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ORIGINAL PAPER

Qualitative Research for and in Practice: Findings from Studies with Homeless Adults Who Have Serious Mental Illness and Co-Occurring Substance Abuse

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Abstract This article draws upon findings from the New York Services Study, a Federally-funded qualitative study conducted in practice settings representing two fundamentally different approaches to serving homeless adults with serious mental illness and co-occurring substance abuse. The findings yielded four themes—cumulative adversity, individual acts of kindness in a system designed to control, discordant case managers' perspectives, and the benefits of permanent housing. Recommendations for practice include respecting individuality, being sensitive to previous traumas, and working to achieve housing security sooner rather than later. Future research is needed to study the micro-level contexts of service delivery and how they inhibit or encourage engagement in care.

Keywords Homeless · Serious mental illness · Practice research

In this article, we describe how the New York Services Study (NYSS)–funded by the National Institute of Mental Health from 2004 to 2008–produced findings that inform practice with homeless adults with serious mental illness. The NYSS, using qualitative methods, was devoted to understanding engagement and retention in care of homeless men and women with DSM Axis I disorders (schizophrenia, bipolar disorder, etc.) and histories of substance abuse. Their journeys into (and sometimes abruptly out of) residential service programs in New York City were the study's focus with a comparison of 'housing first' and 'treatment first' programs constituting a primary goal.

Given their status as one of the hardest-to-reach of clients assisted by social workers, formerly homeless persons with serious mental illness were treated as the 'experts' and invited to share their stories in their own words. This represented a distinct departure from the vast literature in the field written from a provider's, policymaker's or researcher's point of view. By also interviewing case managers, the NYSS sought to add another facet to understanding how mental health and other services are delivered in real-world settings.

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Background to the Study

The NYSS was designed to examine two strikingly different approaches to service delivery for homeless adults with serious mental illness. The first and newest of these, known as 'housing first' (HF) began with the formation of Pathways to Housing, Inc. in New York City in 1992. HF provides immediate access to one's own apartment along with around-the-clock access to assertive community treatment (ACT) case management services. In keeping with a harm reduction philosophy, HF clients are not required to be clean and sober to retain their housing.

When HF was put into practice, the vast landscape of homeless services designed to serve adults with serious mental illness consisted entirely of the 'treatment first' (TF) variety. 'Treatment first' (TF) programs require sobriety (via detox and periodic urine testing) and dormitory-style living with rules governing attendance at treatment programs, curfews, and limited or no visitors. Non-adherence to these rules can lead to discharge and/or

institutionalization. Adherence leads to graduating to the next level of less supervised care, usually a congregate apartment. Although it is possible that an individual could move quickly into an independent apartment in a TF program, it almost always takes months or sometimes years before being found 'housing ready'. Interruptions along the way include hospitalization, incarceration, relapse into substance abuse and 'going AWOL' (abruptly leaving the program without approval).

As a model of practice, HF was innovative in a number of ways. First, it adapted a well-known treatment modality–Assertive Community Treatment (ACT) (Stein and Test 1980)–by adding a nurse-practitioner to the ACT team to address the medical problems caused by homelessness and severe deprivation. Second, its embrace of harm reduction was unprecedented in homeless services. Perhaps not surprisingly, this produced wide skepticism that drug- or alcohol-abusing persons can (or should) be allowed to live independently without on-site supervision and monitoring. Last but not least, the HF philosophy of client choice removed the traditional authority accorded providers (who in TF programs had considerable power over their client's access to housing and other services). Rather than act as a gatekeeper, the HF case manager was part of an ACT team expected to work with clients non-coercively and remain respectful of their wishes.

The TF approach became acknowledged as such only after the rise of HF as a distinct alternative to the status quo (Locke et al. 2007; Tsemberis and Eisenberg 2000). Originating as temporary solutions to the homelessness crisis of the 1980s, TF models of practice were represented by a range of residential service options–shelters, halfway houses, adult homes, single-room residences (SROs) and congregate apartments. Treatment consisted of medication management, day treatment and group therapy (with crisis referrals to psychiatric hospitals or inpatient substance abuse treatment as needed). United by their transitory premise and lacking a theoretical model of practice, TF programs had little rationale, need or wherewithal to prove their effectiveness (Locke et al. 2007).

However, after 2000 quantitative evidence from a Federally-funded randomized trial emerged showing that HF had more positive effects vis-à-vis TF in housing stability (Tsemberis et al. 2004), client choice (Greenwood et al. 2005) cost-effectiveness (Gulcur et al. 2003) and dependence on alcohol and drugs (Padgett et al. 2006). In 2003, Pathways to Housing gained recognition as one of few evidence-based practices for homeless adults with co-occurring disorders (Substance Abuse and Mental Health Services Administration, 2003).

Meanwhile, little was known about how clients themselves experienced HF compared to TF programs. More importantly, virtually nothing was known about the day-to-day relationships of case managers with their clients, whether in HF or TF. It was in this context that the NYSS began in 2004.

Methods

The primary focus of the NYSS was in-depth interviews with clients and their case managers. Additional information came from observation recorded by interviewers after each interview noting the interviewee's nonverbal behavior and other observable phenomena (e.g., their apartment or the residential program). The NYSS had two phases. Phase 1 involved collecting life histories from 39 men and women purposefully sampled to represent an array of positive and negative outcomes in their lives related to residential stability, mental status and sobriety (based upon their participation in the randomized trial mentioned above). One, and in most cases, two interviews were conducted with each person to trace the intersecting pathways in and out of services as well as their mental status, use of drugs/alcohol and other important life events. More details on Phase 1 methods can be found in Padgett (2007).

Phase 2 of the NYSS was a longitudinal prospective design in which 83 homeless persons newly enrolled in their residential program (PTH version of HF or three TF programs) were interviewed 3 times over 12 months. We also carried out monthly telephone check-in interviews both to retain and track client participants and to obtain brief updates on their housing status and other aspects of their lives. In addition, study protocols included multiple in-depth interviews with the client's case manager: baseline interviews within a month of their client's enrollment in the study and follow-up interviews either 6 months later or when their client left the program, whichever came first. This resulted in 41 case managers being included as part of the study with just under half (45%) having a social work degree. Further details on Phase 2 methods can be found in Padgett et al. (2011). All NYSS study protocols were approved by the NYU institutional review board.

Findings

Phase 1 life histories yielded a treasure trove of information, some of which fit the portrayal of this population but with added depth and nuance. Other findings were unanticipated and/or led to new ways of thinking based upon clients' needs and aspirations. In Phase 2, we had multiple client and case manager interviews designed to capture how the clients were doing in a number of domains, including housing stability, psychiatric symptoms, substances use and social relationships. For clients who left their program, interviews were conducted in their

temporary residence (with family or friends) or at study offices. Across the results from both phases, the following themes emerged:

1) The impact of cumulative adversity on gender roles, social relationships, and a 'normal' life course.
2) Clients' experiences with services revealed individual acts of kindness within a system of care predicated on control.
3) Case managers had discordant priorities and relationships across the two approaches (HF vs. TF).
4) The benefits of permanent housing extended beyond residential stability.

Each of these themes is presented below with illustrative quotes taken from interviews.

The Impact of Cumulative Adversity

Taken together, participants' life stories revealed deep and lasting experiences with adversity beginning in childhood: sexual, emotional and physical abuse and loss of multiple family members and friends to mental illness, drug addiction, suicide, homicide and fatal accidents (Padgett et al. 2006). As one older male participant noted, *"When I was 14 years old, it was my first use of heroin. The summer of 1962, and the two guys that I started with are both dead. I'm the only guy still alive."*

Adulthood brought more problems: the onset of mental illness, abuse of drugs and alcohol, loss of child custody, absence of steady work or wages, and, finally, homelessness (Shibusawa and Padgett 2009). Embarking on the "institutional circuit" (Hopper et al. 1997), these individuals found themselves traversing between hospital wards, homeless shelters, detox programs and jails. In between, they doubled up with family and friends or returned to living on the street. One woman described this: *"In the beginning I was staying at friends' houses. But, friends, after 3 days, you start bothering them. So I kept going from house to house."*

It is also important to highlight what our study participants did *not* experience: they were not suddenly 'struck down' by mental illness and a subsequent descent into poverty, joblessness and isolation. The turn to abusing drugs and alcohol was not a simple matter of 'self-medication' of psychotic symptoms but instead began earlier in life as a response to living amidst almost constant exposure to substances from a young age (Henwood and Padgett 2007). As one young man said, *"My mother was doing weed and my father was shooting up dope. He's in a gang, my mother's in the gang, a bunch of drug war stuff. That's why I started using drugs."*

Their turbulent lives encompassed more than being a psychiatric patient, an addict, or street-dweller, yet these statuses often defined them to the exclusion of others. Moreover, their families—beset by poverty, illness, substance abuse and violence–were far less able to be caregivers and helpers in their times of need (Padgett et al. 2008a, b). One male participant spoke of mental illness as a family problem: "*I took my dad for shock treatments; when they come out they don't know where they are. And one time I had to go to the store and I was walking with him and he was like a little drunk. And I was going to the store to get some cigarettes. And he started to run away from me. I said, ''No, dad!'' And here I'm running after him on street. And it took everything out of me.*"

Not surprisingly, there was diversity within the sample. Women, for example, had more experiences with sexual and physical assault. As one noted, *"I got raped. Every time I went to sleep I got raped when I was on the street."* Women in the study were more often castigated by others as being unfit mothers, unfeminine and unwanted (Padgett et al. 2006). Social exclusion and homelessness left them few options. As one woman explained, *"I was in a bar…That's the only place a social person like me would go. Where am I gonna go, to the PTA meeting or something?"* In contrast, the men in the study had options available to them shared by other poor males in the inner city—scavenging and street selling, working for drug dealers, gambling and other black or gray market operations.

Cohort and age effects could be discerned in the types of drugs favored (marijuana and heroin among older participants, crack cocaine or benzodiazepine abuse among younger participants. One man recalled the late 1980s: "*I started smoking crack-cocaine again. I got caught up with people, places, and things…the whole fucking block was smoking crack, was selling crack. Every other apartment was a crack house. They had a very, very bad epidemic back them"*.

There were also shared patterns across the sample, in particular, the loss of (or failure to achieve) milestone achievements in life: graduation from college or technical school, marriage and parenting, a job or career (Shibusawa and Padgett 2009). As an older female participant noted: *"I let drugs and alcohol control my life..… I won't ever get back… you know I only went to high school. I never went to college. I almost joined the army and then I didn't. 'Cause I'd always get depressed and …I would have… maybe more than one trade. I would have seen the world. I think about that quite a bit too."*

Individual Acts of Kindness in a System Designed to Control

Phase 1 life histories contained many accounts of being hospitalized, detoxed, rehabbed, counseled, medically treated, arrested and imprisoned. Phase 2 revealed a sharp difference in the engagement of the two client groups, with

over half (54%) going AWOL from their TF programs (i.e., leaving against provider advice) compared to 3 individuals (11%) leaving Pathways, none of which went AWOL but instead left to join family members (Padgett et al. 2010).

Although their deteriorated mental state or inebriation could make engagement difficult, we found participants to be critical of the quality of help that was often offered. A young man explained why he 'went AWOL': "*I felt like there wasn't anybody trying to help. I was going in there for nothing. I would talk to case workers and case managers, and they just do their own thing. And that gets me frustrated, and instead of taking it out on somebody else in there, I'd rather just leave*."

Program- and system-level factors were pivotal in these encounters (Padgett et al. 2008a, b). The norms of service delivery represented by TF were a poor fit with client's perceived needs and aspirations. An older 'veteran' of the system explained: *"And they can come [into residential quarters] any time they wish, without you informed. Go through these urine tests. Insist on taking the medication in front of them. Money management…they give it to you when they feel like it."*

Another concern affecting HF and TF participants alike was the lack of 'one-on-one' therapy. Services were almost always delivered in group format, starting with congregate living (in the TF group) and extending to day treatment and Alcoholics' Anonymous (or Narcotics Anonymous) meetings. Meeting a psychiatrist was brief and conversation confined to medication management. Meetings with case managers were centered on procuring entitlements, money management, and treatment referrals.

Desires for privacy went unmet in a group treatment format. One female participant explained *"I'm quiet in groups cause, you never know who can turn against you and throw it up in your face, and stuff like that. So, I'm not used to that. One on one is better for me, because I could talk."* Another explained how much emotional expression in a safe environment meant to him, "*I'm not holdin' it in no more. I used to think if you talk about it, it won't do you no good. I was wrong. The more I talk about it, the more I release that pressure on me. And it helps me feel better. I'm not as depressed now."*

While negative portrayals of services and providers were often conveyed in generalities, positive experiences were vividly recalled and described. One young man, for example, related being committed to a large upstate psychiatric hospital facility for long-term treatment. While there, his psychiatrist offered him a ride to a nearby store in her car, inviting him to sit in the passenger seat. This gesture was a happy memory because it was completely out of the ordinary to be treated as a 'normal' person. Another participant recalled that his case manager *"was there for me day and night…He told me that you know, if you stay out [of the hospital], I'll take you out to dinner. Me and him go out. Walk around. Have breakfast.*" The rarity of such incidents made them all the more welcome.

Given the crowded, noisy and sometimes dangerous conditions in institutions—whether hospitals, shelters, or jails—it was particularly noteworthy when participants experienced a rare stay in a private psychiatric facility when a bed happened to be available. The amenities—gardens, quiet surroundings, respectful staff—were revelatory for participants whose lives had largely precluded such luxuries (Padgett et al. 2008a, b). As one woman exclaimed, *"It looked like a kingdom…it's like the trees and then the grounds and everything, they were like beautiful. I was like, Oh my God! I've never seen a hospital like this*."

Case Managers' Experiences: Discordance Between Program Models

Conducting in-depth interviews with participants' case managers opened a window into practice with this population. Our findings from these interviews focused on how they felt about client engagement and disengagement (going 'AWOL') and how they viewed their role within the organization and vis-à-vis their clients (Stanhope and Matejkowski 2010).

Speaking about their 'AWOL' clients, the TF case managers tended to blame relapse and substance abuse on poor decisional capacity. *"He wants to use…and until he is committed to living his life sober we can't help."* Moreover, they (unlike their HF counterparts), found themselves consumed with preparing their clients for housing interviews that would, if successful, allow the client to move a step closer to independent housing (usually a congregate residential apartment with on-site staff).

This preparation and accompanying paperwork often crowded out attention to the client's other needs, thus belying the program's mission of 'treatment first' (Henwood et al. 2011). One TF case manager described the coaching he used, *"We hold groups, we do role-play for [housing] interviewing…'this is what you can expect, this is what they're looking for.' I teach them things like body language, eye contact, how to be honest without being too honest. How not to lie but minimize. For instance, we have some clients here that don't really believe they're mentally ill, and they're housing ready. I tell them that it's ok to say that you don't think you have a mental illness. However, [I tell them] you have to add to that, 'but my psychiatrist says I have this.' And they'll ask you how you feel on your medication, and you say it helps you and makes you concentrate better."*

Discordance between HF and TF case managers was largely a result of how their organizations structured services and access to housing. While both groups of

providers gave top priority to housing as the key component of their role, Treatment First providers were consumed with the pursuit of stable housing. One case manager used blunt terminology to describe the situation he was in: *"…if you really look at this whole thing, the client is a commodity. And you are here to sell that client [to a housing provider]."*

Thus, the pressures of having clients comply with the conditions necessary to secure housing placement led case managers to focus more on ways to maneuver through the system rather than address clients' specific clinical needs. This pressure encouraged some to downplay mental or substance use problems since making them explicit could jeopardize a client's chances of moving on into more permanent housing placements. A TF case manager shared his thinking as he was preparing a female client to move on even as she was using again: *"So we really didn't know … we suspected it [drug use] but I don't think we really pursued it because we didn't want to lessen her chance of getting housing."*

In contrast, despite the fact that sobriety and treatment were not required, Housing First providers appeared more open to working on treatment needs because accessing permanent housing was not a preoccupation and clients could be candid about substance use without risking the loss of housing (Henwood et al. 2011). A HF case manager summed it up: *"It completely changes the nature of the relationship to the person, and people will open up to you in ways that they wouldn't otherwise. Because insofar as you have to hide your drug use, you might be inclined to hide this aspect of your life and that aspect of your life, and once people feel as though they have to hide certain things, it turns into a slippery slope."*

Benefits of Having a Home

NYSS study participants gave moving and detailed accounts of their lives on and off the streets. As dangerous and exposed as were the parks, doorways or subway tunnels, the public shelters were almost always worse. As one man explained, *"But Wards' Island you wake up at 6 o'clock and the whole dorm area is closed off 'til about dinner time. They don't care where you go. Just go somewhere and then come back and eat. Then you come back [and] there's violent people on drugs or drunk, people who steal. Most of the cops, they go there at night 'cause you gotta sign for your bed at 10 o'clock and guys commit crimes in the city and they go to Wards' Island to hide out. So it's just all types of folks up in there together."*

Having a mental illness and history of substance abuse made shelters even more dangerous. One male participant was driven to attempt suicide rather than return, *"The shelter was making me do all kind of crazy things. Drugs, alcohol, because it was all in the building. I wanted to get out of there so bad. They kept sending me back there. I didn't want to go so I took an overdose of medication. I went to Bellevue."*

We were not surprised to hear HF study participants express gratitude for their housing, but we were impressed by the sensory detail with which they expressed that gratitude. Examples included having a door key to secure themselves and their possessions, owning a refrigerator where they could keep food fresh (and a cold beer), and knowing that they had a bed to sleep in every night. For women, this also meant not having to fight off sexual predation and physical threats.

Giddens' theory of ontological security (1990) was employed to help understand and interpret the psychosocial benefits of having one's own home. Developed by Giddens to explain how individuals seek continuity and order in their lives in the modern era of global change and transience, ontological security theory was later extended by Dupuis and Thorns to apply to the advantages of home ownership (1998). As operationalized by Dupuis and Thorns, the key indices of ontological security related to housing—constancy, privacy and freedom from surveillance, carrying out one's daily routines, and a secure platform for identity development (Dupuis and Thorns 1998)—hewed closely to the experiences of the HF participants (Padgett 2007). As one woman explained, *"People can't tell you what to do in your own place. You have your own say-so."* Another related having an apartment to pursuing a more normal life, *"You get your own room, you mind your business, you live by yourself, you know. You go down to the park, you look at the birds. Look at the dogs. What the hell. You say hello to normal people."*

The benefits of housing also include decreased reliance on drugs and alcohol (Padgett et al. 2010). One man who had spent years on the streets related the changes that affected him, *"I haven't had like a stable you know, uh, life like in an apartment for a long time. So this is all new to me…I'm just getting adjusted to like… get sober and clean. And doing a lot of things sober."*

Yet the advantages of having a home could not erase the effects of a lifetime of deprivation and adversity. Poor health and debilitating injuries took their toll; mortality was a well-known part of their lives as they witnessed family members and peers die prematurely. As one man explained, *"I didn't expect to live to be 40. So every time I say, when it hits 4 more years, I'll ask thank God, can you give me 4 more? I'm on my medications. I'm doing great having my own apartment. The only problem is the future."*

Implications for Practice

This severely disadvantaged population is of vital interest to social work practice, research and policy. While most front-line workers in homeless services are not social workers, the latter occupy supervisory and leadership positions in the programs that provide these services. A primary recommendation arising from this study involves providing greater training and support for front-line workers to enhance their ability to engage clients through knowledge of their backgrounds and life circumstances as described in this article.

Several of the implications for practice emerging from these findings are familiar to clinicians, e.g., respecting individuality, being sensitive to childhood and early life traumas, maintaining a focus on the person-in-environment. It is also helpful to keep in mind that clients remember acts of kindness as well as cruel disregard—both having an effect on their engagement with providers. Although most of the abusive episodes they recounted took place in psychiatric institutions earlier in their lives, memories of abuse may have been rekindled when subjected to harsh rules and regulation.

Client perspectives showed that group modalities are not always optimal and that one-on-one therapy is desired to address previous traumas and current life problems in confidentiality. Findings also reveal that practice approaches embracing harm reduction rather than abstinence bring benefits in engaging clients 'where they are' rather than imposing restrictions that make non-compliance tantamount to a return to homelessness. The benefits go beyond engagement to an actual lessening of dependence on drugs and alcohol (Padgett et al. 2011).

Practice recommendations can also take into account the challenges of housing first, in particular the 'what's next' phenomenon of having achieved one urgent need and then having the luxury to contemplate what has been lost along the way amidst an uncertain future life span. Although the congregate living of TF is not the same as the warmth of friends and family, the social isolation of living alone characteristic of HF clients can also be a concern. This highlights the need for positioning community inclusion as the starting point of support services rather than a desired outcome.

The Federal Government, in particular the Substance Abuse and Mental Health Services Administration (SAMHSA), has promoted housing first as an evidence-based practice (2007). Local governments have been urged to adopt 'housing first' approaches, their comparative cost effectiveness touted as an attraction to resourced-strapped localities (Culhane et al. 2007; Pearson et al. 2007). Less expensive than a hospital bed, jail cell, residential program or homeless shelter (Gulcur et al. 2003), housing first has an appeal that cuts across conservative and liberal political lines when it comes to bottom-line considerations.

Gradual inroads are being made in traditional homeless services, but the embrace of this innovation as been slow. As noted by Dearing (2008), the 'choosers' (higher level administrators) are not usually the 'users' (front-line staff) and the latter group can resist change if threatened by it (Rapp et al. 2008). Based upon current policy and funding priorities, states and cities in the US. and Canada are open as never before to choosing a housing first approach (see, for example, http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx or http://pathprogram.samhsa.gov/). However, the current service system—resistance to client choice juxtaposed with shortages of affordable apartments–portends a slower move toward using this innovation than homeless adults and their advocates would like (National Coalition for the Homeless 2008).

Recommendations for practice that include housing first, harm reduction and client choice often seem counter-intuitive to homeless service providers who have first-hand experience supervising crowded dormitory-like facilities where behavior can be unruly and even threatening. Yet experience has shown that homeless clients in these programs often relapse, go AWOL, and refuse to accept the restrictive rules of these programs. The 'housing first' alternative did not produce such outcomes.

Recommendations for Future Research

Future research is needed to study the micro-level contexts of service delivery and how they inhibit or encourage engagement in care. Little is known about the give-and-take of case manager-client relationships in low-resource environments such as homeless services (Stanhope and Matejkowski 2010). Observational and interview studies of provider-client interactions are needed during all phases of contact—from street outreach to supportive services after the client is housed. These interactions presumably differ between the ACT teams of housing first and the individual case management approach of treatment first, but it is difficult to disentangle program rules from everyday interactions (and improvisations) without firsthand empirical observation.

Additional recommendations for research center on associations between earlier losses and adult outcomes related to mental illness, substance abuse, and homelessness. Mental and emotional instability is often attributed to a diagnosis such as schizophrenia but acute life circumstances (e.g., traumas and homelessness) can also lead to severe depression and anxiety. Finally, more research is needed on the housing first model and its impact on client outcomes in the long term.

In conclusion, the New York Services Study has produced a number of thematic outcomes linked to practice

with one of society's most vulnerable populations, i.e., adults beset by mental illness, substance abuse and histories of homelessness. The innovative approach of Housing First, while not without challenges related to social and community integration of newly housed clients, has far-reaching consequences for practitioners accustomed to more controlling forms of care and treatment. As importantly, its emphasis on client empowerment and choice are deeply concordant with the values of the social work profession.

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