What is "Support" in Supportive Housing: Client and Service Providers' Perspectives

Jill Owczarzak, **Julia Dickson-Gomez**, **Mark Convey**, and **Margaret Weeks**

Jill Owczarzak is an Assistant Professor in the Department of Health, Behavior, and Society at Johns Hopkins School of Public Health in Baltimore, Maryland. Julia Dickson-Gomez is a Professor of Psychiatry and Behavioral Medicine at the Center for AIDS Intervention Research of the Medical College of Wisconsin in Milwaukee, Wisconsin. Mark Convey is an independent researcher formerly with the Institute for Community Research in Hartford, Connecticut. Margaret Weeks is the Executive Director of the Institute for Community Research in Hartford, Connecticut.

Abstract

Supportive housing programs are proposed as a way of increasing housing access and stability for the chronically homeless, improving access to needed services, and decreasing vulnerability to HIV and other diseases. Little is known about residents' understandings of and experiences with different models of supportive housing and how they fit within residents' broader strategies to maintain housing. We conducted semi-structured interviews with 23 residents and 10 service providers from nine different supportive housing programs in Hartford, Connecticut. Data analysis explored residents' perceptions of and experiences with supportive housing programs in the context of strategies to access resources and receive emotional, financial, and other forms of support. Themes of independence, coercion, and choice pervaded participants' narratives of their experiences accessing services. Concerns with privacy influenced the types of relationships residents formed with program staff and clients. Findings illustrate the need for more ethnographic studies of how supportive housing services are delivered by community agencies and accessed by clients.

Keywords

homelessness; mental health and illness; HIV/AIDS; community-based programs; social support

Introduction

Supportive housing programs have been proposed as a way to keep the chronically homeless more stably housed, provide housing for people with chronic disabilities, and decreasing vulnerability to HIV, substance abuse, and untreated mental illness (Holtgrave et al. 2007; Schubert and Bernstine 2007). Supportive housing builds on the concept that certain populations may require extra support in order to live independently, including budget management, mental health and drug and alcohol services, and health care (Cameron et al. 2009), and that ancillary services facilitate housing stability (Conviser and Pounds 2002).

Supportive housing programs link homeless or at-risk individuals to critical services that address both individual and structural level causes of homelessness. Individual level factors

include substance abuse (Dennis, Bray, and Iachan 1998; Fischer and Breakey 1991; Lehman and Cordrey 1993; Royse et al. 2000; Stahler et al. 1993), levels of social support and degree of contact with service providers (Nwakeze et al. 2003; Nyamathi et al. 2000; Zlotnick, Tarn, and Robertson 2003), mental health diagnosis, and criminal history. Structural and policy factors that affect homelessness include criminalization of many behaviors in which drug users engage that may result in restrictions on receiving housing subsidies or criminal background checks by landlords (Anderson et al. 2002; Crane, Quirk, and van der Straten 2002; Drug Policy Alliance 2003), underfunded rental assistance programs (Joint Center for Housing Studies of Harvard University 2001), an inadequate supply of low-cost rental housing (Cornell et al. 2006; Pendall 2000), and discriminatory rental practices (Newman and Reschovsky 1996; Newman and Schnare 1998; Pendall 2000).

Supportive housing programs vary in their approach to criminal history, mental health or HIV diagnosis, and drug use in terms of housing eligibility criteria, supportive services access, and program requirements. New service delivery models such as Assertive Community Treatment (ACT) recognize that homeless individuals often experience multiple needs that put them at risk for mental illness or substance use disorders (Carton, Young, and Kelly 2010). ACT involves intensive, personalized, direct, and highly accessible case management and service delivery for clients. Similarly, a Housing First (HF) approach promotes immediate access to housing and program services without requirements for substance abuse or mental health treatment (Matejkowski and Draine 2009). ACT and HF promote consumer choice and active participation in guiding the recovery process (Salyers and Tsemberis 2007). In this model, clients share decision making authority and work to develop individualized treatment plans. The ACT and HF models of supportive housing contrast with the traditional Continuum of Care approach to homelessness. Continuum of Care focuses on enhancing clients' "housing readiness" through sobriety and psychiatric treatment requirements prior to placement in more permanent housing (Tsemberis, Gulcur, and Nakae 2004). One consequence of a Continuum of Care model is that continued drug use or relapse is often grounds for eviction, thus perpetuating housing instability (Schubert and Bernstine 2007). A growing body of evidence indicates that both Continuum of Care and other abstinence-based programs and use-tolerant housing achieve similar outcomes in terms of housing stability and use of services (Schubert and Bernstine 2007). Additionally, housing assistance without mandatory drug abstinence also shows that it can decrease HIV and other risk behaviors (Aidala et al. 2005).

Given the growing evidence of the benefits of supportive housing, ACT and other recovery-oriented approaches to treatment and housing have become part of mandatory outpatient commitment orders. As these service models have become institutionalized, the nature of "support" has become contested. In some cases, supportive services have been criticized for being paternalistic and coercive through the use of close monitoring, behavioral contracting, mandated participation, and attempts to contact clients despite their refusals (Salyers and Tsemberis 2007). In addition, supportive housing programs may require residents to make tradeoffs between support, access, and choice. For example, residents in a congregate-living supportive housing program may sacrifice choice over living companions in exchange for positive relationships with housing staff (Nelson 1997). In contrast, clients of scattered-site

supportive housing programs may gain freedom and control of an apartment and lose support through reduced opportunities to interact with staff (Nelson 1997). Despite these potential drawbacks, consumers generally report high levels of satisfaction with ACT services (Salyers and Tsemberis 2007).

Differences between various models of supportive housing are further complicated by the fact that housing programs often incorporate different *treatment* models for clients with histories of substance use. For example, substance abuse treatment models range from a Harm Reduction approach, which aims to reduce social, legal, economic, and biological consequences of drug use (Bonar and Rosenberg 2010) and the Recovery Model, which combines mutual help groups with an emphasis on abstinence (e.g., Alcoholics Anonymous). Moreover, some programs do not clearly articulate a service model that definitively aligns with the more formalized models described above. For example, programs may embrace principles of "guidance and empowerment" or "empower clients to become independent" while providing a "continuum of care" (e.g., Nelson, Hall, and Walsh-Bowers 2007). In such cases, it is unclear whether the phrase "continuum of care" is used in the same way as Tsemberis, Gulcur, and Nakae (2004) described above. Finally, supportive housing programs can involve diverse housing situations. For example, in "congregate" settings, residents share bath and kitchen facilities along with common spaces, and some (or all) meals are prepared for residents (either by residents or staff). In fixed-site programs, residents have private apartments in a single building where supportive services such as case management and employment support are also offered. In scattered-site programs, residents live in apartments owned by private landlords or units owned by the supportive housing program but located throughout the city. Supportive services are offered through the supportive housing program or other providers. In short, supportive housing residents interface with diverse service providers, treatment models, and approaches to housing that potentially blur and reduce the salience of theoretical distinctions in service models for the participants themselves.

While theoretical differences in these models have been articulated, little is known about how they work in practice. Frontline service providers may use their own experiences and beliefs to offer services, independent of the service provision model of the organization. Even less is known about residents' understandings of and experiences with different models of supportive housing and how they fit within residents' broader strategies to maintain their housing, particularly through their supportive networks. At the same time, the support offered through these programs is only one form of support upon which homeless and unstably housed individuals rely. The support provided through supportive housing programs exists within a larger context of social service access and provision, including programs targeted to homeless populations in general, as well as programs for low-income people, people with mental health or disability diagnoses (including HIV/AIDS), prisoners, and individuals with histories of substance abuse and addiction. Supportive housing residents interact with multiple programs, potentially blurring distinctions between which agency provides which service. More broadly, support extends beyond services to include emotional support, or the expression of positive affect and empathetic understanding; financial support, or the provision of financial advice or aid; and instrumental support, or

tangible, material, or behavioral assistance (Hwang et al. 2009). Service providers as sources of support are particularly important for individuals who are alienated from friends and family (Hwang et al. 2009; Zugazaga 2008) and whose most supportive and satisfying relationships while homeless are with other potentially resource-poor, homeless individuals (Carton, Young, and Kelly 2010).

When service provision is not successful or does not live up to its promises, both the service delivery system and clients are blamed. Providers are blamed for being inaccessible, coercive, dictatorial, condescending, and removed from the everyday experiences of clients (Gottlieb 1985). Clients are blamed for lack of motivation, adherence to beliefs in self-reliance, lack of follow-through, and tendency to externalize problems (Gottlieb 1985). In this study, we sought to understand how clients use various forms and sources of support offered through diverse service providers (housing, welfare, HIV treatment and care, substance abuse) and the strategies they employ to meet their needs. We explored how clients of supportive housing programs conceptualize support and the ways in which they use support to access and maintain stable housing, receive treatment for various mental and physical health concerns, and benefit from a wide range of social services, including employment, welfare, and transportation programs. We also explored how service providers of various supportive housing programs understand their service models and benefits to clients, the range of services offered, and how they support and engage clients in these programs.

Methods

Results reported in this paper are part of a larger mixed methods study that compared access to stable housing among drug using and non-using low-income residents and how their housing access affected their risk for HIV/AIDS. It was conducted in Hartford and East Hartford, Connecticut from 2007 to 2011. Hartford has among the highest densities of people living in poverty in the state, with 30 percent of the households living below the federal poverty line (United States Census Bureau 2000). East Hartford is a suburb adjacent to Hartford, and about 10 percent of its population lives below the federal poverty line. Both Hartford and East Hartford include low-income and supportive housing units. The supportive housing in East Hartford is administered by agencies located in Hartford. The quantitative component of the study included longitudinal surveys with drug using and non-drug using low-income residents of the two communities. The survey assessed housing status and stability, access to housing subsidies and other benefits, perceived neighborhood risk, mental and physical health diagnoses, and HIV risk behaviors. The project also included neighborhood mapping and geospatial modeling to assess neighborhood characteristics, including drug-related violence and other crime, quality of housing stock, and proximity to services, businesses, and transportation. The qualitative component of the study explored differences in philosophy and program requirements for various supportive housing programs in the greater Hartford area. This study was approved by the Institutional Review Board at the Medical College of Wisconsin.

For the qualitative component of the study, between June 2009 and September 2010, we conducted semi-structured interviews with 23 residents and 10 providers of supportive

housing programs in the greater Hartford area. Residents from nine different supportive housing programs included 15 men and eight women, 12 of whom had an HIV diagnosis. The majority also had histories of drug abuse or mental illness diagnoses. The large proportion of residents in the sample with HIV reflects that many supportive housing programs were developed specifically for people living with HIV (Conviser and Pounds 2002), and this population generally has greater access to such programs than those without an HIV diagnosis. On the baseline survey, study participants were asked to indicate whether they were residents of supportive housing programs and, if yes, which specific program. Fifty-four study participants of the 392 who completed the baseline survey indicated they lived in supportive housing. These responses were used to identify residents of different supportive housing programs and purposefully recruit a sample that represented the various supportive housing programs in the greater Hartford area. Twenty-three residents were invited to take part in an in-depth interview, and all residents who were contacted agreed to participate in the interview. All interviews were conducted in private rooms at a research center located in central Hartford. Residents provided informed consent and were paid $35 to thank them for their time. Interviews asked about history with the program, experiences with supportive services, perceptions of need, systems of support, and satisfaction with programs.

We also conducted semi-structured interviews with 10 service providers from six different supportive housing programs in the Hartford area. For interviews with supportive housing agency directors and staff, we identified the major providers of housing services to low-income and chronically homeless individuals, including People Living with HIV/AIDS (PLWHA), in the Hartford area. Information about supportive housing providers was compiled from the Corporation for Supportive Housing, which has a national database of supportive housing providers, and study team members' long-term experience working in greater Hartford and familiarity with the various service providers in the area. We invited directors of 11 agencies to participate in the study, and six agreed to participate. Agency directors were also asked to identify one or two caseworkers who worked with the target population, particularly caseworkers who were involved in programs related to daily living skills, job re-entry and support/employment, and recovery and addiction counseling, as well as case managers and property managers (if applicable). This method of recruitment potentially introduces some bias into the study through the possibility that directors selected high performing case managers, staff with the longest experience, and those that would present the agency in the best possible way. However, this recruitment process was necessary to ensure agency buy-in, and we believe caseworkers were able to talk about their experiences in supportive housing programs and with residents in a thoughtful and honest manner.

Caseworkers were contacted and invited to participate in an in-depth interview regarding their supportive housing programs, the clients they serve, and the support services that are offered. Caseworkers were assured that participation in the study was voluntary and confidential, that refusing to participate in the interview would not affect their employment within the organization, and that their responses, participation, or refusal would not be shared with their employers. Written informed consent was sought and obtained before the interviews began. Provider interviews asked about the type of services offered by the

agency, client eligibility and selection criteria, housing and neighborhood characteristics, organizational philosophy, and experiences providing services to clients. Providers were not paid to participate in the study. All interviews were conducted by trained qualitative researchers, digitally recorded, and lasted between 30 minutes and two hours. Supportive housing clients who had been stably housed for many years and who did not use agency-provided services tended to have shorter interviews compared to supportive housing clients who recently joined programs, had recent histories of housing instability, and were currently struggling with unemployment, substance use, and personal issues.

Analysis

All interview recordings were transcribed verbatim and entered into a computer-based text file. Transcripts were then transferred to the software program MAXQDA to be coded and analyzed. Transcripts were analyzed for emergent themes using principles of grounded theory analysis (Strauss and Corbin 1990). Transcripts were initially examined to identify primary coding categories as well as the range of themes present in each category. Identified coding categories and themes were organized into a formal code book that was then used to code a subset of interviews. New themes that did not appear to fit the original code book were discussed, and modifications were made when appropriate. When suggested by associations, overlap, or diversions in the data, thematic categories were refined, merged, or subdivided.

Transcripts were first coded by gender, interview type (e.g., agency director, caseworker, supportive housing resident), program name and type, and population served by the agency. Supportive housing residents' interview transcripts were additionally coded according to HIV status, mental health diagnosis, and participant type (i.e., drug user or non-drug user). Then the documents were coded with text codes that reflected key analytic concepts, including program application process and eligibility criteria; strategies to access services and resources; program rules and requirements; relationships with neighbors and residents, staff and landlords, family, and friends; neighborhood characteristics; and perceptions of housing and service quality. Data analysis explored similarities and differences in program type and philosophy, target population, and services offered. Data analysis also explored residents' perceptions of supportive housing programs, the relationship between supportive housing models and residents' experiences within these programs, and supportive housing services within the context of other strategies to access resources and receive emotional, financial, and other forms of support. Of particular interest were notions of trust and self-reliance in support seeking efforts.

Results

Many of the interviewee participants, particularly supportive housing clients, had experience with multiple supportive housing programs and other agencies at the time of the interview and over time. As a result, their comments about service access and availability, relationships with caseworkers, and program quality reflected their linkages with multiple agencies. Therefore, data analysis focused on notions of support in general, although distinctions between particular programs were made when appropriate.

In general, residents indicated a low level of awareness regarding types of programs available, eligibility criteria, and program requirements. Some even struggled to recall the name of the particular supportive housing program in which they were enrolled. They also did not distinguish between Housing First or Continuum of Care models, particularly evident in their lack of discussion regarding periods of sobriety or mental health treatment as prerequisites to enter the program. Many described filling out paperwork at the request of case managers or other program staff (for example, the staff at a transitional living shelter) and then simply being told that they were eligible for supportive housing. Their specific qualifications remained unclear to them. Some speculated that they were eligible for supportive housing due to existing sources of assistance (e.g., receiving state funding), income level, disease diagnosis, or time spent homeless or in a shelter. Others attributed their acceptance into supportive housing to past demonstrations of personal responsibility and caring for others. One resident, for example, attributed his acceptance into a supportive housing program to his history volunteering at a local food program and a shelter, despite being homeless himself.

Access and Independence

Residents described complex relationships with case managers and other program staff that highlighted both an appreciation for what case managers had helped them access and frustration about the limits of what case managers could do for them. Residents' stories also revealed a tension between knowing that staff were critical to service and program access and an ethos of independence that demonstrated they were savvy and capable navigators of the system on their own. While most residents voiced ambivalent narratives about the nature of support, independence, and responsibility, many participants recognized the essential role that case managers played in their access to a range of services and navigation of complex bureaucratic systems. Jeff, an HIV-positive resident of a fixed site program, described that his counselor helped him access computers for job searches and training, provided transportation, helped him complete paperwork, and promoted medication adherence. In addition, he described how she helped him identify who he should talk to if she could not help him and how she would explain to him what he needed to do and why in terms of accessing and maintaining services and benefits.

As clients' time in recovery lengthened and their housing situation stabilized, they relied on case managers for less. A more distant relationship with a case manager developed from a perceived lack of need. Dave, for example, had lived in various shelters for over 10 years as he struggled with drug use, alcoholism, and incarceration. While in the shelter and immediately after receiving his certificate for supportive housing, Dave regularly contacted his case manager to help him with paperwork, find housing, and establish care. However, at the time of the interview, he had been in his scattered-site supportive housing apartment for two years. His decreased contact with his caseworker reflected his increased housing and treatment stability:

> I really don't have much to say to her.... All I knew was I figured I had it. It was okay with me as far as her helping me out with my place, and I just left it alone after that. I mean, I still kept in touch talking to her, asking her how she was doing, and she would ask me how I was doing and stuff like that. But, that was really it. It

wasn't like an every week thing. I would see—I would talk to her, like we would talk mostly when they had events—stuff like picnics.... We didn't talk much. There wasn't much to talk about really.... I told her earlier that I was homeless, and, you know, I worked and I was on drugs and stuff like that. I was slowing up then. I was on my way away from drugs then. (Dave, HIV-negative, scattered site, personal communication)

Decreased frequency of contact between providers and clients over time reflected that providers saw themselves as providing the "tools" for clients to meet their goals, based on the idea that clients need to be "active participants in their own lives" (Female, case manager #1, personal communication). Providers recognized the strong ethos of independence within clients and tried to house clients along bus routes, near stores, and within the general proximity of health care and other services they commonly use to encourage this independence. Residents' valued this aspect of programs, particularly the sense of responsibility that came with independence. Bob, who was HIV-negative, described that since becoming a resident of a scattered site supportive housing program, he cooked his own meals, slept when he wanted, took hot showers, and had responsibility for his own well-being, which he highly valued:

Resident: I have my own. I can do what I want to do, you know. It's a big responsibility. I like that.

Interviewer: You like having responsibility?

Resident: Yes.

Interviewer: Why do you like that?

Resident: Because of the self-esteem, doing things you want to do instead of being told what to do. Being in the shelter, you have to be told what to do, when to eat, when to lay down, when to leave. That is the kind of life for nobody. (Bob, HIV-positive, scattered site, personal communication)

Reliance on case managers and other program staff has been demonstrated in other supportive housing programs in which staff members serve as "crucial links" between clients and specific agencies (Cameron et al. 2009). The widespread practice that it was up to clients to contact case managers in times of need, rather than relying on case managers to continually maintain intensive contact with clients, reflected the role of case managers as access channels to needed services:

Interviewer: Can you tell me about times that you contacted your caseworker and reasons why?

Resident: Yes, to be honest with you, when I first got into the apartment and I was settled. She was so busy because the program was up and starting that we kind of really lost track. She had more priorities because they had a certain quota to fill to get the Vets in. She was working hard doing that, and I really wasn't. And I got hurt at work, so I was a little depressed. So I relapsed. And once I started relapsing, I started saying, "Karen, I'm getting into trouble." And, at first I was in denial. I didn't want her to know. But, eventually, she'd come over to the apartment, and I

was high and she'd ask me. I'd deny it, but later on I called her up and said, "Listen. I need to get back into the program." So, I mean, I used her for support, you know. (Tim, HIV-negative, scattered site, personal communication)

This example illustrates the idea that case managers can only be successful if clients disclose their needs. From this perspective, the "support" in supportive housing programs is *people* (i.e., staff members who facilitate access, maintain relationships with clients and other agencies, assist residents in basic house repairs, help residents apply for welfare benefits) rather than a prescribed set of services and programs.

While clients of supportive housing programs and other services recognized the essential role caseworkers could play in facilitating access to services, they also acknowledged the limits of caseworkers' ability to help them. Specifically, while clients recognized the important role that case managers played in access to services and maintaining housing, they also used the language of independence and personal responsibility to explain the limits of case managers' ability to help them:

Interviewer: Are there other people that helped you during [your transition to a supportive housing program]?

Resident: No. I did all the foot work. I used to do the foot work myself. I feel better when I know that I'm doing it, because then I can't blame anybody if anything gets messed up. It would be me. I fucked up, okay, really. So, I don't put anything on anybody else that I can't handle, okay. If they say I need to go to Social Security and get a budget sheet, I go to Social Security and get a budget sheet. If I have to go to the Department of Social Services and get another budget sheet or read out, I will go get it myself. I don't have anybody do anything for me that I can't do for me. (Betsy, HIV-positive, scattered site, personal communication)

In addition to a belief in independence and personal responsibility, residents pointed to overburdened caseworkers, inconsistency, and staff turnover as limitations on their ability to help. This same client of a supportive housing program for PLWHA, for example, described having her case management services dropped due to funding cuts and the replacement case manager leaving the agency after a week, before she could finish the intake process. She gave up trying to find a case manager and decided she could "case manage herself." She now prides herself for serving as a resource for others, telling others in the program how to access housing, food pantries, and other services. Similarly, another client explained that he tried to connect to the appropriate providers on his own because, "I don't have no other way to supposedly be done like that. You might get somebody to help you, and you might find somebody that doesn't want to help you, depending on who you get. It can't be consistent no matter what. If it don't work here, you will have to try somewhere else" (George, HIV-negative, scattered site/Section 8, personal communication). In such circumstances—in which case managers were unable to facilitate access to housing and services—clients often turned to friends, family, residents of shelters, and program staff from other agencies.

Finally, for some clients, the ethos of independence and personal responsibility converged to create a sense of fatalism and lack of motivation to access potentially helpful services. At the time of the interview, Pete was living in a temporary shelter after earlier failing a drug

test and getting kicked out of a house for PLWHA. He had been placed in this home for PLWHA after being released from prison. Now, he worried how he would stay off drugs given the shelter's daytime lockout policy, a problem he had struggled with earlier. In his most recent stay at the temporary shelter, he enrolled in a day program for PLWHA that offered mental health treatment and other services, including drug addiction counseling. When explaining previous failed attempts to remain sober and maintain his housing, Pete concluded, "The problem was me. I was my own problem because I never followed through with anything. Instead of me sticking with the program, going to out-patient, trying to stay clean, I didn't put any effort in it. I didn't really allow myself to stay clean long enough to get benefits." Pete used a similar reasoning to explain why he did not take advantage of available services, concluding, "I've been in and out of treatment for so long, I know how to stay clean.... Outpatient can keep me clean for so long, but if I'm not applying myself, then eventually I will probably end up using."

Balancing Privacy and Support

While residents of supportive housing programs generally accepted program rules and requirements, themes of privacy pervaded interview participants' descriptions of these programs. Concerns over privacy, coupled with a desire for independence, infused clients' interactions with staff, residents, and neighbors, and their willingness to take advantage of available services. In one case, a strong sense of privacy motivated a resident of a congregate, supportive housing program to save money and work toward acquiring his own apartment (Bob, HIV-positive, fixed site, personal communication). Concerns over privacy also discouraged some clients from forming close relationships with neighbors and asking for help from case managers. This perspective was expressed by a resident of another comprehensive supportive housing program who commented, "I'm uncomfortable there as it is because people tend to be nosey and ask too many questions. I like to separate my personal from where I live" (Miguel, HIV-positive, congregate housing, personal communication). As a result, this particular client did not seek all the available services from which he may have benefited.

Cesar, who was HIV-positive, articulated his ambivalent feelings about the balance between support, privacy, and independence. He described that he benefited from the various programs that helped him "stay busy" through meetings and appointments and regular check-ins with his case manager to make sure he was adjusting to the program. At the same time, he saw such things as apartment inspections as an extreme invasion of privacy and undermining his dignity:

> Come on, at the age of 50? Me, going to probation every other week to tell the person everything about my life. And that person comes to my house when that person feels like it. It invades my privacy. You know, I wasn't comfortable with that and I said, "Wait a minute. This is no life no more." It's like I opened my eyes up and I said, "This is no life. I can't live this lifestyle." And that is when I said, "No more." (Cesar, HIV-positive, personal communication)

He described that he was paying $250 per month to stay in a shelter that consisted of just a bed in a single room with no other amenities (such as a kitchen). He felt as if he were

"incarcerated" and got "kind of desperate" to find an apartment. After a period of detoxification and rehabilitation for heroin addiction, he eventually succeeded in accessing a supportive housing program with the assistance of a case manager.

Some residents saw privacy as essential to maintaining their sobriety. Veronica, an HIV-positive resident of a scattered site program, recalled that she only achieved and maintained sobriety once she received supportive housing. She concluded that supportive housing provided her with privacy and a sense of control over her physical and social environment:

> Interviewer: What do you see as the benefits of supportive housing programs?
>
> Resident: Privacy. You can put your own key in your own lock and shut yourself away from all the other ills of the world. And as it didn't—you know, I just used to pay lip service to my father years ago when he used to tell me, "Get a place by yourself and be alone and just get away from all of your drinking buddies and everything. You can shut your door and your friends can come and visit you, but ultimately say, 'it's time to leave.'" (Veronica, HIV-positive, scattered site, personal communication)

In other words, the supportive housing program enabled this particular participant to establish a new context to maintain her sobriety and a sense of pride in and responsibility toward her possessions.

Choice, Risk, and Danger

Supportive housing contexts, particularly congregate living arrangements, highlight the complex dynamic between supportive and negative relationships. That is, there may be competing needs: remaining "clean" by not exposing oneself to risky situations, former friends, and old habits, and forming supportive relationships that can be used in times of need and crisis. In response, residents may hesitate to form relationships as a way to reduce potential conflict and avoid threats to their sobriety that may cause them to lose their housing. In general, supportive housing clients described two types of dangers they navigated on a daily basis: (1) threats to physical well-being that arose from the neighborhoods in which they lived, and (2) threats to mental health and—for those in recovery—their sobriety. Clients hesitated to form relationships with other clients, fearing that other clients might negatively influence them to get caught up in a lifestyle that might jeopardize their housing security. In our analysis of interviews, we explored the idea that people in supportive housing programs may isolate themselves rather than form new relationships that can be cultivated for support. Michael, a resident of a supportive housing program that followed the Continuum of Care model, summarized the general sentiment regarding relationships with neighbors:

> My neighborhood is alright, quiet. You don't see nobody in the streets. You don't see people screaming in the hallways. Nobody touches your door. I like to leave it like that because I don't touch nobody's door. I don't go to nobody and "tack, tack, tack." I don't want no friends where I live. I don't like to have friends cause friends where you live—they want to be in your house all of the time, and I'm not that kind of person. I don't be in nobody's house, so you don't be in my house. Yeah, I don't

like to tack my door, "Hey, what's up," whatever. No, I don't like that, so I have no friends. I have a friend out of the building, (personal communication)

For supportive housing clients who lived in scattered site apartments or single-family homes, the majority described their relationships with neighbors as generally cordial (e.g., exchanging greetings when coming or going) but not consisting of close, supportive relationships. One participant summarized, "I don't want to have friends. Neighbors— because they're not friends. They start as friends, and then they're just backstabbers, and I don't deal with it" (Teresa, HIV-negative, scattered site, personal communication). These friendly but distant relationships helped residents reduce conflict and maintain their sense of privacy.

The ways in which service providers and organizations interpret this dynamic affects rules and policies within the housing unit and how residents interact with each other. In ACT, consumers/clients are expected to become more active, engaged members of their communities as part of their recovery. However, interaction and engagement between clients could be potentially harmful. For example, one staff member of a program that embraced a "recovery model" described, "If we take somebody early in their recovery and then we take someone who is clean—who has been clean for a long time—and this person starts using, it's like a domino effect. Everybody starts picking up.... We put other people at jeopardy" (Female, case manager #1, personal communication). Similarly, congregate settings could make certain residents, such as those with mental illness, disability, or substance use, vulnerable to exploitation by other residents (Female, case manager #2, personal communication). From this perspective, the Continuum of Care model of supportive housing —which requires residents to be in treatment for drug addiction before placement in permanent housing—makes sense. At the same time, the potential negative effects of one resident's behaviors on the well-being of others can be a source of motivation to address behaviors. One service provider, for example, told that she would use the negative consequences of a resident's behaviors on other tenants as an opportunity to confront the client and suggest that he seek treatment (Female, case manager #6, personal communication).

Some programs addressed this complex dynamic by involving residents in the process of selecting new participants. One such program required applicants to participate in a group interview with a committee of residents, after initial interviews with the director and the resident resource specialist, in order to determine who they think would "be the best neighbor and would fit" (Male, director, congregate supportive housing program for PLWHA, personal communication). At the same, however, a group setting can help clients who tend to isolate themselves have social interactions with other residents (Female, case manager #2, personal communication). Through this selection process, program staff hoped to "organically" develop supportive relationships within the group home. For clients, relationships with residents helped them feel that they "weren't out in the middle of the ocean" by themselves (Dan, HIV-positive, congregate housing for PLWHA, personal communication).

Conclusion

Both HIV-positive and negative supportive housing residents described similar themes of individualism, support, dependence, and privacy and how these conceptualizations affected their experiences with supportive housing programs and access to housing and other resources. Narratives of individualism, independence, and a "do it yourself" ethic pervaded residents' descriptions of strategies to access welfare benefits and supportive services. These themes were embedded in concerns about coercion, choice, and privacy. Residents discussed these issues in the context of their histories of substance abuse, mental health diagnoses, HIV status, and other personal factors.

Providers recognized the complex relationship between clients' needs, the types of services available, the particular housing context, and other residents. They acknowledged, for example, that other residents could be both a source of support to clients and a potential detriment to fragile stages of recovery. In order to address this potential downside of supportive housing programs, particularly those in congregate or fixed-site contexts, providers sought to select residents whom they thought would succeed in that environment. Providers also recognized the desire for independence and building a sense of personal responsibility. They fostered the development of these qualities through program placement.

This study sought to shed light on how clients of community-based care and supportive housing programs understand the supportive services offered through these programs and their willingness and ability to access them. Residents described supportive housing programs as part of broader strategies to access services and maintain housing. They often described the services they accessed through personal rather than programmatic terms, thus blurring distinctions between Housing First and Continuum of Care models of supportive housing. In addition, residents could not clearly articulate what made them eligible for particular services and programs, further undermining distinctions between different models of supportive housing. Finally, residents expressed a reluctance to form relationships with other residents and neighbors. They were concerned—typically based on prior experience— that such relationships could undermine their recovery process. This finding raises questions about the extent to which supportive housing programs should foster and encourage relationships between residents and what types of relationships can be harmful or helpful for different types of residents (e.g., those struggling with sobriety, those with mental health diagnoses).

As Cameron et al. (2009) described, staff members are critical to the success of supportive housing programs. In particular, they can connect clients to necessary services through their own professional networks, respond with flexibility to clients' evolving needs, and exhibit general care and compassion for clients. This study illustrated that supportive housing program residents recognize the critical role program staff play in facilitating and managing their care and access to resources. At the same time, an ethos of independence and self-reliance pervaded clients' understanding of how "the system" worked.

Notions of "readiness" pervade housing program eligibility requirements, participant selection, and the range of services offered to clients (Dordick 2002). As the interview

excerpts presented here illustrate, obtaining and maintaining stable housing is a challenge, particularly in the context of substance abuse, criminal history, and mental health diagnoses. When participants of supportive and other housing assistance programs (e.g., emergency shelters and monetary housing assistance) lose their housing or are deemed ineligible for benefits in general, "lack of readiness" is often identified as the reason. This study suggests, however, that the conditions of supportive housing, particularly those that counter participants' notions of privacy and independence, may undermine clients' desire and ability to remain in the programs.

In academic literature and policy debates regarding the effectiveness of housing as a public health intervention, such programs are described in general terms and within strictly defined service models. In some cases, they are described in idyllic terms that presume trust between residents and care-givers, relationships built on mutual aid, and support during times of adversity (e.g., Gottlieb 1985). This portrait of community-based care does not consider the personal histories clients bring to these programs and how the service models fit with clients' preexisting and shifting sense of what they need. This study illustrates the need for more ethnographic, descriptive studies of how supportive housing services are delivered by community agencies and accessed by clients. Understanding clients' experiences with these programs and the ways in which they evaluate the services could be used to develop supportive housing programs that better reflect clients' goals and sense of dignity as they seek to improve their health, well-being, and stability.

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