems with staff and other residents were the most frequently cited dislikes, and respondents reported the least satisfaction with other people in the home. This finding fits with existing work that finds that smaller group homes and apartments offer more supportive environments than board-and-care homes (Nelson, Hall, Squire, & Walsh-Bowers, 1992). These concerns are related to problems associated with for-profit housing. For example, the profit motive of operators makes it less likely that residents will be provided with single rooms or offered flexibility around meal times. Staffing may also be affected by for-profit status. Jobs in for-profit facilities are poorly paid, and municipal regulations require only a single staff member on duty at any one time. An inability to attract better-qualified workers, coupled with the demands placed upon staff, may increase the likelihood of tensions between staff and residents. Similarly, with few staff on duty it may be difficult to deal constructively with tensions between residents.

People's concerns with other residents also resonate with existing scholarship. Studies have shown that congregate settings do not facilitate social integration, with a consequence that residents mainly socialize with other people in the facility (Aubry & Myner, 1996). While such relationships may be valuable, the existence of tensions among residents may place a significant strain on a social life centred on the facility. Moreover, such problems erode a sense of the facility as a safe space. Lehman (1983) argued that safety in board-and-care homes was a key influence on global well-being. The current study raises particular concerns about safety for women in mixed facilities. Given the small number of respondents here, more work is needed to understand the challenges women confront in residential facilities.

This study confirms that people with psychiatric disabilities continue to desire alternatives to board-and-care homes. Notwithstanding the relatively high levels of expressed satisfaction with current housing, people consistently articulate a desire to move beyond such settings. Yet they often face very limited choice as demand for dedicated housing for people with psychiatric disabilities outstrips supply (Sylvestre et al., 2007), and lack of income remains an enduring constraint on housing choice (Wilton, 2004).

In policy terms, several implications can be identified. While policy in Ontario, for example, has consistently identified affordable supportive housing options as a key priority for the provincial community mental health system (Nelson, Lord, & Ochocka, 2001), the government continues to fall short in its willingness and ability to implement these policies. Thus, there remains a stark contrast between the mental health system as imagined in policy and the lived experiences of many people with psychiatric disabilities. In this context, a pressing question concerns the extent to which board-and-care homes can be "reengineered" to offer housing that is more consistent with principles of recovery and empowerment (Pulier & Hubbard, 2001). The current study suggests a number of factors that need to be considered when evaluating the potential for change.

First, reengineering is likely to be constrained by the interests of facility owners, particularly if they are for-profit operators concerned about the financial costs associated with a shift away from a "philosophy of containment" (Nelson et al., 1999). Second, in practice reengineering will almost certainly be a political process, involving multiple stakeholders with differing levels of organization and influence. In such contexts, there is a danger that the voices of people with psychiatric disabilities will be marginalized. In Hamilton, consultations informing the revisions to municipal regulations were wide-ranging, but it quickly became clear that the facility operators' organization carried more weight among municipal politicians and staff than that of people with psychiatric disabilities and their allies. This power differential was evident in the final draft of regulations that omitted any provision for lockable storage, failed to require single rooms for all residents, and did not mandate a complaints procedure. Third, any effort at reengineering requires a commitment to funding for implementation, as well as resources for effective inspection and enforcement. The regulations passed in Hamilton in late 2001 were not being consistently followed 4 years after they were introduced. Such inconsistencies suggest that there is a need to "raise the bar," penalizing facilities that fail to meet required standards while offering incentives to operators who move ahead with improvements. However, such actions require adequate funding, and recent developments have not been encouraging in this regard. In 2006, the Ontario government drafted model regulations for residential care facilities to be adapted by municipalities. The stated logic of this move was to ensure comprehensive yet locally tailored regulations across the province. However, these actions can also be seen as a way to ensure that responsibility for regulation remains at the municipal level. Moreover, emphasis on the necessity for regulation was not accompanied by any mention of extra resources for implementation and enforcement.

Experiences in Hamilton point to the difficulties inherent in creating change in board-and-care housing. The obstacles to "reengineering" these facilities raise fundamental questions, in turn, about whether for-profit, congregate living facilities should continue to play a central role in housing for people with psychiatric disabilities.

NOTES

1. Rooming and boarding houses are broadly similar environments to the privately run residential care facilities in that they are congregate living environments with shared bath, kitchen, and common areas. They differ from residential care facilities in that there is no requirement for in-house services, and bedrooms are not shared.

2. The presence of only 5 tenants does not indicate the number of beds, as some facilities were operating below capacity.
3. This percentage was derived from all respondents in the earlier study, although the analysis found no significant difference between facility residents and respondents living in other settings.
4. Participants included staff from several of the survey sites who were familiar with some of the issues facing people living in residential care facilities. A member of the local Assertive Community Treatment team who had worked in residential facilities was also interviewed.
5. The small sample size for women clearly limits our ability to interpret gender differences and to establish statistical significance.

RÉSUMÉ

Les établissements de soins pour bénéficiaires internes occupent une place importante le système de soins de santé mentale communautaire en Ontario. Mais, si ces établissements offrent un hébergement abordable et constituent des lieux offrant une certaine protection aux bénéficiaires, ils sont peu adaptés aux objectifs de guérison et de réinsertion sociale. Dans cet article, grâce à une étude de cas portant sur de tels établissements situés à Hamilton, en Ontario, nous examinons dans quelle mesure ils pourraient être transformés pour ainsi permettre d'améliorer la vie quotidienne des bénéficiaires. Grâce aux données d'un sondage réalisé en 2005 auprès de 50 personnes ayant des problèmes de santé mentale et vivant dans de tels établissements, nous avons évalué la qualité de vie des bénéficiaires et établi dans quelle mesure les propriétaires des établissements ont appliqué les changements apportés aux réglementations municipales. Nous avons comparé nos observations aux données d'une étude similaire réalisée en 1986 à Edmonton (Taylor, Elliott et Kearns 1989). Nous en concluons que, si les deux études montrent des différences sur des questions particulières, une comparaison plus générale suggère que la situation a peu changé. Cela pose donc la question suivante : ces établissements devraient-ils continuer à jouer un rôle majeur dans le domaine de l'hébergement des personnes ayant des problèmes psychiatriques ?

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