Published in final edited form as:

Adm Policy Ment Health. 2017 January ; 44(1): 103–114. doi:10.1007/s10488-015-0707-0.

“We always think you're here permanently”: The paradox of “permanent” housing and other barriers to recovery-oriented practice in supportive housing services

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Abstract

This qualitative study examines the views and practices of frontline providers working in supportive housing for adults with serious mental illness and how frontline workers understand their work as it relates to consumer mental health recovery. Utilizing 84 interviews with providers (N=35) and 106 hours of observations of provider practice, a grounded theory of frontline practice in supportive housing is provided. Analyses revealed distinct differences between providers working within transitional versus permanent housing programs in their orientation to recovery. Implications for the design of the supportive housing continuum of care are discussed.

Keywords

mental health recovery; supportive housing; case management; qualitative

Introduction

Mental health recovery is now the guiding concept in a paradigmatic shift within services for individuals with serious mental illness. Recognizing that current care “simply manages symptoms and accepts long-term disability” (U.S. Department of Health and Human Services [DHHS], 2003, p. 1), the United States federal government has now called for the fundamental transformation of the mental health system from a system focused on pathology and the indefinite provision of supportive services to one “driven by consumer and family needs that focuses on building resilience and facilitating recovery” (U.S. Department of Health and Human Services [DHHS], 2005). Recovery has been defined within the literature as a personal, self-directed journey toward a life beyond mental illness in which one reclaims control and responsibility for one's own life decisions (Anthony, 1993).

A recovery-oriented approach to direct service provision has been defined within the literature as practice that promotes consumer self-determination, choice and risk-taking, the individual nature of recovery pathways, strengths-based care, and a non-linear recovery

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The author reports no competing interests.

process which provides individuals the opportunity and resources necessary to lead meaningful and productive lives (Davidson, Rowe, Tondora, O'Connell, & Lawless, 2009; Substance Abuse and Mental Health Services Administration [SAMHSA], 2006; SAMHSA, 2012). Yet, a translational gap remains between knowledge of the recovery approach and routine practice in mental health services (Brown, Mahoney, Adams, Felton & Pareja, 2010; LeBoutillier et al., 2015; Salyers, Rollins, McGuire & Gearhart, 2009; Tse, Siu & Kan, 2013).

Supportive housing, a combination of case management and subsidized housing for individuals with serious mental illness, is a sector of the mental health system included within this transformation. However, limited evidence exists on how frontline providers working in supportive housing understand their role in addressing consumer mental health recovery and there is little evidence that recovery principles have been systematically integrated across the homeless service system (Gillis, Dickerson & Hanson, 2010).

While supportive housing models have achieved high rates of housing retention, effectively ending homelessness for service recipients (Collins, Malone, & Clifasefi, 2013; Stefancic & Tsemberis, 2007; Tsemberis, Gulcur & Nakae, 2004; Tsemberis, Kent, Respress, 2012; Tsemberis, McHugo, Williams, Hanrahan, & Stefancic, 2007), these services have produced mixed results in regards to consumer recovery outcomes (e.g. community integration, clinical mental health status and rates of substance abuse) (Benston, 2015; Padgett, Gulcur, & Tsemberis, 2006; Rosenheck, Kaspro, Frisman, et al., 2003; Siegel, Samuels, Tang, Berg, Jones, & Hopper, 2006; Tsemberis, Gulcur & Nakae, 2004). Housing programs that demonstrate closer fidelity to a recovery-oriented model of services have been shown to produce more positive consumer recovery outcomes (Mental Health Commission of Canada, 2014) and yet considerable variability exists in the views and practices of supportive housing providers (Henwood, Padgett & Tiderington, 2014; Henwood, Stanhope & Padgett, 2011; Kriegal, Henwood & Gilmer, 2015; Tiderington, Stanhope & Henwood, 2013). These studies of service provision in supportive housing have begun to articulate the views and practices of housing providers, however the mechanisms underlying the connection between consumer recovery and supportive housing provider practice, as well as the barriers to implementation of recovery-oriented supportive housing remain unclear.

As the mental health system continues this transformation to a recovery-orientation, further research is needed in order to articulate the mechanisms for facilitating recovery and barriers to recovery-oriented practice present within housing services for individuals with serious mental illness. Rogers' (2003) theoretical work on diffusion of innovations, as well as a growing body of research from the field of implementation science (Damschroader, 2009) has indicated that barriers to successful uptake and adoption of innovative practice models can exist at the individual, organizational, or macro-systemic level.

The purpose of this study is to articulate frontline practice related to recovery in these services and identify provider-perceived barriers to recovery-oriented practice in housing programs for adults with serious mental illness. Frontline providers (i.e. case managers and social workers) working in housing programs are those "street-level bureaucrats" (Lipsky, 2010) tasked with interpreting and implementing recovery-oriented policy and practice on

the ground in these settings. In order to get inside the “black box” of frontline service provision and examine these issues, this study employs qualitative methods and asks the following research questions:

1. How do frontline supportive housing providers understand their work as it relates to consumer mental health recovery?
2. What, if any, variation exists in frontline providers' conceptualization of their practice as it relates to recovery?
3. What, if any, barriers do frontline providers identify to the provision of recovery-oriented supportive housing services?

Method

Sampling

A purposive sample of frontline providers (N= 35) was recruited through consumer participants from a five-year longitudinal study of consumer mental health recovery in supportive housing programs for adults diagnosed with serious mental illness. Provider participants were selected from two social service agencies in the same large urban city. Housing programs within these agencies were chosen because they conform closely to what Locke et al. (2007) describe as the two predominant models of housing and services for homeless adults beyond emergency shelters – *Transitional* (TRANS) and *Permanent Supportive Housing* (PERM). Study Site 1 operates both a PERM and TRANS housing program, while Study Site 2 offers only PERM housing. The two sites also reflect the range of program philosophies seen in supportive housing services, a range often dichotomized into *Housing First* (HF) and *Treatment First* (TF). Study Site 1 operates from a TF program model in that individuals in receipt of PERM housing must demonstrate at least one year of sobriety and the ability to function with minimal support services in order to be eligible for services. Study Site 2 explicitly identifies as a Housing First agency, meaning that the program does not require demonstration of “housing readiness” through sobriety or treatment engagement in order to receive services.

Provider participants for this study were identified through the consumers with whom they worked. Consumers in these housing programs were invited to participate in the larger study on mental health recovery if they met inclusion criteria (Axis I diagnosis of serious mental illness and a history of substance use). Providers were contacted to participate in this study on service provision only if the consumer with whom they worked provided consent. This was because the provider would be asked to speak specifically about their work with this consumer in addition to speaking about their overall approach to practice. Inclusion criteria for participation in the study of service provision was having a position at the agency that involved direct service and having the assigned consumer's consent for participation. All but two of the providers who met inclusion criteria (N=37) gave informed consent for participation in this study, constituting a 95% consent rate and a total of 35 provider participants.

Data Collection

Semi-structured interviews with frontline providers took place within a month of the participating consumer's enrollment in the housing program and then every six months until the consumer had been in the program for a total of 18-months or at the consumer's discharge from the program, whichever came first. Because provider recruitment was dictated by the consumer's consent and participation in the larger study, the resulting distribution of interviews with providers was rather complex. All 35 provider participants were interviewed at least once. For ten of these providers, this was their only interview. This was either due to late enrollment in the study (e.g. a consumer participating in the larger study was assigned to their caseload 12-months into the consumer's tenure in the housing program and therefore was only able to participate in the 12-month interview) or because the consumer was transferred from their caseload or left the program or study following the first interview. The majority of provider participants (N=25) had follow-up interviews concerning multiple clients enrolled in the larger study in addition to their initial interview. Overall, 35 providers were interviewed for a total of 84 interviews (45 initial interviews and 39 follow-ups).

Four trained interviewers conducted the interviews, which lasted approximately 45 minutes each. Interviews took place either in the study offices or in a private room at the housing agency, depending on the preference of the participant. Interview questions elicited providers' appraisals of consumers' needs for recovery, how they viewed their role in consumer recovery, and provider perceptions of facilitators and barriers to recovery in housing and the provision of recovery-oriented services.

Observations of frontline provider and agency practice included staff meetings, chart reviews, and site visits. Kusenbach's (2003) "go-along method" was used to examine practice *in situ* during ride-alongs with providers as they conducted home visits. Sampling of events/days for these visits were timed to capture typicality (e.g., routine case conferences and all-staff meetings), as well as special events (e.g., a staff lunch and two consumer "graduations"). In total, 106 hours were spent in the field resulting in 164 pages of field notes collected by five different researchers. Data collection took place between March 2011 and February 2014. The university human subjects committee approved all study protocols and all participants provided informed consent.

Data Analysis

Given the dearth of knowledge on this topic area, this study followed an inductive grounded theory approach (Strauss & Corbin, 1990). Both interview transcripts and field notes were coded according to Saldaña's (2012) coding method that divides the process into first- and second-cycle coding. Initially, this author and the co-principal investigator of the larger parent study independently reviewed and open coded these materials separately. We then met together for co-coding to reach consensus on all content areas. The final first-cycle codebook included codes that reflected the various supportive housing case management practices (e.g. addressing substance use, service planning, money managing), as well as descriptive, in-vivo and process codes. These codes were then categorized into three levels

of factors that influence provision of supportive housing (individual/dyadic, organizational, and system-level).

This author then undertook second-cycle coding and thematic development independently. Throughout this process emergent codes and concepts were cross-referenced with a priori concepts present within the services and recovery literature (e.g. consumer choice, individualized services, self-directed care) in order to identify points of tension and the levels at which these tensions were operating. An organizational case study (Stake, 2006) was also conducted in order to provide the background and context of service provision in these settings and coded data were sorted by individual participant, by program, and by agency in order to compare and contrast responses. These steps were used to better understand the organizational culture at the two agencies and how provider views and practices varied within and across programs.

Interview data were utilized for thematic development, while observational data were used primarily to flesh out the grounded theory with “thick description” (Geertz, 1973). In order to promote analytic rigor, several “strategies for rigor” in qualitative research (Padgett, 2008) were also employed. These included peer-debriefing, use of an audit trail, negative case analysis, memo-writing and prolonged engagement with study participants.

Findings

Findings identify distinct differences between the views and practices of providers working within PERM and TRANS models of supportive housing. PERM housing providers from Site 1 appeared to be more similar to Site 2 PERM housing providers than they were to TRANS providers at the same agency. Even within the same housing program, PERM housing providers and TRANS housing providers differed in their conceptualization of practice related to recovery. Thematic differences between PERM and TRANS providers (presented below) illustrate that the program's position on the continuum acts as both a facilitator of and barrier to recovery-oriented practice, highlighting a paradox within supportive housing services.

The grounded theory of provider practice within supportive housing and differences by housing program type provided at the conclusion of this section (Figure 1) is a result of analysis of the relationships between these categories and their subcategories (Strauss & Corbin, 1990).

Explicit practice in Transitional Housing: Active/directive skill-building

Transitional providers described their work as preparing consumers for the next level of independence, “help[ing] them to gain independence, so this way they could go to their permanent housing [2110-TF-TRANS]” and this was accomplished through the development of “life skills”. “Like the type of services we deal with, we are getting them prepared for a permanent environment. So just learning how to do life-skill type stuff, as far as their chores, managing their money, you know...stuff like that. Um, making sure they are connected to resources and medical resources, and community...like a lot of that involvement.” [2112-TF-TRANS] Skill-building focused on concrete activities of daily

living, such as cooking, cleaning, and purchasing food, as well as prepping consumers for housing interviews which they would need to pass in order to move on to permanent supportive housing. “Whether it's doing mock housing interviews or informing them on the difference between transitional housing versus independent living. Um, you know, there could be other things, like I said whether it's money management or you know with their ‘DLS’ in the sense of daily living skills - helping them learn how to clean their apartment, or whether it's wash their clothes, or wash the dishes.” [2133-TF-TRANS]

The rationale given by providers for this skill-building approach was that consumers of TRANS services were “practicing for independence”, or as this provider stated:

The things you do now in this single apartment are some of the things you will be doing, plus more, when you move on to independent living. Like, you are practicing to be independent now. So when you move on you have more responsibility *plus* what you do now. So now is not just about the cleaning and maintaining the cleanliness of the apartment, purchasing household products, supplies, paying light bill, gas bill, cell phone bill, cable bill. You know, it becomes more. So I always tell them, ‘These are some of the things you got to think about. You are independent now, but when you move forward, the independence becomes more. You have more things to do, more things to expect.’ So, that's how we work with them. [2108-TF-TRANS]

Additionally, frontline staff described providing services using a directive, *teaching* approach. Providers understood the program to be a treatment-focused rehabilitation program that then oriented them to “treat” or restore consumers' deficits in functioning. While these frontline workers actively assisted consumers in building capabilities, this approach was at times enacted in a paternalistic manner.

It's a treatment program...we provide basically restorative services to our clients in terms of like trying to teach them to do things that we are doing at a level—we pay our rent, we do certain things. So we have to try and work with them some. It depends on our clients'—um, how you say?—mental status, where some need more work than others. But you have to maybe stand over them and show them how to clean a stove, show them how to cook dinner, show them how to go grocery shopping, show them how to budget their money in general. So that's what we try to work with them in doing. [2132-TF-TRANS]

The purpose of TRANS services then being, “to see them start from one place and to get to another place and not really need the support because they can do these things now on they own, *after* being taught, after being in this program.”

Explicit practice in Permanent Housing: Passive/non-directive support

This explicit approach to practice differed from PERM housing providers who described their work as less directive and in some ways as more passive support. In contrast to the directive, teaching approach described by TRANS providers, PERM providers highlighted the importance of “sitting back”.

If we jump in too soon, if we become too directive and not so consumer-driven, but more our own 'you need to do this, this would help, you should be doing this' or any sort of judgmental talk about substance use *especially*, nobody wants to hear that. [2104-HF-PERM]

Specifically, providers described offering non-judgmental support, empowering consumers, and providing hope for recovery over the long-term, as this provider stated:

Just giving people the hope that they can do something that they feel is valuable when they've been told they couldn't do it... I think that specifically telling people who...consumers who have worked with the mental health system for 20 or 30 years, empowering them that recovery is possible and that they can do things, valuable contributions to society. I think that that is the most... that is really effective because I've seen some many people just sort of who had lost hope gain it. [2103-HF-PERM]

While this non-directive passive support approach guided the majority of the work, PERM providers also described a more active period of "setting a client up" in housing, which occurred at move-in. This involved getting household goods together, ensuring that a consumer's entitlements were in place, and linking them out to other providers.

For the first six months, right...making sure they've got steady income, they're getting food stamps if they need it, they have Medicaid or Medicare to cover whatever health issues they have, they're seeing a psychologist, they're seeing a doctor on a regular basis, or—you know, basic needs are taken care of. And then, you know, you're in your home, and, and all of these things are in place. *Now* what personal goals do you want to set? What do you want to do with the rest of your life? [2118-HF-PERM]

Following this active period of getting a consumer situated in their apartment, providers then settled into a *passive support* approach.

Honestly, I'm just a vessel. I don't feel like I'm making anything happen for you at this point...I'm just a vessel, you know? And I think my being genuine with them, my being there to support them, to listen to them, you know, those are the things that I can do, and I try to do it as much as possible. [2118-HF-PERM]

But not all PERM providers saw this approach as ultimately benefitting consumers over the long-term. While the values underlying the PERM approach were more explicitly in line with the literature on recovery-oriented practice (e.g. hope, empowerment, honoring consumer choice), some PERM providers took issue with the lack of concrete skill-building support offered to consumers in these programs that could facilitate recovery beyond supportive services.

We just doing this - Okay, get you in. [snaps fingers] Let's buy the [household] stuff. [snaps] Okay, next visit. [snaps] See you in two weeks. [snaps] Let's do a service plan. And it's nothing really to build *life skills*. You know? I'd be angry if I was a client, because I'm in a program and I'm beholden to this program, but I'm not really advancing. Some people—now, self-actualization is different for everybody, you know? Some people are advancing, but most are not. They're just

here and all they want and ever wanted was an apartment, and that's all we ever give them. [2114-HF-PERM]

And there was a belief among some of the PERM providers that without more directive assistance, consumers would be left without the independent living skills necessary to thrive in permanent housing or beyond.

I think we're not good at that, because we're not asking the question. 'Okay, here's your apartment, here's the keys. It's furnished. We'll see ya next week!' But what does that mean? Like, do I feel like I've graduated if I'm now in an apartment by myself? When was the last time I cooked a meal? I've been in the shelter for two, three years - I don't remember how to make macaroni and cheese or the stuff that—and then it's frustrating to have to figure out that I need to take a cooking class. I don't think we are preparing people properly. Nobody's asking the question. I don't think we're preparing people... I don't think we're having the right conversations. [2114-HF-PERM]

Skills-training was also understood to be an essential part of supportive services for moving consumers on from permanent supportive housing. When asked what a particular PERM consumer would need in order to live successfully in housing outside of the mental health system, this PERM provider responded: "She would need someone to train on her independent living skills. She would need that. All she wants right now is her own private place where she can do what she wants when she wants." [2118-HF-PERM]

This left some PERM providers working in the Housing First program critical of the model, advocating for the existing transitional continuum of care where consumers learn "readiness skills" to prepare them for permanent housing.

In my opinion, most of this population should go from a shelter to a residence first. Not to scatter-site housing, but from the residence where they learned...they have a kitchen there, they shop, they have people that help them shop. You check the cabinets, do they have food? From the residential *then* onto scatter-site housing. But that's just my opinion. It's not the way the world works. [2139-HF-PERM]

PERM providers working in the TF-housing program also echoed this sentiment, that some of their consumers required more support than what the program had to offer, "We have a lot of clients that don't belong in supportive housing. They belong in a facility where they have staff onsite. [2121-TF-PERM]"

Implicit practice in Permanent Housing: Pragmatic flexibility

Providers at both PERM housing programs – TF and HF – described an implicit flexibility underlying their work that staff used to engage and maintain consumers in care "permanently".

Because it's the long term—As this provider explained, providers stayed flexible in response to consumers' decisions because ultimately they needed to take the long view:

We have to be very vigilant about maintaining a supportive stance, uh, even in the face of something so obviously not helpful...because it's the *long-term*, it's the

bigger picture that matters. It's keeping that person engaged in treatment that's more important than making some point that is sort of meaningless. [2104-HF-PERM]

This meant that providers needed to be willing to accept choices made by consumers, even when the choices were potentially harmful. And it involved a long-term process of exploration, aided by the “permanency” of housing.

You have to be extremely empathic. You have to believe fully in harm reduction and understand what that means. That does not mean you are condoning drug use, doesn't mean you are telling somebody to go smoke crack. What it means is that you are able to sit with the uncomfortableness (sic) of other peoples' choices and understand that it is their choice and try to *explore* why they're doing the behavior that they're doing versus judging it or feeling hopeless about them. [2104-HF-PERM]

(Almost) everything is voluntary—PERM providers, in general, described few “non-negotiables” in their work with consumers.

There are some areas that it's not negotiable... You gotta pay rent! Whether you want to or not - that's life! And in life everyone pays rent one way or another, unless you're Donald Trump. But even he gotta pay the rent! But other than that no, it's client-centered. You want to go to a psychiatrist, you go. You don't want to go to a psychiatrist, we can't force you. But will you end up in a hospital? Will you end up decompensating and hauled off in an ambulance? That's the consequences if you don't go. But that's your free will. [2139-HF-PERM]

In the HF program this was influenced by the model underlying the services, “I mean that's pretty much what this agency expects. Their approach is you can't force them to do anything.” [2118-HF-PERM], flexible program rules being a defining component of the Housing First model:

When we first meet a consumer in the hospital we tell them there is really only two major rules in this program, you know, because they are used to programs with tons of rules. The one is we have to see you six times a month, so we put that right up front. And the other is you can't hurt or threaten to kill, you can't act violently against a staff or consumer. Other than that, everything is voluntary. You don't have to take meds, you can use drugs and alcohol if that's where you are at. You know, we will work with you no matter what is going on. We don't demand that you do anything else. [2104-HF-PERM]

The TF-PERM program, on the other hand, required consumers to demonstrate sobriety before being accepted into housing. But these frontline providers also, in the end, enacted a harm reduction approach on the ground, staying flexible to consumers' more risky behaviors...with some stipulations:

I always tell them, ‘You know, it's fine. It's fine for you to do that [smoke crack in the apartment]. That is your business; this is your apartment. But please, when I come... you know I'm coming because you know I have a schedule, please don't have that on the table. Please put that stuff up!’ You know? And they respect that.

So that's one of the boundaries I create with them, so they know [2126] is coming, you know, not to be high. So that's kind of creating, like, a boundary. [2126-TF-PERM]

However, this more passive, flexible approach was not well-received by all PERM providers,

I always said, I told them, I said, 'You need to tweak the model 'cause there need to be some consequences. There needs to be some stipulations of our help. Okay, you don't have to take medication... Can you just be *clean*?' I mean, one of the consumers said...um... well, one of them left the apartment. She says, 'They didn't *do* anything. They just put me in a apartment and they just left me there, just to get high and get high and get high.' And I heard that and it stuck in my head, you know? [2111-HF-PERM]

Implicit practice in Transitional Housing: Punitive pressure

The implicit flexibility used by PERM providers in response to consumer choice contrasted with a more punitive approach underlying the work of TRANS providers. Unlike the indefinite nature of permanent housing, the TRANS program in this study had been given a set timeline of two years by the State Office of Mental Health (OMH) within which frontline providers had to prepare consumers for the next level of independence and transition them to PERM housing. This motivated providers to actively assist consumers in building independent living skills, but providers also reported feeling an inherent pressure to move consumers along within a set amount of time. "We start [talking about transition] after a year, so if they do take six months they are still within that one or two-year mark. Because after two years, the OMH is like... really gets on us. [2113-TF-TRANS]

Pressure from the State OMH to move individuals along within this timeframe was then passed down to frontline providers by mid-level management. On our first visit to the TRANS agency, we observed a staff meeting in which management sat at the head of the table reading down a list of the "long-term stayers" (i.e. consumers who had been in the program over the two-year mark). The frontline worker assigned to that consumer was then expected to report the progress that they had made that week on the consumer's referral application to the next housing program and the report took place in front of a room full of other staff and managers.

This arbitrary two-year timeline meant that consumers could request to move-on earlier, but long-term stayers were prioritized. "The priority is the long-term stayers. So, you don't....I mean I guess you could get permission [to move them earlier], but it would be very rare to start working on moving somebody out when they haven't been here for two years yet. ... They don't want those people to be competing with the long-term stayers. Because then... that's a [permanent housing] spot the long-term stayers could get." [2107-TF-TRANS]

The goal is 'not to get them comfortable'—This set up an expectation that providers would transition consumers onto another housing program within that two-year mark and this was communicated to consumers in a variety of ways. Providers often emphasized the temporary nature of housing, discouraging consumers from getting too comfortable:

Some people really do want to change, to become better, and to move on. And some people come in and they get comfortable really quickly because some of apartments are really nice....and they just don't want to move on! It's like, you know, 'this is my place'. It's like no, this is not *your* place! This is temporary. The goal is to *get* your own place. [2101-TF-TRANS]

Making aspects of the program unattractive to consumers (e.g. requiring them to have a roommate when they wanted to live alone) was seen as a way to motivate individuals to move along.

Well, to me, personally, [the goal is] not to get them comfortable because this is an 18 to 24 months program. So, you try to get them to get into their own apartment. So, having a roommate and not wanting to have a roommate? That should make them want to achieve their goals and do everything They're supposed to do to move to permanent and independent living! [2105-TF-TRANS]

Taking a hard line and using fear to motivate—In contrast to the flexibility that PERM providers described, TRANS providers in general offered less choice to consumers “This is transitional housing and they can't stay here forever. So I think that's a main reason we set—we help them to set their goals. We *suggest* goals.” [2128-TF-TRANS] and they took a harder line,

I really do try to take what you could interpret as a 'hard line'. You have to! You cannot just say 'Ok.' You can't be on their side in that way. You have to say 'Look, sir, you're here... this is a program for mentally ill people. I need you to take your medication right now or we're going to have to call the ambulance.' Because at first I didn't play that game, and that's great to not play that game. But within a week you're going to end up in the ambulance with the guy, and it's not pretty. [2107-TF-TRANS]

Many described leveraging consumers into compliance, which one provider described as “using fear to motivate”,

Well, I don't want to use fear to motivate, but with some clients you have to, because again their reality is not right. You have to use the fear of 'if you don't take your medication, I might have to hospitalize you. If you don't do this, I might have to call so-and-so.' Sometimes you have to use that to motivate them to get them back on that *line* and then once you get them back on that line with that fear, then you have to use happiness to like keep them on the line - 'Well if you stay keeping on that medication eventually you'll move out! If you keep taking that medication, you won't have to deal me coming by to visit you. If you keep on taking your medication, maybe you'll go back to school. If you keep on taking your medication, maybe you'll get off of parole!' You know what I'm saying? It's like fear gets them back on track and happiness guides them along the line. (smiles) [2117-TF-TRANS]

Another TRANS provider talked about using her client's Social Security check as a punitive tool to get him to go to his psychiatric appointments,

You could tell them ‘You know, you won't get your check, if you don't go to the appointment’...and I always get them to do everything for their money. I had to tell him that yesterday because he has another appointment today for a different program. So, if he don't make that appointment today, he won't get his money until he goes for his appointment. [2105-TF-TRANS]

Moving consumers up or out—TRANS providers often emphasized the voluntary nature of the program in relation to consumer non-compliance. “Just understand that you *are* in a mental health program, so we require certain things of you. So, if you don't want to be here, that's fine. You can move on! But while you're here, these are the things that we need. So, that can get rough. (laughs)” [2101-TF-TRANS] As another provider said, “Well being that this is voluntary, no one is making them come here, then I guess they have a say in a lot of things. If they wanna *not* do something then we can't make them do anything, so they have a say. They don't want our program they can go (laughs)!” [2112-TF-TRANS]

Providers talked about consumers “voluntary-ing” themselves out of the program (i.e. leaving by choice), and said that they often did so in response to a program rule that they did not want to follow. There was also evidence that consumers were moved to another transitional program or back down the continuum to a higher-level of care – either to a community residence or to the shelter – if they could not comply with program rules. “Sometimes we get clients that just don't want to stop [using drugs] and you know, if people don't want to stop you can't make them stop. Usually they move them out... move them to lower level or the same level housing.” [2113-TF-TRANS]

The transitional nature of housing and two-year expected time frame for moving on then meant that consumers would eventually move up or out of the program by demonstrating compliance with program rules or they would be sent back to a higher level of care for non-compliance.

I think the agency's looking at what would benefit the client the most at the end of the day. I think they're willing to give the client the benefit of doubt in terms of, even if they're struggling and not making much progress, they're willing to give them a shot, a second chance...even if they have to go to another program. Let's say somebody's not doing well at this level of care, they're willing to... instead of send them to the shelter, maybe give them a chance to go back to the CR [Community Residence] or the SRO [Single Room Occupancy]. I think that's a good thing, yeah. [2120-TF-TRANS]

Next steps and the role of the housing continuum

Analysis also showed that these different orientations to facilitating recovery and independent living were likely influenced by providers' perceptions regarding the accessibility and availability of the next level of independent living. Focused efforts to build consumers' capabilities for a higher level of independent living were only necessary if there was a next level of independent living to be attained. While the TRANS program had a clear next step on the housing continuum of care (i.e. PERM housing), the PERM programs had limited ways to get consumers affordable housing outside of the mental health system and

their housing program. Consumers were sometimes titrated down in service intensity or “graduated” from higher- to lower-levels of care, but few moved on from the housing program altogether into housing completely independent of the program.

On a ride-along with a PERM provider, we visited a consumer described by the provider as “the star of [the agency]” who had many months ago requested assistance in moving on from the housing program, but had been unable to find affordable housing without a waitlist of a year or more. He continued to reside within the supportive housing program, receiving regular visits and apartment “inspections” from a housing case manager. After we went to his apartment, I asked the case manager what she does when people ask to move on from services. She responded, “I have yet to see anybody graduate. People view [the agency] as a place to secure apartments. We struggle to move away from that perception. [The agency] guarantees *housing*, not apartments” [2114-HF-PERM] echoing the perception that program-related housing may be the only guaranteed housing option for these individuals whether or not they were capable of moving on.

There was also some recognition at the agency-level that limited opportunities for transition from PERM housing was starting to become an issue, as this provider explained,

We've now been talking about transitioning for about probably the last year that it's really come up again, and it's like ‘What's happening? Why are the people here so long?’ So it's become a discussion a lot. I think every month in the community meeting we talk about it in one way or another. ...We have to get better at making this conversation part of the initial interview - that this is not a ‘for-life’ program, there is an expectation that at some point you will not need this level of service anymore. [2104-HF-PERM]

But even for the few consumers who had a Federally-subsidized portable Section 8 voucher, enabling them to leave supportive housing services, few were able to reach that next level of independence.

They're very stable. They have benefits. Section 8 is paying their apartment. They've got good relationships with their landlords, no issues there. And They're just kind of scared to leave [the agency]. We *do* have people that graduate from the agency - there was about 12 last year. They literally move on, meaning no case management, they have their own lives and They're managing it. Do I see the majority of people graduating like that? I really don't. But I know that that's the goal. [2131-HF-PERM]

In general, PERM providers viewed the likelihood of “moving on” from permanent supportive housing as bleak. “They'll all be here a while unless they can get Section 8. But with Section 8 with a freeze on it, where are they gonna go?!” [2129-HF-PERM] Unless consumers came in with that portable Section 8 voucher, there were few options to depart from the subsidized supportive housing that the program provided. “The ones that want out, relocate. They move to the Carolinas, or they become couples and put their monies together and try to find low-income housing in some type of a place, you know? But that's far and few.” [2129-HF-PERM] Another said, “There's no other source of funding - if it's not [this program], it will be another program.” [2131-HF-PERM]

This lack of easily accessible next steps on the continuum and the perceived “permanency” of permanent housing then oriented providers toward the long haul. Unlike TRANS providers, who said the ultimate goal of their work was to “move consumers on”, PERM providers focused more on stability and maintenance. When asked about the ultimate goal of their work, one TRANS provider said: “My ultimate goal is to see the client progress and move onto independent living and achieve the goals that they set, and that they want to achieve.” [2105-TF-TRANS] Another TRANS provider said, “Ultimate goal? To move him to permanent housing. But also to make sure they are *ready* for permanent housing, I should say.” [2113-TF-TRANS]

This stood in stark contrast to PERM providers who instead focused on keeping consumers stable over the long term and maintaining them in care, as this provider said, “There is no ultimate goal! (laughs) That’s the first time I ever heard that one. (laughs) I mean just to have all your clients like doing well and just stable, and whatever that means in their life, you know. Whatever that baseline is, we just want them to be there or get there.” [2126-TF-PERM] When asked about the ultimate goal of his work, this PERM provider replied, “Maintenance. Because that’s basically the goal of the program – to have these clients sustain housing...by any means necessary.” And when I probed, “How long do you anticipate he’ll be here?” he responded, “I *have* no anticipation. I’ve never thought about it. Because this is permanent housing...we always think you’re here *permanently*.” [2121-TF-PERM]

Discussion

These findings suggest that the nature of the housing program, whether “permanent” or “transitional”, acts to influence the recovery-orientation of provider practice (ROP) on the frontlines of services. PERM housing providers and TRANS housing providers working within the same housing program differed in their conceptualization of practice related to recovery, suggesting that the housing program’s position on the continuum of care (whether PERM or TRANS) may hold greater influence over frontline practice than the culture of the organization within which providers work. Even providers working in the HF-PERM program in this study, a program that utilizes a manual that clearly articulates a recovery-oriented program philosophy (Tsemberis, 2010), diverged from the active focus on “building resilience and facilitating recovery” called for by the Federal government (U.S. Department of Health and Human Services [DHHS], 2005) and from the program philosophy.

While the views and practices of these PERM providers appear in some ways closer in line with ROP as it is defined within the literature (i.e. empowering consumers, instilling hope, etc.) and HF-PERM providers in previous studies have been found to endorse the values of recovery, more so than providers working in traditional TRANS programs (Henwood, Shinn, Tsemberis, & Padgett, 2013; Henwood, Stanhope & Padgett, 2011), PERM providers at both TF and HF sites in this study were paradoxically less likely than TRANS providers to assist consumers in skill-building for recovery and independence beyond supportive services.

“Opportunities for skill-building” and more specifically, opportunities for physical, intellectual, psychological, emotional, and social skill-building, have been framed in the

literature as essential components of a “capability-enhancing” service environment (Shinn, 2015) in parallel with Martha Nussbaum's (2000, 2011) “central human functional capabilities”. Nussbaum (2000) argues that these capabilities must be satisfied (at least to a minimal degree) in order for individuals to be afforded a fully human life, echoing the goals of a recovery-oriented system of care. In this sense, PERM providers' perception of the *permanency* of consumers' tenure in supportive services then functions as a barrier to the provision of recovery-oriented, capability-enhancing services, as these providers were less likely to offer opportunities for consumers to skill-build for independence.

However, this perception of the *permanency* of permanent housing also paradoxically acts to facilitate recovery-oriented practice. PERM providers found that they pragmatically had to remain flexible with consumers, honoring consumer choice to a greater degree than TRANS providers who were not expected to engage and maintain a consumer in care for an indefinite period of time. Without easily accessible options for housing outside of services, providers settled in for the long haul, developing ways to maintain consumer engagement in services over the long term. In order to do this, providers in PERM housing utilized passive, non-judgmental support as a mechanism for engaging consumers over the long term, reflecting Stanhope's (2012) account of HF-PERM providers' use of “paying attention” and “making a connection” with consumers in an effort to develop the “ties that bind” consumers and providers together in a working relationship.

In a similar manner, the transitional nature of housing also combined contradictory features in that it encourages providers to prepare consumers for the next level of care, but the transitional nature of services also put pressure on providers to enact a more punitive approach in order to move consumers along the housing continuum within the allotted timeframe. Overall, these findings suggest that providers may orient their practice to whatever is next on the housing continuum. The existing structure of the housing continuum of care then, with transitional programs focused on “housing readiness” and permanent programs focused on “maintenance” over recovery beyond services, in the end functions to both promote and impede recovery-oriented practice. Thus, creating a paradoxical dilemma for the housing service system in the new era of recovery – how can services be structured in a way that will promote an active focus on recovery skill-building, without also producing the pressure to move consumers along the continuum?

Implications

Both agencies in this study reside in the same municipal system (and perhaps more critically, the same expensive housing market), so results may look different in other policy and economic contexts. Additionally, this study draws from just three programs across two service agencies, therefore findings cannot be generalized to all service settings. However, these qualitative findings may be transferable to similar settings and the views of providers explicated in this study raise important questions for the design and implementation of a recovery-oriented service system.

Findings suggest that alterations should be made to the structure of the supportive housing continuum of care. If transitional care promotes punitive practices, the use of arbitrary time limits for transitional housing (e.g. the 24-month limit on Housing and Urban Development

(HUD)-funded transitional housing) should be reconsidered. Instead of having a “two-year program”, as providers understood it, services should be titrated exclusively to the needs of the individual. Findings also indicate that expanding access to exit doors from supportive housing for individuals who do not require life-long supportive services may promote a more active orientation to recovery, preparing consumers for the next level of independence in the community.

Providers in this study generally understood permanent supportive housing as the last step on the continuum. However, the U.S. housing continuum in fact has many more steps, including subsidized housing without supportive services attached, rentals in the private market, and the golden ring of private homeownership. Yet few providers in this study mentioned assisting consumers in a move to housing outside of the mental health system, let alone goals or efforts to facilitate a move to non-subsidized, private market housing. This permanency of permanent supportive housing has been framed as beneficial to consumer recovery because it promotes “ontological security” (see Padgett, 2007). But could the permanent nature of services also be detrimental to consumer growth and recovery in hindering the recovery-orientation of services? Could opening up routes to mainstream affordable housing beyond supportive services be the solution to promoting a more active skill-building approach orienting both consumers and providers to the next level of independence and recovery beyond the mental health system?

Several pilot programs commonly referred to as “Moving On” initiatives have arisen in cities across the United States. These programs create preferences for permanent supportive housing consumers in Public Housing Authorities and/or Housing and Urban Development (HUD) Housing Choice Voucher programs (Corporation for Supportive Housing, 2015). While these pilots show promise for creating next steps on the continuum of care by opening up exit doors for consumers to move on to affordable units outside of the mental health system, little is known regarding the effectiveness of these initiatives in improving consumer recovery outcomes or enhancing provider recovery-orientation. Further research is needed on these and other innovations in housing for individuals with serious mental illness in order to complete the transformation of the mental health system to a genuinely recovery-oriented system of care.

Acknowledgments

This research was supported by a grant from the National Institute of Mental Health (NIMH F31MH100772), as well as a fellowship from the New York University Global Research Initiative. The author would like to acknowledge Drs. Deborah Padgett and Victoria Stanhope and the study team from the larger parent study (NIMH R01MH084903).

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Figure 1.
Emergent themes in supportive housing provider practice related to recovery.

Table 1
Provider Participant Demographics

	Site 1 TF PERM/TRANS N (%)	Site 2 HF PERM N (%)	Total N (%)
Gender	24	11	35
Male	10 (42)	3 (27)	13 (37)
Female	14 (58)	8 (73)	22 (63)
Race/Ethnicity			
White	1 (4)	4 (36)	
Black/African	20 (84)	5 (46)	5 (14)
American	2 (8)	2 (18)	25 (71)
Other	1 (4)		4 (11)
N/A			1 (3)
Employment Tenure			
<1 year	8 (33)	6 (55)	14 (40)
1-3 years	10 (42)	2 (18)	12 (34)
>3 years	5 (21)	3 (27)	8 (23)
N/A	1 (4)	0	1 (3)
Highest Degree Completed			
Graduate	1 (4)	7 (64)	8 (23)
Bachelors	13 (54)	2 (18)	15 (43)
Associates or less	8 (34)	1 (9)	12 (33)
N/A	2 (8)	1 (9)	
Prior Experience			
Yes	19 (79)	8 (73)	27 (77)
No	4 (17)	3 (27)	7 (20)
N/A	1 (4)	0	1 (3)