WELLESLEY INSTITUTE
advancing urban health

Critical Characteristics of Supported Housing:

Findings from the Literature, Residents and Service Providers

Bonnie Kirsh, PhD.
Rebecca Gewurtz, MSc., PhD candidate
Ruth Bakewell, MSc(OT).
Brenda Singer, Progress Place
Mohamed Badsha, Reconnect Mental Health Services
Nicole Giles, Canadian Mental Health Association, Toronto Branch

August 2009

Advanced Grants

The Wellesley Institute's Advanced Grants programs supports and funds community-based research on housing, health equity, poverty, social exclusion, and other social and economic inequalities as key determinants of health disparities.

The Wellesley Institute's strategic focus is Health Equity, and we work in diverse collaborations and partnerships for social innovation, progressive social change, policy alternatives, and solutions to pressing issues of urban health and health equity.

Acknowledgements

We gratefully acknowledge funding through the Wellesley Institute, Toronto.

This project was funded by the Wellesley Institute (WI). The views and opinions expressed in the paper do not necessarily reflect those of the Wellesley Institute.

Table of Contents

1. Executive Summary

The importance of good quality housing in people's lives cannot be overstated. Its impact is articulated by a resident of supported housing:

> *It's allowed me to stop worrying about those things that were holding me back. [Previously], I was so suppressed with all this negative energy and, and these negative things going on around me. I just felt hopeless and trapped. But due to my housing situation being changed - 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 do, I'm going to help somebody if I can, and I'm going to make somebody smile…I can focus on more positive things, now.*

Canadian governments have come to recognize that a significant proportion of the homeless population has mental health problems. As these governments attempt to alleviate homelessness in our communities, the role of supported housing (SH)[1] for those with mental health issues is paramount. Furthermore, it is critical that supported housing programs be designed to ensure the highest degree of housing success and stability for residents. It is therefore necessary to determine what factors contribute to the success of supported housing[2].

Impacts of SH on mental health service usage (Dickey, Gonzalez, Latimer, Powers, Schutt, & Goldfinger, 1996), costs (Dickey, Latimer, Powers, Gonzalez, & Goldfinger, 1997), and residential stability (Sylvestre et al., 2004; Rog, 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 supportive housing (Corporation for Supportive Housing). Yet there are a limited number of studies that investigate characteristics of SH that influence outcomes and even fewer that do so from the perspectives of persons who use and deliver these services. The purpose of this research was twofold: 1) to synthesize findings in the literature regarding essential components of SH and 2) to develop an understanding of important characteristics of SH for persons with SMI based on perspectives of residents and service providers. This research lays the foundation for the development of principles that can be used to guide SH programming and that can continue to be examined in future research. It also provides a set of key characteristics critical to supported housing that can be used by supported housing programs to modify and evaluate their current programs and in the development of new housing programs.

[1] We use the definition of supported housing described by Parkinson, Nelson and Horgan (1999), discussed on p. 12 of this document.

[2] Successful supported housing is secure, affordable and decent, and is considered to be satisfactory by its residents.

Key Findings

Although the purpose of this research was to delineate a set of key characteristics, it was impossible to ignore some of the other themes that emerged from the interviews conducted with residents and service providers. Primary among these was the idea that housing is clearly a determinant of mental health. Good housing is a foundation for productive and meaningful engagement in life roles, which is key to long term stability and improved mental health.

Characteristics of successful supported housing include:

Choice and flexibility: Each resident of supported housing has a unique set of needs and goals that must be addressed, and individuals respond most positively to SH when they are able to participate actively in decisions about their housing. Housing programs are most successful when residents are provided with as much choice, control and autonomy over their living environments as possible.

Neighbourhood fit: The fit between the resident and the neighbourhood in which he or she will be living is an important consideration when arranging SH. Individuals have a variety of needs and goals that determine the nature of the environment best suited to them. For example, individuals may be more successful in SH if it is located close to their existing community resources and social connections. Some individuals who have addiction issues may find greater stability in a neighbourhood with lower drug crime rates.

Awareness and attention to stigma: An awareness and consideration of the role and impact of stigma on residents' lives is an important factor in setting up and maintaining supported housing. Both residents and service providers noted that some residents benefit from housing that is integrated within mainstream apartment buildings and neighbourhoods where they can be 'anonymous' and neighbours are not necessarily aware of their mental health status; others benefit from the support of nearby peers in clustered housing arrangements. Literature suggests that the more diverse a neighbourhood is the more accepting the community tends to be of supported housing.

Quality relationships between residents and service providers: The relationship between service providers and residents is viewed by both parties to be very important in ensuring success in SH. Long term support is seen to be critical, requiring the persistence and commitment of service providers as well as flexibility on the part of housing programs to foster this long term connection. Dignity, respect, trust and choice are fundamental elements of this relationship, which must be incorporated into a client-centered, individualized approach. Accessible support from service providers and information-sharing that enables thoughtful decision making is needed. Although the outcome literature does not address the relationship between SH workers and residents specifically, it does indicate that continued access to a support worker and long term case management services are associated with housing success.

A range of supports: Key supports that are necessary and helpful in SH programs were highlighted by both residents and service providers. These supports include:

- Support with independent living: Assistance in learning community living skills is associated with improved housing outcomes in the literature. Support managing finances and learning skills related to caring for the home (e.g. cooking, cleaning, caring for pets) are important according to service providers and residents. Some residents felt that learning these independent living skills was a necessary and sometimes missing component of the support provided in SH. Service providers also highlighted that they frequently provided support around dealing with landlords and paying rent.

- Support in preventing and managing a crisis: According to residents, having stable housing in itself reduces the likelihood of mental health crises. They highlighted that, in the event of a crisis, access to a support person is critical. It was noted that if hospitalization occurs, it is important to have someone to communicate with the landlord. Service providers spoke about the need to help clients prepare for the possibility of a crisis and to help them learn how to access resources if they begin to experience symptoms. Many also noted that it is important for service providers to be attuned to changing events and cues in a client's life (for example, the state of his or her surroundings or self-care), in order to prevent potential crises.

- Support with pursuing work and school: Literature indicates that having access to specialized services, including vocational services, is associated with increased housing stability. Residents appreciated help in learning how to set goals and break tasks into manageable steps. Service providers noted that pursuing work and school is often the next step for residents after they have found stable housing and they promote the importance of providing support in connecting residents to appropriate resources.

- Support and assistance with creating and maintaining social connections: The literature indicates that having social supports has positive outcomes for residents, including housing stability. Many residents felt that support from their friends (often including other residents) and family members was key to stability. Clustered housing arrangements were noted to provide a sense of community to some residents. Service providers noted that being isolated can be a major barrier to recovery and they often worked to connect residents with resources to help them develop social connections.

- Support and assistance with health issues: Service providers noted that they frequently discussed with residents ways to improve their general health and touched base with them about taking their medications consistently. Several service providers also worked to connect residents with health care resources in the community and acted as liaisons with health care providers.

Implications and Recommendations

The key characteristics highlighted in this study can be used to review and assess the quality of current programs, and as guidelines in the development of new supported housing programs. Programs may choose to use these findings to self-assess, to conduct peer reviews of supported housing programs, and/or to inform residents of important housing characteristics so that they may determine whether they are receiving services that are reflective of those considered to be best practice. In this way, this research will provide residents with greater tools for self-advocacy when accessing supported housing. It is recommended that future research address the impact of these characteristics on outcomes as well as the importance of program fidelity to these characteristics.

Specific recommendations are:

- More good quality supported housing is needed.
- A range of housing types and levels of support should be available.
- Choice in housing options must be offered
- Housing must be long-term or permanent.
- Flexibility within programs and within service provider roles is necessary.
- Housing must be located in safe neighbourhoods with access to public transit and amenities.
- A range of supports is required including those that focus on social networks, accessing community resources, crisis prevention and management, skills for independent living, and landlord education.
- More integration among services, collaboration and good communication between all support personnel and services is necessary.
- Attention needs to be paid to the relationship between residents and service providers.

2. Research Overview and Background

Research shows that individuals with severe mental illnesses who live in supported housing do so with some degree of success. A review of evidence on supported housing by Rog (2004), suggested that people with mental illnesses who enter supported housing show housing stability for approximately one year. However, even after obtaining housing, many people with severe mental illnesses experience high levels of isolation and relatively low levels of social support (Lam & Rosenheck, 1999), factors which threaten housing stability and community participation (Kloos, Zimmerman, Scrimenti & Crusto, 2002). Therefore creating appropriate and effective housing for persons with mental illness and addictions that result in lasting improvements in residential stability, enhanced social support and increased community participation is a pressing issue. Indeed Kloos et al (2002) argued that systematic efforts are needed for housing programs to promote greater social integration and housing success of persons with mental illnesses.

In the current environment of evidence-based practice, community mental health services must reflect the evidence that is associated with desired outcomes. This includes determining which program components are valued and effective, and developing best practice standards and policies. Although research in the area of supported and supportive housing for persons with severe mental illnesses (SMI) has developed substantially over the past several years, most of it focuses on characteristics of residents (Goering et al., 2002; Sylvestre et al., 2004) as well as impacts of supported housing on mental health service usage (Dickey et al, 1996), costs (Dickey, Latimer, Powers, Gonzalez & Goldfinger, 1997), and residential stability (Sylvestre et al.,2004; Rog, 2004). There is, however, a limited amount of research that examines characteristics of supportive housing that influence these and other outcomes, and very little research that does so from the perspectives of persons who use and deliver these services. An understanding of characteristics of supported housing that are valued by residents and service providers, and that are associated with positive outcomes, will lay the foundation for a set of best practices in the field. This project sets the groundwork to develop principles and practices that can be incorporated into supported housing, and that can be further tested through future research.

2.1 Literature Review

It has been generally accepted that supported housing can have an enormous impact on the lives of persons with SMI. Individuals living in SH report better quality of life outcomes in a number of domains compared to those living in other settings. In their evaluation of the Mental Health Homeless Initiative, Sylvestre et al (2004) found that over one third of residents reported that their health and well being had improved over their period of involvement with SH and specifically reported being happier, more positive and optimistic, more relaxed, secure and comfortable. Some residents reported improved physical health and well being, more control over substance abuse as well as feeling more personally empowered and independent with increased self-confidence and self esteem, and new social relationships. Brunt and Hansson

(2004) compared inpatients with residents of two types of SH (small congregate community residences and independent living with support) and found greater satisfaction in living situation, social relations, leisure activities and work amongst those in SH settings. However, no differences in quality of life were found between the two supported housing settings, suggesting that a closer and deeper examination of the characteristics of supported housing and the impact of these characteristics on outcomes such as quality of life is needed.

Fakhoury, Murray, Shepherd and Priebe (2002) found that there is considerable diversity in various models of SH, and that inconsistencies in terminology make it difficult to compare or advance the field. These authors lament that little information is available on factors that mediate outcomes and on skills required by staff. Accordingly, they position a research agenda that includes "not just what to provide but how to provide it" (p. 301). Rog (2004) agreed, reflecting that "there is little research available to provide definitive guidance on what organizational approaches work best for delivering supported housing" (p. 341). For example, it is not clear whether housing and services need to be offered by different agencies (Bebout et al., 2001, cited in Rog, 2004) or whether congregate housing with on-site services best meets individuals' needs (Lamb & Lamb, 1990). Furthermore, the nature and type of support most needed and wanted within supported housing is not known. As stated by Carling (1990), further research is needed on key questions such as "Where do [people with mental illnesses] want to live? How can we help them succeed there?" (p.973).

Recently, the "Housing First" model has been studied as a best practice in supportive 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 multi-disciplinary 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 percent of participants were still housed at five-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 homelessness comprises the experience of only a small proportion of persons with SMI, additional research is needed that considers the needs of all persons with SMI who seek to attain and maintain satisfactory housing.

There has been some preliminary work to suggest that certain housing and program characteristics might be important and require further examination. Specifically, the level of independence, the nature of support, and other housing characteristics have been examined and seem to have an impact on outcomes. Preliminary research suggests that most residents of SH prefer regimes with low restrictiveness and more independent living arrangements despite the risk of loneliness and isolation (Fakhoury et al., 2002). Furthermore, the frequency and availability of support seem to have an impact on housing stability (Parkinson, Nelson, & Horgan, 1999; Rog, 2004). Parkinson et al. (1999) also suggest that features such as social support, location, privacy and choice have an impact on outcomes. Most importantly, a number

of researchers have pointed out that resident preferences must be addressed in the type of SH available in the community (Carling, 1990; Nelson, Hall & Forchuk, 2003; Srebnik, Livingston, Gordon & King, 1995; Yeich, Mowbray, Bybee, & Cohen, 1994).

Almost twenty years ago, Carling (1990) described a US national housing policy forum attended by nationally recognized resident leaders in which it was concluded that providers should develop housing options that most people prefer; that housing should be decent and permanent; that it should be developed in neighborhoods that are safe and near services and transportation, that residents should be trained as service providers, and that there must be increased resident involvement in planning and developing housing and supports. More recently, Sylvestre et al. (2004) proposed several principles to guide best practice in housing based on their evaluation of the Mental Health Homelessness Initiative. They include: 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 residents 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).

Hannigan and Wagner (2003) provide an overview of different program models including single-site versus scatter-site designs. Although single-site housing may provide staff with more frequent access to tenants and more opportunities to build a community of support, scattered-site housing makes use of the housing already available in the community and provides more autonomy and anonymity to tenants. Nelson and Peddle (2005) suggest that key features of all approaches to housing and support for persons with mental illnesses should include resident empowerment, access to valued resources, and community integration.

Despite advances in the field, there is much work to be done in substantiating and articulating best practices in SH for persons with SMI. In a review of the evidence on supported housing, Rog (2004) noted that there were significant improvements in residential outcomes for individuals with mental illnesses who enter a range of housing supports but found very little evidence supporting any specific form of SH. Chilvers, MacDonald and Hayes, (2005) attempted to review the effectiveness of SH for the Cochrane collection but found no studies to meet the inclusion criteria. They point out that decisions regarding housing are now a matter of opinion and lack a research base. Unfortunately, the existing research tells us little about how housing services and supports should be structured and organized to best meet the needs of residents. There is a need for greater investigation to clarify which characteristics of housing and support are critical for generating positive outcomes for persons with SMI living in SH.

2.2 Purpose of Research

The purpose of this research was to examine characteristics of SH that are associated with positive outcomes and that are valued and desired by residents and service providers in the field, and/or have been documented in the literature. Delineation of these characteristics, through a systematic approach, can contribute to the development of best practice guidelines in supported housing for persons with mental illnesses and addictions.

The study objectives were:

- To identify critical characteristics of SH as perceived by residents and service providers
- To identify best practice SH characteristics documented in the literature
- To understand the influence of these characteristics on outcomes that are meaningful to residents (e.g. satisfaction, social integration and community involvement)

3. Research Design and Methodology

This project consisted of a two-pronged approach to explore characteristics of supported housing that relate to outcomes: 1) a comprehensive literature search and review, and 2) in-depth interviews with residents and service providers of supported housing (SH). The focus was on collecting data on characteristics of SH that relate to positive outcomes such as enhanced quality of life, residential stability and satisfaction and participation in life roles.

3.1 Data Collection

We collected three sets of data: literature that addressed housing characteristics and outcomes, interviews with residents of supported housing, and interviews with service providers.

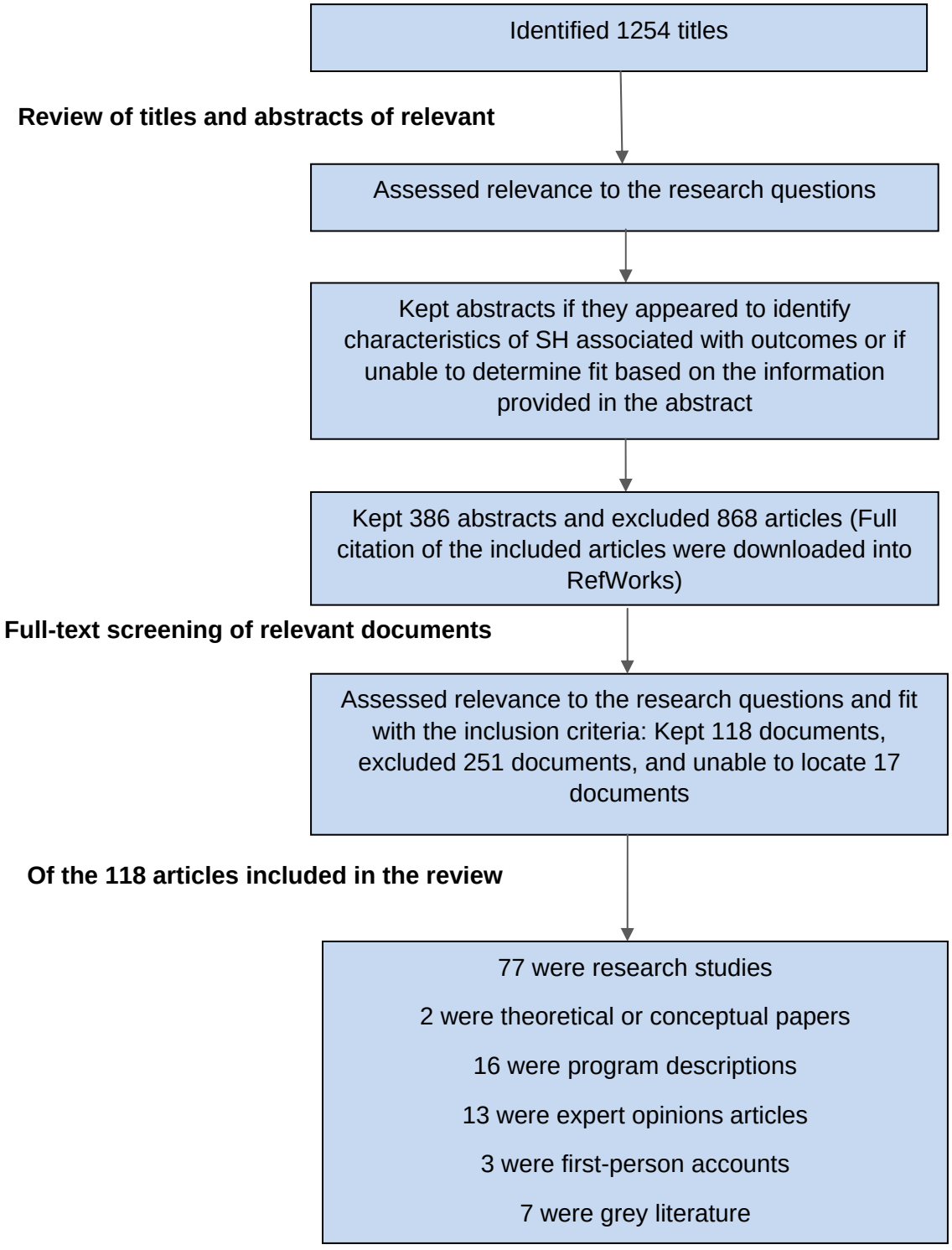
a. Literature search and review

The goal of the literature review was to identify housing characteristics that have been found to be important in producing positive outcomes for individuals with SMI. We conducted a comprehensive and systematic search of the literature in the area of supported housing for persons with mental illness and addiction. Inclusion criteria were: the paper was published within the years 1990-2006 and it identified housing characteristic(s) associated with outcome(s) for individuals with serious mental illnesses. The literature search spanned the academic literature (research studies and theoretical papers), “grey” literature (unpublished reports, government documents and program evaluations), as well as first-person accounts and expert “armchairing” documents. We excluded documents that were reviews of the literature on SH and persons with mental illnesses to avoid duplication. However we did check the reference lists of these articles to identify additional documents that we could include in our analysis. The principal investigator and project coordinator consulted with University of Toronto library staff to

structure the terms and strategies to be used in the systematic review. Keywords such as “Housing”, “Public Housing” and “Support* Housing” combined with “Mental Illness”, “Psychiatry”, “Mental Disorder”, “Mental Health”, “Mental Health Services”, “Community Mental Health Services” were used to search the following databases: Campbell Collaboration, CINAHL, Cochrane Library, Medline, PsychInfo, Scopus, Social Sciences and Abstracts, and Web of Science. A search of the unpublished literature was also conducted by searching the websites of national and international organizations who do work in the area of housing for persons with mental illness. Specifically, the following organization websites were searched: Canadian Mental Health Association (National), Canadian Mental Health Association (Ontario Division), Centre for Addiction and Mental Health, National Resource and Training Centre on Homelessness and Mental Illness, St. Michael’s Hospital, Centre for Urban Community Services, Corporation for Supportive Housing, Ontario Non-Profit Housing Association, and International Centre for Clubhouse Development.

Using these strategies we initially identified 1254 potential documents. From a review of the titles and abstracts of these documents, 868 articles were excluded because they did not meet the inclusion criteria outlined above or they were clearly not relevant to the research question and kept 386 articles for full-text retrieval and review. Of these, 251 articles were excluded after reviewing the full-text because they did not identify characteristics of SH that were associated with outcomes and we were unable to locate 17 articles. Therefore, a total of 118 articles were analyzed to extract housing characteristics associated with outcomes. Of the 118 included in the analysis, 77 were research studies, 2 were theoretical or conceptual papers, 16 were program descriptions, 13 were expert opinion articles, 3 were first-person accounts, and 7 were grey literature. See Figure 1 for an overview of the literature search.

Figure 1: Overview of Literature Search



A coversheet was developed for the purpose of extracting relevant data and included the following headings: Purpose, Design, Context, Definition/principles of SH, Participants, Methods, Findings/Conclusions, Characteristic of SH associated with outcomes, Quality indicators (See Appendix A). Three research assistants reviewed all the documents included in our analysis using this coversheet. Every tenth article was reviewed and checked by the project coordinator or the principle investigator to ensure consistency. The research assistants, the project coordinator and the principal investigator met regularly to discuss any issues or discrepancies in extracting the characteristics and outcomes.

Definition of Supported Housing:

Developing a definition of SH to guide our work was an important and challenging step. There is a lack of clarity with regards to the terms “supportive housing” and “supported housing”. While some studies use the terms interchangeably, many others use the terms to refer to different approaches to providing housing supports. We consulted with our community partners and decided to use the definition of supported housing described by Parkinson, Nelson and Horgan (1999). According to these authors, *supported housing is based on the underlying values of empowerment and community integration. Resident/survivors are viewed as tenants/citizens and staff are considered to be facilitators. It is a strength-focused approach that provides considerable choice to residents over housing, living companions, and daily activities. Receiving treatment is not a requirement and the role of the landlord and the support provider are separated or “de-linked”. However, supports and rehabilitative services are often accessed as desired by individuals to help them stay in their home and participate in their communities.*

While this guiding definition has been helpful, it is not always easy to determine whether services described in the literature abide by this definition, as full descriptors are not consistently offered and different terminology is used by different researchers and in different jurisdictions. We therefore faced the challenge of differentiating which studies are about SH and which are about other types of housing services. Nelson and Peddle (2005) noted that many housing programs have made a shift towards a supported housing approach as defined by Parkinson et al. (1999) and that there now exist a blurring of approaches in many cases. Given this ambiguity, we broadened our definition in the document review component of the research to include variations of SH in order to ensure we were not excluding relevant data.

b. Interviews with residents of SH and service providers

The above definition provided by Parkinson et al. guided our work and we recruited interview participants from programs that specifically matched this approach to SH. Mental health agencies with a housing component played a critical role in the recruitment process by distributing flyers about the research study to their clients and front-line staff. We conducted 25 semi-structured interviews with resident living in SH and 10 interviews with service providers working with individuals living in supported housing. In the interviews, participants were asked to share their views on characteristics of SH through reflection on their own lived experiences.

Resident interviews were conducted by a research assistant and two peer researchers. Past research has indicated that involving peer researchers has a positive impact on the lives of the individual researchers and the quality of the research itself (Ochocka, Janzen & Nelson, 2002). Therefore, we recruited and trained two peer researchers to carrying out the resident interviews.

Using the principles of maximum variation sampling and the constant comparative approach (Creswell, 1998), we recruited residents and service providers who had different backgrounds and different perspectives to offer. Specially, we targeted residents who lived in supported housing provided by a number of different initiatives: rent geared to income (RGI), homelessness, and mental health (MH) and justice. We also included residents who had been in supported housing for differing lengths of time (those who resided in SH for less than a year and those who have been living in supported housing for more than a year) so that we could identify both transitional and longer term issues of importance. Among service providers, we included housing workers, as well as case managers or general rehabilitation workers who provided support to individuals living in supported housing (see Table I).

We included residents and service providers from two different types of supported housing programs. In the scatter housing arrangement, the program offered independent units in regular apartment buildings across the city. In the clustered housing arrangement, the program provided independent units in designated buildings. These different housing arrangements offered further variability among participants.

To address the objectives of the project and ensure we captured the issues and challenges that are relevant to the field, we developed a semi-structured interview guide in consultation with community partners, and also considered the initial findings of our literature review. The interview guide was specifically designed to provide sufficient flexibility so participants 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 the nature and quality of community living (see Appendix B and C). All interviews were tape-recorded and transcribed verbatim. The qualitative computer software program NVivo was used to organize the data for efficient analysis.

Table 1: Description of Interview Participants

Residents

Type of Housing Participant	
RGI, <1year	3
RGI, >1year	9
Homeless, <1year	2
Homeless, >1year	8
MH and Justice, <1year	3
MH and Justice, >1year	N/A

Service Providers

Type of Participant	
Housing support worker	5
Case manager/Rehab worker	5

3.2 Data Analysis

Analysis of all data was guided by the constant comparative approach proposed originally by Glaser and Strauss (1967); this approach involves the stages of unitizing, categorizing and forming themes to uncover embedded information from the data (Lincoln & Guba, 1985). Unitizing is a coding process that involves taking data apart and grouping them together in new ways to build analytic and theoretical interpretations. It allows the researcher to consider the ways in which ideas and concepts seem to vary in the data and the conditions under which such variation occurs. In this way, researchers construct codes to make sense of the data and organize emerging ideas. Categorizing is a process by which coding units are grouped into higher level groupings that provide an organizing framework for understanding the data. In this analysis, categories were organized along the lines of their properties and dimensions so we could begin to explore how different perspectives, contexts, conditions, and consequences were represented in the data and influencing relationships among concepts and

categories (Charmaz, 2006). Based on these categories, central themes were constructed to capture the experience and characteristics of supported housing.

As is customary in qualitative research, data collection and data analysis occurred in tandem and emerging ideas were used to direct and focus subsequent data collection efforts. New data were compared to existing units and categories to refine, verify and alter the emerging theoretical propositions. As suggested by Charmaz (2006), comparisons were made to explore similarities and differences in order to examine the phenomenon from different perspectives. This process continued until categories were saturated and new data did not further enhance our understanding of the concepts under study (Charmaz, 2006).

The data analysis was carried out by the project coordinator, the principal investigator and two research assistants. Throughout the process, we met regularly to discuss the findings and issues emerging in the different data sets. For the most part, the three data sets were kept separate throughout the data analysis; however, initial findings from the literature review were used to inform our interview guides. Furthermore, as we progressed with our analysis and began to develop themes from each of the data sets, we discovered that several themes appeared in both the resident and service provider data. This is not entirely surprising, as informants had many shared experiences and common understandings of supported housing and its essential components. We began to consider how certain themes were relevant across different perspectives in order to begin to better understand key concepts relevant to SH for persons with mental illnesses.

Our approach to data collection and analysis enhanced the dependability and credibility of our findings through triangulation of methods and researchers (Brannen, 1992; Sharts-Hopko, 2002). Specifically, we used two sets of data (literature and interviews) and maximum variation sampling procedures to answer our research questions. Analysis was conducted by the principal investigator and three research assistants. Regular meetings were held to obtain input from peer-researchers and community partners, each of whom brought different perspectives to the data. Sharing and discussing the findings with the community partners allowed us to explore the relevance and applicability to the field through a form of member-checking (Lincoln & Guba, 1985). Together, these strategies enhance the trustworthiness of the research findings and the relevance and utility of the findings to the field.

4. Findings from Literature Search and Review

Through our literature search and review, we identified characteristics of SH that contribute to outcomes. Through our analysis, we found that influential characteristics of SH could be categorized within three areas: the community/neighbourhood in which SH exists, the service providers who work in supported housing, and the living environments of the residents.

4.1 The Community/Neighbourhood of SH

The local attitude was found to hold significant influence on the outcomes of SH. Specifically, within the community, discrimination, stigma and a lack of acceptance towards persons with serious mental illnesses was identified as restricting the potential for community integration (Boydell, Gladstone, Crawford, & Trainor, 1999), leading to housing instability (Canadian Mental Health Association [CMHA], 2005), and a sense of isolation (McCarthy & Nelson, 1993). Conversely, increased community acceptance was found to contribute to enhanced quality of life (Aubry & Myner, 1996; Boydell, 2006; Ridgway & Zipple, 1990), increased opportunity for socialization with neighbours (Aubry & Myner, 1996), and increased housing stability (CMHA, 2005; Canada Mortgage and Housing Corporation [CMHC], 2002). Herb, Miller & O'Hara (2003) found that units located in buildings identified for persons with disabilities were associated with more stigma and a loss of anonymity. Furthermore, a concentration of SH in particular neighbourhoods led to heightened stigma and social problems (Guhathakurta & Mushkatel, 2000). Although living with others with mental illnesses offered shelter from social stigma (Dorvil, Morin, Beaulieu & Robert, 2005), it also resulted in high stress (Walker & Seasons, 2002). Housing that physically blends into the neighbourhood can avoid stigma associated with being “specialized” housing (CMHC, 2002).

The extent of diversity present in the neighbourhood was also associated with outcomes within the literature. For example, Yanos, Barrow & Tsemberis (2004) found that some buildings or neighbourhood settings that featured homogeneity or a lack of tolerance for ‘difference’ were simply not good places for SH because persons recently transitioning from homelessness would not fit in and feel comfortable. Neighbourhoods with more racial diversity were found to be associated with lower rates of mental health hospitalizations (Harkness, Newman & Salkever, 2004).

Several documents identified the safety of the neighbourhood as being important. Specifically, safe neighbourhoods seemed to help individuals cope with problems that may come up in housing (Wong et al., 2006) and were associated with increased stability (CMHC, 2002). A lack of safety or the existence of crime were associated with difficulty adjusting to life in SH (Boydell, et al., 1999), maintaining housing (Wong et al., 2006), and affected individuals’ chances of staying sober and managing stress (Wong et al., 2006).

Support from other community members, family and friends was found to have a positive impact on housing in several documents. This type of support was associated with a sense of freedom (Boydell, 2006), improved health and well-being (Forchuk, Ward-Griffin, Csiernik & Turner, 2006), increased satisfaction with housing (Forchuk, Nelson & Hall, 2006), increased housing stability (Calsyn & Winter, 2002), enhanced coping skills (CMHC, 2002), and increased self-esteem and confidence (CMHC, 2002; Sylvestre et al., 2004). Social support was found to be important for personal empowerment and quality of life (McCarthy & Nelson, 1991). Contact and support from neighbours was associated with a decreased reliance on professional supports (Sutherland, 1999) and increased connection to the outside world (Borg et al, 2005). Although Forchuk, Ward-Griffin, et al. (2006) noted that social support was critical to maintaining independent housing, Calsyn and Winter (2002) noted that social support on its own has no significant impact on symptoms or the housing situation of individuals with mental illnesses. The availability of community resources and amenities were important in terms of tenant satisfaction (Boydell, 2006) and led to increased stability (CMHC, 2002).

4.2 Service providers, services and programs

Living in housing with onsite staff or supervised apartments was reported to be a source of frustration due to limitations on privacy and independence (Yanos et al., 2004), and had no impact on hospitalization rates or lengths of stay when hospitalized (Hodgins, Cyr & Gaston, 1990). However, Taylor and Jeffrey (2004) found that night workers were able to respond to the needs of tenants and manage potential neighbourhood nuisances. In some cases, on-site support services were found to be important in terms of providing a safety net (Houghton, 2001) and combating isolation that could jeopardize housing stability (Kloos et al., 2002). Having structured programming in the living environment allowed tenants to progress through graduated levels towards independent living in transitional housing programs (Goering et al., 1992) and provided access to more mental health services (Hadley, McGurrin & Fye, 1993), but also reduced the sense of normalcy of the living environment (Boydell & Everett, 1992). Living in a group home where staff took charge of or supervised medication management was perceived as being an additional guarantee of control over the illness (Dorvil et al., 2005) but was associated with shorter tenure (Lipton, Siegel, Hannigan, Samuels & Baker, 2000).

Maintaining the morale of staff in SH was found to increase program effectiveness (Goering et al., 1992). A lack of staff training to effectively communicate with clients was associated with difficulty identifying client goals in SH (Fakhoury, Priebe & Quraishi, 2005). Establishing a broad base of staff support and training extra staff in each role was found to provide program stability (Weissman, Covell, Kushner, Irwin & Essock, 2005). Furthermore, having residents trained as staff or peer advisors resulted in better overall outcomes as residents seemed to relate better to resident staff (Besio & Mahler, 1993). Positive experiences with resident staff also helped improve staff attitudes towards persons with mental illnesses (Weissman et al., 2005).

Several articles found that support services including housing-related supports were associated with success in maintaining independent housing for individuals with mental illnesses (Newman & Ridgely, 1994; Pathways to Housing Inc., 2005). Access to a support

worker to help make links to the community was associated with decreased feelings of social isolation (Chesters, Fletcher & Jones, 2005). Conversely, Slade, Scott, Truman and Leese (1999) found that the absence of ongoing support - specifically having no support following the withdrawal of the “resettlement team” - was associated with an increased risk for failed tenancy. Having insufficient support during crises also had a negative impact on tenancy (Forchuk, Nelson & Hall, 2006; Slade, Scott, Truman and Leese (1999). Calsyn and Winter (2002) found that support from professionals had no impact on number of days in stable housing between baseline and 3 months but had a positive effect on days in stable housing between 3 and 12 months. Parkinson and Nelson (2003) found that more time spent with service providers increased motivation for empowerment and recovery. Nelson et al. (2003) noted that the availability of support staff to handle difficult situations helped ensure that residents maintained their housing.

Having access to services, supports and resources was associated with improved outcomes in SH. Having timely access to community-based services and supports was found to help reduce the need for hospitalizations and decrease feelings of social isolation (Chesters et al., 2005; Forchuk, Nelson & Hall, 2006). Having access to practical resources increased stability and enhanced quality of life (Boydell, 2006; Nelson, Clarke, Febbraro & Hatzipantelis, 2005). Providing information about tenant rights enabled residents to feel empowered and secure in their living environments (CMHC, 2002). Access to a range of meaningful activities and ready access to transportation were also seen as important means of combating loneliness (Hamilton District Health Council, 2001). Having flexible supports provided a safety net (Hamilton District Health Council., 2001) and improved housing stability (CMHA, 2005) leading to increased recovery, empowerment, and security of tenure, and an improved sense of one’s own capabilities (Allen, 1996; Burke, 2005; Moxham & Pegg, 2000; Parkinson & Nelson, 2003; Pyke & Lowe, 1996). Furthermore, clients experienced less choice and satisfaction when services were linked directly to their address (Forchuk, Nelson & Hall, 2006). Substance/drug abuse treatment was found to be associated with improved outcomes; in addition to greater drug abstinence (Milby, Schumacher, Wallace, Freedman & Vuchinich, 2005), such intervention was found to be associated with success and stability in independent housing (Newman & Ridgely, 1994; Shern et al., 1997) and to be predictive of housing satisfaction (Yeich et al., 1994).

The provision of skill training was associated with improved outcomes. For example, community living skills were found to be predictive of increased satisfaction with housing (Yeich et al., 1994), social survival and independence (Goering et al., 1992), improved psychosocial functioning (Middelboe, 1997) and improved housing stability and self-sufficiency (Lakefront Supportive Housing, 2004). Life skills training was found to be associated with progress through graduated levels of independent living (Goering et al., 1992) and appeared to be critical to helping individuals remain housed (Morse, Calsyn, Allen & Kenny, 1994). Social skills training was found to improve self-perception, reduce the risk of relapse and increase time between hospitalizations (Aubry & Myner, 1996). Conversely, Hodgins et al. (1990) noted that a lack of training in social skills, life skills and effective management of neuroleptic medication made residents vulnerable to negative events.

Case management was important for individuals living in SH. Those who continued to receive case management services were more likely to be successful with SH and be independently housed (Mares, Kasprow & Rosenheck, 2004; Shern, Felton, Hough, Lehman, Goldfinger & Valencia, 1997). Conversely, Wood, Hurlburt, Hough & Hofstetter (1998) found that when no case management services were provided many individuals were unable to maintain stability in their housing. Hurlburt, Wood & Hough (1996) found that individuals with comprehensive case management were no more likely to achieve stable housing or stable independent housing than those with only traditional case management

A coordinated system of services was also found to be important in terms of housing stability and tenure. Specifically, the existence of linkages between housing, employment, and support services was associated with sustained independent living (CMHA, 1999; Newman & Ridgely, 1994) a decrease in shelter use (Metraux, Marcus & Culhane, 2003), and increased satisfaction overall (Tsemberis, Rogers, Rodis, Dushuttle & Skryha, 2003). Access to meaningful activities was found to increase motivation, stability, satisfaction and sense of purpose (Bryant, Craik & McKay, 2005; Champney & Dzurec, 1992; Hamilton District health Council, 2001; Nelson et al., 2005). Other specialized services such as counseling, assistance obtaining public benefits, and vocational assistance were also associated with achieving housing stability (Lamb, 2003; Mojtabai, 2005). When agencies provided a range of services including housing and support, there appeared to be greater system resiliency, greater opportunity for creativity and innovation, greater resident choice and improved ability to meet the needs of clients (George, Sylvestre, Aubry, Durbin, Nelson & Sabloff 2005; McHugo et al., 2004). Having integrated services and working arrangements between health, social and housing supports was important in order to meet the needs of clients and to help clients achieve stable independent housing (Bebout, 1999; Bebout, Drake, Xie, McHugo, & Harris, 1997; Cohen & Somers, 1990; Diamond, 1993; Jarbrink, Hallam & Knapp, 2001; McHugo, Bebout, Harris, Cleghorn, Herring, Xie et al., 2004; Newman & Ridgely, 1994). Conversely, poor coordination between clinical and housing supports (Bebout, 1999) and a lack of collaboration between different government ministries to plan and fund resources for housing supports (CMHA, 2005; N.J. Governor, 2005) was thought to perpetuate the cycle of instability and housing loss. On the other hand, Heaney and Burk (1995) noted that if clinical and housing staff have different ideologies of care, clients may experience inconsistent care.

Affordability is a fey feature of successful supported housing. Access to a rent subsidy was associated with increased likelihood of entering independent housing (Hurlburt et al., 1996; Wood et al., 1998) and increased likelihood to remain in housing (Mares et al., 2004). Other documents noted that rent subsidies were associated with increased affordability and improvements in housing problems, neighbourhood problems, and service gaps (Newman, 1994), and enabled tenants to focus on their recovery rather than where they are going to live (N.J. Governor, 2005). A rent subsidy was also found to be important in terms of increasing housing stability (Champney & Dzurec, 1992; Dorvil et al., 2005; Hogan & Carling, 1992; Mares et al., 2004; Morse et al., 1994; Nelson et al., 2005).

“Rapid placement” into independent living had mixed outcomes. Bebout et al., (1997) found that initial placements in the absence of a stage of supervised living, fostered substance abuse. However a study by Mares, Kasprow and Rosenheck (2004) provided support for rapid

placement: they found that delayed placement into supported housing was associated with a lower likelihood of being independently housed or being employed after leaving the program. Yanos et al. (2004) found that rapid placement could also improve residents' sense of safety and self-esteem as they began to feel part of the larger community (Yanos et al., 2004).

4.3 The Living Environment

Safety was identified as being important in terms of the living environment. Research associated safety and stability in one's living situation with increased ability to work, be productive, and become part of the community (Geller & Kowalchuk, 2002; Herb et al., 2003; Ruas, 2004), and with an increased sense of security (Borg et al., 2005; Browne & Courtney, 2005a). Conversely, being forced to live in unsafe or otherwise inappropriate housing led to individuals living in fear and experiencing a sense of loss of basic human rights (Forchuk, Ward-Griffin et al., 2006).

Privacy was also seen as an important characteristic of the living environment and was associated with improvement in housing tenure and stability (CMHA, 2005; Tsemberis & Eisenberg, 2000). Some articles found that increased privacy improved community integration (Yanos et al., 2004) and meant that tenants did not have to worry about losing their personal belongings (Hamilton District Health Council, 2001). However, too much privacy could lead to loneliness and isolation (Johnson, 2001; Walker & Seasons, 2002).

Living environments in which residents had more control or autonomy were found to be associated with positive outcomes in several documents. For example, documents found that increased control over one's living environment was associated with improved health and recovery (Borg et al., 2005; Forchuk, Ward-Griffin et al., 2006; Greenwood, Schaefer-McDaniel, Winkel & Tsemberis, 2005; Hogan & Carling, 1992), independent functioning (Dorvil et al., 2005; Nelson, Hall & Walsh-Bowers, 1999), feelings of security (Ridgeway, Simpson, Wittman & Wheeler, 1994) higher levels of housing satisfaction and improved stability and quality of life (Boydell, 2006; Nelson et al., 2003; Sylvestre et al., 2004). Being able to make their own decisions in housing increased residents' sense of control over their lives and also led to increased satisfaction and improved quality of life (Chesters et al., 2005; McCarthy & Nelson, 1991; Ridgeway et al., 1994). Brown and Wheeler (1990) found that being involved in the search process for an apartment increased the likelihood that individuals would have a sense of pride and ownership in their home. Furthermore, allowing residents to make choices about their living situation and be involved in creating their living environment was thought to increase the likelihood that a good fit between person and environment would be achieved (Mize, Paolo-Calabrese, Williams & MArgolin, 1998; Ridgeway et al., 1994), thereby further increasing housing stability (Forchuk, Ward-Griffin et al., 2006) and a sense of belonging in the community (Nelson et al., 2005).

Resident choice in housing options was found to increase housing satisfaction, stability, and psychological well-being (Boydell, 2006; CMHC, 2002; Greenwood et al., 2005; Knisley & Fleming, 1993; Sohng, 1996; Srebnik et al., 1995; Sylvestre et al., 2004). Tsemberis & Eisenberg, 2000; Tsemberis et al., 2003). Being able to live in one's own home or with someone of their own choosing led to increased independence (Chesters et al., 2005). A lack of

choice was found to be associated with decreased empowerment (Ware, 1999) and have a negative impact on motivation, well-being and self-esteem (McCarthy & Nelson, 1993). Boydell et al., (1999) found that a lack of housing choices could lead to residents feeling like they did not deserve anything more, leaving them with a diminished sense of autonomy and entitlement. Allen (2003) found that using housing as a leverage to compel treatment compliance could make clients more dependent, could undermine the therapeutic relationship between service provider and resident, and could impede recovery. Clients who experienced a balance between having opportunities to make choices and having support when needed enjoyed an enhanced quality of life (Boydell, 2006).

Fulfillment of housing preferences was found to lead to increased satisfaction (Forchuk, Nelson & Hall, 2006; Ridgway & Zipple, 1990), improved quality of life and increased sense of dignity (Moxham & Pegg, 2000; Nelson et al., 2003), and was found to be an important factor in housing success for persons with serious mental illnesses (CMHC, 2002; Keck, 1990; Yeich et al., 1994; Ridgway & Zipple, 1990). Conversely, living in environments that did not meet personal preferences was found to lead to ongoing unsettlement (Ridgeway et al., 1994). However, Elliot et al., (1990) found that living in preferred housing did not predict satisfaction.

Having stable and permanent housing was associated with positive outcomes in the documents reviewed. Permanency in housing led to increased stability and decreased distress (CMHA, 2005; Goering et al., 1992; Hadley et al., 1993; Moxham & Pegg, 2000). In SH programs where individuals were provided with permanent housing, tenants were more likely to develop supportive social relationships (Browne & Courtney, 2005b; Parkinson & Nelson, 2003; Wood et al., 1998), experience less frequent hospitalizations (Dickey et al., 1996), have an improved sense of well-being and quality of life (Bebout et al., 1997; Hogan & Carling, 1992; McCarthy & Nelson, 1993; Ridgeway et al., 1994; Sutherland, 1999), develop new skills and work towards improved health, education and employment (Herb et al., 2003 Parkinson & Nelson, 2003). Conversely, in short-term housing, improvements were found to be lost upon graduation (Bigelow, 1998) and high stress was associated with each move (Goering et al., 1992; Hogan & Carling, 1992).

Shared or congregate housing led to less privacy (Friedrich, Hollingsworth, Hradek, Friedrich & Culp, 1999), less satisfaction (Aubry & Myner, 1996; Nelson et al., 2005; Pyke & Lowe, 1996), high stress (Dorvil et al., 2005; Goering et al., 1992; Hogan & Carling, 1992), and decreased ability to meet psychosocial needs like meeting people and finding work (Warren & Bell, 2000). Brunt and Hansson (2004) found no difference in measures of quality of life between congregate and independent SH units. Other documents found that congregate housing arrangements led to less loneliness (Dorvil et al., 2005; Singer, 1999; Walker & Seasons, 2002). On the other hand, Browne and Courtney (2005b) found that individuals were more likely to develop and maintain stable and supportive relationships if they lived in their own private housing rather than a boarding home.

Having an independent living environment was found to improve housing tenure (Lipton et al., 2000; Tsemberis & Eisenberg, 2000), bolster self-image and autonomy (Browne & Courtney, 2005a; Chesters et al., 2005; Dorvil et al., 2005; Ridgeway et al., 1994; Sylvestre et al., 2004), and was positively associated with overall life satisfaction (Mares & Rosenheck, 2004) without increasing rates of hospitalization (Dickey et al., 1996). However, an independent

living environment was also associated with increased rates of substance abuse (Bebout et al., 1997; Newman, 1994), less social support (Ridgeway et al., 1994) and a greater sense of social isolation (Browne & Courtney, 2005b; Dorvil et al., 2005; Friedrich et al., 1999; Johnson, 2001). Furthermore, Sylvestre et al. (2004) found that those who lived in their own apartment were less likely to report having money for daily expenses than those in congregate living situations. Isolation was found in some of the documents to lead to difficulties structuring time (Brown & Wheeler, 1990) and could have a negative impact on housing stability (Kloos et al., 2002). Therefore, independence and privacy had to be balanced with access to support, assistance, and social interaction (Borg et al., 2005; Boydell, 2006). Browne and Courtney (2005b) found that housing that provided a break from others was important for improved mental health.

Having strict, rigid rules was found in several documents to be detrimental to housing tenure (CMHA, 2005; Pathways to Housing Inc., 2005), community integration (Allen, 2003; Yanos et al., 2004) and independent living (Allen, 1996), and often led to increased stress (Goering et al., 1992). Having housing rules that did not require sobriety as a precondition was perceived as offering a higher degree of choice, control, and autonomy without an increase in the use of alcohol or illicit drugs and often motivated residents to address their addictions and initiate the recovery process (Allen, 1996; Tsemberis, Gulcur & Nakae, 2004). Housing programs which were contingent on abstinence and compliance with psychiatric treatment resulted in more participants leaving the programs (Greenwood et al., 2005).

Living in affordable housing was found to be associated with a reduction in the number of days per month spent in hospital, greater ability to afford good quality housing (Boydell, 2006; Forchuk, Nelson & Hall, 2006; George et al., 2005; Hamilton District Health Council, 2001; Sutherland, 1999) and greater residential stability (Burt & Anderson, 2005; Nelson et al., 2005; Newman, 1994). Other documents noted that affordable housing led to improvements in other areas of community life such as employment, mental health treatment, and education (Ford, Gibson & Snarr, 2002).; Herb et al., 2003). Conversely, a lack of money had a negative impact on housing stability and restricted quality of life and community integration (Kloos et al., 2002).

5. Findings from Interviews

Analysis of resident and service provider interviews led to the identification of several themes (see Appendix I). The two sets of interviews were analyzed separately; however, as the analysis progressed we found that several similar themes arose in both the resident and service provider data.

5.1 Residents

Residents described the pathways by which they entered supported housing, a set of guiding values that were important to them when considering supported housing and key characteristics of supported housing. These characteristics include supports offered in supported housing, housing features, and the neighbourhood/community where supported housing is located. Finally, residents identified issues associated with moving on from supported housing.

a. Pathways to Supported Housing

Participants described the different ways they came to live in supported housing. Some participants were homeless prior to coming into supported housing and were referred to the program by workers in hostels or the shelter system. Others were referred through the court system. Typically, these individuals described their previous housing as inadequate.

Other participants came from living with family members or in shared accommodations such as group homes. Although these participants were not necessarily in desperate housing situations prior to supported housing, they sincerely wanted the opportunity to live on their own. Many participants described wanting to have the freedom and privacy associated with having their own place.

Several participants were paying market value for their housing prior to moving into supported housing. Because of their limited income, most of these participants described inadequate living environments infested with drugs and/or crime, and often lacking basic necessities such as security and heat. These participants also described how paying their rent caused significant financial strain that would impact other areas of their life. For example, most were unable to afford both their rent and groceries. For these participants, having their rent subsidized represented an improvement in their living conditions and their finances.

A common thread in the different pathways into supported housing was a supportive service provider who helped participants access supported housing. In some cases, their service provider told them about the availability of supported housing and helped them apply. In other cases, participants became involved with an organization that operated a supported housing program. However, in almost all the cases, participants described the help and assistance they received from a service provider that initiated or facilitated their path into supported housing.

Depending on where they were coming from, several participants described how service providers worked with them to find housing that would meet their particular needs. For example, one participant described:

> *And they see the areas you need help in, and they assign workers to you, and the workers work with you to achieve the goals that you want to meet. And the very first thing they do is they find suitable housing for you, so that you're not in .. for me I didn't want to live in.. Parkdale, I didn't want to live in Regent Park, or any of those places, cause they're drug infested, right? I didn't want to be around that so, they got me.. a spot in a condominium building and… that got me away from the drugs, and that crowd you know what I mean.*

In this way, many participants felt supported housing was set-up to maximize their success and recovery in the community.

Accessing Supported Housing

Although participants came from different places, access to supported housing was generally characterized in three different ways: 1) Easy access, 2) Easy access in the face of a crisis, and 3) A long arduous path.

Easy access. For some, access seemed relatively easy and seamless – they either became involved with a particular community agency that happened to also have a housing program they could sign up for, or a service provider they were working with in the community connected them to the supported housing program. Residents typically waited several months after submitting an application before being given their current unit. One resident described:

> *I got a diagnosis of schizophrenia and I lived in a couple of group homes, but I was doing better… so… my occupational therapist told me about [name of supported housing program].. and asked me if I wanted to try it.. so… I did.. .. I just went for an interview… and then they called me two weeks later.. said I was accepted.*

Easy access in the face of a crisis. For others, entrance into supported housing was initiated as a result of a housing crisis. They had nowhere else to turn and signed up for supported housing in desperation. Despite the crisis, they still seemed to experience relatively little difficulty accessing their supported housing. One resident described:

> *Oh yes, and then I got desperate… really desperate.. and I put my application in with [name of housing program].. and about four or five months later they called me .. and said guess what, you've got an apartment. And I couldn't… I just was overwhelmed.. and I thought, thank God, and a one bedroom apartment… and I was so grateful…*

These participants were very grateful for supported housing and acknowledged that supported housing helped them enormously in a time of need. They described the process of accessing supported housing as relatively seamless.

Long arduous path. For a few participants, access to supported housing was not so easy. These participants described their path to supported housing as long and arduous, plagued by multiple challenges, set-backs, and long waitlists. Although less common among participants (there were only two participants whose experience accessing supported housing fit into this category), such stories were filled with desperation and frustration. Participants who described such pathways spent a great deal of time in their interview outlining their struggle and the relief they experienced since finally getting into supported housing:

> *And then, my daughter was born, and then I applied for a larger unit, as soon as one available… I believe it was 1996 at that time. Since 1996, 2004, almost 9 years.. I was on waiting list… Waiting, waiting, my child... my daughter grown up, I had another child, a son.. He grown up... all of them go to school.. writing letters, I went to MPs I wrote letters from doctors, psychiatrists, you name it.. I was, I used to hear that… a larger unit there's no larger things available you wait, wait, you are on the top of the waiting list... My whole life, for that 10 years.. I, am kind of a person who doesn't have, cannot juggle two things at the same time. I focus the whole time finding a larger unit… So when I get a nice place to live, and move. You don't know which part of the city you will move… to… then you can arrange your rest of your life… finding work, and going to school… whatever.. but I, I lost the whole time… trying to get a larger unit.*

Participants with such experiences described how long waits for adequate and affordable housing and supports impacted their life by putting everything on hold. The participants in this category had children and very limited resources. Therefore, they were not able to consider turning to market-rent housing, even temporarily. Rather, they described feeling trapped in very desperate situations waiting for supported housing.

Within these accounts were descriptions of the positive impact that increased government funding had on access to supported housing. One resident recounted that when she was first released from hospital, she was pregnant and unable to find appropriate supported housing, and had to stay in the shelter system until her daughter was born. She was subsequently given a one-bedroom supported housing unit to share with her daughter, and after approximately one year, she was able to move into more appropriate housing that met her needs because of increased funding. Clearly, government funding plays an important role in the experiences of individuals trying to access supported housing.

b. Guiding Values

When speaking about important factors in supported housing, many residents highlighted values that were important to them across all aspects of the housing process. They pointed out the importance of being treated with dignity throughout the process and spoke about the importance of having choice. Many residents valued flexibility within the housing program, which allowed them to make choices about their personal and individual living situation.

Being Treated with Dignity

Participants described the need to be treated with respect and dignity by their support workers. Individuals wanted their support workers to talk to them "*like a human being*", like a person with genuine value and worth. Several specifically noted the importance of being able to talk to their workers in an informal manner in order to build rapport and feel comfortable: "*…We talk and we laugh…it's…He tells me a bit about his background, I tell him a bit about my background…"*

Participants emphasized how important it was to feel confident that their service providers worked hard on their behalf, going above and beyond the call in order to help them find appropriate housing and settle into their communities: *"…my worker worked with me… she worked diligently…and I know she keeps working on it, working on it everyday*". Participants felt that their support workers needed to be more than housing workers; they needed to feel that they could ask for any kind of help they needed and feel confident that it would be provided: *"Just…to help you a little bit more…than just do their job*".

Flexibility and Choice

Flexibility and Choice in Relation to Support

Many participants expressed gratitude for having choice and flexibility in the support they received from their workers in supported housing. Several felt that having support available to them when they needed it was very important: "*It's like we're saying about the visits, they're flexible enough if you require extra supports sometimes its available*." Individuals described how housing workers typically identified what their clients needed and allocated visit times accordingly. If their need changed, many felt confident that their housing worker would be available for increased support: "*For example, if I am not feeling well…they may increase the meetings…"* Participants seemed to genuinely appreciate this type of flexible and fluid support.

On the other hand, some participants struggled with support workers who seemed intrusive in their approach. For example, some participants 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*". Some of these participants also felt uncomfortable about the type of questions their workers asked and were often uncertain about the purpose of their visits and what they were looking for. Others complained about housing workers who showed up unannounced and early in the morning, without respecting their schedule or their needs:

> *Sometimes they just come and knock the door, and…one of the things I really don't like it's… that's one of them. Without calling or doing anything… that aspect I feel is very intrusive… at least you should call the person and tell him you're coming… instead of just a knock at the door, walking in.*

These participants wanted more openness from their housing worker and more respect for their individual needs and right to privacy.

Choice in Housing Unit

Overall, individuals greatly appreciated having choice in selecting their housing. This choice allowed individuals to feel a sense of control of where they lived, and to choose housing that met their needs: "*So I gave them what I was looking for… like bus routes, recreation facilities, playground, and things like that*". Participants generally felt empowered in the process of selecting an apartment that fit their needs: "*The first one they recommended to me, it was a bachelor apartment. But I would prefer a one bedroom*".

Finding the right apartment was often described as a process that included the opportunity for individuals to express their needs and find units to meet those needs. Several participants described how the supported housing program worked with them by providing different options and helping them to choose a suitable arrangement: "*The good thing was 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, participants were encouraged to look for units on their own. Then the housing worker could go in and negotiate with the property management to have them become a part of the supported housing program. In other cases, housing workers were able to find participants a unit that would meet their needs and facilitate their recovery. For example, a participant related that he used to live in various basement apartments prior to living in supported housing, and he associated his post-traumatic stress disorder with basement living. Accordingly, when he was accepted into supported housing, his worker tried to find him a unit that would address these needs: "*In this place one of the things they looked for was an apartment that was very bright, very sunny… and they did, they found a southern exposure apartment with lots of windows*". These efforts to meet the needs of each individual was greatly appreciated and seemed to help participants to create a home for themselves in supported housing.

Despite these opportunities for choice, some participants described feeling pressured to take the first unit they were shown. Some were coming from horrible living conditions and felt desperate to move on as quickly as possible. In these cases, although their unit in supported housing was an improvement from where they were coming from, they still felt there were many deficiencies in terms of the housing quality. At times participants felt that they had few options because they were denied requests for a transfer: "*But I tell my worker, and they told me we cannot transfer, we have no transfer and cause there's line-up you're going to wait, wait…"*

c. Supports offered in Supported Housing

Access to Supports

Many participants attributed their success and stability in supported housing to the ability to access supports when needed. Several participants felt grateful that they could call their support workers at any time. For example, one participant described: "*with my two workers, they both said, 'Call me anytime, please feel free to call me if something comes up.' It's really nice…and that initial support has been just a gift*". Other participants also described the reassurance they derived from the availability of their supports: "*…I get a lot of support from them…I can see them as often as I want…like I can drop by the office*". Participants described

the security they felt knowing they could get support from other workers in the program if their support worker was unavailable: "*So supportive housing, if I have a problem, I know that there's a solution to my problem. There's always somebody there to help me and get me out of whatever, whatever problems I may have*".

Despite the availability of supports in supported housing, a variety of unmet needs were expressed by individuals. They felt attention to these needs could improve supported housing and make it a realistic housing option for more people. Some participants felt that they did not get enough support and would have preferred more frequent visits. While conflicting schedules were sometimes the problem, some participants described having difficulty contacting their housing workers: "*But, I don't understand…why I have to wait so long*". Some participants seemed to doubt their ability to live independently with only occasional support. In addition, a few participants felt that there needed to be more assistance developing skills for independent living such as cooking, budgeting and shopping. They felt this skill deficit was a barrier to living in supported housing for some people: *"We don't have those skills… there's a big struggle that way… just those very basic, simple things…*" Some participants called for more transitional housing programs so that they could learn these skills prior to coming into supported housing. A few participants also acknowledged the special needs of individuals who did not have strong English skills in terms of accessing supports and completing all the necessary forms.

Nature of Supports

Instrumental Support

Participants described how support from their service providers motivated them to care for themselves, manage their finances and maintain their housing: *"…I like the staff when, they try to help me to do what is right… for instance, caring for the home and caring for myself…*" Participants also described the support they received managing their finances. For example, some participants described how they received assistance accessing community resources such as food banks and places to purchase affordable clothes and furniture. These connections enabled them to acquire these necessities without compromising their ability to pay their rent. Some participants also described the support they received when they got behind on their rent. In most cases, they were given the chance to catch up by paying back the money in reasonable instalments. However, support workers also took the time to help them develop banking skills and to teach them to budget and better manage their finances. For example, one participant described:

> *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 at that time I was wasn't even on ODSP so that … when they take the hundred dollars.. it means I have no rent. So for about three months, I didn't pay my rent. But my housing worker did know about the situation. She was understanding but I had to pay it back… every month I had to pay it back in installments. She took me to the bank, she told me things that I could do…*

Support during a crisis

Several participants described the importance of knowing that they had somewhere to turn in the case of crisis. One organization used to have a 24-hour pager that clients could access if needed and this was felt to be helpful: "*…And sometimes, with that beeper…support…they would help you get into hospital if you needed to…and …that was a lot better*". When the pager was no longer available, some participants felt unsure of where to turn if they were in need. Although they acknowledged the distress lines that were available, they felt that the pager used to provide them with access to support personnel they already knew, rather than strangers.

Several participants felt that just having supported housing greatly reduced the frequency of crises by offering more stability and improving their quality of life. Their finances had improved, they had more peace and quiet in their living environment, and they had fuller and richer lives: "*Basically… this situation just 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, supported housing provided a significant amount of protection against crises.

Support with Work and School

Quite often support extended beyond housing to the realm of employment and education. At times work was positioned as an opportunity to improve one's quality of life by earning a bit of extra money. Speaking about her support worker's emphasis on work, one participant stated: *"…she's kind of a hard nut about finances, but she's also very understanding… she'll twist my arm… to take a part-time job…"*

Other participants described how their support workers were persistent in helping them go back to school or pursue employment by breaking their goals down into small, manageable steps. For example, one participant described how her worker helped her move forward with her life and pursue her educational goals: *"…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 participants described how this support was essential to helping them overcome challenges and persevere on difficult days:

> *And she's always the type of person that, sometimes when I don't want to do it she would ask me well, you know [name of participant], if you don't start somewhere you're not going to get anywhere, and …there are days when I don't and she would say well you know, you're entitled to those days. So she would always encourage.*

This encouragement seemed to foster motivation and drive, and help individuals move forward with their lives.

Informal supports

Individuals expressed an immense appreciation for the support of their friends during difficult times. Many noted specifically that friends with similar experiences became role models and inspired individuals to persevere in their recovery:

> *…Well most of the people that I have become really good friends with are…the people in the program…and then you meet these incredible people who have thriving lives…who were exactly where I was…I mean it's just… it's so powerful, and all my friends…you know…these are my friends…you know, which is incredible.*

In many cases, such friendships were grounded in shared experiences of recovery from mental illness, addiction and homelessness: *"…It's just easier if someone is going through the same thing that you went through one time…"* Such friendships helped individuals feel less alone and isolated in their recovery journey, and also protected them from the isolation of living on their own.

Several participants also acknowledged the support they received from their family members, especially during times of crisis. This support included emotional companionship, as well as financial assistance in some cases. Just knowing that someone cared about their well-being seemed to be reassuring: "*My mother.. she's the only one who ask me questions about my health… and she asked me how I'm doing…she worries about me, you know…"* In some cases this support was provided by telephone or the internet because family was out of town. However, in all cases, this type of encouragement was described as fulfilling an important need. Knowing that they had people who cared about them and who they could count on in a time of crisis helped individuals persevere in supported housing, ensure they were doing the things they needed to do to care for themselves, maintain their housing and pursue their goals.

In addition to family and friends, some participants described the support and companionship they received from their pets. This type of support was seen as particularly important in counteracting the tendency for loneliness and isolation as individuals adapted to living on their own and building a new life for themselves in supported housing:

> *But basically when I moved in to this place, I gave up all my friends. So I found myself alone for a while. And that I had… I had a hard time dealing with being alone. That's why I got the two cats. Cause than, at least I had company. Because I didn't want to find myself lonely, and going back, seeking out these people that…I didn't want to be around anymore because I know that the only road that would lead to, would…be me going back to jail.*

These participants were extremely grateful that they were allowed to keep pets in supported housing and spoke about how much comfort their companionship provided: "*I don't know what I'd do without that cat. You know, she greets me at the door and I can talk to her…and it's unconditional love…*"

Participants described the sense of fulfillment they derived from taking care of their pets and their plants. For example, one participant described the sense of pride and responsibility he experienced when caring for his cats: "*They're dependent on me. I'm in a position where I have*

to be responsible. And I love them so I have to take care of them…" There seemed to be an important spiritual aspect behind this caregiving role that provided participants with a great deal of support and satisfaction. When talking about caring for his plants he explained: "*It's really rewarding when I see them grow again and that they don't die. So that's kind of a little spiritual thing I do…And when I see them growing and flourishing with their leaves, it's very rewarding*…"

d. Housing Features

Participants spoke a great deal about the various features of supported housing that were important to them Many discussed the idea of living independently, the manner in which issues that arise in housing are dealt with and other important housing features including; rent subsidies, apartment furnishings, the physical space of their apartments, the stability of the housing and opportunities to interact with others.

Independent Living

Several participants noted that having their own place made them feel happy, secure and comfortable: "*It feels like home…it just that, I'm in my own place, you know*?" Individuals described living alone as fundamental for privacy and living with dignity: "*There's no words to describe this [living in supported housing]…it's very important*". Being able to structure their life so as to pursue their goals was seen as very important. Unfortunately, having roommates who had different priorities was often described as a barrier to recovery:

> *You know, like I was up at six o'clock in the morning and then… people started, they wanted to party until 2, 3 o'clock in the morning, because then they could sleep until noon. And I'm not judging that. But my goal was quite different. My goal was to do what I was set out to do.. so that was a major.. interference…*

In such situations residents described feeling very uncomfortable in their own homes. They often avoided being at home except to sleep, and found that this meant they had little personal space to unwind and decompress. Their reflections suggest that having one's own place may be more conducive to recovery and moving forward with attaining one's goals.

Residents described having their own apartment as being in control and in charge of their living space. "*When I walk in, I know exactly what it's going to be like.. and so… I don't have to concern myself with experiencing perhaps some situation that … that had been quite dangerous in the past…*" Being on their own gave residents the comfort of knowing they had a quiet and peaceful place to recharge at the end of the day. In this way, supported housing served as a foundation for community engagement and recovery:

> *Because 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, that, my own space to do that. I think that would be the key component of having my own space.*

Most importantly, having their own place reduced stress, provided stability, and motivated individuals to take care of themselves: "*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 alone offered the freedom to live independently, doing chores and organizing their daily routine around their personal priorities rather than having set tasks or required routines. This freedom was emphasized by one participant who described how his daily routine was previously restricted by the rigid schedule of the group home. Now that he had his own apartment in supported housing, he could pursue some of the activities he used to enjoy:

> *I used to go for swimming, but I haven't done it for a while..Yeah, I think I'm going to start to again..It is free. I think the [hours] are from six to seven. So I couldn't go when I was in, in the [group home]...because we have dinner at five… right. So… I couldn't miss, you can't miss… the dinner…But now I'm more, I'm a free man you know....*

Participants described feeling more secure in their own unit, because their possessions were safe and nobody could take their things. Several participants described the importance of being able to lock their door and having their own key: "*I am very happy when I go out, I lock my apartment. I have a key…Whatever time I can come…I have my key…nobody is there. So I'm very happy. The key is.. in my hand*". Owning a key and knowing they were the only one with access to their apartment gave individuals the confidence to become more engaged and involved in their communities.

Participants also spoke about how the flexible rules of supported housing improved their quality of life. Rules in shared accommodations, group homes and boarding homes were described as much more rigid and several participants noted how much they appreciated the freedom of having their own place with more lenient rules about personal schedule and lifestyle. One participant noted how grateful she was that she could keep her pet cat: "*I don't know what I'd do without my animal and the subsidized housing allows pets, which is great and so I'm really grateful for that*".

However, a common drawback to living alone described by several participants was the loneliness experienced from not having anyone around: "*So I found myself alone for a while. And I had a hard time dealing with, being alone…*" One participant compared the loneliness and boredom he felt in his apartment to being in prison: "*I feel kind of locked in, you know, something like, being in prison because you know they lock the door, and you, you're in there by yourself, it's you know, it's a little bit on the boring side*".

Building Issues

A major concern among participants was regarding the maintenance and upkeep of their building. Many were concerned about pests such as cockroaches that could infest the building. On the other hand, several participants spoke about how well maintained their buildings were. They were generally satisfied with the building maintenance and the daily cleaning they saw being done by the property management. Many felt that they could get repairs done promptly within their units although it was noted that this was not everyone's experience: "*The only thing is maybe sometimes…other people… told me that I'm lucky because sometimes..they..have to apply for repairing work, it takes quite a long time… I'm lucky...*".

Participants also spoke about services and amenities within their building that they found helpful. For example, several participants mentioned the food banks and clothing drives that were held in the building. Some buildings had recreation rooms where community meetings and events were held, and swimming pools that tenants could use. Some participants specifically wanted a swimming pool, gym or recreation room that they could use to relax, exercise and meet other people. Other participants were able to access such resources in the community and did not feel they needed these amenities in their building. Participants also appreciated having laundry facilities within their building.

Participants had mixed experiences interacting with their superintendents or the property management of their buildings. Some reported very positive relationships and felt comfortable asking for assistance. "*We are in a very good terms, are very considerate… very helpful and… if I need help I feel comfortable enough to call the management… or the, you know maintenance staff or super.. so, I feel that's comforting*". Others had significant complaints but were usually able to direct their concerns to their housing support workers who could intervene on their behalf.

Current living conditions were often contrasted with previous living conditions by participants. For example, one participant described the tiny house he shared with his sister and her nine children prior to being accepted into supported housing. In that previous home, even basic maintenance was absent:

> *But the place was deteriorating.. I remember one time I was .. thinking that … in the main floor in the.. living room, water used to come down, the washroom was.. someone uses, the water come down from the ceiling, and come down and, it was really bad…*

Important housing features

Participants reflected on a range of issues when describing what they liked about their apartments and what made their housing comfortable and pleasant to live in. One of the most salient features that most of the participants spoke about revolved around subsidized rent and being able to afford a decent apartment while still having money left to meet their daily needs. Some participants described how the rent subsidy reduced their stress and allowed them to focus on other areas of their life:

> *When I lived in regular housing, I was always worried about how I'm going to pay my rent cause it was so expensive. I had… like all my worries were financial.. and then of course if your rent's high.. how am I going to pay for my groceries, it just added stress to me.*

Now, with the extra money, participants were able to invest in furthering their education, or leisure and recreation activities. Several participants described how the rent subsidy allowed them to improve their quality of life and meet their basic needs.

Most participants also described how much they appreciated getting a furnished apartment or getting support finding affordable furniture when they moved in. This enabled them to make their apartment into a home without jeopardizing their already precarious financial circumstances or threaten their ability to pay their rent.

There was a great deal of discussion about the physical space and housing features. For example, participants seemed to enjoy living in one-bedroom apartments as opposed to bachelor units. In general, participants felt good about having enough space for their possessions. Some participants were particularly satisfied with the appliances, the fresh coat of paint that was put on the walls before they moved in and new hardwood floors or carpet: "*It's a nice place…because they painted the walls when I got into the apartment…So I'm really happy they, I know that they care for us…I didn't have to buy anything…they bring me everything new. I was really happy*".

The impact of these features was that residents felt a greater sense of comfort and security in their homes. The larger, cleaner spaces of supported housing units reduced stress, provided stability, and allowed individuals to take better care of themselves:

> *When you boil it right down I'm just now, because I'm now living in a clean secure… generally quite tolerable, you know habitable, at least ...I'm just in… an overall better frame of a mind… and therefore I'm more likely to do the proper things… to take care of myself.. and you know.. I have my own kitchen, my own bathroom, so I don't have to wait for other people to get out of the shower. I can lay food somewhere without people stealing it…You know, it's just yeah… the overall ease of living.. is really … psychologically it's picked me up a fair bit....*

Home became a place of comfort, a place for healing and moving forward: "*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...*".

The stability of the housing arrangement was very helpful to participants. These arrangements were considered permanent and available to participants as long as they continued to pay their rent and require support. (There was no maximum length of stay or tenure). This stability provided security and allowed participants to build a home for themselves within the unit. For example, one resident stated: "*Because after all my experience I have stable income and stable apartment. I am settled.*"

An additional feature that participants enjoyed about their housing arrangements was opportunities to interact with others. Those who received their housing through a clubhouse were able to socialize with other members both at the clubhouse and in their buildings. In this arrangement, the supported housing units were clustered on specific floors of various buildings so individuals knew that their neighbours were also clubhouse members. Participants who lived in scattered housing often made use of other community resources or programs to socialize. For example, a young mother described how she met other families through going to the playground with her child.

Some participants who lived in scattered housing wished there were more opportunities for them to meet people and interact socially with others. For example, one participant wished there was a common recreation room in the building where people could sit down together and watch TV. Another participant stated he was looking for a church group to join so he could make sure he was interacting with the "right kind of people" given his past history with addiction and crime.

Making and maintaining a home

Participants expressed appreciation for having their own home and took great pride in the upkeep of their apartments. Many described feeling more motivated to do their chores. Furthermore, several participants found it helpful when housing workers encouraged them and helped them care for their home: *"…I like the staff when, they try to help me…caring for, for the home…I get encouragement to do that too…"* Individuals expressed pride in personalizing their space and making it into a home:

> *I walk into my home now, it's, I made it immaculate. Everybody that comes into my home goes, "Wow!" My hardwood floors, I do them in Murphy oil every two days, I have plants everywhere, big trees and plants, all kinds of ornaments and pictures, and porcelain birds all along the wall. It's really nice. You know. I really made a nice home out of it.*

This transformation had a significant impact on participants' health and well-being. Individuals felt responsible for maintaining their home and made this a priority. The success they experienced in making and maintaining their home provided a sense of ownership and pride, and motivated them in other areas of their life. For example, one participant described the enjoyment he received from living in his own place and keeping up with the chores and how this comfort motivated him to take care of himself and manage his illness: "*Also just the enjoyment...like the place is so homey and [I] feel comfortable cooking and cleaning and, you know, doing the chores. Like it's like a daily thing. As long I'm healthy and taking my medications…Then everything will be alright*". In this way, maintaining a home seemed to be a critical component of recovery.

e. Neighbourhood and Community Context

Disclosure

Among the participants, about half lived in scattered apartments within regular apartment buildings while the others lived in clustered housing arrangements where entire sections of buildings were specifically for clients from particular agencies. The issue of disclosure to neighbours came up more frequently and prominently among tenants living in scattered apartments. Many of these participants spoke about the comfort they took in knowing that their neighbours did not know that they were living in a subsidized unit and receiving support from a community mental health agency. These participants specifically spoke about the lack of stigma that was attached to this kind of housing. For example, one participant described:

> *When you live in that building and you come out... there's nothing on your hat saying, he has a mental illness or he lives in social housing, or anything… you are one of the tenants, nobody know who you are, or whatever illness you have.. and that type of integration, it is very good… it gives you hope....*

On the other hand, the participants who live in clustered apartments were aware that everyone on their floor was an individual in supported housing. In some cases, this gave them comfort, contributed to the sense of community, and created a shared understanding among

neighbours. For example, one participant noted: "*We always poke fun at things… and it's just easier if someone is going through the same thing that you went through one time…It's easier you know…*"

Community Access

Throughout the interviews the participants 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 who had supports established prior to being accepted into a supported housing program wanted to find a unit that would be close to these supports. In these cases, supports included informal supports such as family and friends, as well as support from community mental health programs and doctors. For example, one participant noted that he wanted to be close to his established supports, including his doctor and his church parish:

> *When I came for the interview I specifically had a certain area that I was really feeling, I would feel comfortable in. So I said I need to be in this corridor. And… I wasn't really expecting anything so fast in that corridor. But… I can walk from my apartment to my family doctor in about four minutes, my bank's there, I.. because I was at the parish before and moved into all this other housing. I'd already had… support set up… there was already support in place, I already had friends who lived in the area…so I already had lots of support established so…being in that area was important*

Interactions with Neighbours

Participants generally had positive experiences interacting with their neighbours. Some participants needed time to get to know the other tenants in their building but spoke about how friendly and nice people were when they did eventually get to know them. Other participants spoke about how they generally kept to themselves but found that people were friendly and civilized. However, some participants found that other tenants in the building were part of their larger support network and were comforted to see their neighbours reaching out to other tenants when they were not doing well:

> *As far as.. helping me along with my health, I think, the other people in the building, the essential good will in the building has been tremendous…there are people who may be, not so functional at times.. but... the fact that their neighbours still talk to them or.. still say hi on the elevator and… you know "how are you?".. and also the fact that there are other [clubhouse] members in the building.. So you're not alone…*

Beyond the support provided by neighbours, individuals noted that getting to know their neighbours increased their sense of safety in the building, and made them feel less alone and less vulnerable. This increased security led to increased confidence, and seemed to enable individuals to come out of their apartment and become more involved in their community.

Although most participants described positive experiences with their current neighbours, some participants found it hard to get to know their neighbours. For example one participant noted that she was not particularly good at socializing and found it hard to relate to people in her

neighbourhood. Other participants noted that most of their neighbours were elderly and had different interests. Despite being good neighbours and creating a pleasant and peaceful atmosphere in the building, such age differences made it hard to make friends and establish ties.

Unfortunately, several participants described their experiences in their previous housing arrangements as being hampered by drugs, alcohol, crime and generally not feeling safe. For example, one participant reflected on his life prior to being accepted into a supported housing program. He described the rooming houses he was in as being full of "*men who have lost their way… who lost faith in themselves and lost any hope of ever doing anything with their lives*". He described an environment filled with drugs, fighting and loud music. Being immersed in this housing environment precluded any kind of recovery. In reflecting back on these previous experiences, participants noted that their current living environments resulted in reduced stress: "*My neighbours are.. a good deal more civilized and I don't have the interpersonal stress I used to have…".*

Safety: Impact of Drugs and Crime

Beyond interactions with neighbours, participants discussed the impact of drugs and crime on the overall neighbourhood. Even though most participants 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. Participants described the effects of living in a neighbourhood infested with drugs, addictions, crime, and despair could have on their hope for the future and the development of their children. Unfortunately, several participants associated such environments with social housing and felt that it was important that individuals in supported housing be allowed to live in subsidized units in regular apartment buildings to give them hope and opportunity:

> *When you wake up in the morning, the elevators are clean, you won't see urine, or, dirt, or you don't smell.. some kind of drugs that some people have.. addicted to.. it affects you when you live as a neighbour, you rather live a place (that) builds your self esteem, give you high hope. It also affected your children. When you live in social housing, and.. many of the people have.. a lot of mental illness.. a lot of substance abuse… the kids go in one class together in the neighbourhood school. And also the teachers may not have high expectations.*

Participants with past histories of addiction had to be particularly careful in regards to the neighbourhoods they lived in. They typically wanted to be in buildings and communities that were not infested with drugs so they had a chance of staying clean. For example, one participant described why shared accommodations in boarding homes would jeopardize his chance to recover and rebuild his life:

> *You know when they say, when you're in Rome do as the Romans do. Well, when you're in those places and you're living there, eventually...you can't fight them forever and then.. you give in and you get high, and you drink with them, and before you know it, you're brought right down to the level that they're at.*

He explained how his current neighbourhood has helped him stay out of trouble: "*I didn't want to be around that so, they got me a spot in a condominium building and, they got me a beautiful condo, and that got me away from the drugs, and that crowd*". In his current living environment, he was re-building his life, reconnecting with family, and pursuing opportunities for employment.

f. Moving forward

Being Productive

Participants valued being productive and involved in their communities, and placed great importance on being able to get out of their apartments. At times, they were willing to commute long distances in order to get involved and avoid becoming isolated at home: "*I'm willing to sacrifice. I get up 6 o'clock every morning and…get ready and leave the house 7:30 and by 9 o'clock I'm here…But it's worth it…you know…I can't just sit home…and do nothing…I need the interaction…*" Participants described the importance of having a schedule and being able to connect with others: "*I go, I hit a meeting everyday …I go to gym…and swim…almost everyday…which just helps my mood a lot*".

Participants expressed the positive effects that being able to pursue their goals for employment and education had on their lives and on their ability to maintain and sustain housing. Being able to pursue these goals provided them with opportunities to challenge themselves. It also helped motivate them to take better care of themselves, manage their problems and earn a bit of extra money to improve their quality of life. Some participants provided specific examples of how supported housing was conducive to recovery and the pursuit of their goals for work and school. For example, one participant described how her previous living arrangement in a group home precluded success at school and led to a major set back in her recovery:

> *Because I was attending this full time program which I wanted to succeed in, and move on but then because of the living situation in the group home setting I wasn't able to complete the program, however, after that I... also had major breakdown, which meant that I was re-hospitalized. Which meant that you know, just two steps forwards three backwards.*

Despite these set-backs individuals were still very motivated to pursue their goals once they found stability in their housing.

Another motivating factor in pursuing goals for employment was the opportunity to earn some extra money and improve their quality of life. Some participants highlighted that financial constraints limited their ability to go back to school and pursue their career goals: "*I do want to study but, right now I still can't afford it*". Other participants felt that having chores to do around the house helped them be productive by providing them with some daily structure, responsibilities, and purpose. Still others described how having a safe and secure living environment allowed them to re-engage in their communities as productive and contributing members by finding volunteer work or returning to school: '*My, unit has, allowed me to pursue, because I didn't have to deal with the other issues…work as a volunteer for the past three years now…*". Participants described how supported housing gave them opportunities and flexibility to

pursue their goals by freeing up funds to be able to afford a computer or pay for classes, while ensuring they still had their basic needs met: "*I can afford to have a computer…and that's another good thing ...Good work, is going to give you good income to make your life pleasurable. And good life.. it means happiness*".

Participants expressed interest in a variety of leisure and recreational activities. They specifically mentioned being able to access local fitness centres, yoga classes, libraries, and parks. Many felt that without stable and affordable housing, they would not have the opportunity or the means to pursue these activities. These activities provided them with the opportunity to interact with other people, make friends and enjoy life.

Hopes for the future

Participants described how they became more and more interested in pursuing their goals and building a better future for themselves as they became settled in supported housing. Some participants specifically noted that being given the chance to live in a regular apartment building in a good neighbourhood provided hope and built self-esteem. Participants described moving forward with their goals as they became settled into supported housing: "*I have been able to accomplish some of my goals… and, I'm trying, I'm planning on following up on others now*".

With the stability and security provided through supported housing, some participants began to take stock of their past experiences and consider what they might pursue in the future:

> *I'm thinking if I can take some computer courses, where I can't work physically but I am a very smart person, and I learn quickly, I could learn computers, some programs, and perhaps get a job in the computer industry…you know IT, tech something like that. Cause there's good money being made there and I don't see why I shouldn't be able to make it too. But when I get myself to that level, then I won't be considered to (be) disabled anymore. Because mentally I can make my money…based on my knowledge, rather than my physical strength*.

Impact of good housing

Participants spoke at length about the impact of supported housing on their lives. At a very basic level, participants described how having a warm and heated apartment enabled them to get up and out of bed in the morning. For example one participant noted the improvement he experienced since moving into supported housing: "*It's well heated. So I feel more motivated to some extent because in the winter I'm not clinging to my bed because it's a cold room and I want to stay in bed as long as possible*". Furthermore, participants also described the relief they felt having their own apartment which reduced the amount of stress they experienced at home. They felt they had less physical tension because they had their own private space in which to decompress and unwind.

Almost all participants felt that their lives had improved since their move into supported housing, resulting in increased self-esteem: "*My self-esteem has gone up pretty high from where it was*". There was a particular emphasis on how improvements in one's housing and living conditions helped people feel better about themselves and enabled them to work towards making other improvements in their lives. Participants

described the motivation they felt to take better care of themselves now that they were living in good housing. This self-care revolved around keeping up with cooking, cleaning and being productive in the community in order to ensure they maintained their housing and their health, and moved forward with their goals for recovery.

Individuals emphasized how the stability of their improved housing arrangement made them feel secure and able to pursue their other goals; they knew they were able to keep up with their rent and that they had a quiet and peaceful place to come home to at the end of the day: "*It gives me confidence, you know…just know that… your rent is being paid every month…you know and…I'm okay*". Furthermore, supported housing increased their motivation to become more involved in community life.

5.2 Service Providers

Analysis of service provider interviews revealed that there were many similarities between important characteristics identified by this group and those identified by residents. Service providers described pathways into supported housing, and like residents, identified a set of important guiding values, although these values differed somewhat from those identified by residents. They also spoke about the important supports offered in supported housing, the neighbourhood and community context of housing, and impacts of supported housing. Finally, service providers commented on program and system issues that they felt were significant within the supported housing domain.

a. Pathways into Supported Housing

Service providers have important roles in how individuals enter supported housing programs, from finding apartments, conducting the intake assessment process, and helping clients get settled into their units.

Finding Apartments

In one of the supported housing programs, housing workers were involved in finding and securing units for their clients. In this program, housing workers described trying to secure units that would meet the needs of their clients. The goal was to set the client up for success. Therefore, service providers considered the potential impact that issues such as drugs and racism could have on the client's ability to adjust and succeed in their living environment.

Service providers also highlighted the importance of considering the relationship of the agency with the landlords and with the community when placing clients. At one agency the housing workers described 'selling' the idea of the program to landlords. One housing worker explained:

> *So… the housing workers, we go out and we rent apartments from private landlords. And so we have to go out basically and sell the agency. Sell what we're trying to do, promote the program, educate, so that they can buy into this, so that they can rent us a place, because without them we probably wouldn't exist.*

In this way, service providers described developing relationships with landlords. For this type of program, educating and negotiating with landlords were seen as essential to successfully securing potential housing for the program.

Assessment / Intake Process

During the initial assessment and intake process, service providers tried to ensure a good match between the client, the program, and the type of housing they are able to provide. Several service providers spoke about the intake process which started with an interview and assessment with the client. Participants explained that each program had their own eligibility criteria. They discussed some of the things that are considered during the intake process. One participant explained:

> *We would look at their past housing records. How they get along with other people if there's been any disputes. If they've ever lived independently, cause some people haven't. What their //ADLs (activities of daily living) are, if they're capable of living alone and doing their own housework and cooking and that type of thing. If they're safe. If we feel that they're safe.*

Participants explained that there were different options for clients, different supportive housing models with various amounts of support. Several service providers described the need to take time during the initial assessment process to determine the amount of support that each client needed to be successful in their housing.

Although both case managers and housing workers described a process of considering each client's needs during the initial assessment, the focus of their approach differed. Case managers were interested in considering the client's needs in relation to the different housing options available.

Ultimately decisions about whether a client was accepted into the housing program were made by the housing program team, often with input from a case manager or community support worker working with the client. Service providers highlighted that considering the goals of each client and coming to a decision in partnership with the client was critical to the process. Service providers spoke about the importance of making sure the client had choice in the process. As one case manager noted, "*Of course looking at what the person wants too… it's hopefully a mutual decision.*"

Different agencies have somewhat different intake processes. For example, clients at one agency must be active members within it before applying for supported housing. One service provider described how this requirement provides an opportunity for staff to really get to know the person, their needs and how best to help them be successful in supported housing:

> *Pursuing or developing relationships is one of the reasons why we wouldn't accept an application on their first day of membership. Just really to get a chance to know them and what they're like in the club community, getting a chance to know them as a person here at [name of agency]. And that's a good basis.*

Impact of substance use on SH

Many service providers spoke about clients with substance use issues and the impact of these issues on supported housing. In addition to ensuring that clients with histories of substance abuse are not placed in areas and buildings that are known to be infested with drugs, some service providers noted that substance abuse issues can significantly compromise the stability and success of a client in supported housing.

For some individuals who are struggling with substance abuse issues, a supported housing unit may foster isolation and result in substance use behind closed doors: "*And then there are other people, who once they get into their apartment, they shut their door and they start drinking, or they do drugs, or they don't want to have anything to do with anyone*". Therefore, serious substance abuse issues may compromise success in supported housing and some individuals may require more supervision and support than what is offered through supported housing programs.

Substance use could also affect clients' ability to manage money which would impact their overall stability and ultimately their ability to maintain their housing. Given that many clients in supported housing are reliant on income support through social assistance programs that are paid out on a monthly basis, a pattern will often emerge if individuals are using drugs and alcohol:

> *Alcohol and substance abuse often follows in a pattern where, if it's not gambling it's alcohol usually… they're spending it on. Blow it all in the first week and a half, two weeks and then they go through the rest of the month… I come and see the client. The first week he's great. Second week, you start to see the signs of not eating well, sleeping well from stress that… well not having money. Not being able to make it to the doctor's appointment and all the stress… sometimes it contributes to them forgetting to take their meds, and just a whole pattern, cycle that happens within a month.*

Several service providers noted that it is often difficult to find treatment programs for substance use issues. In such cases, the role of housing workers and case managers is to provide treatment resources or to connect clients to appropriate treatment. Service providers may have to provide more intense support with these clients. Such issues were particularly challenging for housing workers who maintained large caseloads.

Service providers also spoke about the need to be concerned about other tenants in the building when clients are actively engaged in substance use. For example, illicit drug use could introduce a criminal element into an apartment building and disturb the peace and safety of other tenants. Service providers explained that landlords tend to be much less tolerant of substance abuse issues than other mental health issues.

Because of the significant impact substance abuse could have on one's ability to maintain independent housing, some housing programs avoid accepting individuals into their program who are actively using. Although they are willing to work with individuals with histories of addiction and substance abuse, they try to discourage any current use,

b. Guiding Values

Analysis of the interview transcripts revealed certain overarching values and principles that guide service providers in their work with supported housing clients. Several themes emerged: the importance of providing individualized support, being client-centred, providing clients with choice and managing issues of social stigma about mental illness.

Flexible and Individualized Support

Several service providers spoke about the importance of flexibility within their roles and the necessity of providing individualized support based on resident goals. As one case manager described, "*For each client… your role is very specific and… much different than it is from… each and every one of them". Another service provider, a housing worker, further explained the varying levels of support he provided based on the resident's needs, "So from one end of helping people maintain, to the opposite end of just the casual touching base and meeting. Whatever support they think they need…".*

Several service providers noted that the frequency of their contact with clients would vary depending on need. As clients became more settled and stable in their new living environment, visit frequency could generally be reduced. As one housing worker noted, "*There's a lot more contact of course in the first few weeks….*". Service providers also spoke about the need to increase supports over time if things were not going well. As one housing worker commented:

> *Touching base with people and seeing them … and noticing 'hey some things aren't going so great'.. noticing .. 'oh, maybe you're becoming unwell'.. 'I'm having a problem with cockroaches', 'I'm having issues with my neighbours' ...and sometimes on those circumstances at least through here we have that flexibility to meet as that person feels they need. To give them that direction… sort of picking up on that and letting people know they have that as an option as well. So.. 'oh you've been having a tough time lately, do you want meet a little bit more frequently?' and then leave them that choice … following up with them, making sure that things are okay.*

Other service providers noted that different clients needed different levels of support depending on where they were coming from and what their previous experiences had been. In some cases clients were coming from shelters or group homes and required a great deal of support learning how to live on their own. One housing worker described:

> *Some people they come in, they say okay well I need help with finding work, I need help with.. learning how to use the TTC, I need help with laundry, I need help with.. budgeting, I need help with grocery shopping.. And so… you know, we'll do all these things, and then after you've done it, many, many times, for many, many months… usually they've learned how to do it, on their own, and clients will say… you know I don't need you to come… twice a week to help me with all this stuff, can we cut back on the visits... and that's you know… a good thing.*

In other cases, residents were more independent and only required help with finding and securing housing. A housing worker explained, "*sometimes already, our members know a lot of it, so.. then we do not provide them all that help because they're pretty good at it. So it's depending on individual needs.*"

Finally, for several service providers, focusing on each client's goals for their life appeared to be the central determining factor in the level of support they provided. They valued having the flexibility within their job roles and schedule to provide the appropriate amount of support based on client goals. As one case manager commented:

> *And having the supports I think is important and being … like in our case the one thing I didn't mention is that our caseloads are kept low. So that we have the time to spend with clients.. So we can.. go in and spend you know we can see them twice a week. You know three times if we absolutely have to.. And we can spend an hour or more with them if we need to.. not… you know if it's needed, not to make a habit of it, but if it's needed... we can.. so it's not a 15, 20 minute visit …And I just, I think that makes a big difference.*

Choice

Many service providers addressed the idea that clients need to have options and be encouraged to make choices when it comes to supported housing. When choosing a neighbourhood for a client to live in, service providers noted the importance of considering where the client would prefer to live. They also spoke about the need for different housing options with different levels of support. At the same time, they emphasized the need to recognize that supported housing may not be the most appropriate type of housing for everyone at all times;

Certain clients, for example those who are heavily involved in drug use, those who have been in the shelter system for a long time, those who create unsafe living environments (the example of hoarding was provided) may not be suitable candidates for supported housing, according to the service provider participants. They stated that those who require more intensive support than that offered by the housing program may not be not be successful in supported housing. As one service provider described:

> *Maybe it's not the right model for that tenant. Sometimes we have had success just moving someone from a community. Because maybe the community is so drug infested that they didn't have a chance to begin with, so moving them… and they've been fine. We've had some situations where it's worked out nicely. In other situations, the person is so, engrossed in that lifestyle that they participate in it, they allow the people to come in, they invite the people to come in.. So you know for us it impacts the building, the landlord, the other tenants, it impacts us.. So we try to work with the tenant and the supports and getting (them) in to more supportive type of housing.*

One service provider commented that the independent living situation created by supported housing is not necessarily better or worse than living in a group home. Rather, these

are two different options for different people's needs. This service provider felt that options and a range of choices need to be available to clients.

Other service providers also commented on the need for more choice within the system in general. They highlighted the need for more supported housing, to allow individuals with mental health issues to live independently if they choose to. One service provider explained:

> *Well of course the need for more. Which is always going to be apparent in this city I believe. So acknowledging the need for more independent housing. We let go of our group homes years ago and I know that there is still a need for the higher supported group home environments. Yet given a choice, I'm sure most individuals would rather maintain their own separate apartment unit. So pursuing something that's more of an individual lifestyle in the community. So of course need for more units.*

Client-centredness

Service providers spoke about the importance of supporting clients in achieving client-chosen goals. This process involved supporting clients in expressing and delineating their goals, providing clients with the necessary education to make informed choices and ultimately connecting clients with the resources required to achieve their goals.

Once supported housing units were arranged for clients and as the residents became settled into their new homes, the focus of service providers shifted towards encouraging independence in decision making and in community living by teaching skills and providing supports. As one housing worker noted, "*the ideal is… that they become more self-sufficient*." Another housing worker described the importance of ensuring that decisions about setting up the home are in the hands of the client and the importance of supporting that process:

> *Ultimately trying to get the individual to do most of the stuff their own. To encourage that independence… 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*.

Service providers described the importance of being cautious not to make decisions for clients and highlighted the importance of facilitating independence while supporting clients by ensuring they had sufficient information to consider all of their options. This process allowed clients to develop skills and become more committed to following through. For example, one housing worker described:

> *I think you always want to make sure you're not making choices for people. Because if I'm telling you what to do the likelihood of you actually following through and doing it, is going to be lower. Sitting down.. 'let's come up with a plan' and getting that person to draw out the steps of the plan, to be very involved. I think that will, as I was saying before, really end up them committing to it and following through with it, more likely.*

Service providers described situations in which they supported clients in making informed decisions. They spoke about providing education to clients about their options for paying rent and then connecting them to the relevant resources. They also spoke about supporting clients in making decisions that will help them to create a safe and stable living environment. One participant explained, "*They need to have information so that .. we all need information so we can make informed decisions. As much information as possible*." Helping clients think through the consequences of their choices by providing information and support, while ultimately allowing clients to make their own decisions, was seen to be an essential process. One housing worker provided an example of how he helped a resident consider whether or not to get a pet by helping him consider the benefits and responsibilities associated with the decision:

> *If he wants a pet, I see the psychological benefits of having a pet. Go for it. But, is this the right time? If you're manic, are you prepared to realize the money you need to get the shots, to get the animal fixed, to maintain it with food, and all those things. So you want this. Let's do it. But let's make sure we're getting you prepared*

Several service providers spoke about the importance of working alongside clients, of doing things with them and not for them, and of engaging clients in the decision-making and goal-setting process.

Managing Stigma

Several service providers described the significant impact stigma has on clients who are working to create a stable life and trying to integrate into the community. Service providers described how this stigma hampers efforts to help clients feel accepted and welcomed in their communities. As described by one case manager, stigma creates inhospitable conditions for socializing, leading to isolation and destructive behaviours such as drug and alcohol use: "*That's a huge thing… social stigma. Being in the community, and alone. And not knowing people and having a mental health issue and just going out there socializing… usually what they turn to is all the bad stuff*".

Scattered vs. Clustered Housing

Service providers discussed at length the living context for clients of supported housing. Service providers represented two different types of supported housing programs: In the first type, clients were housed in independent units scattered throughout regular apartment buildings across the city. Service providers who worked in this type of arrangement emphasized how it allowed individuals to have a fresh start, to live their lives without everyone knowing about their history with mental illness unless they chose to share it. Several of these service providers felt that housing clients in mainstream communities and apartment buildings allowed them to integrate more fully into the community. Many of them felt that this type of housing was important in allowing clients to escape stigma and to integrate more easily into community life. One housing worker described:

> *That's why I think this housing program is wonderful, it's so unique, because it gives people an opportunity to integrate back in the community because nobody in the building will know that they're affiliated with [name of community mental health agency] unless they disclose that. People need to feel like they... they should be able to walk around and [not] feel like they're being targeted or labeled or discriminated against. This program allows them that.*

In the second type of housing program, clients were housed in independent units clustered in designated buildings within the downtown core of the city. Typically, particular floors were secured for clients within designated buildings. It was noted by some of these service providers that living with other people who struggled with similar mental health related issues led to a sense of community and could act to prevent isolation. In such situations, neighbours were well positioned to show compassion and empathy, and to help each other out during times of need.

Unfortunately, in one case, such an arrangement led to people in one community blaming those with mental illnesses for all the issues and challenges that arose in the area. This created a difficult atmosphere where stigma and discrimination were pervasive:

> *One of the housing.. it's a big tall fifteen story building, we have [name of agency] housing there… people know that [name of agency] housing is there and unfortunately there are biases about mental health, there are stereotypes like, "Oh, those [name of agency] people, they're always causing trouble, this, that whatever and half the time they're complaining about people [who] are not even from [name of agency].*

Different levels of segregation/integration between residents and the general population were seen to be desirable. Although service providers from each program spoke about the advantages and disadvantages of each type of arrangement, several also noted that it was important to have different types of housing available. According to these service providers, some individuals are able to integrate easily into the larger community and thrive in that kind of an arrangement, while others do better in a community of mental health residents.

However, service providers from both program types felt that a more integrated approach to supported housing, in which tenants from a variety of backgrounds live together, can help dispel the pervasive stigma towards people with mental illnesses by fostering greater understanding in the society in general. Service providers noted that integration should carry over into the larger community, beyond the walls of the building, in order to achieve health and prosperity within society as a whole. These service providers felt that a sense of community and connections between people could be created through effective urban planning. For example, one housing worker noted that it was important to ensure that people from different backgrounds live together in communities throughout the city:

> *We need to mix people up, making sure we're not segregating them.. Otherwise we get more and more places like Harlem that you hear all the bad reputations about. Ghettoes wherever they may be in the world. Making sure we're integrating and mixing up different socioeconomic groups…*

Support and Education for Landlords

Several service providers spoke about the importance of providing education and support to landlords who rent units to supported housing programs. Service providers spoke about the challenges they faced due to the amount of mis-information and stigma around mental health issues. Because of these issues, providing education about mental illness was critical to securing and maintaining housing. One housing worker explained: "*It's our role as well to educate those superintendents, to let them know what a mental illness is and to break down the barriers that way.*"

Service providers spoke about the importance of making connections, establishing contact and keep communication open with landlords and superintendents of apartment buildings. Providing support to landlords was also noted to be important so that they were more comfortable with renting units to supported housing programs. One housing worker remarked that the stigma around mental illness often made relationship-building with landlords a challenge, but that persistence and education made a difference:

> *The stigma is… it's very difficult to do but we try to explain to the landlords that this is not people who are what they think of as crazy but people who have [had] some kind of problem but now can be part of the community. And I explain to them that everyone of us can have some time in their life, some kind of emotional problems. So some… I will go back two, three times there then they will accept. They say, 'okay we will try just one of them'. When they see that these people are good people and they will begin to work so we will keep that relationship with the landlords and sometimes they themselves advocate for us, for others to connect to us, other landlords. So they become our reference here. So we have that building for many years. So it's important to keep that relationship.*

The relationship between service providers and landlords was different in the different types of programs. In one type, housing workers act as a liaison between the landlord and the tenant. They provide a significant amount of support to landlords in order to ensure that the tenancy goes smoothly and to maintain the program's units in that building. In this organizational structure, the agency takes on the lease with the landlord and then rents out the unit to the client; housing workers are responsible for supporting both the client and the landlord. This support to landlords was seen as critical to ensuring that the program continues to have units available for clients. Housing workers from this type of program noted that supporting landlords, by providing a 24 hour pager for them to call if there were concerns, has resulted in a very high rate of retention and buy-in from landlords:

In other programs, housing workers do not have the same type of direct contact with landlords. In those programs landlords contact the administration of the program if issues arise. The administration then contacts the housing worker to provide support to the client.

c. Supports offered in supported housing

Nature of Support

Type of Support

Some service providers described their role as providing support to residents over and above housing support alone. Others carried a larger caseload and their role had to be fairly focused on supporting residents in housing and providing support to landlords who rented units to the program. In both cases, service providers described their role as a coordinator of care, helping clients navigate different systems in order to get their needs met in housing and community life: "*We are in the middle. I always tell individuals we're kind of in the middle.. and we're navigating everything, we're coordinating everything*".

Service providers spoke about the importance of maintaining a long-term connection with residents. Some specifically highlighted the importance of this supportive relationship by noting that issues can arise even after years of being successful and stable in supported housing. For example, one housing worker noted:

> *Because we address issues… . as they arise, but just, ensuring that we continue that relationship with them, even if they have been housed and there are no tenancy issues. And 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. Although case managers and other community support workers maybe be involved with some clients, housing workers highlighted that those relationships might eventually end if the client is discharged after a long period of stability or if a client chooses to end the relationship. However, housing workers were in a unique position because residents in supported housing could not end their relationship with their housing worker: "*We're always there… we don't go away..*". Given the cyclic nature of many mental illnesses, this long-term support aims to provide security and stability without being too invasive or intrusive.

Service providers spoke about the challenge of providing housing support for residents who had few or no other mental health supports in the community. In some cases, residents did have case managers but those case managers had specific or limited roles. In such circumstances, housing workers often found themselves extending their role to provide some of this missing support in order to ensure clients were able to maintain their housing. One housing worker noted: "*If the supports aren't there, then we're finding that we're wearing that hat*." Another housing worker further explained:

> *As housing support workers in this particular program, we will move in… and do… everything, if somebody doesn't have case manager.. if they do have a case manager, but the case management program doesn't provide certain things.. then we move in and do that.*

Supporting Independent Living

Several service providers noted that although they provide many supports to clients, they ultimately want to encourage independence. Service providers spoke about the difficult transition from living in a shelter, an institution or being homeless to moving into a place of one's own. One housing worker described this transition as "culture-shock". She described how difficult it was for some residents to be suddenly living on their own with all the responsibilities of maintaining a home.

Another housing worker spoke about this transition in more detail. She described how, in order for the transition to be successful, it is important for residents to have a routine; something to do and a place to go. Otherwise, in her experience, things can begin to break down as participants begin to realize that many of their old problems still exist. She explained:

> *What I've noticed is that when people move in they're so excited to… come in and a lot of times they think their whole life is going to change. And all the problems that they have… are going to disappear… And they think okay… I'm going to have my own place, and all my problems are over.. And what happens is they move in… and they still have all the same problems. The only thing that's disappeared, is that they have one place, that's their own place. And, … once that honeymoon phase is over… then the work really begins.. because then, by then.. their apartments are getting kind of messy… they're still short of money.. they, still don't have loads of friends.. so everything is the same, and … slowly but surely… you know we try to implement some sort of a routine the same kind of routine that you or I, have, right. Get up in the morning… get washed, get dressed, have something to eat… have someplace to go… you know come home.. and do all the chores that, that need to be done, to keep your place in some sort of sanitary condition.. and that's you know.. life.. right?*

Some programs provided residents with furnished apartments. One service provider participant identified this as especially helpful to residents who were making the transition to having a home of their own. In other programs, apartments are not furnished. Under these circumstances service providers help residents find affordable furniture for their apartments and provide assistance moving furniture and appliances into the unit by arranging transportation for them or using their own cars. Getting the apartment set up seems to be an important step towards creating a home that is conducive to independent living.

Service providers noted that working towards true independence required attention to needs and supports beyond housing. For example, one housing worker emphasized the importance of education and employment in facilitating independence and success in housing by describing their intake process and what they were looking for in potential residents: *"We're looking for somebody who, in the long run, will be very independent and being able to find meaningful employment or expand on educational opportunities."*

Instrumental Supports

Support with finances, particularly with paying rent, was described as a key support provided by the service providers and was thought to be essential to maintaining stable housing;

the nature of this instrumental support varied depending on need. Many residents were reliant on income support through various social assistance programs such as Ontario Works or Ontario Disability Support Program. Several service providers discussed the challenges faced by residents who were on such limited fixed incomes. They had to learn to budget the money they did have so they were able to pay rent and meet their basic needs. For example, one housing worker described:

> *Some of the challenges… how can you expect someone to live and be able to support… and create a home when they live on, after they've paid their rent, $400? Once you've paid for your food now what? Not much. Some of them are the systemic problems of people being able to afford to live.*

A key role for service providers was to provide education and support around budgeting. In some cases, education about budgeting included connecting residents to community supports such as food banks.

For some residents who continued to struggle with budgeting, a viable alternative was often to connect them to a volunteer guardian trustee program so that a trustee could be appointed to manage their monthly income. A case manager described this process:

> *I think having the voluntary trustee is really important for some people. And it's hard .. there's not that many agencies that do it. In fact right now I only know of one that does it. And they have a waitlist. So… for some people that's… the caveat that they need, just to help them budget. And it is voluntary so they can change their mind whenever they want to.. and eventually after a certain period of time they may not need it anymore, they can set up their own bank account.*

Another option that worked well for some residents was to have their rent paid directly through the income support programs. In many cases, this option was described as facilitating stable housing by ensuring that rent was paid every month. One housing worker explained that for clients who become hospitalized, direct deposit could provide security and protection from eviction. Service providers described the instrumental assistance they provided in educating residents about their options and in helping them to connect to relevant community resources.

Service providers also discussed their role in helping residents deal with issues that arose when rent had not been paid and disputes with landlords came up. However, this role in supporting clients in such disputes varied depending on the particulars of each program and the relationship the service provider had with the landlord. One housing support worker noted that for some residents, maintaining stable housing would be facilitated if there was more open communication between their program and landlords. He felt that this would allow them to address the issue of unpaid rent before it became 'out of control'.

When issues with unpaid rent did arise, service providers provided a great deal of support to residents. Many spoke about their roles in working with residents and guiding them in how to respond to warnings and eviction letters from landlords. They provided guidance in negotiating back-payment plans and often acted as liaisons with landlords. Service providers described how this type of support was key to maintaining housing, as many clients were unable to manage these situations without support.

Building a Relationship

Several service providers spoke about the importance of building relationships with their clients. According to service providers, building relationships included building rapport, sharing information and establishing trust. One service provider spoke about the importance of other essential skills for service providers, but noted that what was most important was the ability to build relationships and trust with clients. She explained:

> *A certain knowledge about mental illness certainly you need that. And being able to work with the psychiatrists and hospital staff when that needs to be done. But as far as working with the client, I really think it's the relationship building, building the trust. I think that's key. You can have as much knowledge as we want and if we can't develop a relationship, then there's no value to it.*

Other service providers explained that they wanted to build open and trusting relationships with clients in order to be effective in supporting clients through challenges and successes. However, several service providers acknowledged that this type of relationship takes time to develop. Therefore, being patient and persistent and not giving up were seen to be critical. As explained by a case manager "*I think a lot of it is accepting the client for who they are. Starting from where the client's at. Being consistent, being persistent and developing the relationship*." A housing worker further explained the need to be persistent in building relationships with clients:

> *The other thing is, you meet a person, it's a new relationship, it takes time. It could take six months. It could take a year. You know what? Just hang in there. It doesn't mean that you're not a good worker, you're not capable or there's no hope.*

Service providers highlighted the importance of being persistent even when clients say they are not interested in working together. Service providers across programs noted that many individuals referred to these programs were used to people giving up on them. If service providers were persistent and continued to be available to clients, changes and improvements could be possible. One case manager described this process of building relationships with clients over time:

> *It's really difficult to engage with... you know some people are open to it, other people aren't. And it can take a long time to engage with someone. But just being persistent and being non-judgemental and just doing it. For the person to know that you're available. I think its important cause a lot of people have never had supports before so they don't really know what it's about, or how to interact or they're just not used to being supported. They're just not used to having that. So that can take a while for the person just to get used to it.*

Some service providers were critical of workers who gave up too easily or complained that working through challenges and supporting clients who were difficult to engage was not their job. From their perspective, workers had to try harder and find ways to engage clients in

supportive relationships. They felt that being persistent could motivate clients and make them feel worthy of support. One service provider noted that high turnover among program staff could hamper efforts to establishing trusting and supportive relationships with clients.

Access to Supports and Resources

Service providers emphasized that successful supported housing is not just about finding someone a home but about connecting them with other supports to enable them to maintain their housing. Residents often required support in other areas of their life, including establishing a routine and a healthy balance between self-care, productivity and leisure in order to fulfill the daily responsibilities of maintaining a safe and stable living environment.

Service providers often took on this broader role in order to support their clients in housing and maximize their opportunities for success and recovery. Given this role, several service providers discussed issues around accessing resources in the community. One case manager described in detail how access to resources was important in achieving stability in the community. He explained that many clients required access to key resources including appropriate medical care, finances and education as well as basic needs such as food and clothing.

> *When they started, they didn't have any supports at all.. medical, financial, doctors, or even family, they're most times disassociated from their families.. so.. You know just in terms of getting that stability and … making it through with them in the .. first year and helping them to survive that first year is.. important.. and then after that… things seem to fall in place*

Several service providers noted that some resources could be very difficult to access for people with mental illness. For example, some individuals required support accessing income support through social services and the bureaucracy involved was often very difficult to navigate for those with mental illness. They often required someone to advocate for them in this area. In general, service providers noted that access to necessary resources in the community should be simplified so that clients could meet their needs with fewer barriers:

> *Access to whether it's housing, access to social resources, access to education, access to employment, access to whatever they identify as needing. You need access… not just access, seamless access.. no barriers, no hidden agendas, no, you know… needing this, needing that..*

Social Supports

Many service providers spoke about the importance of supporting residents in developing social networks. Social supports were noted to be important both for recovery as well as maintaining stability in housing. Service providers spoke about the danger of clients becoming isolated, leading to a downward spiral in their health. One participant, a case manager, commented on this issue of isolation, "*that social connection is just so important so that people aren't isolated at home*". She went on to explain, "*I think it [being isolated] is a barrier to their recovery.*" Service providers noted that many residents did not have opportunities to interact with people in their communities and were often lacking the necessary skills. Service

providers also commented on how some residents had difficulty leaving their apartments. These participants 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 re-establish a social network. They were involved in connecting clients with social and recreational programs, either through their own facilities or in the community at large. Some service providers provided support to clients who wanted to re-connect with family members. They also provided support around how to get to know their neighbours. For example, one housing worker described:

> *I think socializing too and getting to know the neighbours who they're living with.. you know sometimes.. 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 cause family is also very important and people have maybe a brother and sister in the city or around, and they haven't been able to connect… So trying to make that connection also.. you know making connection with friends.. its just something all of us need… I think to live…*

Housing workers often provided a great deal of support to clients in order to prevent isolation. This support was typically in the form of linking clients to community resources and encouraging them to participate in community programs. When asked about supports to prevent isolation, one housing worker described his role: "*Knowing what's available, knowing the Blue Book like the back of your hand, is a very important aspect of being a community support worker.*"

Other service providers felt that it was important to be part of an agency that provided social recreation programs and employment programs that could prevent isolation. Similarly, a housing worker from one agency felt the structure of that supported housing program could be important in preventing isolation since all staff have a generalist role and are familiar with other programs within the agency:

> *I think that talks more about our agency and how our staff here have a very generalist role. Not only am I a housing support worker but I'm a case manager of a clubhouse. I'm also an employment support worker. So I understand different programs that are available out there. So I can see someone whose in their housing and say, 'Oh, these are other things that you're interested in. Let's get you connected to those other things.'*

When clients have access to this important kind of support, isolation is less likely to become an issue.

Support with Work and Education

The role of stable housing in enabling individuals to find employment and pursue education was highlighted. Service providers spoke about stable housing as a kind of springboard that could lead clients to improving and stabilizing other parts of their lives. Service providers described stable and secure housing as "*a basis and once you have that…you are*

able to focus on things to better yourself". However, there was an overall acknowledgement that housing on its own was not enough for recovery. As 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*."

Participants also spoke about their role in supporting clients to take the next step of exploring further education and ultimately employment. They spoke about connecting clients with community resources for supported employment and education. Some service providers were more involved in providing employment and education support than others. As one housing worker described:

> *I like the way that we're not just focused on housing but we have a whole bunch of other skill sets. So we bring those things in and… helping people get back to school.. help people get back to employment or volunteering or whatever it might be.*

Support during a Crisis

Almost all of the service providers spoke about the support they provided to clients who were in crisis. Service providers worked closely with clients to develop crisis plans when they were well so that issues could be dealt in the case of a crisis. Service providers related that they worked with each client individually to identify the things that had helped in the past when they were starting to feel unwell. They also wrote plans for what to do in the case of a crisis. The plans included phone numbers and lists of places the client could go to get emergency supports.

Service providers also spoke about preventing crises by being attuned to what was going on in a client's life. Several participants noted that developing a close and trusting relationship with clients was key to detecting the onset of possible crises. Being observant and taking note of any signs of deterioration during visits was noted as being important. A case manager described this process:

> *Some of the crises… for someone with.. it's related to their illness, certainly looking for the signs. I think when we go to visit looking for the symptoms, the observation, that's certainly important and something that we should be doing on every visit.*

Getting to know clients, asking about their needs and being familiar with a client's other supports, such as psychiatrists or social workers, was also highlighted. Managing a crisis was described as a team approach, with the housing worker taking the lead in some instances. As one housing worker described, "*We approach in a team, as a team effort, when somebody's is unwell. We approach the problem in a unified way. So a housing worker will take the lead and find out what is going on.*"

Some service providers played an active role in crisis management, depending on the structure of the program they worked for. They spoke about visiting clients more frequently when things were not going well, in some cases doing nightly checks. They also spoke about accompanying clients to psychiatrist appointments or to the hospital when necessary. 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.

Unfortunately, some service providers described feeling that they were working "*from crisis to crisis*" with some clients. These circumstances caused tremendous strain on the service provider and could undermine efforts towards recovery and improved quality of life for residents. For example, one housing worker described:

> *But sometimes you know, you can sense that things are not going well. And if you intervene sooner, rather than later, they may have a little more insight and they may be willing to go into hospital, and the hospitalization might be shorter anyway, because everything is happening sooner. You wait until somebody is really, really sick, and you don't keep them in long enough to get better… then it's like a revolving door. And how does anyone have like any kind of quality of life?*

Housing workers spoke about the importance of educating landlords and superintendents about what to do if a crisis should arise. In one program, superintendents were given a pager number in order to contact the housing worker should a crisis arise. As described by a housing worker in this program:

> *So we do a lot of education and I find that it helps… you know when we first have contact with a landlord, I find that education helps… for when crisis occurs. Then they kind of have an understanding and they know that we're going to be there.*

Housing workers from this program noted that providing this pager helped them stay on top of issues that arose and resolve them before they became larger issues.

Support Managing Health

Service providers spoke about the support they provided to tenants around health issues in general, both mental health and physical health. One support that seemed to be critical in the opinion of some service providers was touching base with tenants about taking their medications. As one case manager explained, "*interacting with them as well, just seeing them on a weekly basis… and checking their meds, and telling them how important it is to take their meds seems to help.*"

Other service providers spoke about providing support and education to clients around improving their physical health. Some service providers emphasized the connection between physical and mental health and how helping clients manage their physical health concerns would ultimately help them feel better and translate into improved mental well-being. This connection was noted to be particularly important for individuals who were aging. One housing worker explained: "*I think in our housing now a lot of people are aging, so providing them with nutritious meals, pointing them in the direction of healthier meals… taking care of their health concerns is important*."

d. Neighbourhood and Community Context

Community response to SH

Several service providers felt that in general the community responded in a positive way to the concept of supported housing for persons with mental illnesses. They described how community members would often help each other out, look out for one and another, and alert service providers when there was a concern: "*So I think in the community around here where they live, the people are… the shop owners and the coffee shop staff are sympathetic and protective and interested*". Service providers also felt that their own presence in the buildings and in the community was seen as helpful, because other tenants, concerned neighbours and shop owners felt they had someone to go to with questions or concerns, and that there was somebody who was providing support and assistance.

Relationship with Neighbours

Service providers spoke about the relationship between their clients and their neighbours, as well as their own relationships with the neighbours in the communities where they worked. Service providers noted that some neighbourhoods were very accepting and supportive of supported housing and persons with mental illnesses and that they had been able to develop good relationships with the other residents in these communities. For example, one housing worker felt that these positive conditions were partly due to the openness and tolerance in the particular community in which he worked:

> *I mean this particular neighbourhood or area… one has to be very open minded and it would be very difficult for anybody who was rather rigid in their outlook to be a resident in this particular neighbourhood for a number of reasons so I would say that in this immediate neighbourhood, there's a lot more acceptance and tolerance of alternate lifestyles.*

Other service providers spoke about neighbourhoods that were not as accepting and how at times, less positive relationships with neighbours could develop. In some cases, clients were taken advantage of due to their mental illness. One housing worker explained:

> *Sometimes it's other people that live in the building, that become a challenge for people… people being taken advantaged of because of their niceness. I can think of one person, I didn't support him directly but he lived in supportive housing, how he was in this building and so nice he would give his shirt off his back, his food out of his fridge… and be taken advantage of because he was so nice. I've seen people who I have supported in housing become unwell and the voices telling them, "I should help the people that are on the streets." Who have then gone out, and let prostitutes and crack heads, and other unsavoury characters move into their apartment and convince them "Oh let's sell your television." "Let's get rid of this." And do things that cause problems in the building… that work against them.*

Service providers spoke about how negative relationships could also develop when a client became unwell and behaviours emerged that were difficult for neighbours to understand or live with. One housing worker explained that the only complaints she had ever heard from neighbours happened when clients became unwell and were unable to access the medical services they required. These clients engaged in behaviours such as yelling, that are very disruptive to neighbours. Substance abuse by clients was also noted by service providers as having the potential to significantly disrupt relationships with neighbours in a very negative way.

Fit – Person to Neighbourhood

Several service providers spoke about the importance of finding a good fit between clients and the neighbourhoods and buildings in which they are housed. Some service providers said that ensuring a good fit is the main purpose of their initial intake assessment. One housing worker described this process:

> *When we do the assessment, we're looking for fit. Cause we already know the landlords in the buildings that we have out there. So we want people to feel like they're being integrated into a community, that they're fitting in, that they don't stand out… 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.*

Another service provider, a case manager, explained that over the time supported housing has been around, the programs have become acquainted with the different areas of the city. They have recognized the importance of finding safe and healthy neighbourhoods for clients rather than just focusing on getting a roof over someone's head. Service providers now focus on ensuring a good fit between the neighbourhood and the resident.

Service providers spoke about the various things that that they take into consideration when attempting to make a good match between a person and the neighbourhood. They explained that they will take culture and demographics into consideration. As one housing worker noted:

> *We want to take a look at what the demographics are [of] the individuals that already live in that building. We wouldn't want to put one of our clients at risk of being targeted so we definitely try our best to make sure there's a good match.*

Service providers also considered the services available in the neighbourhood and accessibility to transportation, shopping, doctors as well as friends and family. One case manager explained that these considerations are particularly important to ensure that clients do not become isolated:

> *A lot of these guys that first came… downtown people that used to live there moving out to another area not really close, not really accessible to the people they knew before, contributed to the isolation that had happened a lot of times.*

For some people, moving closer to family support was extremely helpful. One housing worker related: "*I moved him from the community he was in, so that's put him closer to family support. Family is also crucial. It's another piece. Involvement of family supports working with individuals*."

Many service providers spoke about the issue of placing clients who have concurrent drug abuse issues into housing. They explained the importance of not placing such clients into neighbourhoods or buildings that are drug infested. As one case manager put it, "*If they're dual diagnosed (with) a history of substance abuse… put them in a corner where there's a beer store across the street may not be appropriate.*" Another housing worker provided a very vivid illustration of the impact that the neighbourhood could have on the success of clients in supported housing. She provided an example of the improvements she has seen with clients who have substance abuse issues when they are moved to more suitable neighbourhoods with less illicit drug activity:

> *Sometimes we have had success where just moving someone from a community, because maybe the community is so drug infested that they didn't have a chance to begin with, so moving them… and they'd been fine. We've had some situations where it's worked out nicely.*

Service providers spoke about the importance of considering all of the parties involved when finding housing for clients. As one service provider explained, it is important to make sure that the building is a good fit for the person but also that the client is not going be disruptive in the building:

> *I guess we have two objectives to achieve and that's wanting to make sure that the people who live here are not menacing or a danger to the building, because we want to ensure good relationship… and as well to ensure that they [the clients] are going to be happy here also.*

Safe, comfortable, clean housing

Several service providers highlighted the importance of having supported housing units in safe neighbourhoods when finding housing for clients. Service providers spoke about ways of dealing with unsafe neighbourhoods. For example, one housing worker noted the need for increased security in certain buildings where there were clear safety concerns. Another housing worker explained that the program she works for tries to avoid securing units in neighbourhoods that are known for being unsafe:

> *So we try our best not put any of our clients at risk. We definitely, if we know that there's danger because of drug dealing or prostitution or, we definitely… if we do already have a unit there, we try to get rid of that unit and do what we can to accommodate the clients in terms of transferring them to a safer community.*

Furthermore, service providers commented on the importance of the apartment buildings themselves as a type of community. One case manager suggested that a safe building is essential in achieving successful community integration:

> *I think housing in areas that are safe… there are certainly some neighbourhoods in the city that are safer than others. Some apartment buildings in the city that are safer than others. So I think being able… for the person to be in a mainstream apartment building is important. I think it helps that person feel like they're part of a greater community.*

Beyond the safety of the units, service providers spoke about the importance of providing comfortable and clean housing. They explained that good housing is about more than having shelter; it is about creating a home. As one service provider explained:

> *I think some of those theories… "Oh you've got a house. You have a roof. You have shelter."… forget about having a home. Some people don't necessarily put the weight on that, on having a beautiful place where you feel comfortable and safe and, and it's like, "oh this is just the place I crash." And that's okay if that's what they are like. But if you can't create something, a healthy place to start from. How can you expect someone to have a healthy aspect of… out of that?*

A safe, comfortable and clean environment is critical to self-esteem and a sense of self-worth, which ultimately leads to increased health and wellness. Service providers spoke about helping clients to create this environment for themselves. Due to illness and medications, some clients may struggle to find the motivation to do this on their own. One housing worker explained:

> *Sometimes people don't feel that they want to clean and you know the medication they take… doesn't motivate them to do so many things. So I think helping them with those chores certainly gives them a little perk in their life and I think they feel so happy to know that there is somebody by their side.*

This service provider went on to explain that helping residents maintain a clean and comfortable home should be given greater priority in supported housing services. Specifically, she felt that residents would benefit from a fresh paint job, new furniture, and assistance from a cleaning company every five years to make them feel good and keep them motivated to maintain their housing.

Service providers also spoke about the responsibilities of the landlord to help create a safe, clean and secure building through building maintenance. Unfortunately, service providers noted that not all property management companies and landlords were willing to be proactive and cooperative in this regard.

e. Impact of Supported Housing

Some of the key outcomes of supported housing were discussed at length by the service providers. Service providers highlighted the goals they were striving for in supported housing and the way stable housing acted as a foundation to allow individuals to pursue their other recovery-oriented goals and become more active in community life. Supported housing seemed to result in increased self-confidence, but could at times lead to isolation. Service providers also

described instances when individuals were able to move on from supported housing, into more independent living arrangements in the community.

Goals of Supported Housing

Throughout the interviews service providers referred to the goals of supported housing. Several service providers commented that the ultimate goal of supported housing was for clients to eventually move on into more independent living situations. However, service providers outlined many other more immediate goals of supported housing. For example, service providers stated that enabling clients to maintain housing was the first goal of supported housing. Many clients coming into these programs were previously homeless and living transient lives within the shelter system. Some service providers highlighted supported housing program's aim to meet each individual's goals by enabling them to develop the necessary skills for independent living and to "ensure that someone is maintaining a healthy, happy, safe home environment".

Other goals outlined by service providers included: participation in social recreation and exploring options for work and school. For example, one housing worker noted that ultimately, enabling clients to have a productive role in society is a goal of supported housing.

> *To see that this person can be easily integrated into the community..and can keep their house for some time and they become part of the community, [a] productive person in their community.*

Several service providers noted that employment is one of the goals of supported housing. The aim was to provide a stable place from which clients could begin to explore options for work and look for employment that would lead to greater independence and continued stability. When asked about what outcomes they were striving for in supported housing, one housing worker explained:

> *To see people get gainful employment and you know… what does stable mean? We're all unstable at times in our lives but [to] reach a point where they can live in the community without having us there for them and be able to afford the rent.*

Integrating clients into the broader community was frequently mentioned by service providers as one of the goals of supported housing. For example, one housing worker explained*, "from a housing perspective we look at the length that they've been housed, not just by length of housing but their ability to successfully integrate into the community."* They highlighted the importance of clients becoming engaged in the community and not being isolated in their homes.

Supported housing seemed to play an important role in achieving more integration in the community. One housing worker expanded on this idea. When asked about the goal of supported housing, she described the importance of becoming integrated into the broader community in a way where clients are not defined by their mental illness but where the illness is just one piece of who that person is overall. She explained how secure housing through supported housing was often the first step in this process:

> *It [supported housing] allows people to feel that they're part of the community and move forward with their life. Whatever that might look like. Move their life with their journey. Be part of the community without having to feel that... A mental illness is just one piece of the puzzle of a person, who the person is, it's not they're whole existence it's just a little piece, and often people don't feel that way. Often they're not led to feel that way… You're a person first that has all sorts of goals and aspirations and your identity is not the fact that you have a mental illness.*

A cautionary message offered by service providers was that supported housing involved significant risk for isolation. Several service providers noted that isolation was an important concern and could occur when individuals moved from group living environments into their own apartment. Service providers explained that isolation caused difficulties for clients and threatened their housing stability. For example, one housing worker noted, *"And then there are other people, who once they get into their apartment, they shut their door and they start drinking or they do drugs or they don't want to have anything to do with anyone."*

Housing as a Foundation

Overall, service providers reflected the belief that stable housing is a foundation for recovery and community integration. Supported housing was described by service providers as a first step, a way *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. A housing worker expanded on the importance of housing in the overall process of recovery, *"You have to have a roof over your head, a good night's sleep, somewhere you can go and relax and then the rest follows from there."* Other service providers spoke about how stable housing was a way for clients to begin to improve and stabilize their mental and physical health, to learn how to be more independent and ultimately to be able integrate into community life. For example, a housing worker stated:

> *How can you pursue going back to school and improving your life, getting a job, even if it's only five 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?*

Several service providers described how supported housing was the first step in moving towards stability and independence for many of their clients. Many service providers shared stories of clients who had improved their health, returned to school, returned to work, re-connected with family, began volunteering, became engaged in social activism and re-engaged in social activities after moving into supported housing. For example, one case manager explained:

> *Other clients didn't talk to family… were off their meds for 18 months… and having housing just ignited all those other things to happen… Just having a*

> *telephone, just having a bed to stay in, shelter… sooner or later they… you know the first year they don't budget their money very well.. but after that, just living there and realizing … has helped them learn how to budget their money and buy food properly. My role comes in there just talking about how important three meals a day is, how important taking your meds are, how important it is to look after your physical health and all those things seem to really have happened after being stabilized in housing.*

Increased Confidence and Stability

Service providers felt that their clients experienced an increase in confidence after finding stability in their housing. Service providers noted that this increased confidence became evident as clients became more independent in accessing community services such as public transportation, and reconnecting with estranged family members. For example, a case manager described this change as clients become stable and settled in supported housing:

> *I just find that after awhile they start feeling better about themselves because they get into housing and they think that it's not going to last... it's just a temporary thing, based on their history. They've been transient, they've been all over the place. And when they get it, there's almost a part of them that expects it to fail. And they've been there for a long period of time, and one of the things that has helped too as well, is ODSP is directly deposited their money to us.. So they don't touch it at all.. so that just ensures that the housing, is theirs for as long as they want. So just having that thought that they could stay there for as long as they want and it's just a trickle down effect, everything else seems to happen… they get courage to call their family and say, "Look I've been here for a year or two. This is my place, come and see.*

Participants spoke about the increased confidence of clients in stable supported housing and the impact it often had on the rest of their lives. For some clients this increased confidence enabled them to move forward in their lives and pursue their goals for work and school. For example, a housing worker explained:

> *And that's what we really strive for because again once you have confidence, once you feel good about where you live, then other things are going to take place so you'll be confident enough to go back to school.*

Service providers described how individuals responded to their living conditions. When provided with the right conditions, individuals seemed to thrive and overcome many barriers to recovery. Having a safe and stable place to live, "just makes people feel good about themselves".

Moving on From Supported Housing

Moving on from supported housing was often described as the ultimate goal. For example, one housing worker explained, "*I guess the ideal is to get a job and maybe eventually get out of supportive housing in general and move on to a more independent lifestyle*." Another

housing worker explained that she has worked with clients who have been in supported housing and over time have come to realize that they do not need the support and that it is time to move on:

> *We've had people that have moved on, moved out of our housing because they're doing so well, they're working, making more money than me and you know… they move on, let someone else have the subsidy and that's what it should be. Not everybody can do that but that's what it should be about, people moving on and allowing those who need the housing access to it. We do have people that have moved on. And it's nice to see that.*

On the other hand, some clients may no longer need the support but still require the rent subsidy, especially given the limited income provided through income support programs and the high cost of living. In these cases, housing workers might help their clients move on to a subsidized or affordable unit outside of supported housing.

Moving on from supported housing was described as a complex and individualized process. Although it occurred in some cases, some service providers cautioned that it was not an appropriate goal for everyone. As one housing worker explained:

> *For others, it all depends on how well they are and we have some people who are really, really, really sick. Always in state of being unwell and for those clients it's really just providing support and making sure that they have all the basic necessities, and making sure that they get to the doctor and making sure that they have what they need, that they're not lost out there.*

Despite the fact that some clients may need long-term support, many clients were able to move on from supported housing to more independent living arrangements. Service providers highlighted that there were many prerequisites to being ready to move-on from supported housing. However, consistency in housing could provide the stability needed to begin to improve other areas of client's lives, allowing them to take better care of themselves, become more independent and eventually move on. For example, one housing worker described this process that occurs for some clients:

> *And then with other clients, they come in, if they don't have a doctor they get a doctor, they look after their mental health, they take their medication, they do everything they need to do. They get transitional employment jobs so they start to work, they start to earn a little money, they feel more independent, they decide sometimes that they don't really need so much support. They get themselves on a waiting list for a subsidized apartment without support, get themselves work outside of [the clubhouse] and they move out. That's the ideal. And it happens. That's the great thing.*

In some cases, family support was described as be critical to helping clients stabilize and eventually move on from supported housing.

f. Program and system issues

Throughout the interviews, challenges and issues related to supported housing and the mental health system in general were discussed. In several cases, the service providers highlighted tensions they struggled with in their work with clients in supported housing. Issues included how housing workers worked with other community supports, the separation between housing and community supports, a team approach to providing services, liaison between tenants and building management, the essential skills of service providers, the importance of building relationships, and the fact that the supported housing model is not for everyone.

Housing workers work with other supports

Several service providers commented on the importance of working closely with other supports in the community when trying to help clients maintain stability in housing. The nature of these relationships was different in each program due to differences in service provider roles. However service providers from all programs felt that open communication with a client's other clinical and community supports was important but was not always as effective as it could be. One case manager commented:

> *I think the more communication there is, that helps support the client. Whereas I think some service providers like to keep it more separate… I guess I don't really agree with that separation. I think there should be a sharing of information. I think it works to the benefit of the client.*

Service providers spoke about the challenges of working with law enforcement who were sometimes called in to intervene during a crisis. One manager noted that although training of police officers has improved, there are still many instances where they do not have enough knowledge of mental health issues.

Several service providers spoke of the challenges of communicating and working with clinical supports such as doctors and psychiatrists. Some felt there were few doctors in the medical system in general and believed that this shortage led to shorter and less thorough appointments; furthermore clients could become reliant on walk-in clinics where they were unlikely to build relationships with their doctors. Unfortunately, these conditions limited the capacity of case managers and housing workers to interact and work with other clinical supports involved with their clients. One case manager described:

> *Not enough doctors… so you don't get enough time to really deal with the therapeutic issues that are going on. Most of the time you'll spend two hours in the waiting room, have a five, ten minute meeting communicating your concerns to doctors, most times you know they don't really absorb the gravity of what's going on, and you know that's frustrating from our point, because we see the client is not doing well. But to communicate that to doctors sometimes… I'm not sure if they have time to really focus too much.*

Many service providers highlighted that working with a client's other supports was especially crucial to maintaining housing and getting appropriate help when experiencing crises.

A housing worker highlighted this concern by describing the issue of limited hospital beds. She expressed concern that clients were not being admitted to hospital until they were very ill and then being discharged too soon. From her perspective (working in the community for over 20 years), leaving clients until they were so deeply into a crisis situation caused numerous problems that could significantly threaten their housing. Problems included difficulties with landlords and property managers when clients became so unwell they were causing disturbances in the building:

> *The issue is still the same and that is, when we see people becoming unwell… and we look to the physician, the psychiatrist to admit the client to hospital, the client doesn't get admitted to hospital.. or if the client is admitted to hospital, sometimes the doctor will wait until the client is so sick. It shouldn't have to be that the client has to become so unwell… But when that happens day after day after day, because the person really should be in hospital and they're not and the behaviour continues, we're scrambling to try and pacify the property management…So that they can…satisfy the neighbours and our client can maintain his housing..*

Service providers also commented that there were gaps in the supports that are available to clients in the community. At times, housing workers may provide some of that missing support. However, it can become a challenge to navigate these roles and ensure that clients are getting the support that they need without overburdening housing workers who often carry very large caseloads. A housing worker explained the benefits of having other supports involved with clients. When other supports are present she can focus her attention to housing and tenant issues:

> *So if the supports are there, it makes it a lot easier our role, because then it's clearly defined. They can support the tenant. We can address any issue that might have arisen. If it was behavioural, if it was a tenant issue where it's impacting the housing… and we can also support the landlord and reassure them that we are dealing with the matter.*

Separating housing and community support

Throughout the interviews the issue of separating housing support from other community support was discussed. The type and amount of support each service provider was able to provide varied depending on the unique features of each program. Many service providers commented on the tension between their role in supporting clients around housing issues and providing other types of supports to clients that contributed to their overall recovery and stability in the community. These tensions were exacerbated when clients became disconnected from their community supports or those community supports were unavailable.

Several service providers spoke about extending their roles in supported housing to fill in gaps and meet the needs of their clients. In some cases, this extended role presented particular challenges. One housing worker explained:

> *That's a bit of a… difficult area, because we carry a caseload of fifty right. So it's fifty to one. We can't.. and if you have ten people on your caseload,*

> *that don't have supports and that aren't so great, there's other forty, you know.. how do you respond to any issues that come up?*

In one of the programs, service providers had more generalist roles. They might be housing workers for one set of clients and employment workers for another set. One service provider commented that the advantage of this type of set up was that as housing workers, they were very aware and connected to other community supports and able to easily connect clients to those supports.

Service providers spoke about the challenges that arose when clients become disconnected from their community supports. In these cases, service providers in housing worker roles often 'scrambled' to re-connect clients with appropriate supports and provide them with what they needed. As one housing worker explained:

> *That's a dilemma too, when they're discharged and someone becomes unwell. We've had tenants that's been with us say seven years, and for four to seven years they've been doing great and then they become unwell. And they no longer have supports. And so we have to be out there constantly supporting them through this, trying to get them to engage with a case manager or an ACT Team or whatever…*

Such situations caused particular challenges for housing workers who carried high caseloads and needed to maintain a clear separation between their designated role and a more general community support role. In such circumstances, programs where housing workers are also case managers may be more successful*, "So that part is a bit challenging but I think it's good having the dual role… like they're the case manager and the housing worker I really think that works".*

Another challenge is encountered when the supported housing program carries the lease and acts as the landlord. In such circumstances, conflicts can arise when individuals get behind on their rent and the housing worker is forced to pursue eviction and take them to the housing tribunal. Although housing programs try to be proactive and avoid this type of situation, it did come up. This became particularly challenging when tenants did not have other community support and the housing workers acted as both the source of housing support and community support.

Team Approach

Working together as a team was highlighted as key to successful supported housing by several participants. Service providers from one particular program noted that within their program they had the flexibility to shift caseloads from one person to another; this was felt to be an important aspect of the team approach. One participant described this support from his team and noted the importance of having a team of people to collaborate, brainstorm and problem-solve with around challenging client issues that arise:

> *Knowing that I have a supportive team behind me…That when I go away on vacation, that if I mention that certain things are going on and certain things are happening, that my team is going to be there and support with that. That if I'm struggling with something and I don't have an answer with*

> *something that I can turn to my colleagues and say, 'what can I do? Do you have any interesting ideas?'*

In one of the supported housing programs, mental health residents were part of the team. One housing worker explained that one of the advantages of this model was that residents had much more insight into the experiences and needs of other residents.

In some cases, a team approach was defined broadly, extending beyond the boundaries of a particular program or agency, and included the other supports involved in a client's care. Taking a more integrated approach to supporting clients in supported housing was highlighted by several service providers as being important; however, maintaining a consistent contact with clinical supports beyond the program/agency was found to be challenging in a climate of limited resources.

Liaison between tenant and building

Service providers described their role as a liaison between the tenant and the building in supporting clients in supported housing. They described how they would assist clients to address issues that came up and advocate on the clients behalf if needed. Issues included basic sanitation and cleanliness of the building, noise from neighbouring apartments and rising rent prices. For example, one participant described the housing worker role in this area:

> *Sometimes acting as a liaison between the person that lives there and the building. In case there's problems; a noisy neighbour, not knowing what to do, how do I handle this. If needed sometimes being that go-between person to talk to them and give them that support. But ultimately it has to come from them so maybe if there's a language barrier or writing problems, helping filling out the forms. Giving that confidence and let them know that we're there to give them that help..*

In programs where housing workers were not in direct contact with landlords, communication gaps between landlords and housing workers occurred and threatened housing stability. Housing workers in these programs spoke about their role in acting as a liaison between the tenant and their building.

Several service providers made note of the important balance between helping clients by working with landlords while also trying to get clients involved and do as much as possible themselves. One housing worker spoke about a case where a tenant was hospitalized and the housing worker connected with the landlords to prevent them from sending eviction notices which could compromise the client's recovery. However, service providers once again noted the need to be proactive in preventing these kinds of circumstances by establishing open communication with the property management company and encouraging clients to be actively involved in this process:

> *Trying ultimately to prevent those things, but not doing it on my own. Making sure that the members and the people that live in that housing are part of that process and have a sense of control… that they're capable of doing those things.*

Unfortunately, some of these challenges were grounded in the inflexible policies and bureaucracies of large housing corporations that managed some of the buildings: "*Sometimes it's their policies that they have about certain things that end up being a bit more of a challenge*" . However, establishing relationships with landlords, superintendents, and representatives from the property management corporations did help service providers to support clients in maintaining their housing throughout various crises that came up.

Essential skills of service providers in supported housing

Throughout the interviews, service providers spoke about what they felt were the essential skills needed to be successful working in supported housing. Service providers spoke about some of the practical skills that have helped them in their jobs. They spoke about the importance of basic knowledge of mental health issues, knowledge of community resources and social services as well as knowledge of active listening, communication and problem-solving techniques. They spoke about being creative in problem-solving and thinking 'outside the box'.

Several service providers spoke about the importance of empathy. They spoke about being non-judgmental and open-minded, and highlighted the importance of acknowledging different cultural issues and being open-minded about a client's lifestyle choices. A few of the service providers spoke about the importance of optimism and of holding 'hope' for the clients. As one service provider commented;

> *Ultimately I think a lot of it comes down to your personality. How you see people, how you see people's potential that they have. Having that optimism and belief and hope in people that they can change and they can grow because if you don't believe it, they're not going to believe it in themselves.*

Service providers spoke about the importance of self-awareness, of being aware of their own attitudes and the impression that one makes on others. Others spoke about being respectful and professional, knowing when to draw the line with clients. They also touched on the importance of knowing how to leave work at work and take care of one's own mental health. One service provider spoke about the importance of working for an agency that provides opportunity for learning and growth.

Supported housing model is not for everyone

Some of the service providers spoke about the importance of recognizing that supported housing may not be the appropriate type of housing for everyone. A few service providers noted that moving is stressful and so it is important to make sure that someone is appropriate for the program and ready to be in an apartment on their own before accepting them into supported housing. These service providers explained that certain individuals who are heavily involved in drugs, who have been in the shelter system for a long time, who hoard, and who require more intensive support than provided in supported housing may not be appropriate for this type of program.

One participant also noted that there are critical gaps in the system and that there is not always a place for people who struggle with particular issues. Unfortunately, some individuals

may have nowhere to go except a shelter or the street because of a lack of appropriate services. She explained:

> *The other thing too is, where do people go who have a history of fire setting? Where do people go who are actively involved in smoking crack and all those kinds of things? Should they really be in a shelter only and kicked out in the morning? And they have to hang around on the street all day… maybe that's why they're smoking crack, cause there's not somewhere… Those people have nothing or very little and that doesn't seem quite right either. So there's gaps, you know.*

Despite acknowledging the need for different types of housing, service providers highlighted that there remains a shortage of supported housing for individuals with mental health issues who would greatly benefit from this model of support.

6. Implications of Findings and Recommendations

This study has built on previous research by providing rich information on the characteristics of successful and desired supported housing. Through a review of current literature on supported housing, combined with information gathered from interviews from residents of supported housing and service providers, a set of key characteristics has been developed. It is interesting to note that service providers and residents highlighted many similar characteristics as being important to effectively maintain, enjoy and move forward from supported housing. These key characteristics include the importance of choice in type of housing and in levels and nature of support, the importance of housing that is long-term and permanent, and the central role of the relationship between residents and service providers. The findings of this study also highlight the importance of awareness and attention to stigma about mental illness. Specific supports that lead to success and stability in supported housing include; support connecting residents to social networks, providing access to community resources, support during mental health crises and support for residents who want and need to learn independent living skills. Residents are more likely to find stability and a sense of well-being in safe, clean and comfortable environments and in neighbourhoods that have access to public transit and local amenities.

When supported housing is successful it can provide a foundation from which residents can take stock of their past experiences and begin to consider their futures. It provides a risk-buffering support that enables engagement in opportunities that have been deprived or abandoned in the course of illness and in the face of societal stigma. Indeed, supported housing promotes recovery and provides what Appadurai (2004) refers to as the “capacity to aspire”, the capability to imagine futures and find ways to shape them. Successful supported housing provides residents with the independence, stability and freedom to pursue life goals including returning to work, school, volunteer work and reconnecting with family and other social circles. Many residents expressed that having a home to care for provided them with daily structure, responsibilities and a sense of purpose which improved their sense of well-being. Having a safe and private home of one’s own provides residents with a sense of hope and builds self-esteem. Residents commented that finding stable housing provided them with the motivation to better care for themselves and to become involved in community life. Successful supported housing is clearly the first step towards stability and independence for many residents.

While this research highlights a number of characteristics that clearly contribute to successful supported housing, it also points out some tensions and unresolved questions. The issue of clustered versus scatter housing is a complex one: while some residents appreciate the solidarity and support of clustered housing, the risk of stigma often outweighs the need for support; most residents prefer scatter-site housing despite the loneliness that may accompany it. This “trade-off” is one that requires careful consideration on the individual level, as well as active anti-stigma action on the broader level, in order that individuals may live in their environments of choice. The tension between independence and isolation is another issue that

calls for careful consideration of levels and nature of support that are embedded in supported housing programs; clearly, the desire and need for support and intervention varies across individuals and contexts. Indeed, while this research points out the many forms of support that are valued and associated with positive outcomes, there is a need to further elucidate the ways in which support is enacted, graded, and made available to residents of supported housing.

Current literature calls for more research that outlines best practices for supported housing. The current research begins to clarify some characteristics of housing that generate positive outcomes for persons living with mental health illness. Most importantly, it incorporates the perspectives of the residents and service providers who are most involved in supported housing programs.

It is recommended that the findings of this study be used to advocate for increasing levels of resources for good quality supported housing. The findings also point to the necessity for continued research in this important area. The key characteristics of successful housing outlined in this study require further research to determine whether some characteristics are more influential on outcomes than others and to assess the effects of various combinations of characteristics. These determinations can then be used to formulate standards of service delivery and recommend levels of fidelity. This research can be used in the development of new supported housing programs, in peer review and evaluation of existing programs and to determine plans for expansion or program development. Ideally this research will provide residents with more tools for self-advocacy in the search for adequate supported housing.

Some specific recommendations for supported housing are outlined here:

1. More good quality supported housing: Residents and service providers commented on the need for more housing for adults with mental health issues. They also made clear the very positive impacts of housing, when it is successful.

2. A range of type of housing is necessary: Residents have individual and unique needs. Some residents will benefit from housing that is clustered, where they live in a building with other residents of supported housing. Other residents will find more success if they are supported in a single unit within a conventional apartment building where they can remain ‘anonymous’ regarding their illness. Residents also have different learning curves and are at different stages in their lives and in their illness. The size and requirements of units will differ from person to person as will the neighbourhood in which they are most comfortable. This research and current literature point to choice in housing as central to successful supported housing.

3. Housing must be long-term/ permanent: It is clear that residents require a sense of stability and decreased stress in order to manage their mental health issues and move forward with their lives. Some residents will require ongoing supports in order to remain stable in housing due to the nature of their illness. For these reasons long-term and even permanent supported housing is necessary.

4. Flexibility within programs and within service provider roles is necessary:

a. Flexibility is necessary to provide residents with choice in the housing process. Having choice and the autonomy to make decisions about their living situation empowers individuals.

b. It is important that individualized support be provided to residents. The level and intensity of support must vary as needed by individual residents. Support should be tailored to a resident's unique goals. All of this requires flexibility within supported housing programs and especially within service provider roles. Service providers commented on the limited availability of doctors and community programs such a substance use programs. These gaps in other supports means that housing workers sometimes try to 'stretch' themselves to fill in for other supports but they themselves may have limitations on their time. This highlights a need in the community at large for more services. However, several service providers from one particular agency commented that they found having smaller caseloads and being trained to provide a variety of supports to residents, worked very well.

5. Housing must be located in safe neighbourhoods with access to public transit and amenities such as grocery stores and banks.

6. A series of specific supports is required and has been highlighted by this research as being important to successful supported housing. These include:

a. Support connecting to social networks is key. When residents are able to connect to social networks including friends and family this reduces loneliness and isolation, promotes recovery and leads to greater housing stability.

b. Residents often require support in accessing other needed resources such as health care, financial resources, work and school. Accessing these community resources can often be very challenging and especially challenging for an individual with a mental illness. Access to these resources when needed leads to an increased sense of well-being for residents and stability in housing.

c. Support for and during crises is essential. In order to maintain stability in housing many residents require support in learning how to manage symptoms and plan for how they will manage potential mental health crises before they happen. In the event of an actual crisis, support can be critical to maintaining stability in housing.

d. Support and assistance in learning skills for independent living was noted by both residents and service providers as being important for success in housing. Specific skills to consider are home care skills (such as cleaning and cooking), budgeting skills and self-care skills.

e. It was also noted that when there is an outside landlord involved in the housing, it becomes very important to provide support and education to the landlord about mental illness. It can also be important for service providers to work as liaisons between residents and landlords in some cases.

7. More integration among services, collaboration and good communication between all support people is necessary and improves a resident's chance of achieving stability and staying well.

8. Attention needs to be paid to the relationship between residents and service providers. It is important to ensure that service providers have the training and support that they need in order to develop and nurture good relationships with residents. Essential skills for service providers were highlighted including; 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. It is clear from this research that a good relationship between resident and service provider is instrumental in achieving success at each stage of the supported housing process.

References

N.J. governor signs landmark housing bill for people with MI: State is one of the most expensive housing regions in the nation.(2005). *Mental Health Weekly, 15*(31), 1, 4.

Allen, M. (2003). Waking rip van winkle: Why developments in the last 20 years should teach the mental health system not to use housing as a tool of coercion. *Behavioral Sciences and the Law, 21*(4), 503-521.

Allen, M. (1996). Separate and unequal: The struggle of tenants with mental illness to maintain housing. *Clearinghouse Review,* 720-739.

Appadurai A. (2004) .The capacity to aspire: Culture and the terms of recognition, in Rao, V. and M. Walton (Eds.) *Culture and Public Action*, CA: Stanford University Press (pp.59-84).

Aubry, T., & Myner, J. (1996). Community integration and quality of life: A comparison of persons with psychiatric disabilities in housing programs and community residents who are neighbours. *Canadian Journal of Community Mental Health, 15*(1), 5-20.

Bebout, R. R. (1999). Housing solutions: The community connections housing program: Preventing homelessness by integrating housing and supports. *Alcoholism Treatment Quarterly, 17*(1-2), 93-112.

Bebout, R. R., Drake, R. E., Xie, H., McHugo, G. J., & Harris, M. (1997). Housing status among formerly homeless dually diagnosed adults. *Psychiatric Services, 48*(7), 936-941.

Besio, S. W., & Mahler, J. (1993). Benefits and challenges of using consumer staff in supported housing services. *Hospital & Community Psychiatry, 44*(5), 490-491.

Bigelow, D. (1998). Supportive homes for life versus treatment way-stations: An introduction to TAPS project 41. *Community Mental Health Journal, 34*(4), 403-305.

Borg, M., Sells, D., Topor, A., Mezzina, R., Marin, I., & Davidson, L. (2005). What makes a house a home: The role of material resources in recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation, 8*(3), 243-256.

Boydell Consulting Group. (2006). *More than a building: Supportive housing for older persons living with mental illness*. Toronto, ON: LOFT Community Services.

Boydell, K. M., Gladstone, B. M., Crawford, E., & Trainor, J. (1999). Making do on the outside: Everyday life in the neighborhoods of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 23*(1), 11-19.

Boydell, K. M., & Everett, B. (1992). What makes a house a home? an evaluation of a supported housing project for individuals with long-term psychiatric backgrounds. *Canadian Journal of Community Mental Health, 11*(1), 109-123.

Brannen, J. (1992). *Mixing methods*: *Qualitative and quantitative research*. Vermont: Ashgate.

Brown, M. A., & Wheeler, T. (1990). Supported housing for the most disabled: Suggestions for providers. *Psychosocial Rehabilitation Journal, 13*(4), 59-68.

Browne, G., & Courtney, M. (2005a). Exploring the experience of people with schizophrenia who live in boarding houses or private homes: A grounded theory study. *Contemporary Nurse, 18*(3), 233-246.

Browne, G., & Courtney, M. (2005b). Housing, social support and people with schizophrenia: A grounded theory study. *Issues in Mental Health Nursing, 26*(3), 311-326.

Brunt, D., & Hansson, L. (2004). The quality of life of persons with severe mental illness across housing settings. *Nordic Journal of Psychiatry, 58*(4), 293-298.

Bryant, W., Craik, C., & McKay, E. (2005). Perspectives of day and accommodation services for people with enduring mental illness. *Journal of Mental Health, 14*(2), 109-120.

Burke, N. (2005). Supportive housing in brooklyn. *Health Progress, 86*(2), 32-34.

Burt, M. R., & Anderson, J. (2005). *Program experiences in housing homeless people with serious mental illness*Corporation for Supportive Housing.

Calsyn, R. J., & Winter, J. P. (2002). Social support, psychiatric symptoms, and housing: A causal analysis. *Journal of Community Psychology, 30*(3), 247-259.

Canada Mortgage and Housing Corporation. (2002). *Evaluating housing stability for people with serious mental illness at risk for homelessness.* Ottawa: Author.

Canadian Mental Health Association. (1999). *Housing for people with serious mental health problems*. Toronto, ON: Canadian Mental Health Association, Ontario Division.

Canadian Mental Health Association, Ontario. (2005). No place like home: Homelessness, mental health, and the need for supportive housing. *Network,* , 1-22.

Carling, P. (1990). Major mental illness, housing and supports: The promise of community integration. *American Psychologist, 45*, 969-975.

Champney, T. F., & Dzurec, L. C. (1992). Involvement in productive activities and satisfaction with living situation among severely mentally disabled adults. *Hospital & Community Psychiatry, 43*(9), 899-903.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications Ltd.

Chesters, J., Fletcher, M., & Jones, R. (2005). Mental illness recovery and place. *Australian e-Journal for the Advancement of Mental Health, 4*(2), 1-9.

Chilvers, R., Macdonald, G. M., & Hayes, A. A. (2005). Supported housing for people with severe mental disorders. *The Cochrane Library.(Oxford),* (3)

City of Toronto Mayor's Homelessness Action Task Force Report. (1999). Taking responsibility

for homelessness: An action plan for Toronto. Toronto, ON: Author

Cohen, M. D., & Somers, S. (1990). Supported housing: Insights from the robert wood johnson foundation program on chronic mental illness. *Psychosocial Rehabilitation Journal, 13*(4), 42-49.

Corporation for Supportve Housing. *Toolkit for Developing and Operating Supportive Housing.* http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=3685&grandparentID=10&parentID=3647

Creswell, J. (1998). *Qualitative inquiry and research: Choosing among five traditions*. California: Sage.

Diamond, R. J. (1993). The psychiatrist's role in supported housing. *Hospital & Community Psychiatry, 44*(5), 461-464.

Dickey, B., Gonzalez, O., Latimer, E., Powers, K., Schutt, R., & Goldfinger, S. (1996). Use of mental health services by formerly homeless adults residing in group and independent housing. *Psychiatric Services, 47*, 152-158.

Dickey, B., Latimer, E., Powers, K., Gonzalez, O. & Goldfinger, S.M. (1997). Housing costs for adults who are mentally ill and formerly homeless*. Journal of Mental Health Administration, 24(3)*, 291-305.

Dorvil, H., Morin, P., Beaulieu, A., & Robert, D. (2005). Housing as a social integration factor for people classified as mentally ill. *Housing Studies, 20*(3), 497-519.

Fakhoury, W. K., Murray, A., Shepherd, G., & Priebe, S. (2002). Research in supported housing. *Social Psychiatry & Psychiatric Epidemiology, 37*(7), 301-315.

Fakhoury, W. K. H., Priebe, S., & Quraishi, M. (2005). Goals of new long-stay patients in supported housing: A UK study. *The International Journal of Social Psychiatry, 51*(1), 45-54.

Falvo, N. (2008). The Housing First model: Immediate access to permanent housing. *Canadian Housing*, 2008 Special Edition, 32-35.

Forchuk, C., Nelson, G., & Hall, G. B. (2006). "It's important to be proud of the place you live in": Housing problems and preferences of psychiatric survivors. *Perspectives in Psychiatric Care, 42*(1), 42-52.

Forchuk, C., Ward-Griffin, C., Csiernik, R., & Turner, K. (2006). Surviving the tornado of mental illness: Psychiatric survivors' experiences of getting, losing, and keeping housing. *Psychiatric Services, 57*(4), 558-562.

Ford, J. P., Gibson, G., & Snarr, R. H. (2002). *Identifying best practices in public housing for people who are homelss and have a mental disability: The role of engagement and collaboration*. Austin, Taxas: Taxas Department of Mental Health and Mental Retardation.

Friedrich, R. M., Hollingsworth, B., Hradek, E., Friedrich, H. B., & Culp, K. R. (1999). Family and client perspectives on alternative residential settings for persons with severe mental illness. *Psychiatric Services, 50*(4), 509-514.

Geller, G., & Kowalchuk, J. (2002). Supportive housing needs of women with mental health issues in Regina. *Prairie Forum, 27*(1), 83-100.

George, L., Sylvestre, J., Aubry, T., Durbin, J., Nelson, G., Sabloff, A., et al. (2005). *Strengthening the housing system for people who have experienced serious mental illness: A value-based and evidence based approach.* Unpublished manuscript.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory.* Chicago, IL: Aldine Publishing Company.

Goering, P., Sylph, J., Foster, R., Boyles, S., & Babiak, T. (1992). Supportive housing: A consumer evaluation study. *International Journal of Social Psychiatry, 38*(2), 107-119.

Goering, P. Tolomiczenko,G., Sheldon, S., Boydell, K. & Wasylenki,D. (2002). Characteristics of persons who are homeless for the first time. *Psychiatric Services, 53(11)*, 1472-1474.

Greenwood, R. M., Schaefer-McDaniel, N. J., Winkel, G., & Tsemberis, S. J. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Psychology, 36*(3-4), 223-238.

Guhathakurta, S., & Mushkatel, A. H. (2000). Does locational choice matter?: A comparison of different subsidized housing programs in phoenix, arizona. *Urban Affairs Review, 35*(4), 520-540.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S. & Fischer, S. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and Housing First programmes. *Journal of Community & Applied Social Psychology,* . 13, 2, 171-186.

Hadley, T. R., McGurrin, M. C., & Fye, D. M. (1993). Community residential services and community tenure. *Psychosocial Rehabilitation Journal, 16*(3), 33-41.

Hamilton District Health Council. (2001). *Background report: Housing and support requirements for persons with serious mental illness*. Hamilton, ON: Author.

Hannigan, T., & Wagner, S. (2003). *Developing the "support" in supportive housing: A guide to providing services in housing*. New York, NY: Corporation for Supportive Housing.

Harkness, J., Newman, S. J., & Salkever, D. (2004). The cost-effectiveness of independent housing for the chronically mentally ill: Do housing and neighborhood features matter? *Health Services Research, 39*(5), 1341-1360.

Heaney, C. A., & Burke, A. C. (1995). Ideologies of care in community residential services: What do caregivers believe? *Community Mental Health Journal, 31*(5), 449-462.

Herb, M., Miller, E., & O'Hara, A. (2003). *A housing toolkit: Information to help the public mental health community meet the housing needs of people with mental illness*. Arlington, VA: National Alliance for the Mentally Ill.

Hodgins, S., Cyr, M., & Gaston, L. (1990). Impact of supervised apartments on the functioning of mentally disordered adults. *Community Mental Health Journal, 26*, 507-516.

Hogan, M. F., & Carling, P. J. (1992). Normal housing: A key element of a supported housing approach for people with psychiatric disabilities. *Community Mental Health Journal, 28*(3), 215-226.

Houghton, T. (2001). *A description and history of the new York/New york agreement to house homeless mentally ill individuals.* Corporation for Supportive Housing.

Hurlburt, M. S., Wood, P. A., & Hough, R. L. (1996). Providing independent housing for the homeless mentally ill: A novel approach to evaluating long-term longitudinal housing patterns. *Journal of Community Psychology, 24*(3), 291-310.

Jarbrink, K., Hallam, A., & Knapp, M. (2001). Costs and outcomes management in supported housing. *Journal of Mental Health, 10*(1), 99-108.

Johnson, L. C. (2001). The community/privacy trade-off in supportive housing: Consumer/survivor preferences. *Canadian Journal of Community Mental Health, 20*(1), 123-133.

Keck, J. (1990). Responding to consumer housing preferences: The toledo experience. *Psychosocial Rehabilitation Journal, 13*(4), 51-58.

Kloos, B., Zimmerman, S. O., Scrimenti, K., & Crusto, C. (2002). Landlords as partners for promoting success in supported housing: "it takes more than a lease and a key". *Psychiatric Rehabilitation Journal, 25*(3), 235-244.

Knisley, M. B., & Fleming, M. (1993). Implementing supported housing in state and local mental health systems. *Hospital & Community Psychiatry, 44*(5), 456-461.

Lakefront Supportive Housing. (2004). *Best practices in community supportive services*. Chicago, IL: Lakefront Supportive Housing.

Lamb, M. (2003). A different path: Providing community housing for people with mental illness in montreal. *Occupational Therapy Now, 5*(5), 1.

Lam, J.A. & Rosenheck, R.(1999).Social support and service use among homeless persons with serious mental illness. International Journal of Social Psychiatry, 45, 13-28.

Lamb, H.R. & Lamb,D.M. (1990). Factors contributing to homelessness among the chronically and severely mentally ill. Hospital and Community Psychiatry, 41, 301-305.

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. London: Sage.

Lipton, F. R., Siegel, C., Hannigan, A., Samuels, J., & Baker, S. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiatric Services, 51*(4), 479-486.

Mares, A., & Rosenheck, R. (2004). One-year housing arrangements among homeless adults with serious mental illness in the ACCESS program. *Psychiatric Services, 55*(5), 566-574.

Mares, A. S., Kasprow, W. J., & Rosenheck, R. A. (2004). Outcomes of supported housing for homeless veterans with psychiatric and substance abuse problems. *Mental Health Services Research, 6*(4), 199-211.

McCarthy, J., & Nelson, G. (1993). An evaluation of supportive housing: Qualitative and quantitative perspectives. *Canadian Journal of Community Mental Health, 12*, 157-175.

McCarthy, J., & Nelson, G. (1991). An evaluation of supportive housing for current and former psychiatric patients. *Hospital & Community Psychiatry, 42*(12), 1254-1256.

McHugo, G. J., Bebout, R. R., Harris, M., Cleghorn, S., Herring, G., Xie, H., et al. (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin, 30*(4), 969-982.

Metraux, S., Marcus, S. C., & Culhane, D. P. (2003). The new york-new york housing initiative and use of public shelters by persons with severe mental illness. *Psychiatric Services, 54*, 67-71.

Middelboe, T. (1997). Prospective study of clinical and social outcome of stay in small group homes for people with mental illness. *British Journal of Psychiatry, 171*, 251-255.

Milby, J. B., Schumacher, J. E., Wallace, D., Freedman, M. J., & Vuchinich, R. E. (2005). To house or not to house: The effects of providing housing to homeless substance abusers in treatment. *American Journal of Public Health, 95*(7), 1259-1265.

Mize, T. I., Paolo-Calabrese, M. A., Williams, T. J., & MArgolin, H. K. (1998). Managing the landlord role: How can one agency provide both rehabilitation services and housing with collaboration? *Psychiatric Rehabilitation Journal, 22*(2), 117-122.

Mojtabai, R. (2005). Perceived reasons for loss of housing and continued homelessness among homeless persons with mental illness. *Psychiatric Services, 56*(2), 172-178.

Morse, G. A., Calsyn, R. J., Allen, G., & Kenny, D. A. (1994). Helping homeless mentally ill people: What variables mediate and moderate program effects? *American Journal of Community Psychology, 22*(5), 661-683.

Moxham, L. J., & Pegg, S. A. (2000). Permanent and stable housing for individuals living with a mental illness in the community: A paradigm shift in attitude for mental health nurses. *Australian and New Zealand Journal of Mental Health Nursing, 9*(2), 82-88.

Nelson, G., Clarke, J., Febbraro, A., & Hatzipantelis, M. (2005). A narrative approach to the evaluation of supportive housing: Stories of homeless people who have experienced serious mental illness. *Psychiatric Rehabilitation Journal, 29*(2), 98-104.

Nelson, G., Hall, G. B., & Forchuk, C. (2003). Current and preferred housing of psychiatric residents/survivors. *Canadian Journal of Community Mental Health, 22*(1), 5-19.

Nelson, G., Hall, G. B., & Walsh-Bowers, R. (1999). Predictors of the adaptation of people with psychiatric disabilities in group homes, supportive apartments, and board-in-care homes. *Psychiatric Rehabilitation Journal, 22*(4), 381-389.

Nelson, G., & Peddle, S. (2005). *Housing and support for people who have experienced serious mental illness: Value based and research evidence.* Unpublished manuscript.

Newman, S., & Ridgely, M. S. (1994). Organization and delivery of independent housing for persons with chronic mental illness. *Administration and Policy in Mental Health, 21*(3), 199-215.

Newman, S. J. (1994). The effects of independent living on persons with chronic mental illness: An assessment of the section 8 certificate program. *Milbank Quarterly, 72*(1), 171-198.

Ochocka, J., Janzen, R.& Nelson, G. (2002). Sharing power and knowledge: Professional and mental health consumer/survivor researchers working together in a participatory research project*. Psychiatric Rehabilitation Journal, 25*, 379-387.

Padgett, D.K. (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States.*Social Science & Medicine,* 64 (9), 1925-1936.

Padgett, D.K., Gulcur, L.,& Tsemberis, S. (2006). Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice,* 16 (1), 74-83.

Parkinson, S., & Nelson, G. (2003). Consumer/survivor stories of empowerment and recovery in the context of supported housing. *International Journal of Psychosocial Rehabilitation, 7*, 103-118.

Parkinson, S., Nelson,G., & Horgan, S. (1999). From housing to homes: A review of the literature on housing approaches for psychiatric consumer/survivors. *Canadian Journal of Community Mental Health, 18(1)*, 145-164.

Pathways to Housing, Inc., New York. (2005). Providing housing first and recovery services for homeless adults with severe mental illness. *Psychiatric Services, 56*(10), 1303-1305.

Pyke, J., & Lowe, J. (1996). Supporting people, not structures: Changes in the provision of housing support. *Psychiatric Rehabilitation Journal, 19*(3), 5-12.

Ridgway, P., & Zipple, A. M. (1990). The paradigm shift in residential services: From linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal, 13*(4), 11-32.

Ridgeway, P., Simpson, A., Wittman, F. D., & Wheeler, G. (1994). Home making and community building: Notes on empowerment and place. *Journal of Mental Health Administration, 21*(4), 407-418.

Rog, D. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal, 27(4)*, 334-343.

Ruas, D. (2004). Having an address: The importance of clubhouse housing. *The Clubhouse Community Journal, 5*, 22-24.

Sergeant, E. V., & Brown, G. (2004). Housing people with complex needs: Finding an alternative to traditional service models. *Housing, Care and Support, 7*(1), 25-30.

Sharts- Hopko, N. (2002). Assessing rigor in qualitative research. *Journal of the Association of Nurses in AIDS Care, 13(4),* 84-86.

Shern, D. L., Felton, C. J., Hough, R. L., Lehman, A. F., Goldfinger, S., Valencia, E., et al. (1997). Housing outcomes for homeless adults with mental illness: Results from the second-round McKinney program. *Psychiatric Services, 48*(2), 239-241.

Singer, B. (1999). Why do housing? *Clubhouse Community Journal, 1*, 28-31.

Slade, M., Scott, H., Truman, C., & Leese, M. (1999). Risk factors for tenancy breakdown for mentally ill people. *Journal of Mental Health, 8*(4), 361-371.

Sohng, S. S. L. (1996). Supported housing for the mentally ill elderly: Implementation and consumer choice. *Community Mental Health Journal, 32*(2), 135-148.

Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal, 31*(2), 139-152.

Sutherland, R. (1999). My experiences in progress place housing. *Clubhouse Community Journal, 1*, 32-33.

Sylvestre, J., Trainor, J., Aubry, T., George, L., Nelson, G., & Ilves, P. (2004). *An evaluation of phase I of the mental health homeless initiative: Summary integration and analysis of findings.* Report to Ministry of Health and Long Term Care. Toronto.

Taylor, B., & Jeffery, G. (2004). Managing risk for tenants with mental health problems and offending histories. *Housing, Care and Support, 7*(3), 9-12.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

Tsemberis, S., Rogers, E., Rodis, E., Dushuttle, P., & Skryha, V. (2003). Housing satisfaction for persons with psychiatric disabilities. *Journal of Community Psychology, 31*(6), 581-590.

Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services, 51*(4), 487-493.

Walker, R., & Seasons, M. (2002). Supported housing for people with serious mental illness: Resident perspectives on housing. *Canadian Journal of Community Mental Health, 21*(1), 137-151.

Ware, N. C. (1999). Evolving consumer households: An experiment in community living for people with severe psychiatric disorders. *Psychiatric Rehabilitation Journal, 23*(1), 8-10.

Warren, R., & Bell, P. (2000). An exploratory investigation into the housing preferences of residents of mental health services. *Australian and New Zealand Journal of Mental Health Nursing, 9*(4), 195-202.

Weissman, E. M., Covell, N. H., Kushner, M., Irwin, J., & Essock, S. M. (2005). Implementing peer-assisted case management to help homeless veterans with mental illness transition to independent housing. *Community Mental Health Journal, 41*(3), 267-276.

Wong, Y. I., Hadley, T. R., Culhane, D. P., Poulin, S. R., Davis, M. R., Cirksey, B. A., et al. (2006). *Predicting staying in or leaving permanent supportive housing that serves homeless people with serious mental illness*. Philedelphia. PA: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

Wood, P. A., Hurlburt, M. S., Hough, R. L., & Hofstetter, C. R. (1998). Longitudinal assessment of family support among homeless mentally ill participants in a supported housing program. *Journal of Community Psychology, 26*(4), 327-344.

Yanos, P. T., Barrow, S. M., & Tsemberis, S. (2004). Community integration in the early phase of housing among homeless persons diagnosed with severe mental illness: Successes and challenges. *Community Mental Health Journal, 40*(2), 133-150.

Yeich, S., Mowbray, C. T., Bybee, D., & Cohen, E. (1994). The case for a "supported housing" approach: A study of consumer housing and support preferences. *Psychosocial Rehabilitation Journal, 18*(2), 75-86.

Appendix A: Coversheet for Articles under Review

Date of Review:

Reviewer's Initials:

Full Citation and RefWorks ID:

Type of Article:

_Qualitative

_Quantitative

_Expert Opinion

_Other_____

_Review

_Program Evaluation

_First Person Account

Purpose:
Design (type of article as described above and any further details provided by the author)**:**
Context (in which study took place or article was written):
Definition/Principles of Supported Housing:
Participants (Sample size, mean age, gender, population)**:**
Methods (Data collection, Measures used, Approach to analysis)**:**
Findings/Conclusions:
Characteristic and Associated Housing Outcomes (include page reference)**:**

Qualitative Quality Indicators:

Indicator	Y/N	Comments
Attention to rigor		
Discussion of approach to data analysis or reference to a known approach		

Quantitative Quality Indicators:

Indicator	Y/N	Comments
Control Group		
Sample Size		
Randomization		
Reliability/Validity		

Housing Characteristic	Outcome	Type of article	Type of finding (primary/secondary/interpretation)

Appendix B: Interview Guide for Residents of SH

Thank you for agreeing to be interviewed. As you may know from the discussions you had as you agreed to this, we have decided to interview a number of people who have lived in supported housing so that we can get an in-depth understanding of what some of the issues are and what the experience is like. We hope to be able to identify important characteristics of SH. I have some questions to ask, but they are meant to be starting points, so please feel free to add anything that you think is important.

Let's start by talking about your experiences –

Background Info:

Tell me a little bit about yourself?

Where born, education, training, family, age, involvement in MH system

Tell me about how you came to live in SH?

Can you tell me a bit more about the housing you live in?

General atmosphere, size, safety, others in house, programming

Who do you pay your rent to?

How do you feel about the housing you are in?

What are some of the things that you find helpful?

Probes: Are there any people/ services/ approaches that have helped you to

- stay in your housing
- deal with crises as they come up
- become productive
- participate in the community
- socialize

Are there things you do not like or that are not helpful?

Tell me about the support that you receive here.

What type of support, frequency, meaning of support to participant

Tell me about the kinds of opportunities you have to interact with other people.

Tell me about the community that you are in here.

How would you describe the neighbourhood, the people around you?

What is your sense of community here?

Is there anything that you feel is missing in your Supported Housing?

What kinds of changes do you think should occur?

Is there anything else that you would like to say?

Appendix C: Interview Guide for Service Providers

Thank you for agreeing to be interviewed. As you may know from the discussions you had as you agreed to this, we have decided to interview a number of people provide services to supported housing so that we can get an in-depth understanding of what some of the issues are. We hope to be able to identify important characteristics of SH.

I have some questions to ask, but they are meant to be starting points, so please feel free to add anything that you think is important.

Can you describe your job duties with regards to Supported Housing?

What services do you provide?

What are the outcomes you are striving for?

What are the key services and supports needed to achieve these outcomes?

Probes: Are there / services/ approaches that facilitate

- maintaining housing over time
- crisis management
- increasing productivity
- increasing community participation
- enhancing social network

What challenges do you face in your work with Supported housing residents?

What strategies do you use to overcome them?

How might you describe the community in which the SH is situated?

How do people in the community relate to you and residents of SH?

How do you determine appropriate placements and communities for SH? (not for all workers).

What makes an appropriate match between resident and their housing?

Is there anything else you would like to add?

Appendix D: Resident Demographic Form

Gender:

Age:

Number of Supported Housing settings lived in:

Length of time in Supported Housing:

Referral Source:

Referral Category for Supported Housing:

- mental health and justice
- homeless
- rent geared to income

Length of time in Mental Health System:

Current Mental Health Supports (Mental Health workers involved):

Appendix E: Service Provider Demographic Form

Interview code:

Interview date:

Job Title:

Background – (discipline/profession/training):

Number of years on this job:

Number of years in the mental health field:

Appendix F: Information Letter/Consent Form for Residents

FACULTY OF MEDICINE

University of Toronto

Department of Occupational Science and Occupational Therapy

Project Title: Critical Characteristics of Supported Housing

Investigators: Bonnie Kirsh, University of Toronto; Mohammed Badsha and Karen O'Connor, Canadian Mental Health Association; Brenda Singer, Progress Place

Funded by: Wellesley Central Health Corporation

You are being invited to participate in a research study on Supported Housing. Your participation in this study is voluntary. You may choose not to participate or withdraw at any time freely without any impact on your supported housing services, nor on your access to services of housing support workers.

This research project aims to understand the important features of supported housing. A research team, composed of people from three organizations (University of Toronto, Progress Place and Canadian Mental Health Association) is carrying out the study. Together we are examining characteristics of supported housing that are helpful to people with mental illnesses. We hope to interview approximately 25 residents of supported housing and 10 housing support workers.

This information letter is to tell you about the study and to ask you to share your experiences as a person who has lived in supported housing, and how this experience has affected your life.

If you agree to participate in an interview, you will be asked to share your experiences as a person who has lived in supported housing, the various features of it that you found helpful and those that you did not. We will ask you to make recommendations about supported housing. An interviewer who is part of the research team will conduct the interview. This interview will be about one to one and half hours in length, and will take place at a location that is agreed on by you and the interviewer.

The information we gather in the interview will be confidential. The interview will be audiotaped and then transcribed (typed). When it is transcribed, code names will be given to each interview. Personal and organization names (your name, your service provider, housing name, etc) will be removed from the transcription and replaced with pseudonyms (false names) to protect your confidentiality. We will not use your name or any names you mention in any documents or

presentations that result from this study. Only members of the research team will have access to the tapes and the transcriptions. The tapes and transcriptions will be stored in a locked cabinet in the primary researcher's office. The tapes will be destroyed as soon as the project is completed and the transcripts will be destroyed one year after the completion of the project.

Rehabilitation Sciences Building

500 University Avenue, Suite 160 Toronto, ON M5G IV7

Tel: (416) 946-8571 Fax: (416) 946-8570
www.ot.utoronto.ca

Centre for Function and Well-Being

GREAT MINDS FOR A GREAT FUTURE

You can withdraw from the interview at any time with no effects on your housing or housing services. We believe that there are no significant risks to you in participating in this part of the project. You will not be asked to disclose or talk about anything that you do not want to talk about. There may be some discomfort if you talk about issues that are difficult for you to talk about. The potential benefits include assisting others to develop a deepened understanding of issues associated with supported housing.

To thank you for your participation, you will be given an honorarium of $25.00.

If you have questions about the interview or the project, you can speak with the primary researcher or any member of the research team. Our names and phone numbers are listed at the end of this letter.

If you have questions about your rights as a research participant, please contact Jill Parsons, Health Sciences Ethics Review Office, University of Toronto, at 416-946-5806 or by email jc.parsons@utoronto.ca.

We thank you for considering participation in this study. You are being given a copy of this informed consent to keep for your own records.

_____ _____ _____

Signature Printed Name Date

Bonnie Kirsh, University of Toronto 416-978-4647

Brenda Singer, Progress Place, 416-323-0223 x238

Karen O'Connor, CMHA 416-7897957

Mohammed Badsha CMHA 416-7897957

Appendix G: Information Letter/Consent Form for Service Providers

FACULTY OF MEDICINE

University of Toronto

Department of Occupational Science and Occupational Therapy

Project Title: Critical Characteristics of Supported Housing

Investigators: Bonnie Kirsh, University of Toronto; Mohammed Badsha and Karen O'Connor, Canadian Mental Health Association; Brenda Singer, Progress Place

Funded by: Wellesley Central Health Corporation

You are being invited to participate in a research study on Supported Housing. Your participation in this study is voluntary and you may decline to participate or withdraw at any time.

This research project aims to understand the important features of supported housing. A research team, composed of people from three organizations (University of Toronto, Progress Place and Canadian Mental Health Association) is carrying out the study. Together we are examining characteristics of supported housing that are helpful to people with mental illnesses. We hope to interview approximately 25 residents of supported housing and 10 housing support workers.

This information letter is to tell you about the study and to ask you to share your experiences as a person who has lived in supported housing, and how this experience has affected your life.

If you agree to participate in an interview, you will be asked to share your experiences as a person who provides services to residents of supported housing, the various features of it that you find helpful and those that you do not. We will ask you to make recommendations about supported housing. An interviewer who is part of the research team will conduct the interview. This interview will be about one to one and half hours in length, and will take place at a location that is agreed on by you and the interviewer.

The information we gather in the interview will be confidential. The interview will be audiotaped and then transcribed (typed). When it is transcribed, code names will be given to each interview. Personal and organization names (your name**,** your organization or agency, housing name, etc) will be removed from the transcription and replaced with pseudonyms (false names) to protect your confidentiality. We will not use your name or any names you mention in any documents or presentations that result from this study. Only members of the research team will have access

to the tapes and the transcriptions. The tapes and transcriptions will be stored in a locked cabinet in the primary researcher's office. The tapes will be destroyed as soon as the project is completed and the transcripts will be destroyed one year after the completion date.

Rehabilitation Sciences Building

500 University Avenue, Suite 160 Toronto, ON M5G IV7

Tel: (416) 946-8571 Fax: (416) 946-8570
www.ot.utoronto.ca

Centre for Function and Well-Being

GREAT MINDS FOR A GREAT FUTURE

You can withdraw from the interview at any time with no adverse effects.

We believe that there are no significant risks to you in participating in this part of the project. You will not be asked to disclose or talk about anything that you do not want to talk about. The potential benefits include assisting others to develop a deepened understanding of issues associated with supported housing.

If you have questions about the interview or the project, you can speak with the primary researcher or any member of the research team. Our names and phone numbers are listed at the end of this letter.

If you have questions about your rights as a research participant, please contact Jill Parsons, Health Sciences Ethics Review Office, University of Toronto, at 416-946-5806 or by email jc.parsons@utoronto.ca.

We thank you for considering participation in this study. You are being given a copy of this informed consent to keep for your own records.

_____ _____ _____

Signature Printed Name Date

Bonnie Kirsh, University of Toronto 416-978-4647

Brenda Singer, Progress Place, 416-323-0223 x238

Karen O'Connor, CMHA 416-7897957

Mohammed Badsha CMHA 416-7897957

Appendix H: Consent Form for Audio Taping

FACULTY OF MEDICINE

University of Toronto

Department of Occupational Science and Occupational Therapy

Project Title: Critical Characteristics of Supported Housing

Investigators: Bonnie Kirsh, University of Toronto; Mohammed Badsha and Karen O'Connor, Canadian Mental Health Association; Brenda Singer, Progress Place

Funded by: Wellesley Central Health Corporation

I consent to participate in an interview on the topic of Supported Housing and to have the interview tape recorded. The tape will be used for this project alone and is not intended for future research studies.

_____ _____ _____

Signature Printed Name Date

Rehabilitation Sciences Building

500 University Avenue, Suite 160 Toronto, ON M5G IV7

Tel: (416) 946-8571 Fax: (416) 946-8570
www.ot.utoronto.ca

Centre for Function and Well-Being

GREAT MINDS FOR A GREAT FUTURE

Appendix I: Chart of Themes

Residents	Service Providers

<u>Pathways to SH</u>
• Path to SH
• Accessing SH
  o Easy access
  o Easy access despite a crisis
  o Long arduous path
	<u>Pathway into SH</u>
	• Finding Apartments
	• Assessment/Intake Process
	• Impact of substance use on SH
	• Setting tenants up in the units

<u>Guiding Values:</u>
• Being Treated with Dignity
• Flexibility and Choice
  o Flexibility and Choice with Support
  o Choice in Housing Unit
	<u>Guiding Values:</u>
	• Flexible and Individualized Support
	• Choice
	• Client-Centredness
	• Managing Stigma
	  o Segregated vs Integrated Housing
	  o Support and Education for Landlords

<u>Supports offered in supported housing:</u>
• Access to Supports
• Nature of Supports
  o Instrumental Support
  o Support During a Crisis
  o Support with Work and School
  o Informal Supports
	<u>Supports offered in supported housing:</u>
	• Nature of Support
	  o Type of Support
	  o Supporting Independent Living
	  o Instrumental Supports
	  o Building a Relationship
	• Access to Supports and Resources
	  o Social Supports
	  o Support with Work and Education
	  o Support During a Crisis
	  o Support Managing Health

<u>Housing Features:</u> • Independent Living • Building Issues • Important Housing Features • Making and Maintaining a Home	<u>Neighbourhood and Community Context:</u> • Community Response to Supported Housing • Relationship with Neighbours • Fit – Person to Neighbourhood • Safe, Comfortable, Clean Housing
<u>Neighbourhood and Community:</u> • Disclosure • Community Access • Interactions with Neighbours • Safety: Impact of Drugs and Crime	
<u>Moving forward</u> • Being productive • Hopes for the future • Impact of good housing	<u>Impacts of SH</u> • Goals of SH • Housing as a foundation • Increased confidence and stability • Moving on from SH
	<u>SH program and system issues</u> • Housing workers work with other supports • Separating housing and community support • Team approach • Liaison between tenant and building • Essential skills of service providers in SH Supported housing is not for everyone

The Wellesley Institute is an independent, Toronto-based, non-partisan urban think tank that works at the national, provincial, and local levels to advance urban health issues.

WELLESLEY INSTITUTE
advancing urban health

45 Charles St. East,
Suite 101
Toronto, ON, Canada
M4Y 1S2

Tel 416.972.1010

www.wellesleyinstitute.com

Media and Publications inquiries, please contact us by phone at 416-972-1010 or by e-mail at contact@wellesleyinstitute.com