Evaluating Housing Satisfaction among Mentally Ill Persons in Supportive Housing

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Dedication

This thesis is dedicated to the research participants and all people in vulnerable populations who have a voice but are not feeling heard. It is dedicated to the anonymous callers at Crisis Connection that worried about losing their housing and started me on the path to getting my masters.

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Chapter 1. Literature Review

The United States continues to struggle with a homeless population. In the past three decades, the homeless population demographics have changed from mostly grown, single adults to a population that includes families with children and single youth. It is estimated that almost two million Americans experience homelessness each year. Three factors have played a part in the increase in homelessness; “loss of affordable housing and foreclosures, wages and public assistance that have not kept pace with the cost of living, rising housing costs, job loss and underemployment, and resulting debt; and the closing of state psychiatric institutions without the concomitant creation of community-based housing and services” (United States Interagency Council on Homelessness, 2010, p.10).

A subset of the homeless population that struggles with obtaining and keeping affordable housing are individuals with a mental illness. "Experts believe that between 150,000 and 200,000 people with disabling conditions such as mental illness are chronically homeless" (O'Hara, 2007, p.908).

The study conducted examined the housing satisfaction of mentally ill individuals currently living in supportive housing. The intent of the study was to provide the end user of supportive housing a place to share their opinions and help influence the development and design of future supportive housing.

In the last two decades, there have been different models of housing used for the mentally ill population. One has been the custodial housing approach, or continuum care model. An example is a group home. Housing and services were combined into one

building, most were professionally staffed and the developments were usually segregated from residential neighborhoods (Carling, 1993; Townley & Kloos, 2009; Townley & Kloos, 2010). Housing the mentally ill population was viewed as a" 'housing-as-treatment' approach, in which clinical considerations governing the type of residence provided for the client" (Hanrahan et al., 2001, p.1207). These housing developments became known as "service-dependent ghettos" (Yanos, 2007, p.672). This type of housing does not allow integration into a community in a natural way. It becomes stigmatized as a "mentally ill" neighborhood (Yanos, 2007; Allen 2003). In contrast, using normalized housing has been linked with improved ability to integrate into the community (Gulcer et al., 2007; Kyle & Dunn, 2008).

Supportive housing has emerged as the current preferred model of housing the mentally ill population. In the supportive housing model, services and housing are separate. Housing First is one such model, in which housing and services are not dependent on one another. A person is placed in standard housing, and can choose among available service programs (Leff et al., 2009; Stefanic & Tsemberis, 2007). The individual is empowered to have a voice in his or her treatment plan. If the individual chooses not to use the services, they are not in jeopardy of losing their housing. They hold a lease with a landlord that is separate from the provider of their support services (Stefanic & Tsemberis, 2007). The focus has moved from an institution environment to a normal home setting, choices in services, and integration into the community (Stefanic & Tsemberis, 2007; Townley & Kloos, 2010; Yanos et al., 2007). In New York, the Housing First model is called Pathways. The Pathways model has an 80% housing

retention rate, in comparison, the continuum care model has a 23% housing retention rate (HCH Clinicians, 2003).

In a study by Leff et al., the supported housing model achieved the highest housing satisfaction compared to residential care and treatment (Leff et al., 2009). Yet, in contrast to the Leff et al., study, in research done by Friedrich et al., respondents from three different types of housing were asked to rate their housing satisfaction. Most preferred their current housing, regardless if it was residential care, supportive housing, or independent housing (Friedrich et al., 1999). Research done by Hanrahan et al. supports Friedrich's research findings. In the study on housing satisfaction, there was not statistically significant difference found in housing satisfaction between continuous care residents and intermittent care residents (Hanrahan et al., 2001).

A qualitative study conducted in Ontario, Canada asked mentally ill residents to identify concerns they have with their current housing, and what are their preferences for their housing needs. Themes that emerged were oppression, social networks and support, housing, poverty, and accessing services. Oppression included stigma and discrimination, and the desire for acceptance. Social networks included the landlord relationship and fear of eviction, social isolation and having to choose between housing that provides either support or independence. Housing concerns ranged from lack of affordable housing, poor quality housing and the fear of facing homelessness. Poverty included disability income and being low income. Access to services ranged from proximity of services to transportation issues to access services. The themes indicate that housing the mentally ill is not just about the bricks and mortar of a building. There are

multiple complex components, ranging from stigma within a community, lack of affordable options on a low income, and having to choose between location of housing and location of services (Forchuk, Nelson & Hall, 2006).

The mentally ill state the same type of barriers as a mentally well person to obtaining stable housing: financial resources, social support, structure, unemployment and lack of affordable housing (Kyle & Dunn, 2008; Mojtabai, 2005). In studies conducted, the mentally ill population "could benefit from wider availability of low-cost housing, improved job opportunities, and income support programs—the same structural initiative that have been proposed to prevent homelessness in other vulnerable social groups" (Mojtabai, 2005, p.177). When the mentally ill population is asked what the biggest barrier to obtaining housing is, poverty and social stigma are stated as the main reasons (Forchuk, Nelson & Hall, 2006; Mojtabai, 2005).

Housing Features

Housing features include the amenities, square footage of units, building age, and level of maintenance (Harkness, Newman & Salkever, 2004; Leff et al., 2009). In Newman's review of research studies published between 1975 and March 2000 that focused on the relationship between housing attributes and citizens with mental illness, she identified the following areas as lacking; "which housing attributes or factors are critical to a mentally ill person's capacity to live independently, it has not described the types of residential alternatives that are most effective for persons with serious mental illness, it has not identified specific housing attributes that can be systematically associated with the best type of residential settings, and it has not produced any

agreement on the most appropriate way to conceptualize and measure the effectiveness of the housing setting" (Newman, 2001, p.1316). A study on housing features was conducted at four independent housing developments for mentally ill individuals. All sites were renovated, and similar in building quality. It was found that residents in buildings needing maintenance had a 28% increase in community-based mental health services costs than individuals in buildings with no visible needed repairs. For each additional amenity a building had; such as air conditioning, garage, garbage disposal, there was a reduction in health service cost of 11% (Harkness, Newman & Salkever, 2004). Overall, a low density building (4-6 units) was associated with better mental health in the terms of residential stability, less social distancing, and lower health care costs (Harkness, Newman & Salkever, 2004; Nelson, Hall & Bowers, 1998). The other main occurring preferences were individual privacy, modern facilities, and the ability to have pets. One comment shared was that a garden was needed (Forchuk, Nelson & Hall, 2006).

Often, due to the high rate of demand and cost constraints, many of the supportive housing developments begin to mimic the institution design that they are replacing. The design is non-descriptive and the furnishings are pre-chosen for the residents. "The result is often anonymous and dehumanizing 'cookie-cutter' units" (Ridgway et al., 1994, p.408).

In a post-occupancy evaluation of a renovation of two SRO buildings in New York City, the main complaint was the size of the units. The units ranged from 90-100 square feet. "The units made some respondents feel claustrophobic or like they were in

jail" (Ridgway et al., 1994, p.410). The size of the space limited the residents' ability to entertain and welcome visitors. Preferences were for individual bathrooms and kitchens with standard size appliances. Other amenities desired were counter space, shelving, task lighting, personal telephone service, better sound barriers, and control over unit temperatures. Most positive responses centered on privacy, ability to personalize their space, and control over their space and money (Ridgway et al., 1994).

Even when housing is obtained, if there is not ontological security and a sense of home developed, then housing satisfaction is not achieved, and as seen in the poor retention rates, many individuals chose to leave the housing (HCH Clinicians, 2003). "We believe that it is important to understand housing and mental health issues from the perspective of psychiatric survivors" (mentally ill individuals) (Forchuk, Nelson & Hall, 2006, p. 42). The design of the space should be flexible for individual personalization of the space (Ridgway et al., 1994). The involvement of the mentally ill resident into the decoration and design of their space can build a sense of home, or ontological security. It is best stated by a participant in a qualitative study, "It's important to be proud of the place you live in" (Forchuk, Nelson, & Hall, 2006, p.47).

Neighborhoods

In past research, the theory of "diverse-disorganized" neighborhoods was described as desirable neighborhoods for mentally ill individuals to live. The definition of a diverse-disorganized neighborhood was one "with socioeconomically and demographically diverse populations, with a mix of commercial and residential land uses, and not physically pristine" (Harkness, Newman & Salkever, 2004, p.1344). Empirical

studies did not get to the cause of the preference, but it is theorized that a diverse neighborhood may have less discrimination against a mentally ill person thus they feel more comfortable in their neighborhood (Harkness, Newman & Salkever, 2004).

A study on the Section 8 program used by mentally ill individuals used quality of housing as measured by four variables "affordability, the physical condition of dwelling units, conditions in the neighborhood and service gaps" (Newman et al., 1994, p.178). The hypothesis tested whether Section 8 housing assistance used by mentally ill individuals decreased hospitalization and use of mental health services, while increasing residential stability. The neighborhood condition variable had the most significant impact on length of hospital stays, but surprising, it was the relationship that the higher the quality of neighborhood conditions, the longer the hospital stay (Newman et al., 1994). This study supports the empirical research "that communities characterized by low economic status, ethnic and racial diversity, mixed commercial-residential land uses, and moderate levels of 'social disorganization' are less rejecting" (Newman et al., 1994, p.191) of persons with mental illness. In contrast, a study conducted in Connecticut found that clients "who were living in higher-income neighborhoods were more satisfied with the overall quality of their housing" (Mares, Desai, & Rosenheck, 2005, p.317).

Sense of Community

Sense of community and social integration has been studied in the general public. Actual connections or lack of connections to one's community can have a significant impact on various aspects of life; ranging from health outcome, length of residence, to overall life satisfaction. There has been a lack of research examining sense of

community and the mentally ill citizen, even though social connections have been viewed as having a positive effect on the mentally ill (Townley & Kloos, 2009; Townley & Kloos, 2010).

A study in South Carolina surveyed 402 persons with a mental illness who resided in supported housing. Degree of interpersonal relationships with neighbors was the largest variance in feeling a sense of community. The relationships with neighbors and perceived sense of community may not differ from the general population, but the perception of neighborhood tolerance for mental illness does have a positive correlation with sense of community on the mentally ill individual (Townley & Kloos, 2010).

In a study conducted in Johnson County, Iowa, residents and their families that lived in four different types of housing were asked their housing preference and current problems the mentally ill individual was experiencing with his/her housing. The four types of housing were inpatient, supported housing, residential care facility, and independent housing. The research findings found that social isolation and lack of community integration ranked as the highest issues, with treatment issues, work and financial issues falling below social isolation. The individuals living independently reported an increase in feelings of isolation versus those individuals living in residential care homes. In contrast, those living in communal homes reported higher stressors regarding lack of privacy and various ages of residents (Friedrich et al., 1999).

In contrast to prior research showing that mentally ill citizens do not necessarily want to live with other mentally ill people (Carling, 1993; Forchuk, Nelson & Hall, 2006; Lipton et al., 2000), Townley and Kloos' research found that participants living in

buildings exclusively of mentally ill residents "reported significantly higher perceptions of sense of community than individuals living in non-congregate housing" (Townley & Kloos, 2010, p.8). In support of Townley and Kloos' research, Harkness, Newman and Salkevers' (2004) research also found that buildings with high proportion of mentally ill residents had greater residential stability than ones with few mentally ill residents. An interpretation could be that mentally ill citizens want to live together, or that the close proximity allows visiting case managers to detect mental health issues earlier.

Research findings that support high concentration of mentally ill individuals within a community suggest that the mentally ill individual may feel less discrimination, and a greater sense of belonging . A sense of belonging is the goal of community integration. The assumption of measuring success for community integration has been the degree the mentally ill individual fits into the non-mentally ill community. The relationships a mentally ill individual holds with another mentally ill individual needs to be respected, and not seen as inferior to a relationship with a non-mentally ill individual (Townley & Kloos, 2010).

A study evaluating the "factors influencing adjustment and stability" (Whitley, Harris & Drake, 2008, p.166) found the main feeling influencing the supportive housing resident's opinion of their home was the concern for safety and security. The responses ranged from not feeling safe with other residents who began to abuse substances to allowing a delivery person into the building. The feeling of safety and security ranked higher than inclusion in the community. Often an affordable housing unit is in a neighborhood within close proximity to illegal activity, such as drugs or prostitution.

The mentally ill individual often feels vulnerable, and unsafe (Forchuk, Nelson, & Hall, 2006). Often a mentally ill person has experienced crime or violence against them. "Some research indicates that more than 25% of people with severe mental illness have been victims of a violent crime in the past year, a rate more than eleven times higher than in the general population" (Whitley, Harris & Drake, 2008, p.168). Fear of crime can leave a mentally ill individual isolated within their housing, and disconnected from the neighborhood community (Townley and Kloos, 2010).

Income constraints

Many mentally ill individuals live on Social Security income. "The relative value of SSI payments has continued to decline and in 2006 was equivalent to only 18.2% of the median national income" (O'Hara, 2007, p. 908). The national average for a studio apartment is higher than the average monthly Social Security disbursement (National Coalition for the Homeless, 2009). In a study conducted on housing trends in 2004, one of the results was that a non-elderly mentally ill person on Social Security would have to spend 109% of their check on rent (Kidd, 2007). In the findings of the 2006 data from the US Department of Housing and Urban Development (HUD), the percentage jumped to 113% of their monthly income to afford a standard one-bedroom apartment (O'Hara, 2007). Due to economic constraints, many chose the single room occupancy (SRO) as a housing option in the private market. During the 1970's and 1980's downtown gentrification, most of these housing units were destroyed. The private market did not offer another choice in affordable housing. Lack of housing choice on a fixed income led to many mentally ill citizens to become homeless (National Coalition for the Homeless,

2009). Due to market constraints, low income, stigma and lack of adequate number of supported housing developments, often the mentally ill individual will live in substandard housing units in underserved neighborhoods (Kyle & Dunn, 2008).

Mares, Desai and Rosenheck (2005) found that mentally ill individuals sharing an apartment with another mentally ill individual had a higher level of satisfaction with their housing than participants living alone. The causal effect is not known, but due to income constraints, it could be that a roommate allows the individual to afford a larger apartment. The preference is for independent and supported housing units, yet due to income constraints, often the mentally ill individual cannot find an affordable unit that fits his/her needs (Forchuk, Nelson & Hall, 2006). Lack of affordable housing is a deterrent for many mentally ill individuals to live independently. The housing that is obtained is "often being of poor quality, too small, and lacking privacy" (Forchuk, Nelson & Hall, 2006, p.46)

Often, research on the benefits of housing the mentally ill focuses on the context of hospitalization costs and mental health services (Gulcer et al., 2003; Newman et al., 1994; Whitley, Prince & Cargo, 2008). Research findings have shown that housing affordability impacts the number of days a mentally ill person is hospitalized per month. The more affordable the unit, the fewer amounts of days spent hospitalized (Newman et al., 1994).

Most research has been based on housing as it relates to the treatment of mental illness (attached to services) versus the actual physical building of the housing unit. Little study has been done on the actual physical environment or the surrounding

neighborhoods (Harkness, Newman & Salkever, 2004; Newman, 2001). It is not fully known what part the physical environment and the neighborhood play in long term housing retention of the mentally ill population. The reason housing as itself is important to study is "the need for housing remains constant over a person's lifetime, while the need for services varies" (Harkness, Newman & Salkever, 2004, p.1343). Having stable housing and income is often indentified by the mentally ill population as the two most important factors in maintaining stable health (Kyle & Dunn, 2008).

The existing housing models have provided shelter. All housing, whether for the mentally ill population or the non-mentally ill population, needs to be an experience that it is one's home (Kyle & Dunn, 2008). The satisfaction a mentally ill individual experiences in his or her actual housing is an area of study that is lacking (Hanrahan et al., 2001; Mares, Desai & Rosenheck, 2005; Ridgway et al., 1994). In the building of new housing developments for the mentally ill population, the main voice not heard is the actual population that will live in the housing and community. The "field continues to ignore the desires and needs of individuals and denies the opportunity for empowerment that accrues when a person makes choices directly relevant to his or her life" (Ridgway et al., 1994, p.408). The mentally ill population is often shown their housing after it is built. In contrast to the private market, there is no survey or input from the consumer about preferences or desires for the housing. Because the mentally ill population has a high occurrence of homelessness, success is viewed as being housed, not if the dwelling is a home. "A home is personal space; to create a home, the voice of the individual tenant must be heard" (Ridgway et al., 1994, p.408).

In the words of one study participant, " 'where I'm at, you can't call that home' " (Forchuk, Nelson & Hall, 2006, p.46). Padgett discusses the need for ontological security within the general population, and most important, the mentally ill population. Ontological security is defined as "the feeling of well-being that arises from a sense of constancy in one's social and material environment which, in turn, provides a secure platform for identity development and self-actualization (Padgett, 2007, p.1926). Ontological security is met by constancy of environment, routines of daily life are performed within the environment, sense of control over one's environment, and home is seen as a secure foundation that allows personal development (Padgett, 2007). In contrast to the general population, "when people labeled mentally ill suffer the effects of controlling environments, these reactions are viewed as negative symptoms of mental illness rather than as predictable person/environment interactions" (Ridgway et al., 1994, p.409).

In summary, the literature review identified the following critical gaps in our understanding successful housing for persons with mental illness; housing features, neighborhoods, sense of community, income constraints, and ontological security. The involvement of the end user of the space is missing from the design process. I studied the housing satisfaction of mentally ill individuals in supportive housing in order for their opinions to be heard regarding their housing satisfaction so that future supportive housing that is built can use the information in the development and design process. The longterm goal of the study is to build upon the past research findings and expand the conversation of supportive housing design to include the individual that will be living in it.

Chapter 2. Theory

Empowerment of the individual and individualism have been the cornerstones of the American psyche since the Colonists dropped the tea into the Boston Harbor (Simon, 1990; Gruber & Trickett, 1987; Rappaport, 1987; Swift & Levin, 1987). "The concept of democracy and its embodiment in our political institutions are based on the principle of empowering citizens to participate in decisions affecting their welfare" (Swift & Levin, 1987, p.72). The social work field has been an area that has emphasized personal empowerment since the 1800s. This was the beginning of a change in social work perspective from helping the poor population to helping the individual help him or herself by developing self-determination and a sense of empowerment (Busch & Valentine, 2000).

The families of mentally ill persons and patients themselves have a long history of advocating for better living conditions. In the 1840's Dorthea Dix established model hospitals for the mentally ill versus the jail-like quarters that previously housed the mentally ill. In 1908, Clifford Beers' book detailed his horrific time in a mental institution. Beers, along with influential people from finance, psychiatry, psychology and politics, established the National Committee for Mental Hygiene in New Haven. In 1946, *Life* magazine published an article and pictures reporting the inhumane conditions of the mental institutions. That same year, Congress passed the National Mental Health Act. Four years later, three main advocacy groups for mental health joined forces, and formed the National Association for Mental Health (NAMH). Their first goal was to dismantle the large state hospitals and relocate treatment to local mental health centers. The

Community Mental Health Centers Act of 1963 accelerated the de-institutionalization of the mentally ill closing institutions and moving mentally ill persons into community facilities (Foulks, 2000).

By the mid-1970's communities were receiving larger numbers of mentally ill citizens as deinstitutionalization of mental health facilities continued. Many families were now faced with providing assistance to family members with mental illness at home or finding local group home accommodations. Mutual help groups such as the twelve step tradition, the 1960s civil rights movement, and subsequently the women's movement propelled the idea that "the only organizations of the historically subordinate could transform their own conditions of existence through accruing and exercising power and influence" (Simon, 1990, p. 29). Out of frustration with the medical model of blaming the family for the individual's illness, two mothers of men with schizophrenia formed a grassroots group called the National Alliance of Mentally Ill in 1979 (Foulks, 2000). The mission statement of NAMI:

> "…recognizes that the key concepts of recovery, resiliency and support are essential to improving the wellness and quality of life of all persons affected by mental illness. Mental illnesses should not be an obstacle to a full and meaningful life for persons who live with them. NAMI will advocate at all levels to ensure that all persons affected by mental illness receive the services that they need and deserve, in a timely fashion" (http://www2.nami.org/Content/NavigationMenu/NAMI_Center_for_Excellence/Tools_for_Excellence/NAMIMissionandIdentityStatement.pdf)

In a U.S. historical context, the cry for empowerment among disenfranchised groups became louder and louder within communities, one example being the NAMI. In the new field of community psychology, mental health became a focus of research.

Julian Rappaport formally published his paper on the development of the Empowerment Theory in 1987. In a call to the community psychology field to pay attention to theory in research, Rappaport (1987) describes empowerment as "both a psychological sense of personal control or influence and a concern with actual social influence, political power, and legal rights" (p.121). Empowerment is multilevel and can be applied to the individual, the immediate community, and society at large (Rappaport, 1987).

The core of empowerment is power, as defined as to "influence the forces which affect one's life space for one's own benefit" (Pinderhughes, 1983, p.332). Empowerment Theory is viewed to be "rooted in three important elements: power, powerlessness, and oppression" (Busch & Valentine, 2000, p. 83). Due to the Empowerment Theory being multilevel, applicable to a person or a group, research using Empowerment Theory is multidisciplinary. Empowerment Theory has been applied to the populations of women, gays and lesbians, the elderly, people with disabilities, the mentally ill, homeless population, and public housing residents (Swift & Levin, 1987; Gutierrez, 1990; Fisher, 1994; Busch & Valentine, 2000).

In social work, the concept of the empowerment theory has developed into empowerment techniques to be implemented when working with individuals. For example, Lorraine M. Gutierrez advocates for using empowerment techniques based from

the Empowerment Theory to enhance a person's sense of personal control and power in the ability to influence those around oneself. She established a model of a social worker helping empower the individual versus helping the individual fix their problems. One is the client in control of their situation; the other is the professional in control of the client's situation.

Gutierrez defines empowerment research techniques as:

1) Accepting the client's definition of the problem (acknowledging they can indentify theirissue).

2) Indentifying and building upon existing strengths (client's current level of functioning).

3) Engaging in a power analysis of the client's situation (how the feeling powerlessness is affecting the individual).

4) Teaching specific skills (gain access to resources).

5) Mobilizing resources and advocating for the clients (client & professional bridging to the larger community to ensure the social structure supports the client empowerment).

As can be seen in these techniques, it begins with the individual, but branches to the social structure supporting the empowered individual by moving beyond the level of client intervention to social support (Gutierrez, 1990).

In the mental health field, the empowerment model of recovery has become more prominent. Within an empowerment model of recovery, the consumer is included in defining treatment, and being active and present in their healthcare plan. This model contrasts with the current model of care that has been medically based where the physicians have the power, dictates the treatment, and has often infantilized the mentally ill consumer. Fisher (1994) discusses health care reform based on the empowerment model of recovery as based on the past experiences of mentally ill persons, and the movement toward independent living by people with disabilities (Fisher, 1994). The leaders of the independent living movement are people with disabilities, so it is a true empowerment movement based on Rappaport's theory of empowerment (Rappaport, 1987). Fisher states the following as the principles of the empowerment model; hope, personhood, achievement of self-defined goals, choices, opportunity to speak for oneself, peer support, end of discrimination, self-control of symptoms, well-being, liberty, and healing from within. One of the applications of these principles is the promoting of choice in housing. The main points of his paper are to recommend that the mentally ill consumer be involved in his or her individual's health care plan, and to maintain federal funding for programs and healthcare that promote their personal empowerment in independent living (Fisher, 1994). This approach to empowering the actual individual "encourages clients to find their own answers to their own questions while making their way in a difficult world" (Simon, 1990, p.35).

The application of Empowerment Theory in conjunction with structural constraints can be seen in the Housing First model of housing that is currently being used

in the U.S. to obtain housing for formerly homeless mentally ill consumers. As the name suggests, the consumer is placed in housing first (overcoming the structural constraint), and subsequently he or she chooses to participate in psychiatric or substance abuse treatment programs (empowerment). Housing is not linked to treatment as in the continuum of care models, and the consumer has choice and a voice in their treatment program model (Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004; Greenwood et al., 2005; Gulcur et al., 2007; Stefanic & Tsemberis, 2007). The basis of the Housing First model is choice by the consumer, with the structural constraints of a lack of housing lessened by affordable housing options being provided by a non-profit agency. The founders of Housing First attribute the success of the program to the fact that "addressing the consumer's needs first is the guiding principle for all subsequent services that are offered" (Stefancic &Tsemberis, 2007, p.3). "By empowering people with mental illness to 'choose, get and keep' the housing and support services they want, the intent is that they will experience their residence as a home rather than as a housing program" (Walker and Seasons, 2002, p. 313 quoting Carling, 1993, p. 443). The shelter model is designed to offer housing and social services for the formerly homeless mentally ill along with support. Staff recommends services specific to the individual's needs, and offers permanent independent housing on the client's schedule, not the providers (Bridgman, 2002).

Riger discusses empowerment as "sometimes equated with participation, as if changing procedures will automatically lead to changes in the context or in the distribution of resources" (Riger, 1993, p.282). There are only finite resources, which

raises the competition for resources between formerly disenfranchised groups. A group's quest for empowerment could be at the expense of another group. As Riger (1993) states "the underlying assumption of empowerment theory is that of conflict rather than cooperation among groups and individuals, control rather than communion" (p.285). She raises the question whether connectedness to the community is more important than the empowerment of an individual. She argues that community connectedness is just as vital to the mental health of a human being. In her view, empowerment theory research has centered on the individual or a particular group, and failed to connect it back to the overall wellbeing of the community in which the individual or group exist. She raises an interesting point that is very pertinent to the mentally ill population; "that community or empowerment can be substituted as a goal when what people actually need is better jobs and more income" (Riger, 1993, p. 289). Mental illness can be a barrier to obtaining work. Often persons with a mental illness are not able to compete for a job, or if obtained, hold steady employment (Baker & Douglas, 1990; Forchuk, Nelson, & Hall, 2006). Going back to NAMI's mission statement, it is empowering the individual to obtain the services that are needed to have a high quality of life for themselves as they define it. An area that the mentally ill population has traditionally experienced little power or choice has been in their housing (Sylvestre et al., 2007; Helfrich & Fogg, 2007; Tsembris, Gulcur, & Nakae, 2004,).

The empowerment lens has also been used in Feminist Theory research. "Women emphasize the importance of empowerment…their purpose is to help those who have shared subordination to achieve autonomy by learning to trust their own personal power

as it has emerged and been tested in the conduct of their daily lives" (Moglen, 1983; p.132). Feminist Theory centers on the woman as the active subject of the research in an open, inclusive process between individuals that respects and includes women's ideas, experiences and action strategies (Linton, 1990).

Within research using the Empowerment perspective, the actual individual being studied should be guiding the research process. "A study in which the type of data sought is determined solely by professionals who evaluate the consumer is inadequate. Surveys of professionals are contraindicated unless comparable surveys of consumers are included" (Rapp, Shera & Kisthardt, 1993, p.729).

"Rather it [data] can be derived by researchers who are willing to hear what consumers are saying and who are engaged with consumers in a way that seek to learn from them rather than to study them" (Rapp, Shera & Kisthardt, 1993, p.730). Expanding on Empowerment theory and Feminist theory has led to a movement of community-based participatory research. Within community-based participatory research, the researcher works in partnership with community leaders and members. As a cohesive group, they identify the research question, develop the research structure and data collection method, the interpretation and dissemination of the findings and then develop future action plans for the community using the research findings. "Partnership creates bridges between communities and researchers, incorporates knowledge and action based upon the lived experiences of community members, and ensures to collaborative development of research to impact individual and community well-being" (Hergenrather et al., 2009,

p.687). A methodology that has emerged out of community-based participatory research is photovoice in which participants use photographs to share their concerns and opinions of their lived experience.

Chapter 3. Methodology and Data Analysis

Method

In order to examine the housing satisfaction of mentally ill individuals living in supportive housing, I sought to obtain their opinions regarding their housing situations so that designers and funders planning future supportive housing can use the information in the development and design process.

Qualitative research methods were used using a psychological phenomenological approach. Psychological phenomenology is a focused study on "the meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell, 2007, p. 57). The participant's description of their lived experience is the focus of the study versus the researcher's interpretation of the data (Creswell, 2007).

Adhering to Empowerment Theory, qualitative research methods encouraged the participant to contribute his or her own words in the research (Rapp, Shera & Kisthardt, 1993). The data collection method used was photovoice. The participant was given a camera, asked one or two questions, and they were asked to take photographs to represent their answer. "This form of photo-elicitation is known as 'auto driving'" (Erdner and Magnusson, 2011, p.146). The participant is in control of their answer as they see and experience it. The researcher meets with the participant, and the participant shares the

meaning of the photos. "Photovoice is a qualitative research methodology founded on the principles of feminist theory, constructivism and documentary photography" (Herenrahter et al., 2009, p.687). Photovoice has been used in past research for vulnerable populations to share their personal experiences and viewpoints (Erdner & Magnusson, 2011; Fleming et al., 2009; Miller & Happell, 2006; Thompson et al., 2008; Wang & Burris, 1994; Wang & Burris, 1997). For example in one study, photovoice was used by psychiatric patients to share their thoughts on living with a mental illness. The patient also shared the best methods the professionals should use in their daily interactions with patients (Thompson et al., 2009).

Miller and Happell (2006) used a comparison of photovoice methods versus standard interviews for people living with schizophrenia to articulate what hope means to them. The interviews without photos tended to center on the person dwelling on their daily-lived-experience, versus the interviews with photos in which the individuals delved into the deeper meaning of hope. One explanation for the difference is that in the interviews with photos, the participant had the camera to take photos for two weeks, allowing them to think about hope longer. "The participant, out of necessity, dwelled on the idea for some considerable period prior to the interview. The taking of photographs was a way of recording the moments at which hope was present in the consciousness of the participant as well as serving as a symbolic reminder of what hope may be for that person" (Miller & Happell, 2006, p.1056).

In applying the empowerment perspective, “the point is that people have different realities, and it is the consumers’ reality that needs amplification” (Rapp, Shera &

Kisthardt, 1993, p. 729). Empowerment perspective research stresses the inclusion of the consumer in the process, and not viewing them only as a subject to be studied. "The Empowerment perspective suggests that the study data not only must come from the consumers themselves but also should be collected by consumers whenever possible" (Rapp, Shera &Kisthardt, 1993, p.729). Photovoice puts the camera in the participant's hands and they select the information they feel is important to share with the researcher (Erdner & Magnusson, 2011; Wang & Burris, 1997). This technique facilitates and empowers participants in the research process, "Although they were not specifically asked to describe their experience, each of the photographers expressed positive feelings toward their participation in the process" (Miller & Happell, 2006, p.1061).

Bias

In qualitative research, the researcher has to acknowledge their part in the research process and examine how they are bringing personal bias such as feeling prejudice for or against someone or something, to the research process. In the psychological phenomenology research approach, the researcher uses the concept of bracketing. Bracketing refers to the researcher setting aside their bias or opinions and examines the data as it presents itself (Creswell, 2007).

I, as the principal investigator, previously worked in the commercial interior design field and came to the research topic interested in how the individual housing unit design impacted the housing satisfaction of the supportive housing resident. I had volunteered at an anonymous crisis line and heard the stories of mentally ill individuals afraid of losing their housing. However before conducting this study, I had no prior

relationship or knowledge of the participants or any prior relationship or investment with the supportive service providers. Thus I was able to bracket my prior housing knowledge and listen to the participants share their lived experience and opinions on their current housing.

Data Collection Procedures

The study was conducted from March 2014 to May 2014 in the Minneapolis, MN metropolitan area. Purposeful sampling procedures were used. The researcher contacted two supportive housing providers and obtained permission to solicit participants living at their housing complex. One of the housing providers has a requirement that in order to live at their development, residents must have a persistent mental illness diagnosis. The other housing provider uses the Housing First model. The residents are formerly homeless and may have mental illness and/or substance abuse issues. The housing providers were not involved in the recruitment of participants. As the researcher, I went to the supportive housing establishment and solicited participants by personally attending a residents' meeting and presenting the research project to individuals. A follow-up flyer was placed in residents' mailboxes or handed to the residents at the meeting. If interested in participating in the study, residents then contacted me directly by telephone. In the first one-on-one meeting, I met with the participant and went over the consent form discussing the research project. I explained the ethical issues involved in photographing people and instructed participants not to photograph people since they did not give consent to be photographed for the research project (Erdner & Magnusson, 2011; Thompson et al., 2008) I also emphasized that the information collected would remain

anonymous; all findings would be reported without indentifying the participant. None of the findings would be reported back to the supportive housing service provider with identifying information. I reiterated that I was not affiliated in any way with the supportive housing provider and that participation would not in any way affect their housing. University personnel contact information, including Human Subjects Protection representatives, was given to the participant to contact if they were not comfortable with any part of the research process. The participants were told that at the completion of the research interview, a thank you gift card to Target for $10 would be given to them.

Each participant was provided with a disposable camera with 27 exposures. I asked participant to take at least five photos showing what the participant liked most about their housing situation and at least five photos showing they did not like about their current housing. All 27 photos could be taken if the participant chose to do so. The photos could be inside their home or the surrounding area. Both participant and I agreed that I would return in three or four days to pick up the camera to get the photos developed. Once the cameras were returned, I had duplicate photos developed. Each photo was labeled with a letter used to reference the participant and a number. In example, the first participant's first photo was labeled "A1", the second "A2". Next, I contacted the participants and set up a meeting to view and discuss the photos. The duplicate set of photos was given to the participant to keep.

I met face-to-face with each participant to discuss his or her photographs. This interview was audio recorded with the permission of the participants. During the interview I laid out the photos and reiterated that I was interested in hearing what the

photographs represented about what the participant did or did not like about their current housing. Participants were told that they could begin to share the photos as they wanted. As the participant shared the reason they took the photo, I verbally referenced the photo number for the recording and also wrote on a post-it note the photo number and the participant's reason for taking the photo. The interview structure allowed the participant to elaborate on the visual representations in the photographs as they felt necessary. Following guidelines from previous photovoice research, the participant led the conversation and I, as the researcher, listened (Erdner & Magnusson, 2011; Lammers & Happell, 2003). The interview times ranged from ten minutes to one hour depending on the number of photos the participant had taken and amount of sharing he or she was comfortable with. If needed, I did ask questions to gain clarity and understanding. At the end of the interview, I asked one common question of each participant, "if you were in charge to design supportive housing, what would it look like for you?" In addition to the photographs and interview data, I also kept a reflective journal throughout the research process.

Data Analysis Procedures

To analyze the interview data I transcribed each interview, typed up the post-it note information for each photo and compared the documents to verify information accurately stated the meaning of the photos. I then went through each document stating the meaning of each photo and used a different highlighter color for like items, coding for emerging themes per each participant. Next, I read the transcribed interview for that participant to verify the words of the participant corresponded with the highlighted color

of that theme. Using poster boards as an organizational tool, I combined all emerging themes and corresponding photos (See Appendix A). Each poster board stated a theme as a header. Appropriate quotations from the interview manuscript stating the meaning of the photo were placed on the respective poster board. All photos were organized into the corresponding themes and a few representational photos for the theme were chosen to illustrate the identified themes.

In the next analytical step, for each theme items that were "likes" were grouped together, and the "dislikes" were grouped together. I then went through the interviews and identified quotes explaining the meaning of the photos and those were put onto the poster board. Each quotation was on a piece of paper that was attached with rubber cement so it could easily be removed if through the analysis process, it fit better under a different theme, or if themes were merged, the information could easily be moved to a new board. On the right side of the poster board the two categories of "like" or "dislike" with bullet point examples given by the participants were included. The interview transcripts were read multiple times throughout the analysis process. Additional consultation with my academic advisor confirmed the emerging themes.

Validity in Qualitative Research

For qualitative data, triangulation is typically used to validate the themes seen in the research. Triangulation in this study was achieved with photos, transcribed interviews, and member checks during the interview. In qualitative studies, a member check is defined as bringing the findings and interpretations back to the participants to examine the rough draft of the analysis (Creswell, 2007). The member check during the

interview consisted of the researcher stating what she heard the participant say and verifying that is the correct meaning the participant was conveying with the photo and explanation.

"Typically, this process involves corroborating evidence from different sources to shed light on a theme or perspective" (Creswell, 2007, p.208). For the research study, the different sources used were photographs, written notes during the interview, recorded interview transcripts, member checks during the interview, and peer review. The interview was recorded and the researcher transcribed the interview, checking it against the handwritten notes taken during the interview and photos taken by the participants. During the interview, the researcher would repeat what she heard from the participants regarding the meaning of the photos to verify she was accurately documenting the information. During the analysis process, the researcher first read through the transcripts of each participant several times and studied the corresponding photos. The next step the researcher wrote down the themes that were emerging from the readings. The researcher assigned a colored highlighter to each possible theme and then went through the transcripts coding the text as applicable. The researcher did this same analysis several times, and would change coding as seemed appropriate during the several readings. The researcher then took a clean copy of all the transcripts and cut out the sentences as coded on the final copy. Each cut-out sentence was marked with the participants code used for the corresponding photo. All of the participants' sentences for one theme were grouped together along with the corresponding photos. Each theme group was laid out together and the researcher read through the sentences, examining if the information did support

the proposed theme. Through this analysis, the researcher moved sentences and photos to the appropriate group and also discarded themes that initially bubbled up in the reading but were not supported by the text and photos once further examined across all participants. The researcher then took poster boards as an organizational tool to combine the text and photos of each theme. The poster board was broken into "likes" and "dislikes". Each piece of paper was attached with rubber cement so it could be removed from the board if needed. The researcher again studied the participant's words and corresponding photos, verifying that the stated theme was valid. The researcher moved participant's words and photos as appropriate between the boards. The researcher would play the recorded interview to verify the written information on the poster boards reflected the message the participant conveyed during the interview. The full transcripts of each participant were read several times throughout the process. The researcher met with her advisor to discuss the themes for validity. The poster boards were used as a way to present the information and a tool to move information and discuss the emerging themes. During this process, the advisor questioned the researcher on the themes and interpretations.

Research Setting

The research was conducted in three locations. Two of the sites were located in the downtown area of Minneapolis and one site was in a Minneapolis suburb. The two locations in the downtown area are operated by the same supportive services organization and are based on the Housing First model, so residents' housing is not restricted or threatened by the use of drugs or alcohol. The residents of the two downtown buildings

are people that were formerly homeless and often have mental illness issues and/or substance abuse issues. Each building is a historic building repurposed for supportive housing.

At one site, there are 70 units in the six-floor building. All floors are designed with double loaded corridors. There are 12 units on floors one through four and floor six. On the fifth floor there are 10 units to accommodate a community kitchen. On each floor, there are 2 units that share one bathroom. The rest of the residents have their own bathroom. Each unit has a small kitchenette with a microwave, coffee maker, sink and refrigerator in each unit. There are community kitchens with stoves for cooking purposes on the basement and sixth floor. In the basement area, there is a community television room and access to an outdoor courtyard.

In the other downtown location, there are 73 units in the six-floor building; five of the floors consist of residential units. The first floor has a lobby and resident's community television/computer room. Floors two and three have 17 units that are single rooms with community bathroom and kitchens. Each resident on the floor is given a kitchen cabinet with a lock to store food in the community kitchen. Microwaves, refrigerators and coffee makers are not allowed in the single rooms. In the renovation project converting the building to supportive housing, floors four through six were added to the building. Each of these floor's layout has 13 efficiency apartments with full kitchen facilities in the individual unit. The building has no outdoor courtyard space.

At each building, there is a 24-hour security desk and on-site case managers are available during regular office hours. Each resident has his or her own bedroom or

efficiency apartment. Laundry facilities, coin-operated washers and dryers, are on the premises. Each resident is responsible for his or her own meal preparation.

The suburban site has approximately 19 residents and is located within a townhome community. Families and residents who do not receive supportive services occupy townhomes in the surrounding complex. The residents in the suburban site are required to have a diagnosis of a severe, persistent mental illness in order to be eligible for the housing. Each townhome in the supportive services housing has 3-4 residents depending on the size of the townhome. Each person has their own bedroom, and then shares the common areas of the townhome. Each unit has its' own washer and dryer and is not coin-operated. One townhome in the complex is the case manager's office building. It has the offices, a community kitchen, and a community room for residents use. The residents come to the office for dispensing of medications and on-site therapy services. There is an optional meal plan in which residents eat meals at the community kitchen prepared by an on-site cook or, alternatively, the residents can cook for themselves in their home.

The townhomes in the development are situated in a rectangular shape with the middle of the rectangle an open green area. All townhomes in development share this green space, and it has a playground for the children living in the homes that do not require supportive services. Adjacent to the office building, there is a private courtyard with a patio for the supportive housing resident's use only.

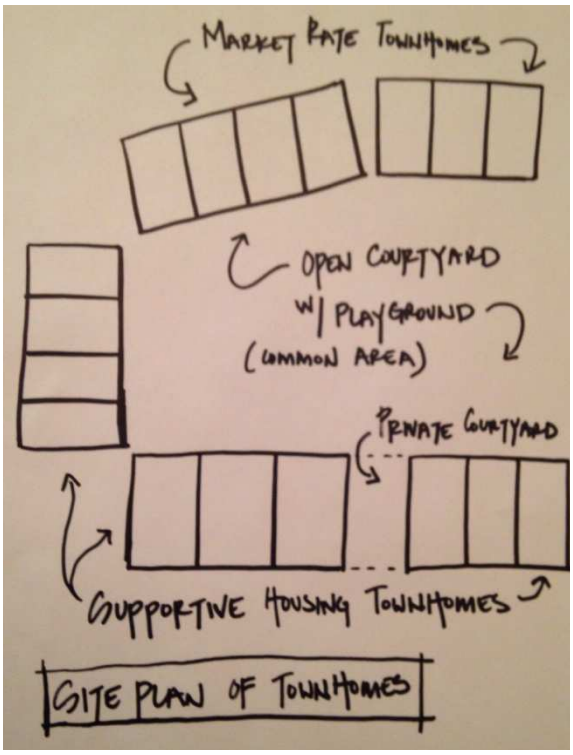

Figure 1: Site plan of suburban townhomes

Participants

Twelve individuals signed consent forms and were given cameras. One returned the camera with no photos and two set up appointments but missed them and did not return calls back to set a new appointment. Nine individuals returned cameras and shared their reasons for taking the photos. Each participant took between 10-23 photos. A total of 179 photos were taken for the study.

Chapter Four. Findings

Six themes emerged from the data. They are discussed in this chapter in the following order as it pertains to the participant's daily living; actual dwelling unit (room/shared house), neighborhood and outside environment, community connection, building maintenance and management, accessibility, and economic concerns.

Actual dwelling unit

Overall, the participants in the study liked their actual living unit, regardless of the type; a bedroom-only one-room unit, efficiency unit with kitchenette or the private bedroom and shared living area townhome. The photos showed personalization of the space, views from the unit's window, and ability to prepare food for many of the participants. Participants liked the layout of the space, and even for those that shared a townhome, they liked that personal space was provided for each individual in the unit.

A few participants stated that their rooms were spacious, had walk-in closets and ample storage space. They liked that there was storage space within their personal unit to store their personal items and that walk-in closets were provided.

Figure 2. Resident's room

Regarding the photos Participant B stated (see Fig.2);

> "these ones I took because I like how spacious my room. I think that is cool. I like that. I like the mirrors that they have on the

doors. I like how deep the space is because you know you have a lot of space to put stuff."

Participant E stated;

"And this one. Oh my closet, yeah my closet. The fact that we have walk-in closets"

Participant E was happy to have multiple windows in her space. A few took photos of the view from their window stating they liked the view. The views ranged from the parking lot next door to a green area in midst of the buildings.

"These are basically taking pictures of my entry and my other window cause I got two like this, no I got great big huge one and then on the other side of my room of my wall is the opposite one that faces the back of the apartment lot".

Participant D did not particularly like his view since it faced a brick wall, but did like the pigeons outside his window.

"And this is my window that I where I have a great view of all the pigeons that come by….I kinda try to get them to fly closer but I even set down bread one time".

He also stated;

"yeah, but it is a place so..I'd rather have a place with no view than no place at all".

They liked the ability to have a kitchenette, microwave, refrigerator and coffee maker in their unit. They liked the layout of the room and that everything is right there

and they do not have to go far within the space. As Participant E explained the layout of her unit,

> "yah, this like when you walk in this is like a little hallway when you walk in. It's just one big room; it's got my kitchen and that and my bed over here and my TV."

Participant F shared:

> "I like these [photos] yeah, they are just the layout of my room and the fact that I can have my coffee maker. I didn't take one of the microwaves but I should have. Everything uh is right there. It is all ah, all ah, in one room. I don't have to go too far to get anything."

Regarding having his own kitchen in his efficiency apartment, Participant D stated;

> "I like it a lot because you know, like I said, I don't have to come down here two in the morning if I want to eat. I can get my food if I have to have, you know."

Personalization of the space was seen in the photos and the participants spoke about it in terms of their interests. Participant L spoke of the computer in his room and said that he was working on a second book (see Fig.3). He also took a photo of his stereo system and described music as his "life-line" because music brings out emotions and takes stress out. He shared the singers he loved to listen to while sitting in him room writing or just hanging out.

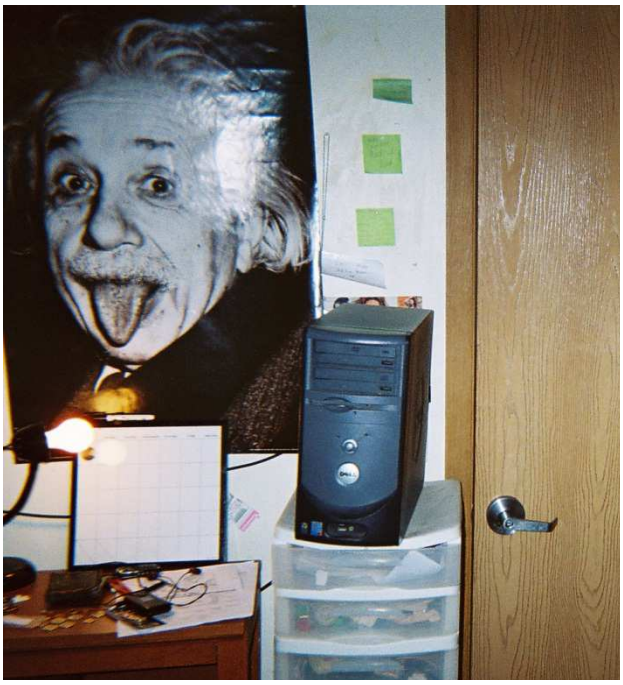

Figure 3. Personalization of space

Participant M shared a photo of her sofa and explained that she spreads out and reads on the sofa.

> "this is our living room and this is the couch is right there and I turn these lights on and I just kind of spread out on the couch so that's kind of my reading corner."

Participant C spoke about being connected to a non-profit that provides home furnishings. He stated without that service, he would have been sitting in an empty room for a long time and was grateful for the non-profit providing him the ability to furnish his space as he wanted. Many of the participant's photos showed walls adorned with photos, pictures and items that had personal meaning. One person had his mother's ashes sitting in his room and shared how he missed her but felt better having her ashes with him.

There were a few dislikes that were shared by the participants. The dislikes primarily centered around personal privacy and hygiene. Participant F lives in one of the units with a shared bathroom. He shared:

> "In mine we share a bathroom and um, it is bothersome, cumbersome." When asked why he did not like it, he said "ah, (the bathroom is) not available to me at all times. He [person that shares the bathroom] tends to knock on my door when he needs something and always at night so I don't think I should be there."

Participant E commented on the community kitchen being the only location of stoves for the residents.

> "This is the kitchen [photo of community kitchen]. I don't, I don't basically hate it but I don't like it, is just the fact that I wish all the rest of the residents had their own, you know, their own stove." The participant shared not only was it the fact that food had to be transported from the personal unit downstairs to the community kitchen but also because "you gotta, gotta um, you know be around others and some don't like to cover their mouth, things like that."

For Participant M that does have a full kitchen, she shared photos of her neighbor's kitchen that was larger and had more space for cooking and dining than her home. She did state that she had a good relationship with her neighbors and was allowed to use their kitchen to cook with them if she desired.

Participant F shared that his unit came furnished; he was not involved in choosing the furniture. He felt the furniture was dated and should be updated.

Neighborhood and Outside environment

Many of the participants from one of the downtown locations dislike the noise pollution in their neighborhood. The building is located near an area of downtown with multiple entertainment venues ranging from a baseball park, sports arena, and music venue. The back alley of the building is shared with a bar and gentlemen's club. The area was also experiencing a large amount of construction (new building and street) during the interview time period.

As Participant D shared (see Fig.4):

> "That's the alley and um, like this is where the trash man comes and picks up at 4 o'clock in the morning and wakes me up. And the clanging of the beer bottles when they dump them into the dumpster there…I mean every morning 4 o'clock that beep beep beep you know"

Figure 4: Picture of Alley behind building

Participant A shared;

> "This is the strip club here so, ah, you can hear people from the strip club and the place like never shuts down…but those pictures are all of that building [hotel] and the noise that they are creating. The noise is just phenomenal, it's just, it's unbelievable. People don't believe it but it's just so."

Participant C stated he understood that the building was located in a busy entertainment area (see Fig.5) and he understands that but still;

> "I am just bothered by the excessive noise pollution that there is…[after music and sports events] there will be, um, people basically panhandlers

that will come out with their plastic drums, plastic barrels. Some its really impressive and good for them, they're doing that and whatever. Sometimes it's just total noise, but its not the drumming itself it's that it can be very late at night…there's noise ordinance they're not suppose to be playing those things ah, after 10:30 or something like that. So it's mostly about that kind of noise and loud noise after hours, and you know some of the bars don't close until 2 [am]".

Figure 5: Busy Entertainment area

Another issue discussed was the location of a homeless shelter and bus garage near the building. The lack of safety and people who use the public space outside the building was discussed by some participants.

Participant D shared:

"then this is um, the homeless shelter over there. This is where you would not want to go ever, it is really bad…oh my experience you know um, right here this is how you get across the street after 5 or 8 o'clock at night you can't even go there you get robbed and beat up [across the street from the homeless shelter]..oh, I know people but I don't go hang out there because like I said when you go over there and they got the guy on the corner selling drugs or the gang members. You know people act really crazy over there they don't talk to you or think you are doing or bothering them or something….yeah so they walk through there [bus terminal] and like I said um I don't catch the bus in there I don't even go up on that street or in front of their building. I try to stay away from that because it is just a lot of bad people. So I stay away".

Figure 6: Relocated bus stop

Due to the construction in the area, a public bus stop was relocated to an area across the street from the one downtown building location. Participant A shared a photo and her thoughts on the new location of the bus stop (see Fig.6):

> "what they did was that used to be a bus stop so they took away the bus stop from there and they put it right across the street from us. And if you ever want to see the lowest forms of human beings you come and look at this bus stop that is all it is. It is just horrible. I mean we've got everyday there's at least somebody gets arrested, somebody gets taken away in an ambulance because of drugs and drinking. The prostitution is horrendous right here across the street from us and plus we have the girls at the [strip club] you know and they're soliciting people and it's just, you know, a constant. This area does not ever die down".

A couple of the participants spoke about having a liquor store located down the street from their building. They shared that many residents in the building struggle with alcohol or drug dependency issues and feel that the outside environment doesn't support their attempt to maintain sobriety.

Participant A shared:

> "I think it is a bad area because they, they want us to um, quit drink, quit being on drugs, give up, you know, our addictions and stuff and you can't, it's almost impossible here, you know, because everything is right in front of you, you know, you have to escape it you".

Participant D stated:

"[liquor store name] right down in the heart, right where all the people need, the homeless people then they go sit on the [street] and get arrested if they have bottle out or whatever…I don't drink. Just another bad place that I thought".

Many participants shared that they liked the outdoors, courtyards and elements of nature that were around their current home or wished they had these elements at their current building. Participants shared that they use the courtyard areas to relax, meditate, drink coffee, smoke and socialize (see Fig. 7). Multiple participants commented on trees either in the green space of their complex or near their building.

Figure 7: Outdoor Courtyard area

Participant D lives in a building without a courtyard and took a photo of another complexes' courtyard stating:

"But you see we, we don't have a barbeque grill or nothing so we can't barbeque, but this one, they can barbeque because they have an outside.

They've got a garden they can barbeque. They can go out there and hang out. So I guess that's the next step up [in supportive housing]".

Participant M lives in the townhome complex that has a patio space facing out to a green courtyard space (see Fig.8); as she explained:

"Here is the one [patio] in the back facing the courtyard and I come out here in the early morning, sit here and drink coffee and stuff. I love being out there in the early morning. Meditating, drinking coffee, whatever".

Figure 8: View from patio to backyard

She also took a photo of a tree outside the building (see Fig.9):

"This tree is so pretty right out, see it right there that old tree".

Participant L took a photo of a tree by his residence and shared:

"And this one here is like the tree of life for me. I use the example last summer I was really examining it I don't know why it just caught my eye it's been there for every since I moved in but last summer it caught my eye and I've monitored it ever since….that tree, the tree it's a beautiful thing and as autumn came the tree started changing colors and it, it just got to me".

Figure 9: Tree outside building

Community Connection

Multiple participants spoke highly of the case managers and staff that provide the supportive services. The participants shared multiple ways the support staff help them and that they appreciate the staff's availability by being on-site. Participant L shared a

photo of the front of the building that houses the offices of the supportive services and described the building as his "home".

> "[house number] represents home. And home I think even though these other ones [photos] some are of home; this is peaceful because this is the part of the home area…that I can do recreational things and get my therapy…it's cool to be around, surrounded by more people, it always feels more, more you know, more better and to see faces 'cause when they leave for the weekend it like, it's really quiet around here. And then the staff comes, yeah, right, so what are we going to talk? Where are we going to go?"

Participant C shared:

> "I just think it is awesome that those guys [case managers] are on-site, made available, ah, business hours, um, and it's yeah, I'm not really sure what this place would be like without their services. Um, they, um, yeah (pauses) they are kind of a necessary part of the whole thing, and um, I totally appreciate".

Participant B shared:

> "And then another thing I like is the staff 'cause they are pretty nice with the exception of maybe a couple"

Participant M commented on the staff longevity. The participant had lived in the housing for thirteen years and had many of the same support staff during the whole time.

"The staff stay here a long time and I have had serious, serious major depression but I haven't had depression for probably, well when I moved in here…I was a little out of sorts then".

Expanding on the work done by the case managers and staff, multiple participants spoke about the activities and events the supportive services organized. The activities ranged from baseball games, basketball games, museum outings, plays, and outdoor parks. The on-site activities included poetry readings, AA meetings, movie nights, art therapy, pizza parties and barbeques. Participants spoke about residents having input into the planning and execution of events. A couple spoke of an organized resident's planning council that was at their site. Participants understood the work that went into organizing the outings and one participant felt frustration with residents that did not take part in the groups and activities.

Participant B shared:

"And this stuff I took 'cause I like how they, how everybody gets to come up with the ideas and stuff to be done and all the little groups they have. I go to a lot of the groups. They have art groups, they have recovery support groups I go to, they got explore art".

Participant A shared:

"I am doing as much as I can for my good. I don't have to worry about any of these people because they are going to do what they feel like so I go to my AA meeting Thursday night here it was one of my, of my neighbors that started it".

Participant A went on to share:

"And then they have movie night so I go to that. That's every Wednesday night. And then Tuesday night is Poetry night. So we can, you know, we do our short stories and poems and the guy that started that's here, uh, lives here on this floor".

Participant B showed a poster regarding the Resident Council (see Fig.10). When asked if the participant was on the Resident Council, she stated, "No, but I plan on it."

Figure 10: Resident Council poster

Participant A shared the following comments about the Resident Council:

"we discuss what we would like to do, you know, like uh we wanted the tickets [baseball] I said let's see if we can get tickets for the home game. We couldn't but we are going to go now on the, I think the 20th of this month, go and get the full tour over at the [local museum]".

Another site had an activities board that the residents could sign up for activities. Participant M took photos of the boards (see Fig. 11) and shared that they had recently gone to a play and another shared going on an outing to a science museum.

> "This is for the whole month [photo of calendar] and this is by the week…everyday of the week and you sign up and there, there is another little spot here on the end—that designates what day we are having morning meeting. So there is a morning meeting everyday that is listed on here. Many times a week it is three or four times a week…it goes for about 10 minutes. People can check in what they are doing".

Figure 11: Activities Board

Participant A shared frustration with the residents in the building not being active or involved in the programs offered by the support services. The lack of resident's

involvement was viewed as leading to a lack of respect for the people living in the building.

> "So in fact our sister building, they are more involved than we are. We've got a bunch of people that couldn't care less…because the staff tries to get you involved in anything and you know, they'll put up people's birthdays in the elevator, ah you know, what's going on all over the place. And they put it up in the elevator nobody reads. Nobody does anything around here".

Participant A shared:

> "This is not a good place for people because there are a lot of people at the end that live here and the noise level and uh, you know right about now you're going to be hearing outside is F, the F word comes in front of everything else…so you get really sick of that. I believe that if this is suppose to be a sober house because I asked if it was a sober house and they put me in here, and you know you've got to be kidding me. You expect people to get better in here? So I don't know why they have it, why they are not more strict because people will come walking in that door, fall face down in the front lobby they are that out of it and ah I don't know, the kid next to me, he's a total threat. So I've called the police on him a few times…there's some people that just should not be here because they are that bad mentally and never going to get better…but my thing is there are

people in here that they need to get off the drugs and the alcohol. They need to be taking their medication. And they won't do it".

Participants shared that the case managers kept them updated on programs they would be eligible to apply and also navigated the county programs for the residents. Two of the buildings have a bulletin board advertising non-profit programs and upcoming activities and outings being held. Participant C shared:

"this is mostly just about there's kind of like a variety of activities they keep us up to date on, other things going on in the community and other programs we might be eligible for, interested in and what not like that. They're, the staff here, is um yeah, are good at communicating all sorts of stuff that would be useful for us".

Participant A shared:

"outta the clear blue my case worker said 'do you want to participate in this theater group?' So I ended up in that you know, that really, I tell ya, that's a good thing for me".

Participant C showed a photo with a bicycle in his unit and shared:

"all they do, they take in bikes, um, and get them up to speed and give them away to people that need them so that is pretty cool. I mean that's, um, that's kind of sometimes those programs are the kinds of things you will see on the bulletin board, talking to [case managers] they'll mention those things".

Two of the participants spoke about pets. Participant E wished that they could have dogs or cats at their residence. They are able to have fish, but the participant felt a larger pet would help individuals become less isolated.

> "We have a no pet policy, uh, we can have fish but I mean something like a small dog or you know, cat. 'Cause I think that would make more come out of their units instead of isolating themselves and, you know, some had like, a what do they call it, pet companion".

Participant A shared a photo of a dog stating she goes to a local clinic that have animals for people to interact with as a means to reduce stress. It was started for the college students, and then expanded to allowing anyone in the community to come in. The participant goes to the clinic to interact with the animals.

> "There's a little dog [photo of dog] and what they have now at [local university] Clinic, ah, on Wednesday they have, you can go over there and for a couple of hours they have the cats, dogs, and they have a chicken. So you can interact with the animals…in fact, you can see it on our way out on the bulletin boards".

Participants spoke about the community within the building, and then connections to people outside of their residence. The personal connections gave the resident a sense of safety and feeling part of their housing community. Participant M shared:

> "Well, I think the main thing here is the community. So much is about the togetherness. Bring everybody together for meals…So, um, I think that

one thing that is unique about this assisted living because it involves everybody. We all really look out for each other".

Participant L shared that the townhome he shares with roommates they have given it a nickname and he likes to cook fried chicken for his roommates. Participant M shared that the residence had a community kitchen and the chef would hold cooking classes with the residents. The resident could propose an entrée or baked goods, and then the chef would guide the class. The resident had participated in many of these classes.

"He will maybe do like we are having a cooking class, um sometimes I am the one with the idea like the pear bread I am going to do with him and then whoever else wants to come in can watch or help. So I do the batter, I do all the stuff in the beginning and he takes it because we are not suppose to be in the kitchen [commercial kitchen]".

Participant M has two roommates and shared:

"My place is wonderful in the sense that um, I 'm very social and want a lot of the activities but in the afternoon I can be in our apartment for three hours at a time without anybody here. I feel like it is my own apartment because it's so quiet there. The three of us it is just wonderful. I appreciate it so much because I see next door where they will say 'do you know what so and so did' and I will say I don't care you need to work it out, you know. That works out really good in our apartment. Really good, and I give [support services provider] on that because they really read people

when they are moving in here for personality to make sure they have a nice fit and the three of us fit".

The two downtown buildings have a 24-hour security desk at the front door. A resident is contacted and told they have a visitor. Participant E shared that she liked the security and safety that provided the residents.

"To where our guests just can't come in like, like they have in ordinary apartments…[visitor has to give] some type of updated ID. Um, then they ring your room, tell you that you've got company down here…[can say] no I don't want to talk to no visitors".

Participant B shared a photo of the intercom system in her room. In her building, a visitor had to option to ring a bell in the hallway that buzzes to her actual unit. The issue is that the buzzing was not loud enough and she misses visitors.

"And this one I took a picture of because you can't hear them [buzzer]. So I miss a lot of my visits. You just can't hear it, not loud enough".

Participant A spoke about the employees of the Downtown Improvement District (DID) that walk the downtown area helping pedestrians with questions, picking up trash and contact police if they see illegal activity happening.

"I took it [photo] (see Fig.12) because there's a DID person and they are working on clean up and I really, I like the DIDs because they do so much around here because this place [downtown] would be a complete pig sty if those people weren't there".

Figure 12: Downtown Improvement District employee

Participant L spoke about his job at a fast food restaurant. He maintains the cleanliness of the lobby and dining area allowing him to interact with a multitude of people during each shift. He shared he has a mentor at work that helped him get a computer. He writes novels and shares them with friends, roommates, and co-workers. He expressed that he enjoys working and it gives him a sense of accomplishment.

> "I like to work, it's not like I told you that everybody hates work. It's just the atmosphere being at work it is great. I mean when you are doing something, I mean especially [fast food restaurant] you get spurts of people, they come in, they go out…then I have time and ah the employees and I myself, or the boss, we can communicate if we have other ideas, things we can take care, relay messages".

Participant A spoke about seeing people she knew in the past that are now working at her local grocery store and one as a security guard in her residential building. Having people from her past now in her present life gave her comfort.

"So I'm running into people that I know so then there's some comfort in that. The other thing is I was raised here in Minneapolis areas so everything is, it's familiar to me".

Building Maintenance and Management

One of the themes that emerged for the majority of the participants was the daily maintenance of the building, both inside and outside. All three locations have some form of a cleaning crew that comes into the buildings. For participants in the downtown locations, they spoke of putting in work order requests for specific items in their individual units. The cleaning staff is present each day for overall building cleaning. For the suburban location, they had a designated crew that comes weekly to do cleaning within their individual townhomes. Many participants were frustrated with the lack of responsiveness shown by the cleaning crew in the daily cleaning of the building.

Participant B shared photos showing a small laundry pile on a counter in the laundry room (see Fig. 13) and a broken chair under the sink in the community kitchen. The participant had lived in the supportive housing for six months at the time.

"The cleaning person that comes because that stuff [laundry] has been here since I have been here and they haven't cleaned it. It is just sitting there. And there is no garbage cans. [The cleaning crew comes] everyday. That is why I am saying it shouldn't be that way".

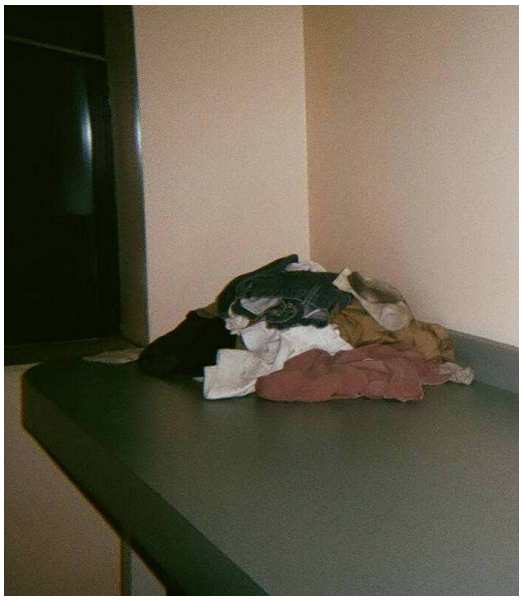

Figure 13: Laundry Room

Participant E shared photos of the walls in her unit and showed the line up to where she could wash the wall, and then could not reach it. She had not put in a maintenance request to have the walls washed and the cleaning completed due to feeling the maintenance people were busy with work orders. She had shown the building assistant manager the work she was able to do, and the part she was not able to complete.

> "So I'm washing the walls so you can see where it is all clean and one part is still dirty. So it is like, you know, I showed the assistant manager but it's just no way of getting around getting the rest of it done, you know what I am saying? But that without hurting myself… they have maintenance people here but they are always busy with, you know, other work orders".

Participant C took a photo of a community kitchen garbage can (see Fig. 14) and stated:

> "What I was trying to illustrate, um, here were two things. There's kind of a disrespect that you would say the majority of the residents have for

keeping the community space clean and useable. Um, now with these garbage cans specifically, I'm not really sure that's the residents who are suppose to do that, I'm pretty sure it's the cleaning that they have come in every day is suppose to take care of it… they don't clean very well and I would say for the most part the residents here don't trash the place or anything, but there's like some, remove obvious stuff that needs to be taken care of on a daily basis but isn't taken care of by the cleaning staff".

Figure 14: Community garbage can

Participant A showed a picture of a garbage can in a community kitchen. The resident felt frustration not only with the cleaning crew but also the other residents that

used the community kitchen and did not properly dispose of grease and food waste. It had led to the resident not using the community kitchen and purchasing food that did not need to be prepared in a kitchen.

> "and that one was the whole kitchen, this garbage you just can't even see it but it's three bags and overflowing in the garbage can…oh these people that live here. They are all so disrespectful, inconsiderate…I 've been here almost a year and I've only cooked twice and almost set off the smoke alarm because everyone here cooks with five tons of grease and oil and there's always oil and grease on the floor, splattered all over. They don't clean anything up, they don't. I said this is just a drain, it's not a real kitchen facility so when they make something they just dump it in there and leave it sit in the sink. Yeah, it's a mess so I have not, I usually try to get things where I don't have to even be in the kitchen to eat them or heat them up. I just can't get into it".

Participant L shared his townhome had a cleaning crew, and then due to cuts lost the cleaning crew. Later, they got a new cleaning crew that comes during the week. The occupants of the townhome have chores that as roommates they have assigned to themselves to keep the home clean.

> "They clean, and then we have our chores which [one] does the dishes, [one] does the floor, I do the bathrooms and [another] vacuums the floor".

Participant I showed a photo of the new stoves in the community kitchens. He liked that there were new stoves. One thing he would like to see in the individual rooms is a larger refrigerator that would have a standard size freezer.

> "I would like to see, is we have our little refrigerators up in our room, um I know there is a fridge up on 5th floor that I am sure is a common fridge for the guys but there is no common refrigerator down here in the basement. There is two freezers and they are locked up tighter than a drum. Staff is the only one that can get in or out...a little box for freezer space, no it is not very much".

Two of the participants spoke about their unit's heating and air conditioning units. Participant E does not like that the residents do not control the temperature in their individual rooms. Participant C felt his unit did not work well and despite maintenance, the unit seemed like outdated technology that did not work well. The resident worried that the unit could start a fire at some time in the future.

> "It is too hot the heat, oh my god, it is just. I think the resident should be able to control their own thermostat".
>
> "Well, mine does not work very well. And despite having put maintenance requests in a number of times it has not been addressed. Once a year they take a look at it and flush it. This is like a constant issue I had never heard of this before I moved here. It's a combination of a heating unit and an air conditioning unit…and in the winter time if um, the heat is on there is a bunch of, like dust that gets in there and I can't get it out. And I am just

worried about it setting fire sometime…it just seems like really, um, strange outdated technology or something like that".

Participant E shared a photo of the windows in her individual unit and stated that the windows were drafty and cold air comes into the unit.

"Oh, those [photos] are because the windows are being really drafty even with the storm windows and the screens all shut down all around here along the windows you could still feel that cold air coming in".

Participant M took photos in her bathroom to illustrate the bathroom had a shower but no tub. She liked to take baths, so would like to have a tub but stated she may have an issue getting out of a tub.

"I was going to get a picture of the shower because it doesn't have a tub and I like a tub. I love tubs but I probably couldn't get out of them".

Participant I shared that his bathroom had a claw foot tub and he needed a doctor's order to request a shower be put into his bathroom.

"Yeah, had to fight for a month to get a shower put in because it is a claw foot tub. I had to see two different doctors, and a doctor, nurse and myself all conference with the nurse acting as a go between. That was a Friday and I had it in by Wednesday."

Participant I took a photo of the inside stairs going up to the entrance of the building and explained the friction adhesive tape had become worn off. He explained he did not see it as a tripping hazard, but felt it did not look good. He felt for aesthetics, it should be either reapplied or removed.

"Well, this was my attempt to do the stairwell. Going upstairs..but ah steps there used to be some friction adhesive tape over the tile and that is all worn off. All that is left is adhesive…it should be off or reapplied or just left off. One or the other. It is not a tripping hazard or anything. But it just doesn't look very good".

Participant I was also concerned with the stairs leading up to the floors that housed the resident's living units. One side of the stairwell has a railing but the other side did not which surprised him since people used that side to go downstairs.

"I took a couple of shots..that's this stairwell leading up and down. Um, one side has got the railing and the other side is no railing which surprised me for going down. The right side of the stairway going down".

Participant I shared photos of the elevator used to go up to residence floors and a photo of the lift used to go from the main floor to the entrance of the building. The main floor was below street level so a small flight of stairs or the handicap lift has to be used to get to the front door.

"I usually use the elevator. Ahh, I can see, I am glad to see they have a lift for those that are handicap. That is why I did that one".

Participant C shared a photo regarding his concern for his ability to get out of the building if there was a fire. It is not a concern he thinks about all the time, but within the past year there had been many false alarms and each time the whole building had to be evacuated. While experiencing the false alarms, the thought came to him that his unit is the furthest from the front door and worried if he

could not get to the staircase. Another concern for him is that in the time period he had lived in the building, there had not been a meeting regarding what to do in the case of a fire or a practice fire drill for the residents.

> "[photo] is about, it's not like a real on my mind 24/7 kind of problem but I'm just talking about the fire exit…there was a rash of like, false alarms, like the whole building had to evacuate and they're just false alarms. Now in the case of a real fire happening, it suddenly came to me that gosh, I am the furthest person from the front door. My apartment is the furthest away from the front door. What happens if I don't have access to the staircase, the door automatically slams up, there's no access obviously to the elevators and what if I can't get to the staircase? There's only one that I can, I think there's only one actual fire staircase from my floor and I guess my point more than anything that for the time that I've been here there never once has been any kind of group meeting about these are the fire drills rules or this is what you have to do in the case of an that it just seems like, wow, you should be doing that at least once a year or something like that…it just seems like ah, there's a real health or safety issue there that is not being addressed".

Participant C shared photos of the lounge with a line of four computers. He shared it is a great perk to have a computer on-site due to the economic constraints residents experience, and may not be able to afford personal internet service. Yet within the last three years, each computer slowly stopped working to the point that only one is a

functional computer for residents to use. In his observation, there was not an IT staff person to work on maintaining the computers, and understood functional computers were as not high on the priority list of needed repairs in the overall building maintenance.

> "This one [photo] is a good and a bad thing. They have these internet stations computers that we can use. I mean considering that a lot of people, most people here can't afford their own computers, stuff like that, much less connection. I think it is really helpful, however I've got it marked down as a bad thing as well and that is maintenance on the machines. I first moved in about two and half years ago all four of these machine were working just fine and since then they degraded over time and only one of them is really working…they just don't seem to have the ah, IT staff to take care of it so that's what I hear anyways. So you know it is something that could really help people…this kind of thing isn't as necessary as a bathroom that works"

Participant I shared a photo of the door to the courtyard. He shared that once the residents came out that door into the courtyard, they could not open it and return inside. They have to walk around the building and enter through the front door. Only staff had the ability to use the door leading to the courtyard, and returning in the same way (see Fig. 15).

> "I took this one mainly because once we leave this door, we have to go around the building and come in the front. That is if you want to come back in. The only ones that can use this is staff".

Figure 15: Door from courtyard -staff accessible

Two of the participants took photos of the historic marker outside of their respective buildings and shared what it meant to them to be in a historic building. For Participant C it was the reuse of an existing structure versus demolishing it and for Participant I it was the security that having the building on the national historic registry meant it the housing could not be destroyed in the future.

> "I just like that the building has history…um like over a 100 years old. I think they did a great job of integrating the new part [extension] and the old part so it seems pretty relatively seamless. I mean that's kind of an overall comment on, um the property management is they do on occasion build from scratch a brand new building but for the most part I think, um, I think they do a great job of seeking out buildings that are about to be

demolished that are totally useable still and refurbishing them and putting good use to them so that's a thing I like".

Participant I commented:

"Well it is, ah, on the historical national registry and it makes it very hard for someone to buy it and knock it down and put something in its place".

Participant I took photos of his building's copper-clad doors remarking how doors like that are not done very often in current construction and he liked the copper doors to the building.

"And this is an outside shot looking in of the outdoor and ah, the copper clad, that's not done very much. Ah not done much at all. It is unusual. It doesn't happen much anymore".

Participant A took photos of the alley that the residents in her building use to take their trash to place in a dumpster. The alley is shared with an alcohol drinking establishment and a gentleman's club. The participant shared that they have to walk through a dungy alley to throw away their personal trash. She commented on the difference in their alley's appearance and lack of upkeep compared to the alleys used by the high-end condominium buildings located two blocks from her building (see Fig. 16).

"This is our garbage right next to [bar name] and the strip club garbage so that you have to walk through this really dungy alley to go throw your garbage in there. This is basically what we all, the alleyways around here look just like this. They're just a mess and you would figure 'cause if you go in two blocks down all those people in those $2,000 one bedroom

condos, stuff like that, so it's above and beyond me we have to live like this. I don't get that".

Figure 16: Alley used by residents

Participant I shared concern for a deep hole that was located between the sidewalk and a utility post outside his building. The work had caused the water being shut off three times within the last two months. The hole had not been properly filled in, and he viewed it as a safety hazard. The work was done by a private contractor versus their building maintenance crew (see Fig. 17).

"We had the water shut off like three times in a couple of months. Part of it was they put a hole in the sidewalk out here. This is a closer shot. Ah, they have since filled it with asphalt of all things so I don't know if they

plan on going back in there or not, should actually be replaced with cement. What I am more concerned about is the hole here. This is sidewalk right here and this is brick and this is a hole. As far as I am concerned, that is a hazard. Somebody could stick their foot in it and really wrench their leg, knee, whatever".

Figure 17: Sidewalk repair outside building

Accessibility

Multiple participants discussed the accessibility they had to retail, transportation and entertainment events. For the participants that live downtown, they discussed the public transportation system of the bus and the light rail train. The location of their buildings in a downtown area afforded them the ability to walk to places. For participants in the suburbs, walking options were not abundant, but the supportive services staff provided vans that they can request to take them places. The ability to travel as they wanted or needed was highly desired by the participants.

Figure 18: Accessibility to downtown retail area

Participant C who was bothered by the noise pollution of the downtown area also stated that even with the abrasive noises late at night, he liked the accessibility being in the downtown area afforded him (see Fig. 18). As he tells it:

> "I like that there is access to just about everything, transportation, um and pedestrian wise you still have access to everything you basically need. Um, so you know there is that and I just, you know, I like the hum of a city. But yeah so I guess my point was sorta that while I can complain about very loud crowds and music and whatever late at night I have to like where I live though."

For Participant A, she shared:

> "Oh yeah, the bus [photo of bus stop] that's a good and bad [photo] though because it's very noisy around [street name], it's a major artery but yet that's how I get around. So I'm thankful for the bus system it's excellent" and then shows a photo of a major retail chain and states "I like that

everything is close to me, everything is like ah two or three blocks or under. I can walk so I like the convenience."

Participant M shared:

"The neighborhood, my church is across the street, down the road is a shopping center that we have access to lots of retail, Chipolte, thrift stores down [the street] a little. They take us all over with the vans."

Participant C did discuss the one thing that they did not have was good accessibility to affordable grocery stores. The downtown area has seen a rise in luxury apartments and condos. High-end grocery stores have opened up in the downtown area, but the participant felt it catered to a specific clientele, one that the residents of his building do not belong. Many residents live on food assistance programs and/or limited monthly budgets that the retail prices of food in the area did not fit. As he shared,

"And this is a positive and negative one [photo]. We have access in this building to food um, like crazy, like Whole Foods, Target has got their grocery department, um Lunds is just down the street ah there's a farmers market in the summer….so we have all this access to food but um, the food the stores that sell downtown in this area are expensive. Right now I am just living off SNAP right now and I know a lot of people in the building are and so they have also reduced our SNAP by whatever, so you know, you hear about food deserts and um well it's not a food desert but to have a exactly the right price and the right variety and whatever is another story."

He went on to share;

> "I mean there is access to food shelves and everything so it just feels like there is food aplenty but you know the stuff you have to buy is too expensive and that's whatever (laughs).
>
> He proceeds to share his feelings on living in an area that caters to high-end clientele,
>
> "I mean it feels like you are kind of invisible but like, clearly it makes sense for these grocery stores to come in because the clientele; that would be people who have enough money to have an apartment downtown so it makes sense."

Economic

Economic concerns came up for several participants. As stated above, accessibility to food doesn't necessarily mean the resident is able to afford it. When asked how he would design supportive housing, Participant F responded:

> "Well, rent first off would be, uh, should be a third of your income… rent is the big issue."

He shared that his current rent was about $100 more than one third of his monthly income. Participant A shared:

> "They were giving me ah, EBT food and then they cut that way back…then I get an $85 bus card which is like gold to me it's like gold. I treat that baby so nice!"

Participant I shared a photo of a washing machine sharing it represented this to him:

"The shot of the washer is more to say a protest because do you know how much they charge? It is a buck seventy a wash. Buck and a half a dry. If you want a super wash it is another quarter. But there is not much they [supportive housing services] can do about that until the contract is up".

Participant L shared a photo of his unit's washer and dryer and stated (see Fig.19):

"Yeah it's in our, ah, townhome which makes it a whole lot easier. A lot of people in our status being mentally disabled but being on disability…they would go to a laundry may and pay a lot".

Figure 19: Washer in townhome

Another photo Participant L shared was the utility box on his building and stated he took the photo:

"because I pay my own utilities to an extent, ah when I get paid. I don't get as much disability as most people here so I pay a good chunk during the winter time".

He also stated:

"And especially jobs and having a job means a lot to a disabled person and there are some people disabled that it's a little hard for them to do but to give them opportunity to work at a job it makes your self esteem. It is why I come back to work cause for myself if I don't do something right everyday me being disabled it makes me feel like I'm, like I've done something really wrong…I may have the quality to do that job but they say no you can't do it because you are disabled, you are on Social Security disability. If you do that job you're not gonna be able to be on Social Security and you are going to lose it all and you go well I have an opportunity to get off welfare and to be not to have that stigma on me that I am being a normal person and as long as somebody doesn't get that normalness to have that normal ability they will always feel locked inside".

Chapter 5. Discussion

As I developed the research question for the study, in my mind the idea was to find out what worked for the individual in their actual living unit in terms of layout, amount of space and architectural details. The two questions asked to the participant were "what do you like and what do you not like about your housing?" During the first recruitment meeting, potential participants asked if they could take photos outside of their individual unit, such as the public areas of the building and the neighborhood. Following past research studies using photovoice and adhering to Empowerment Theory research methodology, I listened to the participant's input and expanded the perimeters of the

definition of "housing" used for this study. Allowing the participants to share their own opinions, and not be hindered by the researcher's constraints, the findings were richer by not limiting the participant to only their individual unit. One participant did want to photograph his place of employment due to his personal definition of "home" but I stated that could be the subject of a future study and did not fit the parameters of this study.

Photovoice Method

Photography as a method of data collection allowed the participants to think about the photos they wanted to take to convey what they did and did not like about their housing. Through the interviews, I noted that often participants commented on the quality of the photo; such as it came out darker than they wanted, should have used a flash, or their finger got into the picture. They commented on the composition; it did not convey in the photo as they had seen it, did not look in the photo as it did in their head when taking the photo. As seen in past photovoice research, the participants took on the role of documentary photographer (Fleming et al., 2009; Molloy, 2007; Wang & Burris, 1994; Wang & Burris, 1997).

The participants were serious about taking the photos and sharing the meaning. One participant brought a notebook to the meeting that detailed each photo and the reason it was taken. I could tell during the sharing of the photos, it was not a process that they did casually and without thought. I reiterated many times to participants that I was not associated with the respective supportive service agency that provided the housing and no identifying information would be shared with the said agency. I did use a room on site as

a meeting room, and would schedule the time to use it with the agency, but did not share who I was meeting with that day.

One day when I was getting the keys to the meeting room, the case manager said the person who was meeting with me was ready and excited. I explained that I can't share that information, and could not confirm nor deny that I was meeting with that individual. The case manager explained she knew many of the residents I was meeting with for the study because the resident shared with her their excitement of taking the pictures and sharing their thoughts and feelings about their housing. As the case manager stated, "no one asks their opinion, so they really like this". This interchange reiterated to me the importance of giving this population the platform to share their opinions.

The photos gave structure to the interview as in terms of being a starting point for discussion; and if the conversation did go onto a tangent, the photos could be used to bring the conversation back to the research subject. During the process of sharing the photo, it often prompted the participant to share additional information that was not in the photo, but the participant felt was important. The use of photography was a good vehicle for the participants to share their thoughts and feelings regarding their supportive housing. As seen in past photovoice research studies "the combination of their images and their words explaining what they represent to them was not just compelling the way only a picture can be, but they were true to the eye behind the camera" (Wang & Burris, 1994, p.180).

Research Findings

The themes that emerged from the data are either supported by past research findings and/or continue to build the body of knowledge regarding housing satisfaction of mentally ill individuals in supportive housing.

Actual Unit

The theme that emerged regarding their actual unit showed that regardless if the space was one room, an efficiency apartment with kitchenette, or a private bedroom with shared living area townhome, overall the participants liked their space. The complaints that did exist were to have a kitchen with a stove in the individual unit and efficiency apartment with kitchenette and a private bathroom. These complaints are in line with past research findings regarding individual unit preferences to have a private bath and kitchen with standard size appliances (Ridgeway et al., 1994). From the photos the researcher could see that walls in all three housing developments were painted white or beige. It did not appear that an individual could choose a paint color for their individual space. Yet, none of the participants stated that as a concern and personalization of the space was prominent in the photos. The researcher could see that the individual made the space his or her own. An observation seen was that the individual that got a furnished unit felt the furniture was dated. Yet, the individuals that used the non-profit agency Bridging that allows a person to chose a certain amount of pieces of used furniture, or else purchased their furniture at retail stores, were happy with their choices. Both groups had furniture that could be viewed as dated, but the ones that had choice in their furnishings were happier with their selection.

Two of the participants shared that they would like to have pets or access to pets. The findings on the actual unit is supported by past research that found preferences for individual privacy, modern facilities and the ability to have pets (Forchuk, Nelson & Hall, 2006).

Neighborhood and Outside environment

Through the findings, the neighborhood had a major impact on the housing satisfaction of the participants. The findings support past research showing the feeling of safety and security is one of the main concerns that influenced resident's opinions of their housing (Whitley, Harris & Drake, 2008). One of the downtown buildings located in a highly concentrated entertainment area had multiple complaints of the noise pollution, safety issues in the immediate area around the building in regards to crime and the population that used the space. Another complaint was the close proximity to a liquor store when many residents in the building were struggling with sobriety. In contrast, the residents at the other downtown location (located on the edge of the downtown area) and in the suburbs did not bring up the issue of being close to a liquor store, even though there were ones that were accessible. One of the participants in the suburban location spoke about his sobriety and past drinking and drug issues. His housing is in a townhome complex with a strip mall center located a few blocks away, but there is not a chaotic atmosphere outside his housing compared to the downtown location. He did not speak of being tempted to lose his sobriety in his current housing situation. For future supportive housing developments, the location should be analyzed and critiqued if it will support a

person's long term health and well being or can deter a person's sobriety and long term health.

Nature and accessibility to a private courtyard was viewed as desirable in the housing outside environment. Participants used the spaces to meditate, have social gatherings, and just enjoy trees and the view. A participant whose housing did not have an outdoor space viewed it as "the next step up" in supportive housing. The finding supported past research study showing a preference for a garden (Forchuk, Nelson & Hall, 2006). Incorporating a court yard or a private open green space for residents to use should be done in future supportive housing developments.

Community Connection

A theme that was prevalent for the majority of the residents was the social connection they had with case managers, supportive staff employees, fellow residents and the surrounding community. This theme is supported by past research findings that relationships held with supportive housing staff and residents have an impact on the resident's quality of life (Nelson et al., 2005). The case managers and staff of the supportive service agencies are highly regarded by the residents. Multiple residents commented on the social activities the case managers organize for group outings, and incorporating the residents in the decision making process via a residential council or resident suggestions. Residents acknowledged the work that case managers did on their behalf with county agencies and finding non-profit organizations whose services would benefit the resident.

The community connection findings show that community rooms should be incorporated into the building design to support the on-site meetings and resident gatherings.

One resident shared that he viewed the supportive staff office as "home" because of the staff and the safe environment they fostered for the residents. Participants liked the security of a manned front desk for obtaining access to the building.

The outside connections discussed by participants centered on seeing people they knew working in the community, church community and having friends at a work place. This finding supports past research studies on persons in supportive housing experiencing a sense of community outside their home (Townley & Kloos, 2010).

Maintenance and Building

The overall cleanliness and upkeep of the public areas were a priority to participants. A few participants shared frustration with the salaried cleaning crews, and then also with fellow residents. The frustration of another person's lack of cleanliness or ability to pick up discarded items seems to be in line with the general public sharing public spaces in their home, such as dormitory environments, work space environments and condominium/homeowners association rules.

Findings showed that residents had safety issue concerns, such as the lack of hand rails on stairs, fire escape routes and lack of safety drills. Yet, they also shared that they liked having an elevator and handicap accessibility. Overall, the participants seem to feel a sense of pride in their home and its surroundings and want the building(s) to be kept up and looking presentable. As shown in the findings, the difference in maintenance and

overall appearance between their alley and the new high-end condo buildings in the neighborhood are recognized. I don't know if the city is intentional or not on the treatment of alleys, but it is a valid concern that should be given attention.

Residents in each of the downtown buildings on the National Historic Registry discussed that they liked it being a historic building that had found a new use providing supportive housing. The designation of a historic site gave the building (and their home) protection from being destroyed and having the land be used for a different purpose. It is inferred that there is still a concern that the housing could be taken from the resident without their consent.

Accessibility

The freedom to be able to independently move around was a prominent theme. Participants in the downtown area spoke about the walkability of their environment and having access to retail and entertainment in a short distance. Public transportation was discussed as another means of travel that was frequently used. For the participants in the suburban location there is a shopping center within walking distance, but the neighborhood was not set up to be a welcoming walkable environment. The supportive services provided van service and the participants felt comfortable asking to be taken to places they wished to go, so the barrier to travel as needed was removed for them.

The one concern that was shared is the access to affordable grocery stores in the downtown area. The combination of accessibility and the correct price point for the population are not present. The downtown area of Minneapolis has seen growth in high-end housing in the last decade, and the gentrification of the area is leaving participants

feeling as they are invisible in their neighborhood as higher-income groups move into the area. For future developments, the location of the building having easy access to affordable food and household products should be a consideration.

Economic

The study findings supported past research findings that a person in supportive housing is often living within limited income constraints (Kidd, 2007; O'Hara, 2007). As seen in the HUD data from 2006, a person relying on SSI "would have needed to pay 113% of his or her monthly income to rent a modest one-bedroom apartment" (O'Hara, 2007, p. 908). As discussed in the previous section on accessibility, the purchase power that the resident has is often not in proportion to the retail outlets available in the area. The person may also encounter the conflict that if they do have a job, if they earn over a certain amount, they lose the government programs that help them stay housed and mentally well.

The findings also supported past research findings that "the benefits that being able to work or volunteer has brought to their lives, such as self-esteem and a sense of purpose" (Nelson et al., 2005, p.102). Participants that did work or volunteer in the community expressed their pride in being able to be part of the outside community.

Conclusion

I became interested in studying the housing of mentally ill individuals while volunteering at a crisis center phone line. I received multiple calls from individuals that felt they could not complain about their landlord or lack of housing maintenance to authorities due to their mental illness diagnosis and not being able to obtain different

affordable housing. They had to "put up" with their current housing situation and stay quiet so they did not anger the landlord and be evicted. Economic constraints played a part that they felt they had only a certain amount of housing options, and could not afford a better place. The bias did creep in that this individual is being paranoid, but as multiple calls came in, it led to validity of the situation.

In addition, I have a relative that has schizophrenia and have seen firsthand the toll the disease takes on the person that has it, and the family that tries to support the individual. Mental illness can affect individuals throughout the course of one's life, and no one is immune to experiencing a form of mental illness in their life, ranging from anxiety, depression, to a severe mental illness such as schizophrenia.

Many of the participants of the research had led "normal" lives that included holding a job that could support market rate housing. Then they had events and/or illness happen in their lives that led to them losing their job, and eventually their housing. I have experienced anxiety and low levels of depression at times in my life. At this point, I have never had to be hospitalized, but I understand that I am not immune to that happening in the future. Many times during the research process, the thought occurred to me that one day I could be the one showing my photos; the one being interviewed. To me, the ability to obtain affordable housing and supportive services is not a “me/them” situation but an “us” situation. It is best for society as a whole to have people safely housed.

The intent of the study was to use the findings for future policy regarding supportive housing, and to influence the design process of future supportive housing

developments. The research study allowed residents in supportive housing to share their opinions on what they like and dislike about their housing. The research findings contribute to the needed body of research on the specific housing attributes that be associated with the best type of residential settings (Newman, 2001). The findings supported past research findings that preferences are for individual bath and kitchens with a standard size refrigerator or a larger freezer compartment for long term food storage. Positive design features are personal space and storage space within their unit. Most of the participants chose their own furnishings and were proud of their individual unit. The one participant that did not like the furnishings did not choose the furniture. Future design of supportive housing should incorporate the ability for the resident to choose their own furnishings (Ridgway et al., 1994).

This information is also valuable for the neighborhood choice and design implementation of future supportive housing. The study findings show that not only is the built environment important, but the location of the building can have an impact on the resident's housing satisfaction. In contrast to past research findings that a diverse-disorganized neighborhood was a desirable neighborhood, the research findings found that the residents desired a clean, quiet environment and not one with a high level of noise pollution (Harkness, Newman & Salkever, 2004). As future housing projects are proposed, the location should be evaluated for the proposed noise level in the area during the daytime and evening. The safety of the area should be considered. In the research findings, the concern for safety was highest from the occupants in the building located in the entertainment area that was viewed as having a high level of noise pollution and

proximity to potentially illegal activity. These findings are supported in past research done by Whitley, Harris & Drake (2008) that found safety was the main feeling that influenced a resident's opinion of their home. Future housing should be located within a safe, walkable access to retail spaces, and provide a quiet outdoor environment. As supported in past research findings, a garden or courtyard is desired (Forchuk, Nelson & Hall, 2006). The research findings supported that the participants either appreciated the outdoor area provided, or else desired one at their site.

The findings supported that participants valued the community connection that they felt with the case managers, residents of the building, and individuals in their personal lives. For future housing developments, the design should include areas for social gatherings.

In conclusion, the design implications for the building location:

1) Location should be in a safe, quiet neighborhood

2) Access to retail stores within walking distance

3) Long-term maintenance and upkeep are consistent

4) Provide a garden or courtyard for outdoor use

The design of the interior of the building should include:

1) Social gathering spaces

2) Individual units should have a bathroom and kitchen with a standard size refrigerator

3) Units should be able to be personalized with furniture and decoration

4) Units should have storage space

Building on the empowerment theory that the consumer needs to be involved in defining the problem, and being active and present in the plan, the design community should invite representation from the mentally ill population to be at the design table. This can be achieved through local focus groups involving potential occupants in the full spectrum of the design phase, from defining the problem to implementation. Using photovoice as a means to communicate the likes and dislikes of their current housing was a tool for the participants to share their opinions. The study asked the question "what do you like or dislike about your housing?. As discussed, even though at first my concept of "home" focused on the individual unit, I soon adjusted the parameters based on what the participants wanted to share regarding their housing, thus taking an active part in defining the study parameters. This used the Empowerment perspective that I was able to listen to what the consumers are saying and seek to learn from them, not study them (Rapp, Shera & Kisthardt, 1993). The study did show that a population that often has their opinion disregarded due to their mental illness and or prior homelessness do have pertinent opinions and should be regarded. The study supports that the end user of supportive housing should be at the design table to give input and guide the design of the housing.

The findings of the research are to be shared with policy makers and the design community of supportive housing as well as with the supportive housing agencies that manage the housing that was studied. I also intend to present the data at local conferences that pertain to mental health and or the designing of supportive housing.

Limitations and Future Research Recommendations

The primary limitation of this study was the small sample of individuals living in supportive housing and the limited number of locations within the Minneapolis, MN area. Housing satisfaction among mentally ill individuals in supportive housing was the focus of this study; however, throughout the project, participants noted a difference between "housing" and "home". A key recommendation for future studies would be to examine the meaning of home in the mentally ill population (Harkness, Newman & Salkever, 2004; Kyle & Dunn, 2008; Leff et al., 2009; Newman, 2001; Whitley, Prince & Cargo, 2008).

Participatory research using photovoice methods should be explored for future studies involving the mentally ill/formerly homeless population. This study demonstrated that the photovoice method is an effective vehicle for this population to express their thoughts and opinions. Building on Empowerment Theory principles, the actual participants should be involved in the development stage of the research question and guiding the question originally asked (Swift & Levin, 1987; Rapp, Shera & Kisthardt, 1993).

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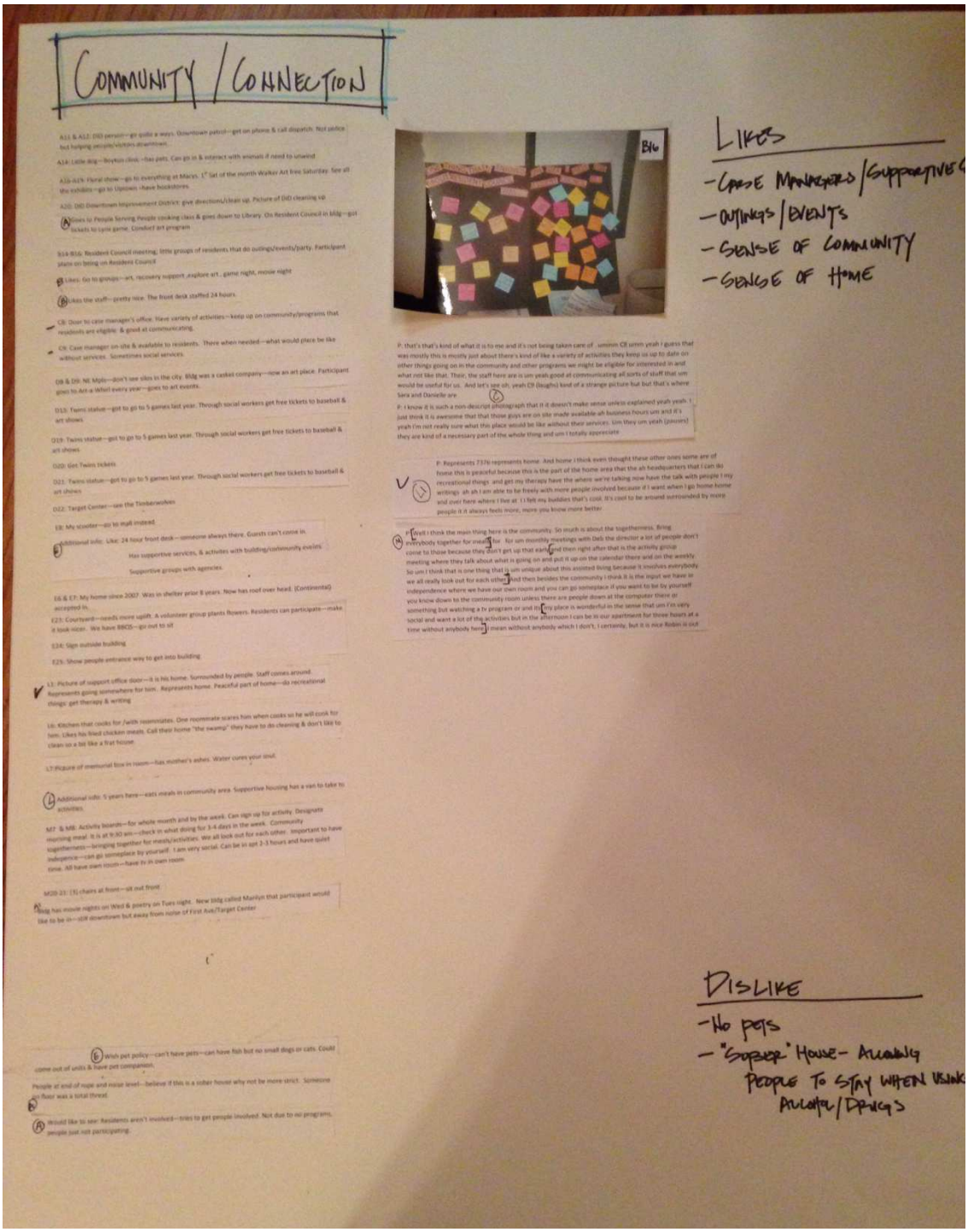
Appendix A


COMMUNITY / CONNECTION
LIKES
DISLIKE
-No pets
-"Sober" House- Allowing People To Stay When Using Alcohol/Drugs