Critical Characteristics of Supported Housing: Resident and Service Provider Perspectives

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ABSTRACT

The purpose of this research was to develop an understanding of important characteristics of supported housing (SH) for individuals with serious mental illnesses. Semi-structured interviews were conducted with residents of SH and service providers. Data were analyzed using the constant comparative approach. Four central themes emerged from data analysis: SH as a foundation for recovery, guiding values for SH, supports offered in SH, and neighbourhood/community context. This research has uncovered several key characteristics of SH that can be used to guide the development of new housing programs, to review current programs, as a tool for self-advocacy, and as the foci for further research.

Keywords: supported housing, community mental health services, program development, community support

Creating appropriate and effective housing that results in lasting improvements in residential stability, social support, and community participation for persons with psychiatric disorders is a pressing issue.

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A growing literature in the area of housing for persons with serious mental illnesses (SMI) has shed light on various models and their effects on outcomes (Leff et al., 2009). One housing model that seems to hold particular promise is supported housing (SH). According to Parkinson, Nelson, and Horgan (1999), SH is based on the underlying values of empowerment and community integration. It is a strength-focused approach where tenants are given considerable choice over their housing. Treatment is not a requirement of residency, and the role of the landlord and the support provider are separated or "de-linked" (Hamilton District Health Council, 2001; Hogan & Carling, 1992; Parkinson et al., 1999). Supports and rehabilitative services are made available to individuals to help them stay in their home and participate in their community. Typically, SH occurs in generic housing units dispersed in the community, offers flexible and individualized support, and has no time restrictions (Hogan & Carling, 1992; Livingston & Srebnik, 1991). The term *supported housing* differs from *supportive housing* in that the latter term is a more generic one that includes a broad range of residential facilities that typically provide a continuum of time-limited supports and have a rehabilitative or skill development focus (Hamilton District Health Council, 2001; Parkinson et al., 1999). There remains much confusion and little consistency around these terms, and "supported" and "supportive" housing are often used interchangeably when discussing housing and supports for individuals with mental illness (Canadian Mental Health Association, 1995).

This paper examines supported housing, as there is growing evidence about the effectiveness of this model within the mental health field. Impacts of SH on mental health service usage (Dickey et al., 1996), costs (Dickey, Latimer, Powers, Gonzalez, & Goldfinger, 1997) and residential stability (Rog, 2004; Sylvestre et al., 2004) have been investigated, as have characteristics of consumers who use and benefit from SH (Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002; Sylvestre et al., 2004). Of late, approaches to housing those who are homeless have garnered increasing attention (Falvo, 2008; Padgett, 2007; Tsemberis & Eisenberg, 2000), and toolkits are now available to assist in developing programs to decrease homelessness through supported housing (Corporation for Supportive Housing, 2006).

There has been some debate within the field regarding the extent to which evidence-based practices such as SH contribute to recovery (Anthony, Rogers, & Farkas, 2003; Bond, Salyers, Rollins, Rapp, & Zipple, 2004). Recovery has been defined as both a process and an outcome (Deegan, 2005). It is often considered in terms of indicators such as work and community integration but also goes beyond these markers to incorporate an individual's self-perceptions and psychological states, such as hope, pursuit of personal goals, self-efficacy, and self-determination. Bond et al. (2004) call for further research related to community integration and recovery, stating, "the degree to which community integration results in the subjective experience of recovery is an important empirical question" (p. 571). As a pivotal component of community integration, supported housing and the ways in which it may facilitate community living is an important line of inquiry. Furthermore, Anthony (1993) has pointed out that "paramount to the recovery concept are the attempts to understand the experience of recovery from mental illness from those who are experiencing it themselves. Qualitative research would seem particularly important in this regard" (p. 18). Currently, there are a limited number of studies that investigate SH from the perspectives of persons who use and deliver these services. The purpose of this research was to develop an understanding of important characteristics of SH for persons with SMI based on perspectives of residents and service providers.

In this paper we use a broad definition of SMI consistent with program and policy documents in the field. This population is typically defined in terms of level of disability, duration and severity, and diagnosis (Ontario Ministry of Health and Long-Term Care, 2000): Disability refers to difficulties that interfere with an individual's capacity to function in major life activities such as maintaining housing and functioning in the community; duration and severity refer to the acute, continuous, and intermittent experience of illness; and diagnoses typically include schizophrenia, mood disorders, and paranoid and other psychoses. Furthermore, individuals with serious mental illnesses often have concurrent conditions such as addictions, substance abuse problems, and physical health problems (Makikyro et al., 1998; Mitchell & Malone, 2006; Regier et al., 1990).

LITERATURE REVIEW

The outcomes of various housing models have been discussed in the literature of late. A recent meta-analysis of housing models for persons with mental illnesses (Leff et al., 2009) evaluated impacts of three housing models (residential care/treatment, residential continuum, permanent supported housing) as well as nonmodel housing (a term used by the authors to denote housing not categorizable according to the three models identified above) on such outcomes as housing stability, symptoms, hospitalization, and satisfaction. Findings revealed that supported housing had the largest effect on housing stability, but only residential care/treatment differed from nonmodel housing with regard to psychiatric symptoms. Both residential care/treatment and permanent supported housing differed from nonmodel housing with regard to hospitalization, and permanent supported housing achieved the highest effect size for satisfaction. The authors concluded that different housing models achieve different outcomes for different subgroups. As these data "were not sufficient to fully answer questions designed to enable program planners and providers to better meet consumers' needs" (p. 473), they suggested there is a need for continued research in this area.

A substantial body of research has examined the supported housing model exclusively. A review by Rog (2004) suggested that people with psychiatric disabilities who enter SH show housing stability for approximately one year. However, even after obtaining housing, many people with SMI experience high levels of isolation and relatively low levels of social support (Lam & Rosenheck, 1999), factors that threaten housing stability and community participation (Kloos, Zimmerman, Scrimenti, & Crusto, 2002). Some research has suggested that certain characteristics of SH are important; for example, in their overview of different program models, Hannigan and Wagner (2003) concluded that while single-site housing provides staff with frequent access to tenants and opportunities to build a community of support, scattered-site housing (which makes use of the housing available in the community) provides more autonomy and anonymity to tenants. Nelson and Peddle (2005) suggested that key features of all approaches to housing for persons with mental illnesses should include consumer empowerment, access to valued resources, and community integration. Social support, location, privacy, and choice also seem to have a positive impact on outcomes (Parkinson et al., 1999; Rog, 2004). Sylvestre et al. (2004) proposed several principles to guide best practice in housing, including use of generic housing dispersed widely in the community, provision of flexible individualized supports that vary in intensity, assistance in locating and maintaining housing, and no restrictions on the length of time consumers can remain in the housing. Other authors have highlighted similar core principles

that are essential to housing and support across all supportive housing programs including permanence, affordability, safety and comfort, and accessible and flexible support services (Hannigan & Wagner, 2003; Nelson & Peddle, 2005; Sergeant & Brown, 2004).

Recently, the Housing First model has been studied as a best practice in supported housing that aims to reduce homelessness. Introduced by the Pathways to Housing agency in New York, this approach—unlike the "treatment first" approach—provides homeless persons with immediate access to permanent housing and includes a harm reduction philosophy along with access to a multidisciplinary Assertive Community Treatment (ACT) team (Padgett, Gulcur, & Tsemberis, 2006). Research on the Housing First approach has yielded positive results; in one study, between 85% and 90% of participants were still housed at 5-year follow-up (Tsemberis & Eisenberg, 2000), and compared to their "treatment first" counterparts, Housing First participants remain housed longer, spent fewer days in hospital, and were no more likely to use drugs or alcohol (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003). While this approach appears to be highly promising, its effectiveness has been determined through comparison studies with "treatment first" approaches for homeless individuals. As only a small proportion of persons with SMI are homeless, additional research is needed that considers the needs of all persons with SMI who seek to attain and maintain satisfactory housing.

The importance of consumer preferences in developing housing options has been addressed by a number of researchers (Carling, 1990; Nelson, Hall, & Forchuk, 2003; Srebnik, Livingston, Gordon, & King, 1995; Yeich, Mowbray, Bybee, & Cohen, 1994). Two decades ago, Carling (1990) called for research on key questions such as "Where do [people with mental illnesses] want to live? How can we help them succeed there?" (p. 973). Tanzman (1993) summarized key findings from 23 consumer preference studies conducted in the United States and in Ontario and concluded that people with psychiatric disabilities prefer to live in their own apartments or houses, prefer not to live with other consumers of mental health services, and want support from mental health staff. More recent research points to residents' preference for regimes with low restrictiveness and independent living arrangements despite the risk of loneliness and isolation (Fakhoury, Murray, Shepherd, & Priebe, 2002).

A small number of qualitative studies have examined the housing experiences of people with SMI (Boydell & Everett, 1992; Forchuk, Nelson, & Hall, 2006; Parkinson & Nelson, 2003). These studies point out the stigma, discrimination, and poverty that reduce access to quality housing for people with SMI, the processes of adaptation in which residents engage as they learn how to deal with personal and practical problems, and the sense of empowerment that is enabled through SH. While this research begins to shed light on residents' experiences within SH, there is a need for a more extensive understanding of characteristics of supported housing that are valued and desired from the perspectives of both residents and service providers.

This paper describes the second part of a two-part research project. The first part was a review of current literature on SH in order to extract documented characteristics associated with positive outcomes among individuals with SMI; the second part involved interviewing residents and their service providers. These methods were used to identify characteristics of SH that are associated with outcomes that are valued and desired by key stakeholders, and to explore the influence of these characteristics on outcomes that are meaningful to residents. It is hoped that this set of key characteristics will add to the developing evidence on best practice for SH.

METHODS

This project used qualitative methods to examine the perspectives of residents and service providers within SH programs. Two community partner mental health agencies participated in this research; representatives from these partner agencies were involved in all aspects of the research, from formulating the research questions and directions, to providing suggestions regarding the research plan, to assisting with recruitment, and providing feedback on the initial findings and drafts of our final report.

Partner agency representatives distributed flyers about the research study to their clients and front-line staff, and individuals who were interested in participating were asked to contact the research project staff directly. This recruitment process resulted in 25 semi-structured interviews with residents living in SH and 10 interviews with service providers working with individuals living in SH. Approximately half of the interviewees were recruited from each agency. Consumer participants were given a small honorarium to acknowledge their contribution to the research and cover their travel costs. Service provider participants were interviewed at their place of work and during their regular work hours. The interviews were carried out by the research coordinator and two peer-researchers who were trained in qualitative interviewing techniques.

Using the principles of maximum variation sampling (Creswell, 1998), we recruited residents and service providers who had different backgrounds and perspectives to offer (see Tables 1 and 2). Specifically, we targeted residents who lived in rent-geared-to-income housing (n = 12), homeless housing (n = 10), and mental health and justice housing (n = 3). The sample of residents comprised 17 males and 8 females with a mean age of 44 years (range was 29 to 62). We also targeted residents with varying lengths of stay in SH (from 2 months to 19 years). The sample of service providers included housing workers (n = 5), as well as case managers and general rehabilitation workers (n = 5), who provided support to individuals living in SH. The service providers had been in their current jobs for an average of 7 years (range was 1 to 20 years).

Table 1
Consumer/Resident Characteristics

Type of housing	
Rent geared to income	12
Homeless	10
Mental health and justice	3
Demographic characteristics	
Male	17
Female	8
Age	Range from 29 to 62 years, M = 44
Length of time in supported housing	Range from 2 months to 19 years, M = 40 months
Length of time in mental health system	Range from 1 to 38 years, M = 14 years

Table 2
Service Provider Characteristics

	Type of service provider
Housing support worker	5
Case manager/rehab worker	5
Number of years in this job	Range from 1 to 20 years, M = 7.2

Although both partner agencies involved in this project ran SH programs that embrace the general principles of SH and recovery, they differed from one another in the type of housing they offered. In the scattered housing arrangement, the program offered independent units in apartment buildings across the city. In the clustered housing arrangement, the program provided independent units in designated buildings where there were entire floors of supported housing specifically for persons with serious mental illnesses. These different housing arrangements offered further variability.

A semi-structured interview guide was developed through a collaborative process involving the researchers, community partners, and initial findings from our literature review. The interview guide was specifically designed to provide sufficient flexibility so interviewees could reflect on their individual perspectives while at the same time providing a consistent framework to gather data. Questions were designed to uncover features of SH that affect community living such as housing characteristics that were helpful or unhelpful, types of supports provided and their meaning, and changes that should be made. All interviews were tape-recorded and transcribed verbatim. The qualitative computer software program NVivo was used to organize the data for efficient analysis.

Ethical approval was granted by a university research ethics board. The procedures of the project were discussed with individuals who received written information on the project. Signed informed consent was received prior to participant involvement.

ANALYSIS

Analysis of the data was guided by the constant comparative approach proposed by Glaser and Strauss involving unitizing, categorizing, and forming themes (Lincoln & Guba, 1985). Following this approach, data collection and data analysis occurred simultaneously, and emerging ideas were used to direct and focus subsequent data collection efforts. Initial coding included in vivo codes (categories used by respondents themselves), as well as conceptually derived codes that emerged through a process of questioning and comparison. In coding the text, the researchers asked a battery of questions of each code and compared new data to existing units and categories; this enabled us to establish the codes' properties, dimensions, and relation to other codes and to refine, verify, and alter the emerging theoretical propositions (Charmaz, 2006).This process continued until categories were saturated and new data did not further enhance our understanding of the concepts under study (Charmaz, 2006).

The dependability and credibility of our findings were enhanced through triangulation of methods and researchers (Brannen, 1992; Sharts-Hopko, 2002). Specifically, we used two sets of data (interviews with residents and interviews with service providers) and maximum variation sampling procedures to address our research questions. Furthermore, analysis was conducted by the principal investigator and three student research assistants, with input by peer-researchers and community partners, each of whom brought different perspectives to the data. We held regular research meetings to discuss codes and code descriptions, to compare them to one another and refine them so that the meanings and properties were clear. These discussions with our community partners also allowed us to explore the relevance and applicability of our findings (Lincoln & Guba, 1985). Together, these strategies enhanced the trustworthiness of the research and the relevance and utility of the findings. During the course of the project, preliminary findings were presented at two housing symposia at which feedback was generated; this feedback suggested a high degree of resonance with the field.

RESULTS

Four overarching themes emerged from the interview data: (a) supported housing as a foundation for recovery, (b) guiding values, (c) key supports, and (d) the importance of neighbourhood and community context.

Supported Housing as a Foundation for Recovery

Residents described the relief they experienced in having a place of their own. Many felt that their stress levels were reduced because they had private space to unwind and reflect at the end of the day. One resident stated,

> When I go back now to my own unit, I'm able to assess and process what took place that day, and what should be happening next. So that gives me my own space to do that. I think that would be the key component of having my own space.

Indeed, SH served as a foundation for recovery. Supported housing offered residents the freedom to live independently, to do chores, and to organize their daily routines around their personal priorities. They described feeling more productive because of their daily structure, responsibilities, and sense of purpose. Residents felt that having their own place reduced stress, provided stability, and motivated them to take care of themselves. One resident stated, "I think that having a decent place to live has reduced my stress and the incidence of depression. I eat better … I exercise more …"

Living with dignity and a sense of self-worth were seen by residents to be outcomes of living independently. Having their own apartment meant that residents were in control of their living space and, by extension, their lives. For many residents, SH was a foundation from which they could move forward. They spoke about being able to pursue their goals for employment and education as they became settled into SH.

Residents emphasized the subjective improvements they experienced in SH as their motivation to become more involved in community life. One resident described his experience of moving from various rooming houses into his own apartment:

> It's allowed me to stop worrying about those things that were holding me back. When I was in the rooming houses, I wasn't able to even think about the things that I'm doing now … because I was so suppressed

> with all this negative energy and these negative things going on around me. I just felt hopeless and trapped. But due to my housing situation being changed, and I have a beautiful home and I'm happy there, now I'm learning to be happy with me.… I'm a good person and I have a good life, things are going good, I'm going to go out today and I'm going to be a nice person, and I'm going to have a good day. And … I'm going to help somebody if I can, and I'm going to make somebody smile, stuff like that … I can focus on more positive things, now.

Service providers also considered stable housing to be a foundation for recovery and community integration. They suggested it was a way for residents to "get back on their feet" after a setback, a way to "move forward with their life" and a "premise" for everything else. Service providers spoke about the practical importance of having a place to live when trying to get a job or go back to school. One case manager commented that simply having an address was important when applying for a job. Others maintained that stable housing was a way for clients to begin to stabilize their mental and physical health, to learn how to be more independent, and ultimately to be able to integrate into community life. One housing worker stated,

> How can you pursue going back to school and improving your life, getting a job, even if it's only 5 hours a week, doing something part-time, or even more than that … How can you do those things, if you don't have a roof over your head? If you can't create a healthy place to start from, how can you expect someone to be able to take the steps forward?

In some cases, however, SH represented a significant risk of isolation. Service providers noted that this sense of isolation could occur when individuals moved from group living environments into their own apartment, and that this effect could threaten housing stability.

Guiding Values

Both residents and service providers spoke about overarching values that were important across the housing process. Residents spoke about the need to be treated with respect and dignity by their support workers, indicating that support workers should relate to each resident "like a human being," a person with genuine value and worth. Residents also commented on the importance of flexibility and choice. These values were important both in terms of the type of housing they lived in and the amount of support they received from service providers. One resident addressed the importance of flexibility in the intensity of support, stating: "It's like we're saying about the visits, they need to be flexible enough that if you require extra supports it's available." Many residents felt confident that when their needs changed, their housing worker would be available for increased support: "If I am not feeling well … they may increase the meetings." Other residents struggled with support workers who seemed intrusive. For example, some individuals wanted their housing workers to respect their privacy and come less frequently: "First of all, I don't like somebody every week … I'm healthy enough to be okay without somebody coming . . . I don't like it, I don't (need) a housing worker to come see me all the time."

Service providers also spoke about the importance of flexibility within their roles that enabled them to provide the appropriate amount of support based on each individual's goals.

> Having the supports is important.… Our caseloads are kept low so that we have the time to spend with clients. So we can go in and see them twice a week, three times if we absolutely have to. And we can spend an hour or more with them if we need to … so it's not a 15, 20 minute visit … I think that makes a big difference.

Many residents felt that having choice in selecting their housing gave them a sense of control. They valued a housing process that included the opportunity to express their needs and find units to meet those needs: "The good thing about the housing worker I had, I was given choices.… She would come with a list and said, 'okay, this is where we have housing, it's up to you.'" In some cases, residents described feeling pressured to take the first unit they were shown. Others felt that they had limited options because they were denied requests for transfer when a unit did not meet their needs.

Client preferences were emphasized by service providers as well. They highlighted the importance of supporting clients in achieving client-chosen goals and in making decisions that would help them create a safe and stable living environment. This process involved supporting clients in expressing their goals, providing them with education to make informed choices, helping clients to think through the consequences of their choices, and ultimately connecting clients with the resources required to achieve their goals. One housing worker described the importance of ensuring that decisions about home are in the hands of the client:

> This is their home, this is their place … it's not my home. To help them set up, to make it their sanctuary … It's such an important thing in people's life, not just to have a roof over their head, but a place that they can have that pride in and that happiness with. And the more control they have over it, the more sense of ownership.

For service providers, an important principle was the need for vigilance and attention to discrimination and negative attitudes toward people with SMI, in order to prevent unwelcoming housing environments. Consideration of stigma was seen to be necessary in determining the pros and cons of scattered versus clustered types of supported housing. Many service providers emphasized that scattered housing in mainstream communities and apartment buildings allowed individuals to have a fresh start, to live their lives without others' knowledge of their history of mental illness, and ultimately to integrate more fully into the community. In this type of housing, service providers noted that educating landlords about psychiatric disability was key to securing and maintaining housing and creating safe, healthy environments for residents. One housing worker explained, "It's our role … to educate those superintendents, to let them know what a mental illness is and to break down the barriers that way."

On the other hand, some service providers and residents commented that living in clustered housing with other people who struggled with similar mental health issues could engender a sense of community, thereby preventing isolation. In such situations, neighbours were well positioned to show compassion and empathy, and to help each other during times of need. Several service providers noted that it is important to have different types of housing available so individuals can choose to live in the arrangement that best meets their needs.

Key Supports in Supported Housing

Connecting to social supports. Residents and service providers spoke about the important role of social supports in decreasing isolation and improving stability in housing. Individuals expressed appreciation for the support of friends with similar experiences who became role models and inspired them to persevere in their recovery: "You meet these incredible people who have thriving lives … who were exactly where I was.… I mean it's just … it's so powerful.… These are my friends … you know, which is incredible."

Several residents also acknowledged the support they received from family members. Knowing that they had people whom they could count on in a time of crisis helped individuals do the things they needed to do to care for themselves, maintain their housing, and pursue their goals.

Service providers noted that many residents did not have opportunities to interact with people in their communities and were often lacking the necessary skills to do so. These residents were at significant risk for isolation and often experienced difficulty maintaining their housing. Service providers discussed the support that they provided to help their clients establish or reestablish a social network. They spoke about helping residents to reconnect with family members, and linking them to community programs.

> I think socializing and getting to know the neighbours who they're living with … introducing people, and sometimes I've also helped people connect with their families. You know they haven't had any connection … and nobody knows how to do it … sometimes helping them with that. So … making connection with friends … it's just something all of us need … I think, to live.

Some service providers felt that it was important for their agency to provide social recreation programs in addition to housing.

Goal setting and accessing resources. Residents indicated that their support workers enabled them to move forward by helping them to go back to school or pursue employment. One resident related: "First I wasn't sure if I wanted to do anything, and she said, 'Well, let's start slowly … Why don't you go back to school and take some courses? … We'll work [in] small steps.'" Several residents described that this support and encouragement fostered motivation and drive, and helped them take new steps in life.

Service providers expressed a consistent message about the importance of supporting clients in pursuing goals beyond housing. They emphasized that housing on its own was not enough for recovery and that successful SH involves connecting residents with other supports to enable them to maintain their housing. Many clients required access to such resources as medical care, finances, and education as well as assistance with meeting basic needs such as food and clothing. One housing worker explained, "Well once they've got their housing stabilized, they need a social network. They need some sort of recreational program. They need the opportunity for meaningful work, whether it's paid or volunteer." Service providers spoke about their role in supporting clients to take these next steps and in navigating a complicated health and social system.

Residents spoke about the importance of subsidized rents, of being able to afford a decent apartment while still having money left to meet their daily needs. For most, the rent subsidy reduced stress and allowed attention to be paid to other areas of recovery. The larger, cleaner spaces that became accessible to residents meant that home became a place of comfort, a place for healing and moving forward. A resident stated, "I have a place to come home to, I have a place to eat, I have a place to shower, a place to sleep … that makes me almost emotional when I think where I was …"

Managing crises. Several interviewees felt that simply having SH greatly reduced their incidence of crisis by offering stability and better quality of life. Their finances had improved, they had more peace in their living environment, and they had fuller and richer lives. A resident succinctly stated, "Basically … this situation protects me against crises." Furthermore, having the responsibility of maintaining a home motivated individuals to take a more proactive approach in managing their illness. In this way, SH provided significant protection against crises.

Almost all of the service providers spoke about the support they provided to clients in crisis. Service providers helped clients develop crisis plans including compiling phone numbers and places the client could go to get supports. Several service providers noted that developing a close and trusting relationship with clients was key to early detection of possible crises. Being observant and taking note of any signs of deterioration during visits was seen as important. Some service providers played an active role in crisis management, visiting clients more frequently when things were not going well. Managing a crisis was described as a team approach, with the housing worker taking the lead in some instances. Some service providers noted that having flexibility in their positions to be able to make more frequent visits or to visit at different times of the day was important in crisis prevention and management. Housing workers also spoke about the importance of educating landlords and superintendents about what to do in the event of a crisis.

Learning skills for independent living. Residents commented that support from their service providers motivated them to care for themselves, manage their finances, and maintain their homes. For example, one resident described how his housing worker helped him develop banking and financial management skills:

> I remember that at that time I really didn't know how to manage money. Or even to go to the bank was like a big deal. So I had student loans, and I had bank accounts, and the student loans people would take money from my account at the beginning of the month and … it means I have no [money for] rent.… She [the housing worker] took me to the bank. She told me things that I could do …

Service providers described helping residents to learn necessary skills for independent living. In some cases, education about budgeting included connecting residents to community supports such as food banks. Service providers also explored other options with residents for ensuring that rent was paid such as having a volunteer trustee or directly depositing income toward rent when appropriate.

Trusting and supportive relationships over the long term. Service providers spoke about the importance of building relationships with residents, a process that involved building rapport, sharing information, and establishing trust. They emphasized the importance of maintaining a long-term connection with residents, noting that issues can arise even after years of being stable in SH. One housing worker noted,

> We address issues as they arise, ensuring that we continue that relationship with them, even if they have been housed and there are no tenancy issues. And even if we never hear from their superintendents and everything's fine … we definitely continue to maintain contact with them.

Service providers noted that this long-term support was especially important as some residents may not have other strong supports or connections in the community. Housing workers were in a unique position because their relationship with residents would not end as long as residents were in housing: "We're always there … we don't go away." Given the cyclic nature of many mental illnesses, this long-term support provided security, stability, and peace of mind.

Neighbourhood and Community Context

Residents spoke about the importance of finding an apartment unit in a neighbourhood that had good access to public transit and amenities such as banks, grocery stores, and religious congregations. Individuals with established supports (such as family, friends, community mental health program, doctor) generally wanted to find a unit that would be close to these existing supports. Several service providers spoke about

the importance of finding a good fit between residents and the neighbourhoods and buildings in which they live. Some service providers indicated that the initial intake assessment is geared at determining this fit:

> When we do the assessment, we're looking for fit.… So we really look at the building, the make-up of the community, where people request that they want to live, and we try to match it that way. 'Cause at the end of the day we want people to be successful in housing. We want it to work.

Service providers noted that in most communities, neighbours and local business people were very accepting of SH. However, some service providers related that they had seen negative relationships develop when a client became unwell and exhibited disruptive behaviours that were difficult for neighbours to understand. One housing worker explained that the only complaints she ever heard from neighbours happened when clients became unwell and were unable to access the medical services they required.

Residents spoke about the impact of drugs and crime on the overall neighbourhood. Even though most residents felt safe in their buildings, several noted that they had safety concerns with the larger community as a result of street drugs and other criminal behaviours. Residents described the negative effects that a drug and crime-ridden neighbourhood has on their hopes for the future and the development of their children. Several residents associated such environments with social housing and felt that it was important that individuals in SH be allowed to live in subsidized units in regular apartment buildings so that there could be hope and opportunity for recovery.

Many service providers also commented on the need for safe housing for residents. Some noted that they have become acquainted with the various neighbourhoods in the city and have determined which neighbourhoods are unsuitable for supported housing. Other service providers spoke about the need for increased security in buildings that were located in less safe neighbourhoods.

A major concern for residents was the upkeep and maintenance of their apartment buildings. Some were concerned about pests like cockroaches, while others felt their buildings were well maintained. Either way, residents said that it was important to feel they could approach their landlords or superintendents about concerns. Service providers also spoke about the importance of providing comfortable and clean housing. A safe, comfortable, and clean environment was seen to be critical to self-esteem and a sense of self-worth, ultimately leading to increased health and wellness. Service providers highlighted the responsibilities of the landlord in maintaining a safe, clean, and secure building. Unfortunately, they noted that not all property management companies and landlords were willing to be proactive and cooperative in building maintenance.

DISCUSSION

This study supports research to date that highlights the importance of supported housing in enabling people to move forward in their lives. It resonates with previous reports that have suggested that lack of decent, safe, affordable housing is a significant barrier to full participation in community life for people with severe mental illnesses (President's New Freedom Commission on Mental Health, 2003) and supports the work of community mental health researchers who maintain that supported housing can be instrumental in launching the recovery process. For example, in their qualitative study of residents in supported housing, Parkinson and Nelson (2003) found acquisition of supported housing stimulated the processes of empowerment and recovery while Chesters, Fletcher, and Jones's (2005) work points to supported housing as an integral part of a recovery-focused service system.

The findings of this research highlight the importance of awareness of stigma and discrimination directed at individuals with SMI and the need for a firm resolve to combat it. While our study indicates that flexibility, choice, and environmental fit are key characteristics of SH, these attributes are challenging to realize in the climate of marginalization that has pervaded the experiences of consumers and service providers. The strength and persistence of "NIMBYism" (Not In My Back Yard) has challenged the development of SH and individuals' experiences within it; numerous fears and myths exist regarding potential negative impacts on local businesses and neighbours from declining property values, increased crime, traffic congestion, and noise disruptions (Hill, cited in de Woolf, 2008). Participants in this research were acutely aware of these attitudes as they highlighted the need to attend to this dimension in their task of selecting and maintaining housing. Social inclusion and the elimination of stigma have been identified as key priorities within the new national framework for mental health in Canada (Mental Health Commission of Canada, 2009), and our research brings the urgency of this mission into sharper focus.

A central intent of this work was to shed light on specific characteristics of SH that are associated with outcomes that are valued and desired by key stakeholders, and to explore the influence of these characteristics on outcomes that are meaningful to residents; the research thus provides rich information on the characteristics of successful SH from the perspectives of residents and service providers. It is interesting to note that service providers and residents highlighted many similar characteristics as being important. A summary of the characteristics follows.

Flexibility and choice. Flexibility is necessary to provide individuals with choice in the housing process. Having choice and autonomy to make decisions empowers residents. It is also important that there be flexibility within SH programs, especially within service provider roles, so that individualized support, tailored to a resident's unique goals, can be provided.

Safe and accessible neighbourhoods. Housing must be located in safe neighbourhoods that are free from drugs and crime, and that have access to public transit and other amenities.

Good fit between individuals and their neighbourhoods. Assessment of the fit between the individual and neighbourhood is needed to guide housing selection. Consideration should be given to the services available in the neighbourhood and accessibility to transportation, shopping, and doctors as well as friends, family, and social networks.

Specific supports. Necessary supports include

- connections with social networks such as friends and family. Support in making social connections reduces loneliness and isolation, promotes recovery, and leads to greater housing stability.
- access to needed resources such as health care, financial resources, work, and school. Support to access these resources leads to an increased sense of well-being and stability in housing.
- crisis support. In order to maintain stability in housing, many residents require support in learning how to manage symptoms and plan steps to be taken in the case of a crisis.
- skills for independent living. Many residents need support to learn skills for independent living, especially home-care skills, budgeting, and self-care skills.

- education for landlords about mental illness. It is important for service providers to work as liaisons between residents and landlords.

Development of a supportive relationship between residents and service providers. It is important for service providers to build trusting relationships and maintain long-term connections with residents. Some residents will require ongoing supports in order to remain stable in housing due to the nature of their illness. Training and support is needed for service providers so that they can develop and nurture good relationships with residents. Essential skills include sound knowledge of mental health issues, knowledge of community resources and social services, active listening skills, knowledge of communication and problem-solving techniques, knowledge of cultural issues, creative problem-solving skills, empathy, non-judgmental attitude, self-awareness, optimism, and the ability to hold "hope" for clients. Building trust and treating others with dignity and respect are essential.

Current literature calls for more research that outlines best practices for SH and a clarification of the characteristics of housing and support that generate positive outcomes. The current research begins to identify some of these characteristics and, importantly, it incorporates the perspectives of the residents and service providers who are most involved in SH programs. The findings contribute to a growing body of systematically obtained knowledge regarding SH and extend the evidentiary base for further development and understanding. The findings also validate the experiential knowledge of consumers living in SH and the practices of recovery-oriented service providers. This research represents a preliminary step in establishing critical characteristics of SH and their impacts on outcomes; further research is required to validate these characteristics and to determine which of them are most salient, for whom and under what conditions.

This research has clear implications for practice and program development in the area of supported housing, as services strive not only to incorporate best practices into their repertoire but to include characteristics of those practices that are most influential and valued; the characteristics identified can be used to review and modify SH programs, as well as to plan new SH programming. This work also underscores the need for social policy that encompasses the development of high-quality SH programs, and the findings can be used to advocate for increased resources for quality SH. Ideally, this research will provide individuals living with serious mental illness with evidence-based information that they can use for self-advocacy in the search for satisfying housing.

RÉSUMÉ

L'objectif de cette étude était de nous permettre de mieux comprendre en quoi le logement subventionné (LS) est important pour les personnes ayant de graves problèmes de santé mentale. Nous avons réalisé des entrevues semi-dirigées avec des personnes vivant en LS ainsi qu'avec des prestataires de ce type de services, puis nous avons analysé les résultats à l'aide de la méthode de comparaison constante. Quatre grands thèmes sont ressortis : le LS comme fondement du rétablissement, les valeurs qui guident le LS, le soutien offert en LS et le milieu environnant (quartier, communauté). L'étude a ainsi permis de mettre en lumière des aspects du LS qui peuvent être utiles pour élaborer de nouveaux programmes et évaluer de programmes existants, pour favoriser l'autonomie sociale et pour servir de points de départ à nouvelles recherches.

Mots clés : logement subventionné, services de santé mentale communautaire, élaboration de programmes, soutien communautaire

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