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## Navigating Risk Environments in Permanent Supportive Housing for Formerly Homeless Adults

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### Abstract

In this study we used ethnographic methods and a risk environment framework to consider how contextual factors produce or reduce risk for substance use with a sample of 27 adults who recently moved into PSH. Most apparent was how the social and physical environments interacted, since most participants focused on how having an apartment had dramatically changed their lives and how they interact with others. Specific themes that emerged that also involved economic and policy environments included: Isolation versus social engagement; Becoming one's own caseworker; and Engaging in identity work. This study underscores the scarcity yet importance of research that examines the multiple types of environment in which PSH is situated, and suggests that a better understanding of how these environments interact to produce or reduce risk is needed to develop optimal interventions and support services.

### Keywords

Housing First; homelessness; neighborhood environment; qualitative research; ethnography

Risk environment has been defined as the space—whether social or physical—in which factors external to an individual interact to increase the chances of certain health risk behaviors such as HIV transmission (Latkin, German, Vlahov, & Galea, 2013; Rhodes & Simic, 2005; Rhodes et al., 1999; Strathdee et al., 2010). Homelessness creates a particularly high-risk environment, with HIV prevalence rates as high as 10%, compared to a U.S. population prevalence of less than 0.5% (Hall et al., 2015), and with alcohol and drug dependence being the most common behavioral disorders (Caton et al., 2013; Robertson et al., 2004).

Permanent supportive housing (PSH), which provides immediate access to an independent apartment along with community-based support services, is an evidence-based approach to ending homelessness (Substance Abuse and Mental Health Services Administration, 2007). PSH is associated with numerous positive outcomes, including superior quality of life, more days of stable housing, fewer criminal convictions, and fewer visits to emergency rooms (Byrne, Fargo, Montgomery, Munley, & Culhane, 2014; Rog et al., 2014; Smelson et al.,

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2016). Despite research that described PSH as a platform for recovery (Henwood, Stanhope, & Padgett, 2011; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Padgett, 2007), randomized controlled trials have shown that substance use outcomes do not necessarily improve (Padgett, Gulcur, & Tsemberis, 2006; Somers, Moniruzzaman, & Palepu, 2015), suggesting that a high-risk environment may persist even after the transition from homelessness to PSH.

Although the risk environment created by homelessness has been well studied, environmental factors associated with increased or reduced risk in PSH are less understood. PSH is disproportionately located in communities with concentrated disadvantages (Henwood, Cabassa, Craig, & Padgett, 2013; Yanos, 2007), which has been shown to impede engagement in positive health behaviors (Sampson, Raudenbush, & Earls, 1997; Sundquist et al., 2006). For example, limited access to affordable healthy food and fewer areas for recreation or safe physical activity have been shown to contribute to health disparities and increased chronic disease burden in underserved communities (Laraia et al., 2012; Stimpson, Ju, Raji, & Eschbach, 2007). Even when resources are available, concerns about crime can impede physical activity (Day & Cardinal, 2007) and social norms may reinforce inactivity, smoking rates, substance use, and poor diet (Dannenberg et al., 2008; Diez-Roux, 2000), all of which may be familiar habits from time spent homeless. There has been limited investigation, however, as to whether or how these environmental factors influence adults living in PSH.

Research on PSH suggests that healthy integration into the community is possible even in neighborhoods in which high-risk behaviors occur (Ecker & Aubry, 2016). For example, Smith, Padgett, Choy-Brown, and Henwood (2015) found that some PSH tenants transformed high-risk places that were once associated with substance abuse and homelessness into low-risk locations. That is, a park that was once a site for heroin use and panhandling became a peaceful and relaxing place to visit during the day before returning home. Alternatively, PSH tenants might create a barrier from the negative influences they encounter in the neighborhood through either increased mobility beyond the immediate neighborhood (Townley, Kloos, & Wright, 2009) or by spending the majority of their time in the safety of home (Brodsky, 1996; Ecker & Aubry, 2016). The latter also raises concerns that home can become an oppressive place that increases social isolation and risk, rather than being a place of refuge (Hopper, 2012).

In the current study, we used ethnographic methods (Kusenbach, 2003) and a risk environment framework to consider how contextual factors produce or reduce risk for substance use with a sample of 27 adults who recently moved into PSH. This study drew on a larger study that examined changes in HIV risk as people transition from homelessness to PSH [blinded for review], but focused on qualitative inquiry, an approach increasingly used to understand the lived experiences of formerly homeless adults who receive PSH (Goering et al., 2014; Padgett & Henwood, 2012; Smith et al., 2015; Townley et al., 2009). A risk environment framework guided the delineation and consideration of environment typologies (i.e., physical, social, economic, and policy) and whether environmental factors that influenced risk were at a micro- or macro-level (Rhodes, 2002). Specific research questions that this study aimed to address include:

1. How do different types of environments (i.e., physical, social, economic, and policy) interact to produce or reduce substance use risk for newly housed PSH tenants?
2. To what extent are PSH tenants able to change or negotiate micro- or macro-level factors that influence risk?

## Methods

### Overview

These data were collected as part of a larger longitudinal study examining changes in HIV risk behavior over time among 421 homeless adults who moved into PSH in Los Angeles between August 2014 and January 2016 (Wenzel et al., 2017). Participants were eligible for the longitudinal study if they had been approved for PSH, were 39 years old or older (turning 40 during the year of participation in the study), spoke English or Spanish, and were considered an unaccompanied homeless adult (without minor children); the age and non-parenting requirements were implemented to maximize our ability to detect changes in HIV risk outcomes by minimizing variability due to developmental life stage or current parenting status. Prior to their participation, homeless adults completed the signed informed consent process in English or Spanish. Participants were initially interviewed prior to or within 5 days of moving into PSH and then again at 3, 6, and 12 months after move-in. For the purposes of this study, we focused on a subsample of 27 participants who agreed to be shadowed by a research team member who used a “go along” approach to ethnographic methods (Kusenbach, 2003) to better understand contextual and environmental factors that influence health risk behaviors. All study procedures were approved by the affiliated university’s institutional review board. Additionally, the study received a certificate of confidentiality from the U.S. Department of Health and Human Services to protect participant data from subpoena.

### Sampling

Participants in the ethnographic shadowing subsample were purposively sampled to represent both men and women with maximum variation (Patton, 2002) in health risk behaviors observed between baseline and 3-month follow-up interviews. This was accomplished by recruiting participants from five risk profile categories that emerged as part of a cluster analysis of the larger sample using the following risk variables: injection drug use, hard drug use (including prescription drug misuse), binge drinking, unprotected sex, exchange sex, and having multiple sex partners. The risk profiles that emerged from cluster analyses were: high-risk drug users who engaged in high-risk sex ( $n = 5$ ); binge drinkers whose sex risk increased after housing ( $n = 6$ ); those with moderate to low substance use but high-risk sex behaviors ( $n = 3$ ); those with low substance use but whose sex risk increased after housing ( $n = 3$ ); and those who did not use substances or engage in risky sex behaviors ( $n = 10$ ).

## Data Collection

Participants who agreed to ethnographic shadowing (Kusenbach, 2003) provided written informed consent to have a research team member spend up to 6 hours observing their typical day. Twenty-three participants were shadowed between 6 and 12 months after being housed while 4 participants were shadowed between 3 and 6 months after move in. Interviewers were two doctoral students and one master's student trained in ethnographic data collection methods by a study coinvestigator who has expertise in qualitative methods, including experience in ethnographic shadowing. Data collection involved taking written field notes on small paper or electronic notepads based on methods outlined by Sunstein and Chiseri-Strater (1997) to capture observations and conversations throughout the day; visual or audio recordings were not used, but notes on the perspectives of study participants were recorded in field notes. Interviewers were matched to the gender of the participant. Participants were asked to conduct their day as usual, which often involved spending time in their apartment, running errands, or attending to health or social services appointments. Examples of other places or venues that interviewers visited with participants included Alcohol Anonymous meetings, traffic court, YMCA swimming pool, HIV testing clinics, doctor visits, and grocery stores. Interviewers spent close to 90 hours in the field, which averaged between 3 and 3.5 hours per participant. Participants received \$40 as compensation for their involvement.

## Data Analysis

Immediately after shadowing, interviewers transformed field notes into a narrative summary that included a detailed map of locations visited throughout the day generated using Google Maps. Interviewers shared these summaries and debriefed with the research team during weekly team meetings. Synthesized field notes from individual case summaries along with demographic data collected as part of the larger study were then entered into a case summary matrix to facilitate thematic analyses (Miles, Huberman, & Saldana, 2014; Patton, 2002). The first three authors reviewed the matrix and independently developed themes before comparing themes and coming to a final consensus. Points of convergence that served as major analytic axes for developing the themes included apartment location (downtown Skid Row area versus outside of downtown), gender, and active substance use. To both ground our thematic analysis and triangulate the ethnographic findings with participants' perceptions of their housing environment, we also examined individual responses to a validated measure of housing environment (Kloos & Shah, 2009) that participants completed as part of the larger study. Finally, we situated our emergent themes within a risk environment framework in order to better understand how different types of environments (i.e., physical, social, economic, and policy) interacted to produce or reduce substance use risk as well as whether PSH tenants were able to change or negotiate micro- or macro- level factors that influence risk. All coding and descriptive statistics for quantitative data from this study were conducted using SAS version 9.4.

## Results

### Characteristics of the Sample

As shown in Table 1, our sample was 55 years of age on average. Fifty-nine percent of the sample were men and 59% identified as Black. The majority (85.2%) identified as heterosexual. Due to the prevalence of veterans entering PSH during recruitment for the parent study, a substantial proportion of the ethnographic sample (40.7%) had served in the U.S. military. Following their entry into housing, 48% of the ethnographic shadowing participants reported using illicit substances and 40.7% reported binge drinking. Most participants reported having been diagnosed with a chronic mental health condition, the most common being major depression (59.3%), followed by posttraumatic stress disorder (33.3%).

### Perceptions of Housing Environment

Many participants lived in single-site PSH ( $n = 18$ ; 67%) and almost half ( $n = 13$ ; 48%) lived in the downtown area of Los Angeles, either in or near Skid Row, which is known for its large homeless population. As shown in Table 2, most participants either agreed or strongly agreed that it is easy to get transportation, find things that they need (food, clothes, etc.), and find a police officer when needed in their neighborhood. Only three people stated it was difficult getting health care in their neighborhood. The majority of people (58%) did not feel that crime was a problem in their neighborhood, but did feel that their family and friends lived too far away.

### Interaction between different types of environments

Nearly all participants commented on an awareness of high rates of substance use in their neighborhood, as was the case when they were homeless. The difference, however, was that now participants had a private space from where they could make decisions about whether and how to engage others in these community environments. In fact, a major theme that emerged from the analysis was that many participants chose between isolation and social engagement as approaches to reduce risk. Another main theme that emerged, which involves the interaction between social, physical, and policy environments, is that participants felt that they needed to become their own case manager. Finally, we note that the economic environment also interacted with the social, physical, and policy environments to influence participants' identities and risk. These themes that include consideration of how different types of environments interact are discussed below.

**Isolation and social engagement.**—Ten of the 27 participants noted that staying at home in isolation helps reduce risk of using drugs. For example, during the 3 hours we spent with one study participant (SP) in his apartment, he discussed spending most of his day home alone because he did not trust his ability to remain drug free if he engaged socially with others. This strategy of avoidance also seemed important psychologically as was evident when the SP became distracted and changed the channel on his television when a scene depicted characters injecting heroin. Such isolation can result in loneliness, however, which can ultimately increase the chance of relapse that occurred some months later with the SP. Another SP, who spoke only English and whose housing placement was in a

neighborhood of predominantly monolingual Spanish speakers, also described keeping to himself and feeling lonely, which he felt contributed to his limited substance use. This SP expressed that part of his motivation, however, was that limited substance use would allow him to see his estranged wife and kids soon. Still, spending time alone did not necessarily entail that participants were lonely. One SP, who described spending most of her time alone in her apartment and distanced from family, was one of the few participants in the larger study who found companionship through pets, having both a dog and kittens.

The majority of participants, however, felt that their ability to navigate widespread drug use in their neighborhood environment was dependent on engaging with others in public, even if it also introduced potential risk. One SP, a 47-year-old African American woman, engaged with neighbors throughout the 4 hours of shadowing. She volunteered at a local foodbank and was willing to lend her food stamps card to those in greater need, which also highlights the interaction between the social and economic environment. Nevertheless, multiple romantic relationships with men were reported to be the source of her ongoing sex risk and substance use. Another SP, who stated that “life is about moving forward” and that his family interactions were in the past, also stood out as socially engaged, stopping to greet at least five people on his block before leaving to lead an Alcoholics Anonymous meeting. This SP also volunteered to drive friends to places, because he was one of the few people in his building who owned a car, which he cofinanced with a woman who lived nearby. This again underscores the interaction between participants’ social and economic environments. During a visit to the County court house to protest a parking ticket that he said he was unable to pay, this SP continued to engage people in conversation and maneuver his way in front of a judge in front of others who had arrived at the courthouse before him.

Social engagement for many, however, did not extend into the private space of their apartment, in part because of the policy environment surrounding PSH. Several participants noted that on-site staff members contributed to their decision to avoid having people visit by enforcing program rules that restricted the number of people (e.g., limit of three visitors at a time) or the amount of time that visitors could stay (e.g., overnight guests cannot stay more than 3 consecutive nights). Another part of the explanation for this decision was also a concern that social network members invited into the apartment, especially those who use substances, would not respect the participant’s boundaries or that the participant did not know how to establish boundaries. Although some participants expressed wanting more freedom to have visitors come and go (i.e., a change in policy environment), women in particular seemed to regard being alone in their apartment as protective from the kinds of past traumas that they had experienced, including sex work, physical abuse, or being stalked by someone they knew. For most participants, therefore, reducing risk entailed an interaction between social, physical, and policy environments so that social engagement occurred in public rather than private spaces.

**Becoming one’s own caseworker.**—As part of the larger policy environment, each participant had an assigned case manager as part of PSH, yet only two participants expressed that they felt supported by their caseworker. This again speaks to the interaction between the social and policy environment. One SP, a 60-year-old African American man, shared that he had multiple chronic medical conditions (heart failure, high blood pressure, obesity, and



mobility issues) and a long history of substance abuse. After several months of not being able to access the medical care he needed, he expressed his frustration with limited provider support and that he had to “become my own caseworker.” Another SP, a 49-year-old African American woman who lived within a few blocks of her six adult children, had regular appointments with a primary care physician, psychiatrist, and psychologist, but described feeling that once she had an apartment, her caseworkers “don’t do shit.” She stated that she had not received any training in “how to live on her own,” which she thought was important because both her and her neighbors, some of whom were also formerly homeless, needed support related to living independently.

For some, the intensity of feeling toward their caseworkers was striking, such as with a 70-year-old Caucasian man who used alcohol and marijuana daily with no major reported health issues impeding his daily activities. John felt that his caseworkers “would not help a dying child unless it would help them sustain the homelessness industrial complex.” This SP discussed avoiding the caseworkers, saying he felt that they make more trouble for him, rather than help. While it is unclear if this ultimately increased or decreased substance use risk, it represents a missed opportunity for policy and social environments to interact in a way that would clearly be more supportive and protective. A 52-year-old African American man, similarly expressed that “you can’t get support unless you are suicidal.” As a result, participants discussed spending much of their time focused on the many appointments and tasks they needed to accomplish. In fact, a significant portion of the time spent shadowing participants involved trips to get medical records, make doctors’ appointments, pay cell phone bills, apply for public benefits, or enroll in school or job training programs.

Lack of support was also expressed through participants’ mistrust of providers and a sense that they were under surveillance by caseworkers. A 49-year-old African American woman living in a scatter-site unit, shared that her caseworker, as her payee, had withheld \$100 and that she was concerned because she had heard from others that this caseworker had stolen from them. This SP also referenced a power differential when explaining that her caseworker refused to take off her shoes when entering the SP’s home as she had asked, which again represents an interaction between the social, physical, and policy environment associated with PSH. One SP mentioned that he does not invite guests over to his home because caseworkers are watching and have “all these little limitations” (i.e., rules regarding guests) that make him feel like he is living in “hell.” Some participants’ resentment toward providers grew out of a perception that many of the caseworkers who had previously experienced homelessness themselves now thought they were “better” than the participants and looked down on them.

**Engaging in identity work.**—The interactions between social, physical, and policy environments that participants experienced in PSH also impacted their identity. For some—typically men—maintaining continuity between their former identity when homeless and their present sense of self was not difficult and also driven by the economic environment. Two African American men aged 55 and 61, respectively, who lived on Skid Row, explicitly identified and interacted with individuals who were currently homeless and even after they had moved into housing, continued to engage in behaviors and exchanges common to when they were living on the streets. For example, one of them who used marijuana and crack

cocaine throughout the shadowing, explained that he continued to be active in the drug trade on Skid Row because he had worked hard to establish himself and his territory. Likewise, the other SP continued his “street hustle” of selling loose cigarettes. During the shadow, he was told by another person who sells loose cigarettes that his corner was “hot” (i.e., the police were there) and to avoid the area. Both of these men conveyed a consistency in how they regarded themselves in the social milieu of their building and neighborhood, including maintaining long-lasting relationships that spanned multiple instances of housing, homelessness, and incarceration.

For other participants, the interaction of the economic environment was more subtle. Several participants described their newfound role as a helper. One SP, who had lived on Skid Row for 7 years and was now living several miles away, took the bus to Skid Row on a weekly basis to help women she met on the streets who were still struggling to exit homelessness. During our shadowing, she offered many people she engaged with advice on initial steps to getting into housing. A 48-year-old Caucasian woman who lives in PSH on Skid Row, was enrolled in a certificate program to become a drug and alcohol counselor. This SP described being motivated to enroll in this program because she struggles with addiction and wants to help others who are also struggling. This SP avoided being out on the streets in general, but while running errands during the shadowing, she encountered several women with whom she had attended a drug rehabilitation program, and she checked in with them to make sure they were still “staying on track.”

The interaction between physical, social, and to some degree economic, environments also resulted in some participants distancing themselves from others who had experienced homelessness. A 52-year-old Caucasian woman, described reaching out to women who were experiencing homelessness because she could empathize, but also saw herself as apart from them and described them as “feral.” One SP, who experienced less than 1 year of literal homelessness, said that he does not feel he belongs in his building because other residents still “act like they are outside.” Similarly, a 46-year-old African American woman who spent 2 years literally homeless and had a history of substance use, said that she does not “fit in” with her neighbors because they are formerly homeless and use drugs. Another participant who had lived in her vintage classic car while homeless and spent most of her life without many monetary concerns until she was diagnosed with cancer and had to pay extensive medical bills, had moved into a building where she, too, felt that she did not fit in. This was clear not only from what she reported but also from what was observed during our ethnographic shadowing—i.e., her avoidance of neighbors who greeted her or attempted to engage in brief conversations in the hallways or by the elevator in her building. The sense of not belonging among many participants was attributed to being in a better position than those around them because they had either turned their life around and no longer fit in with the drug-using crowd or had led more middle-class lifestyles most of their lives and never identified as homeless, which was more often the case with participants who had been homeless for shorter periods of time or who had never experienced literal or “street” homelessness.

For participants who lived in scatter-site units (rather than a single-building dedicated to formerly homeless adults) or outside of Skid Row, there was concern and fear that they



would be identified by their “normal” neighbors as having been homeless. For example, one SP lived in a scatter-site unit and feared that having some of her former shelter peers over for her birthday might lead to the neighbors thinking that she was a “delinquent.” She also expressed feeling ashamed that she had been sleeping on her living room floor instead of in her new king-size bed because she was used to sleeping on cement. A 41-year-old gay Hispanic man living with HIV, discussed feeling like he could not connect with people in his building or neighborhood because he is “so different,” having been homeless, and so he only socialized with a small group of men with whom he drinks. In general, the fear or stigma related to having been homeless seemed to constrict many from developing relationships with new neighbors. There were, however, counter-examples including a 51-year-old African American man who reported feeling supported by a neighbor in his apartment building. Still, this SP did not want to stay because of community violence. Specifically, he pointed out bullet holes in his unit and later, when passing by a scene where police appeared to be investigating a murder, stated that he “did not want to get used to this.”

## Discussion

The findings from this study demonstrate how immersive, ethnographic methods can be used to understand how different types of environments (i.e. physical, social, economic, and policy) interact to produce or reduce substance use risk for newly housed PSH tenants. Most clearly, the distinction between public and private space that is made possible through having an apartment shows how the physical and social environment can interact, yet there were still clear instances when the policy and economic environments surrounding PSH were also influential. Our findings also showed that PSH tenants appear to navigate environmental factors that influence risk, even if they are unable to change these factors. In this study, both isolation from and active engagement in the social environment was made possible because of having an apartment, which has been previously discussed in the literature on PSH (Padgett & Henwood, 2012; Smith et al., 2015; Townley et al., 2009). For some tenants who lived in a high-risk area, such as Skid Row in particular, isolation served as a protective mechanism from those who engaged in risk behavior and from the substance-using behaviors that they engaged in while homeless. Other tenants took a more proactive stance in reacting to their environment by engaging with those around them, including individuals they may have known prior to receiving housing.

At times, it was clear that the economic environment also interacted with participants’ physical and social environments. That is, some were able to return to areas where they had been homeless to continue their work and relationships, whereas others returned to take on a new role as a helper (Chan, Gopal, & Helfrich, 2014; Massey, Albright, Casciano, Derickson, & Kinsey, 2013). As previously noted by Padgett, Henwood, Abrams, and Drake (2008), gender stereotypes appeared to provide more vocational options to men than women, who seemed limited to returning in the role of a helper. This underscores the need to consider how demographic characteristics also interact with different types of environmental risks.

Even for those who were more socially engaged, home tended to be a place of solitude rather than social engagement. Although this served as a protective mechanism for some,

especially for women with past traumas and ongoing PTSD, others cultivated solitude because they were concerned about being surveilled by PSH staff, which introduced the policy environment of PSH. That is, Hopper (2012) described PSH as a possible “abeyance mechanism,” in which tenants are effectively removed from society without necessarily becoming completely disenfranchised. Even without concerns of being surveilled, most participants agreed that they received limited assistance from social service providers that were assigned to them as part of PSH programming. This perceived lack of support may be due to limited provider capacity given high caseloads in this particular service system (Henwood et al., 2017) or may reflect a more general passive and nondirective supportive stance taken by some PSH providers (Tiderington, 2017). Whatever the reason, the policy context that influences how PSH is implemented contributed to tenants’ isolation, difficulty navigating a complex health and social services system, and inability to develop additional life skills.

### **Strengths and Limitations**

Although this study employed many strategies of rigor for qualitative research, including prolonged engagement, in-depth immersion in the data, triangulation between what participants said and observations, and consensus-driven findings (Padgett, 2011), it is important to note the specific contextualized nature of the findings, given that much of the study occurred in the Skid Row area of Los Angeles, which has effectively become a community of people who have experienced homelessness. Further, although most participants seemed open to sharing personal details of their lives, including one person whose daily routine observed by an interviewer included the purchase and use of drugs, we cannot rule out that participants may have been reluctant to share some aspects of their daily lives, as was the case with one person who did not want us to observe her apartment. Finally, given that this study was based on ethnographic observation from a single point in time in people’s lives, the goal was not to identify who was engaging in substance use and why—which likely changes over time—but rather to better understand how different types of environments interact to produce or reduce substance use risk for newly housed PSH tenants. It is important to note that the ethnographic shadowing that took place for this study occurred between 3- and 12-month after participants moved into their new apartments and so our data do not capture the critical transition from homelessness through the first 3 months of housing.

### **Conclusion**

Understanding how tenants who have transitioned from homelessness to PSH integrate into their community and navigate what are often high-risk environments requires an investigation of both the environment and how the person relates to that environment. To date, most research that has examined PSH tenants has focused on individual characteristics, with less focus on how providers support tenants in their environment (Henwood et al., 2011; Tiderington, 2017). This study underscores the scarcity yet importance of research that examines the multiple types of environment in which PSH is situated, and suggests that a better understanding of how these environments interact to produce or reduce risk is needed to develop optimal interventions and support services.

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## References

- Brodsky AE (1996). Resilient single mothers in risky neighborhoods: Negative psychological sense of community. *Journal of Community Psychology*, 24, 347–363. [http://dx.doi.org/10.1002/\(SICI\)1520-6629\(199610\)24:4<347::AID-JCOP5>3.0.CO;2-R](http://dx.doi.org/10.1002/(SICI)1520-6629(199610)24:4<347::AID-JCOP5>3.0.CO;2-R)
- Byrne T, Fargo JD, Montgomery AE, Munley E, & Culhane DP (2014). The relationship between community investment in permanent supportive housing and chronic homelessness. *Social Services Review*, 88, 234–263. <http://dx.doi.org/10.1086/676142>
- Caton CLM, El-Bassel N, Gelman A, Barrow S, Herman D, Hsu E, ... Felix A (2013). Rates and correlates of HIV and STI infection among homeless women. *AIDS and Behavior*, 17, 856–864. <http://dx.doi.org/10.1007/s10461-012-0198-x> [PubMed: 22610369]
- Chan DV, Gopal S, & Helfrich CA (2014). Accessibility patterns and community integration among previously homeless adults: A geographic information systems (GIS) approach. *Social Science & Medicine*, 120, 142–152. <http://dx.doi.org/10.1016/j.socscimed.2014.09.005> [PubMed: 25243640]
- Dannenberg AL, Bhatia R, Cole BL, Heaton SK, Feldman JD, & Rutt CD (2008). Use of health impact assessment in the U.S.: 27 case studies, 1999–2007. *American Journal of Preventive Medicine*, 34, 241–256. <http://dx.doi.org/10.1016/j.amepre.2007.11.015> [PubMed: 18312813]
- Day K, & Cardinal BJ (2007). A second generation of active living research. *American Journal of Health Promotion*, 21, iv–vii. <http://dx.doi.org/10.4278/0890-1171-21.4s.iv>
- Diez-Roux AV (2000). Multilevel analysis in public health research. *Annual Review of Public Health*, 21, 171–192. <http://dx.doi.org/10.1146/annurev.publhealth.21.1.171>
- Ecker J, & Aubry T (2016). Individual, housing, and neighborhood predictors of psychological integration among vulnerably housed and homeless individuals. *American Journal of Community Psychology*, 58, 111–122. <http://dx.doi.org/10.1002/ajcp.12066> [PubMed: 27422121]
- Goering P, Veldhuizen S, Watson A, Adair C, Kopp B, Latimer E, ... Aubry T (2014). National At Home/Chez Soi Final Report Retrieved from <https://www.mentalhealthcommission.ca/English/document/24376/national-homechez-soi-final-report>
- Hall HI, An Q, Tang T, Song R, Chen M, Green T, & Kang J (2015). Prevalence of diagnosed and undiagnosed HIV infection – United States, 2008–2012. *Morbidity and Mortality Weekly Report*, 64, 657–662. [PubMed: 26110835]
- Henwood BF, Cabassa LJ, Craig CM, & Padgett DK (2013). Permanent supportive housing: addressing homelessness and health disparities?. *American journal of public health*, 103(S2), S188–S192. [PubMed: 24148031]
- Henwood BF, Harris T, Woo D, Winetrobe H, Rhoades H, & Wenzel SL (2017). Availability of comprehensive services in permanent supportive housing in Los Angeles. *Health and Social Care in the Community* online publication. <http://dx.doi.org/10.1111/hsc.12510>
- 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, 77–85. <http://dx.doi.org/10.1007/s10488-010-0303-2> [PubMed: 20521164]
- Hopper K (2012). Commentary: The counter-reformation that failed? A commentary on the mixed legacy of supported housing. *Psychiatric Services*, 63, 461–463. <http://dx.doi.org/10.1176/appi.ps.201100379> [PubMed: 22549534]
- Kertesz SG, Crouch K, Milby JB, Cusimano RE, & Schumacher JE (2009). Housing First for homeless persons with active addiction: Are we overreaching? *Milbank Quarterly*, 87, 495–534. <http://dx.doi.org/10.1111/j.1468-0009.2009.00565.x> [PubMed: 19523126]
- Kloos B, & Shah S (2009). A social ecological approach to investigating relationships between housing and adaptive functioning for persons with serious mental illness. *American Journal of*

- Community Psychology, 44, 316–326. <http://dx.doi.org/10.1007/s10464-009-9277-1> [PubMed: 19862615]
- Kusenbach M (2003). Street phenomenology: The go-along as ethnographic research tool. *Ethnography*, 4, 455–485. <http://dx.doi.org/10.1177/146613810343007>
- Laraia BA, Karter AJ, Warton EM, Schillinger D, Moffet HH, & Adler N (2012). Place matters: Neighborhood deprivation and cardiometabolic risk factors in the Diabetes Study of Northern California (DISTANCE). *Social Science & Medicine*, 74, 1082–1090. <http://dx.doi.org/10.1016/j.socscimed.2011.11.036> [PubMed: 22373821]
- Latkin CA, German D, Vlahov D, & Galea S (2013). Neighborhoods and HIV: A social ecological approach to prevention and care. *American Psychologist*, 68, 210–224. <http://dx.doi.org/10.1037/a0032704> [PubMed: 23688089]
- Massey DS, Albright L, Casciano R, Derickson E, & Kinsey DN (2013). *Climbing Mount Laurel: The struggle for affordable housing and social mobility in an American suburb Princeton, NJ*: Princeton University Press.
- Miles MB, Huberman AM, & Saldana J (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage.
- Padgett DK (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. *Social Science & Medicine*, 64, 1925–1936. <http://dx.doi.org/10.1016/j.socscimed.2007.02.011> [PubMed: 17355900]
- Padgett DK (2011). *Qualitative and mixed methods in public health* Thousand Oaks, CA: Sage.
- Padgett DK, Gulcur L, & Tsemberis S (2006). Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice*, 16, 74–83. <http://dx.doi.org/10.1177/1049731505282593>
- Padgett DK, & Henwood BF (2012). Qualitative research for and in practice: Findings from studies with homeless adults who have serious mental illness and co-occurring substance abuse. *Clinical Social Work Journal*, 40, 187–193. <http://dx.doi.org/10.1007/s10615-011-0354-1>
- Padgett DK, Henwood B, Abrams C, & Drake RE (2008). Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. *American Journal of Orthopsychiatry*, 78, 333–339. <http://dx.doi.org/10.1037/a0014155> [PubMed: 19123752]
- Patton MQ (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Rhodes T (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International journal of drug policy*, 13(2), 85–94.
- Rhodes T, & Simic M (2005). Transition and the HIV risk environment. *BMJ*, 331, 220–223. <http://dx.doi.org/10.1136/bmj.331.7510.220> [PubMed: 16037463]
- Rhodes T, Stimson GV, Crofts N, Ball A, Dehne K, & Khodakevich L (1999). Drug injecting, rapid HIV spread, and the 'risk environment': Implications for assessment and response. *AIDS*, 13, S259–S269. [PubMed: 10885783]
- Robertson MJ, Clark RA, Charlebois ED, Tulskey J, Long HL, Bangsberg DR, & Moss AR (2004). HIV seroprevalence among homeless and marginally housed adults in San Francisco. *American Journal of Public Health*, 94, 1207–1217. <http://dx.doi.org/10.2105/AJPH.94.7.1207> [PubMed: 15226145]
- Rog DJ, Marshall T, Dougherty RH, George P, Daniels AS, Ghose SS, & Delphin-Rittmon ME (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services*, 65, 287–294. <http://dx.doi.org/10.1176/appi.ps.201300261> [PubMed: 24343350]
- Sampson RJ, Raudenbush SW, & Earls F (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science*, 277, 918–924. <http://dx.doi.org/10.1126/science.277.5328.918> [PubMed: 9252316]
- Smith BT, Padgett DK, Choy-Brown M, & Henwood BF (2015). Rebuilding lives and identities: The role of place in recovery among persons with complex needs. *Health & Place*, 33, 109–117. <http://dx.doi.org/10.1016/j.healthplace.2015.03.002> [PubMed: 25817939]
- Smelson DA, Zaykowski H, Guevermont N, Siegfriedt J, Sawh L, Modzelewski D, ... Kane V (2016). Integrating permanent supportive housing and co-occurring disorders treatment for individuals

- who are homeless. *Journal of Dual Diagnosis*, 12, 193–201. <http://dx.doi.org/10.1080/15504263.2016.1174010> [PubMed: 27064939]
- Somers JM, Moniruzzaman A, & Palepu A (2015). Changes in daily substance use among people experiencing homelessness and mental illness: 24-month outcomes following randomization to Housing First or usual care. *Addiction*, 110, 1605–1614. <http://dx.doi.org/10.1111/add.13011> [PubMed: 26052657]
- Stimpson JP, Ju H, Raji MA, & Eschbach K (2007). Neighborhood deprivation and health risk behaviors in NHANES III. *American Journal of Health Behavior*, 31, 215–222. <http://dx.doi.org/10.5555/ajhb.2007.31.2.215> [PubMed: 17269911]
- Strathdee SA, Hallett TB, Bobrova N, Rhodes T, Booth R, Abdool R, & Hankins CA (2010). HIV and risk environment for injecting drug users: The past, present, and future. *Lancet*, 376, 268–284. [http://dx.doi.org/10.1016/S0140-6736\(10\)60743-X](http://dx.doi.org/10.1016/S0140-6736(10)60743-X) [PubMed: 20650523]
- Substance Abuse and Mental Health Services Administration. (2007). Pathways' Housing First program Retrieved from <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=365>
- Sundquist K, Theobald H, Yang M, Li X, Johansson SE, & Sundquist J (2006). Neighborhood violent crime and unemployment increase the risk of coronary heart disease: A multilevel study in an urban setting. *Social Science & Medicine*, 62, 2061–2071. <http://dx.doi.org/10.1016/j.socscimed.2005.08.051> [PubMed: 16203075]
- Sunstein BS, & Chiseri-Strater E (1997). *FieldWorking: Reading and writing research* (4th ed.). Boston, MA: Bedford/S. Martins.
- Tiderington E (2017). “We always think you’re here permanently”: The paradox of “permanent” housing and other barriers to recovery-oriented practice in supportive housing services. *Administration and Policy in Mental Health and Mental Health Services Research*, 44, 103–114. <http://dx.doi.org/10.1007/s10488-015-0707-0> [PubMed: 26666521]
- Townley G, Kloos B, & Wright PA (2009). Understanding the experience of place: Expanding methods to conceptualize and measure community integration of persons with serious mental illness. *Health & Place*, 15, 520–531. <http://dx.doi.org/10.1016/j.healthplace.2008.08.011> [PubMed: 19062326]
- Wenzel SL, Rhoades H, Harris T, Winetrobe H, Rice E, & Henwood B (2017). Risk behavior and access to HIV/AIDS prevention services in a community sample of homeless persons entering permanent supportive housing. *AIDS care*, 29(5), 570–574. [PubMed: 27654072]
- Yanos PT (2007). Beyond “Landscapes of Despair”: the need for new research on the urban environment, sprawl, and the community integration of persons with severe mental illness. *Health & place*, 13(3), 672–676. [PubMed: 17178251]

**Table 1**

## Demographic and Clinical Characteristics of the Ethnographic Sample

	% ( <i>n</i> ) or <i>M</i> ( <i>SD</i> )
Age	55.2 (6.6)
Male	59.0 (16)
Race	
Black	59.0 (16)
Latino	7.4 (2)
Multiracial	3.7 (1)
Native American or Alaska Native	3.7 (1)
White	25.9 (7)
Heterosexual	85.2 (23)
Veteran	40.7 (11)
Lifetime literal homelessness (years)	7.7 (6.2)
Substance use	
Lifetime history of alcohol or drug use	100.0 (23)
Hard drug use since housing	48.0 (13)
Binge drinking since housing	40.7 (11)
Mental health conditions	
Schizophrenia	22.2 (6)
PTSD	33.3 (9)
Major depressive disorder	59.3 (16)
Bipolar disorder	22.2 (6)
Location	
Downtown Skid Row area	48.0 (13)
Outside of downtown	52.0 (14)



**Table 2**

Proportion of Ethnographic Sample that Agreed or Strongly Agreed to Each Item on the Housing Environment Survey<sup>a</sup>

	Agree or Strongly Agree % (n)
It is easy to get transportation in my neighborhood.	92 (24)
I can get the things that I need from stores in my neighborhood (food, clothes, supplies).	92 (24)
There is a lot of traffic on the streets in my neighborhood.	81 (21)
People can find police officers when they are needed in my neighborhood.	73 (19)
I have good sidewalks in my neighborhood.	65 (17)
My family and friends are too far away from where I live	58 (15)
My neighborhood looks nice.	46 (12)
There is too much noise in my neighborhood.	46 (12)
I can't do things outdoors in my neighborhood.	46 (12)
There are things to do for fun in my neighborhood (movie theatre, bowling).	46 (12)
Crime is a problem in my neighborhood.	42 (11)
There are nice parks in my neighborhood.	38 (10)
There are not enough street lights in my neighborhood. <sup>b</sup>	24 (6)
I have a hard time getting health care services in my neighborhood.	12 (3)

<sup>a</sup> n = 26; data missing for one person in shadowing sample.

<sup>b</sup> n = 25.