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NEGOTIATING THE BOUNDARIES OF MENTAL HEALTH AND ILLNESS: A STUDY OF RECOVERY IN PERMANENT SUPPORTIVE HOUSING

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ABSTRACT

Current sociological understandings of the effect that mental health services on consumers' daily lives are still heavily informed by research conducted during the era of institutional treatment. This is problematic considering that changes to mental health care have shifted the locus of treatment to community settings for the majority of those living with serious and persistent mental illness (SPMI). With this shift there has been a greater focus on consumer-centered recovery in mental health care. The current study addresses this gap in the research by studying the recovery process for formerly chronically homeless individuals with dually diagnosed serious and persistent mental illness (SPMI) and substance use disorder who are living Housing First programming. Housing First is a model of permanent housing with supportive services that has been demonstrated to produce positive outcomes for "hard-to-serve" dually diagnosed consumers. I employed a combined case study and grounded theory approach that involved the collection and analysis of administrative, consumer, and staff data at four Housing First organizations in a large Midwestern city. My findings demonstrate that the recovery process in the programs was a negotiation between mental health and illness that consumers engaged in order to attain the highest quality of life possible in spite of symptoms related to their diagnosis. The structure of mental health services is key to this process, as it is more often than not the policies that guide programming that determine access to the resources that are necessary for consumers to engage in this negotiation.

CHAPTER ONE

INTRODUCTION

> Well, [the] first part of my recovery is not going into the psych wards anymore; I continue to use medication management effectively in my life. The second part is to be totally abstinence [*sic*] from drugs and alcohol. The third is to get into the profession that I chose to stay at. My other recovery is to become independent again. And when I say be independent again, that means not depending on the government programs to help me…Those are the things I wanna recover from. Those are the things like, yeah my drug use has reduced a little bit, but total abstinence is the goal. I don't have hospitalizations because of my depression anymore…[A]nd my other goal, I don't wanna depend, be dependent on food stamps and social security. I wanna buy my own health insurance, pay my own way…It's been seventeen years now and the hope that I see today is different than what I saw coming in here, cause I didn't have this hope…They [the staff at his housing program] all gave me this hope. I had no hope [before]. I'll be forever indebted to those people (Rodney, 45, HIVHA consumer)

This dissertation is a sociological study of mental health recovery. More specifically, it is a study of the recovery process for formerly chronically homeless individuals with dually diagnosed serious and persistent mental illness (SPMI) and substance use disorder who are living within the context of community-based services. I have chosen to start this work with the above quote from Rodney, a consumer of services at one of the four programs I collected data from, because it demonstrates that factors such as employment and physical health can be as important or more important to recovery than symptom remission and/or abstinence from substance use. Rodney's description of feeling indebted to staff also highlights the important role that services play in the recovery process for many individuals.

Sociologists who study mental health and illness have largely overlooked the study of recovery (Markowitz 2005; Thomas 2004; Yanos, Knight, and Roe 2007). Additionally, there has been a call within the sociology of mental health for researchers to reengage the study of SPMI and its treatment (Pescosolido, McLeod, and Avison 2007), both areas that sociologists moved away from in the 1970s and 1980s. There has also been a concern that sociologists need to develop better understandings of the consequences of illness itself, rather than focusing on it as a consequence of other factors (Markowitz 2005; Pescosolido et al. 2007). The current study addresses all of these concerns, as it is a study of recovery for those with dual diagnosis who are living within the structure of mental health programming/services.

The specific service structure of interest in this study is the Housing First model. Housing First is a form of permanent housing that offers wraparound supportive services (e.g., case management, mental health and substance abuse services, employment services, physical health services, transportation services, etc…). The mode was specifically designed to serve people who are chronically homeless, a population demonstrated to have high rates of mental health and substance abuse problems (see Nooe and Patterson 2010). I collected qualitative focus group and interview data from staff and consumers in four programs in order to develop an understanding of recovery as it occurred in the context of this model of service provision.

Some might question my choice to study recovery in the context of Housing First programming. This is because the primary objective of the Housing First model is housing and not mental health services. However, shortages in funding and cracks in the

mental health service system have made it necessary for other types of social services to provide mental health treatment to some degree (Frank and Glied 2006; Scheid and Brown 2009). Cuts to mental health services that have resulted from the recent recession make it likely that other types of social services will take up even more slack from the mental health service system (Associated Press 2011). Additionally, previous research has demonstrated that services that provide access to resources (e.g., housing, benefits, employment, transportation, education, case management) often have a more positive effect on consumers' lives than more "therapeutic" services that are designed to explicitly address consumers' symptoms (Frank and Glied 2006; Harris and Bergman 1987; Scheid and Brown 2009). Indeed, Housing First programming itself has been demonstrated to lead to significant positive outcomes for consumers with dual diagnoses such as higher rates of retention in housing and engagement in therapeutic services than other models of housing (National Registry of Evidence-Based Programs and Practices 2010). This combined with the fact that the model was designed to serve individuals with some of the most complex problems related to their mental health make it an excellent setting in which to study recovery. I provide a more detailed discussion of my scope of study in Chapter Three.

Previous research has demonstrated that SPMI and substance use disorders are closely related phenomena and consumers with dual diagnoses generally do not experience or conceptualize recovery from each separately (see Davidson and White 2007). Because of this, I have chosen to conceptualize recovery in general terms, i.e., recovery from both SPMI and substance abuse, in this study. As I demonstrate in the

pages that follow, the understandings and experiences of recovery that both the consumers and staff I spoke with had were highly dependent upon the structure of the programs in which they lived/worked. In order to demonstrate this, I take a social psychological approach to understanding recovery that connects macro-, meso-, and micro-level phenomena through the organizational processes of the programs I studied.

Qualitative social psychological methods developed out of the Chicago School of Symbolic Interaction are what make the study of mental illness in sociology unique from that of other disciplines. The ability of qualitative social psychological methods to make visible the social processes that affect the mental health of individuals is unique and has much to offer the study of recovery.

Despite this strength, beginning in the 1970s sociologists began to become more interested in studying mental health outcomes than the social processes associated with mental illness (Pescosolido et al. 2007). Though a number of sociologists have continued to conduct social psychological investigations using more positivistic/quantitative approaches, today relatively few studies of mental illness are conducted using a qualitative symbolic interactionist framework as their guide. There is a need for more sociological studies of mental illness and the factors associated with it that employ a symbolic interactionist approach, as their unique ability to uncover social processes can help us to understand the connections between the social structure and individual and group mental health outcomes (McLeod and Lively, 2005; Schnitteker and McLeod, 2005; Schwartz 2002). Indeed, the findings that I discuss beginning in Chapter Four demonstrate how macro-social forces (i.e., policy, professional and moral ideals)

influenced organizational processes that in turn shaped consumer and staff understandings and experiences of recovery.

My Interest in the Study of Recovery and Housing First Programming

I started my academic career with a desire to study mental illness. My career goal as an undergraduate majoring in psychology was to become a clinician. I decided to double major in sociology during my junior year because I preferred the more complex and nuanced understandings of mental illness I was learning from the elective courses I was taking in that department. My interest in social psychological approaches to the study of mental health and illness is rooted in my early experience as a student in both of these fields.

My specific interest in mental health and substance abuse recovery comes from one year in which I worked as a case manager in an inpatient substance abuse rehabilitation program and three years I spent working in long-term care directing therapeutic services and mental health rehabilitation. During my time in these positions I became fascinated and frustrated with the contradictions that existed between the interests of health care facilities, managed care, professional and paraprofessional workers (e.g., case managers, therapists, counselors, psychiatrists), and consumers. I oftentimes witnessed how the incompatibility between the interests and goals of these groups regularly benefited facility owners and insurance companies, while often doing more harm than good to the patients who were at their mercy. I also recognized the importance of understanding the unique position of professionals and paraprofessionals within mental health programs. This is because I witnessed how (as employees, recipients

of insurance reimbursements, and/or initiators of therapeutic services) their interests were often divided between facilities, managed care, and consumers.

I first learned of the Housing First model while listening to a program on National Public Radio in 2007. The program described Housing First as a model that did not place requirements like medication compliance or abstinence on consumers in order for them to receive housing. I remember the program stating how mental illness and substance abuse are often exacerbated by homelessness. Therefore, the logic behind the model's success was that removing the stresses associated with homelessness though the provision of housing reduced the expression of symptoms associated with these disorders.

I became a fan of the model almost immediately because of what I understood to be a more humane and realistic approach to housing and mental health services than I was familiar with as a clinician. I had worked with many homeless individuals during my time in long-term care. I had witnessed firsthand how individuals who are homeless come to nursing homes seeking shelter and are given the promise of "rehabilitation" (or recovery) services aimed at community reintegration only to become stuck there because the facility is more concerned with keeping its beds full (thus keeping Medicaid money flowing in) than it was in letting patients move to independence, something that the state saw as the primary responsibility of long-term care regarding this population. In light of this experience as a provider, Housing First stood out to me as not only a possible answer to ending homelessness, but a possible answer to getting mental health services to individuals who desperately need them without having to worry about the private interests of facility owners.

The opportunity to begin conducting research in the area of recovery and Housing First programming presented itself through my position as a Graduate Research Fellow in the Center for Urban Research and Learning at Loyola University Chicago (CURL). The first project I worked on as a fellow was a study of the aging homeless population in Chicago. My knowledge of the Housing First model and the mental health needs of the homeless population grew through this work. An opportunity to conduct research on a Housing First program presented itself soon after the close of this first study when the AIDS Foundation of Chicago requested assistance with a quality assurance study of a Housing First program model that CURL researchers had conducted a process evaluation of two years earlier. After this came the opportunity to conduct a process evaluation of a training and technical assistance program that was being provided to organizations seeking to integrate a Housing First approach to service provision. The community partner for this evaluation (as well as the provider of the training and technical assistance) was Heartland Alliance. While I have been and continue to work with a number of advocates and providers in the areas of housing and homelessness, Heartland Alliance is my collaborative partner on this project. I began working with key staff at Heartland over three years ago to develop this project. The advice and expertise of these staff has been indispensable to the design and execution of this project.

The Applied and Public Nature of this Project

I have recognized the need to give back to my collaborative partner and the larger community of housing and mental health services since the beginnings of this study. Indeed, this study could not have come at a more perfect time for my findings to have

impact outside of academia. The Housing First model has been recognized as an evidence-based practice and is touted as the answer for ending chronic homelessness (see National Registry of Evidence-Based Programs and Practices 2010; see National Alliance to End Homelessness 2000). Despite this, there is currently a heated debate among service providers and policy makers as to its effectiveness. A large reason for this debate is the Housing First models use of harm reduction strategies to address consumer substance use. I describe harm reduction in greater detail in Chapter Three. For now it is sufficient to say that harm reduction strategies do not require consumers to be abstinent from alcohol and drug use, but rather work with consumers to engage in this use in a manner that is both safer for the individual and the community.

While harm reduction is the policy and treatment model of choice in most European countries, it has had a difficult time gaining traction in the United States (see Marlatt 1996). This is largely because of the prohibitionist guided views of substance use and substance users that exist in popular discourse here (see McMaster 2004). These views have found their way into social policy through things such as mandatory sentencing for drug offenders and rules that bar substance abusers from accessing Medicaid. Because of these views programs that offer help to substance abusers without requiring them to be abstinent are, more often than not, seen as enabling negative behaviors. This is evident in the title of a recent article on Housing First that ran in the *USA Today* titled "Homeless Addicts Get Help without Getting Clean, Sober" (Vengerowsky 2011). The use of the word "clean" (i.e., good) in this title is associated with sobriety, which connotes that those who are not sober are "dirty" (i.e., bad).

Additionally, the suggestion that someone or some program is providing help to addicts who are not "clean" points to these programs helping people to remain "dirty" (i.e., enabling them). The entire article does a better job of discussing Hosing First than the title suggests by comparing actual data demonstrating cost effectiveness of Housing First programming with evidence for abstinence-only approaches to substance use that are only anecdotal.

In *Million Dollar Murray,* what is considered by many to be the article that introduced Housing First to the broader public, Malcolm Gladwell (2006) made an argument in the *New Yorker* for why the model is fighting an uphill battle despite the evidence that demonstrates its effectiveness. Speaking specifically about research that has demonstrated the cost effectiveness of the model, Gladwell wrote that approaches like Housing First have little appeal to the conservative right because "they involve special treatment for people who do not deserve special treatment" (Retrieved June 7, 2010). This logic is frequently evident when groups speak out against harm reduction. For instance, in 2010 anti-harm reduction advocates vividly spoke out against a brochure used by the New York Department of Health and Mental Hygiene aimed at educating drug users about safer injection despite the fact that twenty years of harm reduction efforts in the city are credited with an 80 percent drop in HIV/AIDS transmission rates (Papa 2010). Recent developments suggest that the tide might be changing, as the Obama Administration has demonstrated that is it more open to harm reduction approaches to service provision than previous administrations. This was demonstrated in 2009 with the

appointment of Gil Kerlikowske, a former Seattle police chief who is pro-harm reduction, as Drug Czar (i.e., head of the Office of National Drug Control Policy) (Smith 2009).

One of the primary aims of this research is that it will help in some small way to support the spread of the Housing First model and harm reduction practices by demonstrating how they affect the recovery process. In this sense, my dissertation is a work of public sociology. In other words, it is a work of sociology that engages audiences outside of academia (see Burawoy 2005). The reason the study developed in this way is because it was driven by a combination of knowledge located within the discipline of sociology and non-academic communities. My initial idea for this project developed out of collaborative studies I had worked on in the two years prior to its development, which I have already mentioned above (Watson 2010; Watson and George, 2009; Watson, George, and Walker 2008). Through my work on these studies, I became aware of the need to develop a better understanding of how the Housing First model affects outcomes for dually diagnosed consumers, as well as the opportunity this presented for investigating the recovery process in the context of community-based services.

An Overview of the Chapters that Follow

In Chapter Two, I provide an overview of literature on mental health recovery. My focus in this discussion is on **recovery as a social construction**. Through a discussion of historical trends, popular knowledge, advocacy, current policies, research, and approaches to mental health and substance abuse treatment, I demonstrate how the meaning associated with "recovery" is dependent upon historical and social contexts.

After discussing the recovery literature, I detail why a sociological study of recovery is necessary. In this discussion I highlight why sociologists need to be concerned with the study of recovery, as well as what a sociological study of recovery has to offer the broader field of mental health studies.

I present my research questions and provide a detailed rational for my choice to study mental health recovery in Housing First programming in Chapter Three. I then describe the **symbolic interactionist and applied framework** in which I set my study and provide a detailed description of my methods, the programs in my sample, and the consumers and staff who participated in this study.

Chapter Four is a comparison between my study informants' previous experiences in their current Housing First programs and other housing programs with which they were familiar. All of the consumers and staff I spoke with had experiences living or working in/with programs that did not operate under the Housing First model. In comparing their experiences, I demonstrate how what the major differences between the two types of programming were and how they structured consumer and staff understandings and experiences in different ways.

In Chapter Five, I describe how consumers and staff understood recovery and the process through which it occurred. I also introduce two existing theories, Edgework and Disability Theory, which I combine in order to help explain/frame my findings. The findings in this chapter demonstrate how consumer and staff understandings and experience of recovery were very different from those that have developed from the biomedical model.

In Chapter Six, I connect the recovery process outlined in the previous chapter to the larger social structure. I do this by discussing the larger institutional forces that influenced the programs to implement the Housing First model in similar ways. After this discussion, I present a social psychological model of the recovery process in Housing First programming based on the findings I discuss up until this point.

In Chapter Seven, my focus turns to the differences that existed between the programs. I demonstrate how differences were the result of internal and external constraints related to the organizational context. I then demonstrate how these constraints facilitated or hindered the effectiveness of specific key components of the Housing First model. I do this by connecting variations in programming related to constraints to differences in study informants' understandings and experiences of programming. I also introduce a typology of Housing First programming based on the variation of the two dimensions of the service structure I found to be the most important for influencing the recovery process.

In Chapter Eight, I present an overview of the key findings of the study. After discussing these findings I demonstrate how they can be generalized to understand recovery in other types of mental health services by presenting what I call the *Boundary Negotiation Model of Mental Health Recovery*. After outlining this model I propose directions for future research, recommendations for policy makers and programs, and offer some final thoughts.

Definitions of Frequently Used Terms

There are a few terms I frequently use throughout this work that I wish to explain before moving forward. These definitions are only intended to provide a brief orientation to the reader, as a number of these terms will be explained in greater detail later in this work.

- **Consumer** – Any person who is the recipient of social services, mental health, substance abuse, or otherwise. This term is also used interchangeably with "client", "participant", "recipient," and/or "resident" by study informants.
- **Client/Patient** – Any person who was the recipient of mental health or social services prior to the consumer movement in mental health care. This term is also used interchangeably with "consumer," "participant," "recipient," and/or "resident" by study informants.
- **Case manager** – A person who provides case management services, i.e., works with consumers to facilitate care by helping them to acquire and coordinate resources. The majority of staff participating in this study were case managers. I use the term "case manager" when findings apply specifically to this group rather than general staff members.
- **Informants** – All consumers and staff who participated in the study.
- **Program** – A subunit of a larger agency/organization that operates according to its own budget and is designed to provide a specific service. The programs in this study all provided housing and supportive services independently from other programs their larger agencies/organizations might have operated.

- **Sample** – Whereas this term typically refers to the study informants, my sample is composed of the four programs that I collected my data at.
- **Serious and persistent mental illness (SPMI)** – A mental, behavioral, or emotional disorder that meets psychiatric diagnostic criteria, which results in impairments that substantially limit an individual's major life activities such as school, work, parenting (see President's New Freedom Commission on Mental Health 2003). Examples of SPMI include psychotic disorders such as schizophrenia, bi-polar disorder, and major depression.
- **Substance use disorder** – Substance use disorders (e.g., substance abuse and substance dependence) are marked by an individuals continued use of a substance, alcohol or drugs, despite repeated adverse consequences (American Psychiatric Association 2000). Adverse consequences of substance use include such things as negative health consequences, inability to perform work tasks related to major social roles (e.g., school, work, parenting), the loss of friends, and/or the significantly distracting thoughts or emotions related to substance use.
- **Dual diagnosis** –While this can refer to the co-occurrence of any two disorders in medical terminology, I use it specifically to refer to the presence of SPMI and substance use disorder in a single individual.
- **Biomedical model** – An approach, usually employed by psychiatrists and other medical professionals, to understanding health related outcomes that focuses on individual-level physiological, biological, neurological, and/or genetic explanations (see Scheid and Horwitz 1999). From this perspective individual mental illnesses are

identified by unique clusters of symptoms and/or behaviors that are associated with them. I am also considering clinical psychological explanations for mental illness under this category since they have been heavily influenced by the biomedical model (see Schooler 2007; see Pearlin, Avison, and Fazio 2007)

- **12-step model** – A self-help model that understands substance dependence/ addiction as a chronic and deteriorating disease and advocates complete abstinence from substance use as the preferred course of treatment. Developed by the founders of Alcoholics Anonymous (AA) in the 1920s, the model has since become the preferred approach by other addictions self-help groups (e.g., Cocaine Anonymous, Narcotics Anonymous) and the professional treatment community (Ferri, Amato, and Davoli, 2006).
- **Continuum of Care (COC) programming** – Also known as "abstinence-only" or "treatment first" programming, has historically enfolded aspects of the 12-step approach to addiction advocated by AA. As such, these programs have typically required individuals to obtain sobriety goals (typically for 30-90 days) before advancing into some form of temporary housing. Individuals are then required to meet other goals before advancing to a more permanent housing situation. In most COC programs, individuals are at risk for losing their housing placement should they choose to engage in substance use at any stage (see Padgett 2007).
- **Project-based program** – All housing and services are provided in the same location.

- **Scattered-site program** – Housing and services are in different locations. While case managers might visit consumers' homes to provide services, their offices are at a different location.

CHAPTER TWO

RECOVERY: HISTORY, DEFINITION, AND WHAT SOCIOLOGY HAS TO OFFER

Introduction

The purpose of this chapter is to locate this study within the broader literatures on the sociology of mental health and recovery. In order to complete this task, I first demonstrate how recovery is a social construction by discussing the historical, scientific, and political developments that have influenced the way the course of mental illness is understood. I then present the two major theoretical perspectives regarding mental health recovery and how they relate to the understanding of recovery in the substance abuse field. Finally, I point to the current lack of sociological research on mental health recovery and discuss how a sociological investigation of this topic can provide a better understanding of the recovery process as it is understood and experienced.

The Social Construction of Mental Illness: Understanding Historical Changes in Knowledge Regarding the Course of SPMI

Today, sociologists tend to view *mental illness as a social construction* as opposed to biomedical approaches that locate mental illness within the body or brain. The social constructionist perspective focuses on the ways in which society constructs ideas, values, beliefs, and definitions (Berger and Luckmann 1967; Maines 2000), such as those that guide the diagnosis of mental health problems. Szasz ([1961] 1984) wrote what is

considered by many to be the pioneering text regarding the social construction of mental illness, *The Myth of Mental Illness*. In this book, Szaz describes mental illness as social construction that is rooted in the way society reacts to the deviant behavior of those labeled mentally ill. According to Szasz and others, the "myth of mental illness" is perpetuated by social control efforts rooted in the medicalization of specific behaviors (Scheff [1966] 1999; Foucault [1965] 2006), which are understood as symptoms with underlying physiological, biological, neurological, or psychological causes.

For sociologists, the process through which definitions/diagnoses of mental illness are constructed is known as medicalization (Conrad 2007). Medicalization is a professional and political process that transforms abnormal behaviors that exist in everyday life into diagnosable symptoms of medical disorders. Medicalization of mental illness happens when deviant behaviors are turned into psychiatric diagnoses that are in need of treatment (Scheff [1966] 1999). The ultimate expression of medicalization in the mental health field is the Diagnostic and Statistical Manual 4th edition (DSM-IV) of the American Psychiatric Association (2000). The DSM-IV groups observable mental health "symptoms" into different diagnosable disorders. Each disorder goes through a process of professional, and sometimes public, debate to assess the scientific merits to justify its inclusion in this manual.

An excellent example of contemporary issues in the social construction of mental illness is Figert's (1996) book *Women and the Ownership of PMS.* Figert outlines the social construction of what is now called Premenstrual Dysphoric Disorder (PMDD), a supposedly more serious form of Premenstrual Syndrome (PMS), as a clinical mental

health diagnosis. Demonstrating the political process inherent in the definition and categorization of mental health disorders, Figert describes the controversy between competing groups who were struggling to have their voices heard in the debate to include a premenstrually connected diagnosis in the DSM-IV. These groups included women who have experienced PMS, feminists, various clinical professionals (psychiatrists, gynecologists, and psychologists) and journalists. In her work, Figert demonstrates how the conflict between these groups changed the original direction of key psychiatric professionals, leading to a temporary definition for the disorder that was included in the appendix of the DSM-III-R (a previous edition of the DSM) until more scientific legitimacy for its full inclusion in the DSM-IV was "discovered."

Figert and others have demonstrated how the social constructionist perspective is particularly useful for highlighting issues of power and politics related to mental health diagnosis (see: Caplan 2001; Conrad 2007; Horwitz 2011; Scheff [1966] 1999; Szasz [1961] 1984). As such, it also has the potential for illuminating similar issues regarding the social construction of recovery. In the rest of this section I discuss the historical, scientific, political, and professional trends that have affected the way in which recovery is defined and understood by different groups in society.

Traditional Views Regarding the Course of SPMI

The social construction of recovery is intimately tied to changes in the way the course of mental illness has been understood over the past century. Most current biomedical understandings of SPMI are rooted in research conducted by Kraepelin ([1913] 1987) in the early 1900s. The subjects of Kraepelin's research were patients

displaying symptoms we would today associate with schizophrenia. Kraepelin's research led him to the conclusion that schizophrenia, which he called *dementia praecox* (i.e., premature dementia), was degenerative disease from which the sufferer had no hope of recovery. Kraepelin's work still has significant influence today, as it is the foundation upon which the modern neurobiological model of schizophrenia rests.

The legacy of Kraepelin's ideas has extended beyond explanations of schizophrenia to inform treatment, social policy, and public attitudes regarding most forms of SPMI for the past century (Corrigan and Ralph 2005). The reason for the bleeding of ideas about schizophrenia into other categories of mental illness is because schizophrenia is the illness that most readily comes to mind when people think of SPMI. The misunderstanding of the course of schizophrenia and its confusion with other mental health disorders led to a view in both medicine and the larger society that individuals with SPMI are dangerous, and this served to legitimize control of people diagnosed with SPMI by the psychiatric profession in the name of public safety (Davidson 2003; Szasz [1963] 1989). The effect of these developments was the institutionalization of those living with SPIM in state-run long-term mental health hospitals.[1] This institutionalization happened on such a large scale that around 77 percent of all treatment in 1955 occurred in these and similar institutions (U. S. President's Commission on Mental Health 1978, as cited in Frank and Glied 2006).

[1]Frank and Glied (2006) point out that this is not to say that all or the majority of people living with SPMI were institutionalized they estimate that a number of people lived with families, in boarding houses, flophouses, or hotels.

Szasz ([1963] 1989) has discussed how the privileges gained by psychiatrists in the name of public interest were strengthened through the alliances developed between the psychiatric profession and the criminal justice system. According to Szasz, views of mental patients as "dangerous" have historically served to rationalize the institutionalization of persons diagnosed with SPMI through the legal doctrine of *parens patriae*, or the idea that it is the state's right and duty to "protect" persons who are unable to care for themselves. He states:

> Our laws—which regulate the conduct of both normal and so-called mentally ill persons—incorporate this fundamental distinction between contract and status. So long as an adult is considered mentally well, the law treats him as an individual. Once he is considered mentally ill, however, the law defines the patient's next of kin as a "responsible relative," who, for all intents and purposes, is given possession of the patient as a person…The patient cannot effectively refuse permission [for treatment]. As a rule, his relatives will be eager to transfer all the responsibility for the patient's care to "his doctors." (P. 150-51)

As a result of this doctrine, the state can assume "ownership" of the patient without much difficulty. Though not as powerful, it is important to note that the control given to the state and to psychiatrists on behalf of *parens patriae* has existed beyond the days of institutional care.

While Kraepelin's influential work highlighted the course of mental illness from a neurological perspective, groundbreaking sociological research conducted by Goffman (1961) in the late 1950s highlighted the connections between institutional care and the course of mental illness. Goffman was the first to give a strong description of the effects of institutional control on psychiatric patients in his book *Asylums*. Goffman's description of the "moral career" of the mental patient outlined three general phases mental patients

went through within institutional care settings. These were the pre-patient, in-patient, and post-patient phases. Goffman's work focused on the first of these two phases. As the following two quotes demonstrate, his description of these phases outlined an increasing delegitimation of the mental patient as a "normal" human being that served to rationalize the control the institution had over them:

> [The pre-patient] starts out with relationships and rights, and ends up, at the beginning of his hospital stay, with hardly any of either. The moral aspects of this career, then, typically begin with the experience of abandonment, disloyalty, and embitterment. (P. 133)

> The last step in the prepatient's career [and his entrance into the inpatient phase] can involve his realization—justified or not—that he has been deserted by society and turned out of relationships by those closest to him. (P. 146)

Goffman's work highlights the importance of the structure of mental health care in shaping the course of the mental patient's career. It is particularly telling that Goffman put no effort into describing the post-patient phase, as the extreme control institutions had over patients resulted in relatively few of them ever transitioning back into the community successfully. Since the time of Goffman's work, there have been sweeping changes to the way SPMI is treated, and these changes have profound effects on the way that SPMI is understood by society and experienced by those living with it.

Rethinking the Course of SPMI

Neurological/biomedical understandings of mental illness and the overwhelming negative effects of institutional treatment resulted in a pessimistic view of the course of mental illness that largely failed to consider recovery as a possibility. Despite this, recovery is now the guiding principle of mental health treatment today (see Anthony

1993). This is because sweeping changes that occurred within the mental health system beginning in the 1950s.

Deinstitutionalization and the Move to Community-Based Care

Patient advocates, which included psychiatrists, made the dehumanizing conditions of the institutionalized mentally ill known to the general public beginning in the 1950s (Davidson 2003; Frank and Glied 2006). This awareness, combined with advances in psychiatric medications that made the symptoms of SPMI more manageable (Scheid and Greenberg 2007), resulted in the enactment of new laws that established quality-of-care standards, gave mental health patients greater control over their rights, and made it more difficult to commit them to long-term institutional treatment (Frank and Glied 2006; Kaufmann 1999; McLean 2009). A period of dismantling of large psychiatric institutions, known as deinstitutionalization, soon followed (Scheid and Brown 2009).

Deinstitutionalization resulted in sweeping changes to the way that mental health treatment was approached, and was supposed to lead to a new, more humane, community-based care system. As a result, by 1975 the percentage of individuals receiving inpatient treatment in psychiatric hospitals had reduced to half of what it was in 1955 (28 percent versus 77 percent) (U. S. President's Commission on Mental Health 1978, as cited in Frank and Glied 2006). However, community-based care was more of an ideal than anything. In an overview of organizational mental health research Scheid and Greenberg (2007) highlight three reasons why the community-based care system never reached its full potential. First, the shifting of care to community-based organizations resulted in a fragmentation of the mental health care system. Fragmentation

was a natural consequence of the relocation of health services to the community, as mental health services were no longer provided within the confines of a single institution (see also Frank and Glied). However, this fragmentation was exaggerated by funding mechanisms that encouraged mental health organizations to specialize in relatively narrow areas of service provision (e.g., mental health, substance abuse, housing). Second, a large number of small community-based mental health providers were forced to close their doors because they were not as resilient in the face of changes that occurred in the larger economic and political environments as the state-run institutions they replaced were. Both the fragmentation of services and holes left by closing organizations resulted in gaps in services that continue to this day (see also McLean 2009).

Several changes to the way SPMI was perceived by researchers after deinstitutionalization have resulted in a more positive view of the course of mental illness today. These changes in perceptions happened because of research conducted by the World Health Organization (1973; 1979) that demonstrated that the course and outcomes of schizophrenia were not as predictable outside of the institutional setting. This research established that at least partial recovery from schizophrenia occurred in close to 50 percent of people with diagnosable symptoms who were living in community settings (Carpenter and Kirkpatrick 1988; Harding, Strauss, et al. 1987; Harding, Zubin, and Strauss 1987). Even more startling was the research from a study that followed people living with schizophrenia over thirty years (Harding 1988). Results of this research demonstrated that one-third of the sample recovered on their own by using their existing skills and resources to assist them in meeting their life goals. These changes in thinking

about the course of schizophrenia, the most debilitating of all mental illnesses, ushered in a whole new way of thinking about the course of SPMI that gave hope to those living with mental health disorders.

The Rise of the Mental Health Consumer/Survivor Movement

Since deinstitutionalization, other positive social and political developments have increased the quality of life of people living with SPMI by giving them more control over their lives and a greater level of inclusion in society. The rise of the Mental Health Consumer/Survivor Movement (MHCSM) is arguably the most important of these developments. As Kaufmann (1999) notes:

> The mental health consumer movement is an effort by people with mental illness to establish control over psychiatric treatment and the severe social stigma that attends a psychiatric diagnosis. Participants in this movement also try to acknowledge diversity among people with psychiatric diseases and to develop systems of care that reflect the diverse needs and wishes of mental health consumers. (P. 494)

The movement itself evolved in the 1970s from the community-based care movement that resulted in desinstitutionalization (Davidson 2003; Davidson et al. 2006; Davidson and White 2007; Kaufmann 1999; McLean 2009; Power 2009). The development of the movement can be traced to a small number of patients' rights groups that were working to improve conditions in hospitals and community treatment centers (Zinman, Howie the Harp, and Budd 1987), as well as the personal accounts of consumers that were being published. These accounts spurred public awareness of the situation of mental health patients by highlighting the mistreatment and degradation that patients suffered at the hands of the psychiatric profession during the phase of institutional treatment (Corrigan and Ralph 2005; Davidson 2003; Kaufmann 1999).

A group of these former patients adopted the label "psychiatric survivors", after it was demonstrated that the application of psychiatric labels had just as profound effects on patients as the symptoms associated with their diagnoses (see: Kaufmann 1999; McLean 2009; Pescosolid and Martin 2007). Because of the negative views of SPMI in the larger culture, labeling serves to stigmatize the individual. Stigmatic labels have profound consequences since they marks an individual or group as "different" or "abnormal" and exclude them from full participation in society (Goffman [1963] 1986; Link and Phelan 2001; Link, Struening, Rahav, Phelan, and Nuttbrock 1997; Pescosolido, Martin, Lang, and Olafsdottir 2008). Mental health labels are no exception, as research has demonstrated how psychiatric diagnosis causes those with diagnosed mental illness to be rejected by others and/or to avoid social interaction because they expect social rejection to occur (Gove 2004; Link and Phelan 2001; Link, Cullen, Struening, Shrout, and Dohrenwend 1989; Link et al. 1997; Phelan 2005; Scheff [1966] 1999; Wright, Gronfein, and Owens 2000; Wright, Wright, Perry, and Foote-Ardha 2007).

The MHCSM erupted in full force in the 1980s when psychiatric survivors began applying the term "consumer" to themselves rather than "patient" or "client" (see: Kaufmann 1999; Figert 2011; McLean 2009). The use of this term comes from the disability rights movement, and it is an attempt to shift the focus of mental health care from psychiatrically controlled treatment to services guided by consumer choice (Kaufmann 1999; McLean 2009). The MHCSM is just as concerned with humane treatment as its predecessors that that spurred on deinstitutionalization. In addition, the influence of the Disability Rights Movement has resulted in more emphasis being placed

on issues regarding human rights and citizenship as they relate to people living with mental illness. This movement locates the limitations disabled individuals face on the failure of society to provide adequate accommodations to facilitate social inclusion, rather than the disability itself (Shakespeare 2006). For instance, the National Alliance on Mental Illness (NAMI), a consumer advocate group, directs a significant amount of its efforts toward changing images of mental illness in society with the goal that this will reduce barriers to social inclusion and citizenship for people living with mental illness:

> NAMI StigmaBusters is a **network of dedicated advocates across the country and around the world** who seek to fight inaccurate and hurtful representations of mental illness. Whether these images are found in TV, film, print, or other media, **StigmaBusters speak out and challenge stereotypes. They seek to educate society about the reality of mental illness** and the courageous struggles faced by consumers and families every day. StigmaBusters' goal is to break down the barriers of ignorance, prejudice, or unfair discrimination by promoting education, understanding, and respect. [emphasis in original] (National Alliance on Mental Illness 2011, Retrieved March 2, 2011)

As this quote from NAMI's website demonstrates, the MHCSM today directs significant amounts of time toward addressing stigma and changing social policy in an effort to meet its goals.

The advocacy work of the MHCSM combined with new understandings regarding the course of mental illness resulted in less than 10 percent of people with SPMI receiving care in inpatient settings by 1990 (Frank and Glied 2006). Since this time a number of important developments policy and legal developments have served to further increase the rights of consumers. The legislation of the Americans with Disabilities Act (ADA) in 1990, which prohibited discrimination against those with mental disabilities in the public sphere, is arguably the most pivotal. Other important social and political

developments include: the 1999 Supreme Court *Olmstead V. L.C.* decision that mandated mental health consumers right to treatment in the *least restrictive environment* possible; the 1999 US Surgeon General's *Report on Mental Health* that legitimized the existence and treatment of mental health conditions (U. S. Department of Health and Human Services 1999); the 2003 President's New Freedom Commission Report on *Achieving the Promise: Transforming Mental Health Care in America* that established the need for a recovery focused mental health care system driven by consumers and their family members; and the 2005 publication of *Improving the Quality of Health Care for Mental and Substance-Use Conditions* that emphasized the need for evidence-based mental health care and the need for person-centered services (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders 2006). These developments have all resulted in the move toward a recovery-focused health system that places consumers at the center of their treatment.

Anthony (1993) has outlined **eight assumptions of a recovery-focused mental health system**:

1. Recovery can occur without professional intervention. Professionals do not hold the key to recovery; consumers do….
2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery….
3. A recovery vision is not a function of one's theory about the causes of mental illness… Recovery may occur whether one views the illness as biological or not….
4. Recovery can occur even though symptoms reoccur…People with other illnesses that might be episodic (e.g., rheumatoid arthritis, multiple sclerosis) can still recover. Individuals who experience intense psychiatric symptoms episodically can also recover….
5. Recovery changes the frequency and duration of symptoms…That is, symptoms interfere with functioning less often and for briefer periods of time…Symptom recurrence becomes less of a threat to one's

recovery, and return to previous function occurs more quickly after exacerbation….

6. Recovery does not feel like a linear process. Recovery involves growth and setbacks, periods of rapid change and little change….
7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself. Issues of dysfunction, disability, and disadvantage are often more difficult than impairment issues….
8. Recovery from mental illness does not mean that one was not "really mentally ill."…. (Retrieved May 25, 2010)

Anthony's assumptions demonstrate what a recovery focused mental health system should look like: more consumer-centered than provider-driven placing greater concern on the person's ability to manage the negative consequences of their symptoms and the social processes involved. These assumptions are useful for researchers in light of the scant literature that considers the social processes involved in recovery because they can be used as a framework for evaluating the relevance of empirical studies to clinical practice and consumers' experience.

While recovery as a policy has become more focused on individual consumer's attempts to negotiate the limitations of SPMI and barriers to social inclusion, clinical practice and research in this area have not fully caught up. As a number of other researchers have pointed out, many of our conceptions of mental illness and recovery are still guided by neurobiological and medical views that fail to see the person as a whole, let a lone as part of a larger social world (Amering and Schmolke 2009; Borg 2007; Davidson 2003). One of the primary reasons for this is the development of managed care, a form of health care marked by high levels of bureaucracy and rational decision making regarding reimbursement for treatment (Mechanic 2007; Scheid 2003). Managed care places treatment decisions in the hands of insurance providers whose ultimate goal is cost

efficiency (see Scheid and Greenberg 2007). As such, providers are encouraged to engage in acute care aimed at managing the symptoms of SPMI (i.e., provide medication), rather than provide more expensive comprehensive services aimed at recovery (e.g., therapy and case management services). Despite the restrictions to treatment that go hand-in-hand with managed care, treatment prevalence has increased since the 1970s for both insured and uninsured individuals (see Frank and Glied 2006).

Defining Recovery in Clinical Practice and Research

Clinicians and researchers tend to conceptualize recovery in one of two ways. The first and most widely adhered to perspective is guided by the biomedical model. This perspective conceptualizes *recovery as an outcome* that consumers obtain when they reach a predefined state of functioning and/or "normalcy." The second perspective, guided by the social model of recovery, conceptualizes *recovery as a process* that consumers engage in as they attempt to address the issues caused by their mental health problems.

Mental Health Recovery as an Outcome: Provider-Directed Recovery

The outcome perspective of mental health recovery is rooted in the biomedical model. As an outcome, mental health recovery is conceptualized in a very similar way to that of recovery from a physical health problems (Davidson et al. 2006), and is generally measured in one of two ways. The first way it can be measured is the complete or almost complete remission of symptoms or return to a "normal" state of being (Liberman and Kopelowicz 2005; Resnick, Rosenheck, and Lehman 2004). The second way is when the consumer has reached goals that have been specifically defined by mental health

professionals (Deegan and Drake 2006; Liberman and Kopelowicz 2005). These goals are usually related to a predetermined level of treatment adherence or functioning. Treatment adherence is generally measured as compliance with psychiatric orders (i.e., medication compliance), while level of functioning can either be the same it was before the onset of mental health symptoms or a level of functioning determined to be "ideal"/"reachable"/"realistic" in important domains of life such as employment, housing, and relationships.

From the point of view of the advocates and the recovery-focused social policies I previously discussed, the outcome perspective of recovery is problematic in a number of ways. First, measuring recovery in terms of treatment goals overlooks the fact that the modern focus on recovery emerged from the writings of consumers and ignores the more than thirty years of social and political struggle by these consumers and their advocates to shift the locus of power in the consumer-provider relationship away from the psychiatric profession (Anthony 1993; Deegan and Drake 2006; Kaufmann 1999; Timmermans and Oh 2010). This also ignores Anthony's first assumption listed above and the findings of previous research discussed above, which demonstrate that recovery can and does happen outside of the structure of mental health treatment (Carpenter and Kirkpatrick 1988; Harding, Strauss, et al. 1987; Harding, Zubin, and Strauss 1987).

Second, while research has established that the symptoms of SPMI can and do go into complete remission (Amering and Schmolke 2009; Andreasen et al. 2005), this is not always the case. Therefore, to require that an individual's symptoms be in remission for them to be considered "in-recovery" or "recovered" means that the majority of people

living with SPMI will never reach this state, which is against Anthony's fourth assumption.

Finally, the outcome perspective of recovery ignores the everyday experiences of those living with SPMI. Previous research has demonstrated that recovery is a highly individualized and personal process (Davidson 2003; Mueser et al. 2002; White 2007; White, Boyle, and Loveland 2005). For instance, using in-depth qualitative interviews, Borg (2007) demonstrated how consumers' experiences and definitions of recovery were highly personal, and how interactions with services like those recommended by mental health professionals actually interfered with their ability to see themselves as "normal" or "ordinary." Additionally, previous research has demonstrated that consumers see quality of life to be a more important issue in their recovery than treatment adherence (Deegan and Drake 2006). Given that the side-effects of psychiatric medications have been demonstrated to negatively impact quality of life for consumers (see Deegan and Drake 2006), it is inappropriate to use this as a primary means for assessing whether a person is "in recovery."

Mental Health Recovery as a Process: Consumer-Centered Recovery

The process view of mental health recovery addresses many of the problems with the outcome perspective I have outlined above. Davidson (2003) provides an excellent argument for why mental health recovery should be looked at as a process rather than an outcome:

> …[R]recovery from psychiatric disorder may look quite different, and take on different meanings, from the typical use of the term in relation to physical conditions. At its most basic level, the recovery model argues that psychiatric disability is only one aspect of the whole person and that

> recovery from psychiatric disorder does not require remission of symptoms or other deficits. In other words, and unlike in most physical illnesses, people may consider themselves to be "in recovery" from a psychiatric disorder while continuing to have, and be affected by, the disorder. (P. 38)

The process perspective treats mental health as a disability rather than an illness because it tends to focus more on quality of life, personhood, and empowerment than it does on complete remission or a return to normal functioning (Corrigan and Ralph 2005). For this reason, the process perspective is more popular among advocate groups that have developed out of the Mental Health Consumer/Survivor Movement.

When conceptualized as a process, the focus of recovery shifts from medical treatment to the consumer's attempts to address the issues caused by their mental illness and to meet their life goals (Amering and Schmolke 2009; Anthony 1993; Davidson 2003). This shift in focus is reflected in three important ways. First, there is a larger concern with citizenship, i.e., consumers' access to fundamental rights and inclusion in society (Davidson et al. 2006; Ware et al. 2008). Second, it is recognized that the recovery process is a unique endeavor for each person and that any attempts at treatment should involve the full participation of the consumer as a shared-decision maker (Borg 2007; Deegan and Drake 2006; Loveland, Weaver Randal, and Corrigan 2005). Third, the process perspective recognizes that the best setting for recovery is in the community, rather than a traditional treatment setting because it is within this setting that consumers can begin to reengage with "normal" aspects of their lives (Davidson and White 2007).

The process perspective of recovery is reflected in advancements in mental health policy discussed above. As a result of these advancements, a comprehensive panel

including consumers, family members, policy makers, and researchers convened by the Substance Abuse and Mental Health Services Administration (2005) developed a common definition of recovery that included such key terms as: self-direction, individualized, person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope. All of these terms have more in common with the process perspective of addiction than the outcome perspective in that they are focused on individuality, consumer control, and quality of life rather than symptom remission or treatment goals.

Recovery in the Substance Abuse Field and How it Compares with Views of Mental Health Recovery

Previous research has demonstrated that there is a significant association between mental illness and substance use disorders. Results from the National Comorbidity Survey showed over half (51.4 percent) of respondents who met diagnostic criteria for a substance use disorder in their lifetime also met criteria for at least one lifetime mental disorder, while about the same percent (50.9 percent) of those with a lifetime mental disorder also had a history of substance dependence (Kessler et al. 1996). More recently, results from the National Epidemiologic Survey on Alcohol and Related Conditions reported that 19.7 percent of respondents displaying symptoms of a substance use disorder within the past 12 months also met diagnostic criteria for a mood disorder, while 14.5 percent met criteria for an anxiety disorder (Grant et al. 2004). Despite this overlap between SPMI and substance use disorders, recovery focused research in both of these areas tends to concentrate on either mental health or substance abuse recovery, while

largely ignoring the complex interactions between the two. This has led to significant differences between the ways that recovery from SPMI and substance abuse are conceptualized that are important to consider before moving forward.

Recovery has been a major concern of the addictions field for longer than mental health. In fact, most popular knowledge about recovery is informed by the 12-step model of addiction recovery developed by AA in the 1930s and the disease concept of alcoholism developed by Jellinek in the 1960s (Jellinek 1960; see Schneider 1978). From these perspectives, addiction (not just alcoholism) is viewed as a chronic disease from which the individual will never be cured. The only way for the addict to prevent complications of their disease on their overall health and life is to abstain from substance use. As such, recovery in addictions is almost always looked at as an outcome, namely abstinence (White et al. 2005).

The 12-step model has been heavily adopted by the clinicians as the treatment model of choice for all addictions. Because of this, there is a dissonance between the way recovery is conceptualized in the mental health and addictions treatment and research. As Davidson and White (2007) have discussed, mental health recovery goals such as treatment adherence and improvements in quality of life are usually formulated around the concept of "partial recovery" (i.e., recovery without complete remission of symptoms) even though full recovery has been demonstrated to happen, while addiction recovery is focused on the complete elimination of substance use behaviors. Part of the reason for these differences is the fact that mental illness is largely viewed and treated as a disability, while addiction is viewed and treated as a disease. Because mental illness

gets treated as a disability, the symptoms of SPMI are viewed as something consumers need to learn to live with, while the disease symptoms of alcohol (i.e., substance use) are viewed as something that consumers need to be "cured" of. This is why treatment for SPMI is viewed as an ongoing process, while addictions treatment is viewed as an outcome.

The dissonance between the way the mental health and addictions fields view recovery is especially problematic considering the significant overlap between these types of disorders. Despite the fact that abstinence is the defining feature of recovery in the addictions field, research has demonstrated that consumers understand and experience substance abuse recovery in a similar way to mental health recovery and that substance abuse recovery is more personal and unique than the strict abstinence view asserts (Davidson and White 2007; Scott, Foss, and Dennis 2005; Sowers 2007). Laudet (2007) demonstrated that consumers tended to experience and define recovery as more of a process than an outcome. This was the first large-scale study that sought to understand addictions recovery as it is experienced by consumers. Laudet collected qualitative and quantitative data in three waves from 289 individuals who self-identified as "in-recovery" in order to understand how their perceptions of recovery changed over time. A number of people who were not abstinent still considered themselves to be in recovery, *suggesting that abstinence and recovery are two different things*. The findings also demonstrated that informants switched their definitions of recovery between phases of the study. Laudet's findings point to the need to develop a more nuanced understanding of the recovery process in the addictions field. For dually diagnosed individuals this means

developing a better understanding of recovery from SPMI and substance use disorder as a co-occurring process. This is an area where a sociological study of recovery can have significant impact.

The Applicability of the Sociology of Mental Health to the Study of Recovery

There is a long history of studying the social patterns and causes of SPMI within the field of sociology. However, relatively little sociological research has focused on recovery (Markowitz 2005; Thomas 2004; Yanos, Knight, and Roe 2007). Despite this, there are lines of sociological research that have investigated a number of factors demonstrated to be central to the recovery process. Research on social stress has demonstrated the importance that resources such as coping, social support, and mastery have on mental health outcomes (Aneshensel 1992; 1999; Avison and Turner 1988; McLeod and Lively 2007; Mirowsky 1995; Mirowsky and Ross 1990; Pearlin 1999; Wheaton 1999). Research on social integration has demonstrated the positive and negative influences social roles, community ties, and social support can have on mental health (Avison 1999; Cornwell and Waite 2009; Hartwell and Benson 2007; Lin and Peek 1999; Lincoln, Chatters, and Taylor 2003; Rook 1984; Turner 1999; Wethington and Kessler 1986; Yang 2006). Social stratification research has demonstrated the association between social inequalities and mental health disparities (Kessler and Cleary 1980; Muntaner, Borrell, and Chung 2007; Ross, Reynolds, and Geis 2000; Williams and Collins 1995). Research in the area of stigma has demonstrated the significant power that negative cultural views regarding mental illness can have on diagnosed individuals (Gove

2004; Link and Phelan 2001; Link et al. 1989; 1997; Phelan 2005; Thoits 2005; Wright et al. 2000; 2007).

All of these lines of research have implications for understanding recovery in that they have illuminated the social conditions that can harm or improve mental health. However, the majority of studies in these areas have focused on mental health and illness within the broader population or trying to understand how specific social phenomena apply to individuals who have already demonstrated a susceptibility or resilience to mental illness and have largely overlooked the consequences of mental illness that can affect recovery (Markowitz 2005; Pescosolido et al. 2007). There have been relatively few studies investigating the effects of social factors on the mental health outcomes of individuals diagnosed with SPMI who are attempting to manage their illness. In fact, sociologists have been criticized for moving away from studying people living with SPMI in favor of studying the "worried well" (Mulvany 2000; Pescosolido et al. 2007), i.e., individuals in the broader society who display mental health symptoms but do not have diagnosable disorders. Those who study stigma and labeling are an exception, as a number of sociologists who conduct research in this area are concerned with consumers' attempts and ability to manage the negative effects of mental health diagnoses in their lives.

It is disconcerting that sociologists have paid relatively little attention to mental health recovery considering the significant influence the discipline has historically had on the mental health field and the MHCSM. Sociological writings have helped to expose the problems associated with institutional treatment (Gove 2004; Hillery 1963; Lefton,

Simon, and Pasamanick 1959; Street 1965; Wallace and Rashkis 1959), demonstrate that SPMI was more pervasive and not as degenerative as once thought (Carpenter and Kirkpatrick 1988; Harding, Strauss, et al. 1987; Harding, Zubin, et al. 1987; Robins and Regier 1991), and spurred on the growth of the Mental Health Consumer/Survivor Movement (Scheff [1966] 1999; Szasz [1961] 1984). Despite the lack of sociological research on recovery, there are two important areas where sociological investigation can have significant impact regarding its study, which Loveland et al. (2005) have discussed:

> Support is growing for a transactional, multidimensional, process-oriented, and nonlinear conceptual model of recovery…This newer, consumer-survivor conceptualization will require an alternative set of rules, tools, and epistemological assumptions that is comparable with the expansive, fluid, and dynamic structure of the process of recovering from mental illness. (P. 47)

The takeaway from this statement and those of other researchers is that new investigations of recovery needs to focus on the (1) meaning/understandings of recovery and (2) the social processes involved in them (Amering and Schmolke 2009; Anthony 1993; Borg 2007; Davidson 2003; Laudet 2007; Onken et al. 2007). The social psychological tradition within sociology is particularly well suited for this task.

An Argument for a Social Psychological Study of Recovery

Schwartz (2002) has asserted that it is the sociologist of mental health's job to investigate the effect that social structures have on mental health outcomes, and the social psychological study of mental health has the most to offer in this regard. Schnittker and McLeod (2005) provide an excellent description of what social psychological investigations entail:

> Social psychological processes bridge the gap between individual and society by identifying mesolevel structure and interactions through which macrosocial conditions shape the experiences of, and come to have meaning for, individuals. They remind us that knowledge, power, and resources influence health not only through their direct effects on the material conditions of life, but also as they derive symbolic importance in social interaction, and as they define the contexts for individual responses to those conditions. (P. 77)

As this quote describes, social psychological research is ultimately concerned with the effects of the larger social structure on the individual and the processes through which these effects take shape.

There is a long tradition of social psychological research investigating the connections between the social structure and mental health that stretches back to the beginnings of the discipline. Most notable of these early investigations is Durkheim's ([1897] 2007) study of suicide, in which he demonstrated that differences in suicide rates were related to the particular social arrangements of societies and groups within them. The majority of social psychological mental health research that has been conducted has tended to focus on the effects of macro social factors on individuals, while paying little attention to the processes that connect them (Fenwick and Tausig 2007; McLeod and Lively 2007; Schnittker and McLeod 2005; Schwartz 2002). For instance, Pescosolido et al. (2007) have discussed how sociologists of mental health were integral to the research that investigated mental health hospitals in the age of institutionalization (see: Goffman 1961; Hillery 1963; Lefton et al. 1959; Street 1965; Wallace and Rashkis 1959), but have failed to develop similar understandings of the structure and functioning of community-based care.

For sociology to have a significant voice in the study of recovery, sociologists of mental health will need to reconnect with their social psychological roots. As Markowitz (2005), one of the few sociologists who has written about mental health recovery in depth, writes:

> A sociological approach to recovery begins with an assertion that social circumstances and positions are fundamental causes of stress and symptoms of mental illness, while at the same time recognizing that symptoms of illness have consequences for people's self-concepts and social well-being, which in turn, affect the course of illness. (P. 95)

Markowitz's statement points to the connection between social arrangements (circumstances, positions, causes of stress) and individual outcomes (symptoms of mental illness, self-concepts, and social well-being) as they relate to the recovery process. Therefore, social psychological investigations of mental health and illness can contribute significantly to the field of recovery by highlighting the connections between: (1) the way recovery is defined in political and professional discourse; (2) individuals' personal experiences of recovery and the meanings they associate with it; (3) and the social processes that occur within the context/environment of recovery, which connect the political, professional, and personal realms. I have already discussed how recovery has been socially constructed at the political and professional levels through research, advocacy, and policy. In the rest of this section I describe how a sociological study of recovery can add to this understanding through research that looks at the meaning and experience of recovery at the individual level and research that focuses on the context of mental health services in which recovery happens.

The Meaning of Recovery and How it is Experienced by Consumers

As I have outlined above, changes in the way that SPMI and its recovery have been viewed over the past half century have begun to shift focus from a disease concept of mental illness and substance abuse that focuses on symptom treatment to a disability model that focuses on social inclusion and personhood. While this perspective has found its way into the broader policy and treatment discourses, the empirical research is slow to catch up. The majority of scientists who study recovery continue to use medical approaches rooted in Kraepelin's ideas regarding schizophrenia and the disease concept of addiction when investigating recovery from these disorders. Reductionist approaches such as these are weak in that they fail to consider the variety of other factors that impact and are impacted by mental illness, substance abuse, and its recovery. In order for the scientific domain to catch-up with social developments, there needs to be a greater appreciation of recovery as a social phenomenon and the process recovering persons go through as they attempt to manage their disorder(s) (Davidson 2003). Additionally, the traditional discipline-based silo approach to investigating mental health and substance abuse ignores the complex relationship between these two disorders and the lived experience of individuals living with dual diagnoses.

Recognizing this, researchers in the area of recovery have drawn attention to the fact that we need to make greater efforts to understand recovery as it is experienced in consumer's everyday lives because, since deinstitutionalization, the majority of people living with SPMI are attempting to manage the symptoms of their mental health problems in combination with other areas of their lives in community settings (Borg 2007;

Davidson 2003; Davidson and White 2007). Additionally, the community context in which mental health recovery happens leaves the possibility of wider variation in the recovery experiences than there was in the era of institutionalization. This stresses the need to understand mental health recovery as a unique process that can vary between individuals and the personal meaning that those individuals attach to it (Davidson 2003; Mueser et al. 2002), something that sociological perspectives are well situated to do.

Symbolic Interaction and the Meaning of Mental Health Recovery

As I discussed above, mental health policy today emphasizes recovery as a consumer-centered process. From this point of view, individual consumer's understandings are more important than mental health professionals when investigating the recovery process. Despite this, the majority of research being conducted on mental health recovery continues to investigate it as an outcome defined by medical professionals. This tide is starting to turn as a few studies conducted within the past decade have attempted to understand recovery from the consumer point of view (Borg 2007; Davidson 2003; Liberman and Kopelowicz 2005; Topor 2001). Discussing the need for more research to be conducted in this area, Loveland et al. (2005) have pointed toward the need for new techniques aimed at developing this understanding. They discuss qualitative investigations, such as those employed in micro-sociological investigations, to be the best approach at investigating consumer perspectives on recovery. Symbolic interactionism is just such an approach.

Symbolic interactionism is social psychological school of thought that focuses on the meanings that groups and individuals give to social phenomenon and the effects those

meanings have on them (see: Blumer [1969] 1986; Cooley [1902] 1983; Mead 1967). While this tradition was strong in the sociology of mental health at the beginning of the sub discipline, it has been largely abandoned over the last twenty years in favor of more epidemiological and etiological approaches to studying mental health (Aneshensel 2005; Pescosolido et al. 2007; Schwartz 2002). Symbolic interactionist frameworks have much to offer the sociological study of recovery. Writing specifically about mental health research on stress, McLeod and Lively (2007) have discussed how the theories and methods of symbolic interactionism can help to illuminate the "black box" that exists between the beginning and endpoints mental health processes by focusing attention on the perceptions, meanings, and emotions associated with specific variables of interest to researches.

While McLeod and Lively (2007) write specifically about stress research, their argument can be applied to the study of recovery, as symbolic interactionsim's focus on meaning, interactional processes, and the "self" can assist researchers by helping them to: refine and develop social variables of interest in the recovery process; develop a better understanding of the social consequences of mental illness through consumer understandings and definitions of recovery; and bridge the connections between structural factors that affect mental health and the recovery process at the level of the individual.

Mental Health and Illness as a Continuum and the Experience of Recovery

A second argument for a sociological study of recovery is that the way in which sociologists conceptualize mental health makes them more sensitive to consumers' actual experiences. The social constructionist perspective discussed at the beginning of this

chapter makes sociologists more likely to view mental health and illness as continuous variables rather than discrete categories. What this means is that sociologists understand that the severity of mental illness can vary within and between individuals. This makes sociological research more sensitive to subtle variations within the categories of mental health and illness than research carried out in other disciplines (Wheaton 2001).

Because other disciplines tend to view mental health and illness as discrete categories, they are more likely to view recovery as an outcome that is equated with mental health. This perspective is problematic considering that consumers' experiences demonstrate that mental illness and recovery can and often do co-exist (Amering and Schmolke 2009; Anthony 1993; Borg 2007; Davidson 2003; Deegan 1988). Because of this, the continuum perspective of mental health and illness is more compatible with the process perspective of recovery that has been adopted by the MHCSM. As such, sociologists are more likely to capture the variations in functioning that have important implications for the recovery process. For instance, Thomas (2004) has written how micro-sociological approaches, such as those employed by symbolic interactionists, can add to the study of recovery through the investigation of the incremental process social re-engagement, biographical reflection, repair, and improvement.

The Context of Care: How Organizational Research Can Improve Understandings of Recovery

There is a long line of sociological research that has helped to illuminate connections between the social structure and mental health outcomes (see Schwartz 2002). Most of this research has focused on the way in which different structural

arrangements expose different social groups to varying amounts of stress (Aneshensel 1992; 1999; McLeod and Lively 2007; Pearlin 1999; Pescosolido et al. 2007; Thoits 1999). This research has been invaluable for bringing attention to the connections between social factors such as poverty, homelessness, racism, low education, and lack of social support and higher rates of mental illness among disadvantaged groups. Additionally, large community studies have helped reconceptualize the course of mental illness by demonstrating that recovery can and does happen for individuals living with SPMI (Carpenter and Kirkpatrick 1988; Harding, Zubin, et al. 1987; Harding, Strauss, et al. 1987). While research in these areas has been successful in demonstrating that a connection between individual mental health outcomes and the larger social arrangements exists, it has not addressed how these connections are facilitated in a way that is useful for understanding recovery as a process. One area where sociologists have the potential to provide a significant contribution in this regard is through organizational research.

Recovery from mental illness in the United States is generally guided by some form of institutionalized treatment modality or programming; however, sociologists have been criticized for failing to develop an adequate model to reflect the course of mental illness after deinstitutionalization. Organizations that provide mental health services link consumers to the larger social structure through their policies (federal, state, local, and organizational) and practices, which are constructed through larger political and professional processes. Therefore, research on organizations that provide mental health services have the potential to uncover the processes through which the structure of society affects consumers' recovery.

While this potential exists, most of the research that has been carried out on mental health organizations has focused on the effects of external social forces on organizational processes without making the connection between these processes and consumer outcomes. For instance, Scheid's (2003) investigation of CARE, a public sector mental health facility, demonstrated how external pressures that moved the facility towards managed care created tensions for professionals that negatively affect the level of care provided to consumers. Studies such as these are valuable because they highlight how the larger social structure affects organizational processes. However, they do not highlight how these processes affect individual consumers. Research highlighting the connection between these processes and consumer outcomes will provide a more complete picture of mental illness, mental health, and recovery. A quote from Onken et al. (2007) demonstrates why an investigation of these connections is necessary. In a comprehensive review of the existing literature on mental health recovery, Onken et al. stated:

> The dynamic interaction among characteristics of the individual (such as hope), characteristics of the environment (such as opportunities), and characteristics of the exchange between the individual and the environment (such as choice), can promote or hinder recovery. (P. 10)

Therefore, sociological research can make a significant contribution to the study of recovery by paying greater attention to the consumer interactions that occur with and within social institutions and the effects this has on individual consumers (McLeod and Lively 2007; Schnittker and McLeod 2005).

The symbolic interactionist framework discussed above is especially well suited for investigations that seek to make these connections. By paying attention to the social

processes that shape the perceptions, meanings, and emotions that affect recovery, sociologists can make stronger connections between the beginnings and endpoints of the recovery process, provide greater theoretical and translational value that can shape future research and practice, and create bridges between the sociology of mental health and questions regarding recovery that are shaping the larger field of mental health studies (McLeod and Lively 2007; Onken et al. 2007; Thomas 2004).

Conclusion

Recovery is a socially constructed phenomenon that is the result of historical and political processes. As a social construction, definitions of recovery differ between key groups (policy makers, mental health providers, researchers, and consumers). While mental health policy today defines recovery as a consumer-centered process, clinical and scientific approaches largely continue to treat it as biomedically or clinically defined outcome. A pure outcome approach is problematic considering the connections that exist between the structure of mental health services and the course of mental illness that have been demonstrated in classic sociological mental health literature. Though these connections have been demonstrated, sociologists of mental health have not developed new models to account for changes in the structure of mental health services over the past fifty years that affect the course of mental illness. And this has led to a lack of understanding of recovery as it is experienced by those who are living with SPMI (and substance abuse disorders).

Sociologists are in a unique position to develop stronger empirically-based understandings of recovery. Specifically, social psychological investigations that follow a

symbolic interactionist approach have the potential to develop a better understanding of recovery as a consumer-centered social process. They can do this by illuminating the meanings different groups associate with the recovery and bridging the connections between structural factors that affect the course of mental illness at the consumer level.

CHAPTER THREE

RESEARCH SCOPE AND METHODS

Introduction

The three broad research questions I seek to answer in this dissertation are:

- How is mental health recovery understood and experienced?
- How does mental health recovery happen?
- How does program structure affect understandings and experiences of mental health recovery?

The purpose of this chapter is to describe the approach I took to answer these research questions. To do this, I first define the scope of my study by discussing the opportunities for understanding recovery that the chronically homeless population and Housing First programming present. After doing this, I detail my methodology, describe each of the programs in the same, and discuss the studies strengths and limitations.

The Scope of the Study

While this is broadly a study of mental health recovery in the context of community-based mental health care/services, it is specifically a study of the recovery process for formerly chronically homeless individuals with dual diagnoses who are living in Housing First programming. While there are a number of other populations and settings in which one can study mental health recovery, the unique context of Housing First programming and the past and present experiences of the staff and consumers there

present a number of unique opportunities for understanding recovery, which I explain below.

The Chronically Homeless

Research looking at the connections between mental illness and social stratification has demonstrated that there is a strong negative correlation between the two, with the majority of mental illness being concentrated among the lower social classes (see Aneshensel 1992, 2005; Hollingshead and Redlich 1958; Kessler and Cleary 1980; see Schnittiker and McLeod 2005; Williams and Collins 1995). Following this logic, it is more likely that individuals at the bottom of the social ladder who have mental illness will have more complex problems related to their mental health. Indeed, it has been demonstrated that people with SPMI are more likely to experience social isolation, be unemployed, have less income, and live in less desirable housing conditions than other people in our society (Frank and Glied 2006; Link 1982; Markowitz 2005). As occupants of what is arguably the lowest social position in our society, people who are homeless have some of the most complex issues associated with their mental health (see Burt 1993; see Nooe and Patterson 2010), which presents a number of opportunities for studying recovery.

There is debate as to whether the high rates of mental illness in the homeless population are a result of deinstitutionalization and the failure of community-based care (see Frank and Glied 2006; see Shinn 2007), however it is likely not a coincidence that rates of homelessness increased dramatically with the closing of state-run psychiatric institutions (Nooe and Patterson 2010). Despite where increases in the number of

homeless came from, research suggests that the prevalence of mental illness among homeless adults has increased over time (see Frank and Glied 2006). In a comprehensive review of the literature, Nooe and Patterson (2010) have discussed previous research demonstrating that over half of all homeless people have some form of mental illness or substance abuse problem. They also discuss how the problems associated with homelessness are even more complex for those living with dual diagnoses of SPMI and a substance use disorder as it has been demonstrated to increase stigma, risks related to incarceration, and barriers for achieving housing and employment.

Dual diagnosis is an even larger problem among the chronic homeless population. According to the federal government, a chronically homeless person is an unaccompanied adult who is disabled (physically or mentally) and has been homeless continuously for one year or has had four or more episodes of homelessness in the past three years (U. S. Interagency Council on Homelessness 2010). The chronically homeless have been demonstrated to make up anywhere from nine percent to twenty-seven percent of the overall homeless population (Kuhn and Culhane 1998; National Alliance to End Homelessness 2000; U. S. Department of Housing and Urban Development 2010). Regardless of their numbers, the chronically homeless are of particular concern to providers of homeless services, largely because of the high levels of dual diagnosis they posses. In fact, the issues associated with dual diagnosis in this population are so difficult to address that the population has been labeled the "hard-to-serve" by the majority of service providers (Padgett, Gulcur, and Tsemberis 2006; Pearson, Locke, and McDonald 2007; Pearson, Montgomery, and Locke 2009).

Dennis Culhane is frequently credited as the first researcher to shed light on the significant differences that exist between the chronically homeless (episodic and chronic subgroups of shelter users) and the transitional homeless population, as well as the need for different approaches to serving them (Culhane 1993; Culhane and Metraux 2008; Culhane, Metraux, and Wachter 1999). Kuhn and Culhane (1998) have also demonstrated that chronically homeless, in comparison to short-term or transitional homeless, account for over half of shelter system expenditures because of the difficulty that the system has in addressing their problems. Additionally, the lack of comprehensive treatment programs that adequately address both SPMI and substance abuse mean that the dually diagnosed homeless often "fall through the cracks" of service provision (Culhane 1993; Nooe and Patterson 2010).

Based their findings that the chronically homeless have different shelter use patterns, individuals characteristics, and service use characteristics, Kuhn and Culhane (1998) write that different approaches to assisting homeless individuals should be more appropriately tailored to their needs. As a result of their work and others, the federal government has begun to recognize the need to better tailor homeless services in the United States to meet the needs of the chronically homeless. This is particularly true of housing services. For instance, a number of new laws require programs seeking funding from the HUD to provide appropriate supportive services that will lead to independent living (see Pearson et al. 2007). One new and promising service approach to helping homeless individuals with dual diagnoses is the Housing First model (Pearson et al. 2007).

Housing First Programming

The Housing First model was expressly created to *target chronically homeless dually diagnosed individuals* and provide them with supportive services (Tsemberis and Asmussen 1999). Because the model was designed around a population that has been demonstrated to have some of the most pervasive and complex mental health needs, Housing First programs are an ideal setting in which to study recovery. Before explaining the Housing First model in detail, I discuss the traditional COC approach to housing and the problems associated with it that the model was designed to address (see Chapter One for a definition of the COC model).

COC Housing as a Problem for the Chronically Homeless

The chronically homeless have historically had problems meeting the minimum eligibility requirements of and/or staying housed in traditional forms of housing for the homeless. Problems with housing stability among this population are most often attributed to behavioral symptoms related to their illnesses and lack of independent living skills, related to the significant amount of time they have spent living on the street, which make it difficult for them to adjust to living in highly structured environments (Padgett et al. 2006; Pearson et al. 2007).

There have been a variety of attempts to house homeless individuals living with dual diagnoses, the most popular of which is the COC model. The COC model has been demonstrated to be particularly ineffective when it comes to housing the majority of chronically homeless consumers, particularly due to complications that arise due to the co-occurrence of SPMI and substance use disorders. For instance, a comprehensive

review of 109 residential treatment studies showed that traditional programming was not significantly related to any positive results in terms of symptom reduction, increased self-sufficiency of consumers, or community functioning (Cometa, Morrison, and Ziskoven 1979). More recently the COC approach has been associated with high consumer dropout rates (Simpson et al. 1997). Research shows that homeless individuals who are dually diagnosed typically rotate between temporary housing placements, and use them more for shelter than treatment purposes (Hopper et al. 1997). The ineffectiveness and high dropout rates associated with COC programming are not surprising since it is recognized that consumer dissatisfaction with systems providing services they do not accept often leads to disengagement from service delivery (Substance Abuse and Mental Health Services Administration 2003).

Housing First as an Answer to the Problems Associated with Traditional Housing

The original Housing First model was developed by Pathways to Housing Inc. (hereafter known as Pathways) in New York City during the early 1990s. The model as it was developed by Pathways recognizes that housing is a basic human right, rather than a privilege that must be earned. And though it was designed with the unique mental health and substance abuse needs of dually diagnosed consumers in mind, the model does not force consumers to partake in services to address these issues.

Tsemberis and Asmussen (1999) cite several reasons for the failure of the COC model, which were behind the eventual development of the Housing First model: (1) constant changes as one moves through stages of housing are stressful and not conducive for developing relationships; (2) changes associated with movement through

programming coincide with decreases in support, which might not be appropriate for consumers with severe mental disability; (3) skills learned in a structured setting might not be transferable to independent living; and (4) lack of choice, privacy, and/or control. Therefore, the Pathways model was developed to provide immediate access to housing while offering high levels of choice and support with minimal demands being placed upon the consumer in terms of service participation or sobriety/abstinence.

In general, housing programs serving dually diagnosed consumers that have less restrictive sobriety requirements and provide more personalized treatment have been shown to be more effective than COC programming (De Leon et al. 2000). Building on this knowledge, the Housing First model places low demands on its consumers and has been recognized for service structure flexibility and emphasis on consumer preference (Greenwood et al. 2005; Tsemberis and Asmussen 1999).

The Housing First model recognizes that homelessness is itself a stressor leading to a variety of negative mental health outcomes, including substance abuse. In most cases substance abusers may view their housing and associated services as a more pressing need than dealing with substance abuse and mental health issues (see Dobransky 2009b; Hopper et al. 1997). Therefore, housing stability helps to alleviate stress related to homelessness so that individuals can begin to seek help for other problems, like substance abuse, on their own terms. Because of this, housing retention is seen as the most important outcome when evaluating the effectiveness of Housing First programs. Studies of Pathways to Housing have shown housing retention rates that are significantly higher than COC programming (Tsemberis and Eisenberg 2000; Tsemberis, Gulcur, and Nakae

2004). For instance, in one controlled trial, the Pathways to Housing, Inc. model retained 84.2 percent of consumers over a 3-year period, while only 59 percent of consumers maintained housing in COC programming after only 2-years (Tsemberis 1999).

There is evidence that the Housing First works beyond the original model implemented by Pathways to Housing. For instance, in another controlled study that looked at the Chicago Housing For Health Partnership located in Chicago, 73 percent of consumers in Housing First placement retained housing over an 18-month period, compared to only 15 percent of consumers in COC programming (Chicago Housing for Health Partnership 2008). Studies of other Housing First programs have demonstrated similarly high retention rates (Mares and Rosenheck 2007; Perlman and Parvensky 2006) in addition to another of other positive outcomes such as improved consumer functioning (Sadowski et al. 2009), and reduced cost in services (Gilmer, Manning, and Ettner 2009; Larimer et al. 2009). Additionally, the model has been associated with increased consumer perceived choice (Greenwood et al. 2005; Tsemberis et al. 2004), a factor demonstrated to lead to significantly better consumer outcomes than more confrontational housing options (i.e., COC programs) that require abstinence and participation in specified treatment from consumers (Miller and Page 1991). In addition to studies of individual programs, a more than a 10 percent drop in chronic homelessness documented between 2008 and 2009 has been largely explained by the national diffusion of the Housing First approach (U. S. Department of Housing and Urban Development 2010).

Despite the significant attention given to the model as an answer to ending chronic homelessness and the promising results associated with it, relatively little

research has been conducted seeking to understand how the Housing First model works to produce the specific outcomes related to recovery. I sought to address this issue in the current study by following the methods I outline below.

Theoretical Framework

This study is set within a constructionist framework with an advocacy/applied focus. The constructionist perspective is uniquely sociological. This perspective is often attributed to Berger and Luckmann (1967), but it is largely rooted in the writings of the Chicago School of Symbolic Interaction (see Blumer [1969]1986; see Cooley [1902] 1983; see Mead 1967). Constructionists view the definitions, ideas, values, and beliefs individuals and groups hold as being inseparable from the social context (structures, institutions, interactions) within which they developed (Maines 2000). From this point of view reality is a subjective concept that is the result of negotiations between social actors as they seek to apply meaning to everyday social interactions. Using this theoretical framework allows me move back and forth between the micro- and meso-levels of the housing organizations in my sample and to connect them to the macro social and economic context in order to develop a comprehensive understanding of how meaning is created and shaped by interactions between individuals, between individuals and the organizational structure, (i.e., policies and procedures), and between the organization and the larger social context.

The advocacy/applied focus combined with the collaborative process that this project developed from are what make this study a work of public sociology (Perlstadt, retrieved March 7, 2011). There is a long and rich history of applied sociological work

that stretches back to the beginnings of the discipline. Applied and collaborative approaches ensure that knowledge gained from research will be appropriate for dissemination through both the academic and practice communities (Dalton, Elias, and Wandersman 2006; Nyden et al. 1997; Nyden, Hossfeld, and Nyden 2011).

Though I have received guidance from a number of community organizations in developing and carrying out this project, my primary collaborative partner is Heartland Alliance, a large Chicago-based social service organization that is an advocate for the Housing First model and its associated practices. Using the applied approach, I have made sure that the resources, values, and knowledge of Heartland Alliance have been represented at every stage of the study. Heartland Alliance staff assisted me in the study design. They also assisted me in the crafting of all data collection instruments to assure that the language would be understood by my study informants. Finally, these staff members assisted me in my preliminary data analysis by being available (to the extent that they could with their work responsibilities) to discuss emerging themes and clarify questions I had regarding housing services as they related to the findings.

Methodology

I employed an integrated study design that combined elements of both case study and grounded theory methods in my investigation (Corbin and Strauss 1990). The usefulness of combining these two methodologies has been recognized by previous researchers (Eisenhardt 1989; Eisenhardt and Graebner 2007). Discussing the compatibility of these two methodologies, Andrade (2009) has pointed to the utility of the case study method for defining the boundaries of a study (unit of analysis, number of

cases), while grounded theory provides a step-by-step process for building emergent theory.

There are several types of case study methodologies/designs. I employed a multiple-case, embedded case study design. This involved the comparison of data (interview and focus group) collected from multiple levels (administrative, consumer, and staff) at four programs. This design fits well within the constructionist framework because it emphasizes the collection and analysis of data from multiple levels (i.e., consumer, staff, administrative) within and across two or more cases (Eisenhardt 1989; Yin 2008).

Case Selection

The level of analysis for this study is the organizational level. I developed an initial list of programs for sampling with the assistance of staff at Heartland Alliance. To be included on this list a program had to meet three criteria. First, each case had to self-designate as providing Housing First services. Second, each program had to be considered a strong example of Housing First programming (i.e., were considered to have implemented practices and policies reflective of Housing First programming and were meeting their programmatic goals) according to the expert opinions of my community partner. Third, each program had to possess a minimum of four out of five features of Housing First programming: (a) the direct or nearly direct placement of consumers in housing; (b) not requiring consumers to participate in supportive services; (c) the use of assertive community outreach to engage potential consumers; (d) the use of a "low-demand" approach that does not require consumers to remain abstinent from drugs and

alcohol; and/or (e) the continuing to provide housing and services if consumers leave for short periods of time (e.g., hospitalization or incarceration). I developed this list from features of Housing First programming identified by Pearson et al. (2007) in an exploratory study they conducted for HUD in which they compared the features of three Housing First programs (see Table 1), one of which was Pathways. I only required that programs have four out of five of these features because there is still debate in the homeless service community as to what Housing First implementation should look like (see George et al. 2008; see Pearson et al. 2007; 2009).

I selected four programs/cases[1] from this list based on the significant degree of differences they had from each other in terms of (a) consumer capacity (program size), population served, (b) years providing Housing First programming, and (c) housing type (project-based or scattered-site) (see Table 1). Selecting programs based on degree of difference is recommended when the given number of cases is low because it helps to assure the analysis reflects the differing extents to which cases reflect the subject of study (Eisenhardt 1989; Glaser and Strauss 1967; Mowbray et al. 2003; Pettigrew 1990).

Descriptions of the Programs

The four organizations I selected for this study are Allied Health (Allied), Judy's House, Metropolitan Housing and Services (Metropolitan), and HIV Housing Assistance (HIVHA). Because of the sensitive nature of the data, I have chosen to use pseudonyms for all program and study informant names. I have made subtle changes to program details to further protect my informants' identities.

[1]Four is the minimum recommended number of cases for building complex theory using the case study method (Eisenhardt 1989).

All of the programs were situated in the same large Midwestern city, which has implemented a 10-Year Plan to End Homelessness based on the principles of the Housing First model.[2] Each opened their doors between 2000 and 2005 and they are all nonprofits. With the exception of Judy's House, each of them began as Housing First programs. However, staff and administration at Judy's House all agree that they have always operated in a manner compatible with the Housing First model. Some other similarities between the programs include: they are all considered by local housing advocates and providers to be among the best examples of Housing First programs in the city (as demonstrated through discussions I have had with these groups), they are primarily supported by public funds, and all program consumers hold their own leases.

Additionally, while all of the programs considered themselves to operate under the Housing First umbrella, most staff and consumers were more familiar and comfortable using the term "Harm Reduction Housing" over Housing First.[3]

As a general philosophy, harm reduction is concerned with reducing the negative consequences of high risk behaviors, such as substance use, on individuals and society

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[2]The National Alliance to End Homelessness began advocating *10-year plans to end homelessness* in 2000. These plans are based on the principles of Housing First due to the initial success of the model in working with "hard-to-serve" consumers (National Alliance to End Homelessness 2000). The specific plan implemented in the city where the programs are located started in 2003. It seeks to achieve its goals by concentrating service efforts toward chronically homeless consumers. As such, it redirected all funding provided through the city away from shelters and toward the development and sustenance of transitional and permanent housing and supportive services.

[3]Harm reduction is essentially the same as the "low-demand" service approach defined by Pearson et al. (Pearson et al. 2007) above. In fact, Pearson et al. explain in a footnote within their study that the use of the term "low-demand" was a political choice due to the fact that their study was funded by the federal government, which does not agree with the ideals and approaches of harm reduction as it applies to substance use.

(Cheung 2000; Lenton and Single 1998). MacMaster (2004) has pointed to five assumptions of the harm reduction model for working with substance users:

1. Substance use has and will be a part of our world: accepting this reality leads to a focus on reducing drug-related harm rather than reducing drug use.
2. Abstinence from substances is clearly effective at reducing substance-related harm, but it is only one of many possible objectives of services to substance users.
3. Substance use inherently causes harm: however, many of the most harmful consequences of substance use (HIV/AIDS, Hepatitis C, Overdoses, automobile accidents, and soforth) can be elminated without complete abstinence.
4. Services to substance users must be relevant and user friendly if they are to be effective in helping people minimize their substance-related harm.
5. Substance use must be understood from a broad perspective and not solely as an individual act: accepting this idea moves interventions from coercion and criminal justice solutions to a public health or social work perspective. (P. 358)

Popular examples of the application of harm reduction to substance use behavior include controlled drinking, needle exchange programs, and methodone maitenance. Harm reduction is essentially the same as the "low-demand" service approach defined by Pearson et al. (2007) above. In fact, Pearson et al. explain in a footnote within their study that the use of the term "low-demand" was a political choice due to the fact that their study was funded by the federal government, which does not agree with the ideals and approaches of harm reduction as it applies to substance use (see Chapter One).

Table 1. Characteristics of Sample Programs Based on Selection Criteria

	Elements of housing first programming proposed by Pearson et al. (2007)					Key differences between programs			
Program[a]	Direct/Nearly direct placement of consumers in housing	Does not require supportive service participation	Use of assertive outreach to house consumers	Low-demand approach	Continue housing & services if consumer leaves for short period	Consumer capacity	Population served	Years providing Housing First programming	Housing type
Allied	Yes	Yes	Yes	Yes	Yes	54	Chronic homeless w/ dual diagnosis	11	Project-based
Judy's House	Yes	Yes	No	Yes	Yes	93	Homeless women	8	Project-based
Metropolitan	Yes	Yes	No	Yes	Yes	38	Homeless men w/ dual diagnosis	7	Scattered-site
HIVHA	Yes	Yes	No	Yes	Yes	10	Homeless w/ HIV/AIDS	7	Scattered-site

[a]All program names have been changed and some characteristics have been altered to ensure confidentiality of the programs and informants.

As Table 1 demonstrates, there are also many differences between programming in terms of the selection criteria for the study. Additionally, each of the programs has a unique history, structure, and approach to housing and services, which I detail in the following case descriptions. I developed these descriptions from a review of the administrative interview and document data, as well as information collected from each programs larger agency's website.

Allied

Allied had operated using a Housing First approach since opening its doors in 2000. The primary population served by the program is chronically homeless people with dual diagnoses. During the study, Allied had a capacity of fifty-four consumers, who were housed in individual units. Approximately twenty staff members were employed by the program at the time of data collection, six of who were licensed mental health professionals or substance abuse counselors.

Relationship to larger agency. Allied was part of a larger umbrella organization that provided housing, health, and social services to a wide range of marginalized populations throughout the city and its surrounding area. Housing was one of Allied's parent organization's four primary objectives alongside healthcare, economic security, and legal protections. All housing operated by the organization followed a Housing First approach.

Funding. Allied itself was a project-based housing program funded through a mix of monies from HUD, Medicaid, and private foundations.

Structure of housing and services. Allied was located in a building managed by another arm of the program's parent organization. These different arms of the organization operated so independently of each other that Allied and the property management were effectively managed by two different entities. This building had a mix of low-income and market rate units on additional floors that housed tenants who were not served by the Allied program.

The units dedicated to Allied were split between the third and fourth floors of the building. Each floor could be considered to be a "subprogram" of Allied due to the fact that the units split between them had different sources of funding; different policies/rules attached to them, and targeted consumers with different levels of functioning/need. Third floor programming was targeted toward consumers who had been determined to posses more challenging problems or lower levels of functioning. Due to admission criteria established by the program's policies, consumers on this floor typically came directly from sleeping on the street, rather than a shelter or transitional housing program, and they were less likely to want to make changes in their life regarding their substance use behaviors. Third floor consumers generally lacked income upon entry, were less likely to be medication compliant, and had more pervasive substance use and/or behavioral problems than consumers on the fourth floor did.

Allied offered a variety of supportive service to its consumers including case management, medication training and monitoring, individual and group counseling/ therapy, social rehabilitation services, psychiatric services, and medical services (nursing). No services were mandatory for consumers, however, they did prefer that

consumers met with a case manager at least once a week and involved themselves in a minimum of two group services. This was largely because the program received monies for housing from Medicaid, one of their primary funders, which matched those spent on services.

In terms of policies and rules, visitors were strictly monitored on both floors, and consumers were not allowed to have overnight guests. Rules were slightly stricter on the third floor because of the lower functioning of consumers. For instance, consumers on this floor did not have keys to their own units, they did not have access to cooking facilities they could use unsupervised, and they could not have guests in their rooms with the door closed. There were also higher levels of staffing on the third floor in order to make sure consumers followed the rules and have appropriate levels of support for their problems. However, there were greater expectations placed on consumers living on the fourth floor because of their higher functioning. For instance, it was expected that consumers would attend monthly community meetings, although this was rarely enforced.

While the program did not require consumers to remain abstinent from drug and alcohol use, the building was drug and alcohol free; therefore, consumers were not allowed to possess drugs or alcohol in their units. However, property management did not require consumers to be sober in the building, as long as they engaged in substance use at another location and the behaviors they engaged in while intoxicated do not disturb other tenants.

Eviction practices. Consumers were rarely terminated by the program for negative behaviors, unless they engage in violence or made threats of violent behavior. If they were terminated for negative behaviors it was because the property management initiated eviction.

Judy's House

Judy's House officially began operating as a Housing First program in 2002, although administrative staff stated that they have practiced the principles of the Housing First model since the program opened its doors in 1995. Judy's House offered housing to homeless (including chronically homeless) women, half of which must have some form of mental health or substance abuse diagnosis according to stipulations imposed by one of the programs' funders. The program served ninety-three consumers and employed fifty-four staff members at the time I collected my data. Thirty-eight of these staff had direct contact with consumers as part of their job duties, and seven of them were licensed mental health practitioners.

Relationship to larger agency. Judy's House was one of three project-based permanent housing programs operated by their parent organization, all of which employed the same Housing First approach. The larger organization was the direct property manager of the building the Judy's House program was located in.

Funding. The program was operated largely by HUD funds that were directed to them through the local public housing authority, which held the right to make final decisions in regard to consumer admissions. Additional funding for the program was provided by other government agencies and private individual donations. This funding

source allowed the program to accept women who did not have a source of income; however, they were required to pay 30 percent of their income for rent if and when they did begin receiving it.

Structure of housing and services. Judy's House did not require consumers to engage in any services, including case management, to receive/continue to receiving housing. The program offered a number of supportive services including: case management, education services, employment services, counseling, and health care. The majority of services were operated through the program's learning center. This center was the hub of the program's community and activities. Any homeless woman could access services through the learning center, not just residents of the building. A majority of the women housed in the program at the time of data collection first engaged Judy's House through their Learning Center.

Like Allied, the program did not require consumers to be abstinent and it did not allow them to possess illegal drugs in their unit. Unlike Allied, Judy's House did allow consumers to posses alcohol in their units, although it was expressly forbidden in common areas. Consumers were rarely ever terminated from the program unless they committed an act of violence.

Eviction practices. A unique aspect of Judy's House's programming, which staff stated allowed the program to operate more closely with the Housing First, was the Housing Specialist. The job of the Housing Specialist was to work with the consumer to help prevent eviction and to assist them in finding housing when staff decided to pursue eviction in light of behavioral problems.

Metropolitan

Metropolitan provided scattered-site housing operated by private landlords to homeless (including chronic homeless) men with dual diagnoses. The program had been in operation since 1995. It did not start operating under the Housing First model until 2003, when administration decided to change the program's approach to housing in as a result of the city's implementation of its Plan to End Homelessness. The program provided housing to thirty-eight consumers at the time of data collection. While the larger organization had a number of staff members who worked on aspects of the program, only three case managers worked directly with the program's consumers on a regular basis. While none of these case managers were licensed mental health practitioners, the program's direct supervisor was a certified addictions counselor and there was a licensed social worker on contract who regularly provided consultation assistance to staff.

Relationship to the larger agency. The larger agency that operated Metropolitan had one other large program it operated. This was program was an overnight shelter from which the majority of permanent housing residents were recruited.

Funding. The program received the bulk of its funds from HUD and some additional funding form small local funders. The particular HUD funding mechanism the program operated under is called Shelter Plus Care. This mechanism only provided funds to the program that match those expended on supportive services, (i.e., the amount of funding the program receives depends on the level of services consumers are engaged in).

Structure of housing and services. Despite the program's shift to Housing First in 2003, Metropolitan was missing a key ingredient of the Housing First model until 2007

when administration shifted from an abstinence-based substance use policy to a harm reduction-based one. Before this time, consumers were at risk of losing their housing if they engaged in substance use, even though the program operated under a low-threshold admission policy that did not require a period of abstinence before consumers were admitted to the program.

Though Metropolitan operated on matching funds, it stopped requiring consumers to engage in services other than case management when it implemented its harm reduction policies. Though there was concern from staff that funding would suffer as a result of this policy change, administration informed me that it had not because consumers had continued to engage in programming in the absence of such requirements.

Services offered the Metropolitan included case management, life skills training, medical/nursing, medication management, food pantry services, a temporary work program, and benefits access. In terms of mental health and substance abuse, Metropolitan linked consumers to services offered in the community, which the program could receive matching funds from HUD for. Consumers were required to engage in two case management meetings a month. Meetings occurred in a time and place convenient for the consumers. This meant that case managers typically traveled to the place the consumer was housed to make these meetings. The program also held a monthly consumer meeting that took place at its administrative offices. This meeting used to be required, but became optional with the implementation of the harm reduction policy.

Eviction practices. In terms of eviction practice, the use of private landlords meant the program could not evict consumers directly. However, Metropolitan could

terminate services, i.e., stop paying rent, which generally resulted in eviction of the consumer from their unit. The program tried to work with consumers to address behavioral issues that placed their housing in jeopardy. Often times these behaviors were brought to case managers' attention by private landlords. Case managers worked as hard as they could to address these issues, and would regularly move consumers between landlords to prevent eviction. Non-payment of rent was the most frequent reason behind termination of services. Though the program's policy was to terminate consumers for engagement in or threats of violent acts, it had not run into this issue.

HIVHA

HIVHA started as a Housing First program in 2002. It offered housing to people living with HIV/AIDS (PLWHA). The program served 10 consumers at the time I collected my data. A single case manager operated the HIVHA program. This case manger was not licensed to provide mental health or substance abuse treatment, though he did have access to individuals with these credentials through the program's parent agency who could assist him with any issues that arose. Additionally, based on my personal clinical knowledge, the case manager did demonstrate a strong conceptual understanding of mental health and substance abuse issues and approaches to treatment during our interview.

Relationship to larger agency. The program was part of a larger organization that had offered housing and supportive services for PLWHA since 1990. The majority of the larger agencies programming was abstinence-based. HIVHA was the first program the organization ran according to the principles of Housing First.

In addition to being part of a larger agency, HIVHA was part of the City Hospital to Housing Collaborative (CHHC), which was a partnership between ten housing programs and two hospitals. A large non-profit social service agency managed CHHC. The aim of CHHC was to transition homeless consumers with chronic medical problems from the hospital and into permanent housing. This management agency did not directly provide housing through the collaborative so that it could impartially manage CHHC. The programs that make up CHHC were located in organizations that worked with a variety of different consumer populations (mental health, physical health, HIV/AIDS, etc.). CHHC transitioned new consumers from the hospital into the program that was best able to address their individual needs. As part of CHHC, HIVHA was highly independent of its parent organization, as policies, protocols and practices defined by the collaborative took precedence over those of the parent organization.

Funding. The program was able to take advantage of specific housing and case management funds allocated for PLWHA in addition to standard funds for homeless services. These funds were all managed by CHHC.

Structure of housing and services. HIVHA offered scattered-site housing operated by private landlords to PLWHA. With a capacity of ten consumers, it is the smallest of the four programs in my sample. Of the ten consumers the program served, five had dually diagnosed SPMI and substance use disorders. All of these consumers were funneled to HIVHA through CHHC, which they engaged with after they were admitted to the hospital.

HIVHA's case manager had been with the program two-and-a-half years at the time I interviewed him. This is important to note because HIVHA had very few written policies at the time I collected my data. Though the program was developing written policies, practices and procedures were largely guided by institutional knowledge that was passed down to the current case manager during his new employee training process (this training was provided to him by the programs previous case manager) and what he had learned through CHHC meetings and trainings related to Housing First program offered by other housing organizations.

Consumers of HIVHA did not have to be abstinent or engage in services other than case management. Consumers had access to a wide array of services in the community and through HIVHA's parent organization including health care, group and individual therapy, substance abuse services, and employment services.

Eviction practices. Like Metropolitan, HIVHA could terminate services, but not evict consumers. Consumers could have their services terminated reasons similar to those of the other programs, non-payment of rent and violence/threats of violence. However, no consumers had had their services terminated in the two-and-a-half years the current case manager had been with the program.

Recruiting Focus Group and Interview Informants

I gained access to consumer and staff informants with the cooperation of upper-level management at each program. I asked management to select five to eight informants who could speak directly about Housing First policies and practices for participation in focus groups. For consumer focus groups, I additionally requested that management

select informants who had a dual diagnosis and would be able to interact well in a group dynamic (i.e., whose regularly expressed symptoms or behaviors would not be problematic in a group interview). For interviews, I requested management to provide me a list of all consumers with a dual diagnoses and a list of all staff who had regular consumer contact as part of their job duties from which I selected informants. When there were more than five consumers or staff on a list, I randomly selected informants. While random selection is generally not advised in qualitative research (see Small 2009), the level of interest for the study are the programs, which were selected using theoretical sampling techniques. The random selection of informants was used for interviews in order to prevent programs from selecting only those consumers and/or staff they felt best represented the image they wish to portray, a process known as "creaming", and help assure that my data captures a wide range of views and experiences within each case. Creaming was not an issue in the focus groups because I required participation from clients who could speak knowledgably about the policies of the agency. Consumers and staff who participated in focus group were also eligible for interview selection.

Table 2. Sampling Procedures[a] used for Consumer and Staff Focus Groups and Individual Interviews by Program

Program	Type	Focus group sampling procedure	Interview sampling procedure
Allied	staff	all included	all included
	consumer	random & purposeful	random
Judy's House	staff	purposeful	random
	consumer	purposeful	random
Metropolitan	staff	all included	all included
	consumer	purposeful	random
HIVHA	staff	n/a	all included
	consumer	all included	all included

[a]Methods for selection differ according to the policies of the program/agency.

Regardless of my requests, informant selection differed slightly at each of the four programs, to the extent it could within approved Institutional Review Board protocols. This was because of differences in the programs' policies and procedures regarding access to program consumers and staff by outside researchers, *a reality of conducting research in community-based settings* when organizations are unwilling or unable to accommodate all of a researcher's needs (Nyden et al. 1997; 2011). These differences in consumer selection were not problematic because the primary level of interest was the organization, and not the focus groups or individuals. Table 2 describes the differences in focus group and interview informant selection at each of the programs.

Data Collection

I collected data from a variety of levels within the programs through a review of program documents pertaining to Housing First policies and procedures, one interview with an agency head/agency heads at each program, and audio taped focus groups and interviews with key informants (consumers and staff members) that lasted approximately one hour each. Administrative interview, focus group, and consumer/staff interview guides can be found in Appendix A, Appendix B, and Appendix C respectively.

The primary purpose of the administrative interviews was to gain enough background on the programs so that I would have a basic working knowledge to guide my staff and consumer interviews. As such, the major areas these questions focused on were:

- The relationship of the program to the organization it was a part of
- Programming/services that were offered
- Characteristics of the consumers the program served
- Characteristics of the staff employed by the program
- Implementation of the Housing First model
- The way in which recovery and/or client success was defined by the program[1]

[1]I made an agreement with administrative staff at all of the programs that I would not ask consumers directly about their own mental health and substance abuse issues because of concerns they had for those consumers who might be in denial. Therefore, all questions regarding mental health and substance abuse during focus groups and interview were phrased in a general manner (e.g., "What does recovery look like?" versus "What does your recovery look like") until the consumer directed the conversation to their personal experiences.

I also requested that the programs provide me with copies of any official materials (e.g., written policies, marketing materials, information provided to consumers) related to the program's use of the Housing First model if they existed/were available.

The purpose of consumer and staff interviews was to gain an understanding of how they (1) understood and experienced the structure of the programs they lived and recovery and (2) the connections that existed between program structure and the recovery process. Though I did use a schedule to assist me in facilitation of interview and focus groups, they were largely open-ended. The general topical areas they covered were:

- Informants' familiarity with the program
- Informants' understandings and experiences of other programs they were familiar with
- Informants' understandings and experiences of Housing First programming
- Informants' understandings and/or experiences of recovery and or "success"
- The quality of consumer-staff interactions

I completed each level of data collection in the order presented above. I conducted preliminarily analysis of all data as it was collected so that my incremental learning about the programs could guide data collection at each subsequent level. Overlapping data collection and preliminary analysis is known as flexible data collection, which allows for the researcher to make adjustments during the data collection process as more information about the phenomenon of interest is learned (Eisenhardt 1989; Glaser and Strauss 1967). Additionally, the use of different data collection methods from multiple sources (e.g., consumers, staff, and administrative documents) allowed for stronger

substantiation of constructs and hypotheses in the emerging theory through triangulation of findings (Eisenhardt 1989; Mason 2006; Patton 2002; Yin 2008).

I provided all informants with a stipend for their time: a $30 grocery store gift card for consumers and a $5 coffee house gift card for staff.

Informant Characteristics

Table 3 describes how many staff and consumers in each of the programs participated in focus groups and individual interviews. In all, there were a total of sixty informants. Of these, nineteen participated in both types of data collection activities, and forty-one participated in either one or the other. In total, I completed four consumer focus groups (24 total informants), three staff focus groups (18 total informants), twenty-one consumer interviews and sixteen staff interviews. The average time consumer interview informants were housed at their programs ranged from nine months to ten years with an average of seventeen months. All consumers had dually diagnosed with SPMI and a substance use disorder.[2] The majority of staff interviewed were case managers, however housing coordinators, clinicians, and intake coordinators were also represented. The time staff interview informants had worked in their programs ranged from one to twenty years with an average of five years. I did not keep detailed demographics for focus group informants.[3]

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[2]The administrative staff at the programs could not tell me the exact mental health diagnoses of consumers because of confidentiality issues. The only way I was made aware of a consumer's exact diagnosis was if they revealed it to me naturally through the course of the interview, which did not always happen.

[3]Based on my notes and experience and considering the significant overlap of focus group and interview informants, it is reasonable to assume that the they were similar to those of interview informants.

Table 3. Number of Consumers and Staff Participating in Focus Groups and Individual Interviews by Program

	Focus groups		Individual interviews	
Program	Consumers	Staff	Consumers	Staff
Allied	7	4	5	5
Judy's House	8	9	7	5
Metropolitan	5	5	5	5
HIVHA	4	n/a	4	1

Data Analysis

All audio recorded data was transcribed by student research assistants. I used NVIVO 8 software to assist me in the analysis of the data. In addition to the three broad research questions I detailed at the beginning of this chapter, the following questions guided my analysis:

1. How do staff and consumers understand Housing First programming to work?
    - How do these perceptions affect their experiences within their programs?
    - How does this compare with their understandings and experiences of other programs?
2. How do staff and consumers understandings of the Housing First model impact their understanding and experiences of recovery?
3. How are the programs similar in their operations?
    - How are they different?
    - Why do these similarities and difference exist?

I analyzed data both within and across cases. I looked for themes within each case as they related to my primary research questions (Mason 2006). I then examined differences related to the same theme and how it emerged depending on the source (administrative documents/interview, staff, or consumer). I followed the process of open coding to break the data down into pieces so that similarities and differences across sources could be looked for as they related to Housing First programming and recovery (Corbin and Strauss 1990), and I investigated cross-case patterns by examining similarities and differences between themes as they related to each of the organizations. The search for patterns across cases increased the likelihood of accurate and reliable theory that was a close fit with the data (Eisenhardt 1989). Finally, I discussed findings as they developed with my staff contacts at Heartland Alliance in order to assure that they reflected the reality of Housing First programming as they understood it and to keep with the spirit of the applied and collaborative focus of the study.

I stopped my analysis after reaching theoretical saturation. Theoretical saturation is the point at which learning about the phenomenon in question is minimal (Glaser and Strauss 1967), and it is reached in two ways in case study research. The first way to reach saturation is to keep adding cases until incremental learning has ceased, and the second way is to stop iterating between theory and data once incremental improvement to the theory is minimal (Eisenheardt, 1989). Since my study was limited to four organizations, I depended heavily on the later of these two ways to reach saturation; however, I did continue to recruit interview informants if possible when previous interviews failed yield rich data about the program (see Table 3). Restricting the scope of the study is a

technique for reaching saturation with a limited number of cases because it restricts the phenomena under investigation, thus making it more likely that a researcher will exhaust all possible avenues of investigation sooner (Morse 2000).

Strengths and Limitations

Though there are a great many studies that have considered recovery as an outcome, relatively few have looked at it as a process. In this light, the qualitative methods I employed are highly appropriate considering that they are well suited for the early exploration of topics (Loveland et al. 2005).

My study is also more likely to reflect consumer understandings of recovery that is advocated by consumer groups and reflected in public policy. There is a need for more research on recovery that reflects the consumer point of view (Loveland et al. 2005; Thomas 2004), and an advantage of qualitative methods such as those I employed is that they depict the rich experiences of research informants. Loveland et al. (2005) recommend that factors important to recovery be assessed from multiple levels because:

> A person's recovery from mental illness is considered to be an interactive process that involves transactions between the person and his or her immediate support system, the treatment system, the community, and sociopolitical and cultural variables. (P. 49-50)

Loveland and others have discussed how a better understanding of the connections that exist between micro- and macro-level factors related to recovery are needed, and qualitative methods are designed to identify complex, dynamic interactions between people and their environments which are necessary to develop a strong process-oriented model of recovery (Loveland et al. 2005; Thomas 2004).

The collaborative nature of this study is also a considerable strength. Collaborative methods strengthen the validity of research findings because researchers are more likely to gain insights into the lives of organizations they study that might not have been possible if they were working alone (Nyden et al. 1997; 2011). My study design would have been considerably weaker had I not carried out this project in continual collaboration with Heartland Alliance. Heartland staff made me aware of a number of issues that guided the development of my recruitment and data collection procedures. They made me aware when organizations I was looking to recruit did not actually provide Housing First services.[4]

Regardless of these strengths, the study did have limitations. As a qualitative study with a small sample size, my findings are not statistically generalizable. However, statistical generalizability was far from the goal, and the multiple case study methodology helps to improve the theoretical generalizability of the findings. Theoretical generalizability was also strengthened through the use of key program differences as selection criteria because it helped to assure that there was diversity among the Housing First program in my sample. This diversity made it more likely that any similarities I found between the programs were more likely to be due to the Housing First model and not the individual programs.

Finally, my inclusion of HIVHA as one of the study sites presented a problem in that its small size placed a limit on the amount of data that could be collected there. This

[4]There has been confusion in the housing community as to what Housing First programming entails. This has resulted in a wide variation in implementation of the model (George et al. 2008; Pearson et al. 2007).

problem was easily overcome by holding off data collection at HIVHA until the end of the study. It was at this point that themes had already begun to emerge at the other sites, which were used to better guide data collection efforts at HIVHA. Additionally, including such a small agency was also a strength in that it reflected the reality of Housing First programs that exist.

CHAPTER FOUR

FROM STRUCTURAL CHAOS TO A MODEL OF CONSUMER CHOICE: CONSUMER AND STAFF UNDERSTANDINGS AND EXPERIENCES OF TWO MODELS FOR HOUSING THE MENTALLY ILL

Introduction

In this chapter, I demonstrate how the Housing First model is an expression of historical and political forces that have changed the ideology behind and structure of mental health services. I then demonstrate how the organization of mental health services affected consumers by comparing the experiences of informants (both consumers and staff) in their current Housing First programs with their experiences in COC programs, which I argue are a holdover from the days of institutional treatment.

For the purposes of the information presented in this chapter, I use a broad definition of "recovery" proposed by Anthony (1993). He defines recovery as "a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness" (p. 527). The story of recovery I tell here is essentially about the interplay between social structure and individual agency.

While there is a wealth of literature connecting structure (environmental stressors, social support, social capital) and agency (self-esteem, self-efficacy, mastery) to individual mental health outcomes (Aneshensel 1992; McLeod and Lively 2007; Mirowsky 1995; Mirowsky and Ross 1990; Pearlin 1999; Wheaton 1999), there has been

little research demonstrating the connections between structure and agency to recovery for people who are already living with SPMI (Yanos et al. 2007). For the purposes of this chapter, I define *social structure* as any social phenomenon (policies, rules, laws, resources) that constrains social action and *individual agency* as the process through which a person makes choices to engage in actions that influence their social environments (see Yanos et al. 2007). The interplay between structure and agency therefore affects "the manner in which people make choices of action that influence their environments" (Yanos et al. 2007:410). As shown in this chapter, these choices have significant impacts on mental health outcomes.

History of the Structure of Mental Health Treatment/Services

For the majority of people living with *diagnosed* SPMI,[1] mental health services significantly structure the course of their recovery.[2] Investigating the organization of services and its effect on consumers can illuminate the connections that exist between structure, agency, and recovery. The organization of services at the programmatic level is itself affected by the larger institutional field of mental health treatment (DiMaggio and Powell 1983; Meyer 1985; Meyer and Rowan 1977; Polgar 2009; Scheid 2003), which is in turn shaped by historical and political forces that have changed society's conceptions and treatment of mental illness and the mentally ill. In this section, I provide an overview

[1]Frank and Glied (2006) have pointed out less than 30 percent of people with a *diagnosable* condition have ever received formal mental health treatment. However, they also cite evidence that this proportion has been increasing thanks to the spread of insurance benefits for mental health problems.

[2] This is not to say that recovery does not happen outside of mental health treatment, and there has in fact been research demonstrating that individuals can and do spontaneously recover from SPMI with little or no involvement in mental health treatment (Carpenter and Kirkpatrick 1988; Harding et al. 1987). However, there individuals are not the concern of the current study.

of those forces and describe how they have transformed the field of mental health treatment.

A History of Control in Mental Health Treatment

The conceptualization of mental illness (and substance abuse disorders) and its treatment in the United States have historically been guided by the biomedical model. *Medicalization* is a term often used to explain the transformation of deviant behaviors or traits into mental health diagnoses as a result of viewing social phenomenon through a biomedical lens. This process takes something that was once part of everyday life (in this case deviant behaviors) and places it under the control of the medical profession(s) by transforming it into a pathology/illness that needs to be medically treated (Conrad 2007; Scheid and Horwitz 1999; Szasz [1961] 1984).

Medicalization combined with public fear about mental illness resulted in the psychiatric profession gaining high levels of professional control over mental health patients beginning in the late 19th century (Corrigan and Ralph 2005; Davidson 2003; Foucault [1965] 2006). Control of the mentally ill by the psychiatric profession and away from the criminal justice system effectively resulted in the social isolation of many people living with SPMI into large, state-run mental health institutions before middle of the 20th century (Goffman 1961; Szasz [1961] 1984, [1963] 1989). Much of what we know today about the effect of treatment on mental patients lives during the phase of institutional treatment is informed by Goffman's (1961) seminal paper "The Moral Career of the Mental Patient." In this work, Goffman described these institutions as highly rationalized bureaucracies marked by rigid forms of authority aimed at managing

large numbers of patients. Commitment to mental health treatment served to delegitimize the patient's status as a "normal" person who was capable of taking care of themselves and placed responsibility for their lives in the hands of the psychiatric profession, significant others, and/or the state (Goffman 1961; Szasz [1963] 1989).

The mass processing of individuals though public service organizations like these institutions is not a phenomenon unique to the field of mental health. The medicalization of mental illness and institutionalization of mental patients is an extension of control society has historically exerted over the poor. The result of this control is that individuals are turned into objects at distance from the rest of society by "depriving those who receive public alms of certain civic rights" (Simmel 1972). Because of limitations to their rights, it was often difficult for patients to gain discharge from institutional care once they entered.

From Patient to Consumer:

Shifting the Locus of Control in Mental Health Treatment

The dismantling of large state-run psychiatric institutions has largely been attributed to advances in psychotropic drugs during the 1950s that made the symptoms of SPMI more manageable (Frank and Glied 2006; Scheid and Greenberg 2007). After deinstitutionalization, the combination of research demonstrating SPMI was not as debilitating and deteriorating as once thought and personal accounts of consumers describing their inhumane treatment at the hands of the psychiatric profession resulted in further policy and legal developments that have given mental health patients increased control over their lives and made it harder to commit them to long-term treatment (see:

Corrigan and Ralph 2004; Davidson 2003; Davidson and White 2007; Davidson et al. 2006; Frank and Glied 2006; Kaufmann 1999; McLean 2009). The passage of these policies and laws marks the beginning of the shift from a provider-driven model to a client-centered one in mental health services.

During the 1980s this shift gained a new momentum thanks to changes in the broader medical field that resulted from a combination of the liberal rights-based approaches to medical care and conservative approaches that treat health care as a free market commodity (Frank and Glied 2006; Lupton 1997). Figert (2011) argues that the large amounts of power physicians once had over their patients as a result of medicalization and professional expertise have deteriorated significantly as patients have been encouraged to approach their health care as consumers. This shift in power started what has come to be known as the consumer model in the medical field (Figert 2011; Timmermans and Oh 2010). The influence of this ideology within the mental health field has resulted in a focus on consumer rights and citizenship while also advocating for treatment in the least restrictive environment possible (Davidson 2003; Davidson and White 2007; Davidson et al. 2006; Power 2009). This consumer model has helped many people with mental health problems gain greater control over their treatment (Kaufmann 1999; McLean 2009), and it has become so popular that it has extended itself beyond the field of health care and into welfare services more generally, including services for the homeless (McNaughton 2008b).

Consumer Experiences in COC and Housing First Programs

Consumer choice for those who are chronically homeless has been and largely remains the choice between treatment in a highly controlled setting or no treatment at all. Contrary to the general consumer market philosophy, the majority of COC programs for the homeless (shelter, transitional, and permanent housing) generally require consumers to be engaged in mental health and/or substance abuse treatment (or at least be abstinent from using substances while receiving services) (Atherton and Nicholls 2008; Tsemberis and Asmussen 1999). Not only do requirements like these place the consumer in a position of less control over their own treatment, but they violate the internationally recognized right all human beings have to housing (United Nations General Assembly 1948). In the sections that follow I use the experiences of informants to demonstrate how COC housing programs are an extension of the institutional model of treatment they replaced, how the Housing First model is an expression of the consumer model, and the effects that these different services approaches had on consumers' lives.

Past Experiences with COC Programming

Almost all of the informants in this study I spoke with had experience as a consumer or staff member in COC programming for the homeless or in treatment programs that emphasized traditional biomedical and12-step ideals/philosophies. Informant accounts of their experiences in these programs were vastly different than the ones they described in their current placements. I use Jesse's story to begin my discussion of consumers' experiences in COC programming. Jesse was a consumer at Metropolitan at the time I interviewed him. I have chosen to use his story here because it highlights all

of the important themes I found in relation to consumers' experiences with COC programming.

Jesse's Story

Jesse came from a middle class suburban family. His religiously conservative parents sent him away to a Christian college because of his drug use and because they suspected he was gay:

> My parents had tried their damndest to keep me away from drugs…they were prepared to send me to college but only under one condition, that I went to [a strict Christian University], I don't know if you're familiar with [it]. [It is an] [e]xtremely right-winged, fundamental Christian university in the buckle of the bible belt…[A] lot of the reasons [they sent me there] were [do] to drug use, at that point mainly marijuana and alcohol, and my sexuality. They were afraid that I was gay, which I am. So they were thinking that this going to this university would help straighten me out. (Jesse, 48, Metropolitan consumer)

Though he knew that he was gay, Jesse married and ultimately had two children (a daughter and a son). He worked as a teacher until he lost his job after a drug conviction. Divorced soon after, Jesse and his son lived with his then boyfriend who introduced him to crack. Shortly thereafter, Jesse developed health problems, and he and his son moved home with his parents. It was during this time living at his parents that Jesse tested positive for HIV. After his diagnosis, Jesse decided to move back to the city without his son because he felt he could get better support there as a gay man living with HIV. After spending time "couch surfing" in friends' homes, Jesse made his way into the COC housing system.

Jesse gained and maintained sobriety, which allowed him to move from an emergency shelter to interim housing and from interim housing to a COC program. He

continued to make progress in permanent housing, eventually becoming the president of resident council in his program. In his own words: "I felt really good about myself. It just was a great time for me." This good feeling lasted until his first New Year's Eve at the program when he made the decision not to take his Seroquel (medication for his bi-polar disorder) so he could stay awake for the party he was in charge of as president of resident council:

> So I just tried to nap, and unsuccessfully for the most part. I had set up a date for later that day with a guy that I met…[I]t was a dinner date, like five o'clock on New Year's day…and I was pretty manicy because, again, I hadn't taken my Seroquel and I hadn't slept. [I was] just about at [my date's] stop on the [train], and he calls me and says, essentially, "Maybe next time, something betters' come up"…I was pretty pissed, pretty hurt, whatever. So I got back on the train going the opposite direction, and I met someone from my past on the train…and he was loaded [had drugs,] and just in a weak moment, I was like "Yeah, let's go, it's on!". And [I] spend about two or three hundred bucks [on drugs] over the course of a few days, didn't go back to [my housing]. (Jesse, 48, Metropolitan consumer)

At this point in his story, Jesse has made what is probably not the best decision for someone with bipolar disorder (not taking his meds), but it is an understandable decision considering his reasons (he wants to stay awake for a party he is responsible for). This leads to an even worse decision on Jesse's behalf (taking drugs), which starts him on the road toward termination from his program:

> When I did [go back to my housing], it was kind of obvious [to the staff] what had happened, so they forced me into treatment. At this point I'm nearly suicidal over the fact that I had used again and just went through all this self loathing…[A]nd, like I said, [I was] president of resident council at [my housing], and all that was just stripped. All of a sudden, you're [I was] a second class person again…That doesn't make any sense. I learned a hell of a lot about myself in that nineteen months…They just took it from me, nobody talked to me about it…As a matter of fact, my suitemate at [my housing], whom I had become very good friends with, just cut me

> off. That's it, he was gone, [he felt it] wasn't safe for him to be around me anymore. (Jesse, 48, Metropolitan consumer)

Because of his relapse, Jesse had everything he worked for taken away from him. Feeling depressed and suicidal, the program staff who were his primary source of support were not helping him process his behaviors and their repercussions. In addition, his friends in the program who were his secondary source of support refused to associate with him because of his substance use. Without support, the only means to cope for Jesse was more substance use, which led to his eventual termination:

> [A]fter my first relapse I signed a contract with them. I relapsed again. It was a breach of contract. I lost my housing there. We already started this transition to [Metropolitan]. I do remember, I won't use names, but people at [my old program], they were, the case managers supervisor told me, "You know we're not gonna tell them anything about your relapse, and how you relay to them about your relapse is entirely up to you. But as far as we're concerned, everything's still a go for you with [moving to Metropolitan]. (Jesse, 48, Metropolitan consumer)

Structural Chaos in the COC Model

Like Jesse, other informants, both consumers and staff, described COC housing programs as having strict rules. Tanner's description of a COC program he used to work at before becoming the case manager at HIVHA highlights this:

> Whereas with the abstinence based program that I was working in there were just very finite things I just, you had to have a job within forty-five days of entering the program. And if you didn't, you got a warning, and then you had a month to find a job. And if you didn't get a job within thirty days you got another warning. And then if you had thirty more days, and if you didn't do that then you'd get terminated from the program. And you had to do service hours every month. And if you missed those service hours you'd get a write-up, if you got three write-ups you were terminated. (Tanner, HIVHA staff)

Though Tanner's discussion focuses on the strict demand to adhere to rules related to

employment, the primary goal of most of the rules in COC programs that informants described was to ensure consumers did not engage in substance use. For instance, informants described a "three-strikes" rule regarding substance use in COC programs that was similar to the "three write-ups" rule Tanner described:

> … [B]efore I came here to [Metropolitan] I was in another place up this way. But, basically it was like [a] three strikes you're out type of thing (Male consumer, Metropolitan consumer focus group)

Another staff informant, Jane at Judy's House, described a similar process from a staff perspective:

> And if you [a consumer] came in under the influence that kind of went against you. You had so many strikes and then you were out… (Jane, Judy's House staff)

Rules like these were based in the biomedical and12-step philosophies that view recovery as an outcome people attain when they no longer display symptoms related to their illness(es) (i.e., no longer display symptoms of their mental illness, due to medication compliance, and are abstaining from substance use) (see: Deegan and Drake 2006; Liberman and Kopelowicz 2005; Resnick, Rosenheck, and Lehman 2004).

The focus on abstinence in COC programs informants described was so pervasive that even admissions requirements were developed around them. Jane went on to discuss how these admissions requirements at COC programs acted as a barrier to her attempts to find housing for consumers of an overnight shelter she worked at prior to Judy's House:

> Everybody [consumers] had to be clean. You [consumers] couldn't have used within so many days, and that was what the barrier was. So it was like working with people trying to say, "well yah know you got to work with [the rules]". And they kind of explained that their use of drugs was because, "You don't know how it is out there on the streets, and sometimes

> we can't get into the shelter"…I mean, yah know, it was like a rock and a hard place. (Jane, Judy's House staff)

Jane's discussion highlights how rules rationalized around substance use in COC programs have little connection to the lived reality of the consumers the programs are designed to serve. As she and other informants pointed out, consumers often used substances as coping mechanisms to deal with the hardships of being homeless. In this sense, the abstinence policies that blocked housing access were punishing consumers for engaging in a protective behavior. Consumers readily pointed out the contradictions inherent in this practice:

> I know at shelters you had to be sober thirty days to get in. [I know of an agency that] got a shelter [where] you have to be sober thirty days to get into a shelter, for people with HIV, and how ridiculous is that? If I wouldn't be, if were sober I wouldn't be homeless. So now if I'm homeless, it means I'm not sober. So why do I have to be sober to get into a place that I need housing for? (Male consumer, HIVHA consumer focus group)

What Jane and this focus group informant are pointing to is the very real and complex relationship between homelessness and substance abuse that is often ignored by COC programming. Substance use has been demonstrated to be both a cause and a consequence of homelessness, which consumers often have trouble escaping due to their need to cope with the variety of hardships they face on the streets including adverse physical health consequences, mental illness, social isolation, victimization, and marginalization (Galaif, Nyamathi, and Stein 1999; McNaughton 2008a; Nooe and Patterson 2010).

The rules consumers encountered in COC programs helped form part of the structural reality in which they lived. **Obderateness** refers to codified rules (policies and

laws) and material resources that form part of the social structure and constrain action (Fine 1992), and it is particularly resistant to individual agency. The structure of COC programming was so highly restrictive that consumers were often punished or sanctioned for displaying symptoms of their own illness, i.e., substance use. This meant that consumers did not feel secure within the structures of COC programs. Additionally, the rules in COC programs severely limited consumers' individual agency:

> I think it [the program I used to work for] was more traditional cause you, everybody, you had to abide by the rules, had to follow structure. And everything was set out, lined up. And there was no room for [consumers to do what they wanted]. [Consumers] either sort of got with the program or [they] got out. (Manuel, Allied staff)

As Manuel points out, in the COC programs informants told me about consumers could either choose to follow a very defined and sometimes confusing list of rules and stay housed or break the rules and be evicted (or, less frequently, choose to leave).

The effect this had on consumers was a very limited sense of agency that made them feel powerless in terms of their own fate:

> [The first program I stayed at] was just very very structured and, I felt, punitive. And I didn't like the model [it used]. Because if you didn't fit in with what they expected you to do or be, it was difficult. And so I said, "I don't know if I'm gonna make it here"…And I feel that I've gone through a lot in life, but I've never felt powerless, I've felt that I've been in situations where I wish I had more influence and more power…[I]t was almost like if you didn't agree you had to be quiet. Because you couldn't, if you spoke out they'd say your in denial. (Valery, 61, Judy's House consumer)

In other words, consumers lived in a structural chaos in which they felt they had no control over their own fate and were unable to predict whether they would remain housed because they could not predict or know when they would cause break the rules do to the

expression of symptoms associated with their dual diagnoses. Often, the only way for consumers to exercise agency and control over their placement in the program was to lie to staff:

> You have to work and be sneaky [in COC programs]…they came and they drop you [i.e., conduct a urinalysis test], and if you don't go to so many meetings or do this or that and you flub up so many times out, you go [get evicted]. So that's a threat. That's a threat in my eyes. You either straighten up or get out (Brandy, 47 Allied consumer)

What Brandy is describing is often the only recourse that consumers in COC programming felt they had when they engaged in substance use (a symptom of their illness that placed their housing in jeopardy) avoid staff and/or lie to them so that you do not get caught.

Threat to Consumer's Sense of Self

The rationalized structure of COC programs described to me by informants went beyond the medicalization of consumers' problems to the medicalization of consumers themselves. The aspect of the social structure that best describes this issues is s**ymbolization**. Symbolization refers to the social processes that assign identities to people and things (Fine 1992), and informants discussions demonstrated that it affected consumers in COC programming through the medicalization process that labeled them and their behaviors as "mentally ill." Consumer-staff relationships in COC programs suffered as a result:

> [T]hey [staff at a COC program] didn't care, they were supposed to care but…they didn't…They just ask you a ques[tion]. They don't try to go [ask] "how you doin in there [your room]?"…And then they'll go talk about [ask me] am I goin to the meetings and "How's your housing?", "Have you been trying to look for a job?", "Are you thinkin about goin back to school?"…[T]he case managers, to me they really didn't care.

> They just want you to sign these papers, don't explain nothin to you. They just tell you one thing, and you ain't, you not payin attention, not reading. (Harriet, 51, Allied consumer)

As the above quote from Harriet shows, the highly rationalized rules of COC programs demanded staff treat consumers as their medicalized illness(es) first (primarily substance dependence) and individuals second, which was severely alienating for them.

Staff also recognized how the rules in COC programs they had worked at in the past interfered with their ability to form relationships with consumers:

> … [B]ecause he's not supposed to be drinking period. "Why you got it [alcohol] in your apartment?", that's what you say as a case manager. "Well why do you, why you drinking?" "Why do you have that in your apartment?" "You need to be in a program." That's the first thing that comes out of your mouth because that's what you've been trained to say and do. And you feel that works. "Are you going to AA or NA [Narcotics Anonymous]?" "Do you have a sponsor?"..."Maybe you need to go in-patient, out-patient." Those are things you throw out there to people in that [COC] model. (Sandra, Metropolitan staff)

As this selection from Sandra, as staff member at Metropolitan, demonstrates, the 12-step philosophy based in the disease concept of alcoholism that permeated COC programs conditioned them to relate the majority, if not all, of consumers' behaviors back to their addictions.

The way in which COC programming facilitated and reinforced the labeling process is problematic considering that labeling has been demonstrated to negatively impact such things as quality of life, self-esteem, social networks, treatment adherence, and symptoms of mental illness (for a review see Link and Phelan 2009). Specifically related to consumer-provider interactions, previous research has also demonstrated that negative interactions with service providers, as part of the labeling process, can have

significant negative repercussions for consumers (Dobransky 2009a). And it is possible that these repercussions are even more negative than those caused by reactions from other groups (e.g., friends, family, strangers) (Rosenfield 2008, as cited in Link and Phelan 2009).

Jane, a staff member, provided an example of the effects that the labeling of consumers and the rules detailing how to treat them based on these labels within the 12-step model can have when discussing a consumer who was a member of AA that relapsed:

> [T]his woman [a consumer] chaired some [AA] meetings. She was told she had to immediately step down [when she relapsed]…[S]he was really proud of the fact that she was able to be invited and asked to chair this meeting…[S]he was told, "You have to stop, no longer chair the meeting, can't do that". So, what that did was, that shunned her from that whole entire group. (Jane, Judy's House staff)

Though this is not a story of a COC program, Jane's example does demonstrate the rationality that exists in the 12-step model, which the majority of housing programs follow. As in Jesse's experience previously described, the rules surrounding the 12-step model informed others how to treat the consumer Jane is talking about based on no other factor than the expression of a symptom of her illness (substance use). Regardless of all the progress this consumer made, she was shunned by the group, at least until she could regain her sobriety. Other consumers described similar experiences with AA and 12-step recovery:

> Did you know why I don't go to AA or NA? Because they're snobs… [they] look down on you. I don't deal with that. I [won't] deal with no mother fucking group that will make me feel bad about myself. When you're supposed to feel better about yourself. (Female consumer, Allied consumer focus group)

A significant problem that resulted from the medicalized treatment of consumers in COC programs was that they were not treated as addicts or mentally ill, rather than human beings who had other aspects to their lives. Barry pointed out how COC programs made him feel like less of person:

> Some places [other programs he was familiar with] you just a number or piece of paper in a pile. (Barry, 55, HIVHA consumer)

Other consumers discussed how staff in COC programs only focused on issues related to their dual diagnosis (i.e., psychiatric treatment compliance and abstinence) at the cost of other issues in their lives that needed addressing. The following focus group informant discusses how the failure of staff to consider these other issues caused him to feel as if he was "falling through the cracks" of services:

> … [T]he management [at my old program] in my opinion, they just didn't pay attention to the details of things…Whereas [HIVHA] is really detailed oriented…They pay attention to the small things, like: "Does the client have food, is there enough food there?"; "Is the client able to budget or is he having difficulty budgeting?"; "[Does the client] have adequate transportation, or is that something that we supplement?". And the other agency didn't seem to pay as much attention to those things. So you could slip through the cracks. I think their concern was number one, the biggest concern was, number one, "is the client paying the rent on time?". And then, number two, "is the client keeping an appointment with the case manager?" (Male consumer, HIVHA consumer focus group)

This selection demonstrates that it was supportive services (i.e., housing, transportation, employment services, medical services) that consumers understood to be more important than mental health and/or addictions treatment. This has been supported by other literature that has demonstrated wrap-around services are often more beneficial than

therapeutic services when working with people diagnosed with SPMI (see Frank and Gelied 2006; see Schied and Brown 2009).

The alienation and powerlessness that resulted from this medicalization process severely affected consumers' *ontological security*. Ontological security refers to the sense of continuity one has to their own life events, and it is reliant on people's ability to give meaning to their lives (Giddens 1986). The concept of ontological security was first used by Laing (1965) to describe the lack of continuity experienced by people living with SPMI. Ontological security has connections to **identification**, an aspect of social structure connected to symbolization that constrains action by affecting the identity formation process (Fine 1992). Regarding the identities of homeless people, McNaughton (2008a, 2008b) has demonstrated how the homeless and formerly homeless people she studied had difficulty maintaining ontological security for significant amounts of time because their ability to create coherent self-narratives was seriously affected by their inabilities to exercise agency, establish predictability and routine in their lives, to understand their role within the social structure they were a part of. Dupuis and Thorn (1998) have proposed four markers or conditions of ontological security as they relate to people's housing: (1) constancy, (2) routine, (3), personal control, and (4) security. It is clear from Jesse's story and those of other consumers that attaining all, if any, of these conditions in COC programs were next to impossible.

Ontological security was tenuous for consumers in COC programming due to the highly restrictive limits placed upon their choices by rules and the reality that privileges (when they were gained), relationships, and social status could be ripped away from them

at any time with little explanation. While the COC programs that informants discussed were a result of the move to community-based services envisioned during deinstitutionalization, the threat to individual identity consumer faced in them was reflective of that experienced by the patients in institutions of the past. Referring to Goffman's (1961) work demonstrates this by highlighting the effect that institutional treatment had on the identity of in-patients:

> At the same time, the paucity of equipment and rights means that not much self can be built up. The patient finds himself constantly toppled, therefore, but with very little distance to fall...As the person moves up the ward system, he can manage more and more to avoid incidents which discredit his claim to be a human being and acquire more and more of the varied ingredients of self-respect; yet when eventually he does get toppled—and he does—there is a much farther distance to fall. (P. 166-67)

This quote might as well be about Jesse and many of the other consumers I spoke with during this study. Jesse suffered a huge threat to his ontological security when everything he had attained (his position on resident council, program privileges, his relationships) was "stripped" of him after his relapse, and this had a profound effect on his sense of self:

> Inside an abstinence based model, it's always said relapse is part of recovery. I mean that's a commonly said [thing]. But no one really treats it like that. I mean they might pay lip service to that but the way things function or unfold in reality, you're stripped of who you are [when you break the rules], and what you can do, and everything just changes in one instant. (Jesse, 48, Metropolitan client)

The program rules guided the consumers and staff in how they should treat Jesse (send him to treatment, take away his privileges, do not interact with him) based on one mistake he had made and without any regard to the accomplishments he attained.

Experiences in the Housing First Model

The Housing First model was specifically designed in response to the recognized inadequacies of COC housing to address the needs of dually diagnosed clients (Tsemberis and Asmussen 1999). As such, consumer empowerment is a major focus of the Housing First model. Dobransky (2009b) has discussed empowerment in mental health services as a relational construct where "[t]he subject of empowerment efforts [the consumer] is the person whose power others aim to increase by a given intervention" (p. 40) and "[t]he empowering actor [the provider] is the person, group, or organization that makes the empowering intervention for, or on behalf of, the subject" (p. 40). Dobransky goes further to point out how mental health and substance abuse programs/services that employ empowerment practices or rhetoric generally do so as part of recovery and/or harm reduction ideologies, both of which are employed in the Housing First model (National Registry of Evidence-Based Programs and Practices 2010; Pearson et al. 2007, 2009; Tsemberis and Asmussen 1999). The recovery model views mental health treatment as a process that should be consumer driven. Within the recovery model, empowerment can be conceptualized as the provision of choices and tools necessary for consumers to exercise choices that impact their social environments (Substance Abuse and Mental Health Services Administration 2005). Empowerment in harm reduction is seen largely as the result of the consumer's developing motivation for change (see Miller and Rollnick 2002). This motivation is attributed to work that staff engage in to make consumers aware of their own discrepant thoughts regarding problematic behaviors they

engage in (i.e., substance abuse and the negative behaviors associated with it such as risky sexual behavior, violence, and financial irresponsibility).

As a result, consumer-driven empowerment approach, informants' descriptions of the Housing First programs they were currently working or living in contrasted sharply with those of the COC programs they were familiar with. Manuel, a staff member at Allied, made a statement that summarizes many of these differences between these programs well:

> [W]ith us [Allied] there's a lot more give-and-take [than in COC programs]…[Y]ou've [a client has been] sober for three weeks or a month, and all of a sudden you fall off the wagon. With us there's no judgment, there's no criticism, "Okay, you've slipped. [Do] you want to stay slipped or [do] you want to get back on the wagon?"…[C]ontinue to engage and support them in that…no matter whether you're abstinent or sober we continue to provide services. (Manuel, Allied staff)

As this quote demonstrates, informants' current programs offered consumers a sense of security and predictability in their housing, as well as a greater sense of control over their lives than they had experienced in COC programs or when they were homeless. Harriet's story highlights many of these points.

Harriet's Story

Harriet had been housed at Allied for thirteen months at the time of her interview. Harriet's life narrative as she relayed it to me demonstrates that she had a tough childhood. Both of her parents were alcoholics, and she was raised by her grandmother because her mother chose not to take care of her:

> I had a hell of a up-bringing because my mom didn't like me and my grandmother raised me. My mom, me and my mom we couldn't even stay in the same house, so I had a bad upbringing as far as uh relationship with my parents. I was good, I got everything I wanted…I couldn't put up, my

> mom was alcoholic, my father was alcoholic… (Harriet, 51, Allied consumer)

Though she said she never lacked for anything as a child, she also said that she very rarely experienced what it was like to have someone care about her for most of her life, which affected her ability to form relationships:

> I don't have any friends too much. I deal with everybody around, but I still have that part about trust that have been, since I was sixteen years old, I couldn't trust nobody. (Harriet, 51, Allied consumer)

As an adult, Harriet moved in and out of precarious living situations, and stated she had been homeless on and off for the past twenty-five years. She had lived in three COC programs where she experienced the same lack of control and alienation as I described in the previous section. Her stays in COC programs were relatively short, three to five months. Harriet was adamant about her dislike for these previous programs, but her face grew into a smile when she discussed her current program with me:

> Here, they take time with us…I couldn't believe this was happenin and everybody was there for me…And it felt real good that some people care, really care about [me]…Sometimes I feel kind of kind of scar[ed] [like] this can't be happening cause I'm so used to nobody really caring about me…it scared me for a while, trust me…I was nervous about everything. It was somethin new to me [when I first moved here]… (Harriet, 51, Allied consumer)

Here Harriet expresses how much it means for her to feel as though people care about her, something she had rarely experienced growing up and in the COC programs she had stayed at. Harriet went on to describe the impact this caring had on her:

> It [her current program] made me feel good about myself… [T]hey [the staff] gave me choices where you [I] can do this or you [I] can do [that], it's up to you. [The program is] just trying to provide [me] what [I] need and what [I] want, what's best for me. That's what made me feel good too, cause they wanted, they'd give me information where they know its gonna

> be good for me, its not gonna hurt me or anything. So I could take that chance, and I don't have to worry cause I know they got my back…[O]ut there [when I was not in the program] I didn't have no choice, it [is] either "your gonna help me or you don't". You don't have choices out there, you just have to go with the flow if you want to get some. (Harriet, 51, Allied consumer)

One of the primary ways that Harriet sees the staff as caring for her is that she is provided with choices, something she felt she rarely had in her life prior to her joining the program. Having choice was a powerful thing in Harriet's life she had rarely experienced, and it was important to her because it allowed her to take credit for her own accomplishments. Demonstrating this, Harriet told me about her Hepatitis C diagnosis, and how staff helped her decide to take a shot to treat the illness by providing her with health related information and letting her make up her own mind, rather than forcing her to comply. There was excitement and a sense of personal accomplishment in Harriet's voice when she told me how she was able complete her medical treatment:

> I had to take a shot every once [*sic*] a week for a year. And I did it, I did it! (Harriet, 51, Allied consumer)

Harriet then went on to describe how being in housing helped her to cut down her alcohol use to the occasional beer because having stability in her life helped her to see how alcohol negatively affected her health.

Flexible and Supportive Structure

While the Housing First programs still had a structure to them, this structure was more flexible than COC programming in that it did not have as many rigid rules for consumers to follow. Part of the reason for this was that, unlike the COC model, housing was not contingent upon treatment compliance:

> Because in complete abstinence [housing, i.e., COC housing,] we say "yes housing comes first, but we have stipulations". "You don't follow something you're back out." In Harm Reduction we say "housing comes first, we're gonna work with you, we're not gonna send you out like that". (Geraldine, Judy's House staff)

This quote and Harriet's story demonstrate how the absence of strict rules structured around a biomedical/12-step approach to recovery allowed staff to interact with consumers as individuals rather than their illness(es). This allowed for stronger relationships because consumers felt as though staff genuinely cared about them.

The organization of services and the way staff related to them made consumers feel that they were *more supported*, *not judged*, and *treated like adults*, all feelings they rarely experienced in previous programs:

> … [T]hey [staff] just treat you like a grown individual. They don't look down on you, nothing like that. And it's okay to have a problem or a habit they let you know that first and foremost, and I appreciate that (James, 45, Allied consumer)

And this made consumers feel more responsible for their own behaviors:

> … [T]here's also a little greater responsibility on our part to know that they trust in us…And as the grown men that we are we know that which is better for us. You know, naturally we gonna wanna keep our housing, jobs, such as, instead of being loose where anyone can see that we just went and slipped in cracks and just you let the addiction thing you know takes its toll on us. (Male consumer, Metropolitan consumer focus group)

In addition to this, the lack of rigid rules strengthened consumer-staff relationships because it meant that consumers could take greater security in the knowledge that their housing was permanent:

> Because one of the things is that when my case manager asks me did I use, I can tell him "yeah" and don't feel like I'm being judged. I can tell him "yeah" and don't, and not be afraid of what I'm gonna be disciplined with. I can say "yeah I used" and not be worried about, "am I gonna be kicked

> out next week?" I can tell I can be as honest with my case manager as I want to be and not be judged about it. If I skipped a bill this month, I'm not going to be judged about it…That's what harm reduction has done. You know what I'm saying, I'm not judged by my addiction. I'm helped because of my addiction. (Male consumer, HIVHA consumer focus group)

Staff also discussed the positive effect this had on their relationships with consumers:

> I think the guys [consumers] are a little more honest with you [than they would be in a COC model], a little bit more open… [in an abstinence-based program] you get warnings, you might get thrown out, they hide a lot because they feel they have to because they need to keep their housing…if you [a consumer] divulge information you might get put out. But with my program…I see where they're more apt to be honest with you and they ask for your help. (Sandra, Metropolitan staff)

Relationships like the ones described in the two previous interview selections are necessary for individuals to establish ontological security (Giddens 1986; McNaughton 2008b). For instance, research conducted by Wright et al. (2000) have demonstrated the importance of social relationships to individual agency for people living with SPMI using results from a three-wave panel survey distributed to deinstitutionalized long-term mental health patients. Their results showed that social rejection was a significant source of distress for former mental patients' and that it could weaken the sense of control they had over their own lives.

The greater sense of security consumers possessed regarding their housing also had positive effects on their sense of self. Reduction of anxiety has been demonstrated to be an important part of ontological security that is difficult for homeless individuals to obtain (McNaughton 2008b). This is because the homeless are under chronic stress as a result of their efforts to survive with limited resources. This stress did not always stop when consumers found housing. In COC programs, the consumers I spoke to were under

a different kind of chronic stress because they were always unsure of the permanence of their housing. However, their experience was much different in their Housing First programs. Nowhere was this more apparent than at Metropolitan.

Though Metropolitan considered itself to be a Housing First program since 2004, consumers were still not allowed to use substances and could face termination of services and eviction if they were not abstinent. It was not until ten months before my data collection began that the program changed this rule so that housing was no longer contingent on abstinence. The following selection is from a consumer who is describing their experience before and after this shift in policy took place:

> Because I mean that's scary when your housing is tied to your ability to remain abstinent. I mean you live kind of in a constant fear, you know what I mean. One fuck up and I'm homeless…It's not conducive to remaining sober with that kind of pressure, and it's not conducive to remaining housed, obviously. So it's nice to know that you can, it's nice to know that your housing, it's a huge relief when you realize your housing is not tied to your ability to remain abstinent. Huge relief. (Male consumer, Metropolitan consumer focus group)

For this consumer and others, the fact that their housing was not contingent upon their ability to remain sober had positive effects on their mental health because it gave them a sense of security that allowed them to being addressing other issues in their lives through their own choice rather than through the demands of the program.

Jesse also explained the positive effect that harm reduction had in reducing his anxiety when Metropolitan made the shift from abstinence-based to harm reduction policies:

> … [T]he harm reduction has made all the difference in the world to me…I can be honest with myself, I can be honest with them… [before Metropolitan adopted a harm reduction approach] I was spending every

> time getting high and trying to lie about it [so he would not suffer the consequences], trying to hide, trying to fudge my way around, just trying to manipulate them and everything. Manipulate myself, lie to myself, and lie to them. (Jesse, 48, Metropolitan consumer)

For Jesse the reduction in anxiety that resulted from his program's move to a harm reduction approach helped him to quit lying to himself in addition to staff, which had a positive effect on his self-image.

Lingering Effects of the COC Model

Like Harriet's experience, many consumers discussed how they first had trouble accepting the positive treatment they received from staff in their current programs:

> I don't trust real fast, and I finally found some people that I could trust. And they had no ulterior motives than to be helpful to me. It was almost like they were catering to my needs, and they didn't judge me. Cause I always thought I was gonna be judged whatever I did. (Rodney, 45, HIVHA consumer)

This is because consumers often came to their programs with understandings of services that were based on their past experiences with COC programs, which caused most consumers to feel uncomfortable upon first entering their current programs:

> I don't have to be afraid to go places and do things now. Because I felt like that at one point when I first got into the program, that I was being watched so to speak. (Male consumer, Metropolitan consumer focus group)

Staff discussions also highlighted the effect that COC programming had on consumers. As the following focus group selection demonstrates, staff perceived consumers' experiences with other homeless services as significant barrier to building relationships and accepting services offered to them in their current programs:

> … [B]ecause of historically what they [consumers] have experienced [has been negative]…So when they come here, they don't wanna receive those

> types of services. And they, I think they automatically believe, like that is what will take place, "someone's going to be telling me how to take care of my business while I'm not going to get the assistance that I know that I need." (Female staff member, Judy's House staff focus group)

Highlighting the points made by this focus group informant, staff regularly detailed how consumers behaved in a manner more consistent with how they might in COC programming when they were first admitted:

> I think that [consumers] come to understand that they're gonna be accepted into a housing program and [they have] to be clean or something, [because] most housing programs that they might have come across in the past might ask that they have six months clean or something like that. (Tanner, HIVHA staff).

According to Tanner, most of consumers' expectations are based around rules that COC programs had regarding substance use. A staff focus group informant who worked in admissions at Allied provided a similar description of the lingering effects of COC programs, but in much greater detail:

> I think I found also like when I'm doing intakes with ladies and gentleman that they'll deny substance use and they'll tell me that they stopped using it and they haven't used in six months or whatever the time frame may be. And I'll keep reiterating to them, that "you know its okay, that you can use you know, you can become intoxicated when you come back to the program?". "We're not judging you on your use, you know that it's okay?" [Then they still say,] "Oh no, I don't use I don't use". Then when they do get into the program, they'll start to open [up]…[T]hey've been around so many different programs where they're almost told what, not told what to say but they think they're trying to tell us what we want to hear that "I don't use anymore". And so they kind of keep it on the low, and so that nobody finds out about it. So I mean getting them to trust us and be able to talk about their use is a really important step for them. That's one thing that I've noticed a little bit is that they're a little apprehensive about admitting their use because they don't think that. They think it might keep them from getting the housing that they're looking for. And we can explain to them that that's not necessary, "you know that we want you to be able to talk openly and honestly with us about it?" But I

> think they're conditioned not to talk about it or to keep it down low [i.e., secret]. (Male staff member, Allied staff focus group)

This staff member points to the strength of the conditioning consumers received in their COC programming. Even though the admissions staff at Allied and the other programs expected consumers to be unfamiliar with the Housing First model and make significant effort to educate them from the point they first make contact with the program, consumers still had difficulty understanding or accepting that abstinence was not a program requirement.

As staff explained it, it was the survival strategies consumers had learned in their previous programs, avoiding staff and hiding or lying, that directed their behaviors when they first entered their programs:

> I think overtime you can start to see a lot of that truths, true, what they really are feeling truly: "I don't want to be sober, I don't want to be abstinence [*sic*], I don't want to go to treatment, I don't, but I want housing". And so I think that's we in the harm, in housing with harm reduction brings a lot of that. Those defenses and those barriers [come] down so that we're getting a lot more of the true nature of what they're really feeling, what they're really thinking, what they're really experiencing. As opposed to "well, I'm going to tell him what I, what he want, what I think he wants to hear". (Manuel, Allied staff)

This statement from Manuel demonstrates this how it takes time for consumers to build enough trust to openly discuss issues with their case managers because of the defenses they entered the program with. The structural constraint that describes the survival strategies of consumers is known as **ritualization**. Ritualization refers to cultural traditions and practices that constrain agency (Fine 1992). Lipsky ([1980] 2010) provides an explanation for this phenomenon in his book *Street-Level Bureaucracy*. Most housing organizations as nonprofits rely on considerable amounts of funding from the

government. As such, these institutions recreate many of the features of a government bureaucracy (see also Lipsky and Smith 1989). In his book Lipsky ([1980] 2010) describes how recipients of public services are taught how to be clients because they learn that program employees can facilitate or block their access to resources and that playing the "rules of the game" are better for them in the long run. Following this logic, the adaptations consumers made in order to gain access to resources in COC programs became ritualized and continued to affect their choices within their current settings.

A consumer informant, Colby demonstrated how important it was for programs to educate consumers about the Housing First model in order to counter the effects of ritualization when he discussed a previous Housing First program he was at that did not appropriately educate him about the model:

> … [W]hat I didn't know is that they could house you for life [at his previous Housing First program]…feeling like I was gonna get kicked out of the program, eventually I just uh kind of terminated my things there while I was still in a good standing…I stayed with my, I got several children, so I stayed with my daughter for a while, kind of moved around with some of my other kids…but [I] eventually ended back up homeless again. (Colby, 60, HIVHA consumer)

What is interesting about this case is that the program Colby is describing in this passage operates is part of the housing collaborative that HIVHA belongs to and has a very similar approach to housing. Despite this, Colby's experience of the program was similar to what many consumers described regarding COC programming. The program he was in apparently failed to educate Colby adequately about the Housing First model. He left the program when he began having conflicts with his case manager because he expected to

be kicked out based on his previous experiences with COC programming, even though this was not the way the program operated.

The Power of Consumer Choice in Housing First Programming

According to almost all of the consumers I spoke with, having choices available to them was one of the most important parts of their current programs. This desire for choice in services helps to explain why so many hard-to-serve consumers rotate in and out of housing, shelters, jails, and hospitals if they are able to meet eligibility criteria for admission (Hopper et al. 1997; Howie the Harp 1990). The following consumer focus group selection demonstrates how central consumer choice in services was to the programs in this study:

> But they did make it clear that they won't be forcing us to go to certain meetings and stuff like that. It's kind of like they're taking different approaches to the traditional AA model, and they, if you feel like that will help you then they do encourage it. So they're kind of like more open to our experience and try to walk with us and kind of give us a voice in how we want to move on instead of just saying "you have to do this, you have to do that…" (Male consumer, Metropolitan consumer focus group)

A selection from Anne, a staff member at Judy's House, demonstrates how staff practices in the programs worked to facilitate consumer choice:

> First we're going to ask "what are your goals?" This is individual centered planning. And working with the head of household to say "what are your goals?" And that this person is responsible for his or her own choices, capable of making his or her own choices. (Anne, Judy's House staff)

As this quote and the previous one demonstrate, choice in services and service goals were highlighted within the programs through consumer education about choice and client-centered service planning practices.

The following exchange in which Darius describes the decision making process he went through with his case manager regarding his psychotherapy and continuing education is an excellent example of how staff enforced consumer choice in their daily practices:

> DW: I want to go back to the question about [quitting psychotherapy]. How did that decision get brought to the table [in your case management meetings]?
>
> Darius: Well alright [my case manager] and I had a phone conversation after I had missed like the third meeting [with my psychotherapist]…He believed that maybe I wasn't interested no more, but I would have loved to continue the psychotherapy because there are still some issues that I need to work on. However, if I'm working from 7pm to 12 on Wednesday and I've got to be up at 7:30 in the morning on Thursday to get to him by 9, and I would always sleep over every time…[My case manager] just helped me decide that some things just have to be put on the backburner. And his statement to me was that he was not going to be angry at me for discontinuing [psychotherapy]. He also said the same thing about school because at one [point] I was thinking that school was too much of a burden.
>
> DW: And what decision did you come to?
>
> Darius: Actually I took a couple months off. I took a two month break for the holidays.
>
> DW: And you're back now?
>
> Darius: Yeah. (Interview with Darius, 38, Metropolitan consumer)

In this example Darius' case manager helped him to understand all of his options so that he could make his own decision regarding the continuation of this therapy. This is very different from the COC program model that I described in the previous section. The following focus group selection regarding a COC program further demonstrates this difference:

> Each client has a service plan, but that service plan is consumer-driven rather than case manager driven. Whereas sometimes [in] the old paradigm [COC programming] it was just a dry laundry list of "these are the things you will do in the next six months". And it really didn't value consumer input so much. (Male staff member, Metropolitan staff focus group)

As this staff member points out, consumer choice was limited in the program they worked at because staff made service decisions for consumers based on standard practices or operating procedures rather than consumer input.

Consumers discussed choice as being important to them because it made the programming more meaningful to their lives by allowing them to engage in activities they felt were important and to avoid those activities that were irrelevant to them:

> DW: [W]hy is it better to let people choose services than to have them, than to say "everybody has to do this and that"?
>
> Consumer 1 (male): Because you shouldn't be forced to do something you don't want to. [A]nd then there's certain groups that they've had in the past you know that I didn't like and it didn't have nothing to do with me or my situation, so I wouldn't go, why waste my time?
>
> Consumer 2 (female): Right.
>
> Consumer 3 (male): Right like they got a relationship group, but I ain't in no relationship so why should I go to the group? I ain't trying to get no relationship. (Allied consumer focus group)

Considering the connections between personal agency and ontological security discussed above, it is reasonable to assume that presenting consumers with more choices also made their decisions more meaningful to them and that these decisions helped them to construct a more coherent personal narrative. This is because the focus that Western society places on individualism makes it more likely that people will perceive choice

rather than structural constraints when rationalizing their own decision making process (Furlong and Cartmel, as cited in McNaughton 2008b).

Why is it then that consumers saw structural control rather than choice when discussing COC programs? Did they not after all choose to be in those programs, and choose to engage in the behaviors that jeopardized their housing? I believe consumers experienced control rather than choice because of the close ties that exist between ontological security and self-concept/self-worth. Snow and Anderson (1987) have demonstrated how, though they are at the bottom of the social structure, homeless individuals still have positive images of themselves that are related to the basic human drive we all have for self-worth (Becker 1971). Consumers experienced or interpreted control because options presented to them in COC programs were generally unattractive (the option to live in highly restrictive housing or be homeless) and inconsistent with they way they saw/wanted to see themselves (as independent human beings with self-worth). This phenomenon has been demonstrated in previous research looking at COC housing programs, which has demonstrated that consumers perceive coercion when housing is used as a leverage for treatment rather than something consumers have a right to as human beings (Monahan et al. 2000; Robbins et al. 2006).

Staff also discussed consumer choice as one of the most important aspects their current programs that was not present in the COC programming they were familiar with:

> DW: Now if you had to pick the three most important policies to that make Housing First work [what would they be]?
>
> Geraldine: I would say meeting the women where they're at, which is the harm reduction.

> DW: Okay, so kind of client centered approach?
>
> Geraldine: Client centered approach with choices. Because you can't have it client centered if you don't know what choices are available, so you gotta give them the choices. (Interview with Geraldine, Judy's House staff)

When staff discussed consumer choice, they largely focused on how it increases consumer responsibility and helps to develop the consumer-staff relationship. The following focus group informant discussed how consumer choices helped facilitate the learning process by making consumers responsible for their own decisions:

> It [giving consumers the choice to participate in services] actually also puts a lot of responsibility on the consumer…it's like okay now you're on their turf and they get to decide what their going to do, what their not going to do. And it actually gives the consumer a lot more responsibility because their making choices, and if they make bad choices they live with the consequences of those choices. And that's a lesson that a lot of people just have to learn. (Male consumer, Metropolitan staff focus group)

This sentiment, allowing consumers to make their own choices helped them to establish connections between those choices and their consequences, was repeated by staff members in every program.

Staff also discussed how providing choices for consumers assisted them in relationship building:

> I think because I'm able to allow the clients more room for self determination, I think that I'm able to build report and build trust, kind of earlier on in the process…Services were not voluntary [at the program I used to work at]. Whereas now I'm able to work with folks, and they're, they come into the program and I did I did the intake with them and they told me that they're using, that they had just used drugs the day before, something like that. And [they] come in, and we'll have an open discussion about drug use and the little, and they might be a little standoffish in the beginning, but eventually we just build report and trust and then they come to realize that "Okay, I just told him that I'm using cocaine or I'm using heroine once a week, and he's not telling me to go

> into, he's not telling me I have to go into treatment. He's asking me what I want". And I think that that's kind of one the main differences is just the self-determination aspect and really being able to respect someone's choices. (Tanner HIVHA staff)

For staff, this is a very utilitarian view of consumer choice. It takes the focus away from the meaning choice has for consumer to the use of consumer choice as a tool that is used to facilitate the work of case managers.

Though it might seem as if consumer and staff perspectives regarding choice are not incompatible, this is not so. While informants perceived structure in COC programs as limiting consumers' choices, the reality is that the structural constraints people encounter also enable them to engage in meaningful social action. This is because, as McNaughton (2008b) has pointed out, structure gives people the capacity to make knowledgeable choices and act on them by providing a guide as to how to operate within their social structure and the resources to do so. In this sense, the flexible structure of each program allowed consumers to make meaningful choices while also allowing them to experience the consequences of those choices, learn from them, and integrate that new information into their personal narratives.

Conclusion

COC programs for housing the homeless have more in common with the institutional programs they replaced, while the Housing First model has more in common with the vision of consumer driven services that guide mental health treatment policy today. The major reason for the differences between the models is the rules structured around substance use in COC programming. Though these rules are centered on the substance abuse aspect of consumers' dual diagnosed disorder, they seep into almost

every interaction consumers have with staff and have significant effects on their overall mental health. Due to the differences between the programs, the consumers I spoke to felt more like a client/patient/object controlled by an oppressive structure in COC programs, while the Housing First programs they were a part of made them feel more like a/an consumer/adult/individual who could exercise personal agency. These findings are consistent with other research in a Housing First setting carried out by Padgett (2007) in which she demonstrated the importance of self-determination, predictability and routine, freedom from supervision, and identity formation to the ontological security of consumers.

The different impacts of these program models on consumer's lives highlight the importance of understanding the connections between social structure and personal agency to mental health in general. Obderateness, symbolization, identification, and ritualization are important aspects of the social structure that have significant effects on ontological security through the impact they have on consumers ability to exercise agency. The sense of social and personal stability gained when ontological security is established can be seen as both something necessary to establish for mental health recovery to happen and an element of recovery itself. I address this in more detail in the following chapter.

CHAPTER FIVE

RECOVERY IN CONSUMER-CENTERED PROGRAMMING, WHAT IT MEANS AND HOW IT HAPPENS

Introduction

There has been a movement within the field of mental health to take a more positive outlook regarding the progress of severe and persistent mental illness (SPMI) since the 1980s (Cohen and Cohen 1984; Harding, Zuben, et al. 1987; Anthony 1993). Consequently a strong recovery oriented research agenda has started to develop in most fields that study mental health and illness except for sociology (see Markowitz 2001; see Yanos et al. 2007). Sociology has primarily focused on the etiology and epidemiology of mental disorder and distress (for a review see Thoits 1999). Sociological research that does study issues related to recovery (e.g., mediating and moderating variables that affect mental health outcomes) has been criticized for not being "sociological enough" because of its over reliance on psychological variables and failure to develop an understanding of social processes to help explain mental health outcomes (Aneshensel 2005; Pescosolido and Avison 2007; Schwartz 2002). Additionally, there has been criticism from within the field that sociology has failed to develop an understanding of the effects that interactions with and within social institutions have on individuals mental health (McLeod and Lively 2007; Schnitteker and McLeod 2005). I attempt to address these gaps in the sociological

literature in this chapter by describing how recovery is understood and experienced by the consumers and staff I interviewed.

Informants Describe Recovery in the Housing First Model

As I discussed in Chapter Two, there are generally two lines of thinking about recovery that exist in the literature. The first argues that recovery is an outcome, defining it as something that is attained when an individual is in complete remission of symptoms and/or compliance/adherence to psychiatric orders (Amering and Schmolke 2009; Corrigan and Ralph 2005; Deegan and Drake 2006). This is a traditional view that has been advocated by the biomedical and 12-step models of recovery (Sowers 2007; White 2007). The second line of thinking has been largely influenced by consumer advocate groups, and it argues that recovery is a highly individualized process people engage in to address issues caused by SPMI regardless of symptom remission or medical compliance/ adherence (Corrigan and Ralph 2005; Davidson 2003; Deegan and Drake 2006). The former of these two views is more likely to be followed by programs that specialize in substance abuse treatment, and the latter is more likely to be followed by programs that specialize in the treatment of SPMI (Davidson and White 2007). A staff focus group informant at Allied described how these differences have translated into significantly different approaches to serving consumers within these fields and the effects this has on consumers:

> …[W]e've encountered this really kind of vicious circle where a substance abuse providers [*sic*] won't work with a client because they're not abstinent or because they feel mental health issues haven't been addressed. Then you send them to a mental health provider and a mental health provider won't work [with] them because they're not abstinent, and they feel they can't for example work with somebody who might be dealing

> with major depression and using at the same time. We don't necessarily share that view and some of the mental health providers that we do work with don't either. They will work with somebody who's whose actively using. But the real challenge is, you've got these two different things going on where the substance abuse community doesn't wanna, won't deal with somebody until their abstinent. And there's this segment in the mental health community that also feels the same way. And so you've got this person that's now caught in this, between two things. And instead of trying to work with the person around maybe what's triggering the use first, and getting to treat some of that, talk about some of that as the genesis of the healing process, you have a person that gets stuck between in the system between these you know two competing kind of things that both have this unreasonable requirement. I don't know any substance abuse treatment provider in the city that will um provide services to somebody who's using actively. Whether that's in an in-patient or out-patient setting…And that's unfortunate. And it's a big big gap in our system. (Male staff member, Metropolitan staff focus group)

As this selection demonstrates, the differences between the ways in which mental health and substance abuse services operate are so pervasive that providers often do not know how and/or refuse to serve consumers with dual diagnoses (see: Anthony 1993, 2000; Davidson and White 2007; Frank and Glied 2006). The gap created by these services systems can worsen the already precarious situations of dually diagnosed consumers; often leading them into encounters with the criminal justice system and/or homelessness (see Hiday and Burnes 2009; see Nooe and Patterson 2010). Because of the Housing First model's emphasis on housing and service provision with minimal requirements, the sample programs were an answer to this gap in services for all of the consumers I spoke with.

Because of the difference between the sample programs' approaches to services and those of the larger system, staff and consumer understandings and/or experiences of recovery were very different from those in COC programs, which largely followed

biomedical- and/or 12-step-based service models. Though consumers and staff recognized that there was a difference between recovery in their current Housing First programs and the COC housing and treatment programs they were familiar with, they found it difficult to conceptualize in words. For instance, Jesse, a consumer at Metropoitan, pointed out how his difficulty in describing recovery in his current program was related to the way he had been taught to understand it prior to his current program:

> Most of us are, brainwashed to believe recovery is abstinence. In that regard…I find it difficult to use that [those] word[s] "in recovery". (Jesse, 48, Metropolitan consumer)

While Patrick, a staff member at Allied, did not feel "brainwashed", he did describe a similar feeling from his point of view as a staff member:

> I think we're so programmed in our society that recovery equals abstinence. I don't agree with that and I think most of our people, from what you're saying, a lot of our people think that. (Patrick, Allied staff)

As these two comments demonstrate, consumers' and staffs' difficulty in discussing recovery was due to their experiences with other homeless services and mental health and/or substance abuse treatment programs (as recovering addicts and/or treatment providers) that followed an abstinence-only approach. Because of these experiences, substance abuse specific recovery, rather than general mental health recovery, was the primary thing informants discussed in interviews when I first asked about recovery. Despite their difficulty and strong focus on abstinence, informants were usually able to discuss recovery in greater detail and with consideration of issues related to SPMI once my conversations with them started to flow. Though they used different words, the concepts related to recovery that consumers and staff discussed were very similar. What

follows is a discussion of four of the major themes related how informants understood what recovery is in Housing First programming. There themes are (1) consumer-centeredness, (2) recovery as a process, (3) recovery as multidimensional, and (4) nonlinearity.

Recovery is Consumer-Centered

When discussing the concept of recovery with me, Stanly at first criticized other consumers for not being focused enough on their recovery because they did not have as many or as large of goals as he did. However, upon reflecting further, he stated:

> *[E]verybody's recovery is different*. Everybody looks at it different…Other people their recovery is just real little simple things that they try to put together. I have a real big huge plan...I can't discriminate and say my recovery's different [better] than somebody else's because what their recovery consists of may be important to them. (Stanley, 40, Metropolitan consumer)

The point Stanly is making in this passage is that *recovery is unique for each consumer*, a view that is supported by new lines of research that have begun to provide evidence that recovery is a highly individualized phenomenon (see Davidson and White 2007).

This sentiment was repeated again and again by informants when they discussed recovery. Demonstrating the similarity between staff and consumers' thoughts on this subject, Anne, like Stanley, discussed how recovery cannot be defined in one way:

> Yeah, it [recovery] can look like many different things…We're not expecting a tenet [consumer] that comes, is always on time to every appointment to see a case manager, that is always participating in everything. We would hope to have those things because we kind of, as our own outcomes [are concerned] we hope to see more women participating in community activities… (Anne, Judy's House staff)

Anne's discussion also demonstrates how informants' perceptions of recovery, as something that is unique to each consumer, stood in opposition to prevailing professional and scientific views of recovery. She does this by stating that she still considers consumers to be "in recovery" when they are not meeting outcomes/engaging in activities that the program would prefer them to. This perspective is very different from the provider-directed model of recovery that is associated with the biomedical model, and it is consistent with current trends in treatment that emphasize client-centered/client-directed services (Davidson and White 2007).

Trevor is another staff member whose statement also highlighted the **consumer-centered nature of recover**:

> I think recovery can really be defined in a lot of ways. It can be, at least a compromise between the agency and the client...if they [consumers] have learned skills to manage their use better or if they have been willing to try a new medication and it's been effective and they're taking it or if they improved their ability to communicate within their relationships or if they have found value in trying something new and therefore they're volunteering somewhere and they're finding value in that. I just think that success can be defined in so many different ways that I mean I would consider that. I, cause I don't think of recovery as either, it's either you have or you haven't recovered. (Trevor, Allied staff)

Trevor's statement highlights two things. First, his description of recovery as a "compromise" between the agency and the consumer demonstrates the importance of consumer input as it relates to recovery. Second, his view of recovery "success" as having multiple meanings and reluctance to dichotomize recovery ("you have or haven't recovered") directly challenge the outcome view of recovery espoused by the biomedical model.

Other staff members' discussions further supported the consumer-centered view of recovery:

> It [the recovery model] defines recovery as meeting the individual exactly *where they're at*, and steering them, helping them steer to where their goals are gonna be. (Geraldine, Judy's House staff)

The phrase "where they're at" was used by staff in all of the programs:

> Well I think [informant states another staff member's name] has said before that every participant's different and they all have different goals. And so, what does recovery look like. I think it really is about meeting the client *where they're at* (Male staff member, Allied staff focus group)

Both of these quotes demonstrate that "consumer-centered" means recognizing that recovery goals should be left up to the individual consumer, and it is the job of the staff to support them in reaching those goals.

Consumer discussions also demonstrated the importance of consumer-centered/ directed goals:

> I can work at my own pace, I don't have to rush everything like I did when they [staff] force[ed] you [me]. I can make up my mind and choose which one [goals] I wanna do. (Grayson, 59, Metropolitan consumer)

Grayson's statement further demonstrates the importance of working with consumers "where they're at" by demonstrating how important it was for his own recovery to work "at my own pace." This phrase was used by other consumers when discussing their recovery:

> The one thing that [HIVHA] did was they gave me the opportunity to make the decision [to quit using] at *my own pace* and [in] my own time…They [HIVHA staff] said, "We'll help you in either way you wanna go". "If you wanna use, we'll help you on that." (Male consumer, HIVHA consumer focus group)

These two quotes demonstrate the significance of the consumer-centered approach to recovery by pointing to the value consumers placed on the ability to work on the issues they felt were important at the pace they were comfortable with.

Recovery as a Process: The Journey of Recovery

When talking about her personal recovery, Amy, a consumer at Judy's House, likened it to a *journey* that she was on:

> Well, I did look at it as an outcome you know, in the beginning, but once I learned more and went to meetings and I learned more about the program then I did see and I do see that it's a[n] ongoing, a *journey* that I'll be on for the rest of my life. (Amy, 52, Judy's House consumer)

Viewing recovery as a journey is consistent with sociological views of mental illness that conceptualize it as lying along a continuum rather than a discrete category (Markowitz 2005). This perspective allows sociologists to take account of and measure various gradations of mental illness. As such, a **continuum perspective of recovery** recognizes that consumers can be in various stages of their recovery process (as opposed to being either "recovered" or "not recovered"). Colby directly referred to his recovery as lying along a continuum:

> I think there's a parameter of recovery or a *continuum of recovery*, let me use that word. And then there are different areas of life experience in that continuum…in that continuum I think there's different areas of recovery and the [my] program has taken me from a place where it was a non-stable area in my life to where it's a very stable area in my life. (Colby, 60, HIVHA consumer)

Other informants recognized that to be considered "in recovery" the goal of the process/journey was *self-improvement*, *betterment*, and/or *growth* along the continuum (rather than the complete elimination of all symptoms):

> [I]t [recovery] means that you always have a goal to *try to do better* for yourself. (Male consumer, Metropolitan consumer focus group)

Trevor, a staff member at Allied, provided a similar perspective:

> I don't think of recovery as…you have or you haven't recovered, *I think of it as a process*, and I don't know if the wo[rd], if I like the word "recovery" really as much as I like *"growth"*. (Trevor, Allied staff)

These two quotes demonstrate that consumers experienced and staff observed gradations within recovery. This contrasts with outcome perspectives that dichotomize recovery and illness as separate and mutually exclusive concepts by demonstrating that recovery is an *ongoing process*.

While the 12-step model of recovery might also be viewed as a continuum or a process, the clear focus this model has on abstinence does imply that there is a recovery dichotomy that exists between those who are sober and those who are not. This stands in contrast to the way that recovery was approached by all of the sample programs, which staff demonstrated when they talked about the *"stages of change"*:

> … [W]e recognize that people have a different *stage of change*, and that there's a spectrum to that. And so we embrace and accept people along that spectrum and try to meet them where they're at…And then based on that, we help them um to achieve their goals. (Male staff member, Allied staff focus group)

The "stage of change" terminology this staff member and other used come from the Transtheoretical Model, which explains the process individuals go through on their way to making changes in their lives (see DiClmente and Velasquez 2002). The model is popularly employed as a tool by clinicians to assure that they are working with consumers in a manner appropriate for the place they are at in terms of their readiness to change their behaviors (see Miller and Rollneck 2002). The use of this model is essential

in Housing First programming (see Tsemberis and Assmussen 1999). This is because the Housing First models' emphasis on housing consumers regardless of mental health treatment adherence or sobriety means that they enter programming without necessarily having a plan or desire to address their mental health and/or substance use issues. A selection from Nora, as staff member at Metropolitan, demonstrates this:

> I think a lot of it comes down to, my students [Nora also teaches in a nursing program] call it the Transtheoretical Model now. [When] I was in nursing school taking my training, it was just called like "stages of change"…Pretty much all major change that has to happen, behavior change is based on that. And looking at the individual in terms of where they are on that continuum. And I think you have to respect that continuum. you can't say, "okay you are now going to give up all your bad habits and live in an apartment" if the person is at the stage of "I hate myself so much I don't deserve anything better than this park bench". (Nora, Metropolitan Staff)

Nora's statement further supports existing process-oriented views of recovery that focus on an individual's attempts to address the issues caused by their mental health problems and to meet their life goals, rather than the ability to meet predefined outcomes (see: Corrigan and Ralph 2005; Davidson and White 2007; Deegan 1988).

Recovery is Nonlinear

Despite their recognition that growth was the goal, informants also described the **recovery process as nonlinear**. What this means is that consumers could *improve and regress along the recovery continuum* and still be considered to be "in recovery" within their program. And this is consistent with the view of most consumer advocates (see: Anthony 1993; Kaufmann 1999; McLean 2009). For instance, Deegan (1988) has stated how recovery "is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup, and start again" (p. 15).

Consumer and staff considered *relapse to be part of the recovery process* because of this nonlinearity. Tanner's thoughts on this issue represent the typical staff point of view:

> I really do think that *relapse is a part of recovery*. I think that anyone who is in recovery has had unsuccessful efforts to stop or control use, and I think that's just kind of, I think, more practical. That's what's happening in people's lives when they're in recovery. (Tanner, HIVHA staff)

Tanner and other staff's reasoning for approaching relapse as part of recovery was purely for pragmatic reasons because they understood symptoms (psychotic episodes, substance use and abuse) as expressions of consumers' illnesses that were bound to express themselves. The following selection from the staff focus group at Allied further demonstrates this:

> You can look at all the stats in the world and it's 75 percent of the people don't, do not stay abstinent or sober, however you wanna put it, after they've been through treatment and things like that. And so *there's gonna be slipups*. And how are you gonna handle those slip ups? Is it one [slip up] and your out? Is it two [slip ups] and your out? I think those are things that are [what need to be considered] if that's the model [i.e., Housing First] that you're gonna go for. (Male staff member, Allied staff focus group)

This staff member demonstrates how it is important for providers working in a Housing First program that accepts people with dual diagnoses to understand relapse as part of the recovery process because they need to be cognizant of how they are going to handle it when it inevitably occurs.

As for the consumer perspective regarding this issue, discussing his experience being kicked out of a COC housing program for a substance use relapse, Jesse stated:

> Those *relapses don't define who I am. They don't define my recovery*. They don't define what I'll be in the future. And they don't negate

> everything I did in that nineteen months [at a COC housing program] …The relationships of primary importance in my life aren't ruined because of those, but kind of even enhanced. My relationship with myself…I know more about who I am and what I am. I'm more comfortable with that. And that helps me to, in a way, I relate to other people, these other relationships [better]. (Jesse, 48, Metropolitan consumer)

Jesse's statement reinforces the connections between relapse and recovery by framing it as a learning experience that helped him to move forward in other areas that were important to him in his life and to his overall recovery.

Valery, a consumer at Judy's House, provided perspective of relapse as it related specifically to SPMI. She provides a unique perspective in that she is a consumer who used to be a social worker. This, combined with her warm personality, meant that consumers frequently came to her with their problems:[1]

> I think people take vacations, people who are mentally ill that I know…[T]hey take their meds, they feel better, and for whatever reasons they stop taking them. And symptoms might reappear…[S]o part of it is, the person that is mentally ill being aware that if they don't take their meds then their going to maybe have some behavioral, some mental whatever's. And [they] either say "I'm gonna go through it anyway cause I'm just sick and tired of these damn medications and their side effects", or because they wanna drink, or because they wanna use. (Valery, 61, Judy's House consumer)

Valery described relapse as a vacation consumers take from their progress. In Valery's understanding, people choose not to take their medications because they do not want to deal with side effects that they often see as being worse than the symptoms of their mental illness or because they get something more from substance use than they do from their medications. This perspective of relapse views it as a rational choice and supports

[1]The fact that consumers came to Valery with their problems was supported through interviews with other consumers and staff.

existing evidence that consumers choose to use medication or not based on how it contributes to their quality of life rather than its ability to resolve their symptoms (see Deegan and Drake 2006).

Recovery is Multidimensional

Informants discussed recovery as applying to *various dimensions/facets of life*, not just the symptoms of mental health and substance abuse. The following four selections from consumers and staff demonstrate how they perceived recovery to be composed of multiple facets. Grayson discussed employment as an important part of his recovery:

> To me it's [recovery is] getting along with everybody, having a job, going out and being sociable. (Grayson, 59, Metropolitan consumer)

Harriet also discussed employment, but she also connected this to the education she would need to meet her employment goals:

> A year in the future? Oh, [my recovery goals are] to have, to learn this computer, get into the technology field, and get to learnin[g]. (Harriet, 51, Allied consumer)

In addition to mental health and substance use, Manuel, a staff member, discussed personal the establishment and growth of personal relationships as an important part of recovery:

> What we want to do is move the participant along in recovery with their mental health, recovery with their substance use, recovery with their relationships, rebuild relationships if that's something they've set as a goal or an idea. (Manuel, Allied staff)

These statements suggest **that recovery is made of multiple dimensions or continuums**, rather than just one, each covering a different domain or area of life.

Research conducted by Ruefli and Rogers (2004) has demonstrated the importance of accounting for different dimensions of life (e.g., housing, family, benefits, physical health, legal issues, substance use, etc…) as they relate to the recovery process in programming that follows a harm reduction approach such as my sample programs did. This perspective is compatible with the individualized/client-centered explanation of recovery that most informants provided in that it reinforces the idea that consumers most likely have different goals related to unique combinations of life areas that might be in need of repairing. In this sense, it is the consumer as a whole person that informants' programs were concerned with, not just the problems that clinicians can medicalize.

Previous research has demonstrated the importance of recognizing that there are multiple dimensions or continuums in the recovery process (see Loveland, Weaver Randal, and Corrigan 2005). Attempting to understand recovery as it applies to "everyday life", Borg (2007) demonstrated the connection between "personal roles, relationships, arenas and ambitions, as well as surrounding social, cultural, and economic/material conditions" (p. 37) as they relate to recovery. Additionally, Anthony (1993) has stressed the importance of multiple services in recovery oriented community care that includes treatment, crisis intervention, case management, rehabilitation, enrichment, rights protection, and basic supports. The importance Borg and Anthony place on these various areas of life and treatment highlight the fact that recovery is more than just the treatment of symptoms.

Colby, a consumer at HIVHA, provided strong description of his own recovery, which demonstrates how it is a holistic process that covers a number of areas of his life and how they are connected:

> If we can relate it to homelessness recovery, for me recovery was going from either living on the streets or transitioning from house to house to house or staying in unsafe environments, to having an apartment of my own, with secure shelter. If I look at recovery for my medical condition, it's going from a place where I'm not taking meds and continually getting sicker, to a point where now I'm 99.9 percent adherent, meaning I'm taking my medications every day, on time, as prescribed. In terms of financial recovery, it means that I'm no longer taking my money and just spending it on whatever or blowing it every week and now being able to budget and making sure that I have funds available to pay the rent, the utilities. To make sure that I have enough food all month and things like that. Going from a place where that wasn't a stable area in my life where that is a stable area in my life. I think there's different areas of recovery and the HIVHA program has taken me from a place where it was a non-stable area in my life to where its a very stable area in my life, in all of those areas. (Colby, 60, HIVHA consumer)

For Colby the key to recovery is stability in the various areas of his life he has pointed to as important (homelessness, physical health, finance). Notice that Colby does not mention mental health or substance use when he discusses recovery. This is because, from his point of view, his mental health and substance abuse problems resulted from the lack of stability he had in his life related to homelessness. This reinforces the connections between recovery and ontological security I discussed in the previous chapter. Though he had encountered other programs before HIVHA, they failed to help him because they did not look at his mental health and substance abuse issues as they related to these other areas, particularly housing. Colby stressed that the most important thing HIVHA did for him in terms of his mental health and substance use was to get him into housing:

> We'll [HIVHA as a program] get[s] you housing. "We [the program] don't care about the other, we do care, but we don't care about the interactions of the other areas in your life cause we'll help you through those." "But the first thing that we're gonna do is put you in some stable housing." "And then as other issues arise, we'll deal with those as they come up to keep you in the stable housing." Like I was sayin', I don't have to be sober, for ninety days…Getting me into that environment became the number one thing to do first, and then out of that we were able to identify what the cause of the problem was, treat the cause, and then go onto to stability in the other areas. (Colby, 60, HIVHA consumer)

Colby considers the admissions policy of HIVHA to be the most important part of the program because it took account of the connections that existed between his mental health and substance abuse problems and his homelessness (I elaborate on the importance of the programs admissions policies to recovery in the next chapter). Once he gained access to housing, these other areas were able to be addressed.

Negotiating the Boundaries of Mental Health and Illness: Combining Theories of Edgework and Social Disability to Explain Recovery

The four themes presented above provide a sense of how recovery was more or less explicitly understood by consumers and staff. The data suggest that **recovery in the programs was a unique, nonlinear process that happened along a multidimensional continuum**. Figure 1 is a visual conceptualization of what recovery might look like taking the themes discussed above into consideration. This conceptualization of recovery challenges perceptions that mental health and illness are dichotomies or that see them as opposite ends of the same continuum. In fact, previous research has demonstrated that mental health and illness are most likely separate phenomena that coexist within the same individual (Amering and Schmolke 2009). For instance, theorizing that mental health was a "syndrome of symptoms of positive feelings and positive functioning in life" (p. 208),

Keyes (2002) has demonstrated that symptoms of mental health have only a modest negative correlation with symptoms of mental illness. The work of Keys and others makes a strong argument for why mental illness and mental health should be treated at separate constructs (Davidson 2003; Davidson and White 2007; Davidson et al. 2006).

Figure 1. Recovery as a Nonlinear, Multidimensional[a] Process that Co-occurs with Mental Health and Illness

[a]The individual dimensions are determined by the consumer, and the number of dimensions will vary based on the individual consumer's situation and needs.

If mental health and illness can coexist within the same person, then recovery must be something different than just the process of reducing or eliminating symptoms, more than just the move from illness to health. My data suggest that recovery, at least in the four programs that are the focus of this work, is instead an active negotiation between the boundaries of illness and health that consumers engage in. The purpose of this

negotiation is for the consumer to improve his/her overall functioning or quality of life in spite of their illness, rather than completely eliminate their symptoms.

Just how did this negotiation happen for the consumers who participated in this study? If I stopped my investigation at this point, the perspective of recovery diagramed in Figure 1 could be understood from an individualized/medical/psychological perspective (i.e., the negotiation between health and illness people engage in could be understood as a function of treatment compliance, resilience, will power, self-esteem, etc…) or it could be understood as a social process. As a sociologist, I am interested in the latter of these two perspectives. I demonstrate how recovery is a social process in the next section. However, it is important for me to first introduce the theoretical tools I used to structure the themes related to recovery as they developed. These tools are the theories of (1) edgework and (2) social disability.

An Overview of the Theory of Edgework

The theory of edgework was first proposed by Lyng (1990) as an explanation for risk taking behaviors. Explaining edgework, Lyng writes:

> Activities that can be subsumed under the edgework concept have one central feature in common: they all involve a clearly observable threat to one's physical or mental well-being or one's sense of an ordered existence…The "edge," or boundary line, confronted by the edgeworker can be defined in many different ways: life versus death, consciousness versus unconsciousness, sanity versus insanity, an ordered sense of self and environment versus a disordered self and environment. (P. 857)

Synthesizing ideas of Marx (Marx and Engels [1846] 1976) and Mead (1967), Lyng goes on to discuss how the primary motivation for edgework is the attempt for the person to apply meaning to their existence in a world where they view their behaviors as being

constrained by oppressive forces. Largely considering the experiences and activities of middle-class risk takers (e.g., sky divers, rock climbers, recreational drug users, etc…), Lyng proposes that the structure of modern capitalistic society alienates individuals from their true selves, and that it is the risk takers attempt to regain meaning in their life by exercising control over life threatening situations through risk taking behavior.[2]

I have already discussed how recovery is a process of negotiating the boundaries between mental health and illness (i.e., sanity and insanity). In this sense, recovery can be considered edgework. However, Lyng's focus on the middle-class limits his theory as an explanatory tool when considering the recovery activities formerly homeless people with SPMI and substance abuse problems. This is because it assumes that people engage in edgework starting on the stable side of the boundary line (life, consciousness, sanity, ordered sense of self and environment).

Taking Lyng's work further, McNaughton (2008b) has used the theory of edgework to explain the risk taking behaviors of marginalized individuals, specifically the homeless and formerly homeless. McNaughton recognizes that a person's resources will affect their capacity to negotiate with risk. She refers to the work of Durkheim ([1897] 2007) and Weber ([1930] 2008) to demonstrate how the anomie inherent in street life and the rational control imposed by bureaucratic structures limit homeless peoples' ability to give meaning to their existence in ways similar to the alienation experienced by the middle class:

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[2]Though the individuals perceive the risks they take on to be life threatening, Lyng points out that a distinguishing feature of edgework the situations are often highly controlled and hold relatively little threat of true harm.

> [P]eople engage in edgework as a means to individually find some self-actualisation [*sic*] or control in the context of increasingly disenchanted, liberal individualised [*sic*] modern society; or to escape the isolation or disaffection they feel by being marginalized [*sic*] and 'poor' within the structural conditions of inequality and poverty that exists. (McNaughton 2008b:72)

The findings I presented in the previous chapter support McNaughton's use of edgework as an explanatory mechanism for the behaviors of homeless individuals by demonstrating the high levels of control and lack of agency experienced by consumers when they lived in COC housing programs. McNaughton argues that people engage in edgework in order to develop a sense of self/ontological security when their personal agency is limited by their resources. In this sense substance use and the refusal to take medication can be seen as edgework behaviors people with dual diagnosis engage in to give meaning to their lives because it is one of the few things they have control over. I will discuss how this can be applied to the recovery process after discussing social disability theory.

An Overview of Social Disability Theory

SPMI is a disabling condition for many people, and social disability theory is useful for considering the effects that SPMI has on people's lives. In the context of a social disability model, disability is seen as stemming from oppression rather than impairment (Mulvany 2000; Shakespeare 2006). From this perspective, it is society that causes disability, not a medical disorder. Society causes disability when it fails to provide appropriate resources for impaired individuals to participate fully in society. Like McNaughton's conception of edgework, social disability theory recognizes how structure affects agency through its effect on resources.

Lester and Tritter (2005) have demonstrated the applicability of disability theory for understanding the experiences of people living with SPMI. They conducted focus groups with consumers and practitioners of mental health services, and demonstrated that consumers experienced both bodily impairment (aligned with the medical model of disability) and social disability (aligned with the social model of disability), which both contribute to their circumstances as oppressed individuals. They suggest that framing consumer experiences through a disability discourse supports evidence that they are treated as less than equal citizens, and that mental health consumers need to "become empowered to act as citizens rather than patients" (p. 666), something they believe can be accomplished through understanding guided by the social model of disability, which can help guide policy and practice.

Social disability theory is an answer to critics of the literature on mental health recovery as being too focused on the individual. For instance, Onken et al. (2007) explain that:

> The recovery literature has a tendency to exhort the power of the individual in the face of insufficient services and outdated treatment philosophies. Limiting emphasis to descriptions of recovery celebrating the unique process generated by the willing and strong individual who combats the illness and reemerges in society able to function can inadvertently perpetuate the myth that those who are psychiatrically disabled can earn their way back into the mainstream of society through simple acceptance of disorder, embracement of recovery, and actualization of self-agency…The lives of people contending with overwhelming symptoms and the role of the larger community in fostering the recovery process are topics that must be examined if we are to accurately represent the shared effort involved in recovering from a psychiatric disability and overcoming the barriers imposed not only by the disability but by the stigma and discrimination linked to the disability. (P. 18)

This individualistic approach Onken et al. (2007) disagree with is compatible with the outcome perspective of recovery that literature has demonstrated to conflict with the experiences of recovering individuals. Taking a disability approach to recovery can address many of the issues Onken et al. point to because it focuses on recovery as a social process. As such, it places attention squarely on aspects of the social structure that facilitate or block an individual's access to rights/citizenship/social inclusion, which is more compatible with the process oriented view of recovery that is supported by the literature and my data.

Edgework and Social Disability Theories Combined

Edgework (specifically McNaughton's conceptualization) and social disability theory view the social structure as the ultimate determining factor in the extent to which a person is able to participate in society as a fully functional and self-actualized human being. When the social structure blocks access to resources, individuals suffer both internally (unable to develop a coherent sense of self/ontological security from the edgework perspective) and externally (unable to participate in society as full citizen from the social disability perspective). What does this mean for recovery? It means that material conditions affect the recovery process through their ability to either facilitate or block consumers' ability to manage risk and to access their rights, both of which have been demonstrated to be important elements of recovery (Anthony 1993; Topor 2001). In this sense, the largest problem for the population of interest in this study is not their mental illness or addiction; it is their marginalization as poor/homeless/formerly homeless people and the way in which the social structure blocks marginalized groups

from accessing resources necessary for recovery (Hollingshead and Redlich 1958; McAlpine and Boyer 2007; McNaughton 2008a, 2008b; Mechanic 1972; Nickens 2005; Prior 1999; Robins and Regier 1991). From this perspective, recovery in the programs I studied hinged on the resources consumers were provided with because they allowed them to exercise personal agency, thus facilitating their ability to attain ontological security (construct a coherent sense of self) and participate more fully in society.

Recovering from Homelessness:

How Housing and Services Increased Agency and Ontological Security

Highlighting the connections between access to resources and recovery, informants often discussed recovery from mental illness and/or substance abuse and recovery from homelessness as the same or co-occurring processes. For instance, Colby's experience I discussed above demonstrated the connections between these different types of recovery by pointing to the connections that exist between them and how stability in housing assisted him in addressing the mental health and substance abuse issues in his life. A different consumer at HIVHA gave a similar description of these connections during a focus group:

> … [I]t [housing] actually made my using better. Cuz like now, I still struggle with my sobriety, and I think I use now about twice a month. Whereas when I was homeless and stuff, I used almost every day or every other day. [I] [d]idn't take no medicine, didn't eat properly, didn't have no place to sleep unless it was on somebody's floor or couch. (Male consumer, HIVHA consumer focus group)

Other informants discussed the connections between homelessness and mental health recovery more explicitly. Nick, a staff member at Metropolitan, discussed the connections between homelessness and recovery in this way:

> Recovery first is, just staying housed. Because that's a recovery from homelessness. And I think right now we have between 70 and 75 percent [of consumers] who are [were] chronically homeless. So the first thing that, that is the primary issue for everyone coming to us. And that is, I think also ties into Housing First, is you're homeless, you're biggest issue is being homeless, so recovery is staying permanently housed. Whether that's with us or whether that is with us for a while and then going somewhere else. So I think that is the first thing. (Nick, Metropolitan staff)

For Nick, getting housed and staying housed was one of the most important parts of mental health recovery for the consumers he worked with. He recognized that as "the biggest issue", homelessness affects all other aspects of a consumer's life, including, and arguably most especially, their mental health.

James, a consumer at Allied, discussed the connections between recovery from homelessness and mental health recovery in a different way. In his interview, James discussed how he no longer saw himself as an alcoholic since obtaining housing, even though he continued to experience health complications due to his drinking:

> I wouldn't say I'm an alcoholic. I abuse alcohol sometimes…But now that I'm getting my vitamins and I'm taking my medications and stuff like that. I feel a lot better, now [that] I've recovered a lot from the way I used to do things in the past…Living on the streets and drinking everyday [was how I used to be,] and now I'm not like that. I can take care of my hygiene better, I've always got food and stuff to eat like that, and I take care of my unit. I'm more responsible that way…I get [got] housing, that's recovering from that [the way I used to be, i.e. homeless]. I ain't out there no more, and I could go out, have a drink or whatever, come back home and chill out. (James, 45, Allied consumer)

From an edgework perspective, the resources James had access to through his program allowed him to better negotiate the risks associated with his substance abuse and maintain a stronger sense of self (so much so that he no longer considers himself and alcoholic),

while from a social disability perspective, they allowed him to more fully access certain basic rights he has as a citizen (housing, nutritional food, health care).

Brenda is another consumer who discussed the connections between recovery from homelessness and mental health recovery in detail:

> Well, recoverement [*sic*] from homelessness to me means having a home and being able to maintain and keep your home going. And then your recovery process from being homeless, this lets you have the responsibility to go to the store, to budget your money and things like that. So you get to a point to me you have recovered from homelessness when you can maintain your independent lifestyle. (Brenda, 61, Judy's House consumer)

Brenda's discussion connects recovery to independence, something that she does not see as being possible when one is homeless. Similar connections between recovery and independence have been made in the literature. For instance, Davidson et al. (2006) have written:

> What recovery seems to entail is that people overcome the effects of being a mental patient—including rejection from society, poverty, substandard housing, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to retain, or resume, some degree of control over their own lives. (P. 38)

Davidson et al.'s statement highlights the connections between mental illness and the loss of control over one's life that can result from a lack of recourses and social isolation, both of which often develop as a result of stigma that has been placed upon the mentally ill person.

Despite the advances to consumer rights that have resulted during the past half-century (see Chapter Two), stigma is still a significant roadblock for the recovery process due to the discrimination and/or expected discrimination that results from it. This is

because, despite growing public awareness of mental health issues, popular society still largely views people with SPMI as dangerous (Frank and Glied 2006; Link and Phelan 2009; Phelan et al. 2000). This perception and its consequences in terms of social distancing have been demonstrated to have serious effects on consumers' self concepts (Amering and Schmolke 2009; Borg 2007; Davidson et al. 2006; Goffman [1963] 1986; Link et al. 1989, 1997; Onken et al. 2007). Additionally, it has been demonstrated that self-concept affects recovery through the extent to which it motivates individuals to engage in behaviors to help improve their lives (Markowitz 2001). For Colby, James, Brenda and others, the access to resources and rights they gained from their housing helped them to at least partially reject or neutralize the stigmatic labels society had placed upon them as homeless and/or mentally ill individuals, thus allowing them to see themselves as "normal."

Becoming "Normal"

Informants regularly connected normalcy with recovery. In the scholarly literature, recovery as normalcy has been discussed as either a return to a previous state of symptom free being and or as the ability to accomplish life goals in important domains such as work, housing, and improved quality of life (Amering and Schmolke 2009; Borg 2007; Corrigan and Ralph 2005; Thomas 2004). Only two of the consumers I spoke with, Stanley and Betty, discussed wanting to return to a previous state of being. For instance, Stanley discussed how normalcy for him was regaining the life he had as a working class person:

> Recovery to me is trying to do everything I can to be a regular productive person. I want a go back to work. I want a have regular insurance and not

> public aid…there's things that I want that I had. I mean I had a house, I had a wife, I had all these things. I had cars…that to me is a normal life…so for to me to say "a normal life" is to try to obtain that stuff that I lost. (Stanley, 44, Metropolitan consumer)

Previous research has demonstrated that gaining a lost identity is more often than not a goal of consumers from middle- or working-class backgrounds (Laudet 2007), and, unlike the rest of my informants, Stanley used to be part of the working class. While he discussed wanting to return to a previous state of being, Stanley was more concerned with regaining things he used to have. Betty, also from a working-class background, made a similar statement. Before this part of our conversation, Betty told me that she wanted to go back to school to become a counselor:

> …[M]y husband just didn't want me to work, but you know I always had great ideas and a lot of em worked, and that's what I would like to do, would be my goal [to get a degree and work as a counselor]. And then have me another nice place, another nice apartment, like I had [when I was with my husband]. (Betty, 57, Judy's House consumer)

Nowhere in their interviews did Stanley or Betty discuss recovery as being symptom free, which suggests recovery was more of a quality of life issue for them than the complete remission their illnesses.

Unlike Stanley and Betty, the majority of the consumers I spoke with were *disadvantaged most of their lives*. They tended to discuss normalcy as higher functioning or controlling the symptoms of their illness so it does not interfere with their lives:

> When I look at recovery, recovery as takin care of your business and not wakin up sick and not wakin up with one idea on your mind and to use and just *doin things that normal people do*. (Ben, 53, HIVHA consumer).

By stating that recovery is to "use and just doing things normal people do", Ben suggests that being normal and continuing to use substances are not incompatible with one another

as long as a person is able to continue to *function independently*. Grayson also connected normalcy to independent functioning:

> I don't think you ever get rid of it [mental illness]. I think you just learn how to control [it]…you *control it* where you can live a *pretty well normal life*…getting along with everybody, having a job, going out and being sociable. (Grayson, 59, Metropolitan consumer)

According to Grayson, consumers can lead a "normal" life with mental illness as long as they are able to *control the symptoms* so that they do not interfere with their functioning to such a degree that they negatively impact social inclusion through such roles and activities as friendship and employment.

A selection from Nora, a staff member at Metropolitan, demonstrates how her view of normalcy was similar to that of consumers:

> Well for a lot of people I think the best hope is that they're able to *function in society*. They're able to have friends, hold a job, basically have what you or I would consider a *normal life*. It may mean that they have to take their medication every day, visit their therapist once a week. But if they do those things they can function. (Nora, Metropolitan staff)

Nora was the only staff member who spoke directly about normalcy as it related to the recovery process. However, the attention staff paid to the various dimensions (housing, physical health, education, employment) of recovery, rather than just mental health symptoms and substance abuse behavior, suggest that they understood at least one aspect of recovery to be higher functioning and independence in multiple domains of life.

What all of the informant statements in this section demonstrate is that normalcy is connected to the **resources people have rather** than the complete remission of their illness. For the most part, the resources consumers had through their programs allowed them to live "normal" lives by helping them to exercise agency (greater control over their

lives) and ontological security (stronger sense of self), both of which have been demonstrated to have important effects on the recovery process by previous research (Davidson 2003; Mueser et al. 2002; Onken et al. 2007). Prominent consumer advocate and researcher Deegan (1996, as cited in Amering and Schmolke 2009) has discussed how the purpose of recovery is the transformation of selfhood: "Recovery often involves a transformation of the self wherein one both accepts one's limitation and discovers a new world of possibility" (p. 13). Exercising agency and developing a ontological security are necessary parts of this transformation individuals must go through in order to establish "normalcy" in their lives (McNaughton 2008b; Onken et al. 2007; Thomas 2004; Topor 2001).

If exercising agency and gaining ontological security is the key to recovery, then how do people get there? While not a study of recovery specifically, McNaughton (2008b) has demonstrated how (1) access to resources, (2) social networks/relationships, and (3) the edgework people engage in affected the degree to which homeless and formerly homeless informants in her study were able to exercise agency, establish ontological security, and transition in and out of homelessness. Research by Markowitz (2001) supports the applicability of the first of these two factors to mental health recovery, as his analysis of items from a longitudinal questionnaire of consumers in self-help groups and outpatient treatment demonstrated that economic stability and social relationships were positively related to life satisfaction and decreases in mental health symptoms. I demonstrate below all three of these factors played a role in helping the

consumers of interest in this study to recognize and exercise their agency in order to transition into recovery.

Housing, the Most Important Resource

Engagement with their programs provided consumers with housing, an important resource that has been demonstrated to be a necessary part of exercising agency and establishing ontological security (McNaughton 2008b; Padgett 2007). In a previous study that interviewed consumers living in a Housing First program, Yanos, Barrow, and Tsemberis (2004) demonstrated the connections between gaining housing and the feeling of being "normal" or part of the mainstream: "housing helps to facilitate a psychological return to a state that is perceived as 'normal' or 'human'" (P. 140). Barry, a consumer at HIVHA, discussed how his housing allowed him to feel "normal":

> Recovery in the [HIVHA program] is living a regular sober life to me. Alright, being able to go home and look at T.V. and sit down and watch a movie you know. Things I wasn't able to do for the last twenty years man. I haven't probably watched a movie all the way through in twenty years man. Since I got my own housing I can watch sit up there and look at *CSI* [*Crime Scene Investigation*] watch the whole movie [television show]…I was so behind in the movies man the last movie I saw on the T.V., at the show was *The Mack* twenty years ago. (Barry 55, HIVHA consumer)

Barry's housing has allowed him to lead what he sees a "regular sober life" because he is able to engage in leisure activities (watching television). While popular images of the homeless might depict people with no commitments or worries who have unlimited time for leisure, Barry's statement paints an image of someone whose life was so chaotic until he received housing that he was not able to engage in simple recreational activities that the majority of "normal" people take for granted.

Other consumers' statements demonstrated how important housing was for gaining access to basic resources and entitlements. In the following focus group selection, consumers from Judy's house discuss all of the resources they were bared access from when they were homeless:

> Consumer 1 (female): A lot of programs don't even come out until you housed. In my case, I could pay for housing, but my credit was bad, so I couldn't get housing. So until I get into somewhere and deal with that problem, I couldn't find anywhere to stay. And I couldn't deal with that problem cause I didn't have anywhere to stay. So I needed housing before I could build my harm part of it [reduce the harmful things in her life]….
>
> Consumer 2 (female): …But you have to have a stable residen[ce] in order to deal with anything….
>
> Consumer 1 (female): …How do you focus on anything else when you don't have an address? I mean how do you do anything if you don't have, you can't even get mail to get income or anything. You can't even get food stamps without an address.
>
> Consumer 3 (female): Even when you submit the applications, and you need to have a contact phone number on the application it's hard to say, "well whose number can I put on the application?". And then, "am I gonna see this person [whose number I gave them] on a regular basis?" so that I can get my messages. It was really difficult to do those things without having, living in a secure environment.
>
> Consumer 1 (female): I actually went and got a job once at a thrift store, and was homeless. And the people got tired of me bringing everything I [own] in this bag [to work] because I'm at a thrift store, and they don't know if I'm walking in and out with there's [their property] or mine. So you need housing. (Judy's House consumer focus group)

Like Barry, these consumers point to a number of resources (e.g., postal services, telephone service, employment) were not available to them because they either lacked an address or because the problems associated with the lack of housing (e.g., stress, the lack of a place to store belongings) were barriers to gaining them. Other informants frequently

discussed how gaining a permanent address assisted consumers in accessing income either because employers are more likely to hire housed individuals or because the government has a location to which welfare entitlements can be sent. Two other important resources consumers gained once they found housing that informants discussed were psychiatric and medical care.

For other consumers I spoke to, the most important things that their housing provided them were personal safety and security:

> I've been in and out of psychiatric ward[s] for awhile but...and I was so grateful to get in here that I could relax. You know how hard it is to relax out there [when a person is homeless]? You have to watch your back and everything. So now I leave my door open, walk outside for fifteen [minutes] [inaudible] I come back and nobody messed [with my property], everything [is] in same place. You don't have to…have locked your door every time you go out. Some people do, but I don't. (Harriet, 51, Allied consumer)

Like Harriet, other consumers discussed the safety and security they gained from their housing as important because it helped them to relieve the stresses associated with homelessness. It has long been established that stress plays a significant roles in mental health and illness (Aneshensel 1992, 1999; Pearlin 1999; Pearlin and Skaff 1996). The largest benefit of this stress removal was that, no longer having to worry about basic survival, consumers relaxed and began to concentrate on other areas of their lives that they saw as important.

Another selection from Barry demonstrates how the provision of housing and services assisted consumers and staff in addressing other issues related to mental health recovery:

Well, like you said, as far as the housing go, most places want you to be

> stable before they give you housing. Now at the time I got the housing I just got out of the nursing home, and I was dipping and dabbling a little bit [with drugs]. I'm not gonna lie to you, with my addiction, but he [my case manager] got me that housing. And that housing helped me a lot because I had a place to go, I had a roof over my head. That's one worry I didn't have to worry about. And that's very important to have something that, you got a roof over your head, you ain't gotta worry about that problem. Now you can start dealing with other problems. But as long as you got somewhere to stay, somewhere you can lay your head at night, you don't got to worry about that during the day. Yeah that helps a lot. (Barry, 55, HIVHA consumer)

For Barry and other consumers, not having to deal with the daily stress of now knowing where they were going to sleep freed their minds so they were able to concentrate on other issues in their life:

> … [T]he most important thing is give them housing first, housing first. And then deal with all the other issues that come along. (Judy's House staff focus group).

This statement demonstrates how staff also recognized housing was a necessary prerequisite for consumers to be able to concentrate on other areas of their lives that they needed assistance with.

The following selection from my interview with Darius demonstrates how the reduction of stress consumers experienced once they gained housing allowed them to work on issues specifically related to their mental health:

> DW: What effect does housing have on your mental health?
>
> Darius: [In] my case is I don't have to worry about it [mental health]. I know it's, that I don't have to worry about it cause I got my housing covered. I just have to work on getting myself better. (Interview with Darius, 38, Metropolitan consumer)

According to Darius, not having to worry about his housing allows him to concentrate on his recovery ("getting better"). Other consumers expressed similar sentiments:

> It [housing] helped me focus on my life a lot. Because you know I had nothing when I came back on the north side [of the city], so I really, like now I usually drink twenty-four ounce cans of beer and that's it. And I used to, [I] could drink drink drink, but now I feel good. So I'm trying to learn the computer. Just trying to do something. (Female consumer, Allied consumer focus group)

Like this focus group informant, other consumers connected reductions in their drinking to a decrease in stress that resulted from their housing.

As I mentioned in the two previous chapters, Metropolitan operated for a number of years with a low-threshold admission policy but required consumers to be abstinent upon entry. This resulted in the program forcing abstinence on consumers who were not ready or accepting of it but who wanted housing (which is in conflict with the Transtheoretical Model/"stages of change" approach they were taking at the time I collected my data). Consumers at Metropolitan discussed how this was stressful for them because they were always afraid of the day they would begin to use/get caught using and be terminated from the program. Consumers then described a vicious cycle where they used drugs as a stress release, and how this led to more stress over the possibility of losing their housing. After discussing how this process affected him, Jesse described how the positive effect Metropolitan's shift to harm reduction had on him:

> I mean these are rules I'm imposing on myself—my apartment has to be clean, my laundry has to be done, all my obligations have to be met. And of course when I'm sitting here writing this [the goals for his individual service plan] I'm thinking "oh, oh, I do all this shit, I can get high". But, so then all that stuff is done, I got a little money in my pocket, [and now] it's really not that important to get high. That's how I mean that this reduction, harm reduction model takes the pressure off you. I mean before it would be the pressure inside myself, "I gotta get high and I gotta hide it…". (Jesse, 48, Metropolitan consumer)

Even though the goal Jesse had in mind when he developed his service plan was to

balance his housing with his drug use, drugs became less important for him as the stress of losing his housing disappeared. This demonstrates how the *receipt of housing and housing permanence were two separate things*, with the latter being just as important as the former.

A consumer who participated in a focus group at Judy's House described why harm reduction is so important when working with "hard-to-serve" consumers:

> Harm reduction is always better because if you take a person that has dual diagnosis and they have issues in which they need to address, harm reduction is what they need. I mean to tell them and say "well hey if you, if we put you in this option and you live here and you mess up, now we're gonna put you back to square one". That's only gonna make they problems they had even worse than they already are. If you take a person that says, "I'm already mentally ill and that I'm already a cocaine, I already use cocaine, I had a house, then I didn't have a house, then I had a house". "So okay, I can work on my issues". "Then I messed up and they put me in the street again". How is that helping? Now you can't work on your issues, and you're back to square one (Female consumer, Judy's House consumer focus group)

The logic of this statement was supported by a consumer focus group informant at HIVHA:

> One of the best things they could give me was [that they] brought me into [HIVHA] with less rules, with no restrictions. Because coming into something new I wasn't a rule follower or restriction follower. I was in most programs were, you'd be sober this amount of time…Like just to be housed in a homeless program you had to be there for ninety days and then you go to another second stage program for another six months, then another program for eighteen months. Then they give you your housing. One of the things that [HIVHA did for me was they took the restrictions away. They said, "We're gonna house you first and then we'll work on everything else after that". And that was the best thing they coulda gave me. (Male consumer, HIVHA consumer focus group)

This consumer's experience demonstrates how the rules/restrictions and stipulations that accompany placement in COC housing programs have a negative effect on consumers

because the permanence of their housing is always in question. Consumers did not know whether they were going to be able to make it through all of the stages leading up to permanent placement or if they were going to be able to hold on to their housing once they got there because they could not be sure, due to their mental illness, whether they could abstain from behaviors that would lead to their termination from the program. As a result, consumers' experiences in their current programs were very different from those they had in their previous housing situations:

> This [program] make[s] it [my situation] real better [than other programs she has been at] because I don't have to worry about going [leaving her housing]. Because I've been with [Judy's House as a] tenant for about a year. And they also had housing [the COC housing program she was a consumer of] and see I've been in they housing one night long, but I moved out of they housing. Then I went to another housing and got kicked out of there. So it [has] been like a long time [since she had stable housing] (Annette, 44, Judy's House consumer)

Though Annett had been kicked out of previous housing programs, she took comfort in the knowledge that she would not have the same experience at Judy's House. The reason Annette and other consumers did not have to worry about the permanence of their housing was because of the flexible structure of their Housing First programs.

Geraldine, a staff member at Judy's House, described why housing permanence was so important from the programmatic standpoint:

> Success is that the woman is not on the streets anymore, that she does have a key and she can come in even if she is too intoxicated, so she can just lay down. For some of our ladies, they will come in, and have a rough weekend, but they will come in the learning center and get a cup of coffee and engage in groups to find out and try to change their life in a different way…But it doesn't mean that when she gets her money that she's not going to use. Success comes from them actually being able to know that they have a place that they can lay their head and then coming in from the cold. (Geraldine, Judy's House staff)

Geraldine is making a connection between housing permanence and consumers' piece of mind. In fact, housing permanence was such an important precondition for positive changes in consumers' mental health that the programs used housing retention as their primary measure of program success (COC programs are more likely to use mental health and substance abuse outcomes, i.e., treatment adherence, as a primary indicator of success):

> … [T]hey [consumers have] had a hard time staying housed. And the basic goal is now we're measuring success based on they're ability to stay housed a longer period of time. (Male staff, Allied staff focus group)

Forming Supportive Relationships

Forming strong consumer-staff relationships considered by informants to be a necessary part of recovery because it provided consumers with social support they were previously lacking in their lives:

> It's like having a good friend that you can talk to and that supports you no matter what. And that's rare for addicts because most of the people that are in their lives, they've ruined the relationship because of the drug use and [Metropolitan staff] has been there for me. (Male consumer, Metropolitan consumer focus group)

While all social service and housing programs offer support, informants' discussions of the support demonstrated that it had a unique quality in the Housing First model. The reason this support was unique had to do with the harm reduction policies and practices of the program (see Chapter Three for a definition of harm reduction), which made the relationships more unconditional than they were in other the COC programs consumers and staff were familiar with:

> Because one of the things is that when my case manager asks me did I use, I can tell him "yeah" and don't feel like I'm being judged. I can tell him "yeah" and not be afraid of what I'm gonna be disciplined with. (Male consumer, HIVHA consumer focus group)

Because they did not have to fear being judged, consumers were able to establish stronger relationships with staff that allowed them to better perceive the support that was being offered to them.

Perceived support has been demonstrated to have independent effects that have more important positive implications for mental health than the actual support people receive (Wethington and Kessler 1986). For instance, in a study looking at the effects of disability on depression, Yang (2006) demonstrated that perceived social support buffered the effects stress related to disability on depressive symptoms in his research participants, but the actual support they received did not. Additionally, Pescosolido, Perry, et al. (2008) have demonstrated that perceived support is so powerful that it can weaken the influence of genetics on the expression of addictive behaviors.

Once consumers were able to perceive support, they were more likely to confide in staff and ask them for help, a form of agency:

> Recovery for me is, they've taught me how to reach out when I really need to reach out. Now when [my case manager] and I first started our relationship, sometimes I'd go three or four weeks without talking to her [because I did not trust her]…[Now] we talk just about everyday. (Darius, 38, Metropolitan consumer)

As this selection shows, recovery for Darius is accessing support, something he was not able to do in the past because it was either lacking or he did not trust enough or know how to. Staff discussions also reflected the importance of the social support consumers received from their relationships with them:

> [I]t's been so long since anybody cared about what's going on with them that the floodgates will just open...But be[ing] able to say, "this is happening and this in my life and it's really bringing me down and I'm afraid I might go out and have a drink or something, or use something", they're comfortable doing that once that relationship is there. Being able to say, "this feels like it's going bad for me; I need some help". (Nora, Metropolitan staff)

Consumer discussions of the support they received reinforced Nora's statement by demonstrating that they did indeed interpret staff actions as "caring":

> …[M]y case manager he really genuinely, genuinely cares about me. I've been to the hospital a number of times, and each time he comes to the hospital and sees me. He don't have to do that, but he takes out his time to do that for me. And I really appreciate that about [him]. (Barry, 55, HIVHA consumer)

In actuality, it was part of Barry's case manager's job to visit him in the hospital. Barry did not understand it this way because he had never been part of a program that was flexible enough to allow case managers to visit their clients when they were hospitalized. Barry experienced his case manager's behavior as "caring", which helped to solidify the relationship between them.

Finally, discussions with consumers also demonstrated that their relationships with staff had a profound effect on how they saw themselves. Rodney was ready to give up on life before meeting his case manager; he discussed his relationship with her as being the main thing to help him begin to see himself in a more positive light:

> Because I couldn't believe that someone was caring about [me] cause I didn't care about me. I was just ready to give up. I was tired of using. I was tired of living with HIV. I was tired of doctor visits. I was tired of appointments. (Rodney, 45, HIVHA consumer)

The importance of relationships with staff to consumers is not surprising considering the significantly impoverished social networks most homeless people have (Nooe and

Patterson 2010), the negative effect that SPMI has been demonstrated to have on the formation of significant social relationships (Wright et al. 2007; Phelan 2005), and the protective benefits of social support in regard to individual mental health (Hartwell and Benson 2007; Pearlin 1999; Rook 1984; Turner 1999). Onken et al. (2007) have discussed how a person's social network is important in helping them to transform or re-author their self-narrative within the recovery process. The importance of social relationships in shaping self-concept has long been established in sociology since Cooley ([1902] 1983) developed his theory of the looking glass self, and Markowitz (2001) has demonstrated how self-concept, an important psychological dimension of recovery (see Davidson 2003; see Onken et al. 2007), is a product of social interaction.

The higher level of social integration mental health patients have has also been demonstrated to increase personal agency, an important component of ontological security and quality of life. In a qualitative study of mental health patients, Ware et al. (2008) demonstrated personal agency that necessary for improving quality of life. For the authors, agency is a combination of an individual's capacity and the social opportunities they have available to them. Social opportunities increase the more socially integrated a person becomes.

Risk Management as Edgework

McNaughton (2008b) conceptualizes edgework as risk management. Risk management is the primary goal of harm reduction (see Chapter Three), the philosophy under which all of the programs in this study operated. Because of this, consumers and staff were well versed in speaking about risk management activities. For instance, Stanley

discussed how the purpose of harm reduction was to give him the tools to "deal with problems":

> Harm reduction is putting ourselves in a better position so we deal with problems that we have (Stanley, 40, Metropolitan consumer)

The primary theme that connected discussions of harm reduction was *safety*. Some of the consumers I spoke with discussed safety as it applied to them personally:

> They offer these harm reduction groups. Like they give you tips or pointers on if you gonna do drugs or alcohol or something like that it should be *safe* ways to do it…they know we be drinking and stuff like that up here. But they say "we rather see you be safe than out there on the streets and hurt", stuff like that…I still drink and just being in here knowing I got a safe place to call home. I can sit in my room look at T.V. or socialize with some of the participants up here. So I think that's like a form of harm reduction for me [to socialize with other people instead of drinking all day]. (James, 45, Allied consumer)

Other consumers discussed safety as it applied to other people, like Rodney who recognized that he needed to start engaging in safer sex. Before making the following statement Rodney told me that his depression and substance use were major factors behind his not engaging in safer sex before moving to HIVHA:

> My first goal was to practice safe sex and *reduce the harm of my addiction*. Not allow my addiction to put me homeless again, not allow it to put me in the hospital again…I didn't practice safe sex a lot [prior to moving to HIVHA]. (Rodney, 45, HIVHA consumer)

Though not discussing harm reduction specifically, the following selection demonstrates the connection that staff saw between recovery and safety:

> I think it [recovery] starts with *safety*. Being *safe*, staying *safe*. It's not a measure of clean time. I think that becomes irrelevant. Well, maybe irrelevant not a good word. But it's not as important, it's not the top of the list. But I think it [is] really reducing high risk behaviors, those types of things. (Male staff member, Metropolitan staff focus group)

From this staff member's point of view, safety meant teaching consumers to reduce their engagement in high risk behaviors, a form of edgework that his the primary focus of harm reduction.

Although they did not call it edgework, the consumers I spoke to understood the risk management they engaged in through harm reduction as coming from one or more of three places. First was not wanting to lose the resources they had gained through housing or wanting to gain additional resources:

> … [D]rug use wise it [harm reduction] has eliminated I'd say 75-80 percent...because I had to get my priorities in order. Do I want this or do I want that. I got cable. Do I wanna have a phone? These little things. Okay, it's only $50 a month to pay for the phone site, but I gotta think, "do I wanna?" I'm compromising more with myself. Okay so $50 worth of drugs, is that gonna last as long as thirty days with a phone. (Brandy, 47, Allied consumer)

Second, was from their relationships with staff:

> If somebody gonna love me and [inaudible] love myself, then it's time for me to love myself a little bit more. And that's when using started becoming a less less priority of mine and abstinence became more of a priority of mine. (Male consumer, HIVHA consumer focus group)

The third was from the choices their programs gave them in their own treatment, which made their decisions to engage services more meaningful:

> DW: If you were forced to stay in the group [therapy session], how would you feel about that?
> Consumer 1 (male): You wouldn't be able to appreciate it, you wouldn't. You would ignore everything that was being said cause you'd be so busy getting ready to get up out of there…
> Consumer 2 (female): …If you go willingly, you go there, you pretty much gonna get a whole lot out of it. But [if you are] forced to be in there, the first thing in your mind is, "I don't wanna be here". (Allied consumer focus group)

I have already discussed the importance of resources and relationships above. Having choices was something consumers had not experienced in previous social services they were engaged with. The way in which social service providers train recipients of their services to be ignorant of their rights so they do not exercise agency has been documented by Lipsky ([1980] 2010). In this sense, they were blocked from agency and gaining full access to their rights. This is problematic considering that the consumer-centered nature of recovery implies a certain level of self-determination, empowerment, and self-efficacy in the recovery process, all of which are necessary for individuals to fully exercise their agency and have been demonstrated to be necessary elements of recovery (Amering and Schmolke 2009; McNaughton 2008b). When consumers were able to exercise agency through making choices, services were more meaningful to them. Because of this, the consumers were able to integrate these choices into their self-narratives in a more meaningful way, hence making those self narratives more coherent with the activities they engaged in.

Conclusion

Recovery in the four programs in this study was a *social process* consumers engaged in that involved the negotiation of the boundary between mental health and illness, rather than the complete remission of symptoms. The goal of this process for consumers was to attain a sense of "normalcy" in their lives through the redefinition of self, rather than the complete remission of their symptoms. This redefinition could only happen once individuals were able to exercise agency and gain some level of ontological security. The programs assisted consumers in this process by providing the resources and

supports necessary for consumers to exercise their rights, participate more fully in society, and effectively overcome limitations imposed by their SPMI and substance abuse. The fact that informants had difficulty discussing recovery due to their previous experiences suggests that the understanding and experience of recovery in other programs was very different. This supports the social disability perspective that social oppression, discrimination, and exclusion are significant factors that need to be explored in the recovery process and highlights the important need for further sociological study of recovery.

CHAPTER SIX

PROGRAM IMPLEMENTATION AND RECOVERY: HOW THE INSTITUTIONAL FIELD CREATED SIMILARITIES BETWEEN THE SAMPLE PROGRAMS

Introduction

This chapter is unique from the previous ones in that I begin to present findings from the structured interviews I conducted with administrative staff. The original purpose of these interviews was to collect enough information to have a decent working knowledge of the programs to guide data collection from staff and consumers. However, as I moved forward through my analysis, I recognized that what I learned from administrative interviews was important for understanding how macro social forces affected the organizational processes that shaped what recovery looked like in the programs. After considering these forces, I discuss how they resulted in the implementation of three features of the programs' structures that consumer and staff interviews demonstrated was key elements of Housing First programming. I then present a social psychological model of the recovery process in Housing First programming as it relates to my findings in this and the previous two chapters.

How Similarities Between the Programs Developed

Previous researchers have demonstrated that wide variation in the implementation of the Housing First model exists (George et al. 2008; Pearson et al. 2007). Despite significant variations in implementation, the programs in my sample were very similar in

terms of their policies and practices. These similarities are important to account for because they shaped the processes that connect consumer and staff understandings and experiences of recovery discussed in the previous chapters to the larger social structure that existed outside of the programs. In this section I discuss those forces and the policies and practices that resulted from them. These policies and practices are what structured organizational processes that resulted in the differences between consumer and staff understandings and experiences of their current programs and COC programs that I discussed in Chapter Four.

Similarities that existed between the programs were the result of influences within the field of housing services that provided incentives for them to implement the Housing First model in specific ways. **Institutional isomorphism** is a term used to describe the phenomenon that occurs when programs within the same organizational field (i.e., a group of similar types of organizations that fill similar functions) begin to look similar to one another due to influences in their external environment (DiMaggio and Powell 1983; Meyer 1985; Scheid and Greenberg 2007).[1] There are three types of isomorphism that can affect organizations. What follows is a discussion of each of these types of isomorphism and how they influenced Housing First implementation in each of the programs.

[1]It is important to distinguish boundaries between fields of services (see Polgar 2009). The programs in this sample can be considered part of the organizational field of homeless services. While it can be argued that the programs are also part of the organizational field of mental health services, I choose to place them with homeless services because: (1) their primary service offered is housing; (2) they receive the majority of their funding for the provision of housing; and (3) two of the programs do not restrict their services to consumers with mental illness.

Coercive Isomorphism

Coercive isomorphism stems from political influences and the need for organizations to establish legitimacy in their field. Coercive influences are stronger the greater dependence organizations in a particular field have on similar sources of support (i.e., funding) and/or the greater the extent to which organization interact with government agencies (DiMaggio and Powell 1983; Hallett and Ventresca 2006; Meyer and Rowan 1977). Coercive isomorphism was the most visible at HIVHA, Judy's House, and Metropolitan. All three of these organizations started calling themselves "Housing First" when funding mechanisms all of the programs (including Allied) relied on for support began emphasizing a Housing First approach.

As I discussed in Chapter Three, HIVHA was part of a larger agency that specialized in housing people living with HIV/AIDS. During the administrative interview I conducted with Sally, the director of all housing programs in the larger agency, she informed me that HIVHA was the first program within the larger agency to operate formally using the Housing First approach (HIVHA administrative interview notes, January 26, 2010). This is because of the requirements of CCHC, the larger housing collaborative, that managed the funds of all its partner agencies/programs. CCHC emphasized that all housing should operate using a Housing First approach. As a result, HIVHA started operating as a Housing First program from its beginning despite the fact that its parent agency had not implemented this model in any of its programs before.

Regarding Metropolitan and Judy's House, each of these programs became "Housing First" programs after the city adopted a 10-year plan to end homelessness

based on the principles of Housing First (Metropolitan administrative interview notes, October 23, 2009; Judy's House administrative interview notes, October 26, 2009). This 10-year plan, like others across the country, was based on the Housing First model (see National Alliance to End Homelessness 2000). It emphasized integrated homeless services to eliminate barriers that have traditionally kept chronically homeless people from finding stable housing by diverting city-managed funds from shelter services to temporary and permanent housing programs. Metropolitan implemented a number of policies and practices associated with the Housing First model as a result of the city's10-year plan (Metropolitan administrative interview notes, October 23, 2009; HIVHA administrative interview notes, January 26, 2010). For Judy's House, requirements attached to city-managed funds simply meant the adoption of the "Housing First" label, since, as the administrative staff explained to me, Judy's House operated under the principles of Housing First programming prior to the city's implementation of its 10-year plan (Judy's House administrative interview notes, October 26, 2009). Both of these programs' decisions were based in the desire to remain competitive in light of local changes in funding policy.

Normative Isomorphism

Normative isomorphism results from the process of professionalization or "the collective struggle of members of an occupation to define the conditions and methods of their work" (DiMaggio and Powell 1983:152). Normative influences affected the programs through the professional networks of homeless service professionals that were the result of the national spread of 10-year plans to end homelessness like the one

implemented by the city the programs were situated in. Advocates for the Housing First model became visible on the national stage after the National Alliance to End Homelessness began advocating for cities to take up 10-year plans in 2000. Since that time a number of networks composed of Housing First advocates and providers have formed. The influence of these networks is highly visible at the time I am writing this, with over 234 communities in the United States having implemented plans to end homelessness based on the principles of Housing First as of 2009 (National Alliance to End Homelessness 2009). All of the programs in my sample were involved in these networks at either national or local levels.

Through my community partner Heartland Alliance, I learned that Allied was one of the programs at the forefront of these trends nationally. Staff at Allied and its parent agency regularly promoted Housing First and harm reduction approaches using the program as an example. In fact, Genie, the staff member I conducted my administrative interview at Allied with, was in charge of these activities within the organization (Allied administrative interview notes, October 23, 2009). Genie told me that she was regularly scheduled to present and provide technical assistance to people and organizations seeking to implement policies and practices associated with the Housing First model. Though it was not part of my data, I was also aware that staff at Allied were participants in a local group of providers, policy makers, and researcher who were seeking to develop better professional and clinical guidelines for assessing the effectiveness of harm reduction practices associated with the Housing First model. I was aware of this information

through my community partner and connections I had made with other providers and advocates for homeless services while formulating the current study.

While Allied was strongly connected to networks on the national stage, all of the other programs were connected to Allied through a local support network established with the assistance of the organization that manages the city's homeless service system monies,[2] and the Corporation for Supportive Housing, a national organization that advocates for the development of permanent supportive housing. Through training and technical assistance offered (largely by staff at Allied), this network was responsible for the adoption and/or refinement of Housing First policies and practices by Metropolitan and HIVHA (Metropolitan administrative interview notes, October 23, 2009; HIVHA administrative interview notes, January 26, 2010).

Mimetic Isomorphism

Mimetic isomorphism occurs when organizations are uncertain of how to operate in the face of changing knowledge and/or services, which results in a form of copying from other organizations that are thought to be implementing new knowledge and/or technologies well (DiMaggio and Powell 1983; Hallett and Ventresca 2006). Mimetic influences shaped the programs through consultation and training mechanisms that led to the frequent sharing of policies and practices between the majority of Housing First programs in the city. Through my community partner, I was aware of a number of trainings and consultations that were organized through the local networks of Housing

[2]This local organization, known as a continuum of care (not to be confused with COC housing), is designed to organize and deliver housing and services to people who are homeless. All communities submit a plan to HUD for the use of federal funding to support permanent housing. Because of this process, local continuums have the ability to set higher standards for program performance than the federal minimum (see Schwartz 2006).

First providers I discussed above. Trainings were largely carried out by Genie and other staff at Allied and its parent agency, and all of the programs in my sample participated in them at one time or another (Allied administrative interview notes, October 29, 2009; Judy's House administrative interview notes, October 26, 2009; Metropolitan administrative interview notes, October 23, 2009; HIVHA administrative interview notes, January 26, 2010). To illustrate I highlight the following passage taken from a brochure that is provided to most programs who take part in the frequent trainings and consultations in the city:

> Programs will not bar or eliminate substance users and those who in [*sic*] engage in other high-risk behaviors from housing. Instead, they will work to reduce barriers to housing and find ways to encourage the participation of those who continue to engage in high-risk behaviors. (Brochure used to educate staff about harm reduction and Housing First practices)

This brochure was used by Allied, Judy's House, and Metropolitan, which demonstrates the strength of mimetic influences on the sample.

Key Features of the Programs that Resulted from Isomorphism

The coercive, normative, and mimetic influences I witnessed within the sample programs often operated as part of tandem or interconnected processes. For instance, changes in funding expectations (coercive influences) led to the formation of professional networks (normative influences), which in turn led to opportunities for the sharing of program policies and procedures (mimetic influences). The end result of the process of institutional isomorphism was four programs that called themselves "Housing First" that looked very similar to one another when compared with the traditional, abstinence-based model that typified housing services prior to 2000.

My analysis demonstrated that three of the features most responsible for differentiating these programs from those operating under a COC service models and structuring staff and consumer understandings and experiences of recovery were: (1) low-threshold admissions policies, (2) reduced service participation requirements, (3) and harm reduction-based policies/practices. All three of these features have been discussed as key features of the Housing First model by other researchers and were part of my selection criteria (Pearson et al. 2007; Tsemberis and Assmusen 1999). I discuss each of these polices separately before demonstrating how they are connected to the larger social structure outside of the programs.

Low-Threshold Admissions Policy

Each of the programs had an admissions policy that was designed to place as few requirements as possible on potential consumers for entry into housing. For example, Nick provided a discussion of this **low-threshold admissions** policy and how it relates to the larger Housing First model:

> Housing First should have as *few barriers as possible*. As long as people for us meet the criteria of dual diagnosis, that they pretty much should be able to get housing. And that we should work to try and get people that housing regardless of what they come to us with, whether that's criminal backgrounds, obviously active substance use or untreated mental illness, lack of an income. (Nick, Metropolitan staff)

As Nick's statement demonstrates, the low-threshold admissions policy was important because it helped consumers to *overcome barriers to housing*.

Research in the sociology of mental health has demonstrated how the social structure creates barriers to services for certain groups by determining who will be eligible and what type of services they will receive (see: Hollingshead and Redlich 1958;

McAlpine and Boyer 2007; Nickens 2005; Prior 1999; Robins and Regier 1991). In terms of housing services, this social selection process is most visible when the demands of programs (e.g., income, criminal background, abstinence, and/or medication compliance) that offer housing to the homeless are too great for hard-to-serve consumers with dual diagnoses to meet (Atherton and Nicholls 2008; Tsemberis and Asmussen 1999). The low-threshold admissions policy that characterizes Housing First programming was developed largely in response to this problem (see Tsemberis and Asmussen 1999). Though it does not completely erase the effects of social selection in the larger homeless system (for instance, programs have limits on how many consumers they can take), the low-threshold admissions policy opens up the eligibility criteria for "hard-to-serve" consumers because it makes it more likely that they will have access to housing by placing less demands on eligibility, while also oftentimes blocking program access for those who have less severe problems.

For staff the low-threshold admission policy was the defining element of their programs that made them "Housing First." For instance, this is what Melinda told me when I asked her to define Housing First:

> To me Housing First means that *housing is*, it's not considered a luxury, it's *a priority*. You know, people...despite what they may have been diagnosed with or dealing with they are entitled to housing. (Melinda, Judy's House staff)

Like Melinda, a number of staff highlighted the importance of the low-threshold admissions in eliminating barriers to services by discussing *housing as a right* that consumers were entitled to regardless of their behaviors or choices:

> I'd just like to add to all of that too is just recognizing that each person has a *right to safe affordable housing*…even if they are currently using substances. (Female staff member, Allied staff focus group)

Tanner also discussed the low-threshold policy as the most important element of programming:

> The most important element in terms of running [a Housing First program] is that you have to have, you have to be open about who you're going to accept. (Tanner, HIVHA staff)

While they were generally unfamiliar with the exact details of the admissions policies in the programs, consumers' discussions pointed to its importance in creating an admissions experience that was simple in comparison to that of COC housing programs. The general narrative in consumers' stories was that someone in the community (e.g., friend, government worker, social worker, clergy member) connected the consumer to the organization, and shortly thereafter a staff member from the program met them somewhere in the community and/or they submitted an application with a social services worker or by going to the program's office. For instance, Brenda first encountered Judy's House through a crisis center:

> I was involved with the ladies crisis center…and they had a housing program [to assist in finding housing]. And as time went on I would talk with my case managers in a timely fashion about housing, and I just happen to be in my case manager's office when she got a call from [a staff member at Judy's House] to tell the ladies that we're having an application date on July the 30th. And she told me, and I was here for the interview for the interview on July the 30th. (Brenda, 61, Judy's House consumer)

Sam encountered Metropolitan through a referral made by a psychiatric hospital he was admitted to:

> I was at [the psychiatric hospital], and I had stayed my length of time that I could stay at [there]…my counselor there said, "I really don't wanna see

> you go back to [the shelter], but that's going to be our only option if we don't find some where for you to go". And so then she researched and found [Metropolitant]. And [staff from Metropolitan] came and interviewed me that day…I was discharged the next day, went to the shelter for one day and came here the next day (Sam, 48, Metropolitan consumer)

Consumer discussions also demonstrated that it took anywhere from one day to more than a year to gain entry into their programs once the process was begun. Despite this, all of the consumers discussed the admissions process as simple. This potentially says something about tremendous barriers to housing that exist in the permanent supportive housing community, which the low-threshold admissions policy seeks to address.

Reduced Service Participation Requirements

Each of the programs had **significantly reduced service requirements** for consumers when with compared with COC models of housing, either requiring participation in case management only or no service requirements at all.

I have already discussed in Chapter Four how interview and focus group informants understood choice in services to be an important part of their current programs. Previous research on homelessness has demonstrated that it is often the desire for social services, e.g., housing, employment, benefits, that lead homeless consumers to programming rather than the treatment services they are attached to (Dobransky 2009b; Hopper et al. 1997). For instance, Scott, Foss, and Dennis (2005) demonstrated that homeless individuals use treatment as a path out of homelessness, i.e., for shelter purposes, in addition to being a path to recovery. This desire for choice in services helps to explain why so many hard-to-serve consumers rotate in and out of housing, shelters, jails, and hospitals if they are able to meet eligibility criteria for admission.

Colby's explanation of the factors that led him to the decision to become a consumer of HIVHA rather than another more traditional housing program (though not a COC program) demonstrates how reduced service requirements can make Housing First programming more attractive to consumers:

> [T]hey [the program operating under a traditional model] wanted people to go into jobs and I'm kind of a self-employed guy. I like working for myself. I don't make a very good employee for anybody. But anyway, they [HIVHA] were willing to work with [me] where I couldn't find any other agency that would work with trying to do self-employment stuff. And so that's the difference between [HIVHA] and any other agency that I've ever been with. (Colby, 60, HIVHA consumer)

Colby discussed how choice in services was the deciding factor for him to engage with HIVHA rather than the other program he was offered a placement in because this other program required his involvement in employment services. His statement also suggests that *choice* was something all other programs Colby had been housed with did not have.

Previous research has demonstrated that open-mindedness of clinicians to consumer decision making and consumer attitudes toward mental health services positively influence help seeking and engagement in treatment (McAlpine and Boyer 2007; Mojtabai, Olfson, and Mechanic 2002; Pescosolido, Gardner, and Lubell 1998). Taking this into consideration, it is reasonable to assume that reduced service requirements are a facilitating factor for consumer help-seeking behavior and engagement in treatment after they are housed. In fact, the Housing First model has been demonstrated to facilitate consumer engagement in supportive and therapeutic services (National Registry of Evidence-Based Programs and Practices 2010). My discussion with Grayson demonstrated how the Housing First model can do this. Grayson discussed how

he avoided participation in services, particularly medical services, until the Metropolitan reduced its service requirements in the prior year:[3]

> Grayson: … [T]hey're giving you the chance to make up your mind. And they're there to help you but you have to do it on your own. And that's what they did with me. They're back there to help me, but I have to make the first steps by myself.
>
> DW: How's that make you feel when you make those steps?
>
> Grayson: It makes me feel like that I'm doing it on my own. That no one's pressuring me and no one's hounding me about it. They're just suggesting that I do it.
>
> DW: And that makes you feel better or worse about doing it? I mean…
>
> Grayson: You know, it makes me feel better. Because then, that sort of brings pride into it cause you're doing it on your own, and your helping yourself without nobody else helping you. (Interview with Grayson, 59, Metropolitan consumer)

Grayson's statement is reflective of those of other consumers I discussed in Chapter 4 who felt that their services were more meaningful to them when they had choice over which ones they would participate in. This is also supported by previous research conducted within Housing First programming (Greenwood et al. 2005).

Harm Reduction-Based Substance Use and Eviction Prevention Policies

Harm reduction focused policies and procedures stood out as the *most critical* element for running a successful Housing First program in all four sites. Since I have already presented a detailed definition of harm reduction (see Chapter Three), I use a selection from my interview with Nora to briefly reintroduce the concept. Nora used the example of cigarette smoking to explain her understanding of harm reduction to me:

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[3]This change in policy regarding service participation happened alongside the Metropolitan's integration of harm reduction policies (see Chapter Three and Chapter Four).

> I've worked with people long enough to know that some people are ready to quit [using substance] and some aren't. And if they're not ready to quit, then the best I can do for them is to say, "okay let's talk about cutting down on your smoking". "Let's talk about seeing how long you can make a pack last". "Let's talk about doing one less cigarette a day or seeing how few cigarettes you can smoke in a day". That's how I do it. When I know this person's not, you know if I say to them "okay, you're smoking too much you have to quit end of story", that's not going to do any good. But to start with "okay, you're maybe not ready to quit I can hear that from you". "Let's see if you can talk about making that pack last longer, smoking fewer a day"; you know, harm reduction. At least if they're smoking fewer cigarettes they're doing less harm to themselves. (Nora, Metropolitan staff)

Nora's discussion points to risk management, an important part of the recovery process described in the previous chapter, as the main concern of harm reduction. From the harm reduction perspective, services should work with consumers who are not ready to give up negative behaviors, i.e., primarily substance use, by helping them to choose to engage in those behaviors in a manner that is safer for both themselves and the community.

Staff regularly discussed the essential nature of harm reduction as a component of the Housing First model. In fact, the staff at Judy's House had difficulty describing the difference between the Housing First model and harm reduction:

> [A]ll the time harm reduction [and] Housing First are working hand-and-hand [*sic*], you can't have one without the other at [Judy's House], you just can't" (Female staff member, Judy's House staff focus group).

When asked staff at each program to describe to me the difference between harm reduction and Housing First model, they often discussed Housing First as being synonymous with the low-threshold admissions policy that gets consumers in the door, where harm reduction was the practice or "tool" used to keep them housed:

> At one point I think maybe one [Housing First or harm reduction] becomes dominant…[P]articularly in, when you're doing case

> management, I think harm reduction is in the forefront because that's the practical application…but Housing First is the philosophy we're working from, which encompasses harm reduction. (Male staff member, Metropolitan staff focus group)

Tanner provided a description of harm reduction as it applied to a consumer he was working with when I asked him to define success:

> How do I define success?…I guess I would just use the example of a client of mine who, he's in a, I don't know if I like the term, but kind of like controlled [substance] use. Where I mean he still uses, he still is able to meet his needs with that use and then still be able like he pays his bills every single month. He pays his rent on time every month and makes his doctor's appointments. And he doesn't really suffer from a lot of physical complaints. (Tanner, HIVHA staff)

As Tanner demonstrates, one marker of success for consumers from the program's point of view is their ability to stay housed, which includes risk management. In fact, overall consumer housing retention is the primary outcome used to define housing programs' success at the local and federal level. According to email communications with a staff member in the development department of Allied, HUD's minimum standard for housing retention is for "at least 77 percent of homeless persons staying in permanent housing remain in permanent housing for at least 6 months", but "locally [in our continuum of care], we have set the bar much higher—at least 85 percent of those served [should have] remained in permanent housing for at least 12 months" (personal communication with Allied administrative staff, April 15, 2010).[4] Each of the programs in my sample has a housing retention rate that is at or above this local standard.

[4]I confirmed this information by looking at the funding renewal application for the local continuum of care that managed the city's homeless system funds.

Eviction prevention is a specific subcomponent of harm reduction that was an important part of the process for keeping hard-to-serve consumers housed in light of behaviors that would have resulted in their being evicted from a COC program (e.g., failure to participate in services, substance use, non-compliance with treatment, disruptive behavior, etc…). The most frequent behavior consumers and staff pointed to that needed intervention was for non-payment of rent/service fees. The only behavior that could lead to immediate eviction in any of the programs was violent behavior (and in some cases the threat of violent behavior). All of the programs had different processes to prevent eviction, from informal practices to formal policies, but there were large similarities between the overall approach. A staff focus group member at Allied gave a strong description of eviction prevention that applied to all of the programs:

> …I think what we do in order to sort of help that [i.e., prevent eviction] is sort of is just continue to be aware of problems that are going on, sort of help prevent some of the things by engaging [consumers]. If we have to hospitalize somebody because they're off their medication, they're having psychotic episode and it turns violent and we hospitalize them and get them stable again. [We] [t]ry to reach them before it becomes a problem…Be aware of what's going on, aware of conflict and try to have some conflict resolution if there's ongoing conflict within the program. I mean really the, like I mentioned earlier, the only reason, the only thing that will get you discharged immediately is violent, very violent or aggressive behavior. [It is] very hard for us to tolerate those behaviors because of the safety of the person, the individual, and the community. (Male staff member, Allied staff focus group)

As this statement demonstrates, the process of eviction prevention generally involves being vigilant of consumer behaviors that could lead to eviction before they get out-of-hand and advocating on behalf of the consumer when they break program or property management rules.

Discussions with consumers reinforced the importance of eviction prevention, as they told stories of themselves and of others who were able to remain housed thanks to the policies and procedures related to it. Darius, a consumer at Metropolitan explained how his case manager worked with him when he got behind in his rent:

> Darius: …[It was] probably six or seven months after I moved in, I relapsed. So, I went through a period of drug addictions like [I thought] "I'm not going to be able to do this one or the other has to go". The option was to continue to use drugs and move home with [my] ma [mom] or stay at my apartment and get, pay my bills, which leaves me no room for using drugs.
>
> DW: And how did they [the staff] work with you on that issue?
>
> Darius: They actually helped me out. I had fallen behind on rent for a few months, so they gave me the opportunity to make up the rent that I hadn't paid… (Interview with Darius, 38, Metropolitan consumer)

Chester, a consumer at Allied, explained how his case manager advocated to their property management agency for him:

> DW: Have you ever had any run-ins about breaking the rules?
>
> Chester: Oh yeah.
>
> DW: Do you remember one of those times?
>
> Chester: Yeah about a month ago I had, they found some beer cans in my room
>
> DW: How did they [the staff] approach that situation?
>
> Chester: …[T]hey [the property management] was talkin about puttin me out, but my counselor [case manager], I guess they told em that I was no real problem up here, so they just gave me a new treatment plan.
> DW: Okay, so the property management was talking about kicking you out or of the program?
>
> Chester: Yeah.

> DW: Okay, and so they interfered with the property management to get them to let you stay?
>
> Chester: Well the property management talked to them, and I guess they gave me a good report, so the property management let me stay. (Interview with Chester, 51, Allied consumer)

Chester would have become homelessness again if his case manager had not advocated for him to the property manager of the building Allied is located in and prevented his eviction.

As I discussed in Chapter Four, consumers regularly described harm reduction as increasing their sense of security or reducing the stress and/or fear related to the possibility of losing their housing. Informant interviews demonstrated how this reduction in fear resulted in consumers being more open with staff:

> I would go into a treatment program for thirty days until the next check came. With this harm reduction I don't have to do none of that. [My case manager] come over to my house [and asks], "When was the last time you used?". [And I will say,] "Oh yesterday". [And she will say,] "Was it okay for you? Did any crisis come up?". [And I will say,] "You know, no, didn't no crisis come up" or "Yeah a crisis came up; I didn't pay this bill, I didn't pay that bill". (Male consumer, HIVHA consumer focus group)

This consumer did not feel afraid to discuss his substance use with his case manager because he knew the case manager would help him rather than punish him for his use. A selection from Nick demonstrates how staff also understood harm reduction policies and practices to improve consumer-staff relationships. In this selection, Nick is discussing how relationships between consumers and staff improved after the introduction of harm reduction policies into the program:

> I am finally starting to see uh the residents open up, to be straight up honest and to even take the initiative to say, "I'm ashamed of myself, I used yesterday". And we can explore that a little bit. And we can explore,

> what are the things that played into that. We can talk about what you [the consumer] learn[ed] from that. We can talk about trying to build [their self] up a little bit, like [get them to understand] "you haven't lost anything". "Look how much better you are this time that you used than other times because of things you've set in place". People are willing to be honest. People are saying things like, "I'm not scared to lose my housing". And it feels good to know that we aren't, that people know that that's where we stand. And that they aren't going to end up homeless because they can't manage their addiction. (Nick, Metropolitan staff)

These improved relationships made it more likely that consumers would see their *case managers as a source of support*, rather than an authority figure that should be avoided.

In the previous chapter I discussed how social support was an important part of the recovery process in the programs and how research has demonstrated that support, particularly support that is easily perceived by consumer, is capable of buffering the negative effects of stressors on mental health (Hartwell and Benson 2007; Pearlin 1999; Rook 1984; Turner 1999; Wethington and Kessler 1986; Yang 2006). The findings presented above demonstrate that one of the key mechanisms for increasing perceive social support for consumers was harm reduction because it fostered *stronger relationships* with staff. This is important considering that relationships with service providers are often some of the most significant, if not the most, significant relationships homeless/formerly homeless people have due to the demonstrated poverty of their social networks (see Nooe and Patterson 2010)

It is also likely that the strong relationships that developed through the use of harm reduction had a positive effect on ontological security for consumers because it increased their sense of mastery. Having strong connections with personal agency, mastery refers to the sense of control a person has over their own life. Like perceived

social support, mastery can also be affected by the quality of social interactions, and it has been demonstrated to be inversely related to mental distress (Pearlin 1999). For instance, Wright, Gronfein, and Owens (2000) demonstrated that the sense of mastery within a sample of deinstitutionalized mental health patients was weakened by experiences of social rejection in their lives. The results of their study demonstrate the importance of social integration to consumer's ability to exercise personal agency, which is supported by my findings.

A Social Psychological Model of Recovery in Housing First Programming

Macro structural forces resulted in the implementation of the key elements described above through the process of institutional isomorphism. These elements created a unique "Housing First" service structure, which, as I demonstrated in Chapter Four, was considerably more flexible than that of the COC housing models. This flexible structure is in turn the foundation upon which consumer and staff understandings and experiences of recovery I described in Chapter Five were built on since it helps to assure that consumers will obtain the important components of recovery related to ontological security: housing, social support, and the ability to manage risks. When considered together, a more nuanced understanding of the recovery process within the programs begins to take shape.

The social stress perspective helps to explain how the flexible program structure affects the recovery process. This perspective is largely concerned with identifying the social and structural conditions that serve to harm or improve mental health outcomes by helping to determine number and types of stressors people encounter in their daily lives

(Aneshensel 1992; Pearlin 1999). In the programs I studied, the flexible service structures allowed consumers access to housing through the low-threshold admissions policy and helps to assure that they will stay housed through the use of harm reduction, primarily eviction prevention policies/practices. Additionally, reductions in service requirements that were a part of the flexible structure made programming more meaningful to consumers, which resulted in those services consumers choose to engage in being more effective. However, there is one more piece of the process that needs to be considered.

I demonstrated in Chapter Four that there can be a lingering effect of COC programming on consumers, in terms of both their attitudes and behaviors. Because of this effect some consumers continued to act as if they were in a COC program when they were first admitted, avoiding staff and lying to them, because they believed and acted as though they would be kicked out of housing if they got caught engaging in "unacceptable" behaviors, primarily substance use. This prevented consumers from perceiving and accessing the full extent of staff support available to them. It also perpetuated their mental health symptoms because they continued to live with the anxiety that they might lose their housing if they broke the rules, which in turn increased their potential for substance abuse. The only thing that broke this cycle, though not for all consumers (I discuss this further in the following chapter), was education about the Housing First model and its associated policies and practices. Brant, a staff member at HIVHA, highlighted the importance for consumers to understand the Housing First model; he stated:

> …[Consumers] come to understand that they're gonna be accepted into a housing program and [they have] to be clean or something, which most

> housing programs that they might have come across in the past might ask that they have six months clean or something like that. (Brant, HIVHA staff)

As Brant points out, consumers generally have little understanding of the Housing First model *upon entry* to their programs, which makes it necessary for them to educate consumers so that this understanding will develop, as it did for the majority of consumers I interviewed, over time.

Metropolitan provides an excellent example of how educating consumers in Housing First and harm reduction policies led to changes in consumer staff relationships and improved behavior. The constant threat that consumers at Metropolitan perceived before the implementation of harm reduction was a chronic stressor that they had to deal with on a regular basis (see Chapter Four), and chronic stressors have been demonstrated to have a greater negative impact on individual mental health than stress associated with an isolated event (Avison and Turner 1988; Simon 2007; Wheaton 1999). The constant threat of having services terminated was discussed by some consumers as exacerbating their substance use due to the need to self-medicate. The program's switch to harm reduction removed the threat of program termination for substance use. However, *the change in policy/practice was not enough to affect consumer outcomes on its own*. As I discussed in Chapter Four, Jesse's relationship with his case manager did not begin to develop in a positive way until he learned through repeated violations of the rules that Metropolitan's shift to harm reduction meant the program was going to work with him to address his high risk behaviors rather than terminating his services. Jesse's story

demonstrates how it took time for consumers to learn what these new rules meant and to trust that they would be consistently enforced:

> I mean I had heard [about the program's switch to harm reduction], but I wasn't aware of what that meant or how that would work or what it would look like and exactly how that would relate to me. (Jesse, 48, Metropolitan consumer)

Therefore, it was the strategies that the program used to inform and educate consumers that lead to a reduction in fear and, consequently, substance use for some consumers:

> But as far as policy is concerned in making the switch to a harm reduction model, they let us know that clearly, even in one of my meetings with my case manager. They're real clear about, after a group meeting you know, then the one-on-one [discussions] [inaudible], you realize that your housing is not tied to your ability to remain abstinent. So it was nice that they made it clear when they made the switch. (Male consumer, Metropolitan consumer focus group)

This demonstrates that consumers needed to understand the changes the program was making in order to attach the meaning of security to the policy.

McLeod and Lively (2007) have argued that more attention needs to be paid to the social processes that shape the perceptions, meanings, and emotions associated with stress inducing stimuli. The experiences and attitudes of consumers at Metropolitan pre- and post-harm reduction implementation demonstrate how perceptions and meaning can positively influence consumers' levels of stress. Even though consumers were *not suffering consequences* related to the abstinence-based policies the program had, they *still had fears* that they would lose their housing when staff became irritated enough with their behavior. Even though the practice of Metropolitan did not change, consumers began to feel more at ease once the program shifted to harm reduction and they began to understand what this meant for them:

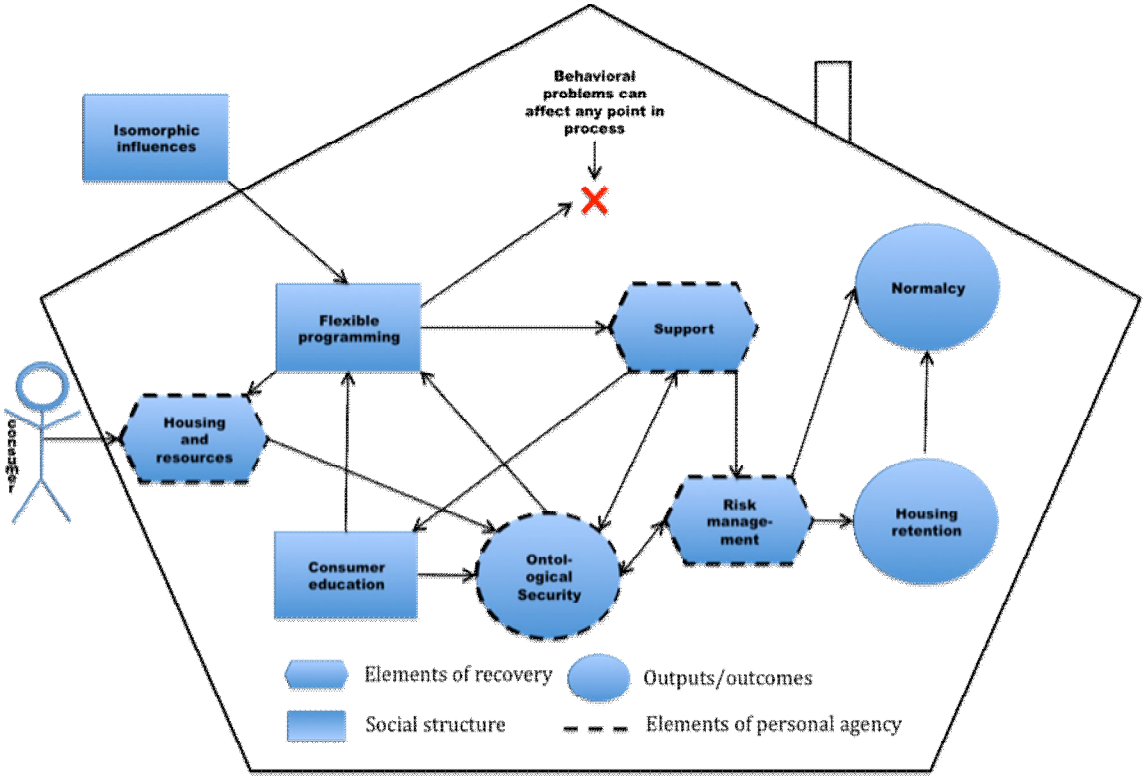
> We also had a client that we had a conversation with a while back that, he reported that his use has actually decreased because the stress of worrying about "I'm going to lose my housing if I've been, because I've been using" has been removed, it's not on the table…and now that that's been removed, some of those reasons for using have mitigated some what. And so his use has decreased over some time. (Male staff member, Metropolitan staff focus group)

Figure 2 is a representation of the general "Housing First" recovery process in the four programs taking into consideration all of the factors related to recovery considered here and in the previous two chapters.

As I discussed above, the low-threshold admissions and harm reduction that are part of the flexible structures of the programs work together to reduce consumers' levels of stress by giving them access to housing, an important resource for recovery, and putting procedures in place to assure they will not lose it. Reductions in fear related to possible housing loss also result in improvements in consumer-staff relationships (i.e., social support), which, in turn, made harm reduction more effective since consumers were more likely to out staff assistance when they engaged in behaviors that placed their housing at risk. This in turn affected the level of support consumers perceived from those services. Increased support led to improvements in functioning, which in turn led to the final outcomes. Increased housing retention was the primary outcome of concern for the programs, while a feeling of normalcy was the primary outcome of concern to consumers (staff have interests in both of these outcomes). All the while through this process, behavioral problems threatened consumer housing retention. However, the flexible program structure, largely through eviction prevention/harm reduction helped to assure the final outcomes would be achieved. Finally, education has been demonstrated to play a

large role in the development of mastery (Mirowsky 1995), so it is likely that strategies that informed and educated consumers about policies and procedures positively affected this resource.

Figure 2. Model of the Recovery Process in Housing First Programming



Conclusion

Previous literature has demonstrated that programs often make significant adaptations to the Housing First model. However, the programs in my sample were very similar in terms of implementation as a result of isomorphic influences that existed in the institutional field of homeless services. Consumer and staff interviews demonstrated that there were three key features of the service structure that make the programs unique from other models of programming. The low-threshold admissions policy, reduced service requirements, and harm reduction policies and procedures implemented by the programs made their service structures significantly more flexible than that of COC programs I described in Chapter Four. It is not surprising that consumer and staff interviews pointed

to these features as being distinguishing features of the programs considering that they were all part of my sample selection criteria I outlined in Chapter Three.

Considering the uneven power relationships inherent in mental health and social services and the personal and group histories of oppression that consumers have experienced mechanisms to educate consumers about policies and practices are necessary for programs with flexible service structures. Without this education, programs run the risk that consumers will continue to act as if they are in highly structure programming. This demonstrates that education is a fourth key element of Housing First programming that is separate from but related to the flexible service structure. Consumer education is something that previous literature regarding the Housing First model has not discussed.

The recovery process I outlined in Figure 2 demonstrates how consumer and staff understandings and experiences of recovery hinged on the presence of a flexible service structure and mechanisms to educate consumers. While his is the general process of recovery my data point to, I also noticed several contextual differences between the programs that influenced the four key elements in particular ways, making them more or less effective. I describe these differences in the following chapter.

CHAPTER SEVEN

CALMER ON THE SURFACE: UNDERLYING DIFFERENCES BETWEEN THE SAMPLE PROGRAMS AND THEIR EFFECTS

Introduction

I have argued that institutional isomorphism led to four "Housing First" programs that looked very similar on the surface. Deeper investigation revealed *several subtle differences* between them that were the result of internal and external forces that were part of the programs' organizational contexts. I highlight these differences in this chapter and discuss their effects on the two most important dimensions of the programs' structures (1) the level of flexibility in the programs' service structures and (2) the degree to which consumers were educated about Housing First policies and practices (see Chapter Six). After discussing differences between the programs, I present a typology of Housing First programming based on observed variations in these two dimensions and their effects (both observed and hypothesized).

Structure of Housing and the Separation Between Service and Housing Providers

Informants' discussions in focus groups and interviews demonstrated that the **degree of separation between the providers of services and providers of housing** had a strong effect on consumer-staff relationships. As discussed in Chapter Three, I purposefully selected the programs so that they varied in the structure of their housing.

The housing at Allied and Judy's House was project-based (all housing and services were in one location), while the housing at Metropolitan and HIVHA was scattered-site (housing was located throughout the city in buildings operated by private landlords). As I demonstrate below, these differences in housing had a noticeable effect on consumer-staff relationships.

Because the potential for monitoring was greater in project-based programs, consumers were highly aware of the rules at Judy's House and Allied:

> … [Sometimes I] wake up with some kinds of attitudes because you don't live like you supposed to when you want company. Or you can't do what you wanna do cause there's too many rules that a grown person shouldn't have. (Janet, 47, Judy's House consumer)

Brandy expressed similar sentiments regarding the rules at Allied.

> … [I]t can be like aggravating with the staff too, like you know that they're lurking. It's like "why are you asking me or like knocking on my door for like crazy stupid shit?". [Staff bother consumers and ask things like] "You wanna go to a relationship group?", stuff like that. (Brandy, 47, Allied consumer)

While consumers at Allied and Judy's House frequently made statements like these, they were all but absent in the scattered-site programs. This frequency in the project-based programs demonstrated that consumers were much more aware of and bothered by rules at these programs than they were in the other two.

While there were many examples of positive relationships described by consumers in the project-based programs, interviews consistently demonstrated that their awareness of rules combined with the conflict inherent in case managers' roles as both *consumer advocates* and *enforcers of program rules* led to greater levels of indifference and/or negativity on the part of consumers:

> My case worker, me and him always going at it cause this dude, it be like he be singling me out for some reason…We [he and other consumers] have caught him listening [at our] doors. One time I snatched the door open so quick that he almost broke his neck falling in my door. I'm like, "what the hell is you doing at my door listening?" "What is you trying to hear?"…He'll knock one time and then next thing you know he came in. Coming in, I don't like that when they just came [*sic*] in your room. I don't like that at all. I can be in there with my woman getting my groove on [or] whatever, and I don't like that when they just came [*sic*] in your room. (James, 45, Allied consumer)

James's statement demonstrates how enforcing program rules can make consumers feel as if they are being monitored and having their personal boundaries violated and how this is problematic in terms of their forming relationships with staff.

My discussions with staff at Allied and Judy's House supported consumers' experiences. Case managers at these programs often discussed how *it was difficult for them to act as advocates* because they had to enforce the rules of housing. Sarah, a staff member at Allied, discussed how this lesser degree of separation affected her:

> [Y]ou know, that is something that I've struggled with…let's say they're not paying their program fees, so where does that enforcement come from? Does that come from me reminding them?…I'm trying to work with them to maintain their housing, and then, but I'm also the one reminding them, well they're violating [their lease]…[T]he difference is like if I worked at scattered-site, if there was an issue it would be the landlord going to the participant, going to the participant and or the caseworker, saying this is the problem that I'm having and it's up to us to advocate for them, instead of [me] work[ing] both roles…[in scattered-site housing] my relationship with the participant [could] be solely [about], "how can I help you maintain your housing here, if that's what you want?". (Sarah, Allied staff)

As Sarah points out, the lesser degree of separation between their duties as advocates and rule enforcers led to significant role conflict for project-based case managers. Jane, a staff member at Judy's House, also discussed this conflict:

> [T]he way the process is goin is that the case managers and property management and the eviction prevention individual [are] work[ing] together as a team [to] come up with a plan…Then they say "well she's [the client in question] [is] gonna be on [eviction prevention]". "She's gonna work with our homeless prevention specialist"…After so many months then it goes to the next level which would be…[the] Executive Director…Even if we [the team that includes the case manager] voted [that] we think that she needs to be evicted, we think this is not the most appropriate place for her, they [administration] make a determination [that] they're not going to file an eviction [that they are] gonna go ahead with the eviction. We've voted [the team that includes the case manager], [and] it's been decided that an eviction would probably be the best recourse for individuals, and they've [administration] turned [our recommendation] down. (Jane, Judy's House staff)

The case management staff at Judy's House are acting as the advocate for eviction, i.e., arguing in favor of eviction for a lease violation, in this example, while the administration is acting as the consumer advocate by overturning case managements' decision. This is a *reversal of the way that eviction procedures worked* in the other three programs, where case managers' primary duty during eviction proceedings was to protect the consumer from losing their housing. Jane and other staff also discussed how the program's refusal to enforce what they thought were necessary evictions frustrated them as they tried to carry out their jobs. I discuss this in further detail below.

In contrast, at the scattered-site programs the roles of case managers and property management were much less blurred, and this had a positive effect on consumer-staff relationships. This was largely due to the fact that case managers only worked with the property management to assist them in addressing the concerns they had about consumers and their behaviors. Therefore, case managers could not enforce property management rules directly. This meant that case managers were more freely able to *act as advocates*

for consumers. This was demonstrated in consumer discussions about the staff at the scattered-site programs. One consumer stated:

> I got in a lot of trouble when I first got into Metropolitan cause I went off the wall. Geez, I mean I missed my service fee I wanna say four months in a row. And just was getting high and just didn't care. I mean things were really out of control, but they really advocated for me. I mean building management was ready to get rid of me and break the lease and get rid of me. But [the staff] really went to bat and then helped me turn things around. (Male consumer, Metropolitan consumer focus group)

This passage demonstrates how case managers in scatter-site programs worked with consumers and property management to prevent eviction, rather than directly enforcing the rules of housing that can lead to eviction. While this was an effect of the structure of housing, consumers often perceived it as "caring" on the part of case managers. A consumer at HIVA said:

> I think its the culture of [HIVHA] that is "care first"….they find loving people, and then they place them in case managing situations where they love the case, I guess the cases that they manage…you [a case manager] have to bend this rule but your loving the people, then [the case maanger will say] "we'll figure out a way to work it out". As opposed to "alright, you gotta go strictly by the rules no matter what". (Male consumer, HIVHA consumer focus group)

While it is entirely possible that this consumers case manager did "bend" the rules, it is more likely, considering I have demonstrated in the previous chapters regarding the use of harm reduction in the programs, that he was better able to work as an advocate for the consumer to address specific issues because he was not charged with enforcing the rules that could have led to the consumer's eviction. These types of descriptions were much more frequent in scattered-site housing, demonstrating that consumers were better able to perceive the support offered to them in their programs.

Property Management and Funding

Issues surrounding **property management and funding** had major effects on the programs in that they *limited the flexibility of the model* by affecting who the programs could serve and the extent to which staff could use harm reduction strategies to address consumer substance use/abuse. Metropolitan, HIVHA, and Allied worked with property managers who were all external to the programs. My interviews demonstrated how the flexibility of the program model was affected by rules of external property managers, which were often stricter than those of the programs:

> Yeah, these are the rules [of housing], and this is what we have to abide by…their [property management's] degree of flexibility is different from ours, from a program standpoint. (Male staff member, Allied staff focus group)

One way in which these rules could affect the programs is that staff could not always guarantee landlords would agree to house consumers who were admitted. At Metropolitan, this resulted in the program skipping over consumers waiting for housing who had the most problems (e.g., severe addiction, criminal backgrounds, and/or bad credit):

> One of our housing providers in particular is much more restrictive [in terms of who they will house]. And that presents a problem because if that's where we have an opening then that means we have to bypass certain people on the waiting list. (Nick, Metropolitan staff)

This is problematic considering that **hard-to-serve consumers are the targeted population of the Housing First model** (National Registry of Evidence-Based Programs and Practices 2010; Tsemberis and Asmussen 1999).

While Judy's House managed its own property, its staff discussed how funding posed a similar constraint to that of external property mangers:

> They [the primary funding agency] have certain information or certain criteria that they [potential consumers] have to meet in order for them [potential consumers] to fit. Their [the primary funding agency] decision [for potential consumers] to move into our housing is affected by a woman's history of incarceration. (Female staff member, Judy's House staff focus group)

I learned from further discussion with the clinical director of Judy's House that the local public housing authority (Judy's House's primary funder) reviewed and made the final decisions on housing applications (Judy's House administrative follow-up interview, August 27, 2010). This funder's criteria for admission were much stricter than Judy's House's, which meant that the *hardest-to-serve* women, i.e., the women the program has a goal to serve, *were not eligible for housing*. In effect, this created a "creaming" effect where women with some of the more complicated issues (e.g., ex-offenders and those with bad credit) who the staff understood the program as being designed to serve were often not accepted for housing.

A second constraint related to both property management and funding was evident at Metropolitan. Nick explained how funding in his program resulted in difficulties placing consumers in housing with private landlords:

> … [W]e do a lot of moving around. Like just recently a guy moved out of a Shelter Plus Care [federal funding] contract. And we had a guy who wouldn't have gotten into the because of the criminal background. So what we did is we moved a guy directly into the Shelter Plus Care [funded unit], and then moved someone from the Shelter Plus Care [funded unit] into a Housing Trust [local funding] [funded unit]. Because he was at one of the buildings already…Sometimes we feel hamstrung because certain landlords are tied to contracts. (Nick, Metropolitan staff)

As Nick pointed out, funding streams are often attached to *specific* properties. That, combined with landlord restrictions concerning who they will house, led to difficulties finding housing for people or moving them between housing when problems presented themselves. A similar problem was demonstrated at Allied:

> DW: …[I]s [the program] set up to try to transition people from the fifth floor to the sixth floor, or is that just something that happens because it happens or is it a goal that's theirs?
>
> Staff member (male): well that's something we had in the beginning when I started here eight-and-a-half years ago. That that happened a lot more frequently than now. But because of funding restrictions and HUD housing rules, that's not possible anymore. But before that was one of [program names] goals to enter in, can enter in through the Safe Haven and then end up in permanent housing. That was sort of sort of, and then move out to more independent housing if possible, if that was the end goal of the participant. But since the HUD rules have changed that's not possible anymore.
>
> DW: So what about the HUD rules makes it [cut off by informant]?
>
> Staff member (male): Well the, cause we at, for the longest time Safe Haven was able, participants were able to maintain a homeless status as far as housing was concerned. And now the HUD changed the rules on that. Now we're considered permanent housing, although we still use harm reduction, but we don't have, our participants that live here no longer have a homeless status. And a lot of the housing programs require that you're homeless. So [both floors now] requires [potential consumers to be admitted] to be homeless, requires you [potential consumers] to be homeless. So in order for participants to transition from safe haven to permanent housing, they need to be homeless. (Allied staff focus group)

As this statement demonstrates, even though it used to be possible for the program to move consumers between floors according to their level of functioning, changes in funding made it so that this was *no longer possible*. This, in effect, meant that consumers who were initially lower-functioning could not move to more independent units as their functioning improved. Staff later informed me that they have had consumers choose to

become homeless again, moving into a shelter, for the required minimum to time to be considered homeless in order to be eligible for one of the more independent rooms.

Finally, property management and funding restrictions both limited the extent to which programs could practice harm reduction strategies, the most important component of program flexibility. This was a very important issue considering that staff at each of the programs described harm reduction as the primary key to success when running a Housing First program:

> … [W]hen you're doing case management, I think harm reduction is in the forefront because that's the practical application…but housing first is the philosophy we're working from, which encompasses harm reduction. (Male staff member, Metropolitan staff focus group)

Property management and funding restrictions prevented the programs from allowing consumers to use drugs in their units in all of the programs, not just Metropolitan. Therefore, one very real consequence of drug use consumers might face was eviction:

> I have some clients that they use in their apartments, the places that they live. And the consequences, the possible consequence of that is that if the land lord finds out, they could be they could be evicted…I would still work with them on finding another place. I would still house them, but they could potentially be homeless for a short period of time while I'm trying to find them another place. (Brant, HIVHA staff)

Additionally, property management restrictions on consumers at Allied prevented them from consuming alcohol on the premises:

> I have no problem with participants drinking or using substances in their program's space, but HUD tells us by the rules, the funding rules, that can't happen, so we have to respect that…I mean to if we could wipe that [the rules] out that would even reduce harm more if they were able to use within the program's space. [1] (Manuel, Allied staff)

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[1]Later it was clarified that the rule prohibiting alcohol use in units was not a restriction of HUD but of the building's property management.

Considering that harm reduction is concerned with reducing the negative consequences of risky behaviors, allowing consumers to use in their units would have been a preferable policy for the programs because use would occur in a more secure environment. This would have effectively allowed consumers to better manage the risks associated with their substance abuse and lowered the chances of an arrest, overdose, and/or death. While this was an issue in all of the programs, it was more problematic in the project-based ones since staff had to enforce the rules of property management. While staff in scattered-site programs did not advocate use in consumer units, the disassociation between them and the landlords and status of the consumer as the lease holder meant that they had no obligation or right to enforce the rules of housing.

Program Mission and Goals

Most Housing First programs require consumers to engage in case management services. In fact, this is a recommendation of the original Housing First program developed in New York City in the early 1990s (Tsemberis and Asmussen 1999). All of the programs except for Judy's House had this requirement for consumers. Judy's House *did not require consumers to engage in any services* because its **stated mission** emphasized that they should have access to housing without any service requirements. This mission included such words as "creative expression", "self-determination", and "individual freedom" (taken from Judy's House official mission statement November 23, 2011). Part of the reason for this that the program serves all homeless women, not just those who are chronically homeless with dual diagnoses, and the emphasis on housing as a right would not allow the program to: (1) demand service engagement for higher

functioning consumers or (2) to only demand service engagement from dually diagnosed consumers. While it can be argued that the absence of service requirements was a positive feature of the program because it made the service structure more flexible, the reality was that it resulted in a *lack of education about the Housing First model* among Judy's House's consumers. The following selection from my interview with Brenda, a consumer at Judy's House, demonstrates this:

> DW: … [H]ave you ever heard the term harm reduction housing or harm reduction?
>
> Brenda: Yes.
>
> DW: Have you heard that here [at Judy's House] or elsewhere?
>
> Brenda: I heard it here, this is what this interview was about, harm reduction.
>
> DW: Do you know anything about what that term means?
>
> Brenda: I believe that harm reduction is anything that you could be involved in for a crisis that's going on in your life. Say like in my situation, I would be involved in domestic violence, drug counseling for family issues and drugs and that. So going to places and talking to people to get this harm out of my life.
>
> DW: Has anyone at [Judy's House] before you knew you were coming to this interview used that term harm reduction with you?
>
> Brenda: One time.
>
> DW: Do you remember when that was or who that was?
>
> Brenda: [My case manager], when she first told me about this interview. (Interview with Brenda, 61, Judy's House consumer)

In this passage, Brenda states that she had never heard of harm reduction, something that staff understood to be the *necessary component* for a successful Housing First program.

Compare the above selection to one from the interview I conducted with James, a consumer at Allied:

> Harm reduction housing to me, it's like a safe haven, a safe place to be. They offer these harm reduction groups, like they give you tips or pointers on if you gonna do drugs or alcohol or something like that, it should be safe ways to do it…They know we be drinking and stuff like that up here. But they say we rather see you be safe than out there on the streets and hurt. (James, 45, Allied consumer)

The focus James places on *safety rather than treatment* demonstrates how consumers in programs other than Judy's House had a better understanding of the policies and practices associated with Housing First.

Melinda, a case manager, expressed her frustration over Judy's House's consumers' lack of understanding of program policies and procedures related to harm reduction:

> DW: You mentioned a little bit about women need to be educated about harm reduction, and what specifically do you feel they need to be educated about in order to understand harm reduction.
>
> Melinda: What exactly it is, what exactly us staff are doing when we're put in that situation. Like the lady who came in here drunk [mentioned earlier in the interview]...instead of lookin at it as, "oh [this staff member] is being friendly, cool, way down to earth". No, she needed to be educated. No [that staff member who intervened with you] was usin' the harm reduction approach, and this is what it looks like. And that's the thing too, we can offer that class [on harm reduction] [and] we do. To be honest, we have offered harm reduction, but it goes in one ear and out the other. It it's kind of like I feel they need to be mandated to attend these classes. (Interview with Melinda, Judy's House staff)

From Melinda's point of view, consumers need to be educated about policies and practices of the program or else they do not learn from the interventions staff engage in.

This is an important observation since interventions that protect consumers without facilitating learning have the potential to enable negative behaviors.

The mechanism primarily responsible for the development of consumer understanding of the model was the services consumers engaged in, primarily case management. The following statement from Jesse demonstrates how involvement in case management led to a better understanding of the Housing First approach:

> … [I]t was shortly after that in one of our one-on-one sessions where [my case manager] said…"You realize your housing is not contingent on you being abstinent?". And I hadn't realized that at that point… [T]hen things started to change. I started working real close with them, being honest with them. (Jesse, 48, Metropolitan consumer)

Jesse's understanding of the model resulted in his being able to view his case manager as an ally. Upon realizing this, Jesse began to change his behaviors and a deeper relationship between him and his case manger developed.

Because Judy's House did not require consumers to engage in services, a number of consumers had not formed strong relationships with their case managers. For instance, even though Janet had been living at Judy's House *for ten years*, she stated that she did not have a strong relationship with any staff:

> …I don't know no nobody in here. I really don't talk too much to the staff up in here, I stay to myself. I stay in the apartment too. I'm trying to find me another place to stay…I really don't socialize with anybody in here (Janet, 47, Judy's House Consumer).

Though consumers did talk about positive relationships with staff, they only occasionally discussed case managers. For instance, when Barbara discussed the staff member she had the closest relationship with, she discussed Ms. Lucy, a woman who worked at the front desk to the building:

> Barbara: …I love Ms. [Lucy who works at the front desk, she's] my favorite…we're not friends, it's business when she, at work. But it's just how she talk to people and how she, if you have a little problem or something she'll talk to you and try to ask you what's going on and try to help you out if she can. So that's what I like about her.
>
> DW: So who, is she who you usually go to when you don't know what to do about something or...?
>
> Barbara: Oh, no, no, no, no, no, not all the time. I see, I have a family and I go talk to my family. (Interview with Barbara, 53, Judy's House consumer)

Not only is Barbara's strongest staff relationship with a person who works at the front desk (which is not really problematic in itself), she does not even seek support from her case manager for things that case management is designed to assist consumers with. Other consumers at Judy's House also discussed seeking help from family or from outside social service entities instead of the case management staff at Judy's House. What this suggests is that the lack of strong relationships with staff interfered with consumers' ability to perceive the full support available to them at Judy's House.

The lack of understanding of the Housing First model and weak consumer-staff relationships resulted in there being little positive change in relation to behaviors and/or goals for all but one of the consumers who I conducted individual interviews with at Judy's House (this was not true for consumer focus group informants; however, as I described in Chapter Three, these consumers were chosen by staff to participate in the focus group because of their high levels of functioning). I recognized this issue during my data collection and how it contrasted with what I was seeing in the other programs in my sample. Because of this recognition, I conducted two additional consumer interviews to assure the salience of this theme. Staff discussions also support this finding:

> I've also seen it where it [the harm reduction component of the Housing First model] doesn't work, where the ladies are spending their monies on everything but paying their rent. And that harms not only the agency but the women themselves because it empowers them or enables them to say "I'm not gonna go nowhere [i.e., not going to be kicked out if they violate rules]". (Geraldine, Judy's House staff)

Geraldine's statement demonstrates how the lack of positive change was a problem for the program that extended beyond those consumers I conducted individual interviews with.

The negative behaviors Geraldine described would have resulted in eviction at one of the other programs; however, they rarely did at Judy's House:

> …[S]ome of them [consumers] don't, some of them don't progress. They are able to maintain housing and that's [Judy's House's] mission, just maintain housing. Whether they become incarcerated [or] come home high, that's still a part of harm reduction, and they still maintain their housing. (Melinda, Judy's House staff)

In fact, Judy's House had *retained the most people in housing* out of the four programs—a 100 percent housing retention rate during the year I conducted my data collection (Judy's House administrative follow-up interview, August 27, 2010)—and most of the consumers I had interviewed had been housed for a significant amount of time (a range of one to ten years) in relation to their previous housing situations. As Geraldine pointed out, this was because the program's mission to "break the cycle of homelessness" that prevented the program from requiring any service participation also emphasized consumer housing retention:

> … [T]he ultimate failure to me as far as a mission is [a consumer's] eviction to homelessness…if we used the [H]ousing [First] model but then we said abstinence [only after consumer admission] or we said pay rent or things like that, its failure because ultimately they would end up evicted, back to homelessness you know, and that's what [Judy's House] was

created to try to avoid… (Geraldine, Judy's House staff)

While all of the programs had housing retention as a primary goal, it was even more emphasized at Judy's House. This was demonstrated by their *highly formalized eviction prevention process*, which resulted in consumers being able to retain their housing in light of major infractions of rules. While this was beneficial to the program because it allowed them to meet their goals in light of minimal change in consumers' behaviors, staff discussions demonstrated they were frustrated because consumers had no reason to change their behaviors because they rarely had to face the consequences of their actions:

> … [T]he board is constantly overturning the eviction, and then the tenant that were back to square one. The tenant [is] show[n] they can get away with what caused them to be placed on the eviction prevention case [load] in the first place (Melinda, Judy's House staff)

Further underscoring the significant difference between Judy's House and the other programs in terms of eviction prevention, while the other programs discussed evicting tenants for three to six months of overdue rent, Jane described a tenant who had refused to pay rent so long that she owed the program over $10,000:

> I have a woman that is addicted to prescription medication and mentally ill. And the only time she comes down is when she wants to use her telephone. She hasn't paid rent in three, four years. Our administration, they do not want to evict, and they will not…Because here's how the process goes: We have an eviction prevention person that supposed to work very hard with these people one-on-one, and that's to get them to pay their rent, find out what the barrier is why they aren't able to pay their rent. And then from that point on she owes us 10,458 dollars [as of] today. (Jane, Judy's House staff)

The Effect of Contextual Constraints

Contextual constraints resulted in a phenomenon known as **loose coupling** within each of the programs. Loose coupling happens when the "structure and process [in rational organizations] are loosely connected with organizational goals" (Scheid-Cook 1990). It is a useful theoretical concept for organizational researchers to pay attention to because it allows them to see how organizations continue to operate according to established routines despite outside pressures that result in structural changes (Meyer 1985; Orton and Weick 1990). Loose coupling frequently occurs when the organization needs to conform to external expectations, usually imposed by funders or regulatory agencies at a surface level (i.e., program policy) (Dunham, Scheid, and Brandon 2008; Scheid 1994; Scheid 2003), but ritual and staff knowledge of effective practices result in *little change underneath* (i.e., day-to-day practice) (Meyer 1985).

Coercive isomorphic influences were largely responsible for loose coupling in the sample programs. Discussing the phenomenon of isomorphism, Hasenfeld (2000) has demonstrated how it is restricted by contextual factors can lead to a decoupling between organizational policy and practice:

> … [W]hen closer attention is paid to the organizational forms and practices they enact, especially regarding the delivery of services and their interaction patterns with clients, considerable diversity is found. One is likely to expect diversity rather than uniformity of organizational practices when one recognizes that organizations doing moral work must contend with abstract, conflictual, and ambiguous moral rules; that their work is highly contextualized at the local level; and that discretion prevails both at the organizational and street levels. (P. 337)

Hasenfeld's focus is on the *moral work* that organizations engage in. All of the programs in this study engage in moral work. Institutional isomorphism resulted in the programs

enfolding specific moral attitudes into their program structures, e.g., consumer-choice, empowerment, and basic human rights. However, contextual factors like the structure of housing, competing rules of funding, and program mission and values affected the degree to which the program could implement the model and/or the extent to which it was effective.

I have already discussed the coercive influences that affected the organizations through the city's implementation of a 10-year plan to end homelessness (see Chapter Six). The adoption of Housing First as a result of this plan resulted in loose coupling at Allied and Judy's house because they were attempting to fit a model designed for scattered-site housing to a project-based program (see Tsemberis and Asmussen 1999). Also, the demands of funding sources and property managers often interfered with the implementation of the Housing First model by restricting who the programs could serve and whether or not staff could practice harm reduction in a proper manner. Finally, the mission of Judy's House prevented the program from requiring case management of consumers, a primary feature of Housing First, and caused the program to implement strong eviction prevention policies that protected consumers from discharge beyond what the Housing First model was intended to do when it was developed (see Tsemberis and Assmusen 1999), which allowed the program to meet its housing retention goals.

What these findings demonstrate is that **variations in the flexibility of program structure and consumer education resulted in variations to the recovery process** described in Figure 2. This was particularly noticeable at Judy's House. While it was arguably the most flexible of the programs thanks to its strong eviction prevention policy

(the program had 100 percent housing retention rate), Judy's House also had some of the weakest consumer-staff relationships. The key difference behind Judy's House and the other programs besides their strong eviction prevention policy was that consumers were not required to participate in any services, including case management. Because of this, consumers had little understanding of the Housing First model and they continued to act as if they were in COC housing.

A Typology of Housing First Programming

The findings I discussed above demonstrate how contextual constraints affected implementation of the Housing First model in my sample programs through the effects they had on (1) the flexibility of the programs' service structures and (2) the level of education about Housing First policies and practices consumers received. These effects are important to understand because, as I demonstrated in Chapter Six, these two dimensions are what led to consumer and staff understandings and experiences of recovery that were unique from those study informants described in COC programming. Based on the finding presented I have presented in this chapter, I argue that program flexibility is high when programs are not limited to the extent to which they can practice low-demand and harm reduction approaches and it is low when constraints like those imposed by funding and external property managers described above limit the extent to which they can use these approaches. Additionally, consumer education is high when there are staff members who can act solely as advocates for consumers and when there are processes in place, such as minimal case management service requirements, that develop consumers understanding of the Housing First model, and it is low when these

things are not present. I present four theoretical types of Housing First programming in Table 4. These types are based on variations in these service structure flexibility and consumer education. These program types are: Empowerment, Enabling, Treatment, and Alienating.

Table 4. Housing First Program Types Based on Variations in Program Flexibility and Consumer Education

	Consumer Education	
	High	Low
Program flexibility		
High	*Empowerment*	*Enabling*
Low	*Treatment*	*Alienating*

It is important to point out that threes types are not definitive, and programs might or might not fit clearly within them. Table 5 demonstrates where each of the programs in the sample fit according to this typology: Metropolitan and HIVHA fall under the Empowerment-type program; Judy's House fits most closely with the Enabling-type program; and Allied fits somewhere between the Empowerment- and Treatment-type programs. I have also chosen to demonstrate where Metropolitan would have fit before the introduction of harm reduction policies and procedures. I have chosen to do this because of the significant amount of attention I have given to Metropolitan informants' discussions of the program before this switch. The program type that Metropolitan would have best fit under at that time is the Alienating-type program. I define each of these proposed types and my reasoning for assigning each program to its respective type below.

Before moving forward, it is important to point out that **low flexibility does not mean that the program structure is as rigid as a COC program**. My data demonstrate that even though variations in these two dimensions affected the recovery process outlined in Figure 2 (see Chapter Six), staff and consumers still experienced the their current Housing First programs as being more flexible than the COC programs they were familiar with.

Table 5. Sample Programs by Type

	Education	
Program flexibility	High	Low
High	Metropolitan HIVHA Allied	Judy's House
Low		Metropolitan before harm reduction

The Empowerment Program

Empowerment-type programs are the ideal expression of the Housing First model. An empowering program should operate using a pure **citizenship/rights approach** because its focus on unhindered access to housing and consumer-centered services. This fits closely with disability perspective that emphasizes the barriers social inclusion as the root case of disability (see Corrigan and Ralph 2005; Shakespeare 2006). It is the flexible structure of these programs that allows them to operate in this manner. Consumers are well informed about program rules and regulations, and they are enforced regularly and consistently by the program. Staff roles are clearly defined within this program type and high levels of staff support are geared toward assisting consumers in reducing barriers to

independence/self-sufficiency. “Empowerment” is the term that best describes this program type because access to resources and high levels of support give consumers the tools they need to manage risk in their lives and crate positive change. Metropolitan and HIVHA fit the closely within this Housing First type because the scattered-site nature of housing allows case managers to act a pure advocates for consumers, while also letting case managers practice harm reduction and low-demand approaches more freely (see Table 5). Allied has some of the features of an Empowerment program, but other features with Treatment-type program I describe below because of its project-based nature (see Table 5).

The Enabling Program

The Enabling-type program takes an approach to housing that places the **individual liberties** of consumers *above all other program goals*. It has a very flexible structure that uses a harm reduction approach to substance use and has no service requirements. Because of its lack of service requirements opportunities for education are low. Therefore, the level of staff support depends on consumers’ individual levels of engagement. There is a lack of consumer education across the program, as those who choose not to participate in services are generally not well informed about program rules and regulations and/or do not understand the roles of staff. These programs should have low housing retention since a significant number of consumers do not have the necessary tools to manage risk and are resistant to change. However, the flexible nature of the program ensures that these consumers will not be evicted into homelessness. The label “Enabling” is the most appropriate for this program because it supports positive

behaviors of engaged consumers while equally supporting negative behaviors of non-engaged consumers by allowing them to continue with little consequence. Judy's House fits closely within the enabling-type program because its lack of service requirements were demonstrated to lead to weaker staff-consumer relationships and perceived support (see Table 5). Additionally, the formal eviction prevention procedures protected consumers from one of the most significant consequences that their behaviors might pose reentry into homelessness.

The Treatment Program

The Treatment-type program has high levels of control marked by rigid rules and regulations with high levels of staff monitoring. The approach it takes to housing and services is informed by the **biomedical and 12-step models**. This type of program requires abstinence (and possibly medication compliance) of consumers after admission, or has policies and practices that punish consumers for substance use. There are high levels of staff support and services. However, the largely therapeutic focus of supports and services and monitoring by staff make it *difficult for consumers to form strong positive relationships with them out of fear of punishment or sanctions*. This is a particularly strong threat since eviction in this type of program should be enforced in accordance with substance use guidelines. Consumers are informed and educated about rules and they are regularly and consistently enforced. Therefore, it is very difficult to have high housing retention without allowing some exceptions for relapse and having high levels of well trained staff support. Additionally, since consumers risk eviction when they break rules, the large number of rules consumers has to navigate in treatment

programs increases the number of risks they have to manage. This is a largely a theoretical program in that it does not show up in the sample; however, Allied shared some features of it because property management did not allow consumers to possess alcohol, a legal substance, on-site. The programs project-based nature made it more likely for consumers to be caught and sanctioned for possession of substances on-site since staff were required to regularly act as enforcers of housing rules. This slightly weakened the quality of consumer-staff relationships (see Table 5).

The Alienating Program

The Alienating-type program's approach to housing and services, like the Treatment-type program, is informed by **biomedical and 12-step models.** Alienating programs require abstinence (and possibly medication compliance) of consumers after admission and has rigid policies/rules/regulations and requires consumers to be involved in high levels of services. As a consequence consumers are usually ill informed about the strict policies/rules/regulations, and/or staff enforce them at their own will. "Alienating" is the best term for this type of program because the *rigid structure combined with lack of education and/or at-will enforcement of rules* leads to distrust of program and staff among consumers, which does not allow them to perceive support. It is difficult for Alienating programs to enforce rules if it wants to keep high housing retention rates because the alienation experienced by consumers leads to stress which perpetuates substance use/abuse. Metropolitan used to operate in a manner consistent with this type of program (see Table 5). As discussed in Chapter Four, Metropolitan required abstinence of consumers after entry before it implemented harm reduction practice one year before I

collected my data. At this time the program had a "three strikes" rule regarding substance use. However, enforcement would have lead to poor housing retention, which would have reflected poorly upon the program. As a result, consumers were not kicked out, but lived in constant fear eviction because of discrepancies between policies/rules and practices/ enforcement.

Conclusion

All four of my sample programs had implemented many of the same elements of Housing First programming (e.g., low-threshold admissions policy, reduced service requirements, and harm reduction) that made their programming structures more flexible than COC programs. However, internal and external differences related to the organizational contexts of the programs affected the extent to which these elements were effective. The structure of housing, property management and funding, and program mission all limited the extent to which these elements were effective. These differences also affected the extent to which consumers were educated about program policies and procedures. This education was an important for consumers to receive because without it they were less likely to recognize the support available to them and potential for agency that the flexible service structures provided.

The importance of education was most visible at Judy's House where the consumers I interviewed received the least education out of the four programs and had the weakest relationships with staff and least personal growth as a consequence. The fact that Judy's House had the highest housing retention of all the programs despite these issues demonstrates that research must pay as close of attention to implementation and

programmatic processes as it does to outcomes when defining and measuring program success.

CHAPTER EIGHT

CONCLUSION

My primary aim for this study was to develop a sociological understanding of recovery. Investigations of recovery are important for sociologists of mental health to carry out in order to keep the subfield relevant within the larger context of mental health studies. An understanding of the social factors that affect mental health is essential for crafting approaches to effectively address the problems associated with mental illness, its diagnosis, and recovery from/in it. Without a sociological understanding of these issues, there is a risk that policy-makers will place too much emphasis on individual-level factors related to recovery. While my data and findings are specific to the recovery of dually diagnosed consumers in four Housing First programs, the similarities between the different cases and sources of data (consumers and staff) strengthen the generalizability of these findings to mental health services more generally. I summarize the most important of these findings and present a more general theory of recovery in this concluding chapter. Because this study also has an applied and policy focus, I also present several policy and programmatic recommendations for mental health services and Housing First programming before offering some final thoughts about the issues my findings raise.

Recovery is a Social Construction

The tradition within medical sociology is to understand mental illnesses as social and political constructions (see Conrad and Barker 2010; see Figert 1996). This is not to say that mental illnesses are not "real" in terms of their consequences. Indeed the "symptoms" (i.e., deviant thoughts and behaviors) that are associated with mental illness can have extremely negative effects on the lives of individuals who suffer from them. While it is important to recognize and treat these symptoms, placing too much emphasis on biomedical explanations for mental illness runs the risk of overlooking the social factors that are oftentimes just as, if not more, important.

My findings demonstrate that *recovery*, as part of the illness experience, *is also a social construction*. The meanings people associate with recovery are highly dependent on social context. Recovery means different things to different people at different times and places. To some people recovery is the complete remission of symptoms and/or abstinence of substance use. For others recovery is the ability to maintain a certain quality of life in spite of the problems cause by their illness(es). The former of these two views of recovery is likely to be found in highly structured programming (those that follow strict biomedical and/or 12-step models of recovery), while the latter is more likely to be found in flexible programs that allow consumers to exercise individual choice. Recovery goals are dictated to consumers in highly structure programs. When programming is flexible consumer choose recovery goals that are meaningful to them and that fit more appropriately with their individual circumstances, which shifts the focus from symptom remission and treatment adherence to quality of life.

When quality of life is the focus, recovery becomes a **negotiation between the boundaries of health and illness** rather than the movement from illness to health. It depends heavily on the resources and supports that consumers have access to, which affect their ability to engage in meaningful social action to address the problems associated with their illness. Highlighting this, the consumers and staff I spoke to in this study often discussed mental health recovery as a holistic process that overlapped with their recovery from homelessness. Because of this, the consumers were more concerned with issues like physical safety, financial security, and social relationships than they were in addressing the symptoms of SPMI and/or substance abuse.

Therefore, it seems as though flexible programming facilitates the recovery process through the establishment of an ontological security, which allows consumers to gain a feeling of normalcy in their lives. This supports the social disability perspective that social oppression, discrimination, and exclusion are significant factors that need to be explored in the recovery process and highlights the important need for further sociological study of recovery (see: Lester and Tritter 2005; Mulvany 2000; Shakespeare 2006; Thomas 2004).

The Importance of Program Structure in Shaping Individual and Group Experiences

In this study, I found that program structure is more important than individual-level variables in determining individual and group experiences of mental health services that affect the recovery process. The fact that the consumers and staff I interviewed differed on so many key variables at the individual- and group-levels (e.g., income,

education, social status, and mental health) yet had such strong similarities in their understandings and/or experiences of programming and the recovery process supports this argument. Consumers' ability to exercise **personal agency is highly dependent on the degree of flexibility inherent in the service structure**. This is because consumers are restricted in their ability to recognize and/or exercise choice when aspects of the social structure such as obderateness, symbolization and identification, and ritualization are high. Programs with strict rules like those found in COC programs are likely to alienate and constrain consumers by medicalizing their behaviors and identities as "addiction/addicts" or "mental illness/mentally ill." The effects this has on consumers is very similar to those of large state-run mental health institutions that were largely dismantled between the 1950s and 1980s (see Goffman 1961).

Even programs that allow for greater levels of agency on the part of consumers will vary in the degree of flexibility in their service structures. These variations will have effects on individual- and organizational-level outcomes. For instance, rules external to organizations that limit the degree of a program's flexibility will negatively impact outcomes for consumers who are in need of services but who are not ready to take actions to address their mental health and/or substance abuse problems. In the case of Housing First programs, funders and/or property mangers often limit the degree to which programs can admit "hard-to-serve" consumers into housing and the degree to which they can work with them in a manner consistent with the principles of the Housing First model (i.e., use harm reduction approaches). Limits imposed on housing access will affect retention because restricting admission to "desirable" consumers will likely result in less

need for eviction. When "hard-to-serve" consumers are admitted to programming and/or behavioral problems develop in consumers after admission, restrictions on staff's ability to practice harm reduction can result in further behavioral issues for consumers as they try to hide their problems from staff. This is likely to affect the program-level outcomes as more consumers are evicted back into homelessness.

Indeed, this is one of the primary reasons behind the relative failure of community-based mental health services for meeting the needs of "hard-to-serve" consumers. Policies guiding funding at the federal and state levels create incentives for programs to concentrate on only one area in their provisions of services (i.e., mental health and/or substance abuse). Policies such as these create cracks in the mental health services system that consumers often fall through (see Frank and Glied 2006). Because of these cracks, housing programs for the homeless have effectively become centers of mental health treatment (see Frank and Glied 2006; see Scheid and Brown 2009).

The Importance of Implementation to Programming

The connections between program structure and the recovery process demonstrate how **implementation can make or break a program**, and this stresses the necessity of understanding program structure when tying to assess its effectiveness in treating consumers and facilitating the recovery process.

Community agencies often have to make adaptations to program model designs due to factors beyond their control and are rarely able to fully replicate the conditions under which these original designs were tested (Durlak 1998). This often leads to seriously compromised programming and misinterpretations of outcome data on the part

of researchers when they attribute client-level results to a program that was never fully implemented (Klein and Knight, 2005). Highlighting this, Koepsell et al. (1992) have written:

> [This] focus on final outcomes may result in overlooking the need to characterize both the intervention itself and causal mechanisms by which it is supposed to work. Interventions then become 'black boxes' whose overall effects may be detectable, but whose contents are obscure. (P. 33)

This problem is so common that a special term, "Type III error" was coined in the program evaluation literature to describe research that falsely attributes program outcomes to a nonexistent program model because of the failure of the research design to consider implementation (Scanlon et al. 1997).

Related to Housing First programming, findings from one study of the Pathways to Housing, Inc. model support the idea that housing program characteristics are more important than client-level variables in accounting for program outcomes (Tsemberis and Eisenberg 2000). Research informants assigned to Housing First programming had better outcomes than those in COC programming. Additionally, in a comparison of two studies of Housing First programming, Kertestz and Weiner (2009) argue that program inclusion criteria can seriously affect program outcomes such as cost savings. This literature supports a variety of documented results from evaluation literature that point to the importance of program characteristics' impact on client outcomes (Melnick, De Leon, Hiller, and Knight, 2000).

My findings presented in Chapter Six and Chapter Seven support this previous literature by demonstrating the effect that macro- and meso-level forces had on the sample programs implementation of the Housing First model. The result of these effects

were four programs that looked very similar on the surface, but had sublet differences under the surface that had important implications for program informants in terms of their understandings and experiences of the program structure and recovery.

Generalizing Beyond the Current Study

Based upon the findings in this study, I propose a social psychological model of mental health recovery that can be generalized beyond the confines of my sample based on these conclusions. I am calling this the *Boundary Negotiation Model of Mental Health Recovery*. Taking the perspective that mental health and illness are co-occurring phenomena, this mode understands the recovery process as a consumer's attempt to negotiate between mental health and illness in an effort to attain the highest quality of life possible in spite of symptoms related to their diagnosis. The structure of mental health services is key to this process, as it is more often than not the policies that guide programming that determine access to these resources (see McAlpine and Boyer 2007). This model also recognizes that the implementation of individual programs' service structures is heavily influenced by the organizational field and factors related to the individual organizational context, which often time conflict with one another.

The components of the *Boundary Negotiation Model of Mental Health Recovery* are as follows:

- *Component 1*: When ontological security is firmly established, consumers begin to feel "normal", a state that has been denied them through social processes associated with labeling.

- *Component 2*: Normalcy is relative; it is dependent on the meaning individuals attach to it. Individuals ascribe meaning based on their past and current experiences and future goals.
- *Component 3*: Ontological security hinges on access to resources, perception of supportive relationships, and ability to manage risks in their social environment. Those risks that are most important to manage are the ones associated with the consumer's mental health and/or behavioral diagnoses such as medication management and substance use.
- *Component 4*: A consumer's priorities shift as ontological security is established. This is because stress associated with the lack of ontological security begins to diminish. As stress decreases, so do symptoms associated with it (anxiety, depression, substance use). This shift in priorities increases the consumer's ability to manage risks in their environment.
- *Component 5*: The mental health recovery process, as it occurs within the confines of mental health services for an individual consumer, is more the result of service structure than it is the individual course of illness.
- *Component 6*: The more flexible a program's service structure, i.e., the more it allows for a consumer to exercise agency, the more likely it is that the consumer will establish ontological security (i.e., a stable sense of self).
- *Component 7*: The entire process hinges on the consumer's ability to perceive the flexibility inherent in a program's structure. A consumer is likely to perceive all services as controlling at first due to historical trends in mental health services, power

differentials inherent in the therapeutic relationship, and personal experiences with treatment. Therefore, *consumers must be educated about program policies and procedures before the benefits of a flexible program structure can be realized*. It is entirely possible that this is only for low-income consumers and/or consumers with the most serious mental health issues, as previous research has demonstrated that consumers with higher levels of resources entering services have historically had more control over the type and course of treatment they engage in (see Kaufmann 1999).

- *Component 8*: The organizational/meso-level processes that result from the service structure are what connect actors (consumers and staff) individual-/micro-level understandings and experiences to the larger/macro social structure.
- *Component 9*: The extent to which a specific service model is implemented in a program depends on the strength of isomorphic influences that exist in the institutional field and contextual constraints, both internal and external, that exist at local and organizational levels. Isomorphic influences are responsible for the similarities that exist between programs, while contextual constraints are responsible for their differences.
- *Component 10*: The similarities that exist between programs' service structures exist largely at the surface level, as contextual influences, both internal and external, lead to differences in implementation that result in loose coupling between organizational goals (as defined by the technology guiding the service structure) and processes (the day-to-day interactions that occur within the program).

This model is heavily influenced by Lyng's (1990) theory of Edgework, Social Disability Theory (see Lester and Tritter 2005; see Shakespeare 2006), and organizational theory related to institutional isomorphism and loose coupling that I discussed in the previous two chapters (see: DiMaggio and Powell 1983; Meyer 1985; Scheid and Greenberg 2007; Scheid-Cook 1990). The theory of Edgework, particularly as it has been discussed by McNaughton (2008b), brings the understanding that risky behaviors, like those associated with mental illness and substance abuse, are something that the consumer attempts to manage. From disability theory comes the understanding that the exclusion a consumer faces as a result of their mental health problems are a result of the social structure, rather than the illness itself. Together, these theories point to the social structure as creating and/or blocking opportunities for a consumer to engage in the risk management necessary for greater social inclusion through the way in which it structures access to resources and supports necessary for recovery. Finally, the literature on organizations that discusses institutional isomorphism and loose coupling helps to connect meso-level processes at the programmatic level to the macro-level social structure.

Recommendations for Future Research

As a social construction, the recovery process is heavily dependent on the meanings society and individuals attach to it. There is a need for further research on recovery that looks at the processes through which these meanings are shaped and ascribed. Qualitative sociological studies, particularly those guided by a symbolic interactionist framework, are particularly well suited for this task. While the current study

focused on recovery from dual diagnosis (i.e., considered recovery from both SPMI and substance use disorder as the same phenomenon), it is important to understand what, if any, differences there are in the meanings attached to recovery from different types of mental health problems. While an understanding of the meanings associated with recovery is a start, it will not be enough. Considering that sociology has already demonstrated that the social meanings attached to mental illness have consequences independent of mental health symptoms (see Conrad and Barker 2010), i.e., labeling, there is also a need to understand the consequences of the meanings society and individuals attach to recovery. This will be essential in the crafting of policies and practices necessary for facilitating recovery in groups and individuals.

While the strength of sociological methods is their ability to uncover social processes, sociologists of mental health have been criticized within their own field for being too outcome focused and dependent on psychological constructs (Horwitz 2007; Schwartz 2002). Developing measurements for things like program flexibility, ontological security, risk management, and "normalcy" will help move sociologists away from their dependence on psychological constructs. This will also assist in the construction of stronger arguments regarding the connections between social structure and mental health outcomes.

There is a need for more research that investigates the implementation of mental health services. Though the need for paying greater attention to program implementation has been recognized for many decades, relatively few studies pay attention the implementation process (Durlak 1997; Klein and Knight 2005; Moncher and Prinz, 1991;

Peterson, Homer, and Wonderlich 1982). This is a problem from both a research and a policy standpoint. In terms of the former, it is difficult to establish causality between programming and outcomes without an understanding of implementation. For the latter, the development of policies that influence the diffusion of new "evidence-based" program models are useless unless there is a strong understanding of the elements of that programming which make it successful are considered. The case of Housing First programming demonstrates how diffusion without this understanding can result in varied approaches to programming that can lead to different outcomes. An understanding of implementation will help policy makers to hold programs accountable for the funds they receive.

Policy and Programmatic Recommendations

I have developed a number of policy and programmatic recommendations based on the findings from this study. The first set of recommendations I present are for mental health services generally:

- Social policies that promote the diffusion of evidence-based programs/practices need to include descriptions of said programming/practices. Additionally, policies that attach funding to programming need to be explicit regarding the key elements of programming/practices that need to be implemented before said funding is awarded.
- Policy makers need to hold programs accountable for implementation when their funding is contingent on the presence of a specific service model. This is because there is a risk that programs will modify service models to points where they are no longer effective without this accountability.

- Programs should be careful when mixing different populations of consumers such as consumers with one diagnoses verses those with multiple ones. Though there is always a concern that separating populations might ghettoize those with the most serious problems, the need for different approaches to serving consumers demonstrates the necessity for such separation. This is because different populations have different needs, and programs cannot ethically implement policies and practices that treat consumers differently.
- Programs trying to operate under a flexible program structure (like Housing First) should avoid working with outside entities (e.g., funders, property mangers) that limit their ability to use procedures (like harm reduction) that the program understands to be an essential part of working with consumers.
- That said, the competitive nature of program funding often limits organizations' ability to pick and chose the funders they work with. Programs need to be cognizant of the ways in which funding limit the effectiveness of the models under which they operate. This cognizance can help programs to make decisions about implementation and whether a particular service model is right for them. Evaluation research and quality assurance studies can help programs become and remain cognizant of the appropriateness of the model(s) under which they are working in relation to funders, as well as other issues associated with their organizational context (i.e., local regulations/laws/policies, infrastructure issues, etc…).

- Programs must educate consumers about the policies and practices that guide it. This is essential in both highly structured and flexible programming because both types of programs run the risk of alienating consumers without such education.
- Programs that work with "hard-to-serve" consumers and those who are not ready to give up engaging in "risky" behaviors (e.g., substance use, not taking medications) should implement policies and practices that increase their flexibility in working with such consumers.
- Perceived support is key to mental health recovery. In order to facilitate perceived support, programs should implement policies and practices facilitate it by assigning advocate and rule enforcement roles to different staff. This will help to assure that consumers have at least one staff member who they feel they can trust. It will also benefit staff because they will not feel pulled between conflicting roles when working with consumers.

In addition to these general recommendations for mental health services, I have two that are specific to Housing First programming:

- Policy makers should make it easier for providers of Housing First programming to move consumers between units that are supported by different lines of funding. This will increase program flexibility by allowing staff to maneuver consumers to units that more appropriately fit their level of functioning should it improve or regress.
- Policy makers and programs need to consider outcomes other than housing retention when assessing program effectiveness. Just because consumers are being retained does not mean that they are improving in terms of their recovery. It might simply

mean that programs are not kicking consumers out for unacceptable behaviors, which is essentially enabling.

Final Thoughts

There are inherent contradictions between my findings and the use of the term "consumer" in mental health policy and treatment. These findings, which form the basis of the *Boundary Negotiation Model* described above, shift the focus of mental health recovery from clinical outcomes to such issues as social integration, quality of life, and the ability of those diagnosed with mental illness to access and exercise rights. While the use of the term "consumer" might be more politically correct in the eyes of advocates, this rhetoric as it is employed in neolibral, capitalist-based mental health policy and treatment is in direct conflict with a rights based approach to recovery. This is because the conceptualization of people diagnosed with SPMI, or any disability, as consumers transforms health care into a *commodity that people must earn*, *rather than a right they should have access to as citizens*. That said, scholars have demonstrated that the consumer movement in mental health care has resulted in those diagnosed with all forms of mental illness having more control over their treatment. However, there is evidence that this benefit is class-based (see Kaufmann 1999; see Frank and Glied 2006), i.e., is restricted to those in the middle-class or higher, and most likely does not apply to the chronically homeless individual I focused on in this study.

Housing First programming was designed for "hard-to-serve" consumers and these consumers were the focus of my study. Therefore, I would be remiss if I did not make explicit that my findings might not apply to all people living with mental health

and/or substance abuse problems. In fact, COC programming has not been demonstrated to be an ineffective model for working with other types of consumers. Therefore, high levels of structure might be beneficial for consumers who do not have as severe of problems. This points to a need for a *continuum of housing options* for the homeless that is composed of programs with a range of flexibility in terms of their service structures (see Culhane and Metraux 2008; George et al. 2008).

Kellogg (2003) has written about the possible benefits of a system that operates on such a continuum, as consumers can be placed in programming most appropriate for them and transition between levels when according to changes in need or personal choice for a different level of services. It is reasonable to assume that higher functioning consumers have higher levels of resources and supports before entering programming. Therefore, they might not be as dependent on programming to provide these things to them. It is also likely that higher functioning consumers exercise a higher level of choice when entering programming in the first place because of their resources and supports. If consumers understand entering a program as *their "choice" rather than their only option*, consumers, being more accepting of the terms of the program, might benefit more from it.

Considering the importance of program structure to the recovery process, it is disappointing that implementation is not paid more attention to in research and policy. Failed implementation that results in negative outcomes can result in *good program models getting bad reputations*. Policy makers and organizations need to consider the entire context that a program is situated within during the implementation process.

Blindly replicating a program model without paying attention to internal and external factors that can affect it can also result in problems. Therefore it is important that advocates and policy makers explicitly describe the evidence-based programs they support so that organizations have a sufficient understanding to implement them appropriately. Appropriate implementation includes having enough information to know when modifications to the model are necessary depending on the programs context. These modifications are important for organizations and researchers to document because they will lead to a better understanding of the key components of a model and stronger overall model design.

APPENDIX A

ADMINISTRATIVE SEMISTRUCTURED INTERVIEW QUESTIONS

- **First I would like to ask a few questions to learn more about you and your position within the agency:**
    - What is your title?
    - What is your training/experience/background?
    - How long have you been working in this program?
- **Now I would like to ask some general questions about the agency and your programming:**
    - Is the program non-profit, for-profit, Government or faith based?
    - What is your primary funding source?
        - What other funding sources do you use?
    - How long has your program been in operation?
    - What areas do you serve?
    - What is the primary population you serve?
    - How big is your organization (housing program specifically)?
    - Does your program have multiple offices/locations?
        - If so, where?
    - Does your program offer permanent housing?*
    - How many housing units do you have?**
        - Is your housing project-based or scattered-site?**
        - How many of these units are currently occupied?**
        - Do you have different units for different populations?**
            - (probe: families, mental health, substance abuse, chronic illness)**
                - How many units do you have for each subpopulation?**
    - What is the process potential clients have to go through in order to get housing from your agency?*
        - (probe: direct placement, waiting list, transitional first, application process)
    - Do you use assertive outreach to engage homeless people who are reluctant to go to a shelter? *
        - (probe: mental health and substance abuse problems)
    - What are your eligibility requirements for clients? *
        - Do you place any other requirements on clients? (probe: treatment, behavior?
    - Do you offer supportive housing services? *
        - If so, what are they?
        - Do you require participation in supportive housing services for clients to maintain housing?
    - Does your program offer other services?

        - (probe: mental health services, medical services, employment programming)
    - Are clients at risk of losing their housing once they are in the program for any reason? *
        - (probe: alcohol or substance use)
    - What is your policy if a client leaves for a short time, say for medical treatment? *
        - Do you continue to provide case management?
        - Do you hold their housing?
            - If so, how long?
    - What are your policies surrounding substance abuse?
        - (Probe: wet/dry/damp)
- **Now I would like to ask some questions about your clients:**
    - How many clients do you currently serve?**
    - How many clients have substance abuse issues?**
        - Of this group how many have an official substance use/abuse diagnoses?**
    - How many clients have mental health issues?**
        - Of this group, how many have an officially diagnosed serious and persistent mental illness**?
    - How many clients have been dually diagnosed with substance abuse and a serious and persistent mental illness?**
    - What are some of the most frequent reasons for clients leaving the program?**
- **Now I would like to ask some questions about your staff:**
    - How many staff do you have?**
        - How many of your staff are direct service?**
        - What is your client to case manager ratio?**
        - Of these staff how many are:
            - licensed mental health practitioners?**
                - What are licenses in?
            - certified mental health practitioners?**
                - What are certifications in?
            - How many have some other mental health or substance abuse training/experience?**
                - What is this training/experience in?
- **Now I would like to ask you a few questions about Housing First**
    - How long has your agency employed Housing First programming?
        - Do you also employ harm reduction practices?
            - If so, what do you see as the primary difference between harm reduction and Housing First?
    - How does your agency officially define Housing First programming?
        - Related to harm reduction?

- What were the major changes your agency had to make in order to implement Housing First programming?
- Can you provide me with any organizational documents related to your Housing First programming (policies, marketing materials, guidelines)?

- **Finally, I would like to ask some questions about mental health and substance abuse recovery.**
  - Does your agency have an official definition for client recovery from substance abuse and mental health problems?
    - If so, what is this definition?
    - Do you have any official documents or policies regarding recovery?
      - If so, may I have copies?
  - How does the organization measure client progress related to substance abuse and mental health problems?
    - May I have copies of any instruments used?
- **Ask for Housing First materials, outcome measurement tools, copy of mission statement, strategic goals, and any marketing materials available that will help give a better sense of the organization, etc…****

APPENDIX B

CONSUMER/STAFF FOCUS GROUP SCHEDULE

1. Familiarity with program
    a. For staff: ask department and how long been at agency
    b. For consumers: ask how long lived in housing
2. What policies and procedures are essential to Housing First practices within the agency (probe specifically about substance abuse related policies)?
    a. Why?
    b. Are these policies and procedures regularly followed/enforced?
        i. Why/Why not?
    c. What policies and procedures does your agency have that do not fit or work against the Housing First model?
        i. Why/Why not?
3. What is the intake process like for consumers (probe: waiting lists, threshold level, referral system)?
    a. Discharge process?
    b. Process for consumers who are hospitalized?
4. How does your agency define consumer success as it is related to Housing First?
    a. What do you see as the most effective elements of Housing First related to consumer success?
5. What supported services are offered for consumers?
    a. What is not offered that should be?
        i. Why?
    b. Are consumers required to participate in any of these services?
        i. Why/Why not?
    c. What do staff do when consumers don't want to participate in services (probe about outreach process)?
6. What do staff and consumer interactions look like within the organization (probe: frequency of contact, quality of relationship)?
    a. How are consumers approached regarding their substance abuse and mental health treatment?
    b. What approaches do staff take when consumers use?
7. How does your agency define Housing First?
    a. How do you define Housing First?

APPENDIX C

CONSUMER/STAFF INTERVIEW SCHEDULE

Consumer only question

1. Please tell me about your history leading up to your current living situation (probe: homelessness, family relationships, substance abuse, mental health)?

Questions for all informants (word as appropriate for consumers and staff)

2. How were you first introduced to the Housing First model/How did you first learn about the model (Staff probe: specific training experiences) (Consumer probe: how practitioners introduced/talked about)?
    b. What were your first impressions?
        i. Why?

3. How do your experiences in Housing First compare to your experiences with other programs/what you know of other programs (probe: type of consumers, quality of relationships between staff and consumers, safety, environment, quality of life)
    c. How is your experience living/working in a Housing First agency different from your experiences or what you know about more traditional housing models that require abstinence of consumers?

4. How do you think the model works to assist consumers?
    d. What are the most important pieces/strengths of the model (probe: services, policies, practices)?
    e. How has living/working in the model affected you/your consumers?
    f. What do staff-consumer relationships look like?

5. What is your overall opinion of the Housing First model?
    g. Is it effective?
    h. What types of outcomes does it lead to for consumers?
    i. What can make it better?

6. What is "recovery" for consumers?
    j. How does that relate to the Housing First model?
    k. Harm reduction?

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