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ORIGINAL PAPER

A Place to Call Home: Hearing the Perspectives of People Living with Homelessness and Mental Illness Through Service Evaluation

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Abstract

There is an ongoing need to incorporate the perspectives of people in supported community housing to improve the provision of integrated mental health services. This study aimed to explore the satisfaction and experiences of people who have received supported housing and mental health services. We conducted a retrospective, mixed methods study using a data mining approach, analyzing consumer satisfaction survey responses collected on discharge from the service over a 7-year period. Responses from 178 consumers aged between 20 and 62 years were included. Quantitative results indicated that consumers rated the quality of services as relatively high. Analysis of qualitative responses identified seven themes describing people's views on how they had benefitted from the service. Consumers reported benefits in terms of practical and emotional supports, responsiveness of the team to their needs, socialization and community integration, personal growth and recovery, and finding 'my place'. Themes of learning and skills development were also important. These results suggest that practical support, together with emotional expressions of care and compassion are most valued by people who participated in this service. This research has implications for service evaluation and for future research, which may include focusing on the key role of connectedness, 'my place' and hope for recovery.

Keywords Mental illness · Housing · Recovery · Consumer engagement · Service evaluation · Lived experience

Introduction

Access to adequate housing and somewhere to call home is a fundamental human right. Yet, more than half a million people in the United States (Henry et al. 2014), and 105,000 people in Australia (nearly 5% of the total population) are homeless (Australian Bureau of Statistics 2012). Being homeless is not just 'sleeping rough'; it can involve moving from one shelter to another, 'couch surfing', or living in caravan/trailer parks or boarding houses, with no secure lease or private facilities (Chamberlain and MacKenzie 1992).

People diagnosed with significant mental illness, such as psychosis, bipolar disorder, or major depression, experience high rates of homelessness (Folsom et al. 2005; Siskind et al. 2014). Studies of homelessness have highlighted poorer physical and psychological health, social exclusion, victimization, increased disability, and greater mortality (Fazel et al. 2008; Keogh et al. 2015; Martens 2001). There are multiple pathways to homelessness and mental illness, including socio-economic disadvantage, childhood adversity and trauma, and domestic violence (Shelton et al. 2009). Further, people with mental illness and homelessness

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commonly experience stigma, social rejection, and isolation (Rae and Rees 2015; Siskind et al. 2014).

Service delivery approaches that simultaneously provide integrated treatment of mental illness with safe and secure accommodation are the foundation for effective models of rehabilitation and recovery. A number of supported housing models have positively impacted on housing stability for people with mental illness, expressed in functional and service level outcomes (Meehan et al. 2011; Siskind et al. 2014; Urbanoski et al. 2018) and increased consumer satisfaction (Brolin et al. 2015). Satisfaction with housing and housing support is generally conceptualized as including a number of domains such as choice, safety, environment, and relationships with health professionals (Tsai et al. 2012; Tsemberis et al. 2003). People are generally satisfied with the housing support they receive, with research identifying a number of benefits such as the quality and choice of the accommodation (Harvey et al. 2012), a sense of *home or place* (Kirkpatrick and Byrne 2009; Mifflin and Wilton 2005) and social and community integration (Johnstone et al. 2015). Despite these benefits, limited research to date has integrated the consumer voice into the evaluation of these services.

To advance models of service delivery and their effectiveness, more research is needed that draws attention to people's experiences of supported housing services (Browne and Hemsley 2010). Importantly, active consumer involvement in the evaluation of mental health services is a key principle in line with a recovery oriented approach (Browne et al. 2008; Le Boutillier et al. 2011). Incorporation of consumer voice also aligns with policy developments in Australia such as the Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023 (Queensland Mental Health Commission 2018) which outlines the importance of meaningful representation and participation of people with lived experience in mental health reforms. Services that support individuals to reflect on their care and listen to these points of view, foster empowerment and a sense of 'doing with' rather than 'being done to.' Further, health professionals can play a central role in promoting these perspectives and ensuring they are part of service design and evaluation. The relationships and connections they form with people in the service, the therapeutic alliance, and the degree to which they are 'person-centered' are all catalysts for recovery (Happell 2008; Kitson et al. 2013).

In summary, exploring people's voice as part of service evaluation can be important in highlighting aspects of their experience relevant to recovery and will likely contribute to designing integrated mental health and housing support services that better meet people's needs. The present study was a preliminary service-led attempt to explore perceived benefits and the satisfaction of people who have received supported housing and mental health services from a Transitional Housing Team (THT) in Queensland, Australia. In seeking to maximize the benefit of our services we sought to go beyond a superficial overview of our service evaluation to explore the voices and perspectives of our consumers, people living with homelessness and mental illness in the community.

Methods

Setting

The THT provides mental health services across two health service catchment areas in the Brisbane metropolitan area, for consumers who are homeless or at risk of homelessness (Siskind et al. 2014). The THT program is delivered in collaboration with a local social housing provider that provides 'scatter-site' housing for a 6-month period to obtain a real world, lived experience of managing a tenancy. The THT provides life and independent living skills rehabilitation within the consumer's home as well as community integration opportunities to gain the ability to maintain stable tenancy for the future. It was established with 16 two-bedroom units and provides ongoing mental health support concurrently with associated treatment (which is a pre-requisite for entry onto the program). The THT comprises occupational therapists and rehabilitation therapy aides.

Design

The current study involved a mixed-methods approach comprising data mining of THT consumer satisfaction surveys administered as part of usual care from 2007 to 2014. Data were drawn from the completed surveys of 178 adults aged between 20 and 62 years who were consumers of the THT service. All participants were fluent in spoken English. Individuals with literacy issues, physical disabilities, or concentration difficulties were assisted by a health professional to complete the paper and pencil questionnaire.

Participants

The final sample (excluding 10 participants who had missing data) included 42 females and 126 males, with an average age of 38.76 years. The majority of consumers were diagnosed with psychosis ($n = 112$), or affective and/or personality disorder, and/or any combination of these ($n = 56$).

Measures

The first section of the survey consisted of seven statements pertaining to the experience of the THT service, rated on a 5-point scale, from 1 (*strongly disagree*) to 5 (*strongly agree*). An example item included, 'Transitional

Housing listened to my opinion about my recovery needs'. See Table 1 for a list of the survey items. In the second section, participants were asked to provide a response to open-ended questions about how the service was of benefit to them and suggestions for improvement.

Procedure

Consumers of the THT service were invited to complete the satisfaction survey on discharge from the THT service, regardless of the circumstances of the discharge. Participation in the survey was voluntary and was described to consumers as an opportunity to provide feedback on the quality of, and their experience of the service.

Data Analysis

The quantitative data and demographic information were entered into a Microsoft Excel spreadsheet, and analyzed using descriptive statistics. Qualitative responses were transcribed verbatim and thematically analyzed using an inductive approach (Braun and Clarke 2006). The research and clinical team met on a number of occasions throughout the analysis to look at and discuss the data. Preliminary themes were identified from a sample (approximately one-third) of the responses. Responses were coded to relevant themes, with many responses coded to more than one theme as appropriate. The coding structure was then refined by the research team, and two team members (JO and KR) used the refined structure to code all of the responses. Individual memos were also recorded as part of this process to note potential links between codes and themes as they emerged. The accuracy of coding was confirmed by another researcher (RE) reviewing results. The meaningfulness and credibility of codes and themes was also reviewed by a consumer consultant, who was an employee of the Addiction and Mental Health Service. The consumer consultant provided feedback on the meaning and construction of the themes through verbal discussion. Ethics approval was granted by the relevant institutional review board: Metro South Health, Human Research Ethics Committee, Queensland, Australia.

Results

The results of the quantitative part of the survey indicated that consumers rated the quality of the THT services as very high, with all mean scores greater than four on a 5-point scale (Table 1).

Qualitative responses were available from 155 surveys. Since these were in the form of brief written responses, they are summarized through frequency tallies of relevant themes. Given that there were few detailed qualitative responses, it was determined that the best way to report the findings was through tallies rather than quotes. Responses were categorized into seven overarching themes, which describe consumers' perceived benefit of the THT service (Table 2).

Benefits of the THT Service

Practical Support

The primary theme of practical support encompassed everyday help and instrumental support across a range of day to day activities. More than half of the responses ($n = 104$)

Table 2 Summary of themes and frequencies

Themes	Frequency tally
Practical support	101
Accommodation and moving	47
Day to day activities	37
Transport	17
Responsiveness to needs	41
Emotional support	33
Socialization and community integration	26
Personal growth, psychological wellbeing and recovery	22
'My place'	9
Learning and skills development	9
Other	25

Table 1 Summary of survey items, mean scores, and standard deviations

Survey items	Mean (SD)	N
THT clearly let me know what they could do for me	4.47 (0.66)	169
THT provided a service when I needed it	4.63 (0.53)	170
THT supported me to get the services and information I required	4.58 (0.58)	170
The THT workers treated me with courtesy and respect	4.64 (0.57)	170
THT listened to my opinion about my recovery needs	4.40 (0.83)	168
THT supported me to find satisfactory permanent accommodation	4.53 (0.73)	168
THT assisted me to develop independent living skills	4.22 (0.87)	165
Overall	4.50 (0.17)	169

pertained to the practical benefit of THT supports. This included assistance with finding appropriate accommodation and support with moving. Consumers commented on the benefits of the practical help to move their belongings from temporary to more permanent accommodation, as well as support during the initial sign up with the housing company.

Respondents also described benefitting from support associated with daily activities such as shopping for groceries, cooking, and arranging appointments. For example, respondents wrote that THT staff helped with such practical tasks as getting to know a new area and setting up the new unit. A feature of practical support that was emphasized in responses included assistance with problem-solving, organizing daily and/or weekly activities and offering reminders. These were often around support with structuring an individual's week or providing assistance with what needed to be done next to get settled in their new environment. To a lesser extent, providing transport was reported as a benefit. Some respondents reported that THT assisted in more than one area of practical support, for instance with transport, moving and cleaning.

Responsiveness to Needs

The second most commonly reported theme comprised descriptions of responsiveness of the service and included comments about support when it was needed. For others, responsiveness was about checking in, being available, reliable and just a phone call away. The comments suggested that availability to respond, meeting a person's needs and goals, as well as efficiency and reliability were valued by individuals. The approach to service delivery was seen as individualized and tailored to what the person wanted and indicated that people required and appreciated such personalized and creative care.

Emotional Support

Another theme emphasized the emotional support provided by the THT, with 33 consumers reporting this as a benefit. More specifically, some reported that THT staff always listened and were supportive and non-judgmental, and that staff were emotionally responsive. For some this provided a sense of not being alone with their mental illness. Such emotional support included expressions of care and compassion by the THT staff members, especially during the likely time of distress and instability in their lives.

Socialization and Community Integration

Individuals also described the various social benefits of the THT service, including opportunities to participate in community-based activities. Access to health and fitness programs (e.g., yoga, swimming), sports (e.g., football), employment, fishing, bowling, using the library, and general outings were considered important to facilitate meeting new people and making friends.

Personal Growth, Physical and Psychological Wellbeing and Recovery

A theme of personal growth, physical and psychological wellbeing, and recovery emerged from 22 responses. Some individuals stated that the service supported them to grow within themselves and promoted an easier recovery with their mental health. Improvements in aspects of psychological functioning and wellbeing were found in comments about overcoming anxiety, improving self-esteem, self-awareness and general outlook on life. In addition, some physical benefits were noted with helping to exercise regularly. Comments covered topics of stability, positivity and independence.

My Place

'My place' emerged as a theme through which some of the other data could be understood. This theme pointed to the attachment consumers appeared to have formed to their housing or accommodation arrangements. It coincided with a sense of connectedness to a location and to other people. The theme, 'my place' also reflected a sense of ownership, with example statements of expressing the need to find their own place and the importance of a safe place when leaving hospital. Together, these comments reflected the level of felt connection to their place of living, which emphasized feelings of safety and security and a sense of ownership. While the theme of 'my place' was reported by nine consumers, it was considered distinct from statements relating to accommodation support which were general, and referred to short-term living arrangements often fulfilling the basic need of shelter.

Learning and Skills Development

Nine consumers described learning new skills in a range of areas, including cooking, budgeting and grocery shopping; the word "taught" being used to denote this. For example, one consumer reported being taught cooking and cleaning skills. The nature of the comments reflected learning and personal skill changes rather than the passive receipt of practical assistance.

Suggestions for Service Improvement

Several key themes (detailed in Table 3) emerged from consumer responses to the question about service improvement.

Table 3 Summary of suggestions for service improvement

Themes	Frequency tally
Tailoring therapy specifically and meeting needs	25
Improving communication	21
Practicing micro-counseling skills	13
Better scheduling	8
Enhancing organizational/service capacity	12
Other	29
General appreciation and thanks	17
Not answered	81

While there were fewer responses to this question, there were 25 comments related to tailoring therapy and meeting needs. The majority of these responses recommended increasing the availability and scope of activities such as art classes, volunteer work and an increase in outings offered. There were also a number of responses related to the support being insufficient including the need for the program to be longer and the possible benefit of long-term relationships with staff.

According to 21 consumers, communication could be improved, through use of micro-counseling skills such as reflective listening, effective questioning, and showing empathy could be improved. For instance, that there could be better communication between health professionals and consumers, with more time to be allocated to talk and listen. Having a 'normal' and non-judgmental conversation was also suggested as an improvement. A second subtheme highlighted comments referring to scheduling, such as calling ahead and making a time to visit.

Some comments related to the THT's organizational and service capacity. Examples included more funding for the service, more staff and more housing. Seventeen people included general appreciation and thanks within this section. Of note, 81 (approximately 45%) consumers did not respond to this question.

Discussion

Overall, consumers were highly satisfied with the service provided by the THT, with a combined mean score across the seven items of 4.50 on the 5-point scale. While this was highly encouraging for the service, the uniformly positive responses provided limited information for planning, or detail about aspects of particular experiences. The qualitative results, however, reflected seven themes, which provided suggestions for improvement and meaningful insights into the way in which the THT service benefitted individuals. People participating in the THT program largely benefitted in terms of the practical and emotional supports, and the responsiveness of the team to their needs, socialization and community integration, personal growth and recovery, the concept of 'my place,' and learning and skills development were also considered integral to the THT experience.

Specifically, practical support emerged as a theme, with approximately 65% of people reporting they benefitted from assistance with either accommodation, day to day general activities and/or transport. Assistance with accommodation was the most frequently reported type of practical support. Support with daily activities and transport were also identified as important but to a lesser extent. These findings are consistent with studies in which supported housing was associated with improvements in practical skills and functional outcomes (Petersen et al. 2015).

Only approximately 30% of consumers specifically noted assistance with accommodation (a component of practical support) as beneficial. Given that the provision of 6 months of housing support is a core THT function, it may be that respondents considered accommodation support as a foundational and implicit aspect of the program and therefore they did not comment on this explicitly. A number of people described a range of benefits over and above practical housing support, including responsiveness and emotional support. These findings suggest that engagement in the THT enabled people who are homeless to re-establish and in some cases develop their activities of daily living. This is consistent with the strategic occupational therapy focus of the THT which facilitates living skills and engagement in functional activities.

It appears from the qualitative responses pertaining to emotional support that THT staff were perceived to be providing compassion, including expressions of care and respect. These findings highlight the importance of health professionals attending to the emotional needs of people who are experiencing homelessness and mental illness. Emotional support can be reflected in micro-counseling skills, such as expressing warmth, active listening and showing empathy. This emphasis complements studies that have described the role of the treatment team/case managers in housing support services in attending to the emotional dimensions of the person's recovery (Petersen et al. 2015).

Responsiveness to needs was another significant theme, often linked with emotional support. People who experience homelessness are often disconnected from family, friends and social supports, and may have histories of repeated trauma associated with homelessness or other psychological vulnerabilities which exacerbate feelings of isolation (Patterson et al. 2013). From these results, responsiveness of staff, including kindness and perceived supportiveness was particularly important to a person's care in this state of transition and distress. This was further underscored by

some ($n = 13$) who commented that communication including listening skills could be improved. For people who are vulnerable with high psychological and physical health and housing needs, a compassionate care approach may be most suited. Compassion generally includes an awareness of an individuals' suffering or vulnerability, and an effort to prevent or relieve suffering (Goetz et al. 2010). Inherent in compassionate care are interpersonal processes that can influence psychological health and wellbeing (Seppala et al. 2013; Sinclair et al. 2016). Similarly, the quality of the therapeutic relationship has been emphasized as a critical factor in recovery generally (Martin et al. 2000), and specifically in supported housing (Tsai et al. 2013).

Approximately 16% of respondents indicated that they benefitted from the opportunities for socialization and community integration, via recreational activities such as soccer and art classes. Consumers also suggested that more access to a greater range of activities could improve their experience. Those participating in the THT have often been socially isolated from their community for a significant length of time prior to engaging in the program. The THT model recognizes that a potential secondary gain of stable housing is community participation, meeting new friends and developing social skills. Analyzed responses were consistent with this and previous research in indicating the importance of social supports and relationships (with team members and more broadly) in promoting psychological well-being (Johnstone et al. 2015; Tsai et al. 2012). It is possible that the development of secure and safe connections with health professionals is part of the "transition" to better social connections in the community and promoting longer-term recovery.

A person's idea of 'my place' was closely aligned to the possible emotional and psychological connections people experienced with the accommodation. Distinct from the bricks and mortar, this theme emphasized felt safety and security. While in this study 'my place' was identified by a small number of people, literature has suggested that such notions are strategic to repairing identity, and providing hope and meaning in one's life (Kirkpatrick and Byrne 2009). From our findings, 'my place' appeared to fit with the theme of personal growth and recovery. A number of individuals specified that they had experienced personal growth, more confidence and a sense of self, and improved psychological and physical health outcomes. If people who have been homeless and experienced mental illness are starting to connect 'home' and 'place' to people, and to hope, they may have a better foundation for physical and psychological recovery.

The THT approach, with a focus on practical and emotional supports may provide the initial steps towards developing a sense of 'home' and recovery. In the team review to interpret these findings, it was suggested that a more established connection to 'home' might come into view for people in a later phase of recovery. Patterson and colleagues found that homeless people with mental illness continued to improve in terms of their quality of life between six and 12 months into a supported housing program (Patterson et al. 2013). Future studies could focus on exploring how the theme of home and place are linked to quality of life and the recovery journey. It would seem that a longitudinal study would be particularly suited to exploring the emergence of these factors over time and their relationship to recovery.

Learning and skills development was identified as a theme by nine people. The THT, using a self-determination framework, assists people to be active recipients of support (learning or relearning daily tasks and living independently), rather than passive recipients (having things done for them). Skill development is often a secondary gain to the provision of practical social and community support (regardless of whether that is evident to the person). Individuals may have limited insight into the rationale behind certain activities (due to symptoms of mental illness or cognitive impairment). The team agreed that more explicit communication of the rationale and benefits of engagement in a range of practical tasks, and social and community activities and the associated learning may promote better engagement of consumers and stakeholders.

Consumers who received the THT service were largely unemployed or had a long history of unemployment, receiving government benefits while living in a metropolitan area. There were limited other subsidies for food or social activities, although transport in the area is discounted for people holding a healthcare card. In this region, the mental health clinics were located in central inner city locations, close to public transport. In addition, the vast majority of social housing was located close to public transport. There were also a number of non-government mental health organizations available to consumers. In this study, the level of engagement in these services and social activities, and transition to employment were not assessed. It will be important for future research to examine levels of social engagement and employment as possible outcomes as well as determine whether our findings are generalizable to integrated housing and mental health services in other metropolitan and rural and remote areas.

Strengths and Limitations

While surveys may not be the ideal way to engage consumers in dialogue about mental health service evaluation (Malins et al. 2011), in this case the open-ended questions and the large number of people completing the survey provided a useful data source for eliciting a variety of consumer perspectives. The emphasis on seeking consumer voice as a primary focus, and including a consumer consultant informing

the analysis, contributed to the meaningfulness and credibility of the evaluation.

There are a number of limitations of the present study. While all consumers of the THT service were invited to complete the satisfaction survey, it is likely that some who did not have a satisfactory discharge did not participate. Indeed people who participated in the satisfaction survey were more likely to have been supported into ongoing housing following the THT program, and therefore more likely to be satisfied with the service. Further, some received a degree of assistance from a health professional in completing the questionnaires. This assistance aimed to help consumers put the feedback in their own words and any address barriers associated with completing paper and pencil surveys. However, these factors may have resulted in respondents being more likely to respond favorably. The number of clients in each of the above cases was not recorded. The surveys were conducted over a 7-year period. Anecdotally, the THT service has implemented a number of changes over this time including the location of the services, operating times, clinical staff profiles, as well as leadership changes and staff turnover. Further, it is likely that the needs of people who accessed the service over this time may have changed; we were unable to evaluate changes in survey responses over time. For example, it is possible that support with transport might have been an initial perceived benefit. But with improved infrastructure and access to transportation in metropolitan areas and close proximity to supported housing and mental health services, over time transport could have been perceived as less valued. As a localized study, these findings will have relevance to other similar or related contexts, but may only have limited or more general application to more disparate settings.

Conclusions

Overall, these findings provide useful insights into the perceived benefits of a supported housing service as part of a mental health service model, which has consistently focused on providing practical and emotional supports over a number of years. A transitional housing approach that embraces the whole person, tailors care to meeting individual needs, and emphasizes expressions of care and compassion appears beneficial for individuals. A focus on moving consumers towards 'home' could further facilitate recovery.

In light of the prominence in the findings, THT services provided by health professionals (occupational therapists) and rehabilitation therapy assistants should focus on strengthening the compassionate care approach as a core feature of the service model. Future studies that build on this qualitative feedback might use the findings of the current study as a starting point for focus groups and interviews to enhance our understanding of the needs of these individuals. In particular, they may inform the way in which services can respond more holistically to ensure personal recovery is reached. Engaging consumers as part of the research team, and in the ongoing design and implementation of supported housing and mental health services will ensure richer insights and greater appreciation of their experiences.

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Compliance with Ethical Standards

Conflicts of interest JO and KR are employees of the THT. DS is an employee of MSAMHS which runs the THT. RE is an employee of MSAMHS however, is not involved in running any aspect of the THT service.

Ethical Approval Ethical approval was provided for analysis of de-identified, retrospectively collected administrative data.

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