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Philip T Yanos; Susan M Barrow; Sam Tsemberis
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Community Integration in the Early Phase of Housing Among Homeless Persons Diagnosed with Severe Mental Illness: Successes and Challenges

Philip T. Yanos, Ph.D.
Susan M. Barrow, Ph.D.
Sam Tsemberis, Ph.D.

ABSTRACT: The present investigation used qualitative methods to explore the response to housing and experience of community integration of formerly homeless individuals diagnosed with severe mental illness recently housed in both independent and staffed residential settings. Findings indicate that entering into housing after a long period of homelessness is associated with improvements in community integration for most individuals diagnosed with severe mental illness. However, for a meaningful minority, the adaptation to housing may also be associated with challenges that can complicate the integration process. Implications of findings are discussed in the context of how best to tailor programs to meet the complex needs of persons diagnosed with severe mental illness and to maximize community integration.

KEY WORDS: homelessness; community integration; severe mental illness.

Philip T. Yanos is affiliated with the Rutgers University Institute for Health, Health Care Policy, and Aging Research and the University of Medicine and Dentistry of New Jersey-New Jersey Medical School.
Susan M. Barrow is affiliated with the New York State Psychiatric Institute.
Sam Tsemberis is affiliated with Pathways to Housing, Inc.
Address correspondence to Philip T. Yanos, Ph.D., Rutgers University, Institute for Health, Health Care Policy, and Aging Research, 30 College Ave., New Brunswick, NJ 08901; e-mail: pyanos@rci.rutgers.edu.

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There is a growing consensus that community integration is an important goal in the design of services for persons diagnosed with severe mental illness (Carling, 1995; Wong & Solomon, 2002). It is widely believed that services should facilitate the integration of individuals diagnosed with mental illness into the community at large, allowing them to take part in the full range of activities and opportunities available to the general population. Nevertheless, the process by which programs should be designed and implemented to best facilitate community integration remains at issue.

Persons diagnosed with severe mental illness who become homeless represent a particularly challenging group to the mental health service system and to the goal of community integration. In addition to the problems of severe mental illness and homelessness, such individuals frequently also have problems such as substance abuse, HIV infection, and criminal justice involvement that may complicate the integration process. There is a long record of difficulty maintaining housing tenure for this population (Hopper, Jost, Hay, Welber, & Haugland, 1997; Lipton, Siegel, Hannigan, Samuels, & Baker, 2000).

Currently, there is debate about how best to facilitate the transition to stable housing and community participation among homeless persons diagnosed with severe mental illness. Many advocate a "continuum of care" approach, in which housing and mental health/substance abuse treatment are emphasized (Arons & Weiss, 1997), and individuals are placed in housing programs suited to their level of functional ability as determined by professionals. Housing options may consist of independent apartments, but frequently consist of supervised congregate settings for those who are not "ready" to live independently. In contrast, an alternative model implemented by the program Pathways to Housing (Tsemberis & Asmussen, 1999) based on concepts discussed in the literature (Howie the Harp, 1990), takes a "housing first" approach, offering independent apartments immediately, without assessing "readiness" and without making housing contingent on treatment involvement. Experimental and quasi-experimental research (Gulcur et al., 2003; Tsemberis & Eisenberg, 2000) has found that Pathways' approach eliminates barriers to housing access, is preferred by most consumers, and leads to superior housing tenure, with no difference in clinical outcomes when compared with continuum of care. However, the degree to which the direct transition from homelessness to an independent apartment facilitates community integration has not yet been studied.

There is certainly a strong rationale for expecting that a "housing first" approach will facilitate speedy integration, as this method allows

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consumers to live within the community in buildings rented from private landlords on the open market, rather than institutional settings. Nevertheless, as Wong and Soloman (2002) have discussed, the construct of community integration involves more than simple physical integration into the community. Equally, if not more, important are the social and psychological aspects of integration, which reflect the degree to which a person participates in and feels a part of the general community. Focusing on these aspects of community integration, the impact of independent housing becomes more complex, and depends on the interaction of a variety of individual and neighborhood characteristics. For some individuals, residence in an independent apartment setting may facilitate adjustment into normal social routines and a sense of belonging in a community; for others, residence in an apartment may lead to isolation and difficult adjustment if one does not feel a part of the immediate neighborhood.

Although little research has specifically examined the impact of housing type on community integration, research exploring the impact of different housing settings on a variety of outcomes related to community integration confirms that the relationship between housing and community integration is likely to be complicated (Newman, 2001; Nelson, Hall, & Walsh-Bowers, 1999; Wolf et al., 2001; Schutt, Goldfinger, & Penk, 1997; Ware et al., 1992). The strongest finding from this literature is that residence in independent apartments is associated with greater satisfaction with housing, but positive effects on other outcomes such as symptoms and general life satisfaction are mixed, and may be moderated by variables such as attributes of the neighborhood and the mix of tenants in the apartment building (Newman, 2001).

We concur with Wong and Solomon (2002) that a more in-depth analysis of the process of community integration in the transition to housing, incorporating qualitative methods, is required in order to understand better the complex interplay between individual factors, neighborhood factors, and housing characteristics. Specifically, the impact of housing type on the psychological aspects of community integration requires further exploration.

In the present investigation, we explored the response to housing and experience of community integration of formerly homeless individuals diagnosed with severe mental illness recently housed in both independent and staffed residential settings. We used qualitative methods to examine several important aspects of the experience of making the transition to housing, including reaction to being housed, impact of housing on sense of safety, and the experience of fitting in the commu-

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nity. The implications of our findings are discussed in the context of how best to tailor programs to the complex needs of persons diagnosed with severe mental illness with the goal of maximizing community integration.

METHOD

Participants

Data for the present study were drawn from a subsample of a larger experimental study assessing the impact of the Pathways to Housing "housing first" model in comparison with the "continuum of care" model (Gulcur et al., 2003), with 6 and 12 month follow-up assessments. The original study sample consisted of 225 individuals in New York City who met New York-New York Housing Initiative criteria for severe mental illness and homelessness (Metraux et al., 2003). Criteria for severe mental illness are the presence of a psychiatrist confirmed DSM-IV Axis-I diagnoses or Axis-II diagnoses with functional impairment; criteria for homelessness are a history of homelessness of at least 6 months, with at least 15 of the past 30 days literally homeless on the streets or in public places. Of the 225 participants, 68 were recruited from two state psychiatric hospitals; for this group, criteria for history of homelessness were assessed for the period immediately prior to hospital admission.

For the present investigation, it was decided to select a subgroup of 80 of the 121 participants who had been housed in the 6 month period prior to the 6 month or 12 month follow-up interviews so that more in-depth qualitative analyses could conducted. Initially, we hoped to randomly select an equal number from the experimental and control group. However, nearly two times more individuals from the experimental group than the control group had been housed at 12 months (80 vs. 41), and of the 41 individuals in the control group only 34 had completed the qualitative addendum. It was therefore decided to select all 34 of the available protocols from the control group and to randomly select 46 from the experimental group, leading to a total sample of 80.

Characteristics of the sample are shown in Table 1. Overall, the typical participant was a male person of color, in his early forties, with a long history of homelessness. Over half of the participants were diagnosed with either bipolar disorder or schizophrenia-spectrum disorder, and the average number of prior psychiatric hospitalizations was 4. Nearly half the sample had a recent history of alcohol or street drug use. The majority of the sample was housed in independent apartments at the time of the interview. The demographic characteristics of the subsample were similar to those of the original sample, which was also predominantly male and non-white, with comparable age, education, homelessness and alchohol/drug use histories (Shinn et al., 2002). Demographic characteristics of the original sample were reflective of the overall composition of the homeless severely mentally ill population in New York City (Metraux et al., 2003). The subsample differed slightly from the original sample with regard to diagnosis, where half were diagnosed with psychotic disorders and the average number of psychiatric hospitalizations was 5; this suggests that there may have been some selective attrition of more psychiatrically impaired individuals between the baseline and 12 month followup.

Procedure

The study was approved for human subjects research by the Institutional Review Boards of Columbia University and the Pathways to Housing program. Participants gave informed consent for participation in the study and for randomization prior to the baseline

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TABLE 1

Demographic Characteristics of the Sample ($n = 80$)

Variable	*% or Mean* ± SD
Gender	
Male	75
Female	25
Ethnicity	
White (not Hispanic)	36.3
Black (not Hispanic)	37.5
Hispanic	13.8
Mixed, Other or Unknown	12.6
Diagnosis	
Schizophrenia, Schizoaffective Disorder or Psychotic Disorder NOS	38.8
Bipolar Disorder	22.5
Depressive Disorder	20
Other or Unknown	18.8
Drug Use in 6 Months Before Baseline	27.2
Alcohol Use in 6 Months Before Baseline	38.3
Either Drug or Alcohol Use in 6 Months Before Baseline	45.7
Education	
8th Grade or Less	7.5
Some High School	28.8
Completed High School or GED	30
Some College, College Degree or More	33.9
Housing Setting	
Independent Apartment	70
Other Apartment	3.8
Group Home, SRO or Transitional Living Setting	26.3
Referral Source: State Hospital	30
Street or Shelter	70
Age at Baseline	40.96 ± 11.91
Total # of Years Homeless (Lifetime)	6.98 ± 7.57
Number of Past Psychiatric Hospitalizations	3.86 ± 4.4

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interview. They were randomly assigned to the experimental and control conditions immediately following this interview. Participants assigned to the experimental condition were given a referral to Pathways to Housing. Most control participants were already working with an outreach worker at the first stage of the continuum; those who were not were referred to outreach workers or drop-in centers. Eighty-eight percent of the original sample was re-interviewed at 6 months (n = 197, mean time from baseline = 188 days, SD = 27) and 91% at 12 months (n = 204, mean time from baseline = 387 days, SD = 61). There was at least one follow-up point for 211 participants, or 94% of the original sample. All interviews were conducted in-person by trained interviewers. Participants were offered an incentive of $25 for the interview.

Measures

Demographic variables, including age, race/ethnicity, education, homelessness history and psychiatric treatment history were assessed by self-report. In accordance with the criteria for the New York-New York agreement that provided funding for both groups, psychiatric diagnosis was based on prior records of service providers, or, in a few cases where these were not available, by an interview with a psychiatrist. Type of housing was based on self-reported living situation at follow-up. Responses were recoded to distinguish independent apartments from other supervised housing situations (which included single room occupancy hotels [SRO's] with or without supportive services, boarding house arrangements, and long-term transitional and group home settings).

Quantitative outcome measures were assessed using standardized self-report measures. *Psychiatric symptoms* were assessed with the 14-item Colorado Symptom Index, answered on a 5-point frequency scale (Shern et al., 1994; alpha = .91 at baseline, .90 at both 6 and 12 months). *Overall life satisfaction* was assessed with the mean of two identical items rating overall life satisfaction on a seven-point delighted to terrible scale (Lehman, 1988; $\alpha = .81$ at baseline, .87 at 6 months, .79 at 12 months). *Choice* was assessed using a 16-item index (Srebnik, Livingston, Gordon, & King, 1995), which asked consumers about how much choice they had over aspects of their housing and lifestyle such as the place they live, the people they live with, who can come over, and how they spend their day (at 6 and 12 months, ($\alpha = .92$, 93).

Qualitative Addendum. While prior research has examined the effects of housing on other aspects of life, the process of moving from homelessness to housing has not been well documented. We developed a qualitative "Ethnographic Addendum" to explore this transition and how participants experienced it. Qualitative research approaches that elicit participants' perspectives are particularly well-suited to exploratory investigations that aim to discover rather than confirm meaningful domains and dimensions of important life experiences (Miles & Huberman, 1994; Schensul, Schensul, & LeCompte 1999). The Addendum was administered after the structured portion of the follow-up interviews. It consisted of open-ended questions, which allowed participants to respond in their own terms. Interviewers were trained to use follow-up probes to extend or clarify answers and to record all responses verbatim. The semi-structured protocol's twenty-eight open-ended questions covered eight topical areas (major life changes; denial of housing; safety and security; community ties; daily activities; sense of time; sense of self; and things that remain the same) suggested by prior research, informal interviews with participants, and the investigators' experiences in providing and researching services and housing. Questions on major life changes, safety and security, and community ties were specifically pertinent to individuals who had recently made the transition from homelessness to housing. The Addendum also included a question asking participants to rate their overall *sense of safety* in their current living situation on a 1–10 scale.

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Analyses

Although the initial study (Gulcur et al, 2003) was focused on differences between the experimental and control conditions, for the purpose of the present investigation we decided to focus on differences between participants living in independent apartments and those living in a continuum of staffed settings (including group homes, transitional living settings, and SRO's), regardless of assignment condition. Text data from responses to open-ended questions in the Qualitative Addendum were analyzed using an open-coding approach (Strauss & Corbin, 1990). First, transcripts were read and general categories of response topics were derived (e.g., challenges in response to being housed). Groups of text were placed within these categories, re-read and then re-grouped into subcategories (e.g., challenges in response to being housed—difficulty adjusting to living alone). Responses within each subcategory were reviewed for exemplary passages reflecting the various themes contained within the responses. After codes had been created for qualitative responses, we created dichotomous variables for responses on overall reaction to housing (no challenges versus challenges) and problem fitting in (no problem versus problem). We then assessed the pattern of association among these variables and relevant quantitative outcomes (Symptoms, Live Satisfaction, Choice and Sense of Safety) by computing bivariate correlations.

RESULTS

Qualitative Findings

Table 2 reports findings on the major areas explored by the qualitative addendum. As can be seen in Table 2, the majority of participants housed in independent apartments and staffed settings indicated that they had a positive reaction to being housed, felt that housing improved their sense of safety, and felt that they fit in the community in which they were housed. Nevertheless, a meaningful minority of participants housed both in independent apartments and staffed settings indicated that they had encountered challenges during their early adjustment to being housed. Notably, over a third of the sample discussed having difficulty "fitting in" in the community. Specific themes observed in participant responses are discussed below.

Reaction to Being Housed: Positive Reactions. The majority of participants clearly stated that they had a positive reaction to being housed. Several participants' responses indicated that becoming housed led to important psychological changes. Specifically, many indicated that becoming housed facilitated a feeling of being "normal" or part of the mainstream human experience. For example:

> "I am not homeless anymore. Homelessness is an abnormal condition, and now I'm in a 'normal' condition."

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TABLE 2

Qualitative Findings

	Response Theme	*Housed in Independent Apt. %*	*Housed in Staffed Setting %*	*Total %*
Overall reaction to housing	Positive	80.8	69.6	77.3
	Challenges Met	19.2	30.4	22.7
Sense of Safety	Improved since housed	62.3	69.6	64.5
	No change since housed	20.8	21.7	21.1
	Worse since housed	17	8.7	14.5
Sense of fitting in community	No problem fitting in	58.8	68.2	61.6
	Problem fitting in	41.2	31.8	38.4

"I have some dignity. I feel like a real part of society again."

"I could see myself getting back to normal, back to society, to living. I see a future living independently."

Some chose to contrast their experience as a housed person by comparing homelessness to being an "animal."

"Biggest difference: keys to my own place. Not being chased around like cattle all day."

"I felt like I was not a homeless animal any more."

These statements suggest that housing helps to facilitate a psychological return to a state that is perceived as "normal" or "human." Others responses alluded specifically to psychological changes brought about by housing such as improved self-esteem, hope and an increased interest in themselves and the world around them. For example:

"I discovered a new hope for living life."

"when I live in the street, I don't care about myself. Now having an apartment,

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I care about myself. I take showers, I dress, and care how I look . . . I watch the news to see what's going on."

Other positive responses were more specific and reflected some of the subtle differences in experience between moving into an apartment and moving into a staffed setting. The responses of participants who had moved into apartments frequently indicated feelings of increased privacy, independence and freedom to pursue interests. For example:

"I got my own personal private space . . . if I decide to have someone come in to see me, they can. They want to leave, they can."

"I have my privacy now. I have my own toilet bowl and don't have to share a bathroom."

"I don't feel like a ping pong ball. I can dedicate time to my art. My life is wonderful. I have an art studio in my living room."

Participants who had moved into other settings also indicated a greater sense of safety and privacy, but sometimes with qualifications:

"Things are much better now . . . biggest difference is living in my own place although I don't have my own bathroom."

"I got a place to stay . . . I want an apartment, but for now an SRO is important and good for me."

Reaction to Being Housed: Challenges Faced. A minority of participants reported on the stressors they encountered once housed. In several cases, reactions were specific to the type of housing setting. Participants who moved into independent apartments sometimes indicated that living alone in an apartment was a major adjustment from homelessness. For example:

"It's difficult for me to live by myself."

"I was sad because I got so used to people in the shelter. I did not want to be alone."

"I miss [the state hospital] a little, the people."

"It's been hard. I have to learn to not be on the street . . . I tried to learn to cook again and other things people do in their apartment. I bought a VCR and I'm trying to learn how it works."

Conversely, others reacted to being housed in staffed settings with disappointment and a sense that they were not yet truly housed. For example:

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> "I am not used to living in a supervised residence. I don't like being treated like a child."
>
> "I am not in the hospital anymore, although I'm still homeless in a way."

Sense of Safety. Many participants who indicated that their sense of safety had improved indicated clearly that living in their own room or apartment allowed them to maintain the security of their persons and belongings. For example:

> "I can put my pocketbook and food down without worrying that it will be stolen . . . I know my possessions are secure."
>
> "Being able to be within four walls and being able to lock your door is much different than sleeping under the bridge. I always had to sleep with one eye open."
>
> "I don't worry about people burning me up, like people throwing lighter fluid on me."
>
> "Now I'm living in my own apartment. I can close my door. I can let people in by pressing the bell."

Conversely, some participants, frequently those discharged from hospitals or other institutional settings and moving into their own apartment, had a heightened sense of insecurity or felt their sense of safety was worse.

> "At [the state hospital] it is a protected environment. In the apartment, I am more careful."
>
> "I felt safer at [the state hospital] than I do here, because they had security over there."
>
> "I feel less secure now, people ringing my bell and I'm not expecting anyone."

Nevertheless some participants living in staffed settings indicated that these environments have their pitfalls as well:

> "[In the SRO] you have to look over your shoulder, just like at [the shelter] . . . Staff say to keep my eyes open."
>
> "I feel less safe because my money and my gloves have disappeared."

Sense of "Fitting In." The majority of participants indicated that they felt that they "fit in" in the neighborhoods in which they had been housed. Many responses were non-specific, although those that were specific tended to focus on race/ethnicity. Typically, these responses

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suggested that the participant felt that there was a good "match" between their race/ethnicity and the neighborhood's:

> "It is a black and Hispanic neighborhood. I can't help but fit in."
>
> "Yeah, it's not like me being in an all white neighborhood now."

Others responses suggested that a good mix of ethnic groups in the neighborhood created an "all are welcome" atmosphere:

> "The neighborhood is heavily mixed between Latinos, Chinese and others. I feel like I fit in."
>
> "I feel comfortable. It's mixed Jewish and Dominican—between the two I'm not even noticed."

Others suggested that feelings of fitting in depended on more intangible factors:

> "I'm the only white speck on the whole block but I've never had any problems. I respect people and they respect me."
>
> "Yes, I agree with them—principles, rules, morals."
>
> "Yes [I fit in]. They are trying to keep those apartments from going condo."

Problems with Fitting In. A significant minority of participants indicated that they did not feel that they fit in. Themes for many of these responses also focused on race/ethnicity or language mismatch as a major reason for not fitting in:

> "No, I don't feel comfortable, it's a black neighborhood and I am white."
>
> "I don't pay attention to my neighborhood. I just go to the train and home. If I knew how to speak Spanish, I would stay in that neighborhood because only Spanish-speaking people live there."
>
> "I don't really [fit in], because it's predominantly foreigners—don't speak the same language."

For others, responses suggested that not fitting in resulted from a neighborhood's lack of tolerance for "different" types of behavior:

> "People in the building are friendly but bored to death . . . I don't fit it. I am too wild for them—different. I come from a place that is more like Manhattan."
>
> "No hippies in my neighborhood, just thugs, no one looks like me."

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> "I am comfortable but I don't fit in. I am in between. I am a hip hop gangster but trying to show another side."
>
> "I do not feel that I fit in because I do something different."

Others focused on neighborhood crime or drug dealing as a major factor in creating problems fitting in:

> "The drug dealers took the neighborhood . . . I could not fit in this neighborhood because of the mentality of the people."
>
> "No I don't feel like I fit in because everybody is always talking about robbing, killing somebody and it happens too."

Correlations Between Qualitative and Quantitative Variables

To assess how different aspects of the housing experience might be interrelated, we computed correlations between quantitative variables included in the original study (overall life satisfaction, symptoms, sense of choice and sense of safety ratings), type of housing, and variables created based on the codes derived from the Qualitative Addendum (we also included race/ethnicity and whether the individual was discharged from a state hospital, since these were frequently discussed as a factors related to sense of safety and "fitting in" in the qualitative interviews). Findings from these analyses are reported in Table 3. As can be seen in Table 3, overall life satisfaction and psychiatric symptoms were significantly positively associated with each other, but were not related to other variables other than referral source. Perceived choice was related to type of housing (favoring independent apartments) and reaction to housing, with those responding positively to housing perceiving more choice. Sense of safety ratings were significantly related to both reaction to housing and sense of fitting in, favoring those with a positive reaction to housing and no problem fitting in. Having been discharged from a state hospital before being housed was related to more symptoms and greater life satisfaction, and to a greater likelihood of having met challenges in the transition to housing. The variables of race, type of housing, reaction to housing and problems fitting in were not significantly related to each other.

DISCUSSION AND CONCLUSIONS

Findings from our study indicate that, for most individuals diagnosed with severe mental illness, entering into housing after a long period

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TABLE 3

Bivariate Correlations Between Variables

Variable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
1. Overall Life Satisfaction	—							
2. Perceived Choice	.078	—						
3. Psychiatric Symptoms	.468**	.055	—					
4. Safety Rating (1–10)	.201	.194	.180	—				
5. Type of Housing (1 = Independent Apt., 2 = Staffed Setting)	.052	–.438**	.090	–.002	—			
6. Race (1 = White, 2 = Non-White)	–.077	–.068	–.071	.154	–.017	—		
7. Qualitative Reaction to Housing (1 = Positive, 2 = Challenged)	–.098	–.260*	–.028	–.307**	.123	.089	—	
8. Qualitative Sense of Fitting In (1 = No Problem, 2 = Problem)	–.198	–.004	–.168	–.415**	–.088	–.024	.128	—
9. Referral Source (1 = State Hospital, 2 = Street or Shelter)	–.277*	.213	–.244*	.028	–.167	.074	–.243*	.072

$^{*}p < .05$; $^{**}p < .01$.

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of homelessness is associated with improvements in the psychological aspects of community integration. Individuals generally find that moving into housing improves their sense of safety, improves their self-esteem and helps them to feel a part of the community at large. However, for a meaningful minority of individuals, the adaptation to housing, regardless of setting, may also be associated with challenges that can complicate the integration process. Although our findings indicate that the factors that might predict the experience of challenges in the transition to housing are complex, our findings do suggest some clear patterns which can inform program design and provide direction for further inquiry.

Overall, qualitative findings indicated that persons diagnosed with severe mental illness typically do find the experience of being housed to be very positive, enhancing their sense of community integration and their psychological well-being, and do feel that housing improves their sense of safety. Nevertheless, a number of individuals housed in both independent apartments and other settings articulated the experience of difficulties in reaction to being housed. Although these challenges were reported for a minority of individuals, we feel that they are important to consider as they may offer suggestions for how to improve the community integration of persons who have a difficulty adjusting to housing.

An important theme in many of the qualitative responses of individuals living in independent apartments who reported challenges was difficulty coping with loneliness or adjusting to the tasks of living independently. Correlational analyses indicated that persons discharged from state hospitals immediately before being housed were particularly prone to facing these types of issues. This is consistent with findings that indicate that prolonged institutionalization actually diminishes a person's preparation to return to the community (Goffman, 1968). Many in the post-institutional group also reported difficulty feeling safe without the presence of staff or security guards typically seen in hospitals and shelters. These difficulties may be temporary; a recent ethnographic follow-up study of persons discharged from a "long-stay" psychiatric hospital in Australia (Newton, Rosen, Tennant, & Hobbs, 2001) suggested that "culture shock" and "grief" are common initial reactions to deinstitutionalization, but that they typically dissipate over time. Nevertheless, it is important for housing programs to be attuned to these issues and to make steps to facilitate the emotional process of adjusting to independent housing.

Challenges faced by individuals moving into staffed settings showed a

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different pattern, and frequently reflected frustration with the inherent limitations on privacy and independence dictated by residence in these settings. Qualitative responses indicated that many persons found the rigidity of rules and lack of privacy in staffed housing programs to be detrimental to community integration. Although it is the nature of these settings to be "temporary" steps in the path to permanent housing, there is concern that it is exactly the frustrations described in our interviews that cause individuals to leave them prematurely, resulting in the comparatively poor long-term record of housing tenure for such high-intensity housing settings (Lipton et al., 2000; Tsemberis & Eisenberg, 2000).

Of particular interest were participants' observations that focused directly on the issues of "fitting in" in the community. Although the majority of participants felt that they "fit in" in their community, over a third of the sample reported difficulties fitting in. Findings suggested that sense of "fitting in" can be influenced by a combination of variables, including the match between the ethnic/racial makeup of the neighborhood and the housed person, the match between the individual's values and the neighborhood's, and the neighborhood's atmosphere of tolerance for "difference." Previous research (Segal, Baumohl & Moyles, 1980; Newman, 2001) has suggested that diverse, working-class neighborhoods, and liberal, "non-traditional" neighborhoods are associated with better outcomes for persons with mental illness than high income neighborhoods, possibly because they are more welcoming of different types of persons. Some of our interview responses supported this hypothesis, but there may be other factors that may explain a neighborhood's atmosphere of tolerance for difference. Although we were not able to specifically explore objective neighborhood characteristics in our study, in general, most housing was located in low-income neighborhoods where affordable housing units can be rented using government subsidies. While these neighborhoods are uniformly low income, there is considerable diversity in the race/ethnicity composition across neighborhoods. There is also a range of housing types that affect the "visibility" of tenants and place different challenges in the demands for day-to-day interactions with other neighbors. This role of individual fit and objective neighborhood characteristics in facilitating sense of fitting in is of potential importance and should therefore be explored in future research.

Our analysis of correlations between the variables studied revealed very little of a clear pattern in predicting outcomes related to community integration; however, it is noteworthy that three outcomes, (lower safety ratings, problems fitting in and challenges in reaction to housing) were all significantly interrelated. This suggests that these variables may

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be, as a group, related to an underlying individual level factor or a building or neighborhood characteristic that was not studied in this investigation.

On the whole, our findings offer some important implications for the design of housing programs for persons diagnosed with severe mental illness. Our findings suggest that, though independent housing programs should be pleased with the salutary impact they have on community integration for the majority of consumers, they should also be sensitive to the psychological challenges that are inherent in the process of integrating into the community and transitioning out of homelessness. A major challenge that needs to be considered is the impact of building or neighborhood characteristics on an individual's ability to feel comfortable in a community. Some settings, because of homogeneity or a lack of tolerance for "difference," may simply not be places where persons recently transitioning from homelessness can feel comfortable. Programs may therefore need to consider such factors when deciding where to locate new housing units. The Pathways program gives consumers choice over apartment location, thus engaging the consumer in the selection process. However, the neighborhood seen and apartment selected during the day may appear differently at night. It is important to listen to consumers' responses regarding the challenges they face; if they persist over time the program should be prepared to facilitate access to interventions that can enhance community integration (such as self-help services), or may be able provide the consumer with a choice of housing in alternate locations.

Other challenges, including the need to cope with loneliness and safety concerns, may be transitory; nevertheless, they should be anticipated and addressed by the support services offered by the housing program. Staff, together with consumers, need to discuss the specific challenges faced and to develop housing and community based interventions to reduce the stress experienced during this early transition phase.

Some limitations and qualification of our study should also be noted. Present analyses did not seek to evaluate the impact of "housing first" versus continuum of care, since these analyses are reported elsewhere (Gulcur et al., 2003). However, since data were drawn from a larger study addressing this topic, this backdrop may have had some impact on the present investigation. One practical way in which the larger experimental context affected our study was in the availability of interviews from the control group. A much larger number of experimental than control participants had been housed by 12 months, and the vast majority had been housed at 6 months; in contrast, most of the control

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participants were housed between 6 and 12 months. Randomly selected control participants were therefore drawn from a smaller available pool, and control participants were more likely to have waited for housing for a longer period. It is possible that differences between experimental and control groups in the experience of waiting for housing may have impacted our findings in some unmeasured way.

A further limitation of our investigation was that it did not thoroughly assess the social aspects of community integration, which consist of degree of involvement in community activities, both in the neighborhood of residence and in the community at large. Future research should systematically assess the relationship between different types of housing and the social aspect of community integration in greater detail, as it has important implications for how persons diagnosed with severe mental illness are able to achieve better social functioning by taking on active roles in their communities.

It should be noted that although our study focused on the experience of persons with severe mental illness, the qualitative interview did not address the impact of managing psychiatric symptoms or on the process of community integration. This omission reflects the authors' basic rooting in the "housing as housing" tradition of supported housing (Hopper & Barrow, 2003), which tends to emphasize housing outcomes as separate from and independent of psychiatric outcomes. However, we acknowledge that this emphasis may have resulted in a more limited picture of the process of community integration. Future qualitative investigations should also explore the impact that the management of psychiatric symptoms has on the process of community integration.

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