There's no place like (a) home: Ontological security among persons with serious mental illness in the United States

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Abstract

As the homelessness 'crisis' in the United States enters a third decade, few are as adversely affected as persons with serious mental illness. Despite recent evidence favoring a 'housing first' approach, the dominant 'treatment first' approach persists in which individuals must climb a ladder of program requirements before becoming eligible for an apartment of their own.

Drawing upon the concept of 'ontological security', this qualitative study examines the subjective meaning of 'home' among 39 persons who were part of a unique urban experiment that provided New York City's homeless mentally ill adults with immediate access to independent housing in the late 1990s. The study design involved purposively sampling from the experimental (housing first) group ($N = 21$) and the control (treatment first) group ($N = 18$) and conducting two life history interviews with each participant. Markers of ontological security—constancy, daily routines, privacy, and having a secure base for identity construction—provided sensitizing concepts for grounded theory analyses designed to also yield emergent, or new, themes.

Findings revealed clear evidence of the markers of ontological security among participants living in their own apartments. This study expands upon previous research showing that homeless mentally ill persons are capable of independent living in the community. The emergent theme of 'what's next' questions and uncertainty about the future points to the need to address problems of stigma and social exclusion that extend beyond the minimal achievement of having a 'home'.
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Main text

A sense of déjà vu accompanied the July 2006 announcement by New York City Mayor Michael Bloomberg that homeless encampments in the city would be cleared out and their occupants placed in supportive housing. Mayor Bloomberg's announcement was part of a keynote address delivered at the annual meeting of the National Alliance to End Homelessness, an organization that had earlier announced a plan to end homelessness by the year 2010 (National Alliance to End Homelessness, 2000). Dating back to the early 1980s, the 'crisis' of urban homelessness in the United States has endured despite many millions of dollars directed to its demise.

As the homelessness crisis enters a third decade, few individuals are as adversely affected as persons with serious mental illness. Persons with

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schizophrenia and other major psychiatric disorders have a much higher risk of homelessness and housing instability (Caton & Goldstein, 1984; Link et al., 1994; Phelan & Link, 1999). Whether seen on city streets or hidden from public view, homeless mentally ill adults traverse an 'institutional circuit' (Hopper, Jost, Hay, Welber, & Haugland, 1997) in which the streets and shelters alternate with exhausted family support and various transitional housing programs that exist as way stations on a continuum leading to the final destination of having one's own apartment. Difficulties in reaching this endpoint are many and setbacks are common (Allen, 2003; Hopper, 2002).

Studies of the relationships between housing, health and psychological well-being can be classified as dealing with three interrelated dimensions: (1) the material benefits of housing as shelter from the elements (Shaw, 2004); (2) health threats associated with substandard housing and neighborhoods (Bashir, 2002; Dovey, 1985; Marsh, Gordon, Heslop, & Pantazis, 2000) and, (3) the psychosocial benefits of housing as 'home' (Dupuis & Thorns, 1998; Jackson, 1995; Low & Lawrence-Zuniga, 2003; Shaw, 2004; Somerville, 1992; Wu, 1993). Perhaps understandably, public health officials have been primarily concerned with the second of these, although interest in the positive *and* negative consequences of housing has increased in recent years (Bashir, 2002; Dunn, 2000; Howden-Chapman, 2004; Wilkinson, 1996).

It is a well-known axiom that possession of housing, i.e., a roof over one's head, is necessary but never sufficient for having a 'home' (Rykwert, 1991). Shaw (2004) distinguishes between the 'hard' aspects of housing, i.e., the material conditions of a dwelling, and its 'soft' dimensions i.e., a subjective sense of being 'at home'. The latter connotes 'ontological security', the feeling of well-being that arises from a sense of constancy in one's social and material environment which, in turn, provides a secure platform for identity development and self-actualization (Giddens 1990, Laing 1965).

It has been argued that one way to acquire ontological security is from having a place, such as a home, where one carries out daily routines and gains a sense of mastery and control away from the outside world's scrutiny (Dupuis & Thorns, 1998). Ontological security, or the lack of it, was first used by Laing (1965) to describe the experience of those with serious mental illness. It is ironic that those people whose ontological security is most threa-tened due to mental illness are also those least likely to be in housing circumstances that would promote ontological security.

Thus far, ontological security in the housing and health literature has been studied in the context of home ownership (Cairney & Boyle, 2004; Dupuis & Thorns, 1998; Easterlow, Smith, & Mallinson, 2000, Hiscock, Macintyre, Kearns, & Ellaway, 2003, Hiscock, Kearns, Macintyre, & Ellaway, 2001; Nettleton & Burrows, 1998; Saunders, 1989) and type of housing (Evans, Wells, & Moch, 2003). Viewed as "satisfying some innate desire of human beings in Western societies" (Kearns, Hiscock, Ellaway, & Macintyre, 2000, p. 387), home owner-ship seems far removed from the realities of life for urban homeless adults.

Studies of ontological security and home ownership have often had difficulties in ascertaining the presence of such an amorphous concept (Kearns et al., 2000; Vigilant, 2005). However, this may be because previous studies have not concentrated on situations in which ontological security is most affected. In this study, the focus is on the tran-sition between homelessness and having a home, presumably a key period for changes in onto-logical security that may make it more readily identifiable. Previous work has suggested that the concept of 'home' comes into sharpest relief in the context of 'homelessness' (Gurney, 1997; War-daugh, 1999).

This phenomenological experience of getting a 'home' after losing it is rarely reported on in the literature. The tendency in previous research has been to make static comparisons between 'housed vs. unhoused' or 'owners vs. renters', thereby failing to capture the dynamic experience of housing deprivation among the destitute poor which can range from doubling up with family to sleeping on a park bench (Hopper et al., 1997; Takahashi & Wolch, 1994; Tomas & Dittmar, 1995; Vigilant, 2005). This dynamic experience is difficult to capture given the transient states of homelessness and being housed, particularly among those with serious mental illness (Hopper et al., 1997; Wardaugh, 1999).

This qualitative descriptive study examines the subjective meaning of 'home' among 39 persons who were part of a unique urban experiment that provided homeless mentally ill adults in New York City with immediate access to independent housing in the late 1990s (Tsemberis, Gulcur, & Nakae, 2004). The following questions were

addressed using grounded theory analyses of life history interviews:

1) How do study participants who obtained independent housing experience, enact and describe having a 'home'?
2) To what extent do these experiences reflect 'markers' of ontological security?

Findings will be presented on the housing status and living arrangements of these individuals 2 years after the experiment ended to ascertain changes both over time and between those who had obtained their own housing during the experiment and those who had not.

Policies and services for the homeless mentally ill in the United States

The United Nations has ordained housing as a basic human right that should be secure, habitable, and affordable but this goal remains elusive for much of the world's population (United Nations, 1991). In the United States, the severe shortage of low-cost housing that began in the 1980s and continues to the present day set the stage for the ongoing homelessness 'crisis' (Lovell & Cohn, 1998).

Yet the fate of homeless mentally ill adults is also affected by policies designed to ensure that they are 'housing ready' before approval is given for them to have a 'home' (Tsemberis, 1999). This dominant 'treatment first' approach provides temporary quarters in transitional housing, i.e., group homes, crisis centers, half-way houses, supervised single-room occupancy hotels (SROs), and psychiatric rehabilitation facilities.

For most homeless persons in the US, the status of being without housing is temporary and relatively short-lived (Phelan & Link, 1999). Indeed, recent research has focused on the small subset of 'chronically homeless' who are responsible for a disproportionate share of the costs of care in terms of hospital beds, emergency rooms visits, and incarceration. (Culhane, Metraux, & Hadley, 2001; Gladwell, 2006; Mangano, 2003). This group, afflicted by substance abuse and/or mental illness, is considered among the hardest-to-reach and engage into services (Aidala, Cross, Stall, Harre, & Sumartojo, 2005; Rowe, Fisk, Frey, & Davidson, 2002; Ware, Tugenberg, & Dickey, 2004).

Epidemiological research on the mentally ill homeless in the United States has focused largely on the 'demand side' rather than the 'supply side', thus giving priority to studies of characteristics of homeless individuals rather than systems of care (Hopper et al., 1997). Homeless advocates take a broader view, focusing upon government policies that underfund the building of low-cost housing in favor of interim solutions such as public shelters and residential programs (Mangano, 2003). The federally funded Section 8 program (recently renamed the Housing Choice Voucher Program) offers recipients a subsidy to rent from private landlords, but is limited both in availability and by landlords' willingness to accept the vouchers (Allen, 2003).

Services for the homeless mentally ill in the United States represent several overlapping systems of care: (1) homeless services (shelters, food pantries, soup kitchens and drop-in centers); (2) the public mental health system (hospitals, residential treatment programs, and outpatient clinics); (3) substance abuse programs (therapeutic communities, inpatient programs, and 12-step groups) for the estimated 50–70% who abuse substances (Drake et al., 2001); and, (4) social services and health care programs serving the poor.

Different funding streams, staff expertise and service philosophies distinguish these systems, yet they all share a requirement of clients: gaining access to valued services—especially housing—requires complying with a set of rules and restrictions (Allen, 2003). From the perspective of the homeless service consumer, these contingencies of care can seem daunting. Accepting them is also a high-stakes gamble since rule breaking usually leads to expulsion and a return to the streets.

This 'treatment first' approach, which dominates the landscape of services for the homeless mentally ill in the United States, can be viewed as rungs on a ladder beginning with a shelter or a drop-in center where persons sleep on cots or chairs and usually have access to meals, bathing facilities and lockers. The next steps up the ladder are a supervised dormitory-type facility—usually a bed plus locker—followed by a shared bedroom in a supervised SRO hotel or group home.

Individuals may enter the system on a higher rung, and those less impaired and more compliant may skip rungs, but reaching the top of the ladder, i.e., getting an apartment, requires one to give evidence over a period of weeks or months of: (1)

adhering to the psychiatric treatment regimen (including taking medications); (2) 'clean time', or abstaining completely from substance use; (3) agreeing to have a 'representative payee' (usually the program) control the client's disability and other income while in treatment; and, (4) conforming to behavioral requirements such as curfews, random urine testing, and maintaining personal hygiene (Tsemberis, 1999; Allen, 2003).

Persons may sidestep the ladder altogether if they have family help or financial resources to pay for housing or if they are fortunate enough to obtain a Section 8 voucher and accommodating landlord. But a bout of homelessness usually reflects the exhaustion of personal resources, resulting in dependency upon the system.

From a randomized experiment to a 'natural' experiment: The New York Housing Study (NYHS) and its successor, the New York Services Study (NYSS)

In the early 1990s, a consumer-centered approach emerged that fundamentally challenged the status quo. The 'housing first' approach separated treatment from housing, considering the former voluntary and the latter a fundamental human right (Carling, 1990; Ridgway & Zipple, 1990). As such, it removed the ladder continuum and made access to housing the first step and subsequent steps subject to consumer choice rather than coercion (Tsemberis, 1999).

The first implementation of a housing first approach in the United States took place in New York City with the founding of Pathways to Housing, Inc. in 1992 (Tsemberis, 1999). Pathways to Housing ('Pathways') departed from the 'treatment first' approach by offering: (1) immediate access to independent permanent housing not contingent on treatment compliance and retained regardless of the client's temporary departure for inpatient treatment or incarceration; (2) choice and harm reduction with respect to mental health treatment and substance use; and, (3) integrated case management services that work in conjunction with housing staff and a nurse practitioner to address ongoing housing and health needs. It resembles 'treatment first' in requiring money management or 'rep payee' status by the program for most tenants to ensure that the rent is paid.

In 1997, Pathways to Housing became part of a federally funded randomized experiment, the NYHS. The NYHS was a 4-year trial in which homeless mentally ill adults received immediate housing through Pathways (the experimental condition) or 'usual care' ('treatment first') and were assessed for an array of outcomes (Tsemberis et al., 2004). Quantitative findings from the NYHS revealed significantly greater housing stability among the experimental group members enrolled in Pathways (Padgett, Gulcur, & Tsemberis, 2006; Tsemberis et al., 2004).

The present analyses capitalize upon a natural experiment in examining housing outcomes following the end of the randomized experiment of the NYHS. The NYSS began in 2004 (2 years after the NYHS ended) and its Phase 1 relied upon a sample drawn from previous NYHS participants. As such, it represents a community-based (rather than treatment setting-based) sample whose housing status after 2002 remained an open question.

Ontological security and the treatment first vs. housing first philosophies

Conceptual fuzziness continues to surround terms such as 'ontological security' and 'home' in large part due to their contextual and subjective nature (Hiscock et al., 2003; Kearns et al, 2000; Mallett, 2004; Shaw, 2004). According to Dupuis and Thorns, the four 'markers' or conditions of ontological security are met when: (1) home is a place of *constancy* in the material and social environment; (2) home is a place in which the *day-to-day routines of human existence* are performed; (3) home is where people feel *in control* of their lives because they feel *free from the surveillance* that characterizes life elsewhere; and, (4) home is a *secure base around which identities are constructed* (1998, p. 29, italics added for emphasis).

Transitional housing for the homeless mentally ill offers little to sustain these conditions. Stays are intended to last days and weeks (although they can extend into years) and turnover is high due to dropout, referrals elsewhere, and/or graduation to the next step up the ladder. Nor are most day-to-day routines of normal life possible, since occupants share meals and bathroom facilities and are assigned chores such as kitchen help and cleanup. Also apparent is the constant surveillance and lack of privacy in these settings, where congregate living, staff supervision, medication administration, and random drug tests are common prerequisites to staying housed and in the program.

Dupuis and Thorns' last condition for ontological security (related to identity construction) taps into one of the deepest divides between 'treatment first' and 'housing first' philosophies; With the former emphasizing acceptance of one's identity as mentally ill and (if appropriate) as an 'addict' or 'alcoholic' before treatment can be engaged and effective (Estroff, Lachicotte, Illingworth, & Johnston, 1991; (Koekkoek, Van miejel, & Hutschemaekers, 2006). Interestingly, while addiction-related identities are viewed as mutable and capable of being cast aside or put under control; acceptance of one's mental illness identity is considered an ongoing prerequisite for treatment success (Olfson, Marcus, Wilk, & West, 2006).

The 'housing first' program exemplified by Pathways does not make treatment engagement and effectiveness dependent upon acceptance of these identifying labels. Other markers of ontological security—constancy, control, daily routine, and privacy—are implied by the 'housing first' philosophy of choice and autonomy (Tsemberis, 1999), yet little is known about if or how allegiance to these precepts affects making a 'home' and the subjective sense of ontological security.

Methods

Sampling and recruitment

Purposive sampling was used to select study participants (SPs) from the roster of subjects from the NYHS with the goal of selecting 40 for Phase 1 in-depth interviews. Persons in the earlier study had a documented DSM Axis 1 disorder and were referred for housing and services either from the streets or from hospitals; 90% also had substance abuse problems (Tsemberis et al., 2004).

As part of their final interview in the NYHS, SPs had been asked for contact information and permission to be recruited for future studies. Only individuals who gave permission to be contacted were considered for recruitment. Inclusion was based upon nominations criteria developed to include persons drawn from both the experimental and control groups and who had both 'positive' and 'negative' outcomes in the earlier study (defined in terms of success in psychiatric rehabilitation, controlling substance use and maintaining stable housing). Two members of the NYSS team, who had been senior interviewers in the earlier study and had first-hand knowledge of the study population,

independently identified, with 100% agreement, a roster of 60 eligible participants who met sampling inclusion criteria for the NYSS. Of these, 39 were located and contacted; all of those reached agreed to participate in the study. Of the 39, 21 had been members of the experimental group and 18 were from the control group. The slight imbalance was due to greater ease in locating participants from the experimental group.

Study design and data collection

The study design included two life history interviews, the first an open-ended query eliciting life stories with probes when relevant for experiences related to mental illness and substance abuse, homeless experiences, and other life events deemed relevant by the study participant. The second interview, which was individually tailored, elicited further detail or accuracy checks. Although we occasionally sought factual information, we maintained a strong emphasis upon respecting participants' own 'narrativizing' of what had happened to them.

Interviews, which lasted from 45 min to 3 h, were scheduled at a private location of choice to the participant (usually their current residence or the NYSS offices). Each interview was audiotaped and transcribed verbatim for entry into ATLAS/ti software. Interviewers met weekly to discuss any follow-up actions needed and debrief about their own feelings and reactions regarding the participants and their difficult life stories. All study protocols were approved by the author's university Institutional Review Board (IRB).

Coding and grounded theory analysis

Procedures for coding the transcripts followed grounded theory and constant comparative analyses (Charmaz, 2006; Strauss & Corbin, 1990). First, members of the staff independently coded a single transcript and met to discuss their findings and develop a preliminary list of codes. Second, two members of the team independently coded three more transcripts, thereby adding codes and refining the list. The set of focused codes was complete (saturated) by the tenth transcript. Third, all transcripts were co-coded separately by two members of the team—any discrepancies were discussed and consensus reached. Two study participants and a psychiatric consumer advocate consulted with the

team on the findings to provide feedback and 'member checking'.

Constant comparative analysis (Strauss & Corbin, 1990) was used to identify key themes related to living arrangements, housing and the making of a 'home'. Sensitizing concepts representing domains of ontological security, e.g., privacy, guided these analyses but emergent (unanticipated) themes were also pursued.

Results

Characteristics of the sample

Study participants had a mean age of 48 years and were predominantly male (67%). In terms of race/ethnic composition, they were 41% African American, 41% white, and 15% Hispanic; one person was of Arab descent. The most common psychiatric diagnosis was schizophrenia (56%) followed by bipolar disorder (22%), and major depression (22%). A history of co-occurring substance abuse was common, with 33 of 39 reporting lifetime substance abuse. At the time of the interviews, none reported heavy use of any substances, although 10 participants reported occasional use of alcohol and/or marijuana.

Housing status and living arrangements

As might be expected, housing status had changed for several of the participants since their involvement in the NYHS. Sampling was based on an intent-to-treat strategy, and 5 of 18 control group members subsequently crossed over to Pathways when given the opportunity (this offer was made as an ethical compromise for those who remained homeless at the end of the NYHS). As shown in Table 1, 7 of the 21 persons originally in the experimental group were not residing in Pathways apartments, having entered more intensive

treatment settings (from which 2 subsequently returned to their Pathways apartments shortly after the interviews were completed) or other transient housing. Of the 13 persons remaining in the control group after the departure of the 5 crossovers, 11 were living in supervised facilities and 2 had obtained apartments through Section 8 vouchers (see Table 1). Given the unstable housing arrangements and other life problems of NYHS participants, these outcomes are best viewed as a snapshot rather than fixed over time.

In terms of living arrangements, none of the study participants lived with a partner, family member or close friend. Instead, they lived alone in their apartments or in rooms located in transitional 'treatment housing'. Although many participants maintained contact with family and were acquainted with housemates or neighbors, social isolation characterized the descriptions they gave of their lives.

Themes

Themes that address the research questions as well as emergent or unanticipated themes are presented below. Participant identification numbers (NYSS ID numbers) follow each quote, along with the participant's previous status and any change in status by the time of the interview.

Control and self-determination

Having one's own apartment offered both 'freedom from' and 'freedom to' opportunities (Kearns et al., 2000). One man noted:

> Int: What did you like about it being your own apartment? 108: Just having it… Stay over anytime you wanted to. You know, things like that. Go shopping. You don't have to…. People can't tell you what to do in your own place. You

Table 1
Housing arrangements of study participants at the time of the interviews ($N = 39$)

Original study group	Housing status			
	Pathways apartment	Other apartment	Supervised settings/treatment	Other transient housing
Pathways ($N = 21$)	14	0	5	2[a]
Controls ($N = 18$)	5[b]	2	11	0

[a]One shelter resident was receiving Pathways case management services.
[b]Crossovers to Pathways after earlier study completion.

have your own say-so. What goes on in your own apartment. Things like that. #108 (Pathways group, who had moved to supervised treatment setting at time of interview)

A young woman valued her 'freedom to' stay away from an abusive boyfriend.

> And now I'm here I got my space. I got the balls to be like, yo I'm not taking that shit no more. Get up and just go. If I wanna see him I go see him but he gotta know… I gotta place to live. And I got to go home eventually and you can't hold me down and stuff like that. You can't do that. #121 (Control group, who had crossed over to Pathways by time of interview)

Two other women quoted below were blunt about having 'freedom from' having to trade sex for money or a night's lodging.

> I want it to be my home. I don't want no dirty motherfuckers in there with their dicks hanging or jerking off, or fucking around. I don't want it…As much as I need money, I said no. [He said] '"Come on, 10 or 12 bucks." I Said, "No, it ain't worth it. I'm sorry. I will starve. I'll drink water. I'll make it, somehow. You know, you can live on water for a day or two. #137 (Control group, who had crossed over to Pathways by time of interview)

> Int: Why was it so important for you to have your own apartment…? #118: Because I would have my privacy. I would be able to fix it up the way I like it. And I won't have to put up with a man. #118 (Pathways Group)

Women were especially vocal about the protective benefits of having their own apartment. Given higher rates of sexual and physical assault among homeless women compared to homeless men (Padgett & Struening, 1992), control and self-determination also meant having a safe harbor.

Routines of daily life: 'The simple things'

Study participants spoke with pride of the seemingly minor but deeply gratifying aspects of having a home, whether it was doing the laundry or taking a walk in the park.

> … that's what makes me feel good at times, the simple things. To be able to get up and know that I got two new shirts, a clean pair of jeans, clean

socks and I can feel good about myself. I explain that to my peers too. That's what part of recovery's about. #144 (Pathways Group)

> 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. #137 (Control group, who had crossed over to Pathways by time of interview)

Participants' appreciation of these rather mundane aspects of daily life is set against a backdrop of (and their own extensive experience with) the constrained routines of residential treatment settings, including early wake-up calls and early bedtimes, congregate dining, dormitory-style sleeping arrangements and restrictions on movement beyond the circuit of day treatment, medical appointments, and other approved outings.

Privacy and freedom from supervision

Participants viewed their apartments as havens from the noise and stress of urban life, particularly after spending months or years on the streets or in shelters where privacy was not possible. As one older woman commented:

> Sometimes it gets stressful. But I manage because I got a home to come home to and relax. #118 (Pathways group)

This contrasted with earlier experiences in transitional housing where monitoring of residents was part of daily life. One man noted:

> I don't think I ever really needed all that supervision. Plus I was already in my late fifties and I feel like, oh my god, I really don't need this. But… you know, but it was a necessary evil because I had to go through what everybody else went through. But I'm glad I'm out of that… I'm glad I'm living on my own. #128 (Control group, who had moved to other apartment by time of interview)

Emergency living arrangements such as doubling up could also bring infringements on privacy and freedom. A middle-aged woman related such an experience.

> I stayed with my girlfriend and her mother. I had to sleep in the living room. I couldn't watch TV after eleven. I couldn't give out the phone

number. I couldn't touch anything in the refrigerator. Meanwhile, I put all my food stamps in the house. I gave her three hundred a month. I had no privacy… And they treated me like crap. #140 (Control group)

As illustrated in the above quotes, monitoring by others was a fact of life for participants. Its manifestations ranged from the overtly intrusive, unannounced searches and mandatory urine tests—to passive surveillance intended to prevent rules infractions such as fighting or substance use.

Identity construction (and repair)

As mentioned earlier, ontological security is enhanced by having a 'home' as a secure base around which identities can be constructed. For study participants, this meant self-reflection and repairing identities damaged along the way. A woman recalled a childhood very different from her adult years.

It wasn't until I got with Pathways that I started straightening up, like, learning how to stop using, you know, taking a good look at me, and realizing who I really am. You know… I grew up in a church. I had good discipline when I was growing up. My mother wouldn't even let us say curses. We wasn't even allowed to say the word 'behind'. #118 (Pathways group)

A man in his 40s reflected upon his earlier success as a musician before mental illness and homelessness took their toll:

Int: It sounds like getting this apartment was a turning point. 139: Well yeah, …definitely one of the big turning points because it simply allowed me to um, reevaluate things, you know, and just, and get my life together from there. Int: When you say reevaluate things, what kinds of things did you think about? 139: Direction, just where was I heading…what was my purpose, you know……I've always been a musician, an artist of some sort but things were kind of confusing at that point. I needed just to sit back and just see what was happening. #139 (Pathways group)

As illustrated above, study participants with previous work experience used it as a basis for identity reconstruction (additional examples include nurse, bank clerk, taxi driver, and computer programmer). Others sought out new work identities drawing upon their life experience, e.g., becoming a peer counselor.

Perhaps not surprisingly, the restoration and repair of social roles and identities was a goal. Being or becoming a parent, reaching out to estranged family members, and seeking out new relationships were all part of the pursuit of a 'normal' life. However, as discussed in the following section, having a home base also opened the door to thoughts about an uncertain future.

The 'what's next' of having a home

One of the more salient themes in this study was the existential 'what's next?' question that can emerge after leaving the survival mode of the streets and having the 'luxury' to contemplate a future.

I have to either get myself a job, a volunteer position, or something… I have to be doing something constructive. In other words, go back into society, you know what I mean. I just got this apartment…the goal is to reintegrate you back into society. Int: What does that mean? 128: Kind of like, you know, don't rely on mental health services as much. Try to be a lot more independent… Which I try to do right now only… you know what, actually, I'm very stable here. As soon as I get my money, the rent's paid, all my bills are paid. #128 (Control group, who had moved to other apartment by time of interview)

Some participants were concerned that they could maintain their sobriety when their program did not require abstinence in order to stay in one's apartment.

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, you know, get sober and clean. And doing a lot of things sober. And it's like, I'm learning how to live. #128 (Control group, who had moved to other apartment by time of interview)

It is noteworthy that complete independence from any program involvement was not yet a reality for any of the study participants, and some voiced this with regret.

I wanted like, to pay for my own apartment…do it on my own…it's mostly like a charity case or something in my eyes, you know. I wish I could

just get a job and pay for my own things and yeah, be my own person. #111 (Pathways group)

Finally, participants were keenly aware of their own mortality, having lost many peers to drugs, violence and the cumulative health problems of life on the streets. As one middle-aged man said:

> 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. #103 (Pathways group)

Addressing the 'what's next' questions carries a degree of urgency born of the risk of premature mortality and it also points to the difficulties of overcoming years of adversity and disablement.

Staying in transitional housing

Some study participants reluctantly accepted the need for residential treatment, even if it was not their optimal situation.

> … I miss it. I wish that I can get my apartment back and start all over again. It'd be nice. But, I told my social worker that I'd rather stay here, just in case I get sick again. Then I don't have to go through all the trouble again. Of going through the hospital and-starting all over again, and have to work from the bottom. #108 (Pathways group, who had moved to supervised treatment setting at time of interview)

For others, the abstinence requirement was a barrier to reaching the top of the ladder. An older man described this dilemma.

> So my case manager he said that I had relapses. And that I have to be sober for a year or two… Then they can apply for an apartment…And I have to get a reference or I have to be referred by someone…I'm not a pretentious guy… But I need an apartment. You understand? It doesn't matter distance. We have a subway system so great, you see? #131 (Control group)

For some, the yearning for a 'home' was tangible even as they began to give up hope.

> Int: What do you think would help you to feel better? 140: Something that'll never happen. Int: And what's that? 140: To have my own place… not associated with [adult home] at all. 'Cause

you know even when you get your own place, they still check up on you once a month and they've got a key to your place. You can't have any animals. I really want two or three cats. To tell you the truth, I wouldn't mind a dog either. I can never have pets. I'll never truly be on my own. #140 (Control group)

The above quote was from a woman who had lived in a group home for 3 years since leaving the streets and shelters. In this brief quote, several previous themes are touched on as being absent from her life—self-determination, privacy, and enjoyment of 'the simple things' such as having a pet.

Discussion

Findings from this and previous studies affirm that formerly homeless individuals with serious mental illness can live on their own without the need for on-site supervision and monitoring (Tsemberis et al., 2004; Greenwood, Shaefer-McDaniel, Winkle, & Tsemberis, 2005). Findings specific to this report demonstrate that they can also enjoy the benefits of a 'home'. Markers of ontological security were clearly in evidence for those living in their own apartments—a sense of control, reassuring daily routines, privacy, and the capacity to embark upon identity construction and repair. Participants' ability to maintain the 'rhythms of life' (Jenkins & Carpenter-Song, 2005, p. 407) may seem unsurprising to some, but must be viewed in juxtaposition to an entrenched view among mental health providers that most persons with schizophrenia or bipolar disorder are too unstable to live on their own or experience the psychological benefits of solitude and personal agency (Koekkoek et al., 2006; Lamb & Weinberger, 2005).

Study participants' engagement in everyday activities, e.g., grocery shopping, cooking meals and entertaining friends, is the behavioral counterpart of 'normalizing talk' (Estroff et al., 1991) offered by persons with serious mental illness as a means of gaining parity with their nonmentally ill peers. At the same time, having a secure base after years of struggle affords the 'freedom to' reflect on past losses, ongoing dependencies and future prospects. Regardless of their housing status, all study participants were reliant upon disability income and case management services from programs serving persons with psychiatric disabilities. They were also well aware that they faced an uncertain future,

having witnessed the premature deaths of many of their family members and peers.

Demonstrating that persons with serious mental illness can make a home for themselves when offered housing attests to the rather low threshold of expectations set for them after two decades of homelessness in the United States. International replications of the Pathways model for the homeless mentally ill are being planned in Japan and elsewhere, but their development is still in the early stages (Dr. Sam Tsemberis, personal communication). National and local differences in housing policies, service systems, provider attitudes and housing availability point to the need for adjustments without sacrificing fidelity to the model's core values.

Achieving this minimal first step toward normalcy points to the thorny issue of social exclusion that confronts the seriously mentally ill regardless of where and how they live. The 'what's next' questions raised by study participants reflect an awareness of the challenges they face in seeking full independence and social acceptance. In addition to the disabling effects of cumulative trauma and adversity, societal stigma and discrimination undermine such efforts (Hopper, 2002). The recent growth in support for 'recovery-driven' services emphasizing self-determination and hope (Deegan, 1988; Davidson, 2003; Jenkins & Carpenter-Song, 2005) highlights the legitimacy of calls for system change as well as the difficulties attending such change.

This study is potentially limited by its location in New York City, which may not be representative of other urban areas in the size of its homeless population and the scope of services designed to assist them. Yet it could also be argued that the attainment of a 'home' after a harsh life on the city's streets and amidst its extremely tight housing market is that much more meaningful. Another potential limitation is the lack of full induction in applying the grounded theory analyses, i.e., the use of sensitizing concepts related to ontological security. Although several of these concepts "earned their way" (Charmaz, 2006, p. 68) into the findings and the analyses were structured to remain open to fresh insights (e.g., the 'what's next' dilemma), it is plausible that others were overlooked.

The study has a number of strengths including its deployment of strategies for rigor (Padgett, 1998) such as debriefing, interviewer supervision, member checking and two interviews per participant. A strong emphasis on rapport and trust made it unlikely that the participants misled us, although social desirability bias is still possible. Every attempt was made to stay closely grounded to the data in making interpretations.

Conclusion

Ontological security was originally developed within the mental health field where the emphasis was on the breakdown in ontological security experienced by those with schizophrenia. The treatment approach for such persons reflects the belief that ontological security cannot be regained until the mental illness is addressed. Research in the housing and health field, including this study, suggests that housing can provide a fundamental building block for ontological security, thus lending support to a housing first approach. This study shows the benefits of cross-disciplinary work for policy and theoretical development.

This study capitalized upon a unique experiment in which homeless mentally ill adults were provided immediate access to independent housing without prior restrictions or proof of readiness. Contrary to the dominant policies and practices in the United States, housing first makes an offer that few individuals will (or did) refuse and from which most benefited, both materially and psychologically. Yet the fate of the homeless mentally ill in the United States is heavily influenced by programs and policies favoring transitional over permanent housing in the mistaken belief that such persons are not capable of stable, independent living in the community.

Finally, this study has shown that the subjective experience of ontological security can now be extended from home-owners to newly housed persons with serious mental illness. Yet, just as a house (or apartment) does not make a home, a home does not make a life. Other core elements of psychiatric recovery such as hope for the future, having a job, enjoying the company and support of others, and being involved in society (Davidson, 2003; Deegan, 1988; Jacobson & Greenley, 2001) have only been partially attained by this study's participants. Having a 'home' may not guarantee recovery in the future, but it does afford a stable platform for re-creating a less stigmatized, normalized life in the present.

Acknowledgments

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