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The Moving On Program and Supportive Housing Residents with Histories of Homelessness

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THE MOVING ON PROGRAM AND SUPPORTIVE HOUSING RESIDENTS WITH HISTORIES OF HOMELESSNESS

by

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A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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ABSTRACT

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Supportive housing is the main strategy assisting formerly homeless people to live in the least restrictive settings and as independently as possible. There has been a greater focus on efforts towards homelessness prevention and remedies to minimize the experience of homelessness, which have been further fueled by the demand for supportive housing and a drive for cost effectiveness. Meanwhile, there have been attempts to ensure that those living in supportive housing are only those who continue to need comprehensive long-term support to live independently in the community. To accomplish this, and in line with the Recovery Movement, programs assist people currently living in supportive housing, who are interested in and able to move out into independent apartments in the community. On the other hand, there have been minimal efforts to assist those who want to move on and no longer need comprehensive onsite support.

Utilizing data on 40 formerly homeless persons preparing to transition from supportive housing to independent housing, a narrative approach was used, guided by interpretive interactionism, to examine the factors that assist and discourage residents to move out of supportive housing. Results suggest that residents sought ontological security through secure benefits, autonomy, and comfort. While residents were unable to reach an optimal level of secure benefits, autonomy, and comfort in staying or moving, they experienced ambivalence in making their decisions and considered satisficing certain conditions while aiming to optimize

others. Residents in recovery from mental illness and substance abuse identified a unique relationship with autonomy that was grounded in their recoveries and reinforced their supportive housing tenure. These findings suggest certain considerations for programs for supportive housing residents preparing to move on, specifically for those residents in recovery.

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CHAPTER I: INTRODUCTION AND PROBLEM STATEMENT

Homelessness in the United States

Homelessness is a complex and widespread problem in the United States. Recent research indicates clear and alarming trends in homelessness. On any given night in the US, more than half a million individuals seek safety in temporary shelters or sleep in places not meant for residence (U.S. Department of Housing and Urban Development, 2018; HUD).

Although homelessness affects diverse populations, certain groups are overrepresented. While African Americans comprise 13% of the US population, they represent 40% of the homeless population (Carter, 2011; HUD, 2018; Humes, Jones, & Ramirez, 2011). Single adults may also be at particular risk for homelessness comprising up to 67% of the homeless population (HUD, 2018). Additionally, older adults disproportionately experience homelessness (Culhane, Metraux, Byrne, Stino & Bainbridge, 2013; Culhane et al., 2019).

In addition to a lack of housing, many homeless people have health-related problems that require attention. Homelessness among people with psychiatric disabilities, including mental illness, substance abuse disorders, and co-occurring mental health and substance use disorders, is a specific concern. Researchers estimate that approximately one-third of homeless adults have a mental illness, while another one-third have substance abuse issues (The Substance Abuse and Mental Health Services Administration, 2011 [SAMHSA]; US Conference of Mayors, 2015).

Meanwhile, researchers suggest that individuals become homeless for different reasons. Burt (2003) proposed two homelessness origin typologies. People may become homeless due to structural causes such as changes in housing or employment, lack of education, lack of institutional support for people with disabilities, or discrimination. They may also become homeless because of individual risk factors, such as psychiatric or physical disabilities and other

circumstances. For many, both are at work. These individuals frequently utilize other costly public services, such as in-patient psychiatric care or incarceration (Poulin, Maguire, Metreaux & Culhane, 2010). Despite considerable research, questions still persist about how to develop and deliver the best services to those experiencing and at risk of experiencing homelessness.

Supportive Housing in the US

Supportive housing emerged as a way to overcome a gap in homeless services. Supportive housing is typically provided for individuals who are homeless and experiencing barriers to housing stability, including severe mental illness, substance use problems, and chronic health conditions. It generally includes permanent housing with on-site or off-site staff support to promote the independence, recovery, and rehabilitation of residents (HUD, 2018; Rog et al., 2014).

People experiencing homelessness in the US typically begin receiving assistance in emergency homeless shelters. Though still common, they are no longer viewed as a long-term solution to homelessness. This change in philosophy, along with commensurate changes to federal funding streams, led to the creation of the supportive housing movement. Supportive housing service places "emphasis on the general need for housing among the population who are disabled by mental illness, as well as the critical need for housing for those who are homeless," or otherwise in need of appropriate shelter (Ridgeway & Zipple, 1990, p. 16).

People living in supportive housing come from diverse backgrounds and face a variety of barriers to independent living. According to a survey of supportive housing providers conducted by the Corporation for Supportive Housing [CSH] (2013), 68% responded that they were focused on serving chronically homeless individuals; 73% geared services to people with mental illness; and 53% attended to people with substance abuse issues. Meanwhile, according to HUD (2018),

47% of all of the supportive housing beds were set aside for individuals experiencing chronic homelessness. The other 53% included individuals who had experienced transitional or episodic homelessness. Providing services to meet such a wide array of needs is often difficult and inefficient.

Although the volume of supportive housing units has grown over the past decade, the demand for such housing still greatly outweighs supply (Giblin, 2014; U.S. Conference of Mayors, 2016). In New York City, for example, only one in six of the 20,000 people approved for supportive housing has been successfully placed (Glen, 2014). In fact, the U.S. Conference of Mayors has cited a need for more supportive housing each year since 2008 (U.S. Conference of Mayors, 2016, 2008).

Homeless Prevention and Efficient Use of Supportive Housing

Recently, there have been efforts to shift from a reactive homeless services system to a more proactive system that focuses on homelessness prevention (Montgomery, Metraux, & Culhane, 2013). In a framework originating from the field of public health (Caplan, 1964), homeless services have been categorized into a primary-, secondary-, and tertiary-tiered system. Within this framework, primary, or preventative services would help people maintain housing by targeting poverty and economic concerns that contributed to the homelessness risk of individuals (Draine, Salzer, Culhane & Hadley, 2002; Montgomery, Metraux, & Culhane, 2013). Individuals receiving secondary services would be returned to permanent housing as quickly as possible, for example through rapid rehousing. Individuals with complex needs would get priority in tertiary programs, such as supportive-housing services (NAEH, 2014; U.S Conference of Mayors, 2016).

People with various homelessness experiences have found their way to supportive housing, but within this new framework these programs would only serve individuals who

needed higher levels of support through the mental health system (Montgomery, Metraux, & Culhane, 2013). At the same time, policy has been slowly shifting towards the efficient use of available supportive housing, whereby people who can most benefit from supportive housing receive prioritized admission so that this scarce resource can be applied most efficiently (CSH, 2015; HUD, 2014).

The Emergence of Moving On Programs

Currently, while supportive housing helps people transition from homelessness, these programs typically make no effort to encourage tenants to move to alternative housing with lower levels of support (Woodhall-Melnick & Dunn, 2016). Some studies have suggested that residents may not be interested in staying in supportive housing permanently and are capable of moving on to housing not connected to program supports (Harder & Company Community Research, 2016; Livingstone & Herman, 2017; National Alliance to End Homelessness [NAEH], nd; Tempel, 2013). In recent estimates, researchers have found that between 25% and 40% of supportive housing residents were able to move on to community living (NAEH, nd; Tempel, 2013). Meanwhile, a prevention framework would make supportive housing more efficient by assisting those who no longer need supportive housing so that they might successfully move on from those units; this would open up their units for currently homeless people. Such programs are compatible with the broader Recovery Movement, which promotes recovery as a realistic goal of treatment for persons with psychiatric disabilities; it posits that a "normal" life in the community is achievable (New Freedom Commission on Mental Health, 2003).

Research Aims and Theoretical Approach

Participants for this study came from Moving On programs within several supportive housing programs. This study sought to identify the meaning of the upcoming transition and to

highlight the importance of individual experience within larger systems by exploring the following research questions:

1. How do formerly homeless people currently residing in supportive housing, including people with psychiatric disabilities, experience the preparation for transition from supportive housing?
2. What are the factors that assist or discourage formerly homeless persons, including people with psychiatric disabilities, in their preparation to move from supportive housing into more independent, community housing?

From a recovery-oriented approach, I explored supportive housing as the final step at the end of the homeless service continuum. This study identified factors that might be incorporated into a service approach that assists people who are transitioning from supportive housing by addressing the concerns of residents. It considered services necessary to safely transition residents into appropriate housing that is least restrictive and as independent as possible.

This research was guided by interpretive interactionism (Denzin, 2001; Jefford & Sundin, 2013; Sundin & Fahy, 2008). According to Denzin (2001), this approach is useful in exploring "personal troubles" and the public policies created to address them. It "speaks to the interrelationship between private lives and public responses to personal troubles. It works outward from the biography of the person" (Denzin, 2001, p. 2). To deconstruct Moving On programs in supportive housing, this study includes a review of relevant theoretical, historical, and empirical literature.

The theoretical framework for the research question has been placed within ecological systems theory and the social construction of target populations because individuals are deeply affected on a daily basis by the environments they live in. How groups of people are perceived

affects if and how we mitigate the social problems that impact them. Factors within the systems of care developed to mitigate social problems have lasting effects on the lives of people seeking assistance, changing life trajectories in positive and negative ways.

CHAPTER II: HISTORICAL AND POLICY CONTEXT

Historical Review

Since the Moving On program model extends beyond current supportive housing services, it is important to examine shared historical events affecting people in supportive housing, particularly issues regarding economic disadvantage, psychiatric disability, and homelessness. I approached the review from two broad constructs: an economic and a recovery framework. The factor most closely related to the economic disadvantages experienced by individuals with histories of homelessness, including those with psychiatric disabilities, is the lack of affordable housing. Factors related to the recovery framework include the deinstitutionalization of the mentally ill; the creation of community service initiatives following deinstitutionalization; the criminalization of people who are homeless or psychiatrically disabled; and the Recovery Movement. Specifically, these factors have shaped the services available to people with histories of homelessness and psychiatric disabilities.

Lack of Affordable Housing

In recent years, many people have had unprecedented difficulty finding and maintaining affordable housing. The lack of affordable housing is the primary cause of homelessness and an important factor for people trying to move out of supportive housing and into the community. Over the course of the past several decades in many cities across the US, the affordable housing supply has diminished while the demand has increased. In the 1950s, for example, New York City had 200,000 single-room occupancy units. However, in recent years urban renewal efforts, building codes, and tax incentives have reduced that number to 40,000 units (Supportive Housing Network of New York, nd). Although the New York City Public Housing Authority provides homes for 180,000 low-income residents, there are currently 207,000 people on waiting

lists for these units (Goodman, 2018). Particularly in urban areas, inexpensive housing options such as through federal housing subsidies, rent-controlled apartments, or single-room occupancy units for poor or low-income individuals have become increasingly scarce and difficult to obtain (Goodman, 2018; National Low Income Housing Coalition, 2015 [NHLIHC]; Tucker, 1991).

Many blame Federal disinvestment efforts for the lack of affordable housing (NHLIHC, 2015; Rice, 2016), and local initiatives have been unable to fill the gap. Consequently, many people have had difficulty obtaining and maintaining affordable housing (Pelletiere, Canizio, Hargrave & Crowley, 2008). The recent economic and housing crises have meant that many more low-income renters have experienced problems of rent burden across the US (HUD, 2015). In 2013, almost 8 million people qualified as having worst case housing needs. They were defined as low-income renters who did not receive government housing assistance. They paid half their incomes for housing and lived in inadequate housing, or both (HUD, 2015). Even with rental assistance, only approximately half of very low-income renters have access to affordable housing. At the same time, low-income New Yorkers deal with increased rent burdens and very low vacancy rates (HPD, 2015). While vacancy rates among the housing markets most expensive rentals has grown from 5% to 7%, the rate among affordable units for low-income families has consistently remained around 1% (HPD, 2015). Ultimately, the lack of affordable housing and rent burden hardship are persistent barriers for today's low-income individuals including those with histories of homelessness.

Deinstitutionalization of the Mentally Ill

Deinstitutionalization was a call for change in the care for people with mental illnesses, but issues of care coordination and inadequate community services led to many vulnerable people without the vital services necessary to live safely in the community. The

deinstitutionalization movement gained momentum after World War II when advocates for people with mental illness recommended community alternatives to institutionalization because of overcrowding in psychiatric hospitals and other deleterious conditions there (French, 1987; Goldman & Grob, 2006; Redick & Witkin, 1983). In the decades that followed, court decisions and legislative changes ensured that people with mental illnesses gained the right to receive humane treatment and were protected from indefinite admittance to inpatient treatment facilities (Baxstrom v. Herald; French, 1987; O'Connor v. Donaldson; Rouse v. Cameron). These court cases set the stage for the nation-wide deinstitutionalization of 1.5 million people with mental illness. While the community initiatives that followed deinstitutionalization attempted to support people transitioning from psychiatric hospitalizations, they fell short of their intended aims. People in recovery from psychiatric disabilities still do not get the best possible care in the community that would enable them to live in the least restrictive settings and live independent lives.

Community Service Initiatives

In order to facilitate moving people with mental illnesses from institutions to communities, the Federal government partially covered the service costs for these people. For example, in 1963, the Mental Retardation Facilities and Community Mental Health Centers Construction Act provided grants for the initial cost of staffing newly constructed community centers (Lamb, 1984). Additionally, Medicaid and Medicare in 1965 and Supplemental Security Income in 1972 solidified federal funding streams that attempted to support people with severe mental illness to live and receive services in the community (Koyanagi, 2007).

With increased funding, community service initiatives expanded available community mental health services (Goldman, 1999). While these programs were created in response to the

deinstitutionalization of people with severe mental illness, community mental health centers were promoted as preventative services to a broader group of people with less complex mental health needs (Grob, 1994). The U.S. General Accounting Office criticized the federal government for its failure to prioritize and coordinate the service needs of individuals returning to communities after deinstitutionalization (U.S. General Accounting Office, 1977). At the same time, more psychiatric community services targeted people with severe mental illness living in the community, such as those associated with many supportive housing programs (Grob, 1991). Although community psychiatric services were neither well funded nor widely available, some psychiatrically disabled people who were formerly served in institutions were able to live and receive psychiatric services in the community (Grob, 1991).

In 1978, in an attempt to improve community services, the National Institute for Mental Health (NIMH) supported two broad goals: to create new community mental health services and to promote integration among providers (Goldman, 1999; Turner & TenHoor, 1978). In 1980, Congress passed the Mental Health Systems Act, and NIMH and the Department of Health and Human Services released a joint plan to focus on the health of people with chronic mental illnesses (Department of Health and Human Services, 1980; Goldman, 1999). The plan outlined broad ideas to address healthcare, housing, and disability benefits for people with severe mental illness. Soon after the plan was published, community services initiatives faced implementation challenges such as lack of resources, decreased funding, difficulty with service coordination among providers, and changing federal priorities (Goldman, 1999; Goldman & Morrissey, 1985). Although individuals with mental illnesses returned to communities and acquired funding for these community mental health initiatives, gaps in services resulted from barriers to service

development and care coordination. Although the number of mentally ill people served in institutions declined, many people returned to communities that lacked adequate services.

Advocates and researchers continued efforts to improve services and service coordination. In 1986, the Program on Chronic Mental Illness, a privately funded service demonstration, concluded that in order to achieve desired mental health outcomes among individuals, programs needed "state of the art" treatment and coordination with other service sectors to improve benefits and housing (Goldman et al., 1992; Lehman, Postrado, Roth, McNary & Goldman, 1994; Newman, Rechovsky, Kaneda & Hendrick, 1994). In 1993, the Department of Health and Human Services and SAMHSA created Access to Community Care and Effective Services and Supports (ACCESS) with initiatives such as supportive housing, Assertive Community Treatment (ACT), and employment services programs (Goldman, 1999; Randolph, Blasinsky, Leginski, Parker & Goldman, 1997).

Criminalization of the Homeless and Psychiatrically Disabled

Although steps were taken to secure basic rights for deinstitutionalized mentally ill people, communities struggled to meet the complex needs of these individuals and many people did not get the community-based assistance they needed. Researchers estimate that approximately one-third of homeless adults has a substance abuse issue and one-third has a mental illness; these health concerns contribute to the revolving door of institutional settings such as hospitals, treatment centers, or prisons (Metraux, Byrne & Culhane, 2010; SAMHSA, 2011; US Conference of Mayors, 2015). As a crisis emerged, a policy response aimed at criminalization intended to promote community safety but was rooted in the negative perception of people with psychiatric disabilities and people experiencing homelessness.

Beginning in the 1970s, authorities involved in the War on Drugs focused on reducing the drug supply using criminal justice techniques, such as mandating offenders to court or incarceration rather than focusing on the health-related harms of drug misuse (Drug Policy Alliance 2014, 2015; Reuter, 2013). In the 1980s, substance users were more strongly penalized for both possession and distribution. The Anti–Drug Abuse Act of 1986, for example, required mandated minimum sentences of five years for people convicted of trafficking 500 grams of crack cocaine and ten years for those convicted of trafficking 5,000 grams of powder cocaine. With the Anti–Drug Abuse Act of 1988, anyone involved in these offenses was subject to harsher sentences. According to Schneider and Ingram (1993), because people addicted to drugs are a part of a negatively constructed group with little political power, they are targeted with policies that punish them if they do not comply with the desired behavior. In 2013, of the 1.5 million drug arrests, 80% were for possession only (Drug Policy Alliance, 2015). Additionally, like overrepresentation of minorities in the homeless population, people affected by imprisonment for drug use are disproportionately Black and Hispanic (Carter, 2011).

People experiencing homelessness have also been criminalized. In the 1990s, the New York Police Department enacted quality of life policing in an attempt to improve public spaces (Greene, 1999). In New York City and across the country, homeless people were arrested for behaviors such as sleeping on trains and park benches and loitering in public (National Coalition for the Homeless, 2004; National Coalition for the Homeless & National Law Center on Homelessness & Poverty, 2006). Under this initiative, people who were perceived to be homeless were held accountable for behaviors that were deemed acceptable when displayed by others. For example, homeless people could be ticketed for drinking alcohol in Central Park or in Penn Station, while people attending a concert or waiting for their trains were able to drink

without incident (National Coalition for the Homeless, 2004). In addition, rather than viewed as needing healthcare services, people with substance use issues have been criminalized.

Along with the criminalization of homeless people and those needing drug treatment came the criminalization of the homeless and the mentally ill. Tsemberis and Elfenbein (1999) outline "the involuntary system," comprised of mental health statutes and police involvement, targeted mentally ill individuals experiencing homelessness. Since the 1975 the O'Connor v. Donaldson decision that limited involuntary institutional commitment to people who are a danger to oneself or others, more people with mental illness have ended up incarcerated (Martell, Rosner, & Harmon, 1995). Homeless mentally ill individuals are over-represented in the jail and prison populations; when compared to the general population, homeless individuals are 40 times more likely enter the criminal justice system and 21 times more likely to be mentally ill (Martell, Rosner, & Harmon, 1995). Additionally, according to Barr (1999), mentally ill individuals are more likely to be incarcerated for longer sentences than individuals without these conditions, and they often have less access to alternatives to incarceration programs.

In 1999, after an untreated mentally ill person living in the community killed a woman, New York State passed Mental Hygiene Law 9.60, outlining Assisted Outpatient Treatment (AOT) or Kendra's Law (https://www.omh.ny.gov/omhweb/kendra_web/ksummary.htm). According to this law, individuals with histories of mental illness, violence, and treatment non-compliance have the right to live in the least restrictive environment, but they can be mandated to treatment with an AOT order if they are not treatment compliant. Once the petition is approved, a healthcare professional enacts the order by calling the police and the person with mental illness is handcuffed and transported to court or to an inpatient psychiatric unit.

While people who experience homelessness often need help with such as mental illness and substance abuse, the public responses to the problems of homelessness, drug abuse, and mental illness have resulted in punishment through the criminal justice system as a way to meet the needs of the community, over those of the individual.

Recovery Movement

The Recovery Movement attempted to empower people with mental illness. In 2003, the New Freedom Commission on Mental Health called for a sweeping transformation of the mental health system, guided by the vision of recovery from chronic conditions and increased personal involvement in mental health. Despite a historical context of criminalization and punishment, the Recovery Movement has gained momentum in recent years.

Whereas recovery was initially defined as a reduction of psychological symptoms (Davidson, O'Connell, Tondora, Lawless & Evans, 2005; Harding et al., 1987), the contemporary understanding of recovery is multidimensional and has expanded to include the experiences of people with acute physical conditions, substance-use disorders, histories of trauma, or mental illnesses (Davidson et al., 2005). Additionally, more than symptom measurement defines recovery, people who are in recovery from traumatic experiences, such as homelessness, are engaged in a gradual, potentially life-long process to increase control over their lives and to remove the immediate effects of trauma from daily life (Davidson et al., 2005). A central aspect of modern recovery is that it now "involves the person's self-determined pursuit of a meaningful life in the communities of his or her choice in the face of an enduring impairment" (Davidson, Drake, Schmutte, Dinzeo & Andres-Hyman, 2009, p. 326).

Other key principles of recovery include involving individuals in their own treatment, the possibility of a non-linear recovery process, hope and the expectation for improvement, the

importance of peers in recovery, being involved in meaningful activities, overcoming stigma, empowerment, and the belief that individuals can recover (Bedregal, O'Connell, & Davidson, 2006; Davidson et al., 2005). Recovery-oriented services are person-centered, strengths-based, collaborative, and empowering. They assist people in pursuing meaningful lives that include taking part in "normal" activities such as employment, education, and socialization in local communities (Davidson, Tondora, Lawless, O'Connell & Rowe, 2009; Farkas, Gagne, Anthony, & Chamberlin, 2005).

Despite the growing momentum of the Recovery Movement, there are still questions about how best to implement recovery-oriented services for people with chronic conditions and specifically, those in the homeless services system (Gillis, Dickerson & Hanson, 2010; Le Boutillier et al., 2015, Salyers, Rollins, McGuire & Gearhart, 2009). The recovery framework has been expanded to include other experiences and conditions. Such abstract concepts such as the idea of "a meaningful life" are also a part of the recovery framework and legitimized by the fact that the empirical literature review provides insight into important dimensions of recovery among people with histories of homelessness such as housing stability, recovery from psychiatric disabilities, and community integration. Recovery among people with histories of homelessness may include recovery from psychiatric disabilities, chronic health conditions, histories of trauma, and various other experiences or conditions. Recognizing these challenges is helpful to understand better recovery among people preparing to move on from supportive housing.

Most often, people with psychiatric disabilities require support to find and remain in stable housing. Social services help them secure benefits, qualify for long-term affordable housing, and cope with problems that often co-occur with homelessness. Homeless adults with psychiatric disabilities often obtain this support while living in housing with social service

supports built in. This dissertation puts moving on from supportive housing within the general constructs employed by this recovery framework. The broader construct of recovery may provide an important framework to better understand recovery from homelessness, including the experiences of people preparing to move on from supportive housing, the final stop in the homeless services continuum. Furthermore, the recovery framework may help to guide service and policy development for people making this transition.

Overview of Housing Services for the Homeless

Essential to appreciating the choice individuals face when considering moving out to independent community housing is the level of services they receive within supportive housing. Since the 1990's, supportive housing has become the standard practice for service delivery for homeless individuals, specifically for those who experience such threats to housing stability such as severe mental illness, substance use problems and chronic health conditions (Rog et al., 2014). Researchers and advocates have had difficulty offering a simple definition of supportive housing because such programs may vary in many ways including typical length of stay, presence of on-site or off-site support services, size of dwelling unit, and whether such units are located in congregate or scatter-site settings (Tabol, Drebing & Rosenheck, 2010). Despite these variations, all supportive housing includes some combination of permanent housing and onsite or offsite social support for individuals experiencing barriers to stable independent living.

Historically, professionals have delivered supportive housing services using a "treatment first" model, also known as a linear supportive housing model or the continuum of care model, and it has included several stages that are meant to guide individuals toward independence (Gulcur, Stefancic, Shinn, Tsembelis & Fischer, 2003). A traditional prerequisite in order to receive services is that a person must first achieve sobriety and become engaged in mental health

treatment. Within this framework, only when the provider determines that the client is "housing ready" and compliant with services does the client graduate to less-restrictive settings (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005). Supportive housing is presumed to be the final stop in the continuum of care and generally involves permanent housing tenure (either in a single room with access to shared cooking and bathing facilities or in a self-contained unit) combined with intensive on or off-site staff support to promote independence, recovery, and rehabilitation (Rog et al., 2014; Tabol, Drebing & Rosenheck, 2010).

However, questions about the effectiveness of continuum of care services and the rights of clients have led advocates to propose other ways of delivering services to homeless people with psychiatric disabilities. For example, in 2008, Housing First, a program developed by Pathways to Housing in New York City, was deemed an evidence-based practice (www.nrepp.samhsa.gov). Housing First is a supportive housing model that incorporates principles such as client choice and community integration while providing permanent housing without pre-conditions. Housing First programs allow individuals immediate access to apartments in the community with off-site case management services delivered through a harm reduction model (Padgett & Henwood, 2012). Unlike other programs for homeless people, these programs do not require sobriety and treatment compliance for independent housing eligibility (Tsemberis & Asmussen, 1999).

Meanwhile, supportive housing has changed over time to model more closely aligned with the feature that most defines Housing First: unconditional housing. According to the Corporation for Supportive Housing (2014), all supportive housing, including programs at the end of the continuum of care and Housing First programs, now provide quality permanent and affordable housing; access to housing without any preconditions; a comprehensive, person-

centered approach; and community integration. While there is abundant research comparing Housing First programs to the myriad of services along the continuum of care, including "treatment first" and "treatment as usual," supportive housing program models constituting the final stop in the continuum of care require closer independent examination. For clarity in the following review, supportive housing describes services obtained at the end of the continuum of care. All programs compared in research with Housing First will be called continuum of care and will include any services provided along the continuum of homeless services (e.g., treatment first, temporary and permanent supportive housing programs, and what is called in the literature "treatment as usual").

Evidence-Based Practices

Recently, evidence-based practices have been applied to more effectively organize services to homeless adults. Among these services are Housing First and Critical Time Intervention (www.nrepp.samhsa.gov). The Housing First approach, an established evidence-based supportive housing model, asserts that several of its components contribute to client success. Studies that compare Housing First with programs in the continuum of care have found better housing stability and community integration under the model (Aubry, Nelson, & Tsemberis, 2015; Greenwood, Shaefer-McDaniel, Winkel & Tsemberis, 2005; Gulcur, Stefancic, Shinn, Tsemberis & Fischer, 2003; Yanos, Felton, Tsemberis & Frye, 2007). Housing First clients have lower rates of substance use and higher rates of participation in substance abuse treatment programs; they are also less likely to leave their program and make decreased use of psychiatric hospitals when compared to those in continuum of care programs (Gulcur, Stefancic, Shinn, Tsembelis & Fischer, 2003; Padgett, Stanhope, Henwood, & Stefancic, 2011).

Researchers have also found that other service models are effective in assisting homeless people return to and remain in communities. For example, Critical Time Intervention (CTI), an evidence-based service model designed to help prevent repeated homelessness among people transitioning from institutions to community settings has been found to improve housing stability and decrease the likelihood of homelessness and re-hospitalization (Herman et al. 2000; Susser et al. 1997). It has also been found to alleviate some psychiatric symptoms (Herman et al. 2000). Furthermore, CTI has been adapted for use with different populations in different settings, and it can be applied to various transitions (Baumgartner, Carpinteiro da Silva, Valencia & Susser, 2012; Herman et al., 2011; Lako, et al., 2014; Samuels, 2010; Tomita & Herman, 2012).

The introduction of evidence-based practices, especially those that have incorporated independence, client choice, and self-determination, is vital to policy change for this population. As described in the following review of the literature, Schneider and Ingram (1993) suggest, policies aimed at people with histories of homelessness and psychiatric disabilities, with negative social constructs, are usually coercive or punitive. If services assisting this population are going to change, they need to be evidence-based. As the authors explained, "Negatively constructed powerless groups will usually be proximate targets of punishment policy. …The negative social constructions make it likely that these groups will often receive burdens even when it is illogical from the perspective of policy effectiveness" (Schneider & Ingram, 1993, p. 337-338). One potential strategy for policy change for this population is to continue to test outcomes and efficiency of service models that value client rights and social justice.

CHAPTER III: LITERATURE REVIEW

Both the economic and recovery frameworks are better understood through a review of applicable theories, such as ecological systems theory, social constructivism, and Goffman's (1961) the total institution. Within the empirical literature review, I will examine the foundation of primary, secondary, and tertiary programs for individuals with histories of homelessness. Primary programs are geared toward individuals affected by transitional homelessness and include those with housing subsidies. Secondary programs are aimed at assisting recently homeless individuals and include Critical Time Intervention and Rapid Rehousing. Tertiary programs include supportive housing and Housing First programs, in particular. Lastly, I will assess studies exploring the transition out of supportive housing.

Review of Theoretical Literature

Ecological Systems Theory

Researchers employ ecological systems theory as a framework to understand where a person is situated and interactions among systems including the micro-, meso-, exo-, and macrosystems (Bronfenbrenner, 1979). The microsystem involves "a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (Bronfenbrenner, 1979, p. 22). This suggests that an individual is immediately affected by the systems within which they operate daily such as the supportive housing community. The definition of mesosystem is the "interrelations among two or more settings in which the developing person actively participates…" (Bronfenbrenner, 1979, p. 25). This level may include the resident's family interacting with members of the supportive housing community. Meanwhile, the exosystem contains arrangements that affect the individual, but do not actively involve them. These systems may include housing markets or

government agencies that fund or regulate the supportive housing program. The macrosystem refers to themes at lower level systems that exist among subcultures or the culture as a whole (Bronfenbrenner, 1979, p. 26). For example, supportive housing programs in New York may look different from programs in other states. It might also be true that subpopulations such as veterans or families may receive modified services as compared to those provided to others.

For the supportive housing resident, the ecological transition is another important concept. This term refers to the way in which a change in role or setting effects a person's relative position to their environment (Bronfenbrenner, 1979). The current study investigated supportive housing residents' experiences as they prepared to make an ecological transition from one microsystem to another. As Bronfenbrenner (1979) explains, every transition is "a ready-made experiment of nature with a built-in before-after design in which each subject can serve as his own control (p. 27)." The current study also explored the residents' mesosystems, such as how they experienced their home environment as it interacted with other systems in their lives.

Social Construction of Target Populations

Social construction theory is rooted in symbolic interactionism and posits that reality is socially constructed; it argues that what we know to be true or "reality" is affected by the social context within which it appears (Berger & Luckman, 1966; Hacking, 1999). Schneider and Ingram (1993) introduced social construction theory in relation to populations affected by social problems. According to these theorists, "Social constructions are stereotypes about particular groups of people that have been created by politics, culture, socialization, history, the media, literature, religion, and the like" (Schneider & Ingram, 1993, p. 335). Political power and social constructions of groups are combined to create a typology. When the element of high political power is added to positive and negative social constructions, advantaged and contender target

populations emerge respectively. When low political power is added to positive and negative social constructions, dependent and deviant target populations emerge (Schneider & Ingram, 1993). This has the potential for significant implications on what types of policies or policy changes are likely in the future.

Social constructions influence what policy tools are employed to address social problems affecting different target populations. Policy tools are "aspects of policy intended to motivate the target populations to comply with policy or to utilize policy opportunities" (Schneider & Ingram, 1993, p. 338). For deviants, who are people with low political power and negative social construction, policy tools tend to be coercive in nature and usually include sanctions and force (Schneider & Ingram, 1993). Even programs that are supposed to help people tend to use "authoritarian means, rather than attack the structural problems that are the basis of the problem itself" (Schneider & Ingram, 1993, p. 339). Furthermore, policies geared towards deviant populations try to achieve policy goals by changing a group's behavior, effectively "enabling or coercing people to do things they would not have done otherwise" (Schneider & Ingram, 1993, p. 335). Social constructionism highlights how external elements of power and control can affect someone's daily life through how a population is perceived and what options they are given. Several factors affect what solutions we employ to assist target populations, including how we think about groups of people and how people see their agency to affect change.

Goffman's Total Institution and the Mortification of the Self

Goffman (1961) defines the total institution as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (p. xiii). Some important factors of the total institution are its separation from the wider society, authority by which life

activities are controlled, a group-living environment, and a carefully planned roster of activities (Goodman, 2013).

According to the concept of the total institution, institutionalized people are transformed through a process called the mortification of the self. This process disrupts one's "command of his world- that he is a person with 'adult' self-determination, autonomy, and freedom of action" (Goffman, 1961, p. 42). The mortification of self is achieved through several different processes including role dispossession, programming and identity trimming, dispossession of property, imposition and degrading postures, stance, and deference patterns, contaminative exposure, disruption of usual relationships between the individual and their actions, and restriction of self-determination (Goodman, 2013).

Individuals who are a part of a target population for a program become acclimated to the culture of that program and their experience as a service-user changes how they see themselves and how they are seen by others. Although Goffman was describing the experience of living in institutions such as psychiatric hospitals, the total institution is made up of both concrete and social elements. Even though fewer mentally ill people are held in institutions, the social aspects of the total institution could still affect them.

Empirical Literature Review

A range of studies examine recovery-oriented practice affecting people with histories of homelessness including those with psychiatric disabilities. Policy makers and administrators can best design services that assist people in transitioning from homelessness by examining previously researched models to gain knowledge about effectiveness. Researchers can better understand what is important in the recovery process by examining studies of recovery-oriented service outcomes and studies exploring the meaning of recovery among formerly homeless,

psychiatrically disabled people. The following review is organized into studies of primary, secondary, and tertiary programs.

Primary Programs

Primary interventions have the specific goal of preventing homelessness and are situated within broader efforts to alleviate poverty. While some are universal others are exclusively offered to targeted subgroups (Shinn, Baumohl & Hopper, 2001). Individuals at risk of becoming homeless may benefit from programs that help targeted individuals gain access to affordable housing by decreasing rent burden through housing subsidies (Culhane, Metraux, & Byrne, 2011; Burt, Pearson & Montgomery, 2007; NAEH, 2006).

Housing subsidies. Housing subsidies are a common strategy used to decrease rent burden among individuals at risk of homelessness. While the studies include non-primary programs, housing subsidies are an important preventative strategy to help keep people from ever experiencing homelessness. Housing vouchers have been a component of homeless service programs, including rapid rehousing and Moving On pilots.

Some researchers have found that the type of voucher, temporary or long-term, is an important factor; temporary subsidies have gained popularity but have been scrutinized for increased homelessness risk post subsidy termination (Byrne, Treglia, Culhane, Kuhn & Kane, 2016; Institute for Children Poverty and Homelessness, 2013; Massachusetts Law Reform Institute, 2010; Rodriguez, 2013). Byrne et al. (2016) found for participants of both prevention services and rapid rehousing programs that had access to housing vouchers were associated with an increased risk of homelessness. In another study, Rodriguez (2013) found that a rapid rehousing participant's perception of their housing placement could increase homelessness risk for those participants who perceived that their housing placement was a temporary place to stay

instead of a permanent housing option. Other researchers have questioned the effectiveness of using temporary housing subsidies among homeless families due to risks of repeated homelessness once the subsidy is terminated (Institute for Children Poverty and Homelessness, 2013; Massachusetts Law Reform Institute, 2010).

Meanwhile, research suggests that access to long-term subsidies, such as those available through some supportive housing programs, can be a protective factor against repeated homelessness. For example, in one longitudinal study that included 397 single adults with histories of homelessness, participants were interviewed at baseline, five, and 15 months post housing placement (Zlotnick, Robertson & Lahiff, 1999). Participants who were able to access subsidized housing were more likely to achieve stable housing after exiting homelessness as compared to individuals without access to subsidies (Zlotnick, Robertson & Lahiff, 1999).

Researchers studying veterans also found a positive correlation between housing subsidies and placement duration. In a study of 460 single veterans with homelessness histories and psychiatric disabilities, participants were randomly assigned to one of three groups: living in a rental subsidy supported apartment and receiving intensive case management services, receiving intensive case management without access to a housing subsidy, or standard care (Rosenheck, Kasprow, Firsman, & Liu-Mares, 2003). Those participants with access to housing subsidies were housed for significantly more days when compared both to those without housing subsidies and those receiving "standard care." Specifically, participants in the group with access to housing subsidies were housed 16% longer than the group without housing subsidies and 25% longer the standard treatment group (Rosenheck, Kasprow, Firsman, & Liu-Mares, 2003).

Newman et al. (1994) also explored housing quality and affordability among 299 individuals with chronic mental illnesses in other aspects of life. Participants who perceived an

improvement in their housing conditions were more likely to experience greater housing stability and fewer service needs (Newman et al., 1994). Specifically, an 18 month follow up showed that participants in the housing subsidy program were more likely to perceive greater housing affordability and quality when compared to pre-subsidy housing perceptions. Participation in the housing subsidy program was also associated with fewer reported needs with daily living tasks when compared to pre-subsidy housing arrangements (Newman et al., 1994). Additionally, participants who perceived greater housing affordability spent fewer days hospitalized (Newman et al., 1994). Participation in this program, including utilization of a housing subsidy, was associated with moving to an independent apartment without onsite support.

While research has determined housing subsidies are helpful for housing stability and other desired outcomes, questions remain about how to best utilize this tool for homeless prevention. In a study that examined survey data from 1985 to 1988, researchers explored the effect of housing subsidies on homelessness and concluded that applying normal selection methods to at-risk individuals would result in five people avoiding homelessness per 100 subsidized housing units (Early, 1998). Early (1998) further posited that improved efforts to target those individuals with greatest homelessness risk would be necessary to more effectively prevent homelessness with housing subsidies.

Efficiency and Effectiveness in Primary Programs

Problems of efficiency and effectiveness within homeless prevention programs are a barrier to their implementation (Burt, Pearson & Montgomery, 2007). In the case of 8 million households HUD (2015) identified in worst case housing situations, not all of these households would require intervention to remain housed. To be efficient, homeless prevention programs need to be able to identify at risk individuals. Within homeless services, targeting individuals

with homelessness risk becomes a question of finding the difference between those individuals at risk who are able to avoid homelessness, and those at risk who would lose their housing without assistance. If prevention efforts cast too wide a preventative net, programs would assist "false positive" cases or those individuals who would receive services but would not have become homeless if left unaided. The cost effectiveness of diverting individuals from the homeless services system is eroded by serving "false positive" cases (Burt, Pearson, & Montgomery, 2007; Culhane, Metraux, & Byrne, 2011; NAEH, 2006; Shinn, Baumohl, & Hopper, 2001). In practice, that means that homelessness prevention efforts are flawed because they are typically triggered by only one factor, often some sign of imminent risk such as an eviction notice or an institutional discharge; this leads to a misappropriation of the limited available funding due to the aforementioned problem of identifying individuals at imminent risk for homelessness versus those who might be considered false positives (Shinn, Baumohl, & Hopper, 2001). In response to these concerns, some researchers advocate for increased investments in affordable housing investments (Shinn, Baumohl, & Hopper, 2001). In the absence of universal prevention strategies and to account for issues of efficiency and effectiveness with targeted interventions, typical homeless strategies assist people *after* they become homeless; this is an experience that is known to have deleterious effect.

Secondary Programs

While efficiency and effectiveness have limited the use in homeless prevention programs, HUD (2005) has suggested the value of directing efforts toward secondary interventions. One popular intervention, Critical Time Intervention, involves assisting at-risk individuals to transition from institutions, such as hospitals, prisons, and homeless shelters. Another secondary

program is rapid rehousing, where individuals experiencing a recent instance of homelessness are securely housed as quickly as possible.

Critical Time Intervention. Researchers have found that people with histories of mental illness are at risk for adverse outcomes during transitions from hospitals, prisons, or homeless shelters, such as returning to these institutions through the "revolving door" (Draine & Herman, 2007; Haywood et al., 1995; Herman, Susser, Jandorf, Lavelle, & Bromet, 1998). Critical Time Intervention (CTI) has been shown to result in fewer homeless nights for those participating in CTI when compared to those receiving regular services (Susser et al. 1997). Research has also shown that this intervention lessens the frequency of negative psychiatric symptoms for participants (Herman et al., 2000). CTI shows that by giving individuals the support they need when they need it, vulnerable people are more able to maintain housing and better manage mental illness during transition periods.

As CTI is based on principles and not fixed elements, it offers a flexible model that can be adapted to assist different populations through different transitions. For example, CTI has been adapted to assist homeless families transitioned into stable housing (Samuels, 2010). It has been adapted to help mentally ill individuals released from psychiatric hospitalization to assist with improving housing stability and lowering risk for repeated hospitalization (Herman et al., 2011; Tomita & Herman, 2012). A CTI model incorporating peer support and mental health workers has been used to assist mentally ill individuals in Latin America with continuity of community services (Baumgartner et al., 2012 & Carpinteiro da Silva, Lovisi, Conover, & Susser, 2014). Another adaption of the CTI model has been used in the Netherlands to assist homeless adults transition from emergency shelters to stable housing, and to help domestic abuse victims improve their quality of life when transitioning out of emergency shelters (Lako, et al.,

2014). While CTI has been adapted across populations and transitions, its central aim has been to assist vulnerable people through a critical transition by improving continuity of care and community integration.

Rapid rehousing. Rapid rehousing initiatives provide financial assistance and case management services to individuals with the goal of quickly rehousing homeless individuals in emergency shelters by placing them in private housing (U.S. Interagency Council on Homelessness [USICH]; 2015, p. 20). The three main components of rapid rehousing include housing identification, financial assistance, and individually tailored case management services (US Department of Veterans Affairs, 2015; NAEH, 2014). In recent years, as homelessness prevention strategies gained popularity, rapid rehousing programs were developed for veterans and their families (Byrne et al., 2016; HUD, 2011; U.S. Department of Veterans Affairs, 2015). Meanwhile, there is very little research exploring outcomes of programs serving these individuals.

In one study of homeless veterans and families, researchers evaluated records from the U.S. Veterans Administration Supportive Services for Veteran Families Program (SSVF), a program utilizing rapid rehousing or prevention services to assist veterans in entering or maintaining permanent housing (Byrne et al., 2016). Researchers examined 41,545 records from October 2011 through September 2013 to assess homelessness risk among veterans with histories of homelessness and among veterans at risk of losing their housing and stratified the records by household (individual vs. family) and service type (rapid rehousing vs. prevention). Byrne et al. (2016) found that, among the rapid rehousing participants, 26% of single veterans returned to homelessness within two years of rapid rehousing participation. Additionally, rapid rehousing participants who received assistance with their security deposit and remained engaged in services

for more than 90 days had a decreased homelessness risk following participation (Byrne et al., 2016). Another notable finding was that individuals who received rental assistance had an increased risk for homelessness following SSVF participation. Although the researchers suggest alternative interpretations, this finding may suggest that the temporary rental assistance available through rapid rehousing programs (five months in one year or eight months in three years) was not sufficient to avoid homelessness risk (Byrne et al., 2016; Department of Veterans Affairs, 2018, pp. 59-60).

In another study, researchers examined 9,013 health and homeless management information system records for individuals using homeless prevention services including rapid rehousing to exit homelessness between November 2009 and November 2010 (Rodriguez, 2013). While involvement in rapid rehousing programs ameliorated some homelessness reoccurrence risk, access to these housing subsidies did not effectively negate it (Rodriguez, 2013). For example, in this study, despite access to a temporary housing subsidy, individuals with a disabling condition and a history of homelessness had a greater risk for reoccurring homelessness when compared to people without them. Additionally, individuals who were discharged into housing perceived to be non-permanent had greater risk of experiencing homelessness again in the future. Similar to Byrne et al. (2016), this study also found that in rapid rehousing programs, access to time-limited housing subsidies did not effectively negate homelessness risk.

Tertiary Programs

In their study evaluating community homelessness prevention strategies HUD (2005) identified two broad strategies: short-term support and long-term solutions. Whereas the aforementioned secondary interventions would constitute short-term support, some individuals

with histories of homelessness require long-term assistance to maintain stable housing. Supportive housing typically assists homeless individuals with barriers to housing stability, including psychiatric disabilities and community integration. Supportive housing programs provide long-term, stable housing and support to promote independent living in the community, and in the least restrictive setting (HUD, 2015; Rog et al, 2014).

Supportive housing. Beyond suggesting that supportive housing is a fiscally prudent alternative to continued homelessness, recent studies have shown that supportive housing allows individuals to access and maintain housing better than those engaged with other kinds of assistance (Culhane, Metraux, & Hadley, 2002; Leff et al., 2009; Martinez & Burt, 2006; McHugo et al., 2004). Meanwhile, mixed findings have emerged around public service usage and psychiatric disability recovery outcomes (Kertesz et al., 2009; Kessel at al., 2006; Woodhall-Melnik & Dunn, 2016). A meta-analysis of 30 housing intervention studies involving different types of supportive housing, noted that living in any type of supportive housing showed significant increases in housing stability and decreases in hospitalizations when compared with non-model housing (Leff et al., 2009). The meta-analysis also found significantly increased satisfaction in certain types of supportive housing units; scatter site units were preferred over other types of units, but no significant differences occurred in satisfaction among different types of supportive housing programs (Leff et al., 2009).

Housing stability. Researchers have found that supportive housing programs achieve housing retention ranging from 68% to 86% depending on the type of supportive housing and the length of follow up (Kessel at al., 2006; Martinez & Burt, 2006; McHugo et al., 2004). For example, Martinez and Burt (2006) found that 81% of 236 single adults with psychiatric disabilities had retained housing one year after supportive housing placement. Meanwhile,

McHugo et al. (2004) noted that housing retention at 18 months differed among different types of supportive housing: 68% in scatter site and 86% in congregate care. After two years of follow up, Kessel at al. (2006) found that 74% of 114 participants who had been admitted into supportive housing still retained their housing.

Meanwhile, some research has shown that public service usage remains high despite participation in a supportive housing program. For example, Kessel at al. (2006) explored instances of public service usage among a cohort of 249 homeless and psychiatrically disabled applicants to supportive housing, 114 of whom had been admitted into supportive housing and 135 who qualified for supportive housing but were not admitted. Researchers obtained public service usage data for the two years prior to supportive housing application and for the two years that followed (Kessel et al., 2006). According to this study, there was no significant difference in public service use between those who were placed in supportive housing and those who were not; both groups had consistently high use across various public services for health, mental health, and substance abuse (Kessel, et al., 2006).

Recovery outcomes. Other research has found supportive housing residents experience improvements in recovery from psychiatric disabilities; this is evinced by reduced psychiatric symptoms, fewer visits to the emergency room, fewer and shorter inpatient hospital stays, and improved life satisfaction (Culhane, Metraux, & Hadley, 2002; McHugo et al., 2004). These findings are similar to another study (Martinez & Burt, 2006) that looked at emergency service utilization for two years prior and two years following supportive housing placement among 236 single adults with psychiatric disabilities. Findings suggested that supportive housing placement significantly reduced emergency room visits and inpatient hospital stays. Whereas 19% of participants had been hospitalized in the two years leading up to supportive housing, only 11%

were hospitalized in the two years following placement. Similarly, though, 53% of participants had an emergency room visit in the two years prior to supportive housing entry, 37% had one in the two years following placement.

Specific research exploring differences among supportive housing models found that all residents showed improvement. McHugo et al. (2004) used a randomized control trial to test residents with schizophrenia receiving services from two types of supportive housing, a congregate model with onsite support and a scatter-site model with off-site support. The study found that participants had decreases in psychiatric symptoms and reported improved life satisfaction (McHugo et al., 2004). Residents from various types of supportive housing programs experienced several promising outcomes related to their psychiatric disabilities including reduced symptoms and fewer emergency room visits.

Housing First. Many researchers have compared recovery outcomes between and within such supportive housing modalities such as Housing First and programs within the continuum of care, including treatment first, supportive housing programs, and "treatment as usual." For readability, throughout the review, these programs compared to Housing First will be referred to as "continuum of care." Researchers compare these two paradigms as they relate to outcomes such as housing stability, community integration, recovery outcomes, and client choice.

Housing stability. Housing stability is an important outcome for people recovering from homelessness and psychiatric disabilities. Researchers have found that residents in Housing First programs manifest greater housing stability when compared to outcomes experienced by continuum of care clients. In some studies, housing retention has been measured at the program-level, defined as a greater proportion of people housed. In the Canadian At Home Study, outcomes were compared among 1158 Housing First residents and 990 people receiving

continuum of care services. The study found that, proportionally, there were twice as many Housing First participants who spent all of their time in stable housing over a 6 month period compared to continuum of care participants (62% versus 31%, respectively; Aubry, Nelson, & Tsemberis, 2015). Meanwhile, other studies have tracked housing retention within Housing First programs over various periods of time (Padgett, Henwood, & Tsemberis, 2016, p. 57). Two studies measured housing retention over the course of one year and found that Housing First participants remained housing 97% and 84% respectively (Pearson, Montgomery, & Locke, 2009; Tsemberis, Kent, & Respress, 2012). Two separate studies measured housing retention over a two year period; each found that 84% of participants remained housed (Stefancic & Tsemberis, 2007; Tsemberis, Kent, & Respress, 2012). These were outpaced by a study in Vermont that found housing retention at 85% at the end of three years and, after almost four years, at 68% (Stefancic & Tsemberis, 2007).

Meanwhile other studies, defined housing stability as the absence of a return to homelessness or re-hospitalization and yield results akin to those in the abovementioned studies. In a study of 192 homeless individuals recruited from either the street or hospital using the Residential Follow-Back Calendar (RFBC), Greenwood et al. (2005) tracked changes bi-annually for a period of 36 months. They found that Housing First programs were associated with smaller proportions of time homeless when compared to participants referred to continuum of care programs (Greenwood, Shaefer-McDaniel, Winkel, & Tsemberis, 2005). Researchers from another study recruited 225 participants from similar streams and utilized the RFBC to find that Housing First had greater effects on reducing hospitalization in groups of residents recruited from hospitals and reducing homelessness for those who were street homeless prior to entry (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003). In total, studies have overwhelmingly

lauded Housing First as a service that improves housing retention and decreases hospitalization when compared to continuum of care.

Community integration. Another important outcome to consider in recovery from homelessness and psychiatric disability is community integration, a metric commonly defined along physical, social, and psychological dimensions (Gulcur, Tsemberis, Stefancic, & Greenwood, 2007; Wong & Solomon, 2002; Yanos et al., 2007). While physical integration has been defined as the extent to which an individual goes out into the community to participate in activities or to use services, social integration is the extent of an individual's social interaction with others (Wong & Solomon, 2002). Psychological integration measures feelings of belonging and one's emotional attachment to neighbors (Wong & Solomon, 2002). In the Housing First literature, community integration has been linked to housing setting, or where someone lives, as well as program model.

One study found that tenants, whether in individual apartments or congregate care, of Housing First or continuum of care programs defined their "locus of meaningful activity" as existing within the individual's following spheres: apartment or room, building, neighborhood, employment, or "none" (Yanos et al., 2007). The study concluded that locus of meaningful activity was strongly linked to type of housing, noting individuals living in independent apartments were more likely than people living in supportive housing to report the location of their meaningful activity as their apartment or neighborhood (Yanos et al., 2007). By contrast, individuals in congregate care settings were more likely than individuals living in independent apartments to report either no meaningful activity or that the location of their meaningful activity was the building where they lived (Yanos et al., 2007).

Gulcur et al. (2007) compared community integration among 183 participants of Housing First and continuum of care programs, and found certain predictors to physical, psychological, and social integration. Similar to Yanos et al. (2007), independent scatter-site housing was a predictor of social integration in that those with scatter site housing were more likely to engage with social supports and take part in social activities (Gulcur et al., 2007). Additionally, the study suggested other important predictors of community integration; such as that choice was a predictor of psychological integration. Moreover, it reported that psychiatric hospitalization prior to housing correlated to greater psychological integration whereas those who had obtained substance use services were more likely to have increased physical community integration but lower social integration.

Similarly, the aforementioned Canadian At Home Study suggested that for people with histories of homelessness and psychiatric disability, housing setting was important to community integration (Patterson, Moniruzzaman, & Somers, 2014). This came from examining two follow-ups, at 6 months and one year after receiving housing. Participants who had been randomly assigned to independent housing through Housing First were most likely to agree with "feeling at home" and that they "belong where they live," when compared to other participants who had been randomly assigned to housing through Housing First or still others who had been placed in continuum of care (Patterson, Moniruzzaman, & Somers, 2014).

Recovery outcomes. The Housing First literature also gives important information about recovery from psychiatric disabilities among people with histories of homelessness. When Housing First programs were compared to continuum of care, outcomes measuring improvement in psychiatric disabilities were mixed; it is not clear whether Housing First participants in recovery fare better than residents of other supportive housing programs. One study, employing

a combination of self-report and observation by research staff concluded that Housing First residents had significantly lower rates of substance use and substance abuse treatment utilization when compared to individuals in continuum of care programs (Padgett, Stanhope, Henwood, & Stefancic, 2011). Other studies found when comparing residents of Housing First and continuum of care programs no significant change in the level of psychiatric impairment, frequency of psychiatric medication use, in substance use, or impairment related to co-occurring disorders (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Padgett, Gulcur, & Tsemberis, 2006; Pearson, Locke, Montgomery, & Buron, 2007; Tsemberis, Gulcur, & Nakae, 2004). Another study found program assignment (continuum of care vs. Housing First) was not associated with decreased psychiatric symptoms, although participants in both housing modalities showed a decrease in psychiatric symptoms over time (Greenwood, Shaefer-McDaniel, Winkel, & Tsemberis, 2005).

In reviews of the Housing First literature, Kertesz et al. (2009) and Woodhall-Melnik and Dunn (2016) argue that the evidence around psychiatric disability recovery has been mixed and that future research is needed, specifically focusing on the use of Housing First with sub-populations. Meanwhile, Housing First advocates have concluded that there is "no empirical support for the practice of requiring individuals to participate in psychiatric treatment or attain sobriety before being housed" (Tsemberis, Gulcur, & Nakae 2004, p. 654). Research findings have suggested that Housing First participants had similar or improved substance abuse and mental health outcomes and better housing stability when compared to residents in continuum of care programs; in other words, giving individuals increased choice in housing and services did not impede substance abuse recovery.

Meanwhile, Housing First research suggests the importance of other factors in psychiatric recovery such as choice, mastery, social relationships, and engagement in meaningful activities (Greenwood et al., 2005; Padgett, Smith, Choy-Brown, Tiderington, & Mercado, 2016). In a study previously described in more detail, Greenwood et al. (2005) used models to test the hypotheses that choice and mastery would mediate the effects of homelessness on psychiatric symptoms (Greenwood et al., 2005). Researchers found that as choice increased, psychiatric symptoms decreased. Additionally, mastery and psychiatric symptoms were inversely correlated (Greenwood et al., 2005). In another study, researchers generated quantitative and qualitative recovery assessments from interview data using eight recovery domains (mental health, general medical health, work and employment, family relationships, substance use, significant-other relationships, housing satisfaction, and engagement in meaningful activities (Padgett et al., 2016). Researchers found that the nature of an interaction—either positive or negative—directly affected the recovery trajectories of corresponding social relationships and engagement in meaningful activities, among people with psychiatric disabilities living in either Housing First or continuum of care (Padgett, et al., 2016). While mental health and substance abuse outcomes improve in supportive housing, including in Housing First, the Housing First literature indicates that successful recovery is largely connected with factors that transcend any program model.

Efficiency and Effectiveness in Tertiary Programs

Recently, policy efforts have supported a shift away from a tertiary homeless service system to one that focuses more on prevention. In a homeless prevention system, supportive housing programs would serve only those individuals needing higher levels of support through the mental health system (Montgomery, Metraux, & Culhane, 2013). Other at-risk individuals would receive preventative or secondary services through the homeless services system, achieve

stable housing, and never reach supportive housing programs. In efforts toward a more efficient homeless services system, chronically homeless people would be given prioritized admission into supportive housing programs (CSH, 2015; HUD, 2014). Meanwhile, individuals with diverse histories of homelessness and psychiatric disabilities would have found their way to supportive housing. In a multi-tiered, efficient homeless services system, only people with the highest needs would be served in supportive housing. Consequently, there is a new demand to develop programs that assist supportive housing residents no longer needing or wanting supportive housing services that help them to move out.

Transition from Supportive Housing

While there are few studies that explore the transition from supportive housing to independent community housing, what exists can be examined to better understand the transition and question how best to deliver services that will promote long-term community tenure. Scarce though they are, there have been a few pilot evaluations that provide valuable information (Harding & Company, 2016; Scott et al., 2012). In Scott et al. (2012), a Moving On program in Columbus, Ohio was evaluated as a part of a coordinated, community-wide effort to make supportive housing most efficient by serving individuals and families with the greatest needs. In this pilot, 30 supportive housing residents across 3 sites were provided with vouchers and support to move on to more independent housing not connected with onsite services. All of those who participated moved on, and 93% remained stably housed at 3 months post-move out (Scott et al., 2012, p. 12). Meanwhile, only 41% of residents who qualified for the program but did not participate were able to successfully move out (Scott et al., 2012). Further, those who did not qualify for the Moving On program frequently did not have a stable source of income or preferred not to move (Scott et al., 2012).

The pilot evaluation identified how varied outcomes among programs that were picked to participate. Over the course of the pilot, positive turnover ranged from 2.5% to 22% among the three sites. Additionally, one program clearly outperformed the others; it comprised half of the move outs, had the greatest change in positive turnover rates, and had the highest proportion of residents stably housed at follow up (Scott et al., 2012).

Residents and caseworkers also identified strengths and weaknesses of the transition process. Residents identified the most helpful aspect was the financial support provided by the post-move out housing subsidy. Caseworkers, meanwhile, identified a weakness in the program's assessment and noted their own inability to better understand why some residents opted not to move.

In a second pilot study, 24 supportive housing residents moved on through a program in Los Angeles, California, and 88% of the participants were stably housed at one year post-move out. Within this evaluation, researchers identified facilitators and barriers to moving on from supportive housing. Residents indicated that independence was the main motivation to move out while managing mental and physical health issues, and financial budgeting skills were leading facilitators. Participants also pointed to the financial support from moving on and assistance making connections to key supports in their new communities as vital to their success. Finally, participants identified needed services at the time of move out, directly following their transitions from supportive housing, and throughout one year post-move out as important factors.

Studies have also identified barriers to accessing appropriate and affordable independent housing for residents. Collins, et al. (2012) studied the experience of 75 residents with histories of homelessness and alcoholism receiving services in a project-based Housing First program. These researchers found three major themes pertaining to people leaving supportive

housing: fear of mortality, fear of losing connections with staff members, and needing to leave supportive housing due to disagreement with program rules (Collins et al., 2012).

Other research, including a pilot study that informed this study, suggested that some people felt "stuck" in supportive housing and were unable to move on to more independent housing options in the community (Livingstone & Herman, 2017). These authors studied 21 current and former residents from one agency and noted that participants described feeling "stuck" in supportive housing for various reasons, such as not being able to afford to move out, not being able to access a housing voucher, fear of becoming homeless again or relapsing, concerns about available housing's unsuitability, and feeling as if they did not get the help they needed to move on while living in supportive housing. Still, more research is necessary to determine what services people from various supportive housing contexts will most benefit from in order make this transition.

Other Housing Transitions

While the pre- and post- transition situations vary from study to study, important information can be learned from studying people with histories of homelessness in a housing transition. While there are few studies about the specific transition from supportive housing into community housing, there is some research that covers the transition from homelessness into other housing situations (Cheng, Wood, Feng, Mathias, Montaner, Kerr & DeBeck, 2013; Gabrielian, Young, Greenberg, & Bromley, 2018; Garrett et al., 2008; Thompson, Pollio, Eyrich, Bradbury, & North, 2004). Beyond those in the supportive housing literature, there have been a few other notable studies that have identified facilitators and barriers to transitioning from an experience of homelessness into housing.

One of the main facilitators to housing transitions was supportive relationships, including those with intimate partners, family members, and service providers (Cheng et al., 2013; Drury, 2008; Gabrielian et al., 2018; Garrett et al., 2008; Thompson et al., 2004). Cheng et al. (2013) studied the transition into, and out of, housing among street-involved youth using the At-risk Youth Study from Vancouver, Canada. From a larger study, 386 people were identified to have recently made a housing transition into or out of homelessness. The two groups transitioning were compared to consistently housed and consistently homeless groups. Researchers found that street involved young women were more likely to make a transition either into housing if they were involved in a stable relationship when compared to the two other groups, consistently housing and consistently homeless.

Gabrielian et al. (2018) studied the use of social supports among 17 adults with histories of homelessness and substance use disorders. Researchers used interviews to identify the use of different types of supports (formal and informal) in different types of housing settings (stable, independent housing; sheltered housing; and unstable housing). Individuals housed in stable, independent housing used both types of support to secure and maintain housing. By contrast, individuals with unstable housing also used both supports, but their relationships were described as weak and having negative influences. Meanwhile, residents in sheltered housing predominately used formal supports, including case managers. One notable finding in this study, however, was that there was very little family involvement in this group.

Studies have also identified specific barriers for formerly homeless people making a housing transition. Two of the factors that were identified were substance abuse and difficulty accessing necessary resources. In a previously mentioned study, Cheng et al. (2013) identified that frequent alcohol and crack use were positively associated with entering homelessness after

being housed. Additionally, daily heroin or crystal methamphetamine use were negatively associated with transitioning out of homelessness. This same study also identified the importance of access to necessary resources, including access to addiction treatment and housing (Cheng et al., 2013). In other research, a two year ethnographic study followed 60 homeless, mentally ill adults after a psychiatric hospital discharge to community single-room occupancy housing (Drury, 2008). Drury identified a "cultural divide" that created barriers to accessing basic necessities like housing, money, food, and clothing. Drury also noted that the multiple systems involved in these clients' care, hung in delicate balance and dire consequences followed any misstep or misunderstanding (Drury, 2008).

Summary

While people in the homeless services system have diverse backgrounds and needs, understanding shared histories among this population is important within ecological and social constructivist lenses. People are deeply effected by their daily experiences including how they are assisted with ameliorating the social problems that impact their lives. Further, how people are assisted and the interventions proposed to assist with their social problems are determined by how groups are perceived and the political power they have.

The homeless services system has recently shifted and become more focused on system efficiency and prevention efforts. Within the empirical literature review, I examined the foundation of primary programs for individuals with histories of homelessness, such as housing subsidies. Secondary programs are aimed at assisting recently homeless individuals and include CTI and Rapid Rehousing. CTI can offer valuable information about the importance of supporting vulnerable populations through critical transitions, benefits of doing so, and how to adapt CTI to assist formerly homeless people in this particular transition. Secondary programs

also offer caution in the use of temporary housing subsidies like those offered through rapid rehousing programs. While housing vouchers are a valuable, and underutilized policy tool, there have been questions about whether temporary subsidies can effectively mitigate the risk of repeated homelessness. Tertiary programs included supportive housing and Housing First programs, in particular. Research has shown that supportive housing is helpful to assist people with histories of homelessness to experience improvement in housing stability, community integration, and recovery outcomes. Lastly, very little attention has been given to the transition out of supportive housing. While some pilot evaluations have suggested successful housing stability following move out, more research is necessary to determine what support people need in order to safely and successfully make this transition. Further, additional research is needed to better understand the meaning of this critical transition for people with histories of homelessness.

CHAPTER IV: METHODOLOGY

This current study is a secondary data analysis utilizing data from 40 interviews I previously completed as a part of a parent study, "Moving On From Permanent Supportive Housing: Implementation and Outcomes of the New York City Moving On Initiative" (described below). The data analyzed for the current study were from formerly homeless supportive housing residents who were participating in a Moving On program. I sought to understand better the experiences of residents as they prepared to move out. The following questions were addressed:

1. How do formerly homeless people currently residing in supportive housing, including people with psychiatric disabilities, experience the preparation for transition from supportive housing?
2. What are the factors that assist or discourage formerly homeless persons, including people with psychiatric disabilities, in their preparation to move from supportive housing into more independent, community housing?

Research Goals

To achieve the goals of this study I utilized secondary data that I had previously collected. The primary goal of the current study, utilizing this secondary data, was to better understand the experiences of formerly homeless individuals anticipating their transition from supportive housing to independent housing in the community. In the parent study, participants were asked to talk about what the process looked and felt like and what plans participants had for the future. They were prompted to share their stories about preparing to transition from supportive housing to more independent housing as a "biographical experience," constructing meaning through this process (Denzin, 2001, p. 56). To accomplish the current study's aim, I analyzed accounts of the experience of moving on from supportive housing among participants

with varying histories that were previously collected as part of the parent study. I explored how participants defined the experience and how it intersected with other areas of their lives. I focused on both the facilitators and barriers to moving on as identified by supportive housing residents as they considered the possibility of moving out. A second goal of this study was to investigate the preparation for this transition to better inform service and policy development.

Theoretical Approach: Interpretive Interactionism

While collecting the data for the parent study, I employed interpretive interactionism, a theoretical approach that allowed participants to experience the possibility of a transition in their lives. Interpretive interactionism grew from symbolic interactionism, which was a tradition positing that the value of one's life is the result of the meaning individuals make through interactions (Blumer, 1969). Denzin (2001) further contextualized meaning making, situating the person in the environment, suggesting the importance of examining critically a social problem's history and previous solutions. Interpretive interactionism was a way to explore and seek to understand the lives of ordinary people particularly during critical transitions (Denzin, 2001). During vulnerable transitions individuals often rely on supports to help get them through. Therefore, underlying social systems of support are likely to become visible and can be examined during times of transition, while identifying what vital support is missing. This study examined the social systems supporting people with histories of homelessness and psychiatric disabilities who are facing the critical transition of moving out of supportive housing.

The first two steps in the research process included framing the research questions and analyzing prior conceptualizations of the phenomenon. This study addressed these steps by providing a theoretical framework for the research questions. Specifically, I used the literature review was used to better understand how homelessness is contextually framed as a problem,

theoretically and in history. As Denzin (2001) might suggest, I attempted to "deconstruct the phenomenon" (p. 70). The third step in the research process included "capturing the phenomenon," or finding it in the "natural world," and obtaining multiple occurrences of it (Denzin, 2001, p. 70). The study methodology aimed to capture the phenomenon of preparing to exit supportive housing. From the interpretive interactionism approach, researchers should capture the phenomenon by securing multiple cases that embody the desired phenomenon, locate the epiphanies and crises of the lives of the persons being studied, and obtain multiple personal experience stories concerning the topic under investigation (Denzin, 2001). Here, epiphanies are defined as those "moments that leave marks on people's lives…. In these moments, personal character is manifested and made apparent." Moreover, "Having had such a moment, a person is never quite the same again" (Denzin, 2001, p. 34). In this study, the experience of preparing to transition from supportive housing was investigated as a potential epiphany.

While investigating this experience, both in the parent study and in my secondary analysis of the data for this dissertation, it was not possible to obtain an objective display of this phenomenon because my perception was innate to the investigation. In such cases, researchers use thick descriptions or dense accounts to capture and record an individual's lived experience with the aim of representing the meaning individuals assign to the experience (Denzin, 2001). To get thick descriptions while I was collecting data in the parent study, I conducted interviews with participants who were preparing to move on from supportive housing, and I was able to engage with them as they made meaning of the experience. I was also able to ask follow up questions of all participants, as appropriate. These considerations set the stage for "more insightful interpretation" that constituted thick description (Padgett, 2008, p. 209). Furthermore, interpretive interactionist studies are biographical, located within the larger social structure,

idiographic, and emic (Denzin, 2001). In order for the study to be biographical, the researcher needs to recognize the uniqueness of each case, and "the voices and actions of individuals must be heard and seen in the texts that are reported" (Denzin, 2001, p. 40). The researcher needs to be able to "particularize" experiences, for the study to be emic. Consequently, a narrative approach was a natural fit with this framework because everything studied is contained within a narrative representation, even the representation of self. Additionally, narrative not only conveys reality, but it can also construct reality. As Denzin notes:

> We live in stories and we do things because of the characters we become in our tales of self. The narrated self, which is who I am, is a map; it gives me something to hang on to, a way to get from point A to point B in my daily life. But we need larger narratives, stories that connect us to others, to community, to morality and the moral self. (Denzin, 2001, p. 60)

Whereas the current study explored the experiences of preparing to transition from supportive housing to more independent housing, participants also constructed new meaning in the process of sharing their experiences. Specifically, in this study, I used informant's discrete, topically focused stories to investigate the meaning of this experience (Riessman, 2001). These data were "bounded," or previously transcribed, and were analyzed using framework analysis to investigate the importance of "what" had been said (Riessman, 2005; 2001; 1990).

Typically, researchers working to establish the impact of interventions emphasize such quantitative methods, including randomized controlled trials. While such trials can help to reveal the effectiveness of interventions, other measures are needed to capture how these impacts affect the daily lives of individuals (Davidson, Drake et al., 2009; Denzin, 2001). Drawing on the framework of ecological systems theory (Bronfenbrenner, 1979), interpretive interactionism

(Denzin, 2001) helped to connect how homeless services, such as supportive housing affected people's daily lives. In accordance with the importance of perception and the meaning people assign to experiences, this study used a narrative approach to investigate what is was like for people with histories of homelessness, including people with histories of psychiatric disabilities to prepare to move on from supportive housing to more independent housing in the community (Polkinghorne, 1988).

Research Design

Data Collection

This study involved the secondary data analysis of interviews from 40 participants I previously conducted as a part of a parent study led by Professor Emmy Tiderington of Rutgers University (described below). The 40 interviews were from pre-move out interviews with informants from four New York City supportive housing programs that were involved in the Moving On Initiative, led by the New York City Corporation for Supportive Housing (CSH), and funded through the Robin Hood Foundation. The interviews analyzed in this study were collected from March through September 2016 and while participants were preparing to move out of supportive housing. All data were transcribed and de-identified following the interviews.

Moving On Initiative. The Moving On Initiative was launched in October 2015 when five NYC agencies were awarded funding and housing vouchers to assist 125 supportive housing residents (25 residents from each agency) in moving into housing in the community. As a part of the Moving On Initiative, agencies were encouraged to develop programs using some basic guidelines provided by CSH. All Moving On Initiative participants were provided with a HUD housing choice voucher and a variety of other support services from their respective programs, which included assistance finding housing in the community, financial counseling, and the cost

of moving. Although multiple program models were applied, the common aim among the participating supportive housing programs was to assist tenants in successfully transitioning into independent community housing not attached to supportive housing social services.

Parent Study. Data for this study were collected as a part of a mixed-methods, longitudinal study of formerly homeless individuals and families funded through the Oak Foundation. The parent study was called "Moving On From Permanent Supportive Housing: Implementation and Outcomes of the New York City Moving On Initiative." The goals of the parent study were: 1) To capture Moving On recipient outcomes regarding quality of life, health and recovery, community integration, service utilization, and housing stability, prior to and after leaving permanent supportive housing programs through the New York City "Moving On" initiative; 2) To describe Moving On program implementation processes and experiences within and across the five different Moving On provider agencies; and 3) To identify the individual-, program-, and system-level barriers to, and facilitators of, successful tenant transitions from permanent supportive housing programs to independent living in the community.

Subject Recruitment

Of the 125 potential participants in the parent study, 50 were recruited for pre- and post-move out interviews. While there were 25 eligible Moving On participants at each site, the first 10 were recruited from each agency to participate in interviews. When one of the first 10 Moving On participants was not available or chose not to participate in an interview, another eligible participant was recruited. Demographic information was recorded as they were recruited for interviews to ensure that participants' varying demographic and psychiatric disability histories were noted. Of the 50 informants recruited for interviews, ten were the heads of households from homeless families and, consequently, were purposely excluded to maintain the

integrity of the sample by ensuring that it looked only at the experience of individuals. The 40 remaining interviews form the sample for the current study.

Sample Description

Participant demographics for the sample are presented in Table 1. This sample was predominately male (52% male; 48% female) and Black or African American (70% Black or African American, 13% other, 10% Hispanic, 7% White). Length of stay in supportive housing among those sampled ranged from two to 18 years, with an average stay of 6.4 years. Participants ranged in age from 22 years to 66 years, though 65% of participants were 50 or older. Most participants disclosed various histories of psychiatric disability (65% total; 30% mental illness only, 20% substance abuse only, 15% both mental illness and substance abuse). Participants also disclosed a range of mental health diagnoses including schizophrenia, depression, anxiety, and bipolar disorders. Additionally, they identified various histories of substance abuse with crack/cocaine, heroin, and alcohol.

Ethical Considerations

Potential participants met with research personnel to learn about the study in detail and research staff obtained informed consent from participants prior to participation in the study. The voluntary nature of participation was made explicitly clear, and candidates knew that participation—or lack thereof—would have no effect on anyone's services or housing. The Institutional Review Board of Rutgers University approved the parent study, and permission to analyze the data from the pre-move out interviews for this study was granted by the City University of New York's Institutional Review Board.

Interview Guide Development and Questions

The interview guide used during pre-move out interviews was adapted from a pilot study that explored experiences leading up to, during, and in preparation of the move out of supportive housing (results reported in Livingstone & Herman, 2017). This adapted interview guide (See Appendix A) was revised to focus specifically on the experiences of people preparing to move out of supportive housing. During individual interviews prior to move out, participants were asked to describe the services they received as part of the Moving On program, what they thought about those services, and what the process of preparing to move out had been like for them, including how they felt about, and what they thought of, the process. Unscripted follow-up questions were used as appropriate.

Data Analysis

All individual interviews were audio recorded and transcribed. All transcripts were analyzed using framework analysis (Pope, Ziebland, & Mays, 2000), a deductive approach described in Figure 1, beginning with developing an "a priori" framework that utilized concepts drawn from the aim and purpose of the study as well as issues brought up by the participants. Following this approach, I began with several transcript read-throughs to identify key concepts and reoccurring themes, and created a comprehensive index of the data. Then, using Dedoose, I systematically and thoroughly applied the index to the data. Coded excerpts were grouped into emerging themes and sub-themes using a charting method to place the concepts within the framework. Lastly, I used a mapping method to better understand how the data fit together, effectively creating typologies and associations between themes. To promote rigor, I used peer debriefing and, when possible, member checking (Padgett, 2008). While I engaged in second interviews with some of the participants, and was able to review data from previous interviews,

the transcripts from those interviews were not analyzed for this study. In subsequent chapters, themes from across the dataset are presented. Meanwhile variation was discovered among participants who disclosed psychiatric disabilities, including substance abuse disorders and mental illnesses. These findings are presented in a third results chapter.

Table 1. *Participant Demographics*

Pseudonym	Gender	Race/Ethnicity	Age	Years in SH	Diagnosis	Unit Type
Alexandria	F	Black/African American	60	8	SA	CC-SRO
Alice	F	Other	58	11	MH/SA	CC-Studio
Anna	F	Black/African American	49	2	None	CC-SRO
Audrey	F	Black/African American	52	3	MH	CC-Studio
Beckett	M	Black/African American	64	11	SA	CC-SRO
Bernadette	F	Black/African American	58	3	None	CC-Studio
Cayden	M	Black/African American	22	3	None	CC-Studio
Charles	M	Black/African American	65	3	None	CC-Studio
Claire	F	Black/African American	53	3	MH	CC-Studio
Claudette	F	Other	42	7	MH	Scatter
Daniel	M	Caucasian	65	3	SA	CC-Studio
David	M	Black/African American	39	4	MH	CC-Studio
Elizabeth	F	Black/African American	53	7	MH/SA	Scatter
Emma	F	Other	41	10	MH	Scatter
Everette	M	Black/African American	42	5	None	CC-Studio
Fiona	F	Black/African American	53	7	MH/SA	Scatter
Fred	M	Caucasian	62	15	MH/SA	CC-Studio
Genevieve	F	Black/African American	62	3	MH/SA	Scatter
George	M	Black/African American	60	4	None	CC-Studio
Grace	F	Black/African American	62	2	None	CC-SRO

Table 1. *Participant Demographics* (Continued)

Pseudonym	Gender	Race/Ethnicity	Age	Years in SH	Diagnosis	Unit Type
Henry	M	Black/African American	50	2	None	CC-SRO
Jack	M	Black/African American	66	6	SA	CC-Studio
Jake	M	Black/African American	48	10	SA	CC-SRO
James	M	Black/African American	64	10	MH/SA	Scatter
Javier	M	Hispanic	55	4	SA	CC-Studio
Jaylen	M	Hispanic	48	2	None	CC-SRO
Jeremiah	M	Black/African American	51	18	None	CC-SRO
Joseph	M	Black/African American	57	5	MH	CC-SRO
Josephine	F	Caucasian	48	11	None	Scatter
Mateo	M	Black/African American	51	4	SA	CC-Studio
Natalie	F	Black/African American	50	4	MH	CC-SRO
Nicole	F	Other	57	8	MH	CC-SRO
Noah	M	Hispanic	49	5	MH	Scatter
Penelope	F	Black/African American	33	11	None	CC-Studio
Samuel	M	Black/African American	57	15	MH	Scatter
Susan	F	Black/African American	55	8	MH	CC-Studio
Tiffany	F	Other	26	5	None	CC-Studio
Violet	F	Black/African American	59	7	SA	CC- Studio
William	M	Black/African American	40	4	MH	CC-Studio
Xavier	M	Hispanic	40	4	None	CC-Studio

Note: Psychiatric Disabilities are Mental health (MH); Substance abuse (SA); MH/SA; or None
Type of Units are Congregate care (CC); Studio; CC- Single-room occupancy (SRO); or scatter site (Scatter)

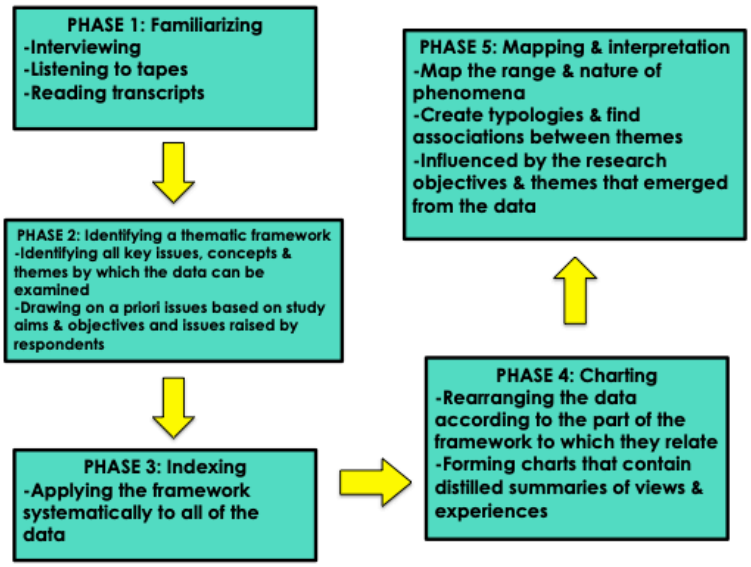

Figure 1. *Framework Analysis* (Adapted from C. Pope, S. Ziebland, and N. Mays, 2000)

CHAPTER V: STASIS

Scholars have described ontological security as the peace of mind, or mental assurance, gained by reliable social and material surroundings, which include a safe and stable home (Dupuis & Thorns, 1998; Giddens, 1990; Kearns, Hiscock, Ellaway, & MacIntyre, 2000; Padgett, 2007; Padgett & Henwood, 2012; Saunders 1984, 1989). For the purposes of this study, "stasis" refers to the fact that in pursuit of ontological security some residents found ontological features that pulled them to stay in supportive housing so compelling that they preferred to reside in supportive housing rather than moving out into the community. Of the residents who were considering stasis as a way to achieve ontological security, three elements stood out as persuasive "pull factors:" secure benefits, autonomy, and comfort. The data also suggested that participants took varied paths and decision-making routes to arrive at their final decisions to move on or to remain. Some residents may have chosen stasis because they were only satisfied in one area, while others were only marginally satisfied in one area but pessimistic about others. Meanwhile, there were others still who had undergone different decision-making processes.

However, among residents who made up their minds about staying in supportive housing or moving on from it, those inclined to stay had one thing in common: an expressed need for ontological security. Dupuis and Thorns (1998) described four constructs related to the notion of home as a source of ontological security. First, home is the site of constancy in the social and material environment. It is also a special context where people perform the day-to-day routines of human existence. Third, it is a site where people feel most in control of their lives, because they feel free from the surveillance that is part of the contemporary world. Lastly, home is a secure base around which people construct their identities. Others have applied the concept of home to people with histories of homelessness, including those psychiatric disabilities, and

explored the psychological meaning and benefits that "home" has for them (Padgett, 2007; Watson & Austerberry, 1986).

Research suggests that the meaning of home is not only a physical location but also includes elements that help people to *feel* at home (Despres, 1991; Dupuis & Thorns, 1998; Padgett, 2007; Somerville, 1992). Some stasis seekers did so because they had found comfort in supportive housing; they had been able to take control over the space they had and make it their home. Moreover, while the core elements of ontological security are essential for individuals to achieve a sense of home, these ontological features transcend a physical space or objects therein. Feeling secure, having control, and privacy in one's home environment are also important elements of ontological security (Dupuis & Thorns, 1998) particularly among formerly homeless, psychiatrically disabled people (Padgett, 2007).

In the search for ontological security, informants in this study relayed complex factors that pulled them to stay in the secure supportive housing environment. Beyond the pull factors, residents also expressed concern over the possibility of losing what accomplishments they had achieved while in supportive housing. For example, those who acquired a degree of financial security were interested in maintaining that security. Others reported that they had achieved acceptable levels of independence and comfort in supportive housing. In some cases, residents detailed how the semi-independence they achieved in supportive housing had enabled them to experience freedom, privacy, and control. For those who seemed inclined to stay, there was a fear that all of this might either be lost or significantly diminished by moving into individual housing in the community.

Time and again, the same ontological features that pulled some participants to stay in supportive housing pushed others to move out. Although informants identified having achieved

secure benefits in supportive housing, for example, expected gains they anticipated in autonomy and comfort pushed them to consider moving. Other participants identified having enough autonomy and comfort in supportive housing that they could justify staying there. Conversely, "leavers," or participants who seemed inclined to move on from supportive housing, considered that they had to risk that which was secure in supportive housing in order to gain access to the possibility of something better, however they defined that.

Whatever trade offs participants faced in deciding whether to stay or to go, ontological security drove both impulses, but "satisficing" got them to their final destination. Within the theory of bounded rationality, "satisficing" occurs when there is no optimal solution and people are left to choose from best available options (Simon, 1979). Some informants satisfied one or more pull factors so completely that they felt comfortable staying in supportive housing, even though it meant that they might have to accept other dimensions that were only sufficient and might have been enhanced by moving out. That is, individuals were weighing out their lived experience in supportive housing against what they imagined they might experience if they moved out, and choosing one that was most likely to satisfy their preferences, even if the chosen option was less than optimal.

While some participants weighed certain ontological features more than others, other residents employed a different decision-making paradigm and weighted all dimensions equally. Still others might have been most persuaded not by the satisfaction they had achieved in supportive housing, but by the pessimism they felt about what independent housing in the community would mean to their personal preferences. Residents acknowledged ongoing barriers to autonomy outside of supportive housing such as stigma, discrimination, and poverty. For example, some participants felt that the satisficing level of independence and comfort was an

improvement from previous circumstances, and it was "good enough" given the uncertainty of how a housing change might affect them. In satisficing, participants were choosing among certain desirable and undesirable elements of ontological security to find the best available housing option for them.

Despite the compelling nature of pull factors, "stayers" also experienced push factors in other areas. Ultimately, all participants felt a degree of ambivalence at some point in their decision-making process. Consequently, stayers acknowledged that they could have achieved ontological security in either supportive housing or elsewhere if other core elements of their lived experience could have been satisfied. Their ambivalence can then be understood not as a struggle to choose their ideal preference, but as an inability to find a definitively better option than what their reality offered or their anticipated reality was likely to afford them.

Secure Benefit Seeking in Supportive Housing

Informants' security was extremely important, and many described the secure benefits they had in supportive housing. However, this measure of success also made them reluctant to move into the community. Residents were only required to pay 30% of their monthly income towards their rent. This made them comfortable and was an important part of feeling secure. Consequently, when they weighed out cost and affordability in moving on, they found supportive housing was less expensive than living in the community; it was difficult to give up this security, particularly as the possibility of doing so raised the chance of becoming homeless again.

Another factor that weighed heavily in the decision-making process was that affordable housing is difficult to obtain for low-income individuals, especially for those with histories of homelessness. Even with rental assistance, only about half of renters with extremely low or very low incomes have access to affordable housing (HUD, 2015). Additionally, some newer

programs for people with histories of homelessness, such as rapid rehousing programs, give participants access to *temporary* rental assistance rather than long-term Section 8 rental assistance. Some research suggests that the temporary rental assistance available through these programs would not provide sufficient security from the risk of future homelessness (Byrne et al., 2016; Department of Veterans Affairs, 2018, pp. 59-60).

Some residents endorsed stasis because they thought it was less expensive to stay in supportive housing compared to maintaining their own community apartments. For example, Susan explained,

> I kind of want to stay and not look towards other things, because it's kind of like cheaper for me to live [in supportive housing]. I don't know if it's going to be as inexpensive. It's cheaper for me to stay where I am, so I kind of look at [moving on] with mixed feelings.

Susan had a history of severe mental illness and had lived in a supportive housing studio apartment for the past eight years. Reflecting her ambivalence, she elaborated,

> I want to stay, but I do want a little bit bigger place. I would probably like to stay with the agency, just in another one of their buildings, [someplace that would give me a bigger space] but the other services would still be rendered to me.

Similarly, Alexandria, who had a history of crack/cocaine use and had been living in supportive housing for eight years, described being comfortable while living in supportive housing. Her reasons to remain were her affordable rent and financial security:

> Thinking about it, going back to the first days, the first time I got here, I was thinking, 'Maybe one day I can get an apartment [in the community].' I don't really see how I can move to a fair market apartment because of my income.

> Rents are so very high. If you can find anything [the rents are] so very high. And I just figured, 'Well, yeah. This would be where I can remain according to my income.' I'm able to pay my rent and whatever little things I need to do. I got used to it. As a matter of fact, I got comfortable with it because I wasn't delinquent with anything. Everything was going smoothly. I don't have any extra monies, but I am able to carry myself day-to-day.

For participants such as Alexandria, financial comfort was an important factor providing security and pulling them to stay in supportive housing.

Other participants described assistance they received in supportive housing that protected them from financial trouble, ultimately shielding them from the risk of repeated homelessness. Residents mentioned getting help with various tasks connected to maintaining income and benefits, such as getting help with benefits recertification or reading important mail. This contributed to their reluctance to leave this support and move out.

Some participants envisioned what would happen if they ran into trouble after they moved to a privately rented apartment. They compared these scenarios to the perceived protection they had while living in supportive housing. For example, some informants suggested that supportive housing protected them from the disregard they would likely experience in the free market, where tenant rights were presumably dismissed, and where there could be consequences for being unable to pay their rent. Natalie, for one, clearly disapproved of the Moving On program. She was reluctant to move into an apartment owned by a private landlord because she would not feel secure about her rights as a tenant, "You have some landlords…one minute they might say, 'Light and gas included.' Then you find out, just a few months after you've moved and everything, 'I'm sorry. Only light is included, or gas.'" Ultimately, Natalie

was measuring the potential gains from moving out against the perceived increased risk of housing instability.

Several residents worried about the potential loss of financial security in new homes. Nicole described a "domino effect" of misfortune that led to her prior homelessness. She explained that she was laid off from her job in 2006 and collected unemployment for six months before she was cut off. Unable to find other work, she lost her apartment. She had very little social support as she had been recently divorced following 20 years of marriage and had just received news that her only sister had terminal cancer. Since she did not want to burden her sister, she entered an emergency shelter. While in the shelter, she fell and broke her wrist, which led to extensive surgeries and her inability to work. Following a period of homelessness, she was able to move into the supportive housing where she had lived for the past eight years. When asked how she felt about moving out, Nicole described her fear of financial instability if something happened to her Section 8 housing subsidy:

> God forbid where you're moving decides they don't want to participate in the Section 8 program anymore. God forbid a fire breaks out or something. Once you have the voucher and utilize it, it's forever…so they claim. But they've said that before, and then Section 8 closed. I'd be lying if I didn't say there's just a *skosh* of concern. You know, I mean we signed a one-year lease. What if they sell the building and the new people say, 'Well you know what?'

Given the severity of consequences from her previous string of bad luck, Nicole's optimism about what she might be able to find in the community was overshadowed by the lack of security she would have after moving out of supportive housing.

Many supportive housing residents did not want to risk financial instability. They felt sheltered, and they knew that if they ran into trouble paying their rent the program would help them. As Jack explained, "You got any kind of problems or say for instance, you get backed up in your rent or your bills, electric or something, they're there to help you so you can get back on track."

In summary, for many informants living in supportive housing had brought them a sense of financial security, protection from financial risks, and independent living. While residents had acquired certain secure benefits in supportive housing, they might have traded off potential gains in comfort and independence that they could have anticipated receiving upon moving out. Meanwhile, participants who experienced the pull of supportive housing security also reported factors pushing them out of supportive housing, creating ambivalence about whether to stay or move on.

Autonomy and Comfort Seeking in Supportive Housing

Independent Enough in Supportive Housing?

Some informants stated they already felt independent, which pulled them to stay in supportive housing. In addition, they attained stasis by achieving a sense of freedom from worry about financial concerns and housing instability. While a number of residents felt independent, others described feeling "independent enough." Although participants noted the presence of some autonomous elements, such as freedom, privacy, and independent decision-making, they mentioned the absence of others. Some called this status, "semi-independence," meaning that they were able to have control over at least one aspect of their lives. For example, some described feeling partial autonomy because they were paying their bills or taking care of their health. Nicole, who previously shared her concerns about giving up the secure benefits of

supportive housing, explained how she felt autonomous because she was able to secure her privacy in supportive housing, saying, "When I got this place, I was like…if they don't bother you, you have your own room. You lock your door. You can do what you want in your room. It's like independence of sort."

Ambivalence and push factors for moving on. Some participants described feeling at home and comfortable in supportive housing even though they did not have complete autonomy. In particular, residents noted the autonomy and comfort afforded by the ability to come and go from their programs, the privacy they had in their units, and their ability to make independent decisions. Jeremiah, who had spent 18 years in supportive housing, lived in a unit that required him to share bathrooms and kitchens with other residents. Although he did not necessarily have the privacy he desired, he described feeling autonomous because he could do things on his own and had the freedom to come and go unsupervised:

> I've lived my whole, most of my life here. At least I'm comfortable. I go and come. I'm very independent. I pretty much do what I have to do. [But, when I move out] I'll have total independence. I'm independent here. I can come and go, as I want. As I said, as good as it is to know I have a case manager; it can be a little stifling a bit. There are requirements we have to meet. I understand that. She has to check and make sure I'm okay. Which is good on one hand. I'm kind of a private person. It'd be nice to be free.

Although Jeremiah said he was both comfortable and independent in supportive housing, he did state that when he moved out, he would have "total independence" and "be free."

Cayden was 22 years old at the time of his interview and had lived in supportive housing for three years. He said other people might need the opportunity to participate in the Moving On

program more than he did, because he was "okay" in supportive housing. He described the comfort he derived from being able to keep to himself, but also spoke about his limited ability to have visitors, which motivated him to participate in Moving On:

> I don't do much, I just stay in my room, or my studio, or I go to school, that's it. I don't have no problems here but I would like to move out. I just don't like the fact that there are certain rules. If you have somebody else is coming in here, they must show ID. If they don't have ID, they can't get into the building. It's very important for me to move out because then I can get an actual real apartment, in a real apartment building.

Cayden was content living in supportive housing; however, he was dissatisfied with the limits on his freedom to have visitors. For Cayden, and others, the visitation restrictions were a regular reminder that their homes were different than ordinary homes.

Many participants described achieving some degree of autonomy in supportive housing. They described feelings of freedom, privacy, and control related to conditions in supportive housing; this contributed to their sense of home. Whereas informants might have experienced a pull to stay in supportive housing because their benefits were secure, they were unclear whether they had enough autonomy to justify staying in supportive housing. Ambivalence about staying or moving was evident in all those who participated in the study.

Stasis: Comfortable Enough in Supportive Housing

Informants described tradeoffs that facilitated some level of comfort in supportive housing. They weighed the secure benefits acquired within supportive housing against any expected gain in comfort upon moving out. Some compared their current comfort to the absence of a previously uncomfortable condition. Consequently, they described comfort as being

problem free. In other words, supportive housing seemed comfortable enough because it was not homelessness, so it was "not that bad." Some felt they were comfortable enough as long as some other condition was met. For example, some were comfortable in their supportive housing residences because they were able to assert control over their residence; they were "making it a home."

Previous research identified factors important to making a place feel like a home (Borg, Sells, Topor, Mezzina, Marin, & Davidson, 2005; Depres, 1991; Padgett, 2007), including control and privacy among individuals in recovery (Borg et al., 2005; Padgett, 2007). Despres (1991) identified several factors including home as a refuge from the outside world, acting upon or modifying one's dwelling, and home as a material structure. In the current study, participants spoke about how they created comfortable homes in supportive housing after experiencing homelessness. They also demonstrated control in their homes by modifying and freely acting within them. Lastly, participants made mention of the physical structure of their homes including their neighborhoods and the conveniences associated with their programs. Some specifically mentioned how the location of their supportive housing and proximity to certain important resources facilitated their comfort despite other undesirable conditions. Although they might have fell short of achieving complete comfort, participants described feeling some degree of contentment in their current homes.

Having a comfortable space. Participants compared supportive housing with their past homelessness and expressed gratitude for the physical structure provided by their current residences. They were thankful for the safety provided by supportive housing after experiencing homelessness. Violet, a woman with a history of substance abuse and homelessness had been sober for 17 years, and she referred to her supportive housing unit as a "safe haven."

Like Violet, other informants expressed gratitude for the safety and comfort provided by their homes in supportive housing. Genevieve had a long history of homelessness and incarceration. She described her transformation from a self-proclaimed thief who had been in and out of prison to her current status as a devout Muslim woman. She felt that her faith allowed her to achieve her goals and her transition from homelessness into supportive housing. From her perspective, her faith helped her get her current home. "As long as I do the positive work, He sees that I have a positive outcome." She explained what it was like when she was first accepted into her supportive housing program. She said, "When I came in I was like, 'Oh, this is for me?' They said, 'We chose you.' I was so happy. Not having [a place of my own]…I am aware. I'm grateful." Faith was also important to Bernadette, who described how she thanked God for her current living arrangements:

> I thank God that I do have a place. Regardless of how big it is. Sometimes you got to accept what you got, and not what you do not got. Yes, it was a time that I did not have a place, you see what I'm saying? … I thank God that I do have something.

Throughout her interview, Bernadette remained focused on the importance of maintaining secure housing. She did not think that she would be able to move out without the housing subsidy she received as part of the Moving On program. When asked what had been positive about the Moving On program so far, she said, "I still got a place. That is the number one, that I am still living in the building, you see? Other than that, if I do not find a [place with the] Moving On [program], I will stay right there."

In light of their past experiences, most informants were thankful for their supportive housing units and considered their current conditions a marked improvement over what they had

previously experienced; they were reluctant to give up security and comfort, which pulled them to stay in supportive housing.

Absence of problems: It wasn't torture. Informants identified a minimum threshold of comfort that was often defined by the absence of some previously experienced discomfort. They said they had "no problems" in their buildings, their units, and with other people. This was usually in connection with being left alone or staying away from others. Xavier, who had been living in supportive housing for 4 years, said, "I have no complaints about the building. It's a good building." While on the surface his comment suggests that he was talking about the physical structure of his home, he was likely referring to his interactions with others residents in the building.

Other participants used graphic language to explain their ability to achieve comfort because of what was missing from their experience in supportive housing. When describing a satisfactory stay in supportive housing after 18 years, Jeremiah said, "It wasn't torture to be here." After only 2 years, Jaylen said, "I've never felt incarcerated or locked in my section. You come and go as you please."

Another poignant example came from Nicole who previously shared her concern about forfeiting the security of supportive housing given the "domino effect" of circumstances leading to her previous homelessness. Similar to others who described comfort in comparison to what it was not (e.g. homelessness), she said she was content because she had not had psychiatric breaks and suicidal thoughts, sharing "That's been my home. It is my home. I've not really - I can't say that I've not been content. I mean I haven't suffered mental breakdowns or feelings of 'Oh my God, I'm going to kill myself' in here." For some who had experienced homelessness, institutionalization, or other hardships prior to moving into supportive housing, the absence of

problems, hardship, and homelessness was all they needed to identify supportive housing as a source of comfort.

I made it a home. Participants often talked about how they had made their supportive housing units comfortable, sharing that they "made it a home." Despres (1991) identified another essential feature of feeling at home as the ability to modify home, demonstrate control, and act freely. Even those who identified strongly with financial affordability made the most of their surroundings by creating a home-like environment. Alexandria shared,

> I thought that maybe I would be moving on into an apartment, but instead I wounded up here, but I've made the best of it the last 8 years. I made it a home. I've brought all the things that I might want to entertain myself, make myself comfortable. This is how I've been living for the last 8 years: okay with the idea that I'm here. I've settled down and dug my heels into the soil here and just figured this would be where I'll remain until I go, so to speak.

Like Alexandria, participants identified that they had enough space to be comfortable and they had created familiar routines in their homes. Some talked about changes they made to the décor of the apartment, asserting control over their physical space. Genevieve, who described supportive housing in terms of comfort following homelessness, also found comfort in making her apartment more like home. According to Alexandria,

> My apartment is, to me it's very nice. I have a beautiful couch. I painted [my apartment] a color I want. I got nice curtains. I only have one of everything, but I would like some spring or summer curtains to switch up. I'd like having some plants. Some fresh flowers at least. That's what I'd like to treat myself to. Every two weeks I spend between $8 and $10 on some fresh flowers. I take care of

> them, and I say, 'I hope this lasts.' It looks so nice. When you come in the apartment, it looks so nice, you know?

Others wanted to be "comfortable" in their homes and, because they had achieved that comfort, they did not want to move out. One example of this reluctance came from a 62-year old man named Fred. He had a history of institutionalization and had been living in supportive housing for 15 years. He identified deriving comfort in his current home from his established routines:

> Why would I stay where I'm at? Because I'm comfortable there. Just the apartment, just being in my studio. It's home. I know where everything is. I know what I do when I'm in my own apartment, stuff in my own studio, what I do, how I cook.

Participants found comfort by asserting control, making their spaces their own, and creating patterns of behavior that highlighted how much better their lives were now that they had made it out of homelessness.

Great location and resources: Convenient for me. Many reported they were comfortable because of the favorable locations where they lived, and enumerated both the services and transportation that were close by. Another essential feature of feeling at home that Despres (1991) identified was "home" as material structure, referring to the concrete physical dimensions, but also including the neighborhood and the facilities available as a part of the unit. In the current study, informants had become accustomed to their neighborhoods. They were also satisfied with the amenities they could access in their programs in addition to the laundry and security. For example, Alexandria commented on the importance of having transportation close to her home. Her current home's geographic proximity to public transit made her further

question taking part in the Moving On program. She said, “In the beginning [the Moving On program] did not [excite me] because I have been here 8 years and I have gotten accustomed to the area. Transportation is ready. Transportation is great over here. The location is ideal.”

At the same time, informants described tradeoffs in comfort that derived from the presence of both accessible resources, enhancing their comfort, and comfort deterrents in their programs and neighborhoods. Jeremiah had been living in supportive housing for 18 years, and expressed how comfortable he felt in his neighborhood despite the discomfort he endured by living in close quarters with other people:

> I'm a very quiet person. The walls are thin. It's not anything terrible. Every little conversation, I'm in the conversation. It's not street loud, but it's loud. Even though I have my TV and I have my stuff going on. You can still hear the talking outside. I love this neighborhood. I don't know what neighborhood I'll end up in. I don't think it'll be that I'll be lucky enough to find something in this neighborhood. In a lot of ways I'm very comfortable here.

Genevieve, meanwhile, weighed the convenience of having supportive people and laundry facilities available to her in her building against the annoyance of living among active drug users and people who smoke. A woman with a history of severe mental illness, substance abuse, and incarceration, she had been living in supportive housing for three years:

> I can't deal with the smoke. You can't say things like that. Like, ‘You shouldn't be smoking on the elevator.’ They'll say, ‘F you B.’ You know. I've been there, but I'm like, you can't say nothing. I still feel fortunate. I feel fortunate. My support is like up here. The people that are supportive of my needs and got my back and everything, it's up here. The little problems are so ... they're tiny. They're tiny.

> Sometimes I want to go to the laundromat early in the morning on Saturday, it's right downstairs under my building. Right there. And, they're open 24 hours, and they keep it so clean. If I go at 5 in the morning, there's nobody there, just the man in charge and everything.

Meanwhile, other participants liked the convenient proximity of their homes to other places in the neighborhood, though their neighborhoods deterred from their comfort. Jack had a history of medical problems and lived in supportive housing for 6 years. He said,

> [I] don't wanna be another summer. Especially on that block. A lot of crimes happening there. People getting shot over there. There's always a lot of killing and robbing and stuff. I just want to get out of there. I shouldn't have to be afraid to walk out of my building to go to the store across the street, fear for somebody running up on me. Even though all of that is convenient for me. The laundromat and the supermarket is right up under me. I can get transportation to bus across the street down the ways from me. Like I said, it's a good supportive housing company. There's so many things that we do. We goes fishing. We goes out to ball games. There's nothing bad I can actually say about [supportive housing] itself, but it's where you live. That's the biggest problem I have: Where I'm living. I don't care to live over there no more.

When describing their homes, residents spoke about the comfort afforded by the conveniences of their supportive housing programs. These included living in desired neighborhoods, having access to public transportation, and having access to various resources within their buildings. Meanwhile participants also recalled tradeoffs of certain gains in comfort with comfort deterrents in their current homes. When participants were preparing to move on,

they were contemplating the current state of their comfort, and autonomy, and the potential gains in these conditions if they decided to leave.

Barriers to Autonomy beyond Supportive Housing

Stigma and Discrimination

Informants anticipated stigma and discrimination would be ongoing challenges to achieving autonomy once they moved out of supportive housing. Nicole spoke plainly about the stigma she faced as a supportive housing resident trying to improve her social position:

> I know there's a stigma. They keep telling me there's a big stigma with section 8. I said, 'No, there's a stigma with people who live in supportive housing.' The stigma is that you can tell us that the sky is red, and we're all either drug addicts or alcoholics, or just second-class citizens of just mental jobs that you can just, 'Oh they'll buy anything that I have to sell.'

Particularly, participants described how social programs, including supportive housing programs, were not really helping vulnerable people because of how clients were perceived. Or if these programs were helping them, they were also holding them back. Nicole described getting help from the homeless services continuum as a process where people were "corralled into this pasture," where she perceived there to be a lack of hope and compassion. She called this the "shelter mentality." When asked to elaborate, she said,

> [The shelter mentality] is despair. A lot of people feel like they're treated like you're not really worth anything. Or if you have an issue, whether it be substance abuse or mental illness, there's no hope for you. This is where you belong. The city has places where it's like cattle. You're just corralled into this pasture. Be glad

> for the best. I think that's very sad. That people, with whatever problems, are treated by places that claim to have your best interest at heart really don't.

Padgett (2007) found that supportive housing residents had questions and uncertainty about the future, highlighting the need to address stigma and issues of social inclusion among formerly homeless people. Additionally, recent research has found that housing discrimination is still a substantial concern (Edelman, Luca, & Svirsky, 2016; Oliveri, 2015). In particular, Ye et al. (2016) explored experiences of stigma among people living with psychiatric disabilities and receiving ACT services. Researchers identified how stigma was manifested, including experiences of housing discrimination among psychiatrically disabled individuals (Ye et al., 2016). Current study participants noted difficult experiences acquiring an apartment due to the stigma attached to histories of homelessness, psychiatric disability, supportive housing tenure, and the Section 8 program.

Residents described the stigma and noted the discrimination they faced while trying to find housing providers willing to accept their vouchers. Other residents suspected housing discrimination was behind the housing providers' responses, despite the provider's claim that they would not reject a potential resident due to Section 8 status. Claudette, a woman diagnosed with schizophrenia, talked about housing discrimination being at the root of the lack of available apartments. She concluded that landlords chose not rent to people with housing vouchers because of the stigma associated with many people who qualified for these programs. She said, "Most of the landlords don't like renting people with Section 8 their apartment because they said they normally destroys the apartment."

Many participants shared accounts of blatant and suspected housing discrimination. Some informants shared that they were told outright that landlords would not accept their

vouchers. In other cases, participants shared with landlords that they intended to use a housing voucher and were told that the previously vacant unit was no longer available. Accordingly, participants expected that certain risks to their autonomy, like stigma and discrimination, would continue to affect them if they moved out.

Stuck in the Circle of Poverty and Programs

Participants identified another barrier to their autonomy beyond supportive housing in the relationship between poverty and social programs like welfare, social security insurance, and low-income housing programs. Some policy analysts and researchers contend that welfare policy has historically served to regulate people experiencing poverty, holding them back while undermining their potential as political or economic threats (Danziger et al., 2000; Piven & Cloward, 1971; Schram & Silverman, 2012). Other researchers have suggested that social program recipients, who were already burdened with much stress and responsibility, were required to deal with an exorbitant number of tasks to maintain eligibility, making it difficult to invest energy in building alternative resources (Gannetian & Shafir, 2015; Schott, Pavetti, & Finch, 2012). Put another way, poor people, including formerly homeless people living in supportive housing, are likely to face barriers to upward mobility and community integration even after they move on from supportive housing.

Claudette, a previously mentioned woman, talked about feeling "stuck" in "this circle" of low-income programs, including the supportive housing program where she had lived for the past 7 years. When asked how her life would be different when she moved out, she shared:

> I don't think my life is going to be different. It's the same thing. These different programs, they takes you around and carry you around in a circle. It's like you're in a circle. The programs, the Section 8, the low income, this program, they're all

> the same thing. They're all the same thing. It's the same ballgame. Some may not visit you on a regular monthly basis, but they visit you. It's the same. It's like, if you're in this program still. Only thing is different terms. It's like you're in a circle. You're moving in a circle.

She had received a minimal monthly income provided from social security disability [SSD] and was only able to save a certain amount before she would risk being cut off from SSD. She spoke poignantly about her mixed feelings about receiving help and feeling stuck. "It's holding me back, but at the same time I have an illness, and my illness is keeping me from moving forward. I'm stuck. I'm stuck in this circle. All these programs: I'm stuck in that." Along with feeling stuck, she still expressed feeling "fortunate" to have the support she did. She explained that she was grateful to get necessary aid from supportive housing and she felt that this was pulling her to stay. The very programs that helped her were also reinforcing her position in poverty.

Conclusion

In seeking autonomy and comfort, some informants described what they had in supportive housing as "good enough," and pulling them to stasis. Those participants most reluctant to consider moving on identified pull-to-stay factors related to secure benefit seeking, autonomy seeking, and comfort seeking. They identified the achievement of secure benefits in supportive housing as their main pull-to-stay factor. At the same time, they expressed ambivalence regarding autonomy and comfort by contemplating whether staying in supportive housing or moving on would yield them the greatest benefit. Some participants described having enough autonomy and comfort in support housing. This allowed them to justify staying in supportive housing given the risks to their autonomy that would continue beyond supportive

housing. Meanwhile, others wanted to stay in supportive housing because, from their perspective, the expected gains in autonomy and comfort were in exchange for the security provided in supportive housing.

CHAPTER VI: MOVING ON

Participants who seemed inclined to leave supportive housing indicated that they believed they could achieve ontological security because of two major push factors: autonomy and comfort. Although all participants expressed some ambivalence when deciding whether to move out or remain in supportive housing, participants were optimistic that moving out would allow them to escape the pitfalls of supportive housing, gain greater access to independence, and increase their feelings of normalcy. Of course, there were also persistent concerns that the advantage of moving out might come at a considerable cost.

According to Goffman, (1961) a total institution is "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (p. xiii). While Goffman was describing the experience of living in institutions such as nursing homes, psychiatric hospitals, prisons, work camps, or convents, a number of these descriptors can be attributed to some supportive housing residences and the experiences of people living in them. This is particularly alarming given that residents of community programs may experience a degradation of self if elements of the total institution are integrated into service systems. While supportive housing services are consistent with the premise that people have the right to live in the least restrictive setting possible, supportive housing is restrictive in many ways, and can have a deleterious effect on residents.

Some informants believed that they could not accomplish a satisfactory level of independence while in supportive housing. Rather, achieving autonomy required moving out of supportive housing so they could be "on [their] own." Informants wanted to be free from the constraints of living in supportive housing. For example, they wanted to be "free" from

supervision. They also wanted a more comfortable place to live in — one with more privacy, separate rooms, and the freedom and space to have their families stay with them.

Although many participants described wanting to improve their autonomy and comfort through moving on, others were motivated to leave simply to be free from restrictive practices, to live like "normal" people, and to do daily tasks in their homes. At times, these tasks were described as doing "nothing." At other times, they wanted to achieve a "decent" living environment. In other words, they anticipated that they would be comfortable enough upon moving out if their new homes were normal, somewhere decent, and where they could complete ordinary daily tasks while living in them.

Those informants motivated to move out to increase their autonomy and comfort, also expressed ambivalence about leaving supportive housing. For example, participants did not identify secure benefits as a motivation for them to move out; those continued to pull residents to stay. However, they did identify factors that helped them to justify taking the risk of leaving supportive housing. For example, participants received housing vouchers through the Moving On program that gave them financial security when they moved out. They identified the helpfulness of a flexible timeline for their leaving supportive housing, predicated upon their readiness to leave. Lastly, residents described the importance of anticipated aftercare services. For some, the housing voucher, flexible timeline, and ability to access services even after moving out helped them rationalize the risk of losing the security of supportive housing.

Seeking Autonomy in Moving On

Autonomy is "a mixture of freedom to and freedom from, that is, the freedom to do what one wants and to express oneself and the freedom from any need to have one's actions approved by others and from any need to conform to others' expectations of oneself" (Kearns et al., 2000,

p. 389). This concept includes features of ontological security such as identity and freedom (Dupuis & Thorns, 1998). One informant, James, described autonomy as "having choices, being on my own, being responsible for myself."

According to Dupuis and Thorns (1998), home is the foundational element that allows people to develop their identities. In particular, people view having a home as a rite of passage to independence (Dupuis & Thorns, 1998). In the current study, some participants had gained a sense of partial independence while living in supportive housing. For others, moving out was imperative to achieving independence. In fact, some viewed moving out as an indication that they were "grown."

When speaking about moving out, residents often used the word "freedom," and described certain restrictions or undesired conditions that they were excited to leave behind once they moved on, such as being free from supervision. At the same time, informants expected to gain certain liberties upon moving out. According to Dupuis and Thorns (1998), people experienced ontological security in their homes because there was greater privacy and a lack of surveillance. Privacy led people to have a greater sense of control in their homes (Dupuis & Thorns, 1998).

Similar to prior research, informants in the current study identified "freedom from" and "freedom to" features of ontological security (Kearns et al., 2000; Padgett, 2007). While Padgett (2007) identified this ontological condition within supportive housing, the participants in this study anticipated experiencing these conditions when they moved out. For example, residents discussed wanting to be free from the monitoring practices they experienced in their programs. Informants anticipated increased privacy and control when they exited this service system by

moving out of supportive housing. These ontological features pushed their desire to move out despite the potential loss in security.

Leaving the Nest

For some residents, moving out of supportive housing was imperative to achieving independence. James, a 64-year old man who had lived in supportive housing for 10 years, had never lived on his own. For him, moving out meant, "Independence. Freedom. Leaving the nest." According to Dupuis and Thorns (1998), having one's own home is a natural part of reaching adulthood. Participants described supportive housing as a place where they were looked after and supervised, but this conflicted with how they described themselves as being old enough or mature enough to live in their own apartments. Furthermore, because they were of a certain age or stage of life, they felt they needed to live alone or free from assistance. According to Alexandria,

> I'm 60 years old. Ain't nobody supposed to be telling me nothing. That's how I feel. Ain't nobody supposed to be telling me nothing. I'm grown enough, been through enough trials and tribulations. I'm supposed to have learned my lessons by now. I'm supposed to be able to tell you something. All the crap that I've lived through, like, 'You people don't tell me nothing. Don't try to tell me nothing because I can tell you something.'

Dupuis and Thorns (1998) emphasized the naturalness of establishing a home. Similarly, informants spoke about their desire to be free from supportive housing regulations and to be "normal" or to live in a "normal" building when they moved out. Alexandria described her desire to be free from onsite assistance:

> I just want to be free. I don't want to be in my old age having to speak to a case manager or people that work in authority. I'm not supposed to have no director on my building. I'm not supposed to have no doctor downstairs for me. I'm supposed to be free as a regular, normal person.

Participants spoke about living independently from support as a natural part of life, a goal "normal" adults should accomplish.

Meanwhile, participants described supportive housing staff supervision, such as visitation rules, to parental monitoring. They spoke about looking forward to living independently when they no longer had such oversight. Violet, a 59-year old woman living in a congregate care setting, spoke about her program's visitor policy:

> What I don't need is mother and father tracking me. When you come in, they sign you in. Your company has got to get signed in. I don't have that much company, but my family or my significant other. But just the point that big brother is watching me. I don't like that you know, but I just want to be somewhere where nobody is clocking my movements. You know? I'm a big girl. I'm 59 years old. My mother and father are dead. I don't like that.

Similar to Violet, other residents with psychiatric disabilities affirmed their ability to monitor themselves despite challenges.

While most participants spoke about parental-like supervision as nagging, one resident, Josephine, had mixed feelings about being free from her "surrogate parents." When asked what she was looking forward to upon moving out, she offered,

> Well, I get to be an adult for the first time in my life, really, without surveying, without people watching over me. And, my mother and father are both deceased,

so I guess I'll really be an orphan. These were kind of like surrogate parents, sort of. And, I'll be an independent lady.

Supportive housing supervision was like parental monitoring, and informants anticipated increasing their autonomy once they were free from monitoring once they moved out.

On My Own

Many residents used the phrase, "on my own," to describe the independence they would achieve once they moved out of supportive housing. Self-sufficiency is a coveted American ideal, similar to "pulling yourself up by your bootstraps" to achieve the American Dream (Adams, 1931; Swansburg, 2014). Meanwhile, receiving government-sponsored support is not encouraged; it is not perceived as independence. Consequently, people receiving this support may see themselves as dependent on the state (Hansan, 2011).

Informants distinguished the independence found in supportive housing from the independence achieved when they moved out with a rental subsidy. While both housing arrangements included government-sponsored rental subsidies, supportive housing provided onsite programmatic support, which included staff supervision. Participants reported that moving out with a rental subsidy provided greater independence than living in supportive housing with a rental subsidy.

Poor people are often required to accept rehabilitation services in exchange for financial assistance. According to Mead (1997), when modern welfare reform caused the poor to be labeled sick and in need of treatment, it had the effect of justifying paternalism associated with teaching the poor what to do. Under the new welfare state, poor people could access rehabilitative services, but they could rarely get financial assistance. Whereas Alexandria had

previously explained that she was “grown enough” to move out like a “normal” person, she went on to clarify why she no longer needed to live in supportive housing:

> Supportive housing? What am I doing here? I don't need your support in this way. If you're going to support me, giving me some money. That's the only support I need aside from my family, love. Supportive housing? That implies that I've got issues that need help, and I did. I did, and I'm not saying I'm all together today. But I don't like that fact that I'm in supportive housing because I don't need you. Supportive housing? Support what? I can live without anybody on my back. I can live nicely, peacefully, un-destructively, without having somebody watching over me.

Alexandria described the difference between financial support and rehabilitative services. While participants needed continued financial support to afford a community apartment, many viewed freedom from rehabilitative services as essential to increasing their independence. Alexandria also went from saying that she can “live nicely” to promising not to be “destructive.” Those are two very different promises. While one seems to have come from within, the other is likely a response to the external stimuli such as stigma.

Other participants gave examples of what they would do with their newfound independence once they moved on. They would demonstrate their ability to live “on their own.” Fiona provided a history of difficult circumstances including homelessness, substance abuse relapse, and her daughter’s death. She had lived much of her life with others, and she anticipated what it would mean to have her own lease:

> I'm able to take care of myself and do things on my own. The experience has taught me more independence. Now I have to take charge. I can't depend on her

lease, his lease, whatever. Now it's time for me to take charge. I got to do what I got to do. This helps me. It helps me.

In other examples of anticipated independence, participants spoke about taking care of themselves in different ways. Some spoke broadly, while others mentioned specific tasks they were going to do themselves, such as going to the doctor, taking medication, or paying their bills. Ultimately, they expected that the autonomy they would achieve when they moved out of supportive housing would grant them more independence, by affording them the opportunity to make their own way in the world.

Freedom from Supervision

Participants wanted freedom from supervision and saw this as an important part of increased autonomy they would experience in the community. According to Kearns et al. (2000), individuals with autonomy have the freedom to do what they want without needing approval from others. Research has shown that an individual's sense of control and freedom from supervision are important aspects of a formerly homeless individual's ontological security (Padgett, 2007). Participants in this study shared these desires and believed that they could achieve when they moved out of supportive housing.

Specifically, many used the word "free" to describe how they would feel once they moved on. They described how supportive housing rules and regulations made them feel as if they lacked control of their lives. Compared to being "free" once they moved on, Natalie likened her supportive housing tenure to incarceration. "I did my four years. It's like I'm in jail. I did my four years." Residents looked forward to being free from externally imposed regulations when they moved out, such as having to check in with staff regularly, participate in room visits, and abide by the program's visitation procedures.

Participants described being monitored in supportive housing, which they compared to the anticipated freedom from supervision once they moved out. Some looked forward not to have to report to their caseworkers. In supportive housing, residents had to report information to the supportive housing staff, including their plans, whereabouts, and progress towards their goals. This reporting was a marker for being a "good client." Good clients were complaint and rewarded, while "noncompliant" clients might be punished (Holm, 1993). For example, noncompliant clients may be labeled as such, and not offered the same services as those residents that met expectations. Additionally, noncompliant clients could be overlooked for opportunities for greater autonomy based on their lack of adherence to program expectations and not necessarily based on their capability for autonomy.

Joseph, a man with a 5-year supportive housing tenure described his experience as an emergency shelter client. He was threatened with a penalty if he turned down too many stable housing options, which is a well-known practice in the continuum of services. His caseworker offered him his current placement, which was inconvenient because it was located a long distance from his family. His shelter caseworker warned him, "If you don't take this, we ain't going to help you because you gone turn down three already." In light of the need to be compliant while receiving homeless services, participants identified privacy and control as anticipated benefits from moving on. Joseph commented on being free from the expectation to comply. "Independent living mean independent living. As simple as that. I do what I want to do long as I pay my rent. Don't ask me about my business. If I don't want to see no director, if I don't want to see no case manager, I don't have to see no case manager." Similar to other informants, Joseph explained that he saw his case manager and shared information about himself, even though he did not want to. When they no longer lived in supportive housing,

participants anticipated they would not have to see people or do things that they did not want to do. They were motivated to move out because they expected increased privacy and control, which are ontological elements tied to a sense of autonomy.

Freedom from apartment visits. As a part of their anticipated freedom from supervision, participants specifically mentioned freedom from apartment visits, which would increase their control and privacy; they did not want people visiting their homes to monitor their behavior. Instead, they described how they planned to monitor themselves once they moved out of supportive housing. At 60 years old, George had lived in supportive housing for four years and had a history of medical issues. He explained his plans to "be responsible" for his own actions, such as cleaning his room in his own community apartment:

> [In supportive housing] I got to report everything I do to my caseworker. Here, once a month, they come to your room and make sure that you're keeping your room clean and stuff like that. I won't have to deal with that once I leave here. You know? I'll just be responsible for myself, not have to answer to nobody.

Other participants also imagined that they would no longer have to endure home visits when they moved out of supportive housing.

Freedom to come and go. Participants indicated the importance of being able to come and go from their homes freely. They looked forward to having their own keys and staying out as long as they pleased. Having keys was normal. For example, Joseph, who had to log in and out remarked, "I want to put the key in my own place and everybody do their own and I do my own. I just put my key in my own door."

Some residents mentioned that they planned to travel more and visit more places once they were no longer under the supervision of supportive housing staff; they would not have to

check in with staff while traveling. Speaking specifically about settling into her new home, Alice planned to travel after she moved because "everybody wants to return somewhere." She envisioned what her life would be like in a year's time:

> In my place, settled, got my place, get it hooked up like I want it and now I'm going to take some trips. I want it to be a nice comfortable place to come back to, but I want to venture out. I have friends in Greece, I want to go see them. I've never been to Massachusetts, over in Boston. I want to go to Massachusetts. I want to go to Canada because I've never been to Canada. …I want to go to Barbados. I wanted to have a place when I come back home. It's like, everybody wants to return somewhere.

These residents wanted to move out of supportive housing so that they could come and go freely. The ability to escape supportive housing's oversight and establish a secure home would open up a whole new world of travel to participants.

In summary, participants seeking autonomy anticipated an increase in liberty upon moving out of supportive housing, including increased control over their homes. They wanted more say in who visited them and who did not once they were free from supportive housing monitoring. Additionally, participants wanted to be free from supportive housing supervision and having to comply with supportive housing procedures, such as apartment visits and visitation restrictions. At the same time, participants hoped to gain additional privacy within their homes upon moving on. They wanted the freedom to be left alone, without having to share information or to meet with caseworkers.

Seeking Comfort in Moving On

While some residents achieved comfort in supportive housing, others described an inability to achieve the level of comfort they required. Those who did not feel comfortable enough in supportive housing were motivated to move on from supportive housing. In describing their desired comfort, participants often referred to "normal" tasks or roles; they wanted to have ordinary experiences with their families and in their homes. For example, residents wanted to be free from living among strangers. Instead, they wanted to be able to experience familial roles, such as parent, grandparent, or partner in their own homes. Additionally, participants aspired to complete ordinary daily tasks in their homes, just like other people not living in supportive housing; in fact, many residents described the desire to simply do "nothing." Audrey compared the comfort residents achieved in supportive housing with the genuine comfort she could achieve elsewhere. She felt that residents could be genuinely comfortable in supportive housing and described those who planned to stay in supportive housing as "stuck;" in her view, they were complacent and unable or unwilling to take the risk of moving out:

> When I say stuck, I meant the people who don't see themselves moving forward or moving to do bigger or better things. Stuck means they have that same mentality, doing the same thing and getting the same results. That's what I mean by stuck. They don't have the mentality to want to progress for their life or want to make another change in their life for the better. Some people get complacent where they're at. 'As long as I have this or as long as I have that, I'm all right.' See? I'm not all right with that, because I know there's better.

Meanwhile, she identified her search for genuine comfort as her motivation to move out.

In seeking comfort, residents described a desire to be free from certain oppressive aspects of supportive housing. These included living among strangers and sharing private spaces with them, and having to do various tasks all in one room. They anticipated the desired freedom and space they would have for family in their own homes. Those who were parents and grandparents wanted to share their homes with children and grandchildren, which they were unable to do in supportive housing.

Freedom from Living among Others

Among the desired freedoms, participants wanted freedom from living among others through the Moving On program. In Goffman's (1961) description of the total institution, one of the central features was having to live among others, "…all of whom are treated alike and required to do the same thing together" (Goffman, 1971, p. 6). Furthermore, one of the processes of the mortification of self is contaminative exposure, a process that occurs when there is a lack of privacy and a "forced mixing" of people leading to interactions between people who would not choose to be together, leading to "status-contamination" (Goodman, 2013, p.81). Participants did not want to live among other residents who caused problems in their buildings. They desired increased privacy through freedom from having unwanted people in their homes and having to share spaces, such as bathrooms, kitchens, and their apartments, with people they did not know.

Residents noted a lack of privacy and boundaries in supportive housing and anticipated an increase in these conditions when they moved out. According to Noah, "Living with people you don't know. [That's] very difficult." The mortification of self is achieved through several different processes including contaminative exposure (Goodman, 2013). Contaminative exposure is a process that occurs when there is a lack of privacy and people who would not

normally be together interact, leading to "status-contamination" (Goodman, 2013, p. 81). This applies to those supportive housing residents who spoke about being aware of other residents' business. Residents indicated that they learned about other people's business by word of mouth or by witnessing events because they were living in such close proximity to other people. At the same time, they wanted to keep their own business private and out of the public eye. When they moved out, residents hoped to avoid sharing bathrooms and kitchens with other people.

Participants described the burden of being a part of or witnessing events involving other residents from their supportive housing programs. Nicole, an 8-year resident in a congregate care program, disclosed a history of mental health issues. She looked forward to moving on so she would not have to witness regular crises or deal with unsolicited requests from neighbors:

> I look forward to the normal things that I don't have to see: the cops outside every day. I don't have to see the ambulance outside. I don't have to see these people when they're not taking their medications, or people asking you for money all day, or people asking you for cigarettes.

Like Nicole, other residents described their neighbors knocking on their doors or approaching them to borrow food, money, or cigarettes, even if they did not know each other. Nicole further detailed their tendencies to "pop up" at any time. Although she described the importance of being able to close her door, this barrier did not provide enough of a separation for her to feel comfortable. Residents expected that when they moved out of supportive housing, they would no longer have to deal with unwanted interactions with other people in their buildings.

Participants did not want to share rooms with other residents. Specifically, participants looked forward to having their own bathrooms and kitchens when they moved out. Javier, a 4-

year resident who shared his unit with a roommate and lived in a congregate style program, spoke about looking forward to having his own bathroom and not having to share it with "people that you never met:"

> I hate a dirty bathroom. That's one thing I don't have to worry when I get my place. I don't have to worry about two people using the shower that I use. If it's my family, yeah, but having people that you never met, never seen before, you don't know their background, you don't know where they've been, and you've got to share a bathroom. It's going to be nice when I get my own place. That's one thing I don't have to worry about: other people.

Similar to Javier, others did not like sharing bathrooms in supportive housing. Participants expressed concern about cross contamination, and they wanted to move out of supportive housing so they would not have to share private spaces such as bathrooms and bedrooms, with people they did not know.

Role Dispossession: All My Children Got Taken Away

Another process in the mortification of self is role dispossession. In the total institution, individuals do not have the normal roles that they fulfill outside of institutions. Instead, they are expected to take on the role of a client or someone who is in need of treatment (Goodman, 2013). In seeking comfort, participants wanted to share their homes with their families and to be in the role of partner, son, parent, or grandparent. They anticipated shedding the supportive housing "client" role and increasing control over their own and their families' lives.

Participants described their conflicts between living in supportive housing and fulfilling their roles in their families. In many cases, their familial roles conflicted with supportive

housing visitor restrictions. Specifically residents felt a lack of control over spending time with their families in their homes, including significant others, parents, children, and grandchildren.

Some participants explained what they experienced while they were in relationships during their supportive housing stay, the corresponding conflicts they had while living there, and the extent to which they were motivated to move out in order to increase the control they had over these relationships. Others talked about times where their attempts to satisfy family roles were in conflict with supportive housing rules. Xavier, a 40-year old father with a history of brain cancer, was interested in being a "normal" son. He said his supportive housing's visitation policy restricted his ability to have his mother stay in his apartment when he needed her support. He said that he had had a brain tumor surgically removed and his mother had travelled from Puerto Rico to be with him:

> Since I had to be stuck in the hospital, they wouldn't allow her to stay in my apartment. They say she doesn't live in the building. Honestly, I felt like it was wrong. That's my mother. It's not like it's a stranger from the street or something. That's my mother. Shouldn't been no problem her staying in my house. They made an issue about it.

Other participants experienced conflicts with parenting while living in supportive housing; they wanted be actively involved in their children's lives. Still others planned to get custody of their children once they moved out of supportive housing. While living in supportive housing, it was difficult to make visitations work and still follow the rules. For example, Alexandria disliked the visitor policy because she could not have her children and grandchildren stay overnight:

> I don't like having to fill out paperwork to have my daughter come spend the night with me, or my grandson from my son to come spend the night with me. I've got to put in paperwork and if they exceed more than the visiting rules, then I can't. That's not supposed to be a 60-year-old woman unless she's got issues, but I don't.

One of the most poignant stories about the effect of the visitation policies came from Penelope. She had six children, and while living in supportive housing four of them were taken from her and put in foster care because residents were prohibited from having children live with them:

> I have six [children] all together. But since I've lived here, I've given birth to 4 children. But they all got taken away because this is a single-room place. You can't have any children living here. So all my children got taken away. Sometimes I blame the building. The caseworkers and stuff that work here. I don't see why the building couldn't find somewhere else for me to live or a place like this, but allow you to live with your children. They were just like, 'You know you can't have any children living here.' I was like, 'I understand that. Well, do you have any other buildings that are like one bedroom and you all have case workers working there that you all can just switch me with someone that's coming out of the shelter and then switch me into the place?' And they were like 'No.' I have my baby in the hospital and then the system takes the baby right from the hospital because they know. I only got to bring one of them home. But he only came here for probably a week and then the system came because he can't live here.

Penelope's story epitomizes some of the difficult choices poor people with limited resources have to make. In her case, she had to choose between difficult options: to be a

homeless mother or a childless mother in supportive housing. In order to remain in supportive housing, Penelope chose to put her children up for adoption.

Supportive housing limited residents' access to friends and family in other ways. Some described the lack of space in supportive housing as a barrier to maintaining these relationships. According to Despres (1991), one of the factors making a place feel like a home is that it is a place to foster relationships with family and friends. Additionally, fulfilling various social roles, rather than the role of a patient or client is part of everyday, non-institutionalized life (Goffman, 1971; Goodman, 2013). Residents wanted more space and less restricting policies around visitation, because it would allow them to bring family and friends together. Alexandria, a 60-year old woman who had described herself as "normal," expressed a desire to care for future grandchildren in her home:

> See, I want [a home that is] comfortable if — or when — my daughter decides to have a baby. I want to be able to play Nana in my own home. I want to be able to be a Nana comfortably, not in the box that I live in now, which wouldn't work. But I want to be able to be a Nana, the regular type of Nana. 'You come on over and spend the weekend, and I've got space for you. I can cook for you. I can heat up your bottle for you.' Those little things mean a lot to me.

Residents wanted to move out of supportive housing in order to have their families involved in their daily lives. Specifically, residents anticipated the benefits of having grandchildren and children visiting them in their homes more often. Another benefit of having more space was increased opportunity to regularly entertain people in their homes. Many residents discussed hosting holiday parties in their own homes for their families. Ultimately, participants wanted to move out of supportive housing to gain more space in their homes, spend

more time with their families in their homes, be the "regular type of Nana," or host holiday celebrations in their new homes.

Place to Do Daily Tasks: In my Own Doing Nothing

According to Goffman's theory of the total institution, one processes leading to the degradation of self is the disruption of an individual's ability to accomplish ordinary daily tasks (Goodman, 2013). For formerly homeless supportive housing residents, being able to complete routine tasks in the privacy of their own homes represented an increase in comfort they anticipated they would have in their new homes. Audrey, a woman with a long history of homelessness, incarceration, and loss, including the deaths of her two children, described what "home" meant to her:

> Home, for one, means love. Love, which I didn't really experience when I was young, but love, protection, security. I don't have to worry about slacking everything. It's plentiful. My home, I have everything I need. Even whatever I want. A place of nourishment, where I'm nurtured, nurture myself. A place where I'm able to take care of myself properly, my hygiene, myself, my being.

Some participants mentioned wanting a home where they could do "normal" things, or even "nothing." Alexandria remarked, "If I do nothing the rest of my years, that's okay in my mind because I'm in my own. I want to be in my own doing nothing." She described a scene from her new home, as an example of what "doing nothing" would look like. She said:

"I want to be able to sit back. I want to buy a rocking chair and just sit back and stare out a window in my own place, that sort of style there. Yeah, I just want to be free. I'm supposed to be free as a regular, normal person."

Other participants spoke about doing "normal" stuff or just "living life." Others described in more detail what "normal" would look like. Claudette, a woman with a history of paranoid schizophrenia, described going to work and "doing the things that normal people do:"

> Normal is like being normal like anybody else. Doing the things that normal people does. Go to the job every day. Wake up every morning, going to your job. Coming home. Cooking. Watching TV. Calling up your families. Communicating with their friends. Keeping up on different appointments and those sort of stuff. That is normal.

Informants described the ability to do normal tasks in their homes as necessary for their comfort. They were motivated to move out so they could do ordinary tasks in private like people who were not living in supportive housing.

Many participants anticipated doing things in their new homes that they were unable to do in supportive housing. According to the theory of the total institution, another process of the mortification of self is "the disruption of the usual relationship between the individual and their actions" (Goodman, 2013, p. 81). In other words, people in total institutions do not have control to complete regular daily tasks in the same way as people who are not in total institutions. In particular, residents planned to take a bath, cook, and decorate in their new apartments. Residents in supportive housing often shared bathrooms and kitchens with other residents and had previously shared concerns for cross contamination in these spaces. Participants also previously mentioned the inconvenience of needing to shuffle things from their private units to these communal areas to complete tasks. Many residents talked about looking forward to having an oven or a stove in their apartment so they could cook and bake. In seeking comfort upon moving out, participants anticipated completing daily tasks in their homes.

Secure Benefit Seeking in Moving On

Residents identified specific conditions they would need to secure the benefits they received in supportive housing when they moved out. If they could count on benefits, they would be able to move on with comfort and assurance. Security was a particular concern because of their previous experiences with homelessness. If people were confident they would have a housing voucher, it would alleviate their concerns about becoming homeless again. Another condition for informants was having a flexible timeline for their supportive housing tenure as opposed to an arbitrary date for discharge. In addition, they wanted aftercare services available when they moved out, which would provide greater comfort and security during their transition to their new homes.

The Housing Voucher: The Freedom to Move

Informants considered the housing subsidy the most important factor that would enable them to move securely. Research indicates that people, including individuals with psychiatric disabilities, have benefited from housing subsidies; they have used them to achieve independent housing without onsite services (Newman et al., 1994). All participants in the current study had been homeless in the past and had experienced housing instability in other ways. They described multiple transitions between residences and from hospitals or incarceration. Because of these experiences, the housing subsidies carried significant meaning for all of them. They were acutely aware of the precise amounts the subsidies provided towards their total rents and could report the exact monetary value of their subsidies. They anticipated that the vouchers would make their rental payments affordable on an ongoing basis and alleviate the worry of becoming homeless again.

Jake, a man with a history of substance abuse who had been living in supportive housing for 10 years described the secure benefits he received inside "the gate" of supportive housing. He explained that he needed a housing subsidy in order to move out because without it, the money he had saved up would eventually "run out:"

> You need some type of support from — it could be Section 8. They're more help because rent today is sky-high. No matter how much you save up, you can get apartment, but can you maintain after you done got into it was a problem. I feel if I have another party helping me towards it, it wouldn't be no problem. That was the whole dilemma with me rushing out, again to just jump into something. You're not really having fifteen hundred dollars a month like that. No matter how much you've got saved, after a while that will run out. If I have some type of program supporting me, I can definitely make it through.

For Alexandria, the ability to subsidize her rent meant "freedom." She had become homeless when she lost her apartment of 17 years because of crack and cocaine addiction. The housing voucher alleviated concerns about becoming homeless again:

> [The housing voucher means] freedom. I'm not weighed down with concerns on, 'Am I going to be living here next month because I didn't get the rent paid?' or 'Am I going to still be here next year because I'm having a hard time paying this rent?' That's freedom for me. That's a load off my back. I know where I'm going to be. I can pay the rent and sit back, sit back and not be threatened to have to be in the street or go to another shelter.

Rental subsidies relieved participants' worries about financial problems that would result in homelessness. They looked forward to the autonomy they would achieve

moving out of supportive housing, and having housing vouchers enabled them to feel comfortable about the move.

Not Permanent, as Long as Needed

Participants framed supportive housing as a temporary condition. It was not "permanent," but only for as long as they needed the support it provided. While some residents were convinced that they would be "stuck" in supportive housing forever, others came to believe that their stays were temporary. These residents described how supportive housing contributed to their readiness to move on. For example, Claudette, who had lived 7 years in supportive housing and had paranoid schizophrenia, said she was never meant to live in supportive housing "forever;" instead, it was available until she was able to maintain her medication and finances independently. Additionally, Jake explained the importance of having a flexible timeline to ensure that he could avoid a return to homelessness upon moving out of supportive housing:

> I came through the shelter system, so once I got here, I was planning on staying like five years just to save up some money and move out. Unfortunately, it lasted a little longer, and I learned through some trial and error because I was going to step out before the Moving On program came about. I was told 'Don't rush, because I saw a lot of people rush out and winded back up in the shelter system.' So I said, 'I'm not going to make that mistake.' I learned from other people's mistake, and I said, 'I'm just going to wait it out another year or two.'

Like Jake, some participants decided on their own that their tenure in supportive housing was for a short time until they were able to accomplish specific goals. Residents often mentioned the goal of successfully securing and maintaining alternative housing.

Aftercare: They Don't Just Leave You in the Cold

Finally, participants discussed supportive housing aftercare services as they prepared to move on; knowing they would have access to aftercare contributed to their sense of security. Some mentioned the importance of not having an abrupt ending and appreciated not being left "in the cold." They referenced the utility of short-term assistance following their move from supportive housing. They emphasized the importance of aftercare services for their anticipated transition out of supportive housing and commented on the continued support of program staff with whom they had built supportive relationships.

Some residents were very specific about the meaning of ongoing support when they moved into their new apartments. According to Josephine who had lived in supportive housing for eleven years,

> I like that they just don't, like, flat leave you, and say, 'Okay, goodbye. You're in your new digs.' And, you know, 'Sayonara.' I like that they have somebody that comes over once a month and checks on you [in your new apartment] and sees how you're doing and that if something goes wrong, that they can help you.

Fiona expressed a similar sentiment. "They don't just leave you out in the cold. They come and visit for a month, for a month up until 6 months. That's good."

However, aftercare expectations varied by resident. Some wanted six months of aftercare following their move, while others anticipated receiving services for a longer period. With a history of 14 years of homelessness, Audrey described the meaning of a gradual separation from supportive housing and the importance of aftercare services. With help from supportive housing staff, she felt that she would be able to learn to do things for herself:

> I think as long as they still around for a while, that'll be good. I think at first they going to come visit us, which is good. Once I'm there maybe a year, two years, then it won't be as intense, because I'm learning to be on my own. I'm learning to do things mostly for myself and I think with that change, slowly but surely, I'll get used to my independence. I know it's going to be something for me to adapt to, but I'm not afraid of change. I can adapt to change.

Some participants mentioned targeted assistance they would need in their transition to a new apartment and help for specific tasks such as taking care of others on their own. Some participants also wanted help locating new local service providers or support in finding new employment. While informants identified increased autonomy and comfort as motivation to move out of supportive housing, maintaining supportive service, flexible timelines, and aftercare services helped them to anticipate the move with greater security.

Conclusion

In seeking ontological security, formerly homeless people were not able to meet all conditions in their homes, but the residents presented in this chapter were motivated by push factors that led them to favor moving out of supportive housing. They described the tradeoffs between either staying in supportive housing or moving on but concluded that having their own apartments would increase their autonomy and comfort. They believed that they would be living "on their own" and away from the burdensome monitoring in supportive housing. Participants desired freedom from supervision and greater privacy and control in their homes and did not want to live among strangers. Instead, they wanted to fulfill familial roles and to complete routine or "normal" tasks in their homes.

Meanwhile, participants expressed considerable concern about the potential loss in secure benefits upon moving out of supportive housing. All participants had previously experienced homelessness and identified the secure benefits in supportive housing, specifically the financial security obtained there, as helping them to avoid future homelessness. While residents were very motivated to move to a home allowing them to feel "normal," on their own and a part of their family, they were also motivated to avoid future homelessness. However, specific conditions such as rental assistance, a flexible supportive housing tenure timeline, and the availability of aftercare services enabled informants to envision moving out with comfort and security.

CHAPTER VII: RESIDENTS IN RECOVERY

In pursuit of optimizing autonomy, residents in recovery from psychiatric disabilities identified that being free of close supervision was a motivation to move on, similar to participants without psychiatric disabilities. On the surface, supportive housing conditions were undesirable and detracted from their autonomy. However, these restrictive practices were essential to the "protective environment" that kept them from relapse. In the case of people striving to maintain their recovery, autonomy was a complicated concept, since they could only remain autonomous as long as they were not actively using drugs or if they were free of psychotic symptoms. Informants were in pursuit of autonomy by staying in recovery. They were in an autonomous state while sober or treatment compliant. They reported that they could achieve and maintain recovery by being medication compliant and good clients. As long as they remained sober or treatment compliant, they had freedom and peace of mind.

These informants also reported risks that were outside of their control, which would likely continue throughout their lives regardless of where they were living. Ongoing problems included the lifelong nature of maintaining recovery in the context of ongoing psychiatric disability and dealing with past trauma. Similar to other residents, wherever participants in recovery lived, they risked stigma, discrimination, and getting caught in a circle of poverty and programs. Residents who perceived ongoing risks to recovery and autonomy that transcended their current residence may have been less motivated to move on, because they believed their conditions would either remain the same, no matter where they lived, or could be even worse if they moved out. According to Claudette, "It's going to be the same thing, because I live my life one day at a time. I can't tell the future, so I hope it's going to be normal and I would be able to

pay my rent." Given the ongoing risks to autonomy, some residents, like Claudette, may not have viewed moving on as a marked improvement over their current accommodations.

Security within the Gates

Residents in recovery, similar to other participants, were pulled to stay in supportive housing to maintain their financial benefits. They identified financial stability and security from repeated homelessness as factors that pulled them to stay in supportive housing. Previous research has found that concerns about material resources affect recovery from severe mental illnesses (Borg et al., 2005). Conditions such as poverty, substandard living conditions, unemployment, and homelessness all affect someone's recovery. In supportive housing, informants had access to material resources that shielded them from repeated homelessness, which helped them avoid relapse.

Beyond financial stability, participants in recovery identified benefits other than the financial ones in supportive housing. The structure of supportive housing gave them "security within the gates." These benefits included supportive relationships with their caseworkers and other people who helped them complete tasks necessary to maintain their independence. Additionally, while many participants talked about wanting to be free from the supervision and rules of supportive housing, others expressed gratitude for the structure. For these people, supervision provided external reinforcement for the conditions that enabled them to remain sober or to avoid relapse. Similarly, Padgett (2007) found that homeless adults in supportive housing were not sure how they were going to handle their sobriety without the strict abstinence rules of their supportive housing programs.

In addition to the financial security and supervision, residents, particularly those with substance abuse histories, identified the value of readily availability peer support from other

residents who were also in recovery. Peer support from other people in recovery aided their own efforts, adding to their recovery maintenance security in supportive housing. However, while peer relationships could be supportive in some cases, in other cases they created risk for people with both substance abuse histories and mental illnesses, since it placed them in proximity to drug trafficking and exposure to peers' mental health crises. Overall, financial security, supervision, and ready access to other people in recovery together worked to help these informants avoid relapse.

Informants described their supportive housing programs as a part of a larger safety net that brought them security and made them reluctant to leave. Jake recognized supportive housing was a "protective environment" that he encountered when he came "through the gate." He talked about the security he felt in supportive housing from his relationship with supportive housing staff. This made him reluctant to move on. "Leaving the protective environment, I would miss a lot of the staff. They made you feel important like you are somebody in spite of what you came from, and they try to make everybody feel like that." Other informants provided specific examples of assistance they received from supportive housing staff, which contributed to maintaining their recovery.

Javier, a resident in recovery for 6 years from heroin addiction explained how supportive housing supervision and rules helped him avoid relapse. When envisioning what it would be like to move on, he questioned whether he could maintain his recovery without the structure and rules he currently experienced:

> I could tell you everything, right here it's easy, right here is easy. You always got people talking to you. You always got people around, watching you. A lot of people when they're here, they stay clean. Once they move on it's a different story.

> For me, when I came here I was already clean so I had close to three years clean. I think my time here I got stronger. Once I go back on my own, it's a different life style all over again, because I'm by myself. I don't have nobody watching me. I don't have no curfew. Any friend that I want could go to my house, things that I'm going to try to stop. I hope so.

In summary, these tenants were reluctant to give up the recovery maintenance support they achieved in the protective environment of supportive housing. These supports included their relationships with staff and peers, assistance with specific tasks, and the structure from the rules and supervision. They indicated that this support provided them with security from relapse.

Optimizing Autonomy

For many participants, the monitoring and supervision built into the supportive housing structure constituted a barrier to autonomy. However, in order to be autonomous, residents in recovery would have to maintain sobriety and mental wellness. They likened the restrictions imposed on them as supportive housing residents to "assistance" and "advocacy." One resident suggested that this type of support saved his life. In tears, Jack, a recovering addict explained, "just to see where I've come from. I wouldn't have made it by myself. There's no way I would've. I'm grateful and I'm thankful. I'm humble."

Another resident, Susan, described the external controls and assistance that supported her and other residents with psychiatric disabilities. She had a history of severe mental illness and lived in supportive housing for eight years. She described being in her program as being "controlled." When asked to elaborate on what this meant, she said, "They give you a lot of assistance," and went on to describe several types of help she received in her daily life. "This has to be controlled because there has to be some assistance there. It's not so much control, as

assisted." This appeared to be a way to reconcile her desire for autonomy with her need for assistance. Not surprisingly, despite her affirmations, during the interview she expressed ambivalence about moving on. Similarly, Nicole expressed a desire to move on to an environment that was less controlled, but she also admitted that there were aspects of the controlled environment, which were "very helpful." Ultimately, she was uncertain that she was capable of moving on and would be "happy to stay where [she's] at."

While reflecting on the monitoring and restrictions in supportive housing, participants shared stories of personal change from their early days in supportive housing. Many acknowledged that even if they did not like these procedures, they recognized that they were in their best interests. Residents shared having experienced a decrease in mental-health symptoms, seeking substance-abuse treatment, and achieving sobriety, improved medication compliance, and money management. They considered what this structured support meant to them.

Alice, a woman with a history of mental illness and addiction said, "[I] had a voice, but I didn't know how to use it. [They] saw something in me that I couldn't see in myself and then they had a voice for me. They advocate for me." While residents wanted to be free from monitoring and restrictive practices, some also recognized and appreciated their role in recovery maintenance and the participant's access to people who would advocate for them.

Peer Support

Participants with histories of substance abuse described the importance of peer support in their supportive-housing tenure and an important part of what kept them secure in supportive housing. While thinking about what life after supportive housing would be like, Fred, a 15-year resident of supportive housing with a history of severe mental illness and substance use said, "I'll

be in a different place. I won't be near the people that I know." Many participants talked about anticipating missing their peers, roommates, and neighbors.

Those in recovery from substance abuse specifically mentioned that once they moved out, they would miss the support from peers that helped to facilitate their recovery. This support came from both staff and other residents and was augmented by onsite activities that brought them together with others. For example, Charles said he was feeling sad about the prospect of losing sober friends. "I'm accustomed to living here and like moving on. I feel a little sad because of my friendship with people that we deal with, that we don't smoke, like use drugs and stuff like that, and I would feel like missing them." He further explained that being around sober people helped him prevent relapse. He worried that if he spent time with people who drank, he risked relapsing:

> I'm going to be lonely most of the time and here, I got friends that are not drinking. Before I have friends, most of my friends in the outside, drinks and smokes and stuff like that and I going to miss my friends that here, that sober people. Yeah, that's very important to me. I find that when I'm with people that drinks, eventually I will end up drinking. When I'm with people that not drinking I don't have no problem thinking about drinking or nothing like that.

In summary, some residents with histories of substance abuse indicated the importance of the support they received from their peers in supportive housing and anticipated difficulty maintaining their sobriety if they no longer had the support from others who were also maintaining sobriety. Meanwhile, residents with psychiatric disabilities, including mental illnesses and histories of substance abuse, described feeling a "security within the gates." Supportive housing with its structure, staff, and peer support was fundamental to their recovery.

Further, for these participants, recovery was essential to maintain an autonomous state. Consequently, they may have been reluctant to give up this support to move out into a community apartment.

Risks to Recovery Maintenance in Supportive Housing

On the other hand, some informants in recovery also described aspects of living among peers as problematic. Problems included exposure to drug traffic and use, or to mental health crises. Some spoke about wanting to move on in order to be free from living among others because of drug activity in their buildings. Genevieve, a woman with a history of mental illness, addiction, and drug dealing described her desire to live in a safe environment away from drugs. "I want to live with people that they just want to be safe, you know? They just want to live. It's not drug infested, scary like —I don't want to live scary."

Genevieve, and others, detailed concern with the drug use in their buildings and their hesitation to confront undesirable behavior. Even when she confronted her neighbors breaking the rules, she reported it could lead to a disrespectful exchange without changing the neighbor's behavior.

Residents were not only concerned for their own safety; they were also concerned about the safety of the loved ones who visited them. Violet, another resident who also had a history of substance abuse described worrying about the safety of her building especially when her grandchildren visited her:

> There's safety issues in the building. You have a lot of drug use. You have a lot of visitors that go from apartment to apartment. That's not safe. My granddaughters will be 9. I'd like to say, 'Go and take out the garbage,' but I'm not going to let

> them do that because I don't know who is lurking in the hallways. That is a safety issue.

Because of a lack of privacy and personal space in supportive housing, informants witnessed other people's behaviors, routines, and struggles. Jack, a man with a history of addiction, said he needed to be supportive to his neighbors, but at times, it was to his own detriment. "I see so much. I hear so much stuff. Lot of people use me as a sign in board. To tell me what's going on with them. I'm trying to get myself more together."

Nicole, a woman with mental illness, described looking forward to leaving supportive housing so she would not have to witness other people's crises, or deal with unsolicited requests from neighbors. She used the word "normal" to describe what she expected in her new home:

> I look forward to the normal things that I don't have to see the cops outside every day. I don't have to see the ambulance outside. I don't have to see these people when they're not taking their medications, or people asking you for money all day, or people asking you for cigarettes. Just the general way that this building, or buildings such as this.

While participants described achieving recovery support from their peers, there were other undesired aspects they experienced living among their peers.

Freedom and Peace in Recovery

Autonomy through Treatment Adherence

While most informants expressed the desire to increase their independence by moving on, wanting to be on their own and free from parental-type supervision from the supportive housing staff, some residents in recovery talked about independence in a different way; they did not identify independence as a motivation to move out of supportive housing. Residents with

psychiatric disabilities used treatment compliance — including abstinence from illicit drugs, adherence to prescribed medication, and being a "good" client — to demonstrate, maintain, and potentially increase their autonomy. Their independence rested on their ability to remain drug or symptom free. They described how compliance helped them to achieve levels of independence in supportive housing. In addition, they described how treatment adherence unlocked opportunities for greater autonomy.

Absence from drugs. Those residents in recovery from substance use described how their independence was predicated on the absence of drugs. They achieved a level of "semi-independence" while being in recovery from substance abuse and living in supportive housing. James, a man in recovery with a history of substance abuse and mental illness explained how he achieved independence through abstinence:

> I never enjoyed things [while I was using]. All I was interested in was drugs, and alcohol, and sex, and rock and roll, and all those other crazy things. I never had my own place. I've either slept on people's couches. I've been in shelters. I never went anywhere. I never did anything. My whole life was drugs and alcohol. Now that I'm semi-independent, I pay my bills on time now and I don't owe anybody any money. I can manage my money. At the end of the month, I still got a couple of dollars in my pocket. I got real friends now, not just friends when I got money. And, that's a beautiful thing. I'm back with my family, and I got people that love me for who I am, not for what I got. I can sleep at night. I can walk down the street and not worry about the police coming or that I got a couple of rocks of crack on me and they might bust me, or something. It's freedom.

For residents like James, sobriety was the foundation for their autonomy. Their independence existed alongside their successes and challenges with recovery.

Being a good client: On my business. Participants with psychiatric disabilities were able to be independent and gain even more opportunities for autonomy by demonstrating compliance in supportive housing. One of the factors of being a "good client" was the importance of maintaining their recoveries, essentially what enabled them to be autonomous. Specifically, residents noted the importance of being abstinent from drugs, as described above, or adherent to prescribed medication. Claudette, diagnosed with paranoid schizophrenia, asserted her independence and commented on the role medication played:

> I can take care of myself. I may have this illness. But, I budget myself every month. I pay my bills, then I buy my food. All those things I do for myself. And I take my medication very serious. If I want to be normal, and I don't want to go in the hospital for nothing at all, I have to take those meds.

Medication compliance was a factor in assessing whether residents were ready for more independence, such as moving into a community apartment with the Moving On program. In other words, participants with psychiatric disabilities may have been medication compliant to maintain recoveries enabling them to move out of supportive housing.

It was important for them to be "good clients." Residents perceived that if they were able to maintain control over their behaviors, they would be able to maintain the support they needed, and compliance was necessary to maintain good relationships with caseworkers. They talked about creating "no trouble" and "no problems" with service providers. They thought staff members evaluated them on how compliant they were. They pointed out the relationship between compliance and eligibility for the Moving On program. In order to move on, they listed tasks

they completed and responsibilities they managed on their own as proof. In particular, these residents felt that being a good client, such as by being medication compliant, proved that they no longer needed assistance in supportive housing and were ready to move on. One woman, Tiffany, listed many ways she showed compliance, and then, said, "I'm like in and out always on my business and stuff like that. Basically, I don't need supportive housing anymore."

Participants identified completing tasks such as taking medication, attending doctors' appointments, paying their bills, cooking their own food, and keeping their apartments clean. In addition to demonstrating to staff that tenants no longer needed assistance, participants also shared their views that compliance showed that they were good tenants and they deserved to move on. When asked why he thought he was chosen for the program, one resident, Henry, replied, "Because I'm a good tenant." Another participant, Audrey, disclosed that she deserved to be chosen for the program in part, because she was compliant in taking care of her day-to-day responsibilities:

> When I looked at the paper it read, Moving On Initiative. Are you current on your rent, electric bill, are you interested in moving on? All of a sudden the bells went off. I went, yes, yes, yes. That's how it started. I think they see initiative in me. My past includes accomplishments in life, so I really think they see something in me to not keep me somewhere, to leave me there stuck. See something in me to say or think, you know what? She seems like the perfect candidate for it, because they see me taking care of my business, amongst other things.

Participants in recovery from psychiatric disabilities described the use of compliant behavior as a way to maintain their recovery and to demonstrate their capacity for greater

autonomy, like the Moving On program. Specifically, residents spoke about the importance of being medication compliant, being a "good client" and being "on their business."

Freedom to Come and Go

All participants anticipated greater liberty to come and go from their residences when they moved out. In contrast, when residents in recovery spoke about the freedom to come and go, it was not as a motivation to move out of supportive housing. They had already attained the freedom to come and go because of their substance abuse recovery. Specifically, residents identified opportunities to travel afforded by their active recovery from past drug addiction. James described how his recovery gave him new and additional options. He explained his freedom:

> Choices. I got choices that I can get up and go where I want to go. Travel, like I said. I went to Memphis, Tennessee last year. It was beautiful. …I went on my own. I paid my own way. I was a tourist. I've never been a tourist in my life. I never went anywhere. I didn't even want to leave the block, because I was scared I might miss something. It means, like I said, having choices, being on my own, being responsible for myself. It's fantastic.

Some anticipated the freedom to come and go upon moving out of supportive housing. Others expressed their plans to travel once they had moved on from supportive housing; they would be under less supervision after they had established their new homes. However, participants in recovery from substance use also explained that they had already achieved the freedom to come and go, specifically to travel, when they stopped using drugs. Their sense of freedom was tied to their sobriety.

Peace of Mind

While some participants talked about their hope for more peace when they moved out, other participants indicated that they had achieved "a peace of mind" in supportive housing. Borg, Sells, Topor, Mezzina, Marin, and Davidson (2005) identified elements that helped to make people in recovery feel at home. They acknowledged "peace of mind" or achieving relief through rest as a recurrent theme (Borg et al., 2005). Likewise, when talking about achieving peace of mind, some informants indicated that they could obtain peace of mind not by changing residences, but by being sober, paying their bills, and taking care of other responsibilities.

Alexandria, a woman with a history of substance abuse and homelessness, explained that her inner peace came in part from paying her rent and other bills:

> I intend to be at peace. I intend to just be comfortable and easy. I know that it's up to me to carry on my peacefulness, my tranquility. It's up to me to do the right things, and just as long as I pay that rent, pay that Con Edison, don't go stupid, I'm going to be good. I want to feel cool, I want to feel cool without these bothers.

Additionally, Alexandria shared in more detail the peace of mind she gained from being able to pay her bills after a long history of being addicted to drugs, or what she called the "no-nos:"

> For a lot of years before getting here, it was always a choice between paying the rent or buying my no-nos, or taking care of the kids or buying the pair of shoes they might need. The monies just wasn't there because I was so busy doing the wrong things. I, through the 8 years being here, have learned how to keep it together. And just as long as I don't spend foolishly, I'm able to live month to month to month without the concern of, 'Oh my goodness, the rent ain't paid last month,' or, 'Oh my goodness, I haven't done laundry in how long?'

> That's freedom for me, to not have to worry about living day to day. I'm able to go to sleep without it on my mind, on my brain. "Aw, wonder when they're going to be sending me that 3-day notice." You know what I mean? That's freedom for me. Simple as that.

Informants in recovery from substance abuse reported they found peace of mind and comfort through sobriety. It was freedom from worry about bills, eviction, trouble with the law, and the burden of worrying others. They associated this peace of mind with maintaining their sobriety.

Risks to Autonomy in Recovery

Like other residents, informants in recovery identified risks to autonomy outside of their control that would likely continue throughout their lives regardless of where they were living. These residents talked about being "stuck" beyond their current living arrangements. Research suggests that factors affecting recovery among people with histories of homelessness transcend their place of residence (Greenwood et al., 2005; Padgett, et al., 2016). Some of the factors most frequently affecting recovery in both positive and negative ways were related to mental health, relationships, and meaningful community involvement (Padgett, et al., 2016).

Current study recovery participants noted that moving to an independent community apartment would make minimal difference on their current problems like poverty, mental illness, and substance abuse. Despite the security they achieved from supportive housing, and their worry that without it, they may have difficulty maintaining their recoveries and their autonomy, residents in recovery acknowledged that there were factors that were outside of their control, wherever they were. Because these conditions transcended their homes, some informants may

have perceived a lack of autonomy regardless of where they lived. One participant, Beckett, said, “The move from here to there don't change anything, just people.”

On a personal level, participants identified ongoing challenges to autonomy such as hopelessness and recovery barriers. Participants in recovery felt there was an ongoing risk to their autonomy regardless of whether they stayed in supportive housing or moved out. Meanwhile, they clearly identified having achieved some level of security and recovery support in their current homes. For some, these external threats to autonomy may have removed their motivation to move out.

Participants in recovery in this study anticipated continued barriers to achieving autonomy, such as past trauma and psychiatric disabilities. The concept of recovery from traumatic events and psychiatric disabilities includes a lifelong pursuit of redefining self, incorporating illness, and managing symptoms (Davidson, O’Connell, Tondora, Lawless & Evans, 2005). Informants highlighted the long-term nature of recovery, noting that these particular barriers would continue throughout their lives, regardless of where they were living.

While some described trying to exit supportive housing successfully, they recounted life-long hardships that threatened their recovery. These included dealing with histories of homelessness and criminality, psychiatric disability, and traumatic events. Informants spoke about a lack of hope because traumatic events had put a weight on their lives that seemed impossible to manage alongside ongoing recovery. They described hopelessness and grief after the deaths of immediate family members including siblings, parents, and children. Fiona, who had a history of mental illness, and was in recovery from crack and marijuana addiction, gave a poignant account of her past, including the loss of her 17-year old daughter to cancer when Fiona was actively using drugs:

> We found out later on that it was cancer. Hopkins disease. [I was] so blind by the drugs. I didn't know what to say, how to do it. I wasn't given that information. I could have took her to a hospital where they specialize in cancer. These people didn't know what they were doing, and my daughter passed. My daughter paid the ultimate price. [She was] 17. I was devastated. I was mad at the world. It drove me into a spiral of drugs. I carried the grief for years.

Audrey, who had a history of schizoaffective disorder and homelessness, reflected on her ability to work towards goals in her life while carrying the grief from the deaths of her children and parents, early childhood trauma, and what she deemed as "bad decisions:"

> A lot of times I was in mourning for things that happened in my life and I wasn't able to move forward because of that. You see what I'm saying? I was stuck in despair. All that time I was there, stuck for all them years, I didn't live. I didn't choose to live. I was angry. I was rebellious. I'm just stuck in my despair. All them times I was hopeless, stressing out because I didn't have a key to get in. I had to get out. They put me out. I was so worked up in my own world, that I lost interest. I didn't want to do nothing else. I wanted to stay stuck where I was at. Leave me alone, I'm all right here. Whatever it is that's keeping a person stuck, it could be grieving, mourning, drugs, rebellion, incarceration, whatever it is.

Participants disclosed extraordinary grief in their experiences with homelessness, drug use, death of loved ones, and other traumatic events. They expressed ambivalence about their ability to progress toward life goals in the face of their grief from loss and trauma.

Grace, a tenant diagnosed with social anxiety, had previously shared how she had been able to manage day-to-day tasks despite barriers caused by her mental illness. Despite her hope

and expectation for continued recovery, she said she felt controlled by her social anxiety. Specifically, she said that it had taken away her "freedom:"

> Freedom. I love that word. I haven't been free in a long time, so I love that word, freedom. Yeah, I'm not free to come and go like I did before [my social anxiety] started. I want to get back to how it was before. Before all of this kicked in. Yeah, before the social anxiety kicked in, I was free. The anxiety is controlling me. I'm being controlled by it. That's not freedom.

Echoed in the concerns of these participants and others, the challenges they faced transcended where they lived. In the context of moving on from supportive housing, these informants may not have perceived a move from supportive housing as a marked improvement, since their challenges were going to be with them wherever they went, in supportive housing and beyond.

Conclusion

For participants with psychiatric disabilities, being in recovery was imperative in seeking autonomy; without recovery, these individuals were unable to achieve or maintain autonomy. Participants with psychiatric disabilities described supportive housing programs as a part of a larger safety net that supported recovery. Participants in recovery in this study also indicated that their program enabled them independence while they received necessary support from peers and staff. At the same time, many described the stigma associated with receiving social services and housing assistance. Although it was necessary to have this assistance, they were unable to improve their social conditions while they were receiving assistance. Many expressed ambivalence about relying on social welfare service systems for assistance, they recognized they needed assistance and had to accept unwanted conditions to get help; these conditions prevented upward mobility and kept them in need of continued assistance.

Participants faced risks to their autonomy that transcended their place of residence. They described their challenges, noting that a change in their housing accommodations "doesn't make a difference." Even if they moved from supportive housing into community apartments, personal, as well as larger structural barriers would continue to challenge them and limit their autonomy.

All supportive housing residents identified elements of security, comfort, and autonomy attached to their homes that pulled them to stay in supportive housing or pushed them to move out to independent community apartments. Without the ability to optimize all conditions, they expressed ambivalence in their decision and satisfied some conditions until they were "good enough." Residents in recovery had to contend with an additional issue. Their efforts to be autonomous were dependent upon maintaining their recovery. Although the restrictive supportive housing structure pushed all participants with a desire to move on, people in recovery were unique in that, for them, moving on might compromise a vital part of their recovery maintenance benefits. In light of the ongoing risks to their autonomy beyond supportive housing, participants in recovery may find enough autonomy in conditions established through their recoveries, such as the ability to come and go, as they liked, and to have peace of mind.

CHAPTER VIII: DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

This study was an analysis of data collected from a purposive sample of 40 participants from four New York City supportive housing programs. All were participants in the Moving On Initiative; they were presumably preparing to make the transition from supportive housing to independent housing in the community. The primary aims of this study were to gain a better understanding of their experiences as they were deciding whether or not to stay in supportive housing or move on to independent living in the community. In addition, I wanted to identify facilitators and barriers to their upcoming transition. This study drew on ecological systems theory (Bronfenbrenner, 1979) and interpretive interactionism (Denzin, 2001), in an attempt to learn how supportive housing services affected people's everyday lives. The study used a narrative approach to investigate residents' perceptions about preparing to move on from supportive housing to housing in the community (Polkinghorne, 1988).

The homeless services system is currently in transition towards prevention and a systematic response to homelessness, while simultaneously attempting to maximize access to supportive housing for those who need it the most. Despite an increase in primary homeless prevention efforts, there is still the need for secondary and tertiary services. This is particularly true given that individuals with varying histories of homeless, including those with psychiatric disabilities, require a wide range of support services. Even when their most pressing needs are met, homeless people experience other threats to ontological security as stigma. Homeless people are vulnerable to the limited supply of supportive housing and whether or not funding streams will still be available to meet their needs.

Moving On programs, such as the one described here, aim to move current supportive housing residents into affordable housing in the community that is independent of services; this

is conceived as a way to open up their supportive housing units for other homeless people. These programs are rooted in a recovery framework. One principle of the Recovery Model is placement in the least restrictive appropriate housing. In the system-wide attempt to maximize access to services for those who need it the most, researchers, policy makers, and advocates should create pathways to the most suitable housing for residents. Some supportive housing residents may find appropriate housing in affordable community housing without onsite services while others may find it within supportive housing. Little research has considered how to best assist formerly homeless people to make a decision to stay in supportive housing or to prepare to move into the community. This study was an effort to add to understanding about these processes.

Discussion

The participants interviewed in this study described the factors that pulled them to stay in supportive housing and those that motived them to leave for apartments in the community. They all shared a common need; those more inclined to stay or to leave expressed a desire for ontological security. Scholars have described ontological security as assurance that reliable social and material surroundings are provided through a safe and stable home (Dupuis & Thorns, 1998; Giddens, 1990; Kearns, Hiscock, Ellaway, & MacIntyre, 2000; Padgett, 2007; Padgett & Henwood, 2012; Saunders 1984, 1989). Findings in the current study echoed previous research about the need for ontological security among people with histories of homelessness and psychiatric disabilities. For example, the financial security that they acquired in supportive housing was extremely important, which made them reluctant to move—even with the promise of housing vouchers or rent subsidies. This appears to be a reasonable concern, since even with rental assistance, only about half of low-income renters gain access to affordable housing (HUD,

2015). Furthermore, some have found that the temporary rental assistance employed in rapid rehousing programs has been unable to mitigate future homelessness risk (Byrne et al., 2016; Department of Veterans Affairs, 2018, pp. 59-60). Every informant in this study had previously experienced homelessness and was personally aware of the difficulty accessing and maintaining affordable housing. This made them reluctant to leave the security of their supportive housing placement, even though they described many other reasons for wanting a home of their own.

The current study findings support previous research that identified control, privacy, and protection from the outside world as factors that make a place feel like a home (Borg et al., 2005; Depres, 1991; Padgett, 2007). Among supportive housing residents, Padgett (2007) identified many features of ontological security, such as exercising control over one's home environment and several "freedom from" and "freedom to" conditions that informed meanings of home (Padgett, 2007). In this study, I labeled these autonomy seeking.

Similar to previous findings, people in this study found these factors enabled them to achieve autonomy and comfort within supportive housing. Participants described how they created comfortable homes in supportive housing after experiencing homelessness, including making changes to their spaces and achieving a level of freedom within them. The neighborhoods and the conveniences associated with their programs provided comfort that pulled them to stay. Even thought they described undesirable conditions in supportive housing, they identified the importance of proximity to important resources as a reason to stay. Although many were unable to achieve complete autonomy and comfort in supportive housing, virtually all described some degree of these ontological features that pulled them to stay.

Social workers and other advocates have been able to establish supportive housing as an essential element of the solution to homelessness. After being placed in these programs,

residents of supportive housing experience housing stability and improvement in outcomes indicative of recovery from psychiatric disabilities (Leff et al., 2009; McHugo et al., 2004). Additionally, supportive housing of various types, including Housing First and continuum of care models, has been shown to have significant meaning for those who have experienced homelessness (Padgett & Henwood, 2012; Padgett, 2007). In Housing First research, residents of these programs experienced improved outcomes in housing stability and community integration when compared to residents of continuum of care programs (Stefancic & Tsemberis, 2007; Wong & Solomon, 2002).

In their search for ontological security, informants described the complex factors that pulled them to stay in the security of supportive housing or pushed them to move out towards increased autonomy and comfort. Nonetheless, both stayers and movers were ambivalent. While informants reported that they had achieved secure benefits in supportive housing, some participants identified having enough autonomy and comfort within their supportive housing program; this allowed them to justify staying in supportive housing. By contrast, anticipated gains in autonomy and comfort pushed them to contemplate moving. With an opportunity to achieve ontological security, some informants analyzed the risk of giving up secure benefits and envisioned what it might be like to move out. Ontological security drove both the impulses to stay and to move on. While achieving a sense of home requires elements of ontological security, these elements can transcend any particular physical space. Consequently, residents acknowledged they could achieve ontological security in either supportive housing or elsewhere. In all cases, they sought security, autonomy, and comfort.

Participant ambivalence represented their inability to anticipate an optimal choice to meet all ontological features. Consequently, they often resorted to satisficing. For example, residents

who were pulled to stasis by the secure benefits found in supportive housing identified circumstances that were "independent enough" or "comfortable enough." This satisficing allowed them to envision staying in supportive housing. Recent research and practice has supported formerly homeless and psychiatrically-disabled adults in living autonomously and comfortably. However, individuals with substance abuse histories and mental illnesses have been previously institutionalized and criminalized as part of policy responses to their social problems, interventions that have limited their independence (Drug Policy Alliance 2014, 2015; French, 1987; Goldman & Grob, 2006; Greene, 1999; Koekkoek, Van Meijel, & Hutschemaekers, 2006; Lamb & Weinberger, 2005; National Coalition for the Homeless, 2004; National Coalition for the Homeless & National Law Center on Homelessness & Poverty, 2006; Padgett, 2007; Tsemberis & Elfenbein, 1999). Given the collective history of this population, and their individual experiences, participants understood that there are limits to the autonomy and comfort that they were likely to achieve, and could expect.

While approaches to motivations for supportive housing have varied among models, achieving housing stability in supportive housing of all kinds has long been the goal for homeless clients. Despite the incorporation of recovery principles in some models, the "permanent" housing attached to supportive housing can promote a mixed message about recovery. While the language "permanent" was originally intended to distinguish it from temporary and transition services, there is also a latent suggestion that people who are recovering from homelessness and various psychiatric disabilities may not progress past supportive housing to move to independent housing outside of the mental health system. For all intents and purposes, housing beyond the continuum of homeless services may be assumed unattainable if residents are expected to receive supportive housing services "permanently."

In the current homeless services system, supportive housing residents have various homelessness experiences and levels of needed support to live independently. For example, all formerly homeless people are able to acquire affordable housing in a difficult housing market when they move in to supportive housing. Meanwhile, some psychiatrically disabled residents have sought services for assistance to live independently.

Within a system-wide transition toward homeless prevention supportive housing programs would serve only those with more comprehensive needs and would require assisting many people currently living in supportive housing to move on. Moving On Initiative (MOI) programs aim to "open the back door;" supportive housing residents are assisted to move into affordable housing independent of services in order to open up their units for other homeless people. Additionally, the 1999 Olmstead mandate declared that psychiatrically disabled people should be able to live in the most independent setting possible (Olmstead v. LC). Within this framework, those formerly homeless individuals, both with and without psychiatric disabilities, who were interested and able to live independently of supportive housing assistance, would be aided to vacate units for individuals needing higher levels of support through the mental health system (Montgomery, Metraux, & Culhane, 2013). It is important to note that *staying in supportive housing* is not framed as a failure. Rather, in the system-wide attempt to make supportive housing services more effective and efficient, researchers, policy makers, and advocates should work to create a pathway to the most appropriate housing for formerly homeless, psychiatrically disabled people.

In the past, many people with severe mental illnesses were housed in psychiatric institutions, which were the total institutions Goffman (1961) described. After deinstitutionalization of the mentally ill in the 1960s and 1970s, community service providers

developed programs to support and monitor people with mental illnesses. However, these programs developed very slowly and did not sufficiently meet their intended goals to support mentally ill people in the community. Supportive housing was one of these initiatives. Nonetheless, participants in this study described supportive housing similarly to a total institution; they had restrictions, monitoring, and the expectation that residents take on the role of "client." Many participants distinguished between supportive housing practices and a "normal life" declaring that they wanted to be "normal" and treated like other people living in the community.

They identified the restrictive practices in supportive housing as push factors, motivating them to move out to increase the autonomy and comfort they experienced in their homes. The details of their desired comfort were conceptually rooted in Goffman's (1961) total institution and mortification of the self. They desired freedom from having to cohabitate with strangers and share intimate spaces with people they did not know. They also wanted to be able to shed their client roles to be active members in their families and to be normal by gaining the ability to complete ordinary tasks in their homes. Because of these ontological features, they expressed a desire to move out despite the anticipated loss in security.

In previous research, people with histories of homelessness and psychiatric disabilities identified autonomy, or the freedom from and freedom to, features of ontological security (Kearns et al., 2000; Padgett, 2007). However, while Padgett's (2007) participants identified autonomy within supportive housing, the participants in this study anticipated they would increase their autonomy when they moved out. Informants also anticipated an increase in privacy and control in their homes.

The search for ontological security was complex for those supportive housing residents who were in recovery from psychiatric disabilities, including people with histories of mental illnesses, addictions, or both. They were pulled to stay in supportive housing for the same reasons as all participants in the current study: to maintain financial security through maintaining affordable housing and to avoid the risk of future homelessness. However, beyond those factors, people in recovery had established recovery maintenance support in supportive housing that made them feel secure from future mental health and substance-related relapses. This presented an ontological conflict for these residents. Many were motivated to move out from under the restrictive practices in order to increase their autonomy. However, they identified these same restrictive practices as providing protection from relapse. Consequently, the restrictive supportive housing practices, such as monitoring procedures and having guests sign in and out of the building, may have motivated them to move out, but they may also have helped them to maintain their recovery.

Previous Housing First research has suggested recovery was largely connected with factors that transcended the program model; the factors likely to affect recovery trajectories in both positive and negative ways included social relationships and engagement in meaningful activities, factors that were not connected to a particular housing model (Padgett et al., 2016). In contrast, the current study identified that recovery maintenance security established in supportive housing pulled residents to stay and constituted the foundation of their sense of autonomy through their recoveries. Researchers should further investigate how these factors facilitate or impede recovery among people with histories of homelessness in various housing settings, including supportive housing programs constituting the end of the continuum of care and community housing not connected with comprehensive in-home services.

Some residents achieved ontological security from being in and maintaining their recoveries while in supportive housing. They experienced autonomy from asserting control over personal actions such as abstaining from drugs, being compliant with medication, and taking care of their business. Some described "a peace of mind" or a sense of freedom from financial worry and the weight of substance abuse. This allowed them freedom to live their own lives. For people who had established recovery from psychiatric disabilities in supportive housing, the pull to stay came from the financial stability and avoiding future homelessness, but also from their desire to maintain their recovery supports. These elements supported the ontological security gained from their recoveries. Moving On programs do not aim to remove the option of stability from supportive housing, as many people want or need this level of services. Rather, Moving On programs aim to provide an avenue out of supportive housing for those willing and able to move on, but who are "stuck."

Strengths and Limitations of the Study

The aim of this study was to explore the experiences of formerly homeless individuals who participated in a program to prepare them to move on from supportive housing. The focus of the study was to identify facilitators and barriers in the process. My intent was to understand better the factors that motivated them to move on, and those that did not. Many supportive housing residents who had experienced homelessness and other challenges, such as histories of trauma and psychiatric disabilities, planned to move on despite the odds they may end up homeless again.

This study highlighted the need for a strengths-based and system-wide approach to service development for homeless people. Such an approach should begin by incorporating the experiences and needs expressed by individuals affected by the problem through the narratives of

those who have been institutionalized, criminalized, and treated as undeserving. A narrative-focused approach is recovery-focused as it infuses participants' experiences into the policy response. Participants in this study had first-hand experiences and were able to systematically describe barriers and facilitators for achieving independent living as formerly homeless people.

Strengths of the Study

Prior to this study, very little attention was given to how supportive housing residents experienced preparing for this important transition. Current study findings help to explain what factors pull residents to stay in supportive housing and which push them to move out. Given the factors that motivate and discourage residents from moving on, service providers and researchers can develop programs to best support residents making this transition.

These findings will also complement and refine the quantitative results from the parent study, a mixed-methods longitudinal study exploring the implementation of the Moving On Initiative. While researchers will be able to determine rates of successful exits from quantitative data, these narrative accounts will help researchers to better understand why some residents chose to move on. More importantly, these findings will assist researchers to appreciate why some participants decided to remain in supportive housing, despite access to a highly coveted housing subsidy.

This purposive sample included participants with various backgrounds and experiences with homelessness and histories of psychiatric disabilities to ensure that narratives were collected from various groups within the homeless population. Further, the participants were receiving services in four supportive housing programs run by different agencies. This sample represents an intentional adaptation from the pilot study (Livingstone & Herman, 2016) to improve the potential for transferability of the findings. These findings were salient across this sample.

Further research will need to explore whether these findings are replicated in the experiences of other supportive housing residents preparing to move out.

Study Limitations

The current study has several limitations. Certain groups were overrepresented in the study sample. While Black or African Americans comprise 40% of the homeless population and 53% of the supportive housing population, they were 70% of the study sample (HUD, 2018; HUD, 2018a). Although one-third of the homeless population has a mental illness and one-third has a substance abuse issue (SAMHSA, 2011; US Conference of Mayors, 2015) 65% of the sample identified a history of either or both.

The current study investigated the experience of preparing to move on from supportive housing among people with histories of homelessness. One limitation of the current framework is that all participants were enrolled in a pilot initiative. Participants had access to resources as a part of this initiative, which was support not necessarily available to residents of typical supportive housing programs. An essential tool given to participants of this initiative was a housing subsidy. While people often wait decades for access to federal housing subsidies, participants of this program received it as part of their participation; this limits transferability of the findings.

Additionally, the current study included the data collected at pre-move out interviews with single adults only. Interviews with families were excluded to maintain the integrity of the sample. The study did not include follow-up interviews, which would have allowed the researcher to engage participants over time, allowing for richer descriptions and capturing changes in participants' experiences over time. I used memoing during data collection and peer debriefing during initial coding to eliminate potential threats to the trustworthiness of the data.

Collecting data from multiple sources or using data triangulation, would have further helped to eliminate trustworthiness threats (Padgett, 2008).

To maximize feasibility of completing the dissertation research in a timely fashion, I did not include multiple data collection points or sources. Consequently, the study focused solely on the interviews of individuals preparing to move on from supportive housing. Additionally, while findings identified motivations and barriers to moving on from supportive housing within the broader context, the results only reflected those factors that participants in this sample spontaneously identified.

Implications for Services and Policy

The residents in this study were clear about what would make it possible for them to move on. A particular concern was how they could be confident that they would have housing subsidies that they could rely on, so they could remain in their own home. They identified the housing subsidy available to them as participants in the Moving On program as essential for them to move on with security. They called the housing voucher a "golden ticket" and compared it to winning the lottery (Livingstone & Herman, 2016; Livingstone, Herman, & Warrington, 2015). Providing housing subsidies to individuals with high rent burdens is a valuable policy tool to prevent and alleviate homelessness. Currently, with a lack of federal funding and long waitlists plaguing the system, the use of housing subsidies is an underutilized policy tool that would alleviate homelessness risk for many.

Informants provided clues on how to best help them make the transition from supportive housing to community living. Designing a supportive housing service structure that allows for flexibility in individual moving timelines might make moving on more feasible for residents. Many in this study identified the need for flexible housing tenures, where services were not

deemed permanent or set to end at a pre-determined date. Instead, a resident's length of stay should be evaluated based on their needs.

Similarly, residents needed to envision lives in their own home with supports that would allow them safety and security. Specifically, they voiced the need for temporary services directly following their moves. A popular evidence-based program, Critical Time Intervention (CTI) assists vulnerable populations through transitions, such as the transition residents in this study faced. CTI is a time-limited, phased approach to care coordination with the goal of helping people to establish long-term supports in their communities. Previous research has established that CTI helps to promote housing stability and prevent homelessness and hospitalization for people with histories of mental illness (Herman et al., 2000; Susser et al., 1997). For clients to move on, this model could help to structure aftercare programs.

Relapse remained a particular concern for residents who had mental health and/or substances use problems. Services that would help them avoid or quickly address a relapse were a paramount concern. One of the most prominent pulls to remain in supportive housing for people in recovery was security from the risk of future relapse. They wanted certainty they would be able to access services quickly when they moved out should they experience indications they might relapse.

In a recovery framework, individuals should be able to live in the community of their choice alongside their efforts to maintain recovery. Recovery trajectories are not linear or predictable, and people should be able to access the level of support they need, when they need it. For those interested in moving on, the pull to stay in supportive housing indicates a need for more accessible and appropriate recovery support options in the community. For those who identified the importance of a structured environment to protect them from relapse, they may be

interested in acquiring additional autonomy, while maintaining structure in a low-barrier program to follow supportive housing.

The findings suggest changes to supportive housing services that would be beneficial. Residents were motivated to move to increase comfort and autonomy in their homes; they should not have to give up important aspects of their lives, in order to participate in supportive housing services. For example, a person should not have to sacrifice being an active member of their family in order to live in supportive housing. Echoing prior research, study informants described relationships with significant others and families as a positive effect on recovery trajectories for them (Padgett et al., 2016). These services should identify ways to utilize family supports in their daily practices. For example, supportive housing programs should relax restrictive practices around family visitation and try to make accommodations to facilitate healthy family relationships whenever possible.

Supportive housing residents were motivated to move on in order to escape program practices they believed were intended to monitor them. Commonly, supportive housing residents were expected to sign guests in and out, comply with room checks, report daily activities, and meet regularly with case managers. A few residents compared supportive housing practices to those found in total institutions such as mental health hospitals or prisons. Supportive housing procedures, especially restrictive practices, should be carefully evaluated and assessed for their effectiveness in reaching their intended goals. Restrictive practices should be employed only when necessary to ensure the health and safety of program residents. These practices may in fact have a counterproductive outcome if the objective is to help people transition into community housing. They may serve to infantilize residents who might be better off learning to monitor their own lives.

People who require financial assistance should not have to agree to continue to receive rehabilitative services to receive support. Rehabilitation services should not be tied to financial support. Those who require financial assistance to live independently should not be required to enroll in rehabilitative services if they do not want them. This practice is rooted in the idea that poverty is caused by some personal deficit that requires intervention (Mead, 1997). With the shift in welfare reform legislation, social programs are designed to alleviate welfare dependency rather than to target poverty (Schram, 2000; Schram & Silverman, 2012; Schram & Soss, 2001). Contrary to this policy approach, poverty is a widespread issue rooted in the unequal distribution of income and wealth in our society.

The current study highlighted the need to address issues such as poverty, mental health, and substance abuse in addressing homelessness. While participants identified motivation to move on from supportive housing and anticipated gains in autonomy and comfort, they also identified ongoing barriers to ontological security, regardless of where they were living. Supportive housing residents faced stigma related to poverty, supportive housing, and psychiatric disabilities. Policies should be developed in ways to mitigate the stigma associated with certain social problems. One policy approach to mitigate stigma is to utilize universal or institutional programs to address these social problems, such as psychiatric disabilities and poverty. These types of programs are built into our systems, offered to all, and become a part of everyday life. Mental health insurance parity and universal health care would allow everyone to access affordable healthcare for psychiatric disabilities. Meanwhile, institutional policies to raise employment wages and change tax laws to provide additional cash benefits to low-income workers would help to address poverty. These few examples are not exhaustive, but illustrate

policy approaches that could solve social problems without increasing the stigma related to getting assistance in alleviating these problems.

A system-wide approach would distinguish between affordable housing and rehabilitative affordable housing. It would solve homelessness with appropriate housing to meet formerly homeless people's various needs, providing affordable housing for all and rehabilitative services for those in need. Supportive housing and the homeless services continuum should provide people in need with long-term mental health services. On the other hand, with accessible affordable housing and the appropriate assistance to transition out of supportive housing, people would not need to agree to rehabilitative services to attain financial assistance.

Thoughtfully planned and research-based programs should be implemented system-wide with efforts to coordinate care of service users. For example, for Moving On Initiatives to be successful, there needs to be an array of resources available to service users in the homeless services system. As noted in the empirical literature review, there is the need for primary, secondary, and tertiary services to address people affected by homelessness. These programs should include prevention efforts such as homeless diversion and rental assistance and affordable housing options, through subsidized housing programs such as public housing and housing vouchers. This service system would include secondary programs such as emergency shelters, rapid rehousing, and CTI, to assist people who had recently become homeless to return to stable housing as quickly as possible. Additionally, a system-wide approach would include tertiary service programs like supportive housing models to assist people with complex needs, requiring long-term assistance. Lastly, this approach would include assistance for people to make a planned exit from the service system when motivated and able to do so.

Implications for Research

This study enabled me to consider changes in philosophy, and in services, and to consider a research agenda for scholars studying people with histories of homelessness and psychiatric disabilities within a recovery framework. Future research should contribute to the development of a system of recovery-oriented homeless services, creating avenues to appropriate and least restrictive housing. Whereas supportive housing is considered the end of the continuum of care, additional research is needed to contemplate a service approach for people with histories of homelessness, who might secure important aftercare and truly place supportive housing as the end of the continuum. Development of a thoughtful program for transition out of supportive housing that addresses the concerns of residents is essential to ensure successful community tenure, and should be the focus of future research.

Residents in recovery from psychiatric disabilities warrant particular attention. Important questions remain about how to provide a least restrictive and recovery supporting environment to individuals in recovery from substance abuse disorders and mental illnesses. Future research is necessary to better understand the complexity of structured settings, autonomy, and recovery experiences among people with psychiatric disabilities.

Additional research could inform the development of an evidence-based service model for moving on from supportive housing. This qualitative study only began to suggest considerations for more robust services for secure housing in the community for formerly homeless people. Qualitative methods remain an essential component of any ongoing research about recovery-oriented services. However, program models that attempt to address the transition from supportive housing into independent, stable community housing would need to

systematically monitor and measure implementation of a research-based service model, identify and measure core components, and evaluate any changes made to previous service models.

Implications for Social Work

Homelessness affects many individuals and families across service sectors where many social workers practice. Understanding the experiences of people who have experienced homelessness and are trying to exit the service system can improve social work with this population. Many social work theories inform work with formerly homeless people. Ecological systems and person-in-environment theories help to connect personal experience with the policy responses that drive service development to address social problems. Policies that lead to the design of services affect the daily lives of vulnerable populations. As an example, on the homeless services continuum, the history of criminalization and institutionalization of this population mirror the policy tools used to alleviate this social problem. The Recovery Movement further helps to guide necessary changes to the system of services for the population. This study utilized narratives of previously homeless people, which empowered them to represent for themselves how they understood the challenges and opportunities, as part of a Moving On program. As the experts of their experiences, they call policy makers and practitioners to attend to their worldview in planning for services.

Certain groups are overrepresented among people affected by poverty and homelessness. Women are much more likely to be affected by poverty than men. People who experience homelessness compared to people who are stably housed are more likely to be Black or African American and psychiatrically disabled. People who are in poverty often do not have access to the resources they need to successfully alleviate their problems. Poverty and homelessness are socially stratified outcomes. Problems which affect individuals are intricately rooted in larger

structures and systems of care. These larger systems reinforce oppression, racism, sexism, and classism. Until structural oppression is ameliorated, people will remain stuck in disadvantaged positions within our systems. Being poor, Black or African American, or a woman is not a personal deficit. But because of oppressive systems, they are at greater risk for negative outcomes, such as homelessness. Researchers and policy developers should be responsible to address structurally oppressive systems. Service approaches aimed at alleviating individual problems should not reinforce oppression. Instead, services should be developed and delivered with compassion.

Final Thoughts

Recently, investigative journalists uncovered the failure of a community mental-health program to transition adult home residents to "scatter-site supported housing." (Sapien, 2018; Sapien & Jennings, 2018). This program was an effort to transition individuals with complex mental-health needs from adult homes and into the community. Similar to the failures that followed deinstitutionalization, the transition from adult homes to scatter-site supportive housing was ill-planned, ill-funded, and not implemented with fidelity and best practice standards. According to Sapien and Jennings (2018), social workers cautioned that the housing was not appropriate given participant needs. This enterprise was so ill conceived that when Pathways to Housing, the founder of the Housing First approach was solicited to provide case management services they declined to participate (Sapien, 2018; Sapien & Jennings, 2018). This is a recent cautionary story about how the mental-health system has failed the most vulnerable in its care.

Clearly, many people with histories of homelessness and psychiatric disabilities need long-term care. In a system-wide approach to address homelessness, people with complex needs would access long-term services through the mental health system in programs like supportive

housing. While structured support is necessary for many, these programs should aim to be least restrictive.

Almost 50 years ago, institutionalization was found too restrictive and unconstitutional for most people with psychiatric disabilities. A service system that truly embraces community integration should provide an array of options for people with varying needs, including least restrictive settings and affordable homes with no restrictions. Programs that assist people to live in least restrictive settings should be modeled after best practices, carefully planned, adequately funded, and based in research. This system should be rooted in the empowerment of people with histories of homelessness and people in recovery as the experts of their experiences and aim to construct service systems around self-identified needs, barriers, and facilitators. This system-wide transformation would help many move to least restrictive settings, while delivering comprehensive, long-term mental health services to those who need it the most.

Appendix A: Interview Guide

I. Transition Services

1. How did you first hear about the Moving On Initiative?
   Probe: Tenant's experiences with the Moving On Initiative assessment/outreach process
2. What (if anything) has the agency done to help you with the process of moving on from this program?
   Probe: Any individual or service that has been particularly useful?
   Probe: Any individual or service that have made things particularly difficult?
3. What (if anything) is the agency *not* doing for you that you think you need in order to successfully transition from the program to independent living?
4. Would you (and/or other Moving On Initiative recipients) find the following helpful in your efforts to move on? Why or why not?

   Probes
   - help locating apartments
   - help completing housing applications
   - financial counseling, e.g. how to deal with credit checks/budgeting, etc.
   - money for application fees/background checks
   - money for moving costs
   - money for transportation to view apartments
   - someone to go with you when you view apartments
   - help finding services (e.g. doctors, etc.) that are closer to your new neighborhood and/or brainstorming how to get from your new neighborhood to your existing services
   - help dealing with items that could impact the outcome of your housing application (e.g. criminal background, rental arrears)
   - more opportunities to network with other "movers" (e.g. to share resources, support one another in this process)

II. Transition Experience

5. What has this process been like for you?
   Probe: Positives? Negatives?
6. How do you feel about the prospect of leaving the housing program?
7. What do you hope to achieve in this transition to independent living?
8. What do you think it will be like once you've moved on from the program?
9. Where do you see yourself a year from now?
10. Is there anything else you think is important to add about your experience with the Moving On Initiative or your transition process?

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