Supported Housing for Individuals with Mental Illness (SHIMI): An Evaluation

Prepared by Catherine Leviten-Reid, Cape Breton University, Pamela Johnson, Cape Breton University, and Michael Miller, Crossroads Clubhouse. Questions about this report may be sent to catherine_leviten-reid@cbu.ca.

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Executive Summary

This report presents a summative and formative evaluation of the Supported Housing for Individuals with Mental Illness (SHIMI) initiative. In this evaluation, the housing experiences of tenants, as well as the effects of these housing experiences, are explored. This evaluation also addresses how SHIMI may be improved.

Background: SHIMI began in 2007 and currently offers 27 units of supported housing in the Cape Breton Regional Municipality. Tenants have access to mental health services through the local health authority, and a housing co-ordinator provides practical assistance, including transportation, budgeting support, in-home support, and referrals. All units are in buildings that house from two to five SHIMI tenants. Buildings are located in 'typical' neighbourhoods in three communities within the municipality. A local, not-for-profit community economic development corporation owns and maintains the units, which are rented at an affordable rate.

Methods: Data were generated through in-depth interviews, the use of photography and a member checking meeting. Researchers endeavoured to interview all current and former SHIMI tenants. At the time the interviews were conducted, this meant 23 current and five former tenants. Fourteen existing and two former SHIMI tenants agreed to participate (N=16). Data were analyzed using a line-by-line thematic analysis.

Key Findings: Most research participants lived in unacceptable rental housing before acquiring supported units. They reported that they had little security of tenure, that units were in need of repair, that units were expensive, and that landlords were unresponsive. These living conditions negatively affected their mental health. In turn, research participants reported that SHIMI provided them with good quality housing and some access to formal and peer supports. Participants reported feeling safe and stable in their new homes, as well as integrated into their communities. They also reported positive changes in their lives, ranging from having greater self-esteem, to managing their symptoms of mental illness, to being able take new steps, such as finding work and re-connecting with family.

Research participants indicated that their SHIMI housing could be improved through more formal and peer supports, through the organization of initiatives that would build their assets and reduce their living costs (for example, bulk buying of food), and by involving them to a greater degree in the management and control of their supported housing. Further recommendations include that the landlord be as responsive as possible to requests for repairs made by tenants, that the SHIMI advisory committee pay attention to accessibility and consider adopting universal design standards, that the SHIMI advisory committee continue to pay attention to the 'ordinary details' of housing that this research suggests are important to tenants (such as windows, porches and being able to paint apartments), and that the advisory committee develop supported housing at a faster pace given both the success of the initiative and the level of need in the community.

Background

Supported Housing for Individuals with Mental Illness (SHIMI) began in 2007 and currently offers 27 units of supported housing in the Cape Breton Regional Municipality, Nova Scotia. Tenants have access to mental health services through the local health authority, and a housing co-ordinator provides practical assistance to tenants, including transportation, budgeting support, in-home support, and referrals. All units are in buildings that house from two to five SHIMI tenants, meaning that consumers living in 'SHIMIs' have neighbours also living with mental illness. Buildings are located in 'typical' neighbourhoods in three communities within the municipality. New Dawn Enterprises, a local, not-for-profit community economic development corporation (CEDC), owns and maintains the units, which are rented at an affordable rate. Funding was provided to the CEDC to purchase and renovate apartments from foundations and different levels of government, while the individuals living in SHIMIs receive rent supplements. Until recently, the initiative has been governed by an advisory committee which included representatives from partnering organizations and a SHIMI tenant. At present, a new, formally incorporated organization has assumed responsibility for managing the initiative. Partnering organizations are the Cape Breton District Health Authority, Cape Breton Mental Health Services, the Mental Health Foundation of Nova Scotia, the Canadian Mental Health Association, New Dawn Enterprises, Crossroads Clubhouse, Pathways to Employment and the Mental Health Charitable Foundation of the Cape Breton Regional Hospital. Currently, there are 60 consumers waiting for a SHIMI unit.

What is Supported Housing?

Supported housing is a specific model of housing for individuals with mental illness. Consumers live independently in their own apartments, and are able to access a range of support services, if they so choose, based on their own goals and needs (Henwood, Stanhope and Padgett, 2011). To facilitate community participation and to counter segregation, housing is integrated into neighbourhoods (Carling, 1995). Models of supported housing vary across the country and around the world; for example, in some, individuals live in their own apartments located in buildings with other individuals living in supported housing units, while in others, consumers live in units which are scattered across buildings and neighbourhoods. The nature of the support available to consumers also varies by project. In the literature, including Nova Scotia's housing strategy (Province of Nova Scotia, 2013) and the federal government's 2013 budget (Government of Canada, 2013), this approach is also called 'housing first'.

Research Purpose

The purpose of this research is to conduct an evaluation of SHIMI. In part this evaluation is summative (Patton, 2002) in that we explore the housing experiences of tenants before and after moving into their supported housing units and the effects of these experiences on their lives. In part this evaluation is also formative (Patton, 2002) in that it explores how tenants feel the

SHIMI initiative may be improved. This evaluation was conducted at the request of the SHIMI advisory group.

Methods

This evaluation is qualitative in approach. Data were generated through in-depth interviews, the use of photography and a member checking meeting. We used a purposive sampling strategy (Robson, 2011), and endeavoured to interview all current and former SHIMI tenants. At the time the interviews were conducted, this meant 23[1] current and five former tenants. Fourteen existing and two former SHIMI tenants agreed to participate (N=16). Participants were evenly divided by gender, and ranged from 30 to 60 years of age. All but two participants lived in rental housing directly before moving into supported housing, while one individual lived with family and one owned her own home. All participants were living in, or had lived in their units, for at least one year, with the range being one to almost six years. Note that the former SHIMI tenants who participated in this project moved out of their units due to reasons unrelated to their housing or their mental illnesses.

Research participants were invited to participate through a letter and a follow-up phone call made by the housing co-ordinator. A session was also held at Crossroads Clubhouse to provide all potential participants with information on why the research was being conducted, the kinds of questions that would be asked, and the ethical conduct of research.

Interviews lasted for approximately one hour each, and were conducted primarily by the second and third authors. In two cases, the first and second authors conducted interviews. All but one interview were recorded and transcribed. For the interview which was not recorded, notes were taken by both researchers during and after the interview. Interviews were conducted in locations chosen by research participants. Twelve consumers opted to have interviews conducted in their own apartments. Three consumers, including the two former SHIMI tenants, requested to be interviewed at the consumer clubhouse, while one requested to be interviewed in the apartment of a friend. Participants received a $20 honorarium. Interviews were held in the summer of 2012.

Reflexive photography was also used as an additional method of data collection: when interviews took place in people’s homes, they were invited to take pictures which they felt captured what was important about their supported housing. The digital camera was used to facilitate discussion and to make the process more engaging for participants (Kolb, 2008; Russell and Diaz, 2012; Schulze, 2007). Photographs were taken at the end of the interviews using a camera brought by the researchers. Nine individuals opted to take photographs, although one participant decided to withdraw her picture at the end of her interview.

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[1] There were 23 individuals living in SHIMI housing but only 21 units because two were occupied by couples.

Finally, data were also collected through a two hour member checking meeting. While this meeting was held to establish validity of the findings, participants also shared additional thoughts and experiences related to the research questions. This meeting was recorded, transcribed and used in the final iteration of the data analysis. The member checking meeting was held in March of 2013.

Data were analyzed using a line-by-line thematic analysis (Robson, 2011). This process was conducted independently by the first and second authors, during which they read and re-read interview transcripts and coded phrases which were then used to generate themes. These authors conferred throughout the analysis to better understand the meaning of the phrases in the transcripts, to bring consistency to coding process and to discuss emerging themes and sub-themes (Meadows and Morse, 2001). The third author then reviewed the draft findings and provided comments, and the analysis was revised accordingly.

Three features of this research contribute to its validity (in other words, that the data collected is actually true). First, one of the researchers is a consumer who is known and well-liked by other consumers in the local community; this helped research participants feel comfortable during the interviews and the member checking meeting, and helped build trust between the research participants and the research team. Second, the draft analysis was presented to research participants. Five participants attended this member checking session and they concluded that we accurately captured, with an exception of one sub-theme, what they shared with us during the interviews. Finally, we bring investigator triangulation to the study in that members of the research team bring different areas of expertise to the project. These include a combination of research, practice and lived experience in the following fields: community development, social work and advocacy, housing, participatory organizations and mental illness.

This evaluation has four limitations. First, only one third of research participants attended the member checking meeting; greater participation would have resulted in stronger validity. Second, a longitudinal research design would have better captured the housing experiences of participants before and since living in supported housing and the effects of these experiences on their lives, since data that is based on reflections of past experiences may have recall bias. Third, tenants were not involved in designing the research questions; having tenant participation at this step of the research process could have made the findings more relevant to SHIMI tenants (Rapp, Shera and Kisthardt, 1993). Fourth, not all former and current SHIMI tenants participated in the research.

This research received ethics approval from Cape Breton University and the Cape Breton District Health Authority.

Literature Review

Individuals with mental illness have reported a number of barriers to finding and keeping housing: for example, the existing literature shows that they face stigma, have difficult landlords,

and are often unable to access housing that is safe, of good quality, and affordable (Forchuk, Nelson and Hall, 2006; Walker and Seasons, 2002). Low incomes and a lack of employment opportunities have also kept individuals with mental illness from obtaining and keeping housing (Mojtabai, 2005; Tsai et al., 2010), while limited access to health care services also compromise the ability of consumers to live independently (Forchuk, Nelson and Hall, 2006).

For consumers who are able to acquire supported housing, there is a growing body of literature on the effects of this housing on their lives. Individuals living in supported housing have reported more control over their lives (Nelson et al., 2007; Parkinson and Nelson, 2003; Tsemberis, Gulcur and Nakae, 2004) and experience greater housing stability compared to those accessing other housing options (Cheng et al., 2007; Goering et al., 2012; Tsemberis, Gulcur and Nakae, 2004). Moving into supported housing has also been found to result in less involvement in unlawful behaviour (Bean, Shafer and Glennon, 2013).

Alcohol use is an additional outcome of interest. Individuals living in supported housing have been found not to differ from individuals in supportive housing options in their use of alcohol and drugs, even though this latter form of housing requires residents to participate in treatment programs (Padgett, Gulcur and Tsemberis, 2006; Tsemberis, Gulcur and Nakae, 2004). Veterans with mental illness living in supported housing were found to use fewer substances than those receiving different levels of case management only (Cheng et al.,2007), while a pre-test, post-test study found that homeless individuals with mental illness reported less substance abuse after moving into supported housing (Bean, Shafer and Glennon, 2013).

There is conflicting evidence regarding the effect of supported housing on community integration. Walker and Seasons (2002) found that individuals living in supported housing felt isolated and, for those who were living in apartment buildings specifically for low-income households, segregated. Participants also felt their illnesses were not understood by landlords and neighbours. However, Gulcur et al. (2007) found that residents living in supported housing reported greater social integration than residents living in different forms of residential housing, while Parkinson and Nelson (2003) found that individuals living in supported housing experienced community integration through their recreational or educational pursuits, their volunteer work, or through new jobs.

The literature on how supported housing affects mental health is also inconclusive. For example, in a longitudinal study, the psychiatric symptoms of individuals living in supported and supportive housing were not found to differ (Tsemberis, Gulcur and Nakae, 2004). Similarly, Cheng et al. (2007) found that homeless veterans with mental illness living in supported housing did not differ in their psychological distress compared to veterans receiving only case management. In testing a core dimension of supported housing, Nelson et al. (2007) found that choice and control over housing did not predict community adaptation, a measure capturing '. . . functioning, adjustment to living, social competence, and behavioural problems.' (page 94) Conversely, Gulcur et al. (2007) also tested the effects of choice and found that it was a

significant and positive predictor of psychological integration and self-actualization. Further, a narrative study of supported housing residents found that research participants reported fewer hospitalizations, better coping skills and more knowledge about their mental illnesses since living in supported housing, and were also able to set new goals for themselves (Parkinson and Nelson, 2003). Siegel et al. (2006) found that those living in supported housing for at least six months within a one year period used fewer crisis services compared to both individuals living in different kinds of community residents and individuals moving in and out of supported housing, while Henwood et al. (2011) found that consumers living in supported housing felt able to pursue personal interests.

FINDINGS

The data are organized into six themes: living with mental illness, housing experiences before SHIMI, the effects of these housing experiences, housing experiences since moving SHIMI, the effects of these housing experiences, and improving SHIMI[2].

Living with Mental Illness

Although we did not ask research participants about their day-to-day experiences living with mental illness, these were shared with us during the interviews. Consumers told us they regularly faced stigma in different facets of their lives, and that living in a small community meant that their illnesses were widely known. This stigma and lack of anonymity led participants to be denied opportunities such as bank loans, jobs, and volunteer work. One participant explained how the stigma of mental illness prevented him from finding housing:

> You need to keep in mind that when you are on social services the landlord knows where the money is coming from. You need to bring the blue sheet and get the landlord to sign it [to receive your rental supplement]. . . . if you are physically able to walk around the apartment, well . . . he can put two and two together. Either you are getting a pension for a physical thing or a mental illness. If the landlord doesn't want to rent to you he just says 'Ah, well, before I sign I have some people I want to show it to.'

Participants also spoke about the lack of attention given to this poor treatment and to mental illnesses in general. One individual stated that 'You watch a movie in the 50s . . . the way Black people are treated, and that is just the way it is. Because it is the same with mental illness, tough for us . . . .' Another individual stated the following: 'There is no advocacy or whatever you want to call it, for people with mental illnesses. You know what I mean? That is just the way it is, nobody cares.'

Experiences with Prior Housing

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[2] When the findings are presented, we sometimes use different gender-specific pronouns (for example, we might use 'he' when the participant is a woman) in order to maintain confidentiality.

Research participants’ experiences with prior housing encompass the physical conditions of rental housing, the safety of rental housing, the responsiveness of landlords, affordability, and stability.

While three research participants had generally positive comments to say about the physical conditions of their prior rental housing, other consumers experienced their rental housing differently. Individuals spoke about structural problems with this housing; for example, one individual stated that ‘They were dives . . . the apartments were falling apart. The windows were cracked in the bathroom before we moved in. It was a nightmare.’ Another individual stated that ‘I lived in apartments that were shacks . . . .’ Participants also spoke of buildings being infested with vermin, and about not having control over utilities. This became a problem during winter months, when they were not able to regulate the amount of heat available or have heat at all. One consumer reflected that ‘They went and cut off the heat in the middle of the night . . . . When I look back it was cold, very cold.’ Another participant stated that ‘I would be sitting around in the winter [in my previous apartment] with my jacket and boots on.’

Participants also spoke about feeling unsafe. This was due, in part, to location: the rental housing that they were able to access was situated in unsafe neighbourhoods, and participants were fearful of drug dealers, addicts and arsonists who were living in their buildings or nearby. Feeling unsafe was also related to the poor physical condition of the housing. As one consumer explained, ‘Someone was trying to get into my house. My door was coming off the hinges. My friend came over with his drill and fixed the door so no one could get in.’

Research participants also indicated that their prior housing was expensive. For example, one individual stated that ‘Some of the landlords around here . . . you would think it was Toronto with the rents that they want.’

Most research participants experienced instability in their prior rental housing. In part this was related to cost; for those who rented, dramatic and unanticipated rent increases resulted in frequent moves. One individual stated the following: ‘…when I gave my notice at the last apartment, the rent had skyrocketed to $200 to $300 more than I could afford. For $600, you could only get a bachelor’s apartment. . . . So that made me homeless. I had the option of living in a dive or a bachelor where I would be sitting in one room all day.’ Cost was also a barrier for a research participant who sold the home she owned because she could not afford to make necessary repairs. Housing instability was also experienced because research participants who rented did not have security of tenure. As one research participant explained: ‘He gave us a sheet that told us we were all being evicted. Well, he didn’t put it like that . . . he told us he was renovating.’ Finally, for one consumer living with family, lack of housing stability was caused by changing household circumstances. This individual explained that: ‘I was fortunate because I had an apartment in my brother's place. But then his son got married and needed a place to live.’

The final sub-theme under this category was the lack of responsiveness on the part of landlords. Research participants indicated that their landlords were uncooperative and uncaring[3]. They explained that they were unwilling to make repairs, and did not have the interests of tenants in mind when making decisions about rent increases, renovations to units and evictions.

Effects of Prior Housing

During interviews, consumers spoke about how their prior housing affected their lives. Participants spoke about being worried and afraid; this was rooted in living in unsafe neighbourhoods, not knowing to whom the landlord would rent units, and not knowing if someone was going to break in to their apartment or start a fire. One individual stated the following:

> When you live in slum apartments, what goes through your mind is 'Am I going to leave the house today and someone is going to burn the place down?' . . . you are walking back towards [your] apartment and see fire trucks going and wonder 'is that my place'?

One individual spoke of living in shame in her rental housing. She explained that 'When you are living in a dump you don't want anyone to stop by. I can clean that apartment top to bottom, and I did, but it still looked like a dump . . . . You still don't want people to see how you are living. It is embarrassing.'

Research participants also stated that their prior housing experiences negatively affected their mental health. For example, one participant stated that 'When I was [at my past apartment] I was at my [worst]. All of my interests were gone. I couldn't get past the shitty living conditions.' Another participant stated that 'For a person who may be having an episode or have mental issues and you hear [vermin] crawling in the walls day in and day out, it is horrendous. For me, I had to get out.'

Experiences with SHIMI

Participants reported mostly positive experiences living in their SHIMIs, and these experiences are primarily in direct contrast with those from their prior housing. One sub-theme concerned the physical aspect of their new space; specifically, consumers spoke overall about the good physical conditions of their units and that there units were maintained by the landlord. Consumers spoke at length about the amenities in their apartments; they were highlighted because most participants had never had them before (such as numerous windows, storage rooms, porches, a range of appliances and adequate heat in the winter) and because the amenities were in working order. One exception mentioned by several participants concerned the furniture; they indicated that SHIMI organizers tried to save costs by buying lower quality living room and bedroom

[3] This is the sub-theme that was not included in the draft findings we presented at the member checking meeting. However, participants indicated that they felt it was a discrete finding.

furniture, and that it now needed to be replaced. In addition, one individual noted that his unit did not meet his accessibility needs. He explained that ‘I have [name of diagnosis] and need to live in a one-level because I fall down a lot . . . . Three times I have fallen here. [Also] sometimes it is hard to get out because the snow comes and piles against the door.’

Consumers repeatedly mentioned the importance of the washers and dryers they had and indicated that laundry facilities were otherwise difficult to access. One research participant explained that before moving into his supported housing unit, he could only do laundry by travelling by bus to a neighbouring town. Research participants often took pictures of the amenities in their housing; examples are included in Figures one and two.

Participants also reported that they found the organization of SHIMI to be convenient. In other words, they appreciated that rent is paid through direct deposit and that utilities are included in the monthly rent. Participants had mixed feelings about the responsiveness of the landlord: some felt the CEDC made repairs quickly, while others indicated their requests for repairs were not addressed.

Research participants also indicated that they felt safe. They had doors that lock, were living in secure neighbourhoods, and had a landlord who they felt would carefully consider to whom to rent units. One participant stated that ‘[The CEDC] would not rent to someone who has been in and out of jail, known to deal drugs, and is going to burn the place down . . . .’

Beyond feeling safe, individuals indicated to us that they felt like they were living in neighbourhoods, not just in housing units. One consumer stated the following:

> . . . there are kids around . . . . There is a soccer field, soccer going on almost every day. In the winter time it gets pretty quiet because your windows are closed. In the summer there are people around you. In [my old apartment], you were stuffed into the back of a building, you had no view. Here you have wide open space, and people coming back and forth to church.

Stability was an additional sub-theme that emerged. Consumers explained that their housing was stable in part because they had a landlord that understood mental illness; if they were hospitalized, they would not lose their housing. They also experienced stability because they did not anticipate significant rent increases, and because they had security of tenure. One individual stated the following: ‘. . . [with] SHIMI there is security . . . if you’re not doing anything wrong you can relax . . . [the CEDC] is not going to say ‘we’re selling it, or we’re renovating and you’ve got to get out.’’

A final sub-theme concerned the support received by research participants; here there was a range of experiences shared. Only a small number of consumers spoke about obtaining support from the housing co-ordinator’s office (including transportation, informal counselling and communicating with the landlord), and those who received it indicated that they found it

beneficial. However, participants were frequently unable to respond to interview questions about supports; when asked what kinds they accessed, consumers typically responded by asking what the interviewers meant. Others indicated that they felt isolated or that proactive support was lacking. For example, one individual noted that ‘I stick to myself. I visit with my neighbours from time to time. They [SHIMI supports] do not drop in to see how you are. They have not come by to see me in eight months . . . they never check in to see how you are doing.’ Another individual stated that ‘I don’t receive any outreach.’ It was also noted that the mental health services available in the community are limited. One individual stated that “When five p.m. comes around everything shuts down, but we don’t. We don’t get sick only between eight and five.’

Some individuals noted they received support from their peers, who are their one or two neighbours also living with mental illness. These research participants spoke about being able to understand their neighbours because of shared life experiences, and about providing direct assistance. One individual explained that ‘The individual next door to me, he has [a mental illness], and I can reach him. I provide him with food through the month and I help him. He comes here and has tea if he has any problems.’

Effects of Supported Housing

Research participants spoke about a range of ways that living in supported housing affected their lives. To begin, individuals indicated that their ‘SHIMIs’ were their homes. This feeling was linked by participants to housing stability, to being able to make choices about décor, to having amenities and to not having to deal with difficult landlords.

Participants also spoke about feeling ‘normal’ as a result of their SHIMIs. For example, one participant stated that ‘. . . [it is a] normal residential street, it is normal housing, this is a normal place. . . . .’ Another individual stated that ‘I can live a typical life. I am not an extreme case anymore.’

Third, participants spoke of an effect of supported housing by noting something that they no longer had to do. Specifically, participants repeatedly expressed that living in their supported housing units meant that they no longer had to worry, and that they no longer had to try to cope with stressors related to their housing. Comments such as ‘I don’t have to deal with [that] anymore.’ and ‘. . . it is a big, big relief, a very big, big relief . . . .’ were common.

Additional effects focus on how consumers began feeling about themselves once moving to supported housing. This includes having a sense of independence, being happy, feeling proud, feeling a greater sense of self-worth and having more self-confidence. Excerpts which capture these dimensions include the following: ‘I feel good about myself . . . . I felt miserable and alone and everything else.’ and ‘At one time I used to be scared to tackle things. I am still not perfect at it, but I can manage more. I have more self-esteem to tackle something.’ Research participants

also spoke about being able to manage their symptoms of mental illness by taking their medication regularly; one individual spoke about using fewer hospital services.

Finally, most research participants spoke about being able to take new steps in their lives. Some named specific new steps, including securing supported employment, writing a business plan, re-connecting with family, and interacting more with others. Others spoke more generally about being in an environment which allowed them to move ahead with their lives. One individual captured this by stating the following:

> Without SHIMI we have nothing to look forward to. If you found another apartment [when you were renting] it was just as bad as the last one, [and in] a bad neighbourhood….it [was] moving from one crappy apartment to another crappy apartment.

Two individuals also captured this sub-theme through photography. One research participant took a picture of the certificates hanging on her wall and stated that 'I can do things with my life.' while a second took a picture of the room she uses to pursue her artwork. These are represented in figures three and four.

Improving SHIMI

During the interviews and the member checking meeting, research participants shared different strategies which they felt would improve their SHIMI housing. Their suggestions focussed on four different areas: housing, support, living costs and asset building, and consumer involvement and control.

Regarding the housing itself, participants recommended that higher quality furniture be purchased for tenants, that units be located close to businesses, and that units of different size be made available so that tenants with family have the opportunity to host them. They also asked that the landlord be more responsive to requests for repairs.

Regarding support, consumers recommended more proactive contact on the part of the housing co-ordinator and the co-ordinator's staff, with the frequency of phone calls or face-to-face visits varying by research participant. It was also recommended that mental health services be made available beyond regular work hours. Having constant access to mental health services was not considered to be something that could only be addressed through formal providers, since it was felt that peer support, provided after hours, could also help fill this gap. Finally, fostering contact among SHIMI tenants was recommended as a strategy to strengthen peer support. Specific suggestions included having more supported housing in close proximity (but not congregated in one location), and having organized activities, such as meals, for SHIMI tenants.

Although the supported housing available through SHIMI is offered below market rent, the general high cost of basic needs and the monthly struggle to make ends meet was discussed by

some research participants. Following this, it was suggested that the supported housing initiative could further assist tenants by co-ordinating bulk purchasing of food, medication and telecommunications services. It was also suggested that the initiative could build the assets of tenants through individual development accounts, whereby SHIMI tenants would set money aside that could be matched by government or a community partner.

The involvement of consumers in the development, management and control of the supported housing initiative was a final suggestion made to researchers. Some participants indicated that although SHIMI was not a stand-alone organization with an incorporated board of directors, consumers were actively involved in early meetings organized to address housing for people with mental illness, and these consumers envisioned that housing would be developed through a formal organization with consumer control. Currently, one tenant is a member of the SHIMI advisory group, and some research participants felt that greater consumer representation was required. Greater communication about the initiative was also requested, including news on the development of new units. It was also noted that because SHIMI housing is owned by a community economic development corporation rather than organization specifically devoted to housing for individuals with mental illness, the housing assets can be leveraged by the CEDC for purposes unrelated to assisting consumers. A final dimension under this theme focuses on how consumers are able to secure supported housing. To obtain a unit, one must be placed on a waiting list through either the local clubhouse (which is operated by the health authority) or through the mental health services unit within the health authority. It was noted that neither of these entities are consumer controlled, and that consumers have to relinquish some of their autonomy to these institutions in order to obtain a supported housing unit. To address this issue, several research participants suggested that consumers be allowed to independently add their names to the waiting list.

Discussion

The focus of this evaluation was to explore the housing experiences of individuals with mental illness before and since moving into supported housing and the effects of these housing experiences on their lives. Secondly, this evaluation explored how individuals living in supported housing feel the model can be improved.

The findings demonstrate that the housing experiences of most participants prior to moving into supported housing consisted of living in substandard apartments. These findings also show that most research participants did not rely on family and friends to obtain housing, despite the supposition that the cohesiveness of smaller regions allows individuals to do so in the face of market or government failures (Saulnier, 2009). Although we did not ask research participants why this was the case, their social ties (at least beyond their consumer networks) are likely weak from the stigma and lack of anonymity they told us they face. As one participant noted, 'Most of us are lonely. It is not loneliness, it is aloneness.' Regarding the effects of these housing experiences, existing literature shows that living on the street, in shelters or in substandard

apartments can often exacerbate symptoms of mental illness (Taylor, Elliott and Kearns, 1989); for the consumers in the Cape Breton Regional Municipality who participated in this study, the poor living conditions created through rental housing were also not supportive of mental health.

Participants' experiences in supported housing were in direct contrast to their pre-SHIMI housing in that consumers reported living in affordable, stable, safe, and good quality units. When asked to describe their current housing, most consumers began by using descriptors such as 'fantastic,' 'the best housing they have ever had,' and 'unbelievable' and struggled to find words beyond these superlatives. Washers, dryers, porches and natural light were features that were frequently highlighted by consumers, and suggests that what might appear to be smaller details in a supported housing initiative may have particular salience to tenants and play an important role in allowing consumers to feel normal, integrated and at home[4].

Beyond the more physical characteristics of their apartments, participants also noted that they were now able to partake in neighbourhood life, and thus spoke very directly to the principle of community integration in supported housing (Carling, 1995). Through the private rental market, individuals with mental illness become spatially segregated because the conditions do not exist for them to live in areas with better housing (Taylor, Elliott and Kearns, 1989), and supportive housing has also tended to be clustered geographically (Wong and Stanhope, 2009). For participants, it was ordinary occurrences of everyday life which represented integration: hearing children play, watching church-goers, and chatting with nearby neighbours about pets. This integration was facilitated both through the location of the housing, and through the housing's structural features, such as large windows and porches, mentioned above.

Research participants were remarkably consistent in expressing that their current housing positively impacted their lives, albeit in different ways. Although research that examines the relationship between supported housing and mental health outcomes is inconclusive, these results contribute to the body of evidence that suggests that the approach contributes to recovery. A resonant sub-theme that emerged in the analysis was the absence of worry, and it suggests that this was an important element in participants' journeys to recovery. In other words, good housing not only addressed a practical need, but provided a space in which consumers could begin focusing inward rather than managing difficult external environments.

While housing was the focal point for research participants, support was also discussed. This was the sub-theme under which opinions and experiences diverged the most. That some participants expressed isolation or a desire for more contact from the housing co-ordinator was not surprising given that other research on supported housing has reported that some tenants feel alone (Walker and Seasons, 2002; Yanos, Barrow and Tsemberis, 2004). Gaps in formal services have also been reported in other studies, urban and rural alike (for example, Forchuk, Nelson and Hall, 2006). Participants pointed to the possibility of addressing these problems through their 'own

[4] We credit Colleen Cann Mackenzie, a member of the SHIMI advisory group, for first making this point during our discussion of the findings with this group.

community’ by fostering peer support among tenants; this strategy might not only be beneficial in the sense of addressing service gaps and dealing with tenant isolation, but because peer support can contribute to recovery (Solomon, 2004).

Recommendations

Based on the findings and discussion presented above, we make the following recommendations to the SHIMI advisory group:

- That the support offered to SHIMI tenants be strengthened. Through the housing co-ordinator’s office, this should include more proactive outreach, communication regarding the range of available community services, and the organization of voluntary activities which foster peer support. Through the health authority, this should include longer hours for mental health services. The health authority may also want to explore the opportunity of partnering with consumers in the delivery of after-hours support. All supports provided to tenants should be tailored to tenants’ individualized goals and needs. Formalized plans should be developed in partnership with tenants when they move into their SHIMI units, with reviews of these plans being done with tenants on a regular basis.
- That the landlord (New Dawn Enterprises) be as responsive as possible to the requests for repairs made by tenants, and that when repairs cannot be made or are delayed, that this information is communicated to tenants.
- Given the financial constraints of individuals who participated in this research, that the advisory committee facilitate projects that reduce the living expenses of tenants and build their assets. The SHIMI advisory group could turn to Affirmative Industries in Dartmouth, Nova Scotia, for advice, since Affirmative Industries has an asset-building initiative in place for individuals with mental illness.
- That the advisory committee review how they involve consumers, and ask both tenants and consumers living in the Cape Breton Regional Municipality how they want to participate in SHIMI and how this involvement may be facilitated.
- That the SHIMI advisory committee continue to pay attention to the ‘ordinary details’ of housing that this research suggests are important to consumers. These details include washers and dryers, windows, porches, and being able to paint apartments. Making long-term investments in amenities which are of good quality is also important to consumers. Attention should also continue to be paid to the location of the housing, so that consumers can easily access businesses and services.
- That the SHIMI advisory committee pay attention to issues of accessibility in the units. Universal design standards should be considered; this would also be a strategy that would allow tenants to age in place.
- That the advisory committee develop SHIMI housing at a faster pace given both the success of the initiative and the community need. One suggestion, made by a research participant, was to increase the amount of fundraising done in the community.

Conclusion

This report presented an evaluation, part formative and part summative, of the SHIMI initiative. This study found that the housing experiences of research participants changed markedly once

they moved into supported housing, and that these changes had positive effects on their lives. Beyond affirming the work of the SHIMI advisory committee and contributing to the body of research which demonstrates an association between this housing model and positive mental health outcomes, this evaluation draws out recommendations on how SHIMI may be improved. These recommendations have the potential to only strengthen a housing strategy that at the very least addresses the poor housing conditions experienced by consumers, but that seems to, as this and other research suggests, help foster normalcy, community integration and recovery for individuals with mental illness.

Appendix One: Photographs

Figure One: Washer and Dryer

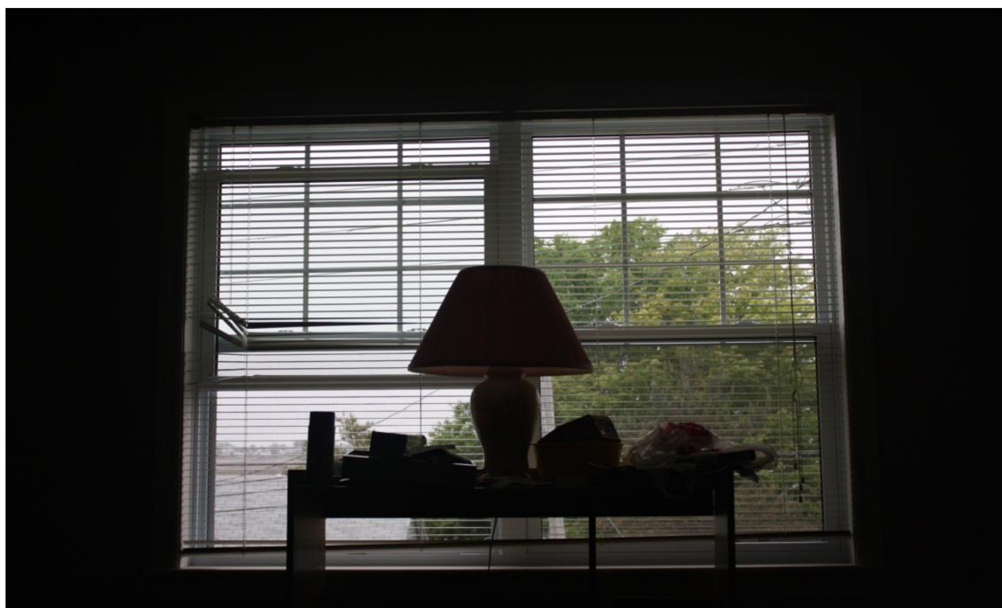

Figure Two: Windows and Natural Light

Figure Three: An Art Room

Figure Four: Certificates

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