



Beth Israel Deaconess  
Medical Center



A teaching hospital  
of Harvard  
Medical School

# Improving Program Implementation: Consumer Preference and Outcomes

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# Research Collaborators

## McKinney Project, 1990-1999

### *Co-Investigators*

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Larry J. Seidman, PhD; Barbara Dickey, PhD; Walter E. Penk, PhD; Norma Ware, PhD; Sondra Hellman, RN, MS, Martha O'Bryan, RN

### *Research Staff*

Brina Caplan, EdD, PhD; Win Turner, PhD, George Tolomiczenko, PhD;

Mark Abelman, MSW

## 20-Year Followup, 2008

Russell Schutt, Ph.D.; Louise Marks, LICSW; Ayana Gonzalez, MA;

Anne Remington

## Mass Mental Transitional & DMH in Generic Shelters, 2003

Russell Schutt, PhD, James Feldman, MPH, MD; Eileen Reilly, MD;

Martha Schinagle, MD

## Veterans Administration, 2001-2002

Russell Schutt, PhD; Benjamin Weinstein, PhD; Walter Penk, PhD

## Generic Shelters, 1990

Russell Schutt, PhD; Richard Weintraub; Barbara Blakeney, RN; William Dillon

# Outline

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# **Policy and Research Background**

# Housing for Homeless Persons with Serious Mental Illness: Policy Background

Preference-oriented placement: a  
fundamental next step in normalization of  
treatment, integration in the community,  
and empowerment of consumers

# Preferences in Policy

- *Consumer preference is a key theme of Council innovations.*

(Interagency Council on the Homeless, 2008)

- *To the fullest extent, homeless mentally ill individuals, like all other members of society, **should be educated and empowered to make choices in matters affecting their lives and to accept responsibility for those choices.***

(Interagency Council on the Homeless, 1992:32)

# Rationale for Preference-Oriented Housing Placement Policy

- Consumer Orientation

*“placements ...on the basis of what consumers say they want, rather than ‘what we think they need.’”* (Daniels and Carling 1986)

- Consumer Empowerment

*“Having decision-making power.”* (Chamberlin and Schene 1997).

- Treatment Compliance

*“Modifying treatment recommendations to reflect patient preferences can enhance compliance.”* (Eraker et al. 1984).

- Learning

*“the consumer is going to have to be given the dignity and the right to fail.”* (Tom Posey 1988).

# Prior Research

- Homeless women in Toronto

*“Most...strongly preferred normal, independent living situations...not wanting to live with the mentally ill.”* (Goering et al., 1990).

- Mental health service consumers in Toledo

*“90% chose ...own home or subsidized apartment...78% wanted continued support.”* (Keck, 1990).

- Homeless adults in a Maryland shelter

*“Strongest preference [67%] was for living alone.”* (Neubauer, 1993).

- Mental health service consumers, Sydney Australia

*“Resistance to traditional, high-expectation group homes.”* (Owen et al., 1996).

- 26 surveys of mental health consumers

*“preferred...independent living ...in every study; group homes least popular in 21 studies.” Common preference for as-needed staff support* (Tanzman, 1993).

- Homeless mentally ill persons in Michigan

*“77%...an apartment or house would be their ideal living situation.”* (Yeich & Mowbray, 1994).

# Professional Orientations

“Mainstream housing where persons live alone in their own apartments and have to manage by themselves is beyond the capability of the great majority of this population” (Lamb, 1990)

“Professional staff tend to think that housing and support preferences expressed by their clients represent naïve wish lists and lack true recognition of clinical needs.” (Minsky et al. 1995)

“The mental health system...believe that we are not capable of living independently.” (Howie the Harp 1988)

“Social meaning of illness...essentially beyond his own control” (Freidson 1988)

# Complexities of Preferences

- **Uncertainty of preferences**

*“Preferences are neither absolute, stable, consistent, precise or exogenous (unaffected by the choices they control).”* (March 1978).

- **Long-run goals vs. momentary desires**

*“A failure of self-control occurs when the short-run preference leads to behavior contrary to the long-run plan.”* (Beshears et al. NBER Working Paper 2006).

- **Stated vs. revealed preferences**

*“Neo-classical economic theory...such an inconsistency is irrational.”* (Jeffrey 2006).

- **Conflict between preferences**

*“When each option has significant advantages and disadvantages, people often experience conflict, makes choice aversive, delay decision.”* (Tversky and Shafir 1992).

# Consumer Housing Preferences

# Sample Summaries

- DMH Shelters: N=66 Population
- McKinney: N=118 Screened
- McKinney 20 Yr Followup:  
N=75 Housing Data  
N=28 Interviews
- Generic: N=154 Random
- Trans & Generic '03: N=42 Availability
- VA: N=141 Purposive

14. How do you feel about having your Clinical Homeless Specialist help you with the things you have a hard time managing alone?

1 = Could use more help \_\_\_\_\_ [14]

2 = Just right

3 = Could use less help

16. If you now had a choice of living with others in a shared residence or alone in your own apartment, which would you prefer?

1 = Group living \_\_\_\_\_ [16]

2 = Apartment

a. How strongly do you feel about that? \_\_\_\_\_ [16a]

1 = Very strongly

2 = Moderately

3 = Not very strongly

20. How would you feel about having staff come in just during the day and help with cooking, cleaning and shopping?

1 = Strongly positive \_\_\_\_\_ [20]

2 = Positive

3 = Neutral

4 = Negative

5 = Strongly negative

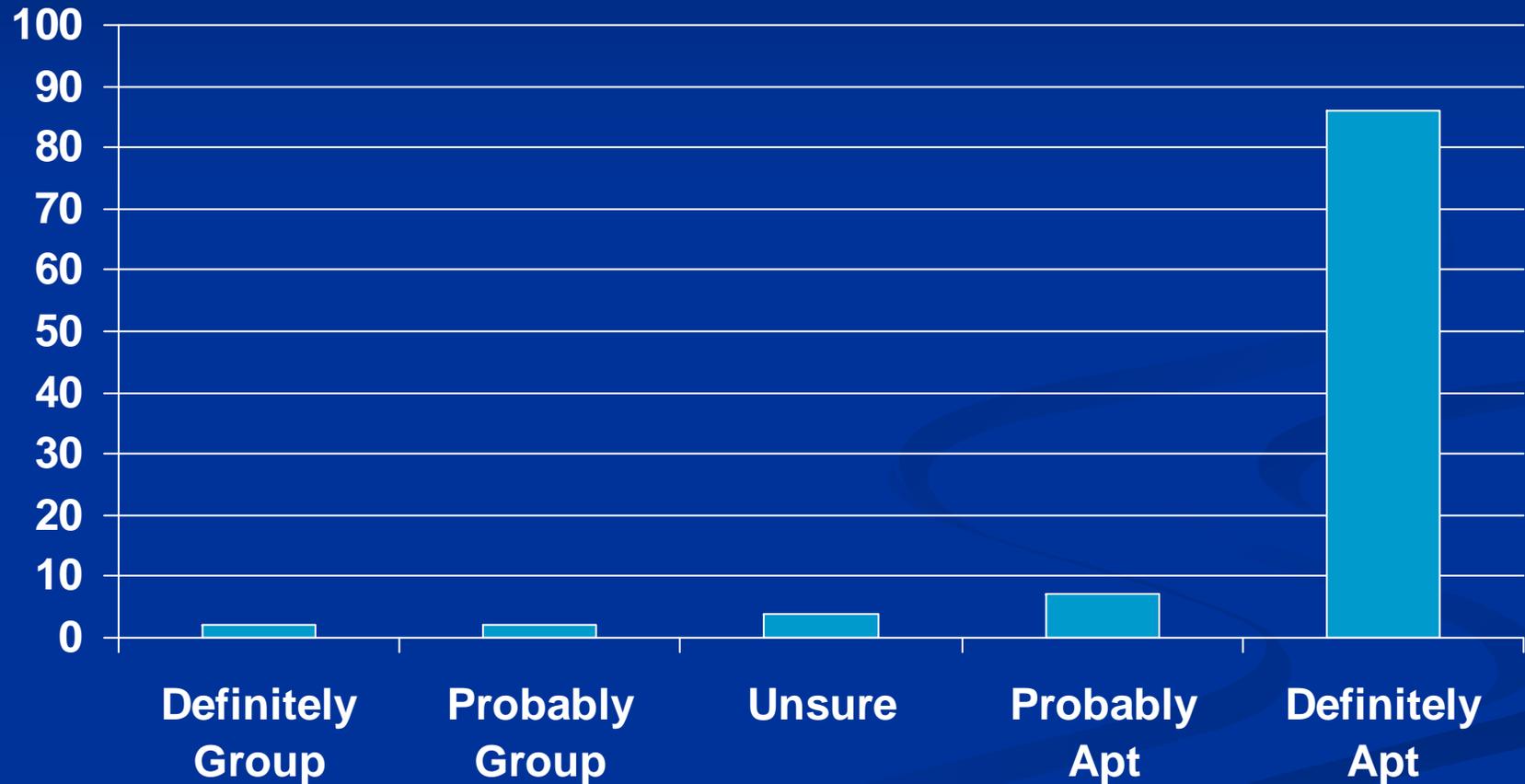
3. How likely do you think it is that this client would be able to manage if he/she moved into an evolving consumer household with intensive case management support?

EXTREMELY LIKELY.....1  
LIKELY.....2  
ABOUT 50/50 CHANCE.....3  
UNLIKELY.....4  
EXTREMELY UNLIKELY.....5

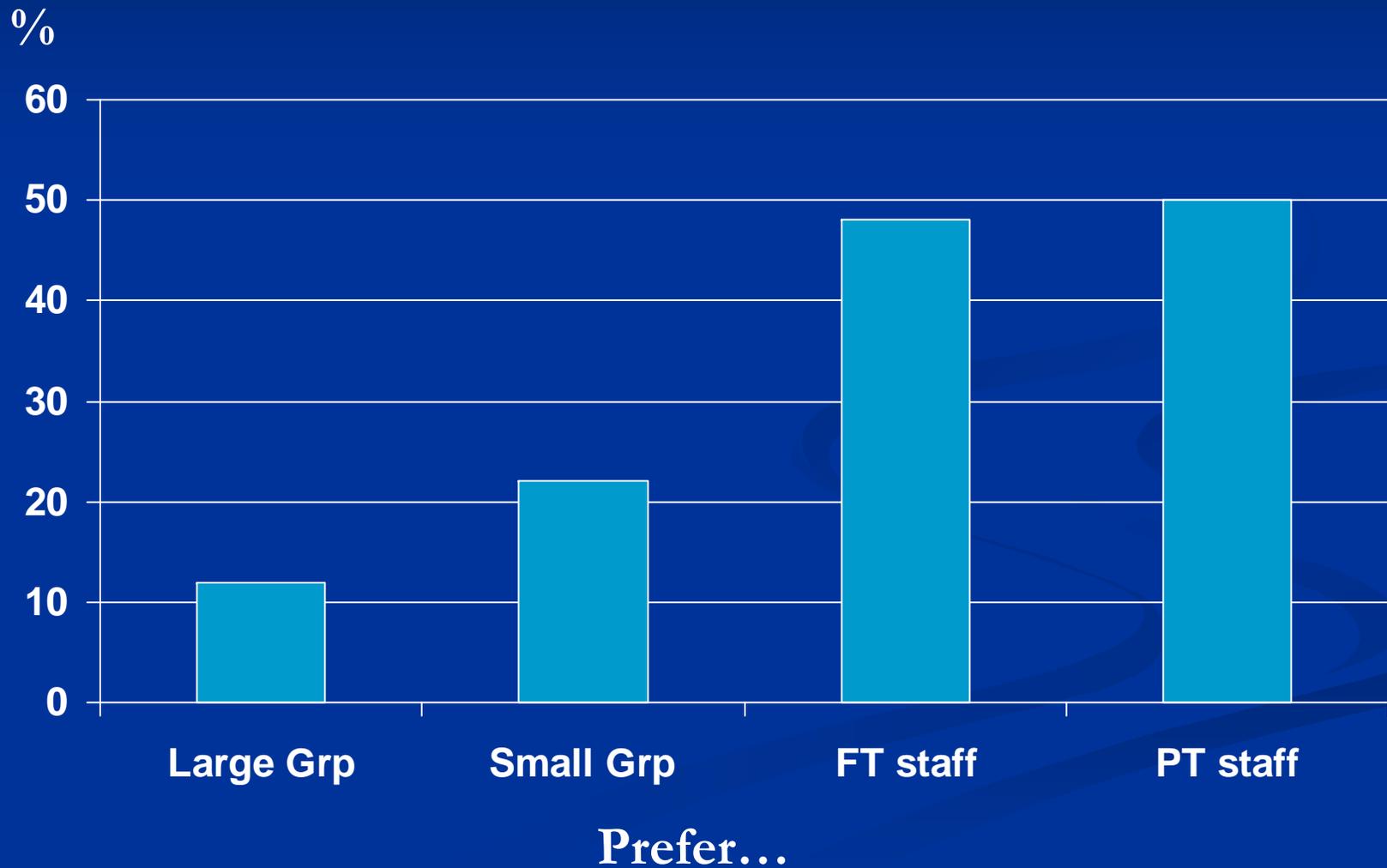
9. Overall, taking into account all of your sources of information, do you believe that this individual will do better clinically in an evolving consumer household or in an IL?

MUCH BETTER IN AN EVOLVING CONSUMER HOUSEHOLD.....1  
BETTER IF THEY STAYED IN AN E.C.H.....2  
ABOUT EQUAL.....3  
BETTER IF THEY STAYED IN AN INDEPENDENT LIVING...4  
MUCH BETTER IF THEY STAYED IN AN I.L.....5

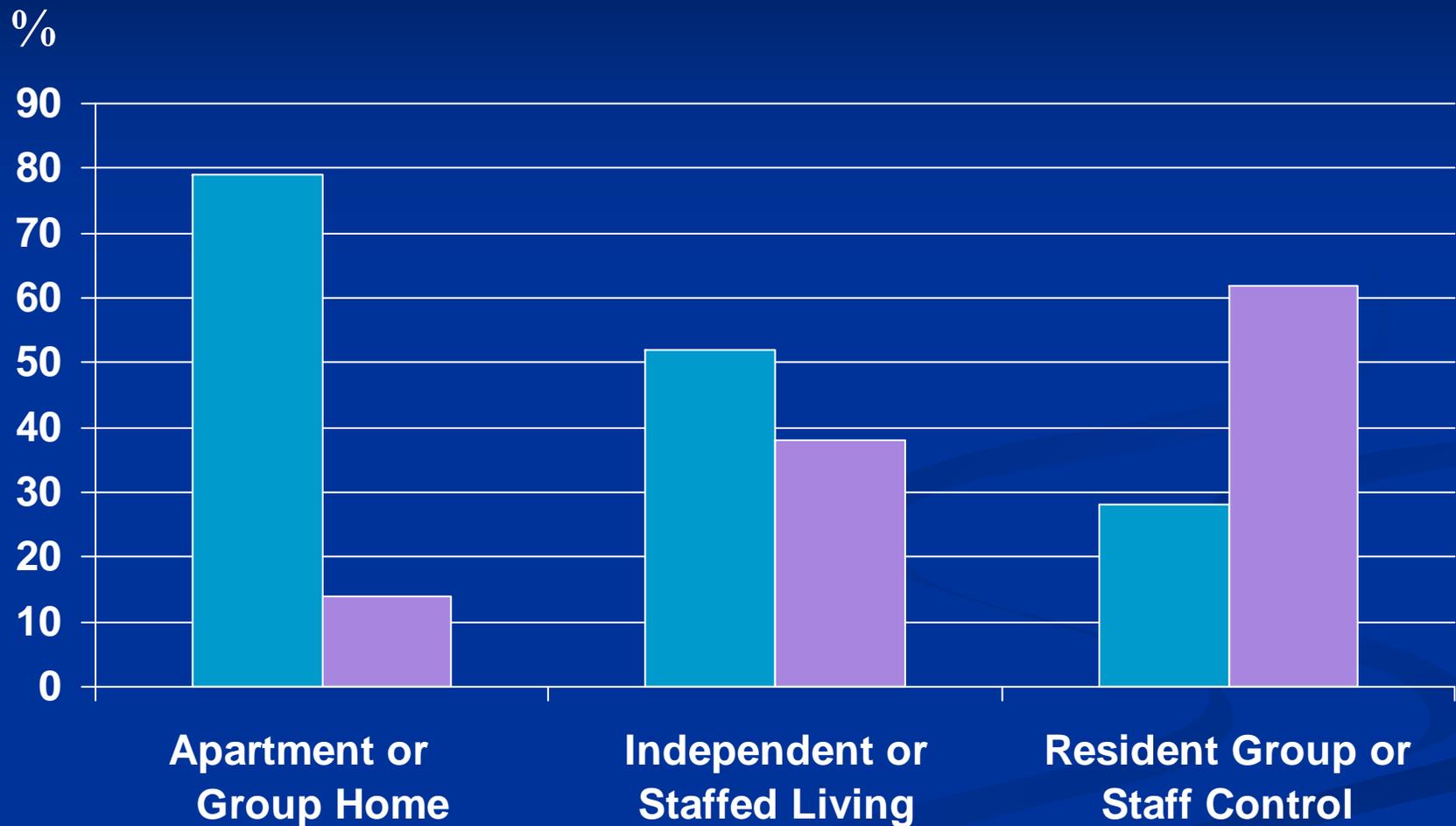
# Generic Shelter Group Preference



# McKinney Baseline Consumer Housing Preferences

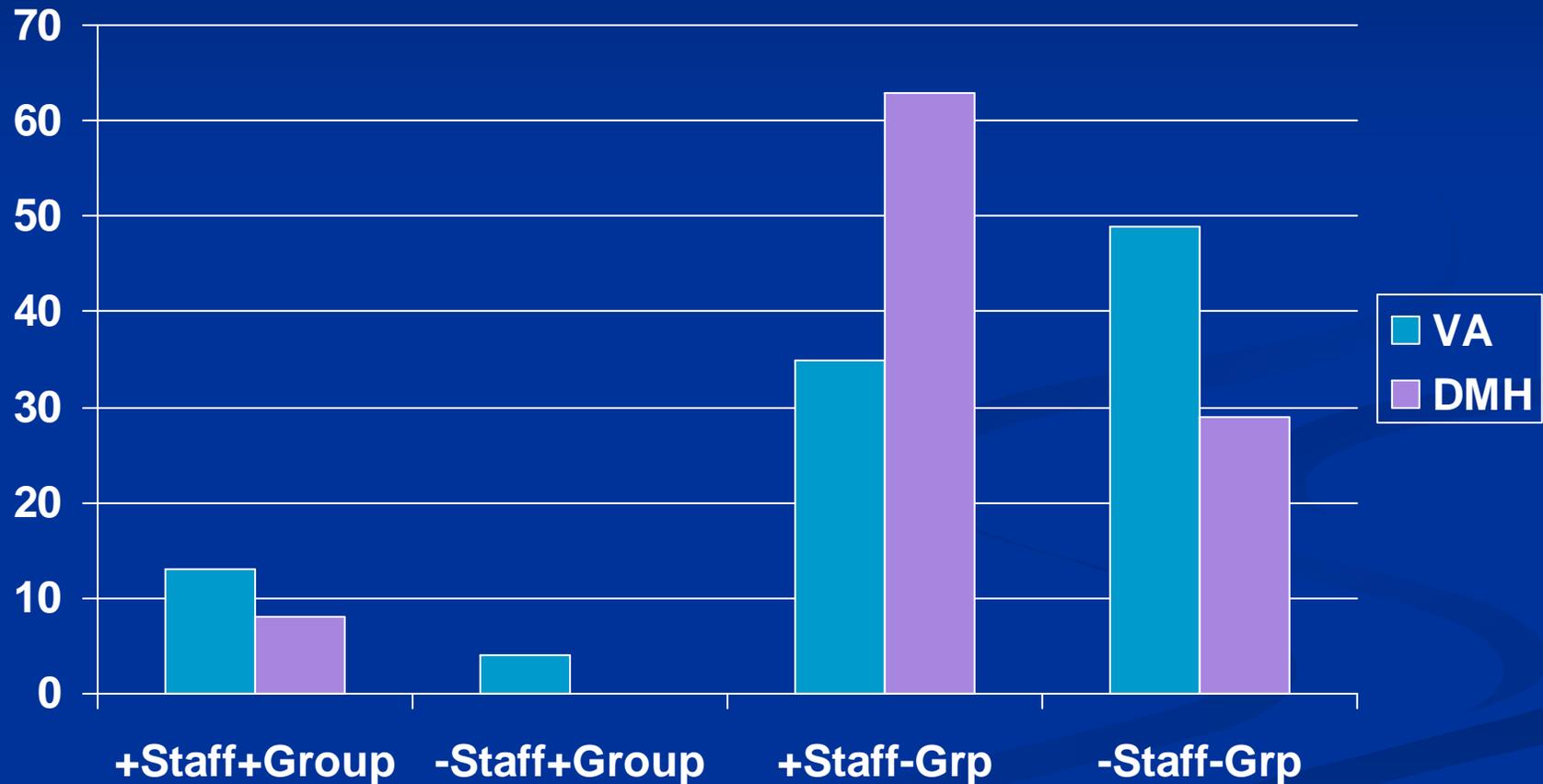


# Consumer Housing Choices, 2003

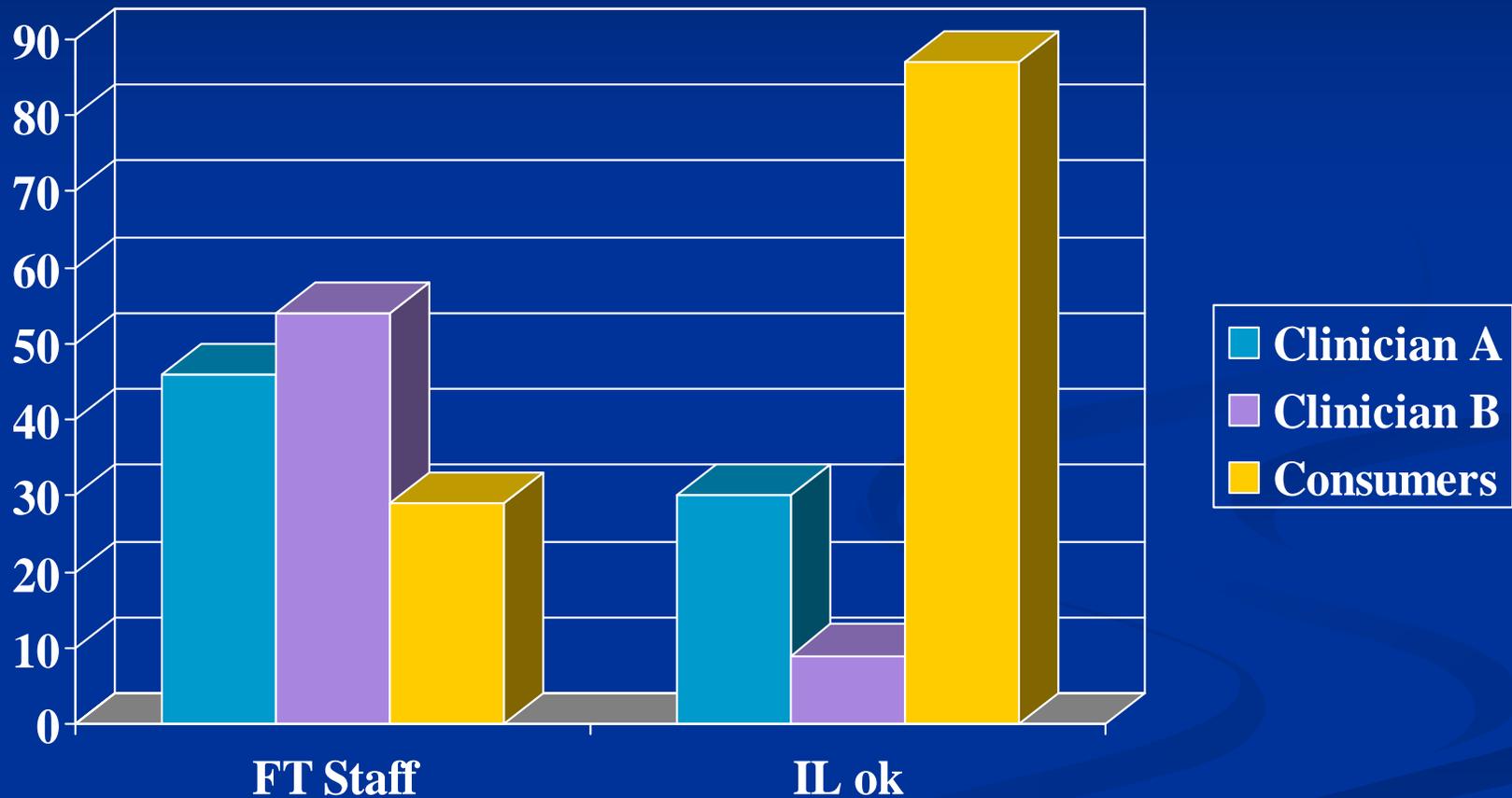


Choice Between Alternatives

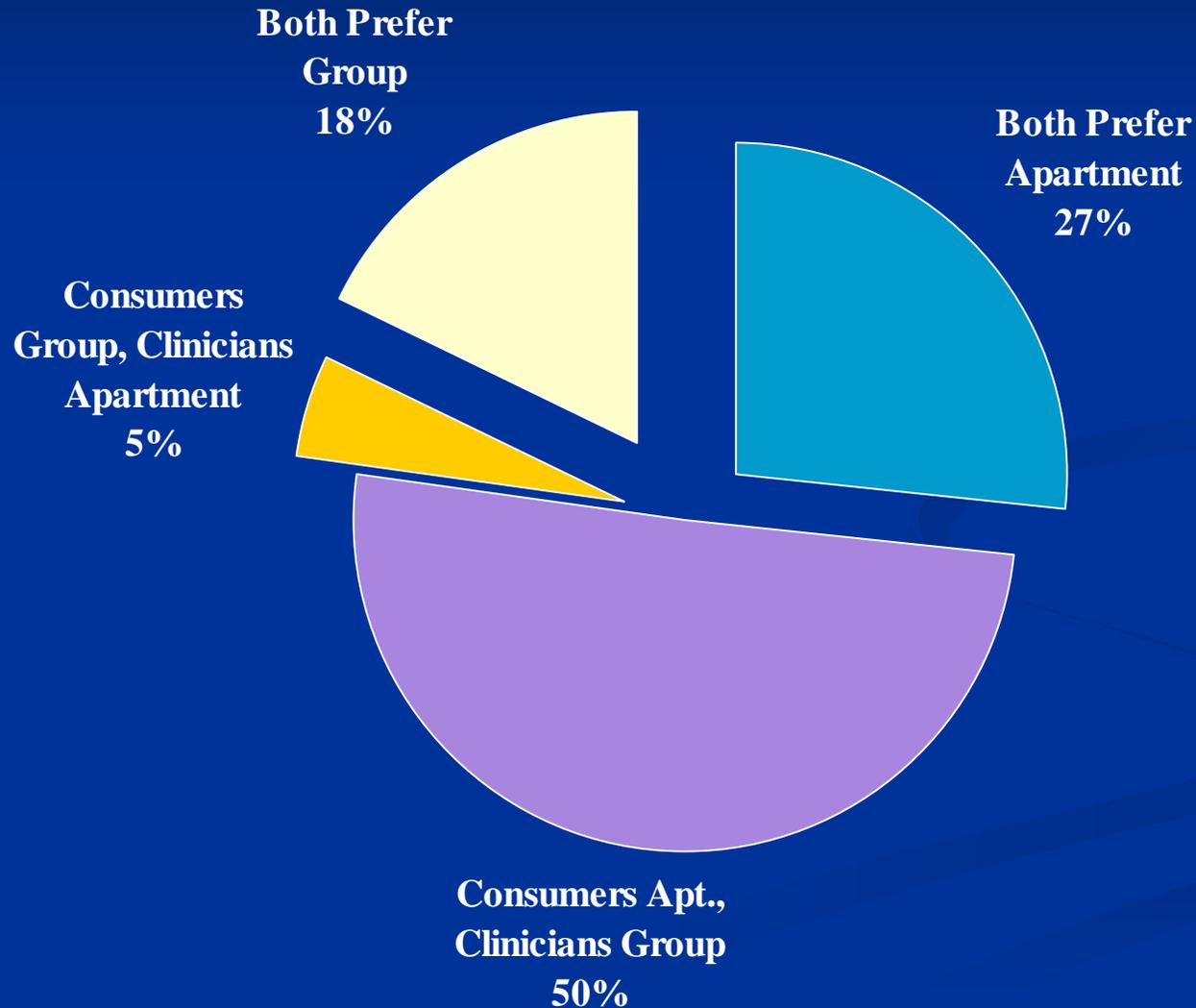
# Homeless Vets & DMH Shelters: Residential Preferences



# McKinney Clinician & Consumer Residential Preferences



# McKinney Consumer & Clinician Housing Preference



# Summary of Preferences Findings

- Consumers overwhelmingly prefer to live alone.
- However, many consumers desire staff.
- Less interest in staff among vets than MH shelter users.
- Little consumer interest in resident-run group homes.
- Clinicians do not concur with consumer preferences (blinded ratings).
- There is no relationship between self-assessed readiness for independent living and clinician rating.

# Consumer Housing Outcomes

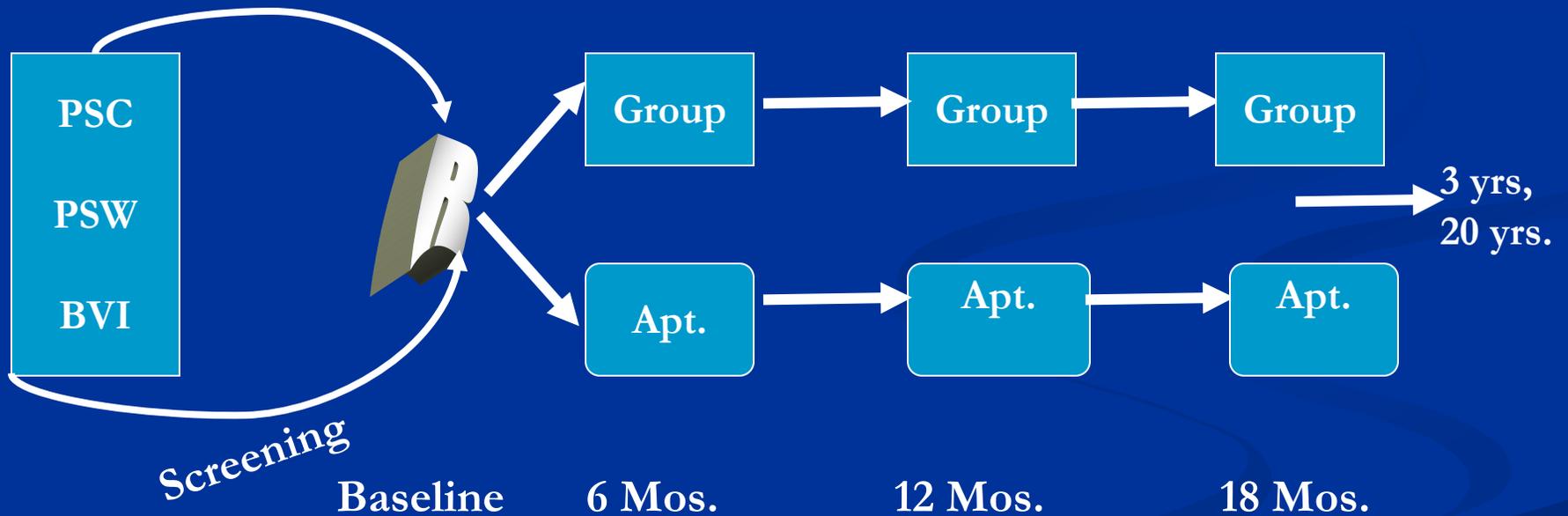
# McKinney Methods

# The Boston McKinney Project

- Evaluation research: homelessness & mental illness
- MMHC+HMS+DMH+Metro Boston+VinFen....
- Funders: NIMH (\$3.1 mill.) and HUD (\$10 mill.)
- Extra funding from UMass Boston, NARSAD, NIMH for shelter surveys, neurocognitive followup, costs, personality, long-term housing followup.

# Research Design

DMH  
Shelters



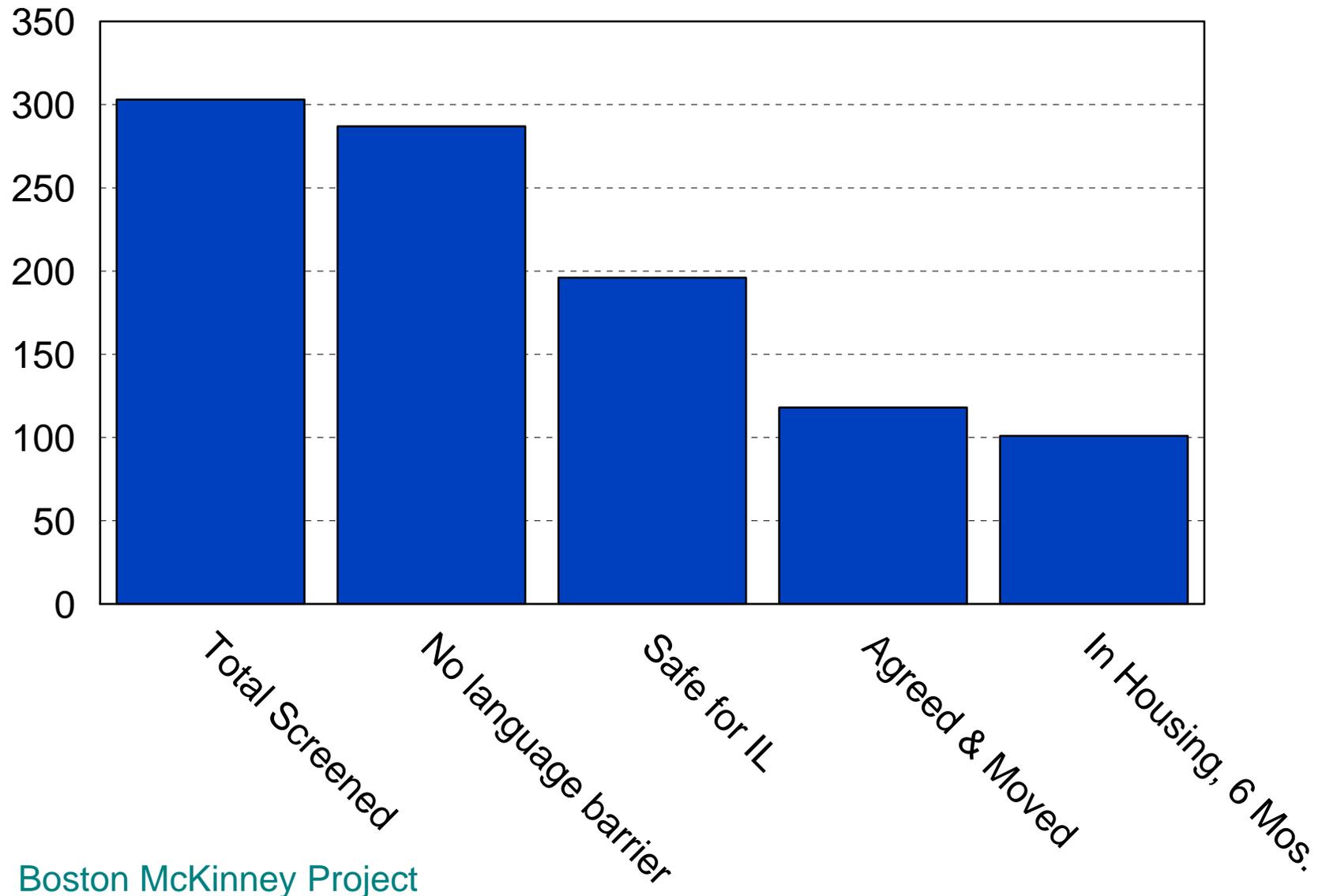
# Boston McKinney Housing Types

Control

Tenants

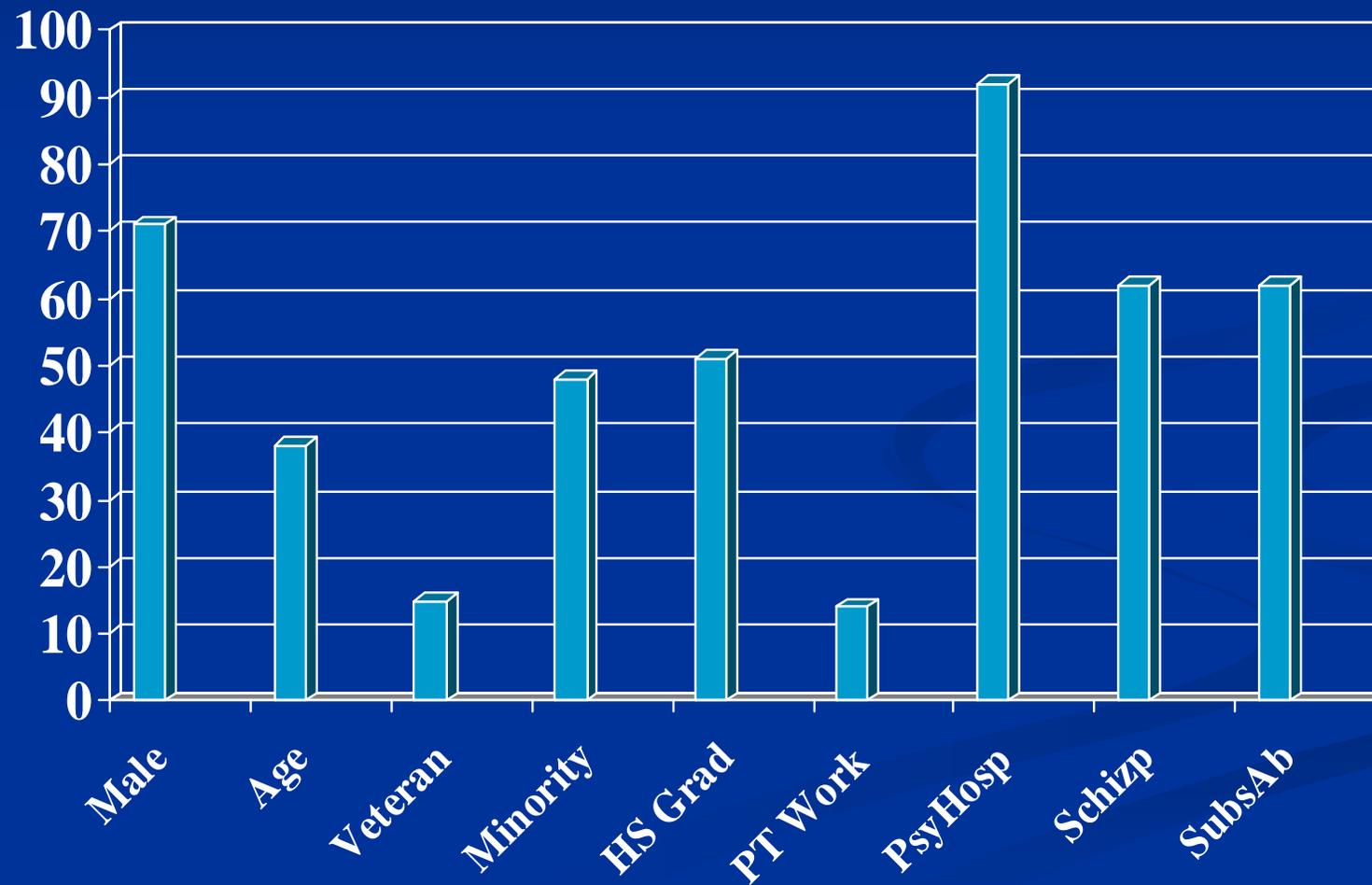
	Staff	Resident
Group	<i>Traditional Group</i>	Consumer-Run
Single	Supported Living	<i>Independent Apartments</i>

# Project Recruitment and Attrition



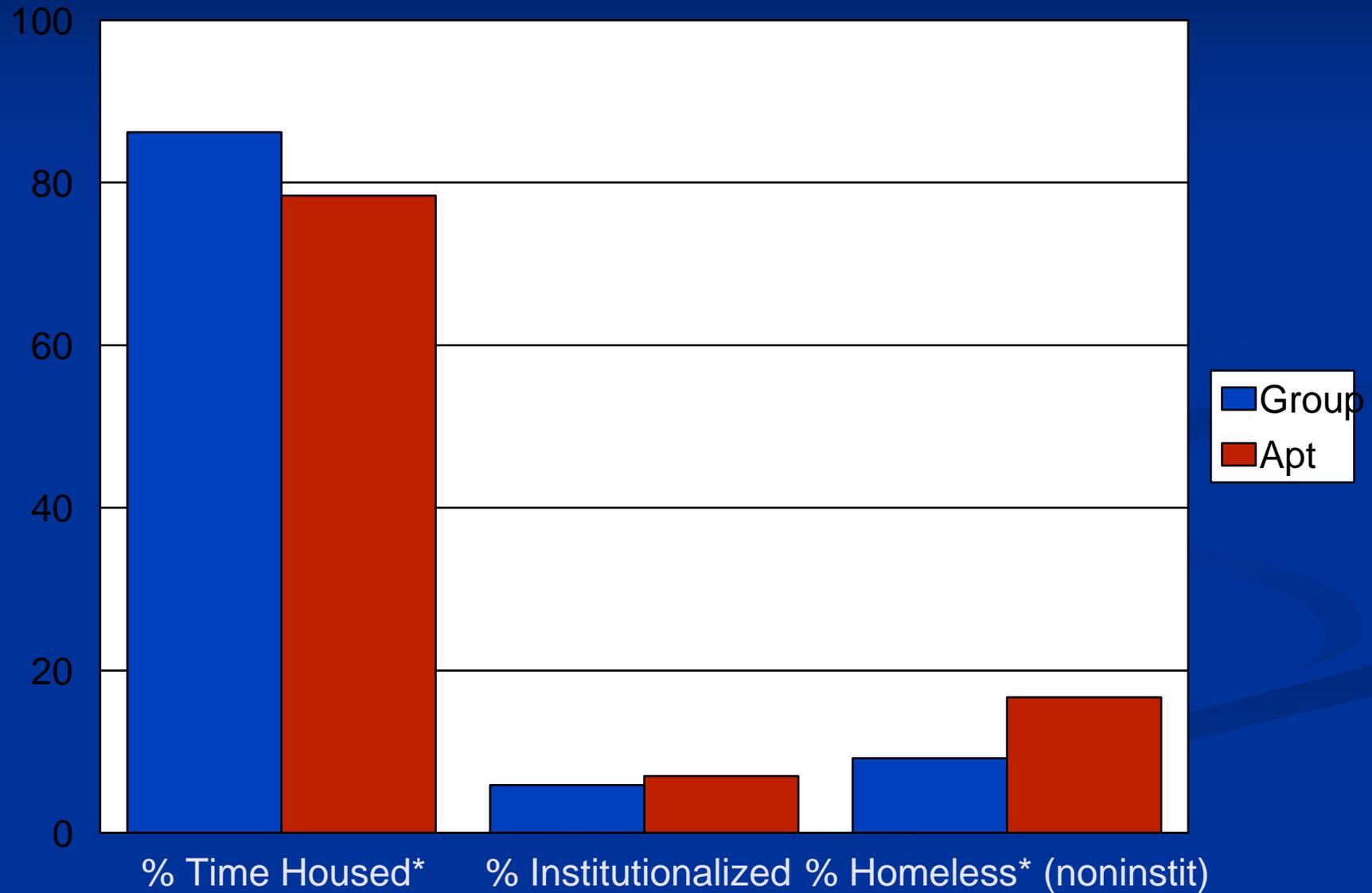
Boston McKinney Project

# McKinney Sample Characteristics

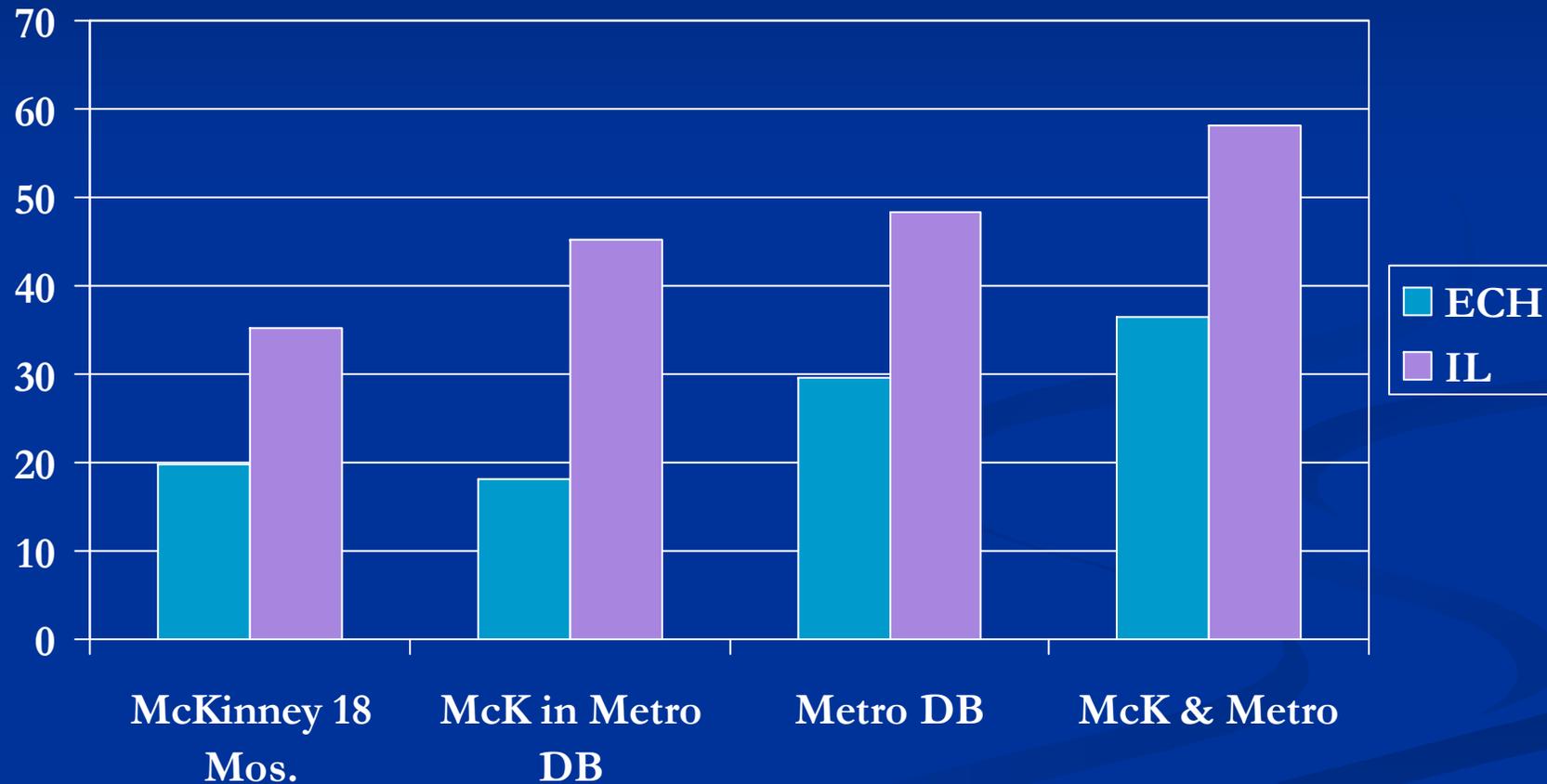


# Housing Effects

# Time Housed by Housing Type

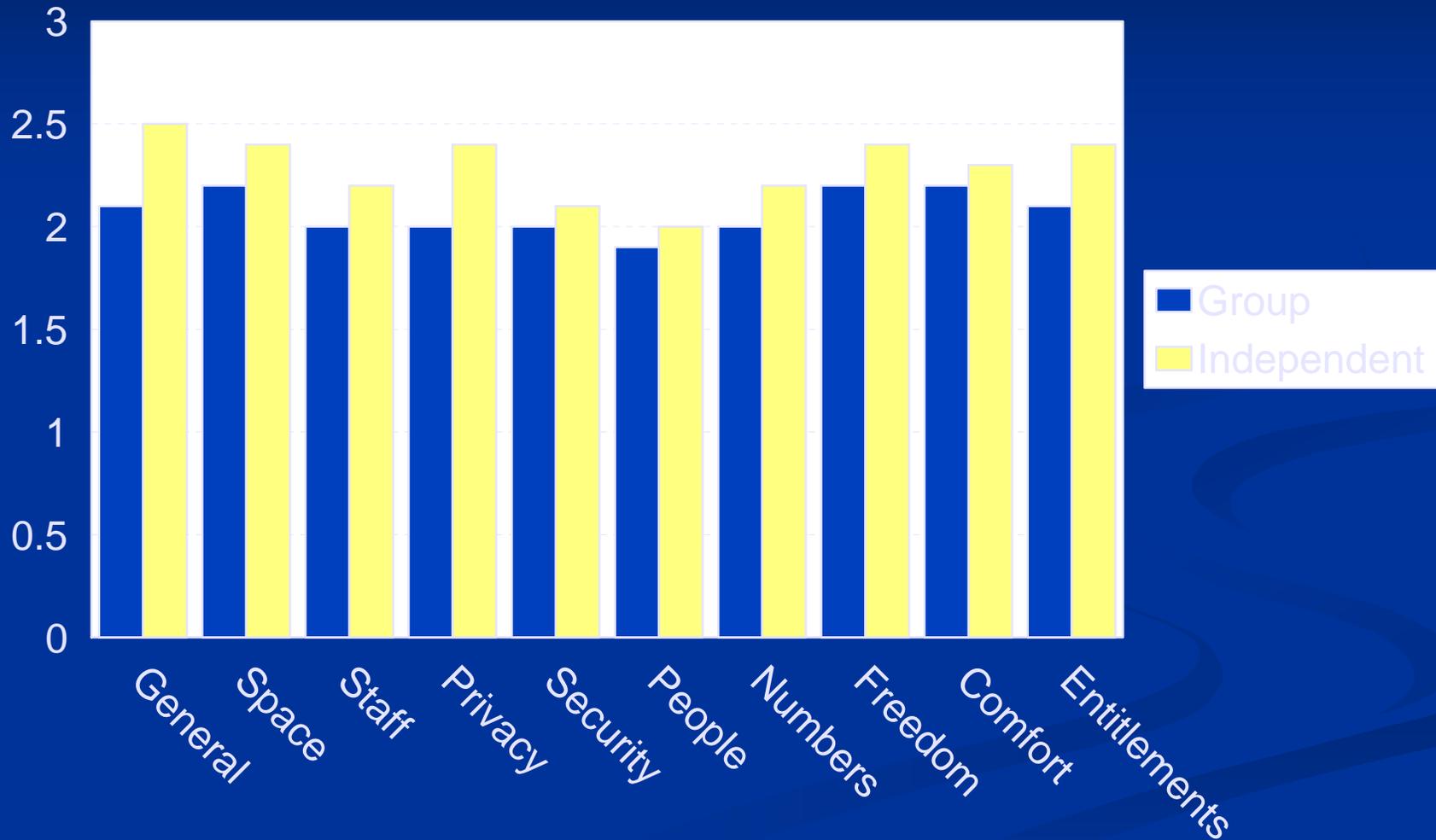


# Any Homelessness by Housing Type, Followup

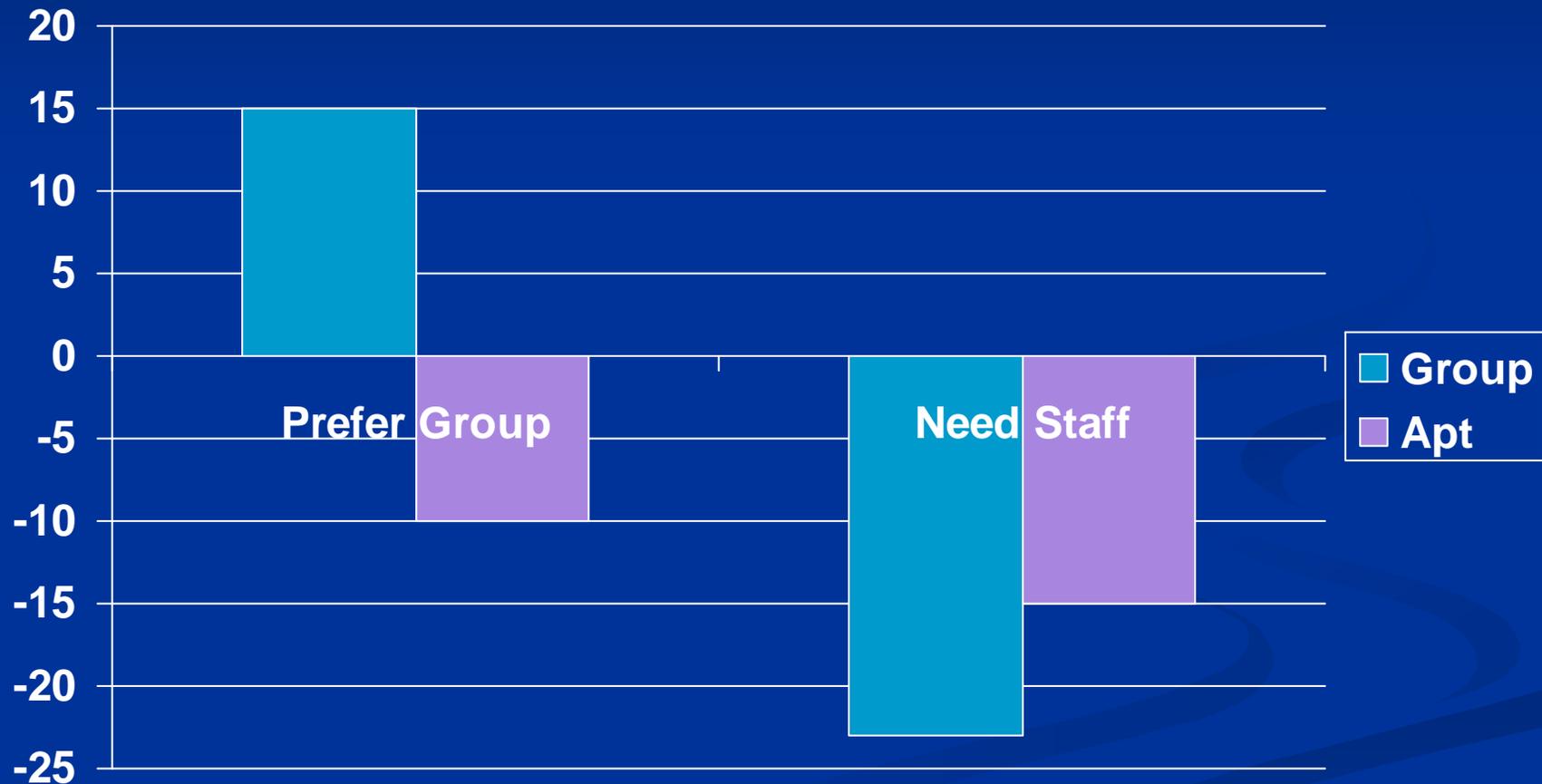


# Satisfaction with Housing Features

## Group and Independent Housing



# Change in Housing Preferences



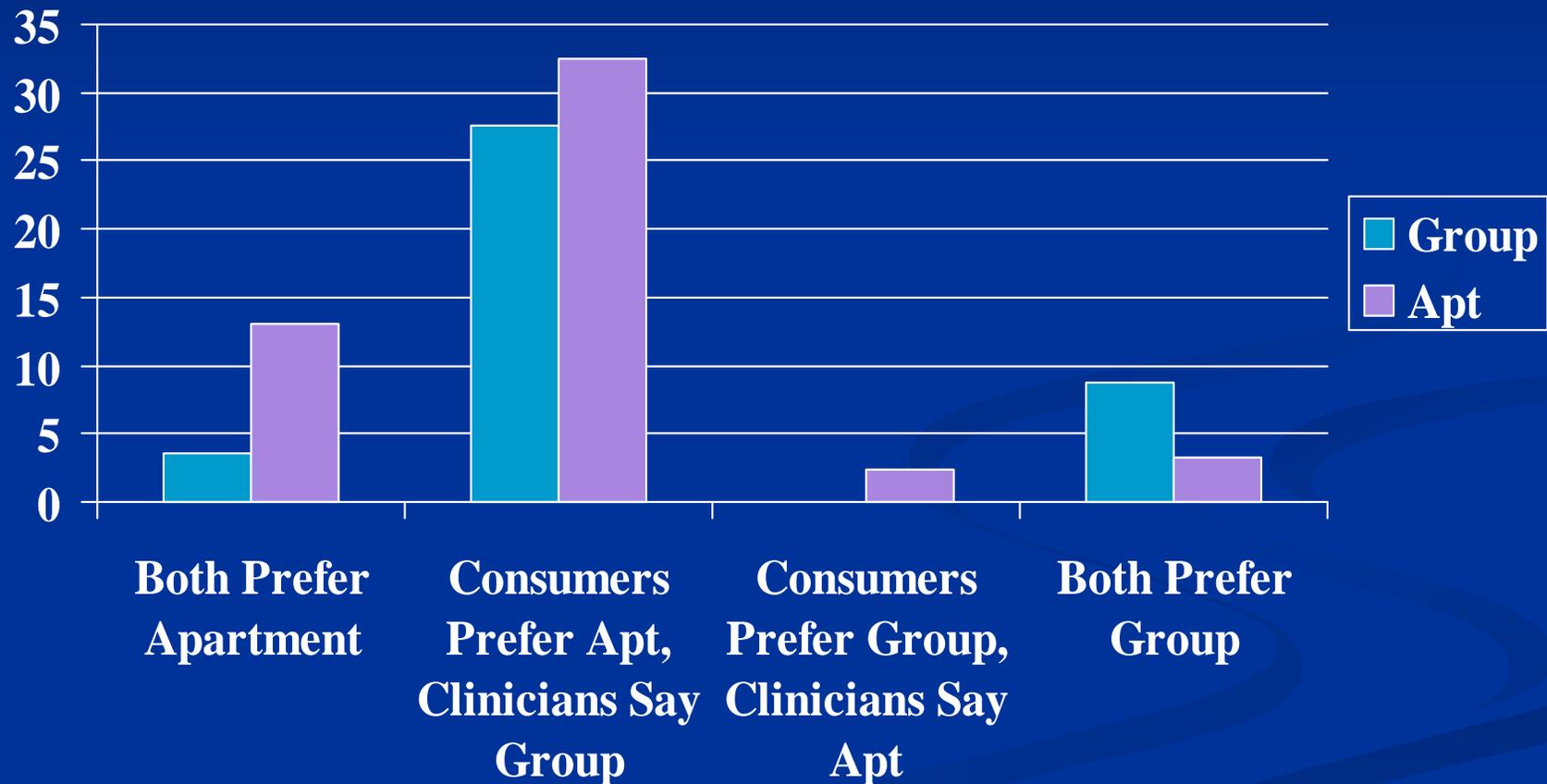
Baseline to 18 Mos.

# Summary of Housing Type Effects for Total Sample

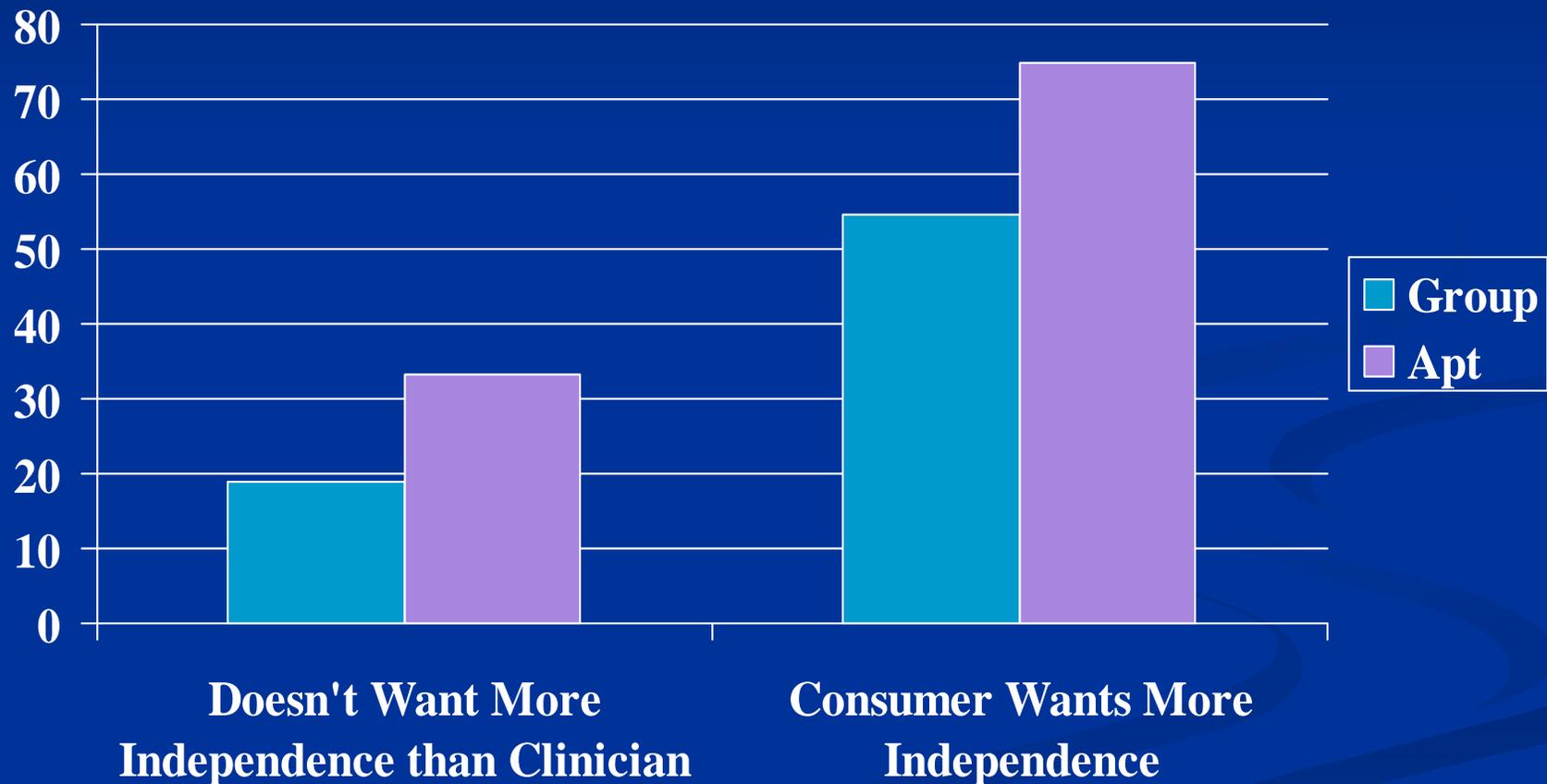
- Importance of Housing Programs
  - 27% had homelessness episode during the project (18 months).
  - 37% have been homeless in 20 year post-project period.
  - Housing experience reduced perceived need for staff.
- Group Home Benefits
  - Somewhat better housing retention.
  - Improved cognition (executive functioning).
  - More inter-tenant relations & liking for group living.
- Group Home Detriments
  - Lower housing satisfaction after 6 months.
  - *McKinney-style* group homes much more expensive.

# Preferences and Outcomes

# % Days Homeless by Housing Type & Preference/Rec.



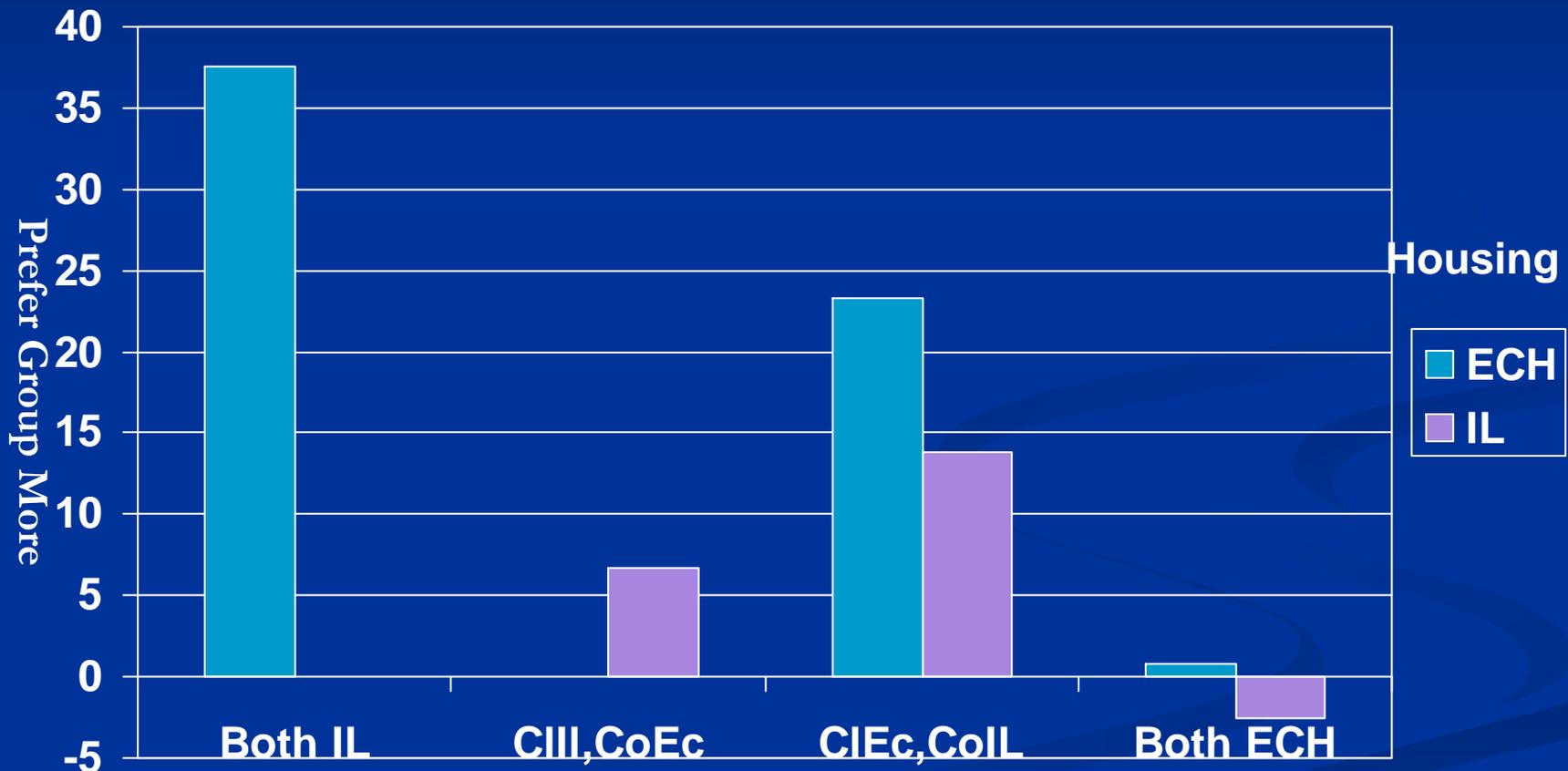
# Ever Homeless in 20 Year Followup



# Change in WCST Score by Housing Type and Clinician Housing Recommendation



# Increased Group Preference by Baseline Preference, Recommendation, Housing



# Summary of Preference-Housing Type Interactions

- Desire for independence when clinician recommends group predicts more risk of housing loss
- Placement on basis of preference increases risk of housing loss
- Cognitive gains from group homes for those recommended for independent living
- Increased liking for group for those seeking independence if randomized to group home

# Conclusions

# Summary

- **Consumer Preferences Do Not Predict Optimal Placement**
- **Clinicians Can Identify Need for Support**
- **Group Housing Maximizes Retention, Cognition**
- **Preferences Change with Experience**
- **Independent Housing Maximizes Satisfaction, Minimizes \$**
  
- **Rejection of Needed Support Predicts Housing Loss**
- **Rejection of Needed Support Interferes with Social Benefit**
- **Social Interaction Helps Some Regain Stability**

# Policy Implications

- Service preferences differ from service needs.
  - Rejection of support predicts poor outcomes.
  - Desire for support predicts good outcomes.
- Staff and peer support are beneficial.
  - Different persons have different benefits, capacities.
  - Social interaction improves cognitive & community functioning.
- Risk of housing loss can be predicted.
  - Treatment-person matching improves outcomes.
  - Substance abuse programming is essential.
- Cost/benefit ratio can be improved.
  - Peer specialist staffing could reduce costs.
  - Long-term benefits of cognitive gains, housing retention, changes in housing preferences.