Supported Housing in a Small Community: Effects on Consumers, Suggestions for Change

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ABSTRACT

We explore the effects of supported housing on the quality of life and recovery of consumers in a rural community, and also explore how this housing approach could be improved. Data were collected from 16 tenants involved in Supported Housing for Individuals with Mental Illness (SHIMI), located in Nova Scotia. The following themes were identified in the analysis: support, security, normalcy and integration, stability and control, and recovery. Suggestions for improvement include fostering a stronger system of supports, coordinating initiatives to reduce the living costs and build the assets of tenants, and having greater consumer involvement in the initiative.

Keywords: supported housing, rural, Nova Scotia

RÉSUMÉ

Nous examinons les effets d'un programme de logement avec services de soutien sur la qualité de vie et le rétablissement des bénéficiaires qui vivent dans un milieu rural, et examinons la manière dont ce programme pourrait être amélioré selon les bénéficiaires. Les données ont été recueillies auprès de 16 locataires

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This research was supported through an internal grant from Cape Breton University and through funds provided by the Shannon School of Business, Cape Breton University. The authors would like to thank research participants and members of the SHIMI advisory group.

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doi:10.7870/cjcmh-2014-020
Published by Canadian Periodical for Community Studies Inc.

du *Supported Housing for Individuals with Mental Illness (SHIMI)* en Nouvelle-Écosse. Les thèmes suivants ont été dégagés après analyse : soutien, sécurité, normalité et intégration, stabilité et contrôle, et rétablissement. Les suggestions pour améliorer l'initiative comprenaient : favoriser un système de services de soutien plus solide; coordonner les initiatives pour réduire les frais de subsistance et bâtir les actifs des locataires; et stimuler une plus grande participation des bénéficiaires dans la gestion et le contrôle de l'initiative.

Mots clés : Logement avec services de soutien, rural, Nouvelle-Écosse

INTRODUCTION

A range of housing strategies have been developed for individuals with mental illness. In custodial housing, safeguarding is the emphasis. Housing is tied to treatment, and consumers do not exert control or choice over their living environments or care (Nelson, 2010). In supportive housing, rehabilitation is the objective, and a continuum often exists whereby individuals transition from residences that provide greater to lesser amounts of supervision, restrictions, and services (Leff et al., 2009; Nelson, 2010). *Supported* housing is a more recent strategy, whereby consumers live independently in their own apartments and may access a range of flexible and individualized support services. Housing is affordable and integrated into neighbourhoods to facilitate community participation (Carling, 1995), and recovery is the focus. In supported housing which adopts the "Housing First" approach, consumers are not required to demonstrate an ability to live independently to obtain an apartment, nor must they receive treatment. While different versions of supported housing have been adopted in Canada, including ones that blend elements of supportive and supported approaches (Kirsh et al., 2009), both custodial and supportive housing are still common (Sylvestre et al., 2007).

This research explores the effects of a supported housing initiative on the quality of life and recovery of consumers in a rural community. Second, it explores how individuals living in this housing feel the model could be improved. This article contributes to research and practice in its focus on implementation in a small population centre.

LITERATURE

There is a growing body of primarily urban-based literature about the effects of supported housing on the lives of consumers. Individuals living in this housing have reported more control (Nelson, Sylvestre, Aubry, George, & Trainor, 2007; Parkinson & Nelson, 2003; Tsemberis, Gulcur, & Nakae, 2004) and greater housing stability compared to those accessing other housing options (Cheng, Lin, Kasprow, & Rosenheck, 2007; Goering et al., 2012; Tsemberis et al., 2004). Moving into this housing has also resulted in less unlawful behaviour on the part of residents (Bean, Shafer, & Glennon, 2013).

There is conflicting evidence regarding the effect of supported housing on integration. Walker and Seasons (2002) identified that individuals living in this housing felt isolated, and that those living in apartment buildings specifically for low-income households felt segregated. However, Gulcur, Tsemberis, Stefancic, and Greenwood (2007) reported greater social integration among tenants compared to those living in different

forms of residential housing, while Parkinson and Nelson (2003) concluded that consumers experienced community integration through recreational or educational pursuits, volunteer work, and new jobs.

The quantitative literature on how supported housing affects mental health is inconsistent. The psychiatric symptoms of individuals living in supported and supportive housing were found not to differ in one study (Tsemberis et al., 2004), and homeless veterans living in supported housing did not differ in their psychological distress compared to veterans receiving only case management in another (Cheng et al., 2007). Further, in testing a core dimension of this housing approach, 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" (p. 94). Conversely, Gulcur et al. (2007) also tested the effects of choice and found that it was a positive predictor of psychological integration and self-actualization. Focusing on a different outcome in the quantitative literature, Siegel et al. (2006) reported that those living in supported housing for at least six months within a one-year period used fewer crisis services compared to individuals living in different kinds of community residences.

The qualitative research more consistently provides evidence of recovery. In a narrative study, consumers experienced fewer hospitalizations, better coping skills, and greater self-understanding after moving into supported housing, and were also able to set new goals (Parkinson & Nelson, 2003). In the same vein, Polvere, Macnaughton, and Piat (2013) found that housing allowed many consumers to think about building new lives for themselves, while Henwood, Stanhope, and Padgett (2011) reported that tenants living in supported housing felt able to pursue personal interests.

Although little research examines supported housing in smaller areas, there are exceptions. Stefancic et al. (2013) and Stefancic and Tsemberis (2007) assessed its implementation in rural and suburban communities in the United States and found that consumers experienced housing stability. The evaluation of the rural component of the At Home/Chez Soi project in Moncton had this same finding and revealed that those living in supported housing were more positive about their lives over time compared to the control group (Aubrey et al., 2014).

Beyond outcomes, this segment of the literature identified challenges to implementation in smaller areas, including staff shortages (Aubry, Cherner, Ecker, Jetté, & Philander, 2011; Stefancic et al., 2013), staff travel time (Stefancic et al.), inadequate transportation options (Aubry et al., 2011), and limited rental stock (Aubry et al., 2011; Stefancic & Tsemberis, 2007).

IMPLEMENTATION

Supported Housing for Individuals with Mental Illness (SHIMI) is located in Cape Breton, Nova Scotia. The local municipality has a population of approximately 100,000 and covers almost 2,500 square kilometres (Nova Scotia Department of Finance, 2013). Although classified as a census agglomeration, provincial initiatives have categorized the municipality as rural (Rural Communities Impacting Policy Project, 2003).

SHIMI is a partnership involving community-based mental health organizations, a community development corporation (CDC), and a health authority; it began through conversations among consumers and staff at the local clubhouse about housing problems. Affordable units are made available to individuals who

demonstrate housing need; prospective tenants do not have to demonstrate housing readiness or sobriety. However, to ensure that individuals are not isolated, and unlike a "Housing First" approach, prospective tenants must either be a member of the clubhouse or have a connection to community rehabilitation staff. Beyond this requirement, services are accessed by tenants if they choose to use them. Tenants access different services from a range of providers, including mental health outreach staff and community-based organizations. A housing coordinator and two support staff provide practical assistance such as rides, budgeting assistance, in-home support, and referrals. SHIMI does not use Assertive Community Treatment (ACT) or Intensive Case Management (ICM) teams because they are not available within the local health authority.

Due to high rates of outmigration and unemployment, there has been a disinvestment in local housing, and the region features a shortage of quality rental stock (Harker Associates, 2010). As a result, small numbers of new apartments are renovated as funds permit, and consumers do not choose their apartments. The housing is owned and managed by the CDC.

Apartments are integrated into neighbourhoods within three small centres with populations of 21,180, 15,487, and 6,358 (Nova Scotia Department of Finance, 2013). All units are in buildings that house from two to five SHIMI tenants, meaning that consumers have a small number of neighbours also living with mental illness. SHIMI is not scatter-site housing because it emerged from the consumer clubhouse where peer support is central; moreover, the initiative has relied on contributions from the community. One donated property, for example, was a former rectory that included five apartments.

Until recently, SHIMI was managed by an advisory committee that consisted of representatives from partnering organizations and a tenant. It is now managed by a new nonprofit organization, with the advisory committee still in place.

METHODS

This research uses a flexible, case study design (Robson, 2011). The need for the research was articulated by a SHIMI partner, and the authors worked with the SHIMI advisory group to establish the research question, methods, and interview guide.

Data were generated through in-depth interviews and a member-checking meeting. We used a purposive sampling strategy (Robson, 2011) and endeavoured to interview all 23 current[1] 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 old. 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. All but two participants had lived in rental housing directly before moving into supported housing, while one individual had lived with family and one had owned her own home. The former SHIMI tenants who were interviewed had moved out of their units for reasons unrelated to their housing or their health.

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 the interviews. All interviews but one were recorded and transcribed. Twelve consumers opted to be interviewed in their own apartments. Three consumers requested to be interviewed at the clubhouse, while one requested to be interviewed in a friend's apartment. Participants received a $20 honorarium.

Data were also collected through a two-hour member-checking meeting. While this meeting was held to establish the validity of the findings, the five participants who attended also shared additional experiences related to the research questions. This meeting was recorded, transcribed, and used in the data analysis.

Data were analyzed using a line-by-line thematic analysis (Robson, 2011), and the research team conferred throughout the analysis to discuss emerging themes (Meadows & Morse, 2001). The theoretical orientation of the data analysis was qualitative description, since the team focused on understanding the "basic nature" (Sandelowski, 2000, p. 338) of participants' experiences and the effects of supported housing on their lives.

Three features of this research contribute to its validity. One of the researchers is a consumer who is well liked by other consumers in the local community; this helped participants feel comfortable and helped build trust between participants and the research team. Second, a draft analysis was presented to all participants. Five consumers attended this member-checking session and concluded that the team had accurately captured, with one exception,[2] what they had shared with the team during the interviews. Third, the team brought investigator triangulation to the study, in that various members provided different areas of expertise. These included a combination of research, practice, and lived experience in community development, social services and advocacy, housing, and mental illness. This research also received ethics approval from the university and the local health authority.

FINDINGS

We identified five major themes in the data: support, security, normalcy and integration, stability and control, and recovery. These are organized according to before and since participants moved into supported housing.

Support

Before supported housing. Participants spoke about feeling unsupported before moving into their new housing. In part, participants indicated that they were lonely, with few ties to family and friends. Those who obtained housing in the private rental market also spoke consistently and negatively about their landlords, whom they described as uncaring. For participants, this uncaringness was reflected in the physical state of the housing provided, as well as in the willingness of landlords to rent to anyone, regardless of their respect for the apartment or other tenants. One individual noted that "landlords in [name of town] don't care. They won't fix their apartments up and when a place is cold they will not try to fix it up."

Since supported housing. Many individuals experienced stronger support once they moved into SHIMI housing. Some talked about being able to reconnect with friends or family, either because of changes they had experienced in their mental health as a result of their new housing, or because the proper living space afforded them the opportunity to have visitors. Consumers also indicated that they were treated well by staff at the CDC. As one individual stated as he showed interviewers his accessible kitchen, "Let me show you my cupboards. [The CDC] did that for me."

Support was also strengthened for some participants through the peer networks they developed within the small, multi-unit buildings that house SHIMI tenants. These participants indicated that they lived in buildings with empathetic neighbours, with people whom they could help, and with individuals with whom they could share meals and holidays. As one individual explained, "It is a duplex that we live in. I felt miserable and alone and everything else. Living there, I can now talk to [name of neighbour] who lives next door to me." However, other participants did not describe any peer support in their new housing, and three consumers noted that they had, in fact, minimal contact with their neighbours. Participants felt that peer support should be fostered among SHIMI tenants and recommended that the housing coordinator do so by organizing activities such as meals. They also felt that more SHIMI housing could be developed in close proximity to existing units.

Several individuals also indicated that they received support from SHIMI's housing coordinator and expressed gratitude for the rides to the store or the informal counselling they received. However, other participants struggled to answer questions related to the kinds of formal supports, if any, they were receiving, and two participants felt that this support was not offered proactively enough. For example, one individual stated, "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." It was also noted that mental health services were not available beyond regular work hours. As one individual remarked, "When five p.m. comes around everything shuts down, but we don't. We don't get sick only between eight and five." Consumers indicated that expanded service hours, along with strengthened peer support offered through phone or Internet, could help fill this gap.

Security

Before supported housing. Before moving into supported housing, participants felt unsafe. Feeling unsafe was related to living in dangerous neighbourhoods and to the poor physical condition of the rental 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." Financial insecurity is the second dimension under this theme: individuals spoke of not being able to afford rent, of living in poverty, of juggling bills, and in one case, of having to sell a home because repairs were too expensive to manage.

Since supported housing. Participants experienced greater security in supported housing, in that they reported feeling safe in their new neighbourhoods and buildings, and confident that their neighbours were not engaged in criminal activities. As one participant noted, "It is great. There's a lock on the door. [You] go to bed at night and know you are safe."

Regarding their financial security, participants strongly emphasized and appreciated the affordable rent charged by the landlord. Still, the high cost of basic needs was also discussed by several individuals. It was suggested that SHIMI could further assist tenants by coordinating bulk purchases of food, medication, and telecommunications. It was also suggested that SHIMI could build the assets of tenants through individual development accounts (IDAs), whereby tenants would set money aside that could be matched by government or a community partner.

Normalcy and Integration

Before supported housing. During interviews, consumers consistently spoke of not having the same basic opportunities to live like others who do not have mental illness; of not being "normal." Some participants pointed to the unusual nature of their housing pre-SHIMI: one individual explained that she had been "stuffed in the back of a building," while another stated incredulously that he had lived in a former bank building and that a vault had served as his bedroom. Some participants spoke of this housing as being atypical in other ways: in terms of the size of the living space available to them, or in terms of the inadequate light, heat, or appliances. Washers and dryers were specific appliances mentioned frequently in the interviews, and individuals noted how they previously had to go without, share a laundry room, or in one case, travel to another community by bus to wash their clothes. As one individual stated, "I used to have to use the laundromat in [name of community]."

Participants also noted that they felt like they were living on the margins of society, rather than being members. For example, they described having to live alongside individuals engaged in illegal activity and people whom they felt behaved inappropriately, such as arguing on the street. They also described living in locations that were not really residential, such as an industrial area and a commercial street.

Since supported housing. Participants consistently mentioned that their new housing allowed them to live like others. They repeatedly identified and emphasized the features of their new housing that were typical of regular housing and that, prior to SHIMI, they did not have. These included adequately sized units, storage space, functional appliances, washers and dryers, clean space, heat, porches, balconies, and windows. For example, one individual stated the following: "It is nice to have a bedroom again. In the other place, I just had a living room. I was sleeping just off from the kitchen."

Consumers also expressed that they were now living in real neighbourhoods and were able to take part in day-to-day activities. For example, one consumer indicated 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 . . . . Here you have wide open space, and people coming back and forth to church.

Despite this sense of integration, however, participants also noted that they still faced the stigma of mental illness. This stigma, coupled with the fact that living in a small community meant that their illnesses were widely known, led them to be denied opportunities such as bank loans and volunteer work. As one individual stated, "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."

Stability and Control

Before supported housing. Participants experienced a lack of stability and control over their living environments in their pre-SHIMI housing. Participants who rented did not have security of tenure: landlords could (and did) evict them, and they faced dramatic or unanticipated rent increases that resulted in frequent moves. One individual noted the following: "When I gave my notice at the last apartment, the rent had skyrocketed to $200 to $300 more than I could afford . . . . So that made me homeless." Another participant

stated, "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." Participants also noted that they experienced a lack of control over their living environments in that they could not turn on or regulate their heat and they had difficult neighbours whose behaviour they had no way to address.

Since supported housing. Participants experienced greater stability in their new units. Consumers explained that they now had a landlord who understood mental illness; if they were hospitalized, they would not lose their housing. Participants also felt confident that they were not going to lose their housing on the whim of the CDC to either raise the rent or renovate. As one individual noted, "If you're not doing anything wrong you can relax . . . [the CDC] is not going to say 'we're selling it,' or 'we're renovating and you've got to get out.'" However, some participants requested greater involvement in the management of SHIMI. They indicated that consumers had been actively involved in early meetings convened to discuss housing, and had envisioned the initiative being developed through a formal organization with consumer control. Currently, only one tenant is a member of the advisory group, and some participants felt that greater consumer representation was required. It was also noted that because SHIMI housing is owned by the CDC, rather than by an organization specifically devoted to supported housing, the assets can be leveraged by the CDC for purposes unrelated to assisting those with mental illness. A final dimension under this theme focuses on how consumers are able to secure supported housing. To obtain an apartment, one must be placed on a waiting list through either the local clubhouse or the mental health services unit within the health authority, neither of which is consumer controlled. For some participants, this means consumers have to relinquish some of their autonomy to these institutions in order to obtain supported housing. To address this issue, they suggested that consumers be allowed to independently add their names to the waiting list.

Recovery

Before supported housing. It was difficult for participants to focus on recovery when they lived in housing environments that were unstable and that they did not control, in which they felt insecure and unsupported, and which made them feel like they were on the margins. For example, when discussing their lives pre-SHIMI, one participant stated the following: "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." A second stated: "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."

Since supported housing. Consumers consistently spoke about having new and positive feelings about themselves. These included feeling more independent, being happy, feeling a greater sense of self-worth, and having greater self-confidence. Excerpts which capture this range include the following: "I feel good about myself," 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." Participants also spoke about being able to manage their symptoms by taking their medication regularly.

Most participants also spoke about being able to take new steps in their lives. Some named specific ones, including securing supported employment, writing a business plan, reconnecting with family, and interacting

more with others. Others spoke more generally about being in an environment that allowed them to move ahead. One individual captured this by comparing his current housing to his former living arrangements:

> 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.

Another individual noted the certificates hanging on her wall and stated, "I can do things with my life."

Finally, consumers spoke of recovery by noting something that they no longer had to do. Many expressed an absence of worry related to their new housing and made comments such as: "I don't have to deal with [that] anymore," and "It is a big, big relief, a very big, big relief."

DISCUSSION

Participants were consistent in expressing that their current housing contributed to recovery, albeit in different ways. Although research that examines the relationship between supported housing and mental health-related outcomes is somewhat inconsistent, these results contribute to the growing body of evidence, drawn mostly from urban initiatives, that the approach supports mental health (for example, Gulcur et al., 2007; Parkinson & Nelson, 2003; Siegel et al., 2006). The absence of worry noted by participants suggests that good housing not only addresses a practical need, but provides a space in which consumers can begin focusing inward rather than managing difficult external environments.

The theme of integration identified in the findings speaks directly to a core principle of supported housing (Carling, 1995). In this housing model, integration is fostered through the geographic decentralization of housing in typical neighbourhoods; this contrasts with custodial and supportive approaches in which consumers are often clustered geographically (Taylor, Elliott, & Kearns, 1989; Wong & Stanhope, 2009). Participants expressed appreciation for their new living environments and conveyed that it was ordinary occurrences of everyday life in these neighbourhoods that represented integration to them: hearing children play, watching churchgoers, and chatting with nearby neighbours about pets. This integration was facilitated both through the location of the housing, and through housing features, such as windows and porches. In the same vein, physical features such as washers, dryers, and natural light were strongly emphasized by consumers as ones that contributed to a sense of normalcy, underscoring that what might appear to be smaller details in a supported housing initiative may have particular salience for tenants.[3]

Regarding suggestions for change and, specifically, consumer involvement as a way to improve the initiative, we located minimal literature that addresses the extent to which consumers help direct or control supported housing. Control has been tested in the literature, but to date this has encompassed perceived control over personal living space (for example, Nelson et al., 2007) rather than housing assets or waiting lists. Although tenant committees are not equal to boards of directors with consumer involvement or control, an early study on a supported housing initiative found that the tenant committee put in place reminded consumers of meetings they were forced to attend while living in supportive housing and was not considered useful (Boydell & Everett, 1992). However, given that consumer participation is now integral to most community-based mental health initiatives and that a track record on consumer management and control

has been demonstrated in consumer-run organizations, practitioners involved in supported housing should review how they involve consumers and ask both tenants and consumers living in the wider community how they want to participate.

Findings also pointed to more systemic issues that did not disappear when participants moved into supported housing: notably, stigma and financial insecurity. The suggestions to implement bulk buying and IDAs would help counter the latter issue and seem like feasible initiatives for community health workers to coordinate. Beyond the limited financial assistance consumers receive across Canada, this recommendation is perhaps of special importance for initiatives in rural, economically challenged communities where opportunities for consumers to find employment are limited by both stigma and a weak economy.

Findings also shed light on other aspects of, and implications for, implementation in a small community. First, despite the assumption that the cohesiveness of smaller regions allows individuals to draw on their social networks in the face of market or government failures (Saulnier, 2009), most participants relied on market rentals rather than family or friends to secure places to live. Most also lived in substandard housing prior to moving into SHIMIs, which is consistent with existing research on rural areas that has found that good quality housing is difficult to acquire (Forchuk et al., 2010). These findings underscore the importance of establishing supported housing in communities of all sizes and also suggest that organizers working in rural communities may have to develop at least some housing stock so that enough units of acceptable quality are available. Interestingly, although tenant choice of units is a component of the "Housing First" approach, participants in this study did not mention lack of choice as a shortcoming. The request for greater consumer involvement, in turn, focused on the initiative in its entirety rather than on single apartments. Recognizing both the importance of consumer choice, on the one hand, and the constraints caused by limited supply, on the other, one way to address the disparity between urban and rural housing choice may be to ensure the involvement of tenants in the management of their supported housing initiative.

The findings related to support are also important with respect to rural implementation. The municipality in which SHIMI operates features limited services, a weak transit system, and large distances among population centres, challenges which have been identified in other studies on smaller communities (Aubry et al., 2011; Forchuk et al., 2010). Findings show that although some tenants felt isolated, the peer support facilitated through the physical proximity of small numbers of units was an important source of assistance for others, and the need was expressed for even greater contact among tenants. Further, it was felt that enhanced peer support could fill a void left by service gaps. Additional research is required to determine how peer support can be most effectively fostered and provided in this setting, as well as how it can best complement formal services in communities in which they are lacking. Peer support has also been linked to recovery in the case of clubhouses and consumer-run organizations (Solomon, 2004), and its role and effects within the context of housing merits future research. With regard to formal supports, participants' requests for more proactive visits from the housing coordinator may stem from the large distances among units and the time required by staff to travel; the use of telecommunications has proven useful in other locations (Stefancic et al., 2013) and could perhaps be considered by SHIMI and organizers in other rural locations where staffing and transportation pose challenges.

LIMITATIONS AND CONCLUSIONS

This study has four limitations. First, greater participation in the member-checking meeting would have resulted in stronger validity. Second, a longitudinal research design would have better captured the effects of supported housing on the lives of participants. Third, tenants were not involved in designing the research questions; having tenant participation during this stage could have made the findings more relevant to consumers (Rapp, Shera, & Kisthardt, 1993). Finally, the current and former tenants who did not participate in this study may have had different experiences to share compared to those who did.

Still, this study contributes to the body of research which demonstrates that this housing model supports recovery. It also highlights suggestions for practice with the potential to improve a housing strategy that—at the very least—addresses the poor housing conditions experienced by consumers, but that seems also to foster support, security, stability, normalcy, and integration for individuals with mental illness.

NOTES

1. There were 23 tenants but only 21 units because two belonged to couples. Since the completion of this research, six more units have been created.
2. Participants felt we overlooked the uncaring nature of landlords.
3. We credit Colleen Cann Mackenzie, a representative of one of SHIMI's partnering organizations, for first making this point during our discussion of the findings with the advisory group.

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