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Employment Experiences of Formerly Homeless Adults with Serious Mental Illness in Housing First versus Treatment First Supportive Housing Programs

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Abstract

Objective: This paper examines how formerly homeless adults with serious mental illness living in Housing First (HF) and "treatment first" (TF) supportive housing programs experience employment. Research questions include: *How do these individuals experience employment in the context of their mental health recovery? What do they perceive as the benefits of and obstacles to attaining employment? Are there programmatic differences in their employment experiences?*

Methods: Case study analyses of data from a federally-funded qualitative study were conducted of 40 individuals purposively sampled from a HF and a TF program. Data were independently analyzed and consensually discussed to develop cross-case themes.

Results: Three themes emerged: 1) the meaning of work, 2) working within the system, and 3) balancing treatment requirements and work. While none of the study participants had full-time jobs, more HF program clients had part-time employment than their TF counterparts. Of the 12 employed participants, all but two worked within their respective programs. Participants in both groups described similar benefits of obtaining employment but TF program requirements inhibited job-seeking.

Conclusions and Implications for Practice: These findings provide insight into the challenges of obtaining employment for formerly homeless individuals with serious mental illness residing in supportive housing. Despite the motivation to work, individual, structural, and organizational factors impeded employment. To address this problem, factors at each of these

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levels will need to be considered. Interventions such as supported employment (SE) offer promise to supportive housing programs committed to employment as a contributor to recovery.

Keywords

employment; recovery; homeless; supportive housing; Housing First

Introduction

Employment has been described both as a marker of, and as contributing to, recovery from serious mental illness (New Freedom Commission on Mental Health, 2003; Walsh & Tickle, 2013). Beyond the financial benefits of work, employment of people living with serious mental illness is associated with better quality of life (Bond, Becker, Drake, et al., 2001; Eklund, 2009; Leufstadius, Eklund, & Erlandsson, 2009), improved self-esteem and better symptom control (Bond, 2004), as well as reduced use of community mental health services (Bush, Drake, Xie, McHugo, & Haslett, 2009).

Most individuals with serious mental illness want to work (Bond, 2004; Eklund, 2009; Waghorn et al., 2012), yet rates of unemployment (Mechanic, Bilder, & McAlpine, 2002; Waghorn et al., 2012) and under-employment (Cook, 2002, 2006) remain high for this population. In seeking and maintaining employment, people with serious mental illness face a variety of challenges, including stigma in the workplace (Brohan et al., 2012; Brohan & Thornicroft, 2010) and educational disadvantage (Waghorn et al., 2012). Qualitative narratives have also highlighted drawbacks to engagement in work such as personal conflicts and stress, job insecurity, and meaningless jobs (Saavedra, J., López, M., Gonzáles, & Cubero, 2016).

Unemployment among people who are homeless is also high, estimated to be around 80–90% (Acuna & Erlenbusch, 2009; Aubry, Klodawsky, & Coulombe, 2011; Pickett-Schenk et al., 2002). A disproportionate prevalence of mental illness in homeless populations likely explains some of this effect. Other impediments include having a criminal record (Peternelj-Taylor, 2008; Tschopp et al., 2007), physical illness or substance use history (Henry & Lucca, 2004; Radey & Wilkins, 2010; Zuvekas & Hill, 2000), as well as poor employment histories (Pickett-Schenk et al., 2002; Waghorn & Lloyd, 2005). Prominent barriers to employment cited by individuals contending with *both* mental illness and histories of homelessness include, 1) current addiction disorder, 2) having a criminal record, 3) work-impeding shelter practices, and 4) difficulties obtaining adequate psychiatric care (Poremski, Whitley, & Latimer, 2014).

Having a job provides a pathway to social integration (Ware, Hopper, Tugenberg, Dickey, & Fisher, 2008) but *obtaining* a job often rests on ‘who you know’. For formerly homeless individuals with serious mental illness, significantly depleted social networks (Hawkins & Abrams, 2007) may present a further hurdle to finding and maintaining work. Because of these various hurdles, homeless individuals often enter the ‘underground economy’ resourcefully finding ‘off the books’ work such as panhandling or recycling (‘canning’) in order to create a source of income or as a supplement to insufficient entitlement benefits (Venkatesh, 2006).

In this population, recovery often begins with securing stable housing, the pursuit of employment deferred or postponed either by the individual or the program until this basic need can be met. Traditional, graduated homeless services start by placing people in temporary shelters before transitioning to a supervised residential setting and, ultimately, permanent supportive housing. Treatment compliance and abstinence are required as a pre-condition to accessing independent housing. A rationale for this model is that individuals need to achieve a certain level of stability before taking on the additional responsibility of living on their own, and likewise, finding a job. Because this approach prioritizes and assumes a need for mental health and substance use treatment before living independently or being competitively employed, it has been described as ‘treatment first’ (TF) (Padgett, Gulcur, & Tsemberis, 2006).

Housing First (HF), as the name implies, has reversed this approach by prioritizing immediate access to independent housing (Tsemberis, Gulcur, & Nakae, 2004). HF reflects a different conceptual understanding of recovery from mental illness - instead of matching step wise services to the degree to which one’s symptoms have resolved, recovery in HF is understood as an ongoing process in which people can have satisfying and contributing lives without a resolution of symptoms (Anthony, 1993). Services are then delivered in a way that supports this ongoing process.

HF has yielded better housing retention outcomes than traditional approaches, demonstrating that consumers’ preferences can be honored and disproving the assumption that individuals with serious mental illness must first focus on treatment before being able to live in independent community settings (Locke, Khadduri & O’Hara, 2007; Stergiopoulos et al., 2015; Tsemberis, Gulcur, & Nakae, 2004). Once housing is secure, HF providers are said to be more likely than traditional providers to work on treatment related goals that may include finding employment (Henwood, Stanhope, & Padgett, 2011). However, little is known about how housing programs—whether TF or HF—specifically address employment as a service user goal in the context of mental health recovery. Surprisingly, in a randomized controlled trial, HF participants had lower odds of obtaining competitive employment compared with a homeless control group that did not receive housing (Poremski et al., 2016) which further begs the question of how individuals experience employment in these programs.

Existing evidence indicates that individuals with serious mental illness view work as central to their recovery (Dunn, Wewiorski, & Rogers, 2008; Killeen & O’Day, 2004; Krupa, 2004; Provencher, Greg, Mead, & Mueser, 2002). But no studies to date have focused on the experiences of supportive housing recipients’ gaining and maintaining work within specific program models. This study examines the work experiences of individuals with serious mental illness who are enrolled in TF and HF supportive housing and who have been identified as meeting a minimal threshold of progressing towards recovery (as defined in Methods below).

This study is guided by a theoretical framework drawn from the principles of psychiatric rehabilitation that defines recovery as a process, rather than a distinct clinical outcome (Drake & Whitley, 2014). It understands involvement in meaningful activities, such as work,

as a common element and cornerstone of recovery (Anthony, 1993; Davidson et al. 2001; Davidson et al., 2005) and it asks the following research questions:

1. How do individuals living in HF and TF supportive housing experience employment in the context of their mental health recovery?
2. What do they perceive as the benefits of and obstacles to attaining employment?
3. Are there programmatic differences in the employment experiences of HF and TF participants?

Methods

Sampling and Recruitment

Because this study seeks in-depth understanding of a topic about which little is known, we chose to employ qualitative methods, as these methods allow for in-depth investigation featuring study participants' experiences described in their own words (Padgett, 2016). Using a case study design (Patton, 2002), this study draws on secondary analysis of data from a five-year NIMH-funded study which focused on in-depth interviews with formerly homeless persons with serious mental illness living in different permanent supportive housing programs (Padgett, Smith, Henwood & Tiderington, 2012). Of the 40 study participants, 20 were recruited from a program that used a HF approach and 20 were recruited from a program using a TF approach. Purposive sampling was used to recruit people who demonstrated markers of recovery using the following inclusion criteria: DSM-IV Axis I diagnosis of serious mental illness, over 21 years of age, Global Assessment of Functioning (GAF) score above 65, housing stability, absence of current substance use disorder, and one or more signs of recovery such as having a job, being involved in meaningful activities, taking active part in a social group, and/or having a stable partner.

Senior staff from both programs were asked to nominate 20 individuals each – 10 who had roughly two years of program tenure and 10 who had five or more years of tenure – who met the inclusion criteria. To avoid biases in the nomination process, two staff members from each program were asked to independently nominate eligible individuals and only those who were jointly nominated would be asked to participate. Of the 40 individuals jointly nominated, all but nine agreed to participate in the study requiring a second round of joint nominations. Those who refused were from the TF program and reasons for refusal were primarily the lack of time or disinterest in study participation. Study participants were paid a $30 incentive per interview plus a public transportation voucher valued at $4.50. All study protocols were approved by the affiliated human subjects committee.

Data Collection Procedures

The study consisted of minimally structured in-depth interviews collected between 2010–2011. Interviews, which lasted on average 90 minutes, were conducted by members of the research team (the co-authors) all of whom had prior research and/or clinical experience with this population. Interviews focused on elucidating participants' experiences with housing and homelessness, employment, substance use, mental and physical health, service utilization, and social and family relationships. They were recorded, transcribed verbatim,

and entered into Atlas.ti software. Interviewers also completed an interviewer feedback form that documented observations, reactions, and significant details about the interview and the participant.

Data Analysis

Using a case study design (Patton, 2002), case summaries were developed for all participants based on transcripts, interviewer feedback forms, and a demographic questionnaire. The case summaries consisted of information about the participant's demographics, family background, education, work history, social and romantic relationships, program experience, physical and mental health, drug/alcohol use, homeless experience, trauma history, other miscellaneous items of importance, and salient quotes. These data were organized into a matrix display to facilitate cross-case comparisons (Miles, Huberman & Saldana, 2014). For this report, we followed a cross-case study approach (Miles et al., 2014) drawing on the pre-existing matrix displays and interview transcripts with an emphasis on understanding employment experiences including barriers to employment. Members of the research team (the co-authors) independently developed cross-case themes and then met to discuss and reach consensus on emergent themes related to employment.

Finally, meaningful passages illustrating the themes within the transcripts were extracted through the Atlas.ti program and consensually agreed upon. The use of memo-writing to track and further develop emergent ideas was used throughout this process (Patton, 2002).

Results

Characteristics of the Participants

Study participants were primarily male, African American, with an education level of high school or better, and never married (see Table 1).

Table 2 shows differences in the two groups in employment characteristics. For example, while none of the study participants had full-time jobs, a considerably larger proportion of those in the HF program had part-time employment compared to their TF counterparts. Of the 12 employed participants, all but two were working part-time within their respective programs as shown in Table 2. Of the two men with 'outside' part-time employment, one worked for a moving company and the other was a self-employed musician.

A greater proportion of unemployed HF participants were interested in obtaining employment (10/11) compared to TF (7/17). Group differences in past work experience--virtually all of the HF participants (19/20) vs. 70 percent of TF participants (14/20)--may explain some of this discrepancy. The thematic findings that follow provide a deeper contextual understanding of both differences and similarities in study participants' views on and experiences of work.

Thematic Findings

Based on our analyses, three themes emerged: 1) the meaning of work, 2) working within the system, and 3) balancing treatment requirements and work. These themes, along with relevant sub-themes, are described below.

The Meaning of Work.—Participants in both the HF and TF subsamples described similar benefits regarding employment including a stronger sense of self and social integration.

Self-esteem and identity.: Participants who reported current employment noted the positive impact of work on their self-esteem and identity. One contrasted this with the stigma he experienced as a person with a mental illness and other hardships he had endured:

> I guess I have a purpose now…And freedom. I was that guy that society would probably write off…All I've ever heard was stuff like you'd be better off dead, or they should just lock you up for life, and you'll never amount to anything, this guy he's just fucking crazy…it's just a wonderful thing to be able to feel. … life is just so much different now…everything could crumble and it's still okay…it's just good to be human.

For another participant, work provided a sense of accomplishment and contributed to improved self-esteem: "I think it makes me feel like I got it going on. You know, that self-esteem. Like I'm doing this. I want a job that provides me…that opportunity to have it going on and to feel good about me."

A sense of belonging and impact.: Participants emphasized that working allowed them to contribute to society in a meaningful way. They noted that having accountability to the job and to other employees made them feel like what they did mattered. This desire for impact was eloquently expressed by one participant who worked as a messenger at his supportive housing program for 13 years.

> It's not just for the money, but also getting along with others, and most important, to be in a position of responsibility. What I do, it means something. It has an impact, which I believe is a human need…What a person does not only matters to themselves but to other people as well…That I'm a productive member of society and not a disruptive one…That I'm being a constructive member of society, not a destructive one.

Being a responsible person and contributing to society via employment meant being able to participate more fully in a valued social role. This participation in broader society and seeing oneself as "part of the working world" benefited participants, allowing them to feel more integrated, as one person put it, "I think that having a job made me stand up for myself more, get respect from people, or show respect to people…and feel like I'm part of the world, feel like I'm part of the system, having something to do. I gotta do this, this is my job."

For many participants, work was seen as an opportunity to connect with others which could then lead to the achievement of other recovery goals, such as meeting an intimate partner.

> I'm basically very lonely. I'm basically living in solitude. And one of the ideas of working and hoping to work is so that I can date…. and I can start meeting people. That's really the main reason and also when SSDI [disability benefits] runs out I have the money to survive…those are my reasons for going back to work, it's not

> for interest anymore. I've resigned myself that I'll never be able to do what I wanted to do.

Staying active, being productive.: Participants described work as a practical way to stay busy and feel productive which had benefits that went beyond a pay check.

> At first it really wasn't for the money. It's just that with me, I'm the kind of person, I can't stay home all day. I have to be active. I have to do things, even if it means just taking a walk outside, okay? I'm just not one of those people who stays at home and does nothing. I want to have something to do, just an activity.

One individual described the experience of staying busy with work as being helpful to his recovery and mental health.

> I learned how to paint and plaster and do floors, so that will keep me busy. Mostly I [learned] that while I was in prison…I also picked some of it up within the last twenty years, out here in the street…working with different construction people. I learned how to cut tiles, do a little bit of plumbing, house electrician…And that has helped me to maintain a more calm me.

Overall, participants in both groups described employment has having significant benefits in a variety of ways that went far beyond the monetary benefits. As this person stated, "I know the importance of employment. For people like us, it's bigger than paychecks. It's having self-worth, it's empowering yourself, it's being independent. You know, coming home tired from work is a good thing. It's just so much more than a paycheck."

Working Within the System.—Despite the perceived benefits of work, participants in both groups encountered a number of challenges related to the lack of outside opportunities. As noted earlier, the few who were employed worked in their respective supportive housing program in part-time positions.

A safe environment.: Participants made the distinction between working 'inside jobs' (in their own program) and working outside in the competitive job market. They were keenly aware of the advantages and disadvantages of both. One explains why she turned down a peer provider opening at her housing program: "You're still in the system…I'm not saying it's a glorified advocate. It *is* in a lot of ways…but you're still in the system. That doesn't mean you can't learn from it or teach someone. What I like about the peer advocacy is that you know more about benefits. You know more about how to *circumvent* the system, but the thing is you're still *in* the system."

Working within the system provided a safe environment with fewer concerns about negative judgments and stigma. As one man points out,

> Being a person with mental illness… what bothers me is when I leave [the program] and get off disability is…what if I'm working somewhere and someone finds out that I have a mental illness? That scares me because people outside of the mental health community, you know, when they think of mental illness, they think of really dangerous people, like serial killers for example. You know people who

> are evil and dangerous, and out to hurt them. And will I be like I don't know, some kind of a pariah or something?

Further, inside employment was viewed as vehicle for building the confidence needed to move on to outside work and mainstream housing.

> I've been a tenant worker…of any job I've worked at, [this program] has been the longest. And I've made mistakes along the way…as an employee working there, they believed in me. They believed in my abilities, not in my disabilities. And I appreciate that, and it gave me the encouragement to move on. As I said before, I do plan to leave [program], so that's one of the beginnings that I just see myself in.

Hard times.: Perhaps not surprising given the timing of the interviews (collected between 2010–2011), participants perceived the 2007–2009 economic recession as a major barrier to competitive employment. A few who had steady work before the recession attributed their job loss to the economic decline. One participant with previous work experience in graphic design described how assignments started to dry up at this time.

> I'm freelancing. And I'm maintaining and then all of a sudden something happens…I don't know if this is the economy or what, but I wasn't getting any more work. I was like wait, I'm the same person, I'm doing the same thing, making these calls. They're like cold calls, you just call up these agencies but there was no warm response.

At the time of this study, the economic downturn had broadly impacted people throughout the U.S., including individuals with mental health challenges, and one participant took comfort from knowing that she was not alone.

> It's hard to create opportunities these days, being that the times have changed. It's very transitional. The economy's transitional, food, everything. It's very different… it's one of those most challenging moments that people are facing. It's not only because I'm sick that I'm experiencing this. I've found everybody's going through it…My friends tell me like they too are going through it.

Competition for work was perceived to be a broader challenge. However, participants also noted that competition for unskilled work, which was the type of work most participants were considering, was even more daunting in these conditions.

Balancing Treatment and Work.—Notably, participants described a balancing act between entering the world of work and the reality of their daily lives. This was manifested in two important considerations: 1) whether the financial incentives to work outweighed disability entitlements (since the latter could be cut when an individual's income exceeded a certain level) and 2) making time to seek and fully engage in work while meeting the expectations and requirements of treatment, both mandatory and elective. The first theme arose in both groups. However, the latter theme was expressed most prominently in the TF group.

Weighing the benefits.: The decision to seek full-time employment was said to be complicated by the perception that work could lead to a potential loss of entitlements such as

Medicaid coverage and disability income. This in turn could lead to a loss of access to psychotropic medications and other forms of healthcare. As one participant stated, “I used to work but I’m on SSI now…If I worked, they’d have to take away my SSI. I’m thinking about getting a part-time job though…I could get a part-time job.”

Disincentives for seeking work also arose when the additional income was already spoken for. One participant explained “getting back to work full-time is a negative at this point in my life with a child support lien going.” Participants further expressed concern that income gained from unskilled jobs could be equal to or less than that of disability income. For this participant, it did not make logical sense to continue working part-time as the income he gained was no more than what he received via entitlement benefits.

> What’s holding me back is I did not make enough money to take care of myself in a job. What’s the use of getting a part-time job and being half in and half out? If I’m going to be independent, I want to be independent all the way…in reality, a step up from disability idealistically [sic] should be…a job of any sort, even if it pays the same as disability. But what kind of smart person is going to do that? Like “Here, we’re going to give you free money…You want a job that pays the same as the free money we’re giving you?” You know (laughs), it doesn’t really make sense.

The constraints of treatment.: The decision to enter or remain in the workforce was also said to be inhibited by the lack of time to find and keep a job, in some cases due to requirements imposed by the housing program. Unlike the HF participants, those enrolled in TF housing programs described expected, mandatory attendance at day treatment programs for mental health and/or substance use as setting up obstacles to engagement in full-time work.

> I have to go to the day treatment program, so I don’t have time to work. Not unless I was to do a little job doing something like mopping floors or something or handing out flyers. I probably could find time to do that.

Additionally, participants enrolled in TF housing programs perceived engagement in work as a step after engagement in treatment, a reflection of the “step-wise” recovery philosophy inherent in TF programs. As this participant said, “I think they want us to graduate from the day treatment program *first*…and then if you want to work, then you can work. I think that’s the protocol, or whatever you call it.”

This approach was said to hinder engagement in work and as a result, possibly prevent financial gains, further community integration, and independence from housing supports.

> If they would leave me alone and stop making me take all these meds and going to all these groups I would be a bike messenger. I try to come home with at least four hundred a week…and start my own business. But they keep making me go to groups and take meds and all this stuff. I can’t do it.

Health problems and psychiatric medications.: Despite having no mandatory treatment requirements, HF participants shared with their TF counterparts the limitations of health problems and medication side effects causing weight gain, drowsiness and loss of mental

acuity. One HF participant noted that her health was interfering with her ‘inside’ job at the program, but her needs were being accommodated.

> My new assignment, they didn’t change my pay which was great. They cut my hours back by two hours a week but in lieu of the kicking up of my stomach, I have a kind of almost healed ulcer as long as I keep taking my medication. I mean like all these medical things are happening to me…

Another participant expressed concern about the effects of her psychiatric medications as preventing her from doing the volunteer work that she hoped would lead to paid labor.

> …at first, I actually volunteered to prepare food for the homeless, I was making sandwiches. But I thought I could do more, I was so sure ‘cause the medication hit me hard, it’s very difficult, it’s very disabling…It creates its own disability because it changes the neurochemistry…I was able to prepare food for the homeless and when I was feeling like I could help somebody that needs help it became a boost to my ego that I could do something until I worked. And then I didn’t work…so it’s a mixed batch of experiences.

Discussion

This study provides insight into the employment experiences of formerly homeless individuals with serious mental illness living in supportive housing. We note that this purposive sample of individuals was chosen as manifesting modest markers of recovery. Nevertheless, none had competitive, full-time outside employment. With the exception of two HF participants, the remaining participants who worked were part-time employees in their own program and were clear that it was not the same as working on the outside. Such ‘inside employment’ was accommodating to their needs and offered a buffer from stigma, yet participants were ambivalent about a ‘sheltered work’ model. Instead, they gave voice to a work ethic closely aligned with societal values regarding the virtues of self-reliance and work-related benefits that transcended financial gain.

Barriers to competitive employment include individual, organizational and structural factors. For individuals, chronic medical conditions, medication side effects and loss of motivation conspired against seeking and maintaining employment. Structural factors included ongoing changes in the national economy that drastically reduced the number of entry-level jobs as well as stigma-related exclusion. Confronted with the prospect of low-paid labor (at best) and the potential for workplace stigma and discrimination, participants often made rational decisions to forego actively seeking employment for fear of losing their medical and disability benefits. Organizational factors inhibiting employment were largely confined to the TF program’s philosophy mandating day program attendance as part of a gradual process toward achieving ‘job readiness’. These multilevel barriers to employment among this population corroborates earlier research (Bond 1991; Bond 2008; Cook 2006; Rosenheck et al., 2006).

This study suggests that despite ongoing evolutions in health and mental health care, individual-level, organizational and structural factors continue to impede employment for this population. To reduce such barriers, supportive housing programs should consider more

flexible treatment regimens that can accommodate job-seeking as well as ongoing employment. Additionally, programs can assist clients in money and time management so that they can work without losing their entitlement benefits.

The growing success of supported employment (SE) models, including the evidence-based practice of Individual Placement & Support (IPS), holds promise for this population but SE has been limited in availability (Hoffmann, Jäckel, Glauser, Mueser, & Kupper, 2014; Johnson-Kwochka, Bond, Becker, Drake, & Greene, 2017; Noel et al., 2017; Sherman, Lynch, Teich, & Hudock, 2014), especially among the formerly homeless. SE programs offer ‘place, then train’ positions in the competitive job market along with job coaching to assist the new employee. Because this ‘job first’ philosophy of SE is more closely aligned to the recovery orientation of HF, the incorporation of SE in HF programs should be encouraged. TF programs could also support SE as long as treatment and other program rules are modified accordingly.

This study raises important questions regarding how infrequently supportive housing programs address outside employment as a service user goal in the context of mental health recovery. As found in this study, virtually all of the employed study participants were working within their respective programs. To the extent that SE becomes more widely available (Noel et al. 2017), future research could better explore its comparative effectiveness in differing supportive housing models.

Study Limitations

Limitations of this study include the use of single interviews per person (multiple interviews offer greater depth) (Padgett, 2016). Given the study’s inclusion/exclusion criteria, we note that the sample is not intended to represent all formerly homeless adults with serious mental illness living in supportive housing. We also note that the HF group had more members with previous work histories and this may have influenced subsequent group comparisons. Further, the interviewers for this study were involved in all phases of the study, including research design and data analysis, which has the potential to introduce bias into the process. However, we closely documented all analysis procedures and ensured validation of analytic decisions through independent review and consensus. Finally, we note that data were collected shortly after a nation-wide recession began in 2008. It is possible that some of the difficulties in gaining employment were exacerbated by this economic downturn.

Conclusions

Full integration of individuals with mental illness into competitive employment is an elusive goal and widespread implementation of SE offers a promising approach that can be adapted for use in supported housing programs. (Bond et al., 2015; Drake, Becker, & Bond, 2019; Mueser, Drake & Bond, 2016). This study has shown that the lingering effects of cumulative adversity (mental illness, homelessness, poor health)—in combination with organizational and structural barriers such as treatment requirements—present obstacles that can hobble the most motivated individuals. Overcoming such barriers through ‘inside’ employment as well as concerted efforts to link consumers to ‘outside’ employment means addressing systemic problems such as the lack of jobs, the disincentives of current benefit programs, and wider

societal stigma and discrimination. Study participants were aware of these problems, able to weigh the advantages and disadvantages of working, and still yearn for meaningful ways to make a living on their own.

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References

Acuna J, & Erlenbusch B (2009). Homeless employment report: Findings and recommendations. Washington: National coalition for the homeless.

Anthony WA (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial rehabilitation journal, 16(4), 11.

Aubry T, Klodawsky F, & Coulombe D (2011). Comparing the housing trajectories of different classes within a diverse homeless population. American Journal of Community Psychology, 49, 142–55.

Bond GR, McDonel EC (1991). Vocational rehabilitation outcomes for persons with psychiatric disabilities: An update. Journal of Vocational Rehabilitation,1(3):9–20.

Bond GR (2004). Supported employment: Evidence for an evidence-based practice. Psychiatric Rehabilitation Journal, 27, 345–359. [PubMed: 15222147]

Bond G, Becker D, Drake R, et al. (2001). Implementing supported employment as an evidence-based practice. Psychiatric Services, 52, 313–322. [PubMed: 11239097]

Bond G, Kim S, Becker D, Swanson S, Drake R, Krzos I, Fraser VV, O'Neill S, & Frounfelker R (2015). A controlled trial of Supported Employment for people with severe mental illness and justice involvement. Psychiatric Services, 66(10), 1027–1034. 10.1176/appi.ps.201400510 [PubMed: 26030319]

Bond GR, & Drake RE (2008). Predictors of competitive employment among patients with schizophrenia. Current Opinion in Psychiatry, 21(4), 362–369. [PubMed: 18520741]

Brohan E, Henderson C, Wheat K, Malcolm E, Clement S, Barley EA, Slade M, & Thornicroft G (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. BMC psychiatry, 12(1), 11. [PubMed: 22339944]

Brohan E, & Thornicroft G (2010). Stigma and discrimination of mental health problems: Workplace implications. Occupational Medicine, 60(6), 414–415. 10.1093/occmed/kqq048 [PubMed: 20719967]

Bush PW, Drake RE, Xie H, McHugo GJ, & Haslett WR (2009). The long-term impact of employment on mental health service use and costs for persons with severe mental illness. Psychiatric Services, 60(8), 1024–1031. [PubMed: 19648188]

Cook JA (2002). The promise of vocational rehabilitation: Results of the SAMHSA Employment Intervention Demonstration Program [Electronic Version] from www.psych.uic.edu/eidp.

Cook JA (2006). Employment barriers for persons with psychiatric disabilities. Update for a report for the President's commission, 57(1), 1391–1405.

Davidson L, O'Connell MJ, Tondora J, Lawless M, & Evans AC (2005). Recovery in serious mental illness: A new wine or just a new bottle?. Professional psychology: research and practice, 36(5), 480.

Davidson L, Stayner DA, Nickou C, Styron TH, Rowe M, & Chinman MJ (2001). "Simply to be let in": Inclusion as a basis for recovery. Psychiatric Rehabilitation Journal, 24(4), 375–388. [PubMed: 11406988]

Drake R, Becker D, & Bond G (2019). Introducing Individual Placement and Support (IPS) supported employment in Japan. Psychiatry and Clinical Neurosciences, 73(2), 47–49. 10.1111/pcn.12792 [PubMed: 30370626]

Drake RE, & Whitley R (2014). Recovery and severe mental illness: description and analysis. The Canadian Journal of Psychiatry, 59(5), 236–242. [PubMed: 25007276]

Dunn E, Wewiorski N, & Rogers E (2008). The meaning and importance of employment to people in recovery from serious mental illness: results of a qualitative study. Psychiatric Rehabilitation Journal, 32(1), 59–62. [PubMed: 18614451]

Eklund M (2009). Work status, daily activities and quality of life among people with severe mental illness. Quality of Life Research, 18(2),163–70. [PubMed: 19125354]

Hawkins RL & Abrams C (2007). Disappearing acts: social networks of homeless individuals with co-occurring disorders. Social Science & Medicine, 65, 2031–2042. [PubMed: 17706330]

Henry AD, & Lucca AM (2004). Facilitators and barriers to employment: The perspectives of people with psychiatric disabilities and employment service providers. Work, 22(3), 169–182. [PubMed: 15156083]

Henwood BF, Stanhope V, & Padgett DK (2011). The role of housing: A comparison of front-line provider views in housing first and traditional programs. Administration and Policy in Mental Health and Mental Health Services Research, 38(2), 77–85. [PubMed: 20521164]

Hoffmann H, Jäckel D, Glauser S, Mueser K, & Kupper Z (2014). Long-Term Effectiveness of Supported Employment: 5-Year Follow-Up of a Randomized Controlled Trial. American Journal of Psychiatry, 171(11), 1183–1190. 10.1176/appi.ajp.2014.13070857 [PubMed: 25124692]

Johnson-Kwochka A, Bond G, Becker D, Drake R, & Greene M (2017). Prevalence and quality of Individual Placement and Support (IPS) Supported Employment in the United States. Administration and Policy in Mental Health and Mental Health Services Research, 44(3), 311–319. 10.1007/s10488-016-0787-5 [PubMed: 28062932]

Killeen MB, & O'Day BL (2004). Challenging expectations: How individuals with psychiatric disabilities find and keep work. Psychiatric Rehabilitation Journal, 28(2), 157–163. [PubMed: 15605752]

Krupa T (2004). Employment, recovery, and schizophrenia: Integrating health and disorder at work. Psychiatric Rehabilitation Journal, 28(1), 8–15. [PubMed: 15468631]

Locke G, Khadduri J & O'Hara A (2007). Housing models In Dennis D, Locke G, Khadduri J(Eds.). National symposium on homelessness research. Retrieved from http://aspe.hhs.gov/hsp/homelessness/symposium07/locke/index.htm.

Leufstadius C, Eklund M, & Erlandsson LK (2009). Meaningfulness in work - experiences among employed individuals with persistent mental illness. Work, 34, 21–32. [PubMed: 19923673]

Mechanic D, Bilder S, & McAlpine DD (2002). Employing persons with serious mental illness. Health Affairs, 21(5), 242–253.

Miles MB, Huberman AM, & Saldana J (2014). Qualitative data analysis: A methods sourcebook (3rd ed.). Thousand Oaks, CA: Sage.

Mueser KT, Drake RE, & Bond GR (2016). Recent advances in supported employment for people with serious mental illness. Current Opinion in Psychiatry, 29(3), 196–201. [PubMed: 27027464]

New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final Report, Rockville MD US Department of Health and Human Services DHHS Publication SMA 03–3832.

Noel V, Bond G, Drake R, Becker D, McHugo G, Swanson S, Luciano A, Greene M (2017). Barriers and Facilitators to Sustainment of an Evidence-Based Supported Employment Program. Administration and Policy in Mental Health and Mental Health Services Research, 44(3), 331–338. 10.1007/s10488-016-0778-6 [PubMed: 27891567]

Padgett DK (2016). Qualitative methods in social work research (3rd ed.). Thousand Oaks, CA: Sage.

Padgett DK, Gulcur L, & Tsemberis S (2006). Housing first services for the psychiatrically disabled homeless with co-occurring substance abuse. Research on Social Work Practice, 16, 74–83.

Padgett DK, Smith BT, Henwood BF, & Tiderington E (2012). Life course adversity in the lives of formerly homeless persons with serious mental illness: context and meaning. American Journal of Orthopsychiatry, 82(3), 421. [PubMed: 22880980]

Patton MQ (2002). Qualitative research and evaluation methods (3rd ed.). Thousand Oaks, CA: Sage.

Peternelj-Taylor C (2008). Criminalization of the mentally ill. Journal of Forensic Nursing, 4, 185–7. [PubMed: 19418776]

Pickett-Schenk SA, Cook JA, Grey D, et al. (2002). Employment histories of homeless persons with mental illness. Community Mental Health Journal, 38, 199–211. [PubMed: 12046674]

Poremski D, Stergiopoulos V, Braithwaite E, Distasio J, Nisenbaum R, & Latimer E (2016). Effects of Housing First on employment and income of homeless individuals: Results of a randomized trial. Psychiatric Services, 67(6), 603–609. [PubMed: 26876657]

Poremski D, Whitley R, & Latimer E (2014). Barriers to obtaining employment for people with severe mental illness experiencing homelessness. Journal of Mental Health, 23(4), 181–185. [PubMed: 24784467]

Provencher HL, Gregg R, Mead S, & Mueser KT (2002). The role of work in the recovery of persons with psychiatric disabilities. Psychiatric Rehabilitation Journal, 26(2), 132–144. [PubMed: 12433216]

Radey M, & Wilkins B (2010). Short-term employment services for homeless individuals: Perceptions from stakeholders in a community partnership. Journal of Social Service Research, 37(1), 19–33.

Rosenheck R, Leslie D, Keefe R, McEvoy J, Swartz M, Perkins D, … & CATIE Study Investigators Group. (2006). Barriers to employment for people with schizophrenia. American Journal of Psychiatry, 163(3), 411–417. [PubMed: 16513861]

Saavedra J, López M, Gonzáles S, & Cubero R (2016). Does employment promote recovery? Meanings from work experience in people diagnosed with serious mental illness. Culture, Medicine, and Psychiatry, 40(3), 507–532.

Sherman LJ, Lynch SE, Teich J and Hudock WJ Availability of supported employment in specialty mental health treatment facilities and facility characteristics: 2014 The CBHSQ Report: 6 15, 2017 Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD https://www.samhsa.gov/data/sites/default/files/report_3071/ShortReport-3071.html

Stergiopoulos V, Gozdzik A, Misir V, Skosireva A, Connelly J, Sarang A, … & McKenzie K (2015). Effectiveness of housing first with intensive case management in an ethnically diverse sample of homeless adults with mental illness: A randomized controlled trial. PLoS One, 10(7), e0130281. [PubMed: 26176621]

Tschopp MK, Perkins DV, Hart-Katuin C, Born DL, & Holt SL (2007). Employment barriers and strategies for individuals with psychiatric disabilities and criminal histories. Journal of Vocational Rehabilitation, 26(3), 175–187.

Tsemberis S, Gulcur L, & Nakae M (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health, 94(4), 651–656. [PubMed: 15054020]

Venkatesh S (2006). Off the Books: The Underground Economy of the Urban Poor, Harvard Business Press, Cambridge, MA.

Waghorn G, & Lloyd C (2005). The employment of people with mental illness. Australian e-journal for the Advancement of Mental Health, 4(2), 129–171.

Waghorn G, Saha S, Harvey C, Morgan VA, Waterreus A, Bush R, et al. (2012). ‘Earning and learning’ in those with psychotic disorders: the second Australian national survey of psychosis. Australia New Zealand Journal of Psychiatry, 46, 774–85.

Walsh FP & Tickle AC (2013). Working towards recovery: The role of employment in recovery from serious mental health problems: a qualitative meta-synthesis. International Journal of Psychosocial Rehabilitation, 17(2) 35–49.

Ware NC, Hopper K, Tugenberg T, Dickey B, & Fisher D (2008). A theory of social integration as quality of life. Psychiatric Services, 59(1), 1–7.

Zuvekas SH, & Hill SC (2000). Income and employment among homeless people: the role of mental health, health and substance abuse. The Journal of Mental Health Policy and Economics, 3(3), 153–163. [PubMed: 11967451]

Impact and Implications

People experiencing homelessness and mental illness have high rates of unemployment. This study investigates how individuals receiving supportive housing via different service models - Housing First (HF) and treatment first (TF) –experience employment. Participants describe similar work-related benefits and challenges in HF and TF. However, challenges in balancing work and treatment were most prominent in the TF group. To reduce unemployment, factors at each of these levels will need to be considered.

Table 1.

Demographic Characteristics of the Sample

	HF	TF	Total
Mean Age	48.15	52.1	50
Sex	20	20	40
Male	14 (70%)	18 (90%)	32 (80.0%)
Female	6 (30%)	2 (10%)	8 (20.0%)
Race/Ethnicity	20	20	40
African-American	11 (55%)	13 (65%)	24 (60.0%)
American-Indian/Native-American	0 (0%)	2 (10%)	2 (5.0%)
Asian-American	1 (5%)	0 (0%)	1 (2.5%)
Caucasian	2 (10%)	2 (10%)	4 (10.0%)
Hispanic-American	3 (15%)	3 (15%)	6 (15.0%)
Mixed Race	3 (15%)	0 (0%)	3 (7.5%)
Education	20	20	40
Grade School	1 (5%)	4 (20%)	5 (12.5%)
High School/GED	6 (30%)	11 (55%)	17 (42.5%)
College/Some College	10 (50%)	4 (20%)	14 (35%)
Post-Graduate	3 (15%)	1 (5%)	4 (10.0%)
Marital Status	20	20	40
Married	0 (0%)	0 (0%)	0 (0.0%)
Divorced	5 (25%)	3 (15%)	8 (20.0%)
Separated	3 (15%)	1 (5%)	4 (10.0%)
Never Married	11 (55%)	15 (75%)	26 (65.0%)
Widowed	1 (5%)	1 (5%)	2 (5.0%)
Primary Mental Health Diagnosis	20	20	40
Schizophrenia	5 (25%)	8 (40%)	13 (32.5%)
Schizoaffective	1 (5%)	1 (5%)	2 (5.0%)
Bipolar Disorder	6 (30%)	1 (5%)	7 (17.5%)
Major Depressive Disorder	3 (15%)	4 (20%)	7 (17.5%)
Not reported	5 (25%)	6 (30%)	11 (27.5%)

Table 2.

Employment among HF and TF participants

	HF	TF	Total
Employment	20	20	40
Unemployed	11 (55%)	15 (75%)	26 (65.0%)
Part-Time Employment	9 (45%)	3 (15%)	12 (30.0%)
Full-time Employment	0 (0%)	0 (0.0%)	0 (0.0%)
Not Reported	0 (0%)	2 (10%)	2 (5.0%)
Type of Position	9	3	12
Clerical/Receptionist *	2 (22.2%)	0 (0%)	2 (16.7%)
Maintenance Worker *	1 (11.1%)	1 (33.3%)	2 (16.7%)
Messenger *	1 (11.1%)	2 (66.7%)	3 (25.0%)
Mover	1 (11.1%)	0 (0%)	1 (8.3%)
Peer Provider *	3 (33.3%)	0 (0%)	3 (25.0%)
Professional Musician	1 (11.1%)	0 (0%)	1 (8.3%)
Past Paid Work Experience	20	20	40
Yes	19 (95%)	14 (70%)	33 (82.5%)
No	1 (5%)	4 (20%)	5 (12.5%)
Not Reported	0 (0%)	2 (10%)	2 (5.0%)
Interest in Obtaining Employment **	11	17	28
Yes	10 (91%)	7 (41%)	17 (60.7%)
No	1 (9%)	6 (35%)	7 (25.0%)
Not Reported	0 (0%)	4 (24%)	4 (14.3%)

* These positions are within the housing program.

** Based on responses of participants who were unemployed at the time of the interview.