# From Structural Chaos to a Model of Consumer Support: Understanding the Roles of Structure and Agency in Mental Health Recovery for the Formerly Homeless

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## Abstract

Current understandings of the effect that mental health services on consumers' daily lives are still heavily informed by research conducted during the era of institutional treatment. This is problematic considering that changes to mental health care have shifted the locus of treatment to community settings for the majority of those living with serious and persistent mental illness (SPMI). With this shift there has been a greater focus on consumer-centered recovery in mental health care. In this paper I seek to develop a deeper understanding of the effect that the organization of mental health services offered in community settings has on the recovery process. I do this by presenting findings from the analysis of focus group and interview data collected from research informants (consumers and staff) at four Housing First programs located in a large Midwestern city. Housing First is based in a human rights approach to services that has been demonstrated to be more successful at housing chronically homeless consumers with dual diagnoses than traditional approaches to housing. My findings highlight the importance of understanding the connection that exists between social structure and personal agency and the recovery process.

## Keywords

Homelessness is a transitional state for the majority of people who find themselves without housing. However, a small proportion, anywhere from nine to twenty-seven percent (Kuhn & Culhane, 1998, U. S. Department of Housing and Urban Development, 2010), of the homeless population has been demonstrated to be chronically homeless. According to the federal government, a chronically homeless person is an unaccompanied adult who is disabled and has been homeless continuously for one year or has had four or more episodes of homelessness in the past three years (U. S. Interagency Council on Homelessness 2010). Those who are chronically homeless are of particular concern to policy makers and providers of homeless services because of the high levels of dually diagnosed serious and persistent mental illness (SPMI) and substance use disorders that exist within the population. In fact, the issues associated with dual diagnosis within this population are so difficult to address that the chronically homeless have been labeled the "hard-to-serve" by the majority of service providers (Padgett, Gulcur, & Tsemberis, 2006; Pearson, Locke, & McDonald, 2007; Pearson, Montgomery, & Locke, 2009). Because of the high rates of dual diagnosis within this population, the majority of housing programs for the homeless are de facto providers of mental health and substance abuse services. As such, these programs have been

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significantly affected by consumer-centered models of treatment that are the guiding principle of mental health policy today see: (Committee on Crossing the Quality Chasm, 2006; President's New Freedom Commission on Mental Health, 2003; U. S. Department of Housing and Urban Development, 1999). Despite the use of consumer-centered rhetoric within housing programs, "consumer choice" for those who are chronically homeless is largely the choice between accepting housing in a highly restrictive and controlling structure or no housing at all.

In this paper, I compare findings related to two models of permanent supportive housing for homeless people as they relate to mental health recovery; these are the (1) continuum of care (CoC) and (2) Housing First models. This study was conducted within a social psychological framework following the symbolic interactionist tradition developed within the field of sociology. As such, my findings provide new insight into how social factors, specifically the structure of mental health services, can affect the course of mental illness. Before presenting my findings, I discuss the need to for a sociological investigation of the connections between program structure and recovery, provide a description of the CoC and Housing First approaches, and outline the methods I employed.

In this paper, my use of the term "mental health recovery" refers to recovery from SPMI and substance use disorders as co-occurring phenomena. I chose to conceptualize recovery in this way because it recognizes the complex interaction between these disorders that occurs in dually diagnosed individuals. The failure to consider these two types of recovery as simultaneous processes in research and practice is problematic because it leads to an incomplete understanding of the issue and because it has perpetuated two separate treatment systems (one for mental health and one for substance abuse) that often causes dually diagnosed individuals to "fall through the cracks of services" (Culhane, 1993; Nooe & Patterson, 2010). Additionally, I conceptualize recovery as a social process rather than a clinical outcome. The process perspective treats mental health as a disability rather than an illness because it tends to focus more on quality of life, personhood, and empowerment than it does on complete remission of symptoms or a return to normal functioning that typify biomedical models of recovery (Corrigan & Ralph, 2005). When conceptualized as a process, the focus of recovery shifts from medical treatment to consumers' attempts to address the issues caused by their mental illness and to meet their life goals (Amering & Schmolke, 2009; Anthony, 1993; Davidson, 2003).

## The Need for Sociological Explanations of Recovery

Recovery has not been a topic of explicit concern for sociologists of mental health (Markowitz, 2005). Despite this, there is a wealth of sociological literature that has demonstrated connections between aspects of the social structure and specific mental health outcomes that have been demonstrated to be important to the recovery process. Most of this research has focused on the way in which different structural arrangements expose different social groups to varying amounts of stress see: (Aneshensel, 1992; McLeod & Lively, 2007; Pearlin, 1999; Pescosolido & Martin, 2007; Thoits, 1999). An area where the sociology of mental health has the potential to contribute significantly to the study of recovery is by developing a deeper understanding of the connection that exists between the structure of mental health services and the recovery process.

Much of what sociology tells us regarding the connection between services and recovery comes directly from Goffman's (1961) essay, "The Moral Career of the Mental Patient", in which he described the effect of treatment on the course of institutionalized patients' lives during the late 1950s. In this work, Goffman described large state-run institutions of that time as highly rationalized bureaucracies marked by rigid forms of authority aimed at

managing the largest number of patients possible. Goffman's work demonstrated how commitment to institutional treatment served to delegitimize a patient's status as a "normal" person who was capable of taking care of themselves. This, combined with the fact that mental health recovery was thought of as a progressively deteriorating illness (Corrigan & Ralph, 2005; Davidson, 2003), made it difficult for patients to gain discharge after being admitted for treatment.

Today, deinstitutionalization has resulted in the majority of patients being treated in community settings where they now see themselves as "consumers" of mental health services (Kaufmann, 1999; McLean, 2009; Timmermans & Oh, 2010). This shift to a consumer model in mental health care, combined with findings from research conducted during the 1980s, which demonstrated that mental illness was not as debilitating and deteriorating as once thought (Carpenter and Kirkpatrick 1988; Harding, Zubin, and Strauss 1987; Harding, Strauss, Hafez, & Lieberman, 1987), has resulted in recovery being the guiding principle of mental health policy today (Anthony, 1993). As a result, Goffman's work is not as relevant as it once was, and there is a need for sociologists to develop new understandings of the connections between treatment and the course of mental illness in the post-institutional treatment era (Gove, 2004; Pescosolido, McLeod, & Avison 2007).

Organizational studies of mental health services have come the closest to developing a contemporary understanding of the effect of treatment on the course of mental illness. However, the majority of this research has focused on the effects of external social forces on organizational processes without making the connection between these processes and consumer outcomes (McLeod & Lively, 2007; Schnittker & McLeod, 2005; Schwartz, 2002). For instance, Scheid's (2003) study of CARE, a public sector mental health facility, demonstrated how the shift to a managed care model resulted in a focus on rationality and efficiency, which was at odds with professional ideas of what effective treatment should be. Studies such as this one are important because they highlight the connections between the larger institutional field and organizational processes see (Polgar, 2009). However, there is a need to go a step further and look at the effect these processes have on individual consumers. Social psychological research that can highlight the connections between these processes and consumer understandings and experiences of recovery will provide a more complete picture of mental illness, mental health, and recovery. A quote from Onken, Craig, Ridgway, Ralph, and Cook (2007) demonstrates why an investigation of these connections is necessary:

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

Therefore, sociological research can make a significant contribution to the study of recovery by paying greater attention to the interactions that occur with and within social institutions and the effects this has on consumers.

Yanos, Knight, and Roe (2007) have developed a framework for understanding the connections between social structure, individual agency, and recovery that is well suited for this task. The authors point to the importance of considering three aspects of the social structure as they relate to recovery. The first of these factors, *obdurateness*, refers to the reality of objects, behaviors, and actions and their consequences—in which they point to legal restrictions and institutionalized poverty as two examples. The second factor is the *ritualization* of traditions and behaviors. Structural constraints connected to ritualization include practices of clients, the media, employers, and mental health professionals. The third and final factor they discuss is *symbolization and identification*, by which they mean the

process by which meanings are attached to objects and people/groups of people. After discussing these factors, Yanos et al. point to choice and negotiation and/or collective agency as ways in which individuals and/or groups can navigate them.

## Two Models for Housing the Chronically Homeless

Housing programs for the homeless present a unique opportunity for investigating the interplay between structure, agency, and recovery as discussed by Yanos et al. (2007). Additionally, the dramatic increase in homelessness that occurred in the 1980s has been linked to the failure of deinstitutionalization to provide adequate community treatment see (Frank & Glied 2006; Nooe & Patterson, 2010). This provides an opportunity to investigate the applicability of Goffman's (1961) findings to community-based mental health treatment since it is highly likely that the chronically homeless population that exists today shares many of the characteristics of institutionalized patients Goffman was writing about forty years ago. Indeed, previous research has demonstrated that over half of all homeless people have some form of mental illness or substance abuse problem (for a review see Nooe & Patterson, 2010)

## The CoC Model

The CoC model has been the preferred method of housing service provision for the past thirty years. Also known as "abstinence-based", "linear", or "treatment first" housing (Padgett, 2007), these programs have historically enfolded aspects of biomedical approaches to mental health and addiction recovery into their service structures (e.g., 12-step guided programming and policies, required drug and alcohol abstinence, medication compliance). As such, these programs have typically required individuals to obtain sobriety goals (typically for 30–90 days) before advancing into some form of temporary housing. Individuals are then required to meet other goals before advancing to a more permanent housing situation. Consumers are at risk of losing their housing placement should they engage in any type of substance use at any stage. Additionally, these programs have strict service requirements such as participation in psychiatric, substance abuse recovery, and employment services.

Chronically homeless people have traditionally had difficulty meeting the demands of CoC programs. This difficulty has been attributed to behavioral symptoms related to high rates of dual diagnosis within the population and a lack of independent living skills due to the significant amount of time they have spent living on the streets, making it difficult for them to live in highly structured environments (Padgett et al., 2006; Pearson et al., 2007). Because of this, the chronically homeless have difficulty gaining admittance to CoC programs or, if they do gain admittance, the program acts as a "revolving door", evicting them back into homelessness in a short time (Hopper, Jost, Hay, Welber, & Haugland, 1997; Simpson, Joe, Broome, Hiller, Knight, & Rowan-Szal, 1997).

## The Housing First Model

The Housing First model was created in the early 1990s in response to the recognized inadequacies of CoC forms of housing and other services to address the needs of dually diagnosed consumers see (Tsemberis & Asmussen, 1999). The model does not demand sobriety or treatment adherence of consumers prior to or after entry and does not demand that consumers engage in any services beyond case management. Housing First programs have been demonstrated to lead to significantly higher levels of housing retention for consumers (see Kertesz & Weiner, 2009; Sadowski, Kee, VanderWeele, & Buchanan, 2009; Tsemberis, 1999). For instance, in one controlled trial of the Pathways to Housing Inc. program, the model retained 84.2% of consumers over a 3-year period, while only 59% of

consumers maintained housing in CoC programming after only 2-years (Tsemberis, 1999). In another controlled study, 73% of consumers in Housing First placement retained housing over an 18-month period, compared to only 15% of consumers in traditional programming (Chicago Housing for Health Partnership, 2008). Housing First is now recognized as an evidence-based program for serving chronically homeless individuals and many cities across the country have adopted 10-year plans to end homelessness based on its principles (National Alliance to End Homelessness, 2000; National Registry of Evidence-Based Programs and Practices, 2010). Current trends in homeless numbers demonstrate that the overall Housing First approach is working with more than a 10% drop in chronic homelessness documented between 2008 and 2009 (U. S. Department of Housing and Urban Development 2010).

## Recovery as it Relates to CoC and Housing First Programming

Regarding recovery, studies have demonstrated that consumers in Housing First programming are no more or less likely to become abstinent than they are in CoC programming see (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Padgett et al., 2006). However, they have demonstrated strong links between the model and a number of other factors related to recovery including *ontological security* (Padgett, 2007). Ontological security refers to the sense of continuity a person has regarding their own life events, which is dependent on access to a stable environment in which to develop a strong self-identity. It is connected to the recovery process because stability and identity affect quality of life issues. The concept of ontological security was first used by Laing (1965) to describe the lack of continuity experienced by people living with SPMI, and research has demonstrated (1) how it is difficult for homeless individuals to obtain and (2) the essentialness of housing permanence to its develop (McNaughton, 2008b; Padgett, 2007).

Dupuis and Thorn (1998) have proposed four conditions of ontological security as they relate to people's housing: constancy, routine, personal control, and security. Padgett (2007) was the first to demonstrate the connections between Housing First programming and ontological security. For the consumers who participated in her study, Housing First programming was a place where they could feel in control of their own lives and where their identities were not based on their mental health and addiction problems like they were in CoC programming.

## Methods

I employed an integrated study design that combined elements of both case study and grounded theory. The method for combining these approaches has been outlined in detail by Eisenhardt (1989) and Eisenhard and Graebner (2007). The strength of combining these approaches is that the case study method is useful for setting the boundaries of the study, while grounded theory approaches to data collection and analysis build strong empirically grounded theory (Andrade, 2009).

### Case Selection and Descriptions

The four programs I selected for the study were situated in the same large Midwestern city. I selected the programs based on (1) the degree to which they were each strong representations of the Housing First model (Pearson et al., 2007) and (2) the degree to which they each differed according to significant variations in program characteristics (e.g., consumer capacity, type of housing—project-based or scattered-site,[1] and population

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[1]The programs either provided project-based housing where all housing and services were located in one location or scattered-site housing where housing is spread throughout the city among private landlords.

served). Selection based on degree of difference helps to assure that the results reflect the differing extents to which cases reflect the subject of study when the given number of cases is small (Eisenhardt, 1989; Glaser & Strauss, 1967; Mowbray, Holter, Teague, & Bybee, 2003).

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

Allied had provided Housing First programming ever since opening its doors in 1999. The program provided project-based housing to 54 chronically homeless consumers with dual diagnoses. Judy's House had officially provided Housing First programming since 2002. The program provided scattered-site housing to 93 homeless women (consumers did not need to have a mental health diagnosis program eligibility). Metropolitan had been in operation as a Housing First program since 2003. The program provided scattered-site housing to 38 homeless men with dual diagnose. HIVHA started as a Housing First program in 2002. The program provided scattered-site housing to 10 homeless people living with HIV/AIDS (consumers did not need to have a mental health diagnosis program eligibility).

## Data Collection and Analysis

The level of interest was the program level. Following the tenants of grounded theory, I conducted data collection and analysis as simultaneous processes (Glaser & Strauss, 1967). I collected focus group and interview data from consumers and staff at each organization. I did not conduct a staff focus group at HIVHA because there was only one staff member within the larger agency who was assigned to the program. All data collection activities were audio taped and lased approximately one hour.[2] I provided all informants with a gift card for their time (a $5 coffee shop card for staff and a $30 grocery store card for consumers). I used NVIVO 8 qualitative analysis software to organize my data for analysis.

All of the informants I spoke to had experience as a consumer living in or staff member working in/with CoC programs. During each interview, I asked research informants to describe their understandings of and experiences with both types of programming. Informants' answers to this question are the focus of my analysis for the findings described in this paper.

Regarding the analysis, qualitative methods are concerned with finding themes/patterns in observable phenomena, while case study research is concerned with finding similarities between cases. I searched for themes both within and across cases in order to enhance my confidence in the validity of emerging relationships between programs (Eisenhardt, 1989; Eisenhardt & Graebner, 2007; Yin, 2008). I also examined differences related to the same theme and how it emerged depending on the source (staff or consumer). The guiding questions for my analysis were: How are the programs similar and different in their operations?; How do staff and consumers understand Housing First and CoC programming to work?; How have these perceptions affected their experiences of programming?; and How do staff and consumer understandings of Housing First and CoC programming affect their understandings and experiences of recovery?.

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[2]I also conducted preliminary interviews with administrative staff in order to inform myself about the programs prior to other data collection activities. These interviews were not taped.

### Informant Characteristics

There were a total of 60 informants. Of these, 19 participated in both a focus group and an interview. I completed 4 consumer focus groups (24 total informants), 3 staff focus groups (18 total informants), 21 consumer interviews, and 16 staff interviews. All consumers had a dual diagnosis. The average time consumer informants were housed at their current programs ranged from 9 months to 10 years with an average of 17 months. The majority of staff I interviewed were case managers, however housing coordinators, clinicians, and intake coordinators were also represented. The time staff interview informants had worked in their programs ranged from 1 to 20 years with an average of 5 years. I did not request detailed demographics from focus group informants. However, it is reasonable to assume that focus group informant demographics were similar to those of interview informants based on my notes and considering that a number of individuals participated in both types of data collection.

## Findings

In this section I present my findings as they relate to both types of housing, focusing first on the CoC model and then Housing First.

### Past Experiences with Traditional Programming

It is important to clarify that the data regarding CoC programming are retrospective, as most of the consumers and staff I talked to had not lived or worked in a CoC program for anywhere from one to ten years. Jesse's story highlights many of the themes I found in relation to CoC programming.

**Jesse's story**—Jesse had been housed with Metropolitan for approximately two years at the time I interviewed him. He came there directly from a CoC program that had evicted him. He discussed how he became the president of resident council at his previous program, the highest status a consumer could hope to obtain there. In his own words: "I felt really good about myself. It just was a great time for me." This good feeling lasted until one New Year's Eve when he made the decision not to take his Seroquel (medication for his bi-polar disorder) so he could stay awake for the party he was in charge of as president of resident council:

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

Jesse detailed to me how this series of decisions and events led toward his eventual termination from this CoC program:

> When I did [go back to my housing], it was kind of obvious [to the staff] what had happened, so they forced me into treatment. At this point I'm nearly suicidal over the fact that I had used again and just went through all this self-loathing…[A]nd, like I said, [I was] president of resident council at [my housing], and all that was just stripped. All of a sudden, you're [I was] a second-class person again…That doesn't make any sense. I learned a hell of a lot about myself in that nineteen

months…They just took it from me, nobody talked to me about it…As a matter of fact, my suitemate at [my housing], whom I had become very good friends with, just cut me off. That's it, he was gone, wasn't safe for him to be around me anymore. (Jesse, 48, Metropolitan consumer)

Because of his relapse, Jesse had everything he worked for taken away from him, including the staff and other consumers who were his primary sources of support. Without support, the only means to cope for Jesse was more substance use, which led to his eventual termination from the program.

**Structural chaos—**Consumer and staff descriptions of CoC programs they were familiar with demonstrated that Jesse's experience was not unique in that program rules often severely *limited consumers' individual agency*:

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

Manuel's statement is reflective of the majority of informants' descriptions of CoC programs. As informants described it, consumers could either choose to follow a very defined and sometimes confusing list of rules and stay housed or break the rules and be evicted (or, less frequently, choose to leave).

Consumers often discussed how strict rules in CoC programming made them feel as though they *did not have any control* over their own lives:

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

The powerlessness that Valery described demonstrates how consumers experienced CoC programs. They described lining in a structural chaos in which they felt they had no control over their own fate and were unable to predict whether they would remain housed because they could not predict or know when they would engage in substance use (a symptom of their own illness) that would cause them to break the rules.

**Rationalization and alienation—**The rules in CoC programs were rationalized around consumers' substance abuse diagnoses, specifically the potential they all had for relapse. The way in which these rules were rationalized demanded staff treat consumers as their illness (es) first and individuals second:

> [T]hey [staff at a CoC program] didn't care, they were supposed to care but…they didn't…They just ask you a ques[tion]. They don't try to go [ask] "How you doin in there [your room]?"…And then they'll go talk about [ask me] am I goin to the meetings and "How's your housing?", "Have you been trying to look for a job?", "Are you thinkin about goin back to school?"…[T]he case managers to me, they really didn't care. They just want you to sign these papers, don't explain nothin to you. They just tell you one thing, and you know you ain't, you not payin attention, not reading. (Harriet, 51, Allied consumer)

The above quote demonstrates how the rules of CoC programs were often alienating for consumers because of the way in which they structured interactions with staff. This is because the focus staff placed on substance use and service participation in these programs had a *negative effect on consumer-staff relationships*.

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

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

As this selection from my interview with Sandra demonstrates, staff often discussed how 12-step philosophies based in the disease concept of alcoholism conditioned them to relate the majority, if not all, of consumers' behaviors back to their addiction in CoC programs they worked at.

### Experiences in the Housing First Model

Consumer and staff descriptions of the Housing First programs they were currently living or working in contrasted sharply with those of the CoC programs they were familiar with. Harriet's story highlights many of these differences.

**Harriet's story—**Harriet had been housed at Allied for thirteen months at the time of her interview. Prior to this, she had lived in three CoC programs where she experienced the same lack of control and alienation as I described in the previous section. Harriet was adamant about her dislike for these previous programs, but her face grew into a smile when she discussed Allied with me:

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

Harriet went on to describe the impact that this caring had on her:

> It [her current program] made me feel good about myself…[T]hey [the staff] gave me choices, you know, gave me choices where you can do this or you can do [that], it's up to you, [the program is] just trying to provide [me] what [I] need and what [I] want, what's best for me. That's what made me feel good too, cause they wanted, they'd give me information where they know its gonna be good for me, its not gonna hurt me or anything. So I could take that chance and I don't have to worry cause I know they got my back…[O]ut there [when I was not in the program] I didn't have no choice you know it['s] either "your gonna help me or you don't". You don't have choices out there, you just have to go with the flow if you want to get some[thing]. (Harriet, 51, Allied consumer)

One of the primary ways that Harriet sees the staff as caring for her is to provide her with choices, something she felt she rarely had in her life prior to Allied. According to Harriet,

having choices was something she had rarely experienced in her life, and the choices Allied provided allowed her to take credit for her own accomplishments so she could "feel good" about herself.

**The power of consumer choice—**Having choices was one of the most important parts of Housing First programming for consumers:

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

As this focus group selection demonstrates, consumers discussed choice as being important to them because it made the services they engaged in *more meaningful to their lives*:

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

As this selection from Grayson demonstrates, one of the primary reasons providing choices to consumer made their programming more meaningful to them was because it allowed them to take ownership and feel proud of their accomplishments.

Staff also discussed consumer choice as one of the most important aspects of Housing First programming. However, staff largely discussed how providing consumers with choices helped facilitate the learning process by making consumers *responsible for their own decisions*:

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

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

**Flexible programming and housing security—**The choices made available to consumers in their programs were a direct result of the *flexible service approach* of the Housing First model. Manuel compared the flexibility of the Housing First approach with that of CoC programs during his interview:

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

As this selection demonstrates, in addition to allowing consumers to make their own decisions regarding the services they engaged in, the flexibility inherent in the programs' structures also meant that consumers were able to make their own decisions regarding substance use and were not judged/sanctioned/punished for it.

Because they knew that they would not be punished for substance use, consumers could take greater security in the knowledge that their housing was permanent:

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

For this consumer and others, the fact that their housing was not contingent upon their ability to remain sober gave them a *sense of security* in their lives. A selection from Annette, a consumer at Judy's House, also demonstrates this:

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

The improvement in her situation Annette described was directly related to the fact that she no longer had to worry about whether or not she was in danger of losing her housing.

**Positive effects on consumer-staff relationships—**Consumers and staff both discussed how the greater sense of security consumers had in their housing resulted in *stronger relationships* between the two parties:

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

Consumer discussions supported this perception:

Because one of the things is that when my case manager asks me did I use, I can tell him "yeah" and don't feel like I'm being judged. I can tell him "yeah", and don't and not be afraid of what I'm gonna be disciplined with. I can say "yeah I used" and not be worried about, "Am I gonna be kicked out next week?". (HIVHA male consumer focus group informant)

This consumer felt he was able to speak openly with his case manager about his substance use because he understood his housing to be secure.

The absence of strict abstinence-based rules also meant that, unlike in CoC programs, staff were able to interact with consumers as individuals rather than their illness. The following selection from James demonstrates the effect this had on him:

> …[T]hey [staff] just *treat you like a grown individual*. They don't look down on you, nothing like that. And it's okay to have a problem or a habit. They let you know that first and foremost, and I appreciate that…it makes you just feel that much better knowing "okay this person [his case manager] is in here working". (James, 45, Allied consumer)

Like James, other consumers discussed how they did not perceive any judgment being directed towards them by staff in their current programs and how this made them feel as if they were more supported than they were in CoC programming they had previous experiences with.

### Lingering Effects of the CoC Model in Housing First Programming

A final finding is related to both models. As in Harriet's case I discussed above, many consumers first had trouble accepting the positive treatment they received from staff:

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

This is because consumers often came to their current programs with understandings of housing and support services that were based on past experiences with traditional programs.

Staff regularly detailed how consumers behaved in a manner more consistent with how they might in a traditional program:

> …[W]hen I'm doing intakes with ladies and gentleman, they'll deny substance use and they'll tell me that they stopped using it…I'll keep reiterating to them, that its okay, that "You can use you know? You can become intoxicated when you come back to the program. We're not judging you on your use, you know that it's okay?" And they will say, "Oh no I don't use, I don't use". And then when they do get into the program, they'll start to open up about…[T]hey've been around so many different programs…[T]hey think they're trying to tell us what we want to hear. (Allied staff focus group)

As this staff member and others explained it, consumers had to adjust to Housing First programming. Until this adjustment happened, *survival strategies* consumers had learned in CoC programs (e.g., avoiding staff and hiding or lying to cover-up behaviors) *continued to guide their actions* in their current ones. Staff and consumers detailed how, even though they were educated upon entry to their Housing First programs, most consumers had to experience pushing the boundaries of programming without being sanctioned/punished before they began to feel comfortable in their current placements.

## Discussion

The sense of continuity in personal narrative that ontological security establishes is a necessary part of the recovery process for formerly homeless individuals living with a dual diagnosis (Padgett, 2006). My findings demonstrate how *Housing First programming can facilitate the development of ontological security* better than CoC-type programs. Though

the CoC programs consumers and staff described had high levels of structure that should have led to such things as constancy, routine, and security, the lack of personal control that consumers experienced made them feel as though their lives were in chaos. This is because these consumers could not predict whether behaviors brought on by the symptoms of their illness would place their housing in jeopardy. Applying the framework proposed by Yanos et al. (2007) to these findings helps to explain how the rigid structure of CoC programming restricted the development of consumers' ontological security.

Consumer discussions demonstrated how CoC programs had *higher levels of obdurateness* than their Housing first programming. This obdurateness was reflected in the strict abstinence-based rules that structured their programming and made consumers feel powerless over their own futures. Like the professionals who participated in Scheid's (2003) study of CARE I discussed above, staff in these programs recognized that these highly rationalized rules prevented them from working with consumers in an effective manner. Consumer discussions supported those of staff by demonstrating how these rationalized rules prevented them from establishing ontological security. This is because of the highly restrictive limits placed upon consumers' choices by these rules and the reality that privileges (when they were gained), relationships, and social status could be ripped away from them at any time with little explanation. This is consistent with findings from previous research on homelessness. For instance, McNaughton (2008a; 2008b) has specifically demonstrated how the homeless and formerly homeless people she studied had difficulty maintaining ontological security for significant amounts of time because their ability to create coherent self-narratives was seriously affected by their inabilities to exercise agency, establish predictability and routine in their lives, and to understand their role within the social structure.

Regarding *symbolization and identification*, the rules in CoC programming negatively affected consumers because they resulted in staff labeling and treating them as "addicts" first and individuals second. This negatively affected consumer-staff relationships. These findings support those of Padgett (2007) by demonstrating how the rationalization of rules can result in a sense of alienation among consumers that negatively affects their ontological security. Sociologists have long pointed to the negative effects of labeling on the mental health of people living with SPMI (Gove, 2004; Link & Phelan, 2001; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Phelan, 2005; Wright, Wright, Perry, & Foote-Ardah, 2007). One of these effects is social distancing, which prevents labeled individuals from establishing supportive relationships, a necessary precursor for ontological security and mental health. For instance, using data from a three-wave panel of deinstitutionalized long-term mental health patients, Wright Gronfein, and Owens (2000) demonstrated how social rejection negatively impacts consumers sense of agency and identity by weakening the sense of control they had over their own lives.

Finally, the effect that CoC programming still had on consumers after they reached their current programs demonstrates the influence of *ritualization* over their recovery. Lipsky (2010) provides an explanation for this phenomenon in his study of street-level bureaucracy. Lipsky describes how recipients of public services like those in housing program are taught how to be clients because they learn that program employees can facilitate or block their access to resources and that playing the "rules of the game" are better for them in the long run. Following Lipsky, I argue that the adaptations consumers made after years of exposure to CoC programming, such as lying about substance use, became ritualized parts of their behavior and continued to affect their choices within their Housing First programs.

There are many similarities between the way informants described these programs and the way Goffman (1961) described institutional treatment in the 1950s:

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

This quote might as well be about Jesse and many of the other consumers with whom I spoke. As I discussed above, Jesse suffered a huge threat to his sense of self when everything he had attained (his position on resident council, program privileges, his relationships) was "stripped" of him after his relapse.

Countering their experiences in CoC programs, informants' descriptions of their current programs demonstrate how the flexibility inherent in the Housing First model led consumers to experience a greater sense of security regarding their housing and how this security established a strong foundation for recovery. The reduction of anxiety is an important part of ontological security that is difficult for homeless individuals to obtain (McNaughton, 2008a). This is because the homeless are under chronic stress as a result of efforts to survive with limited resources. Taking this into consideration, it is likely that the formation of ontological security will lead to other positive outcomes for consumers such as a reduction in criminal behaviors related to basic survival (e.g., panhandling, theft) and/or the need to self-medicate (e.g., the use of illicit substances). Indeed, previous research has already demonstrated the Housing First model's ability to reduce consumer involvement in criminal activity (Desilva, Manworren, & Targonski, 2011).

## Strengths and Limitations

A major strength of this study is the embedded nature of the case study design (i.e., the collection of data from both staff and consumers). Loveland, Weaver, and Corrigan (2005) have recommended that factors important to recovery be assessed from multiple levels because:

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

A better understanding of the connections that exist between these different levels is necessary to develop a true understanding of recovery as a social process. Additionally, qualitative methods like those I employed are designed to identify complex, dynamic interactions between people and their environments, which are necessary to develop a strong process-oriented model of recovery (Loveland et al., 2005).

Regardless of these strengths, the study did have limitations. As a qualitative study with a small sample size, my findings are not statistically generalizable. However, statistical generalizability was not my goal, and the multiple case study methodology helps to improve the theoretical generalizability of the findings. Theoretical generalizability was also strengthened through the use of key program differences as selection criteria because it helped to assure that there was diversity among the Housing First program in my sample, thus assuring that any similarities in findings related to the model were due to the programs use of the Housing First model. There is a need for future research in this are that seeks to associate statistically generalizable recovery outcomes with program structure.

## Conclusion

Though they were a result of deinstitutionalization, traditional programs for housing the homeless have more in common with the institutional programs they replaced. In contrast, Housing First programs have more in common with the vision of consumer-driven services that guide mental health treatment policy today. Due to these differences, the consumers I spoke to felt more like a client/patient/object controlled by an oppressive structure in CoC programs, while they felt move like a consumer/adult/individual who could exercise personal agency in their current Housing First placements. The different impacts of these program models on consumer's lives highlight the importance of understanding the connections between social structure and personal agency in mental health consumers lives in general. Obderateness, symbolization and identification, and ritualization are important aspects of the social structure that have significant effects on ontological security through the impact they have on consumers ability to exercise agency. The sense of social and personal stability gained when ontological security is established can be seen as both something necessary to establish for mental health recovery to happen and an element of recovery itself.

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