

ORIGINAL RESEARCH

Eden Village of Wilmington: A Tiny Home Approach to Permanent Supportive Housing for Individuals Experiencing Chronic Homelessness

Holt Evans, MPH¹, Chase Berman, BS¹, Kiran McCloskey, PhD², Alexis M. Stoner, PhD, MPH¹

¹ VCOM Carolinas, ² Novant Health

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BACKGROUND

Chronic homelessness disproportionately affects marginalized populations and is associated with increased morbidity and mortality. In 2023, Eden Village of Wilmington (EV) launched a 31-unit tiny home community as a permanent supportive housing (PSH) initiative integrating housing, primary care, and trauma-informed case management. This study examines whether this model improves participants' self-reported quality of life, daily functioning, and mental health.

METHODS

Validated surveys were administered to 26 participants before or shortly after move-in, and 25 completed follow-up assessments 4 to 6 months later. Instruments included the Adverse Childhood Experience (ACE) Questionnaire for Adults, modified Colorado Symptom Index, Brief Instrumental Functioning Scale, and RAND SF-36 Health Survey. Outcomes measured changes in psychological symptoms, functional impairment, and quality of life.

RESULTS

Compared to baseline, participant scores on assessment trended positively. Mean Colorado Symptom Index scores improved from 22.7 (standard deviation [SD] = 17.9) to 13.4 (SD = 11.6), indicating reduced emotional distress ($P < .001$). Further, 3 of 8 domains on the SF-36 Health Survey significantly improved: role limitations due to emotional problems, emotional well-being, and energy/fatigue. Improvements in Brief Instrumental Functioning scores were not found to be statistically significant.

LIMITATIONS

Study limitations include a small sample size given the preliminary pilot nature of the study and potential response bias from self-reported survey instruments. Additionally, sample bias may have been introduced by excluding residents who did not provide informed consent, those who had not lived in the community long enough for follow-up, and those who left the community before their next assessment.

CONCLUSIONS

Eden Village's trauma-informed PSH model shows early promise in improving mental health and functioning among chronically homeless individuals. Further research is warranted to assess long-term outcomes and scalability.

Introduction

In January 2024, an estimated 593 people were unhoused in Pender, Brunswick, and New Hanover counties in southeastern North Carolina, representing a 19% increase over the previous year.¹ Chronic homelessness is a growing public health crisis in the United States, as unhoused individuals experience a significantly increased risk of premature morbidity and mortality from infectious disease, mental health disorders, and substance abuse.^{2,3} Additionally, unhoused individuals are at an increased risk of having experienced childhood trauma, as measured by adverse childhood experience (ACE) scores.⁴⁻⁶ Higher ACE scores can be predictive of increased risk for suffering adverse health outcomes; individuals that have experienced 4 or more ACEs are 2 to 5 times more likely to develop substance use disorders, clinical depression, and chronic health conditions like diabetes, cancer, and cardiovascular disease when compared to people with no ACEs.⁷⁻⁹

Permanent supportive housing (PSH) is an intervention that offers individuals experiencing chronic homelessness access to affordable community-based housing alongside support services.¹⁰ In addition to offering previously unhoused individuals a stable housing environment, PSH interventions offer a “foundation for health” to residents by providing them with a venue to engage in health promotion interventions, opportunities for improved access to health care services, and the physical space to engage in healthy behaviors.^{10,11} As such, PSH interventions address multiple domains and levels of influence described by the National Institute on Minority Health and Health Disparities (NIMHD) Research Framework.¹² While the physical and mental health benefits of participation in PSH programs have been well established using tools like the modified Colorado Symptom Index and the RAND SF-36 Health Survey, to our knowledge, there have been no published applications of these measures to quantify the particular impact of using tiny homes as a means of permanent supportive housing on the health of formerly homeless residents.¹³⁻¹⁷

To address this gap in the literature, we examine a newly established tiny-home permanent supportive housing community in southeastern North Carolina. Eden Village of Wilmington was founded in 2021, and formerly homeless residents moved into the tiny home site in July of 2023. In January of that year, there were an estimated 558 unhoused individuals residing in Wilmington and nearby Brunswick, Pender, and parts of New Hanover counties. This was a 61% increase from the previous year, likely due to a

combination of rapidly rising housing costs, a shortage of affordable rental units, and stagnant wages that continue to exert pressure on working families and seniors in the area.^{18,19}

Study Aims

This study aims to provide an initial evaluation of the case management and housing model of Eden Village of Wilmington. Specifically, this analysis seeks to identify trends in individual-level outcomes that point toward program-level success at improving residents' self-reported quality of life, alleviating adverse mental health symptoms, and increasing residents' capacity to perform activities of daily living as a result of their access to stable housing and comprehensive case management. Additionally, we hope that detailing this organization's approach to permanent supportive housing in a small coastal city in North Carolina can yield valuable insights that are transferable to other similar efforts to address health disparities and promote health equity through the provision of comprehensive housing and support services.

Methods

Program Description

Eden Village of Wilmington is a PSH tiny home community that serves individuals experiencing chronic homelessness in Wilmington, North Carolina. To qualify for housing at Eden Village, future residents must be over 18 years of age, have lived in the Wilmington area for 1 year, meet the federal definition of chronic homelessness, receive disability benefits, and maintain a "single" (unmarried) relationship status. All residents pay a \$300 monthly fixed lease and may live in their single-occupancy tiny home indefinitely. Upon move-in, residents receive multi-level case management services centered around direct involvement with the social work team and provision of group services within a safe and secure community.

Individualized case management. Prior to entry into the tiny home community, residents work with the Eden Village social work team to complete a psychosocial assessment that includes the Adverse Childhood Experience Questionnaire for Adults. This intake session not only allows residents to inform the team of their basic needs but also gives staff a rough estimate regarding their risk of suffering adverse health outcomes based on childhood trauma. Knowledge of resident ACE scores also enables members of the social work team to be sensitive to their trigger issues when providing them with assistance on a day-to-day basis. Together, this information allows for the creation of a collaborative and comprehensive care plan for each resident and allows staff to promptly assist them with gaining access to services specific to their needs, which can range from pro-bono primary care appointments to legal aid.

Following intake, consenting residents also meet with a member of the social work team at least once every 6 months at a minimum in order to complete confidential, validated assessments regarding their health-related quality of life, ability to perform activities of daily living, and mental health symptoms, as mentioned above. These meetings serve as a more formalized case management meeting where staff work with residents to develop, refine, and enact plans for the delivery of personalized support services that meet their unique needs. Additionally, every Monday and Tuesday, the site holds “open house” case management hours where a member of the social work team is available to meet with residents, thus offering them the flexibility to seek support as needed. Residents’ confidential individual responses also guide delivery of case management services and opportunities for the entire residential cohort.

Cohort-level services. In addition to the provision of individualized services, the Eden Village team provides cohort-level services such as monthly primary care visits through Novant Health, access to dental care services, ID recertification services through the North Carolina Division of Motor Vehicles (NC DMV), and pro bono podiatry services. Residents are also offered the chance to participate in a wide range of social activities, which include everything from bi-weekly yoga sessions to regular bingo nights and holiday celebrations. Additionally, local churches provide a weekly Monday night dinner for all residents, creating opportunities for socialization and shared experience. For those seeking more personalized support, residents can opt into a home care team, where 4 to 10 community members meet with them at least once a month. These teams assist residents with transportation to appointments, errands, and social outings such as sporting events, meals, or movies.

Secure living environment. The Eden Village of Wilmington site contains thirty-one 400-square-foot tiny homes for resident housing, in addition to a community center, common areas, and a community garden. The community center houses a full kitchen, canteen, resident lounge, infirmary, and staff offices. Eden Village’s trauma-informed practice prioritizes emotional safety (e.g., security gate, biometric locks), and relationship development (e.g., holidays, group activities). This approach has been described in further detail previously.¹⁴ These measures were implemented to preserve the emotional and physical safety of residents at all times, with a special focus on the needs of individuals that have been subject to prior emotional, physical, and sexual abuse. Residents are allowed up to 3 guests at a time within the community; however, guests must always accompany the resident they are visiting while visiting the site. Overnight visitors must register with Eden Village staff prior to their visit and are limited to 2 consecutive nights on the property at a time. All other guests are required

to vacate the premises by 10:00 PM. These measures protect all residents within the community and balance their needs for personal connection with community-wide safety.

Program Aims

Through its multi-level approach to case management, Eden Village aims to improve residents' physical and mental health by providing stable tiny home housing, bridging gaps in health care access, and connecting residents to services tailored to their needs. The model was designed to foster a sense of individual autonomy, allowing residents to maintain a safe and stable living environment while exercising choice and control over their daily lives—an approach that aligns with trauma-informed practices in behavioral health.²⁰ Further, the Eden Village model also aims to facilitate connection and a sense of community among residents through organized social activities, group celebrations, and shared spaces that promote meaningful relationships.

Data Collection

Data for this study were collected from June 2021 to February 2024. Eden Village social workers and collaborators obtained informed consent for data storage within the Eden Village Confidential Resident Data Collection and Management System, potential sharing of de-identified demographic information service use data, and responses to validated assessments for 26 residents. This system was developed by the Eden Village social work team in collaboration with faculty members within the sociology department of Missouri State University, the UNC School of Social Work, and the University of North Carolina Wilmington School of Nursing.

The data were not originally collected for research purposes, but rather to guide the Eden Village social work team's delivery of personalized case management services specific to residents' changing needs over time. Individual results are strictly confidential and are used by social workers at Eden Village to connect residents with the services most appropriate for their circumstances and are also used to iteratively tailor organizational initiatives to better meet the needs of the entire residential community.

Psychosocial functioning was measured at both baseline and then every 6 months after. Specifically, emotional distress was measured using the modified Colorado Symptom Index (CSI), ability to perform activities of daily living was measured using the Brief Instrumental Function Scale, and health-related quality of life (QOL) was measured across the 8 domains of the RAND 36-Item Health Survey (version 1.0). For the purposes of this analysis, baseline scores were collected prior to or shortly after move-in, which was in June 2023 for most participants. Follow-up assessments were collected during January and February of 2024, approximately 4 to 6 months after baseline score collection. To minimize interviewer bias, members of the

Eden Village social work team followed a standardized, internally developed script when administering baseline and follow-up interviews for all validated assessments.

Changes in psychosocial functioning from baseline to follow-up were assessed using paired Wilcoxon-Mann-Whitney tests. To control the false discovery rate given multiple comparisons, the Benjamini-Hochberg procedure was applied to identify significant results, using a maximum false discovery of 0.05.²¹ One participant did not complete all items at follow-up; pairwise deletion was used to manage missing data.

Results

A total of 26 residents provided informed consent and completed baseline assessments at Eden Village. One participant did not complete the ACE survey at baseline, and a different participant did not complete the Brief Instrumental Functioning Scale at follow-up; these individuals were excluded from analyses involving those specific measures ($n = 25$ for each). All other measures were complete at both time points.

Participants had a mean age of 41.0 years (standard deviation [SD] = 7.9), and 50% identified as Black/African American, 42.3% identified as White, and 7.7% identified as American Indian/Alaska Native. Of the participants, 69.2% were male. Participants also reported high levels of childhood adversity, with a mean ACE score of 4.2 (SD = 3.1), consistent with elevated trauma exposure among chronically unhoused populations ([Table 1](#)). Across the 4- to 6-month follow-up period, participants experienced measurable improvements in psychosocial functioning ([Table 2](#)). Emotional distress decreased substantially, with Colorado Symptom Index (CSI) scores dropping from a mean of 22.7 (SD = 17.9) at baseline to 13.4 (SD = 11.6) at follow-up ($P < .001$). Significant gains were also observed in 3 domains of the SF-36 Health Survey. Role limitations due to emotional problems improved markedly (41.0 to 73.1; $P = .01$). Emotional well-being increased from 53.4 to 74.2 ($P = .003$). Energy/fatigue scores also rose significantly (45.4 to 61.5; $P = .003$). Other domains of health-related quality of life measured by the SF-36, such as general health, physical functioning, pain, social functioning, and role limitations due to physical health, showed positive trends that did not reach statistical significance. Performance of instrumental activities of daily living, measured by the Brief Instrumental Function Scale, increased modestly from 4.3 to 4.7 but did not meet significance ($P = .14$).

Discussion

In recent years, tiny-home housing communities have become more popular as a means of combating chronic homelessness at the local level in the United States.^{22,23} Numerous philosophical and logistical approaches to case management are embodied in the myriad tiny home villages for the homeless across the United States. While some organizations like Eden Village of

Table 1. Self-Identified Eden Village Participant Demographics (N = 26)

Demographic	n	%
Race		
American Indian/Alaska Native	2	7.692
Black/African American	13	50
White	11	42.31
Gender	-	-
Female	8	30.77
Male	18	69.23
-	-	-
-	M	SD
Age	41	7.91
Adverse childhood experience (ACE)	4.2	3.11

Table 2. Psychosocial Functioning at Baseline and Follow-Up

Metric	Range	Time 1 M (SD)	Time 2 M (SD)	P value
Colorado Symptom Index	0–56	22.7 (17.9)	13.4 (11.6)	< .001*
Brief Instrumental Functioning	0–6	4.3 (1.8)	4.7 (1.5)	.14
SF 36 Health Survey General Health sub-domain	0–100	48.5 (24.2)	56.2 (21.9)	.10
SF 36 Health Survey Physical Functioning sub-domain	0–100	47.7 (35.7)	60.2 (32.9)	.06
SF 36 Health Survey Role Limitations Due to Physical Health sub-domain	0–100	38.5 (44.3)	54.8 (44.2)	.09
SF 36 Health Survey Role Limitations Due to Emotional Problems sub-domain	0–100	41 (47.4)	73.1 (40.0)	.01*
SF 36 Health Survey Social Functioning sub-domain	0–100	61.1 (37.5)	73.1 (28.2)	.21
SF 36 Health Survey Pain sub-domain	0–100	52 (34.5)	68.3 (31.2)	.04
SF 36 Health Survey Energy/Fatigue sub-domain	0–100	45.4 (27.8)	61.5 (22.0)	.003*
SF 36 Health Survey Emotional Wellbeing sub-domain	0–100	53.4 (30.1)	74.2 (19.7)	.003*

Table Note: * denotes significance after applying the Benjamini-Hochberg procedure.

Wilmington and the Housing First Village in Bozeman, Montana aim to provide residents with a “forever home,” other villages, such as those operated by Seattle’s Low Income Housing Institute, are more geared toward assisting residents until they are able to secure more traditional, stable housing.^{24,25} As detailed above, Eden Village’s comprehensive approach to case management encompasses elements of trauma-informed care to provide wraparound services that cater to residents’ needs.

An investigation into the demographic characteristics of the 26 participants from Eden Village of Wilmington demonstrated an over-representation of persons from marginalized racial groups, as well as individuals who had experienced substantial childhood trauma (ACE scores ≥ 4). The disproportionate number of individuals within the Eden Village Cohort (16) that have experienced 4 or more ACEs is emblematic of the growing body of evidence that points toward the link between childhood trauma and homelessness later in life.⁷⁻⁹ Given that homeless individuals are more

likely to have suffered childhood trauma than the general population and the substantial health risks posed by experiencing 4 or more ACEs, addressing childhood trauma is crucial to the success of efforts aimed at supporting this vulnerable population.³ By integrating trauma-informed care into their comprehensive case management model, Eden Village of Wilmington aims to mitigate the long-term effects of ACEs and assist residents in building resilience, improving health outcomes, and achieving housing stability.

Findings from this project show that residence in Eden Village is associated with a significant decrease in emotional distress and an increase in several health-related QOL domains that are most closely associated with mental well-being. Participant Colorado Symptom Index Scores yielded an average reduction of nearly 41% in symptom burden between baseline and follow-up, indicating a clinically meaningful decline in the frequency and intensity of psychological distress. The marked improvement in the “Role Limitations Due to Emotional Problems” domain of the SF-36 Health Survey suggests participants experienced a greater ability to engage in daily tasks without interference from mental health symptoms. Statistically significant improvements in the “Emotional Well-Being” and “Energy/Fatigue” domains further indicate improved mood, affective stability, and higher perceived vitality over time. Collectively, these changes point toward broad improvements in participants’ emotional functioning and day-to-day psychological resilience.

In contrast, domains more directly related to physical health showed positive but non-significant trends. Although these findings may reflect the relatively short follow-up period and limited statistical power of the study, the consistent direction of change suggests early movement toward improved physical and social functioning. This pattern is consistent with prior meta-analytical research, and it is possible that a larger sample size and longer follow-up period may yield stronger effects.²⁶

Participants’ performance on instrumental activities of daily living via the Brief Instrumental Functioning Scale was also likely impacted by sample size limitations and short duration of residency during the study period. Given the scale’s narrow range and the stability of daily living skills relative to emotional symptoms, meaningful change may require longer residency duration. No adverse effects or negative unintended consequences were reported to the case management team during the study period.

A few additional limitations to this study should be acknowledged. Exclusion of residents who did not provide their informed consent to participate in data collection, had not lived in the community long enough to complete follow-up assessments, and those who were lost to follow-up by leaving the community introduces a risk of selection bias that could color survey response data. Additionally, the fact that the 4 survey instruments administered by the Eden Village case management team are self-reported

introduces a risk of response bias. While team members were provided with a strict script to adhere to during survey administration, it is also important to acknowledge the possibility of interviewer bias. Moreover, residents of Eden Village participate in a number of services outside of the program and have varying degrees of interaction with members of their home teams and case managers, preexisting social networks within the Wilmington area, and local family members, which could all serve as sources of confounding. Low sample size also limited the statistical power of assessment results.

The present analysis utilized a pre–post design without a control comparison; future analyses should compare outcomes to individuals who receive standard support for homelessness. Further, given the racial inequities associated with homelessness, future studies should specifically conduct subgroup analyses and qualitative analyses to understand the impact of PSH on individuals from historically minoritized racial groups. The NIMHD framework provides a useful tool for investigators to assess key mechanisms through which PSH addresses racial inequities associated with a lack of housing. Additional outcome measures, such as connection to primary care and emergency room utilization, would be critical for fully quantifying the impact of PSH on public health.

Conclusion

This preliminary evaluation of the Eden Village approach to permanent supportive housing demonstrates meaningful improvements in mental health and select domains of health-related quality of life for formerly homeless participants. Access to stable tiny-home housing combined with comprehensive individualized case management was associated with reductions in emotional distress and improvements in emotional well-being, role functioning, and energy. Despite study limitations including small sample size and reliance on self-reported data, the present analysis demonstrates that the PSH model of Eden Village is a promising approach for improving the quality of life of chronically homeless individuals.

Declaration of Interests

The authors have no sources of financial support or conflicts of interest to disclose.

Correspondence

Address correspondence to Dr. Alexis M. Stoner, 350 Howard St., Spartanburg, SC 29303 (astoner@carolinas.vcom.edu).

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