CHAPTER 25

SUPPORTED HOUSING, SOCIALIZATION, EDUCATION, AND EMPLOYMENT

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As the President's New Freedom Commission (2003) emphasized, recovery entails living, learning, working, and participating fully in one's community. This chapter addresses four approaches to helping people achieve these important outcomes: supported housing, supported socialization, supported education, and supported employment. These interventions share common theoretical and practical orientations. Each assumes that people know themselves and their personal recovery goals, have personal strengths, and can make use of professional as well as natural supports to live be successful in community environments of their choice. Each starts with the person's phenomenology: How do they see themselves, their situations, their needs, and their goals? Each approach assumes that people have strengths that can be identified, reinforced, and enhanced rather than deficits that must be corrected, or problems to be solved. Each assumes that people can take control of their own lives and recoveries more easily if they have access to relevant information and choices, and opportunities to learn, practice, and take risks. Each entails direct access to valued adult roles rather than stepwise training approaches. Each assumes that integrated, natural settings are preferable to segregated settings (i.e., only other people living with disabilities). Each empowers the consumer or client as *the central* member of a multi-disciplinary team. Finally, each relies on natural supports of the person's choice as well as professional supports.

We begin with a vignette to illustrate how these interventions can be combined and individually tailored. We then describe each intervention, including principles, details, research, and training. Finally, we discuss the commonalities of these approaches.

A YOUNG MAN WITH PSYCHOSIS AND DRUG ADDICTION

Manuel R. was a 23-year-old man when he came to the mental health center. He began struggling with drug use and intermittent psychotic episodes during his freshman year of college and flunked out of school the following year. Afterward, he had numerous admissions to psychiatric hospitals and addiction treatment centers, was unable to hold a job, and experienced increasing acrimony with his parents and siblings. A public altercation eventually led to his arrest and conviction on assault charges.

When he joined a multidisciplinary dual diagnosis team, Manuel was experiencing paranoia, cravings, and severe regrets regarding his school and work failures and the problems he had caused his family. His goals were to live independently, to repair relationships with his family, and to return to school and work. He initially entered a residential dual-diagnosis facility for three months, in which he became stabilized on lithium plus an antipsychotic medication, learned to manage his paranoia and cravings in cognitive-behavioral sessions, received education about his dual disorders, bonded with other young men in the residence, and began to attend Alcoholics Anonymous meetings each evening in the community with mentors (experienced AA members who were hired to help others learn about and join AA). He also applied to take one course at a local community college.

As Manuel transitioned to an apartment in the community, the dual diagnosis team helped him set up his apartment, learn to use public transportation, and enroll at the community college. They also continued to support him and his peers in attending AA meetings. When Manuel completed his first college course in accounting, with help planning his homework schedule from the team, he enrolled in another course and also began looking for a job. The team helped him find a part-time job as a bookkeeping assistant. Weekly telephone meetings with Manuel's family resulted in respectful communications and clear agreements about responsibilities. He feels that they understand his illnesses better, and they feel that they are taking care of their own needs as well as helping Manuel.

Manuel believes that his quality of life is immensely improved. He has an apartment, a job, several friends in AA, a better relationship with his family, and confidence about completing his college education. The team checks with Manuel bi-weekly and provides supports, but his needs are less each month as he begins to rely more on his friends and his own capacity to manage his life.

Manuel's story illustrates how supported housing, employment, education, and socialization are woven together and highly individualized by the same team. We next describe each intervention separately.

SUPPORTED HOUSING

Supported housing combines supports for independent housing with flexible mental health interventions and other services (Rog, 2004; Tabol, Drebing, & Rosenheck, 2010; see http://www.socwel.ku.edu/mentalhealth/projects/promising/supporthousing.shtml). It can be located in different living settings, including self-contained accommodations with professional services on site (at least during office hours) and scattered-site arrangements with regular visits by a support team.

Supported housing emphasizes several principles:

- client-centeredness—the consumer's values, goals, and preferences
- housing choice—type, housemates, supports
- tenancy—lease held by the consumer
- integrated community-living settings—not segregated enclaves
- affordable decent housing—professionals may help to locate
- permanence—do not have to move on once completing a program
- education regarding rights—tenant role rather than consumer/patient role
- separate housing supports—not linked with other services
- personal preferences—use of mental health treatment and other services
- agency oversight—many tasks related to housing
- services in the community—not in mental health settings

Teams of all kinds (assertive community treatment, intensive case management, community support, housing teams, and so on) can deliver supported housing. Members typically have expertise, not only on housing issues, but also in regard to benefits, mental health, addictions, employment, and other resources and services that may be useful or relevant. Services are usually available 24 hours a day, seven days a week. Much of the team's work entails basic support: acquiring furniture, shopping for groceries, making and keeping healthcare appointments, obtaining public benefits, paying bills, preparing meals, keeping a clean and safe home, and so forth.

People with limited education can deliver basic housing supports. Social workers are usually involved in coordination, counseling, and supervisory roles. People with specialized training may be needed to provide skills teaching, addiction counseling, peer advocacy, supported employment, or other interventions. A person with a graduate degree in some area of mental health usually leads the team. These teams may serve one or more specific populations, requiring specialized team training or skills. Examples include teams serving people with co-occurring mental health and intellectual disabilities, people with significant physical health issues, or people who are raising children.

Many supported housing programs deviate from the basic model (Tabol, Drebing, & Rosenheck, 2010). Alterations may involve required treatment, required financial management, multiple units in the same building, or shared living of some kind. Some programs diverge so far from the model that they are called "support*ive* housing" rather than "support*ed* housing." The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes permanent supportive housing: see http://store.samhsa.gov/product/SMA10-4510?WT.ac=AD20100918HP_SMA10-4510.

Research on Housing First and other models of supported housing has shown positive outcomes in terms of maintaining residence, especially for people who have experienced homelessness (Tsemberis, Gulcur, & Nakae, 2004; McHugo et al., 2004). In addition to housing supports and mental health services, successful models usually emphasize harm reduction rather than immediate sobriety, also client choice, personal recovery goals, and financial services to ensure rental payments.

Dependence is a central challenge with supported housing. People easily become accustomed to having extensive assistance, and staff may also find it easier to do tasks for people than to teach them the skills they need to take care of themselves.

SUPPORTED EMPLOYMENT

Supported employment is an approach to vocational rehabilitation that helps people with psychiatric disabilities attain and succeed in competitive jobs (Becker & Drake, 2003). The Individual Placement and Support (IPS) model of supported employment (see www.dartmouth.edu/~ips) is the only nationally and internationally recognized evidence-based approach to vocational rehabilitation for this population.

Several principles define IPS:

- zero exclusion—all clients who want employment are eligible
- competitive employment—client's goal
- client choice—all aspects of selecting, finding, and maintaining employment
- job development—professional approach
- rapid job search—training on the job rather than prior to employment
- service integration—vocational plus housing, mental health, addiction, physical health
- follow-along supports—as long as needed

In IPS, employment specialists help with all phases of vocational services: assessing, planning, developing, acquiring, mastering, retaining, and changing jobs. An employment specialist typically works with 18 to 20 clients at a time. The client makes all decisions; e.g., choosing a type of job, how to find the job, how many hours to work, disclosure of their status, types of support, and so on, through a process of shared decision-making, in which the employment specialist provides information and options.

IPS supported employment is a team-based model. The employment specialist joins one or more multidisciplinary teams: case management, assertive community treatment, intensive case management, supported housing, or other types of teams. Rather than providing the vocational services alone, the employment specialist galvanizes the team to consider work as an essential part of recovery, one needing everyone's attention. The doctor may need to reassure the client that he or she can work and may need to adjust medications to reduce side effects. The social worker may need to educate the family about Social Security rules regarding insurance and income support when people are working. The therapist may need to help the client learn coping skills to manage anxiety on the job. The case manager may need to help the client learn to use public transportation to and from work. The addiction counselor may need to make sure the workplace supports abstinence (e.g., does not serve alcohol).

managing test anxiety, controlling symptoms, compensating for cognitive problems, and learning how to cope socially in an academic environment. Though most colleges offer disability services, students with psychiatric disabilities are often reluctant to access traditional disability services due to fears regarding disclosure (Collins & Mowbray, 2005).

Principles of supported education include:

- client choice—educational goals and services
- educational assessment—informs individually tailored educational plan
- career counseling—education linked with employment
- coping skills—for managing stress and symptoms
- access school resources—enrollment, financial aid, and campus resources
- time management skills—homework, papers, preparing for tests

Supported education has not been standardized by research in the same way as supported employment. Thus, models vary widely in terms of where students attend classes, where they receive supports, what types of supports are available, who provides the supports, the amount of supports, and the linkage with mental health services. For example, supports may be delivered in the classroom, at the school, at a clinic, or in one's residence. Several manuals on different approaches to supported education are available, and different groups are also working on fidelity measures. Until the basic approach is standardized and empirically validated, however, these efforts may be premature.

Supported education is sometimes offered by individual practitioners but at other times as part of a team-based approach. Many newly developed supported education services are operating in a team environment to ensure students have seamless services. The mobile team works with students in different educational settings or modes (local community college, local full-scale college or university, vocational-technical school, and home learners studying via distance learning). The current worldwide emphasis on early intervention involves working with younger people, many of whom have had their education threatened or interrupted by the early phases of mental health problems. Early-episode teams are typically multidisciplinary and include a specialist in supported education and employment (Nuechterlein et al., 2008; Rudnick & Gover, 2009). The team works together to prevent further episodes of illness and disability. Clients often pursue a mixture of education and employment, and usually the same person provides both services.

The skills and training needed to provide supported education are unclear. Experience suggests that supported education practitioners should complete some sort of formal educational or vocational training program, but in reality practitioners come from many backgrounds. Understanding psychiatric rehabilitation principles might also assist practitioners in the areas of situational assessments, direct skills teaching, resource planning, supportive counseling, and using natural supports. An important role of a supported education practitioner is to establish and maintain ongoing relationships between the supported education program and educational institutions in the community (e.g., the school's offices of disability services, admissions, and financial aid).

Supported education so far lacks rigorous research, but non-experimental studies show reasonable rates of enrollment, completion of classes, and obtaining degrees (Unger et al., 2000; Goulding, Chien, & Compton, 2010; Best, Still, & Cameron, 2008). A large, randomized controlled study is underway now, conducted by investigators at Temple University and the University of Medicine and Dentistry of New Jersey, School of Health Related Professions Department of Psychiatric Rehabilitation and Counseling Professions.

and was anxious and fearful around people. The team helped Albert identify his interests and strengths in taking care of animals. All members of the team thought of their own contacts with pet stores, farms, veterinary clinics, pet owners, and so on, to identify potential employers. Each team member made contacts to help develop a part-time job. Within a month, Albert had three job offers. He chose a job on weekends taking care of recovering animals at a veterinary clinic. The employment specialist visited him regularly at work. Albert gradually expanded his time to weekday evenings, gained confidence in his ability to do a good job, and made friends with other employees at the veterinary clinic.

People with a variety of backgrounds—business, vocational services, mental health, lived experience—can become employment specialists. They can learn basic IPS skills via an online course (at www.dartmouth.edu/~ips/page26/page26.html) and can develop their skills through the mentoring of an IPS supervisor. Books, training courses, videos, training, and fidelity tools are available: see www.dartmouth.edu/~ips.

IPS has been developed and refined for over 20 years, based on continuous research. The model has a clear procedural manual, a fidelity scale, and defined training procedures (Swanson & Becker, 2010). In some states, reimbursement, licensing, or accreditation is tied to fidelity. IPS is widely used in several American states, several European countries, Canada, and Australia.

Extensive research on IPS includes 16 randomized controlled trials and numerous other studies around the world. Recent summaries of the research (Drake & Bond, 2011; Bond, Drake, & Becker, in press) show that about two-thirds of clients who enroll in IPS achieve competitive employment within 12 to 18 months. The rate is slightly higher in North American countries than in other countries, possibly due to different workforce, economic, and regulatory factors. Long-term follow-ups show that clients tend to remain employed and be steady workers for at least 10 years. When working, clients tend to improve in terms of self-esteem, quality of life, and symptom control. Current research aims at improving outcomes for the one-third of clients who are not benefiting from standard IPS; for example, by providing compensatory cognitive strategies or cognitive training.

Federal disability benefits from Social Security can be discontinued proportionately or stopped suddenly when people return to work. Health insurance can also be tied to disability status. In addition, many states tie public benefits and rents to earned income. Despite some of the challenges people may face returning to work being employed is a key to helping people to realize their full potential and helping them to be contributing members of their community and society.

SUPPORTED EDUCATION

Supported education assists people with psychiatric disabilities in pursuing academic [illegible] integrated post-secondary schools (Anthony & Unger, 1991). Services are individualized and flexible with an emphasis on student choice, self-determination, and career development. [illegible] are helped to manage post-secondary education, to achieve their academic goals, [illegible] meaningful employment. Supports are highly variable but might encompass applying [illegible] gaining financial support, planning classes, negotiating with teachers, completing [illegible]

Supported education may be even more vulnerable than supported employment to funding difficulties. The current financial climate emphasizes "medical necessity" rather than people's desires to be functional citizens.

SUPPORTED SOCIALIZATION

Supported socialization, though seemingly a natural analogue of supported housing, employment, and education, has neither a consistent definition nor a consistent methodology. People with mental health problems often report loneliness, isolation, and a desire for friendships. Traditional approaches to improving social connections involve social skills training, group activities within mental health programs, clubhouses, and peer support programs. But these efforts may not transfer to new relationships outside of the mental health system.

Supported socialization aims to help people develop and sustain relationships in the community, apart from the mental health system. It emphasizes the concept of community integration rather than mental health segregation. Supported socialization involves a direct effort to help people participate in natural social, organizational, and recreational activities in the community (Davidson et al., 2004). Thus, social experiences and training groups within a day treatment center would not qualify as supported socialization; helping a participant to join a church, a softball team, or a stamp collecting group in the community would be considered supported socialization.

Other aims are often added to the concept of supported socialization; for example, to enhance the depth and quality of relationships (Davidson et al., 2004) or to facilitate exchanges of tangible goods and problem-solving opportunities (Wong, Matejkowski, & Lee, 2011). But these extensions of the concept often revert to traditional mental health efforts to change people rather than to help them find satisfying friendships and social niches in the community.

Emerging principles of supported socialization might include the following:

- highly individualized—based on personal interests, preferences, and goals
- building on strengths—rather than changing personality or skills
- relationships in the community—not in the mental health system
- community opportunities—consider many potential activities
- supports as needed—types, amounts, and durations

No consensus exists on how supported socialization should be delivered. In theory, laypeople, peers, or professionals could deliver supported socialization. Several programs partner community volunteers with mental health consumers to develop permanent supportive friendships. A small team might include a community volunteer and a mental health or rehabilitation professional to oversee the process (McCorkle, et al 2008). Alternatively, teams involved in other interventions, such as assertive community treatment teams, supported employment teams, or supported housing teams, could also provide supported socialization.

The process and skills for delivering supported socialization are also unclear. Discussions and guides on topics as varied as leisure, parenting, dating, and intimacy are widely available (see, e.g., www.tucollaborative.org). The following vignette illustrates a possible process and suggests relevant skills.

John lives alone and complains of loneliness. He currently stays mostly in his apartment but wants to socialize more. He has revealed that he used to bowl and enjoyed the social aspects of bowling. A supported socialization intervention for John might be a stepwise process like the following:

- John and a staff member go bowling together.
- The staff member helps John examine the bulletin boards at the bowling alley for a bowling team or league that he might join.
- The staff member meets with John to address practical issues (e.g., transportation and buying or renting bowling shoes) and to discuss strategies for managing his anxiety about bowling on a team with unfamiliar people.
- The staff member accompanies John during his first league night, observing from a distance and available to help if needed.
- John goes bowling on a next league night without the staff member, who is available by cell phone.
- The staff member meets with John monthly to solve problems until John feels comfortable that he is making friends on the team.

Little research exists on supported socialization. Because many clients reject or fail to benefit from other approaches to finding desired social relationships, supported socialization models need to be constructed, piloted, refined, measured, and tested. To be consistent with other supported approaches, supported socialization should emphasize natural social settings in the community rather than relationships that are paid for by the mental health system.

DISCUSSION AND CONCLUSIONS

People with mental health difficulties identify functional goals such as independent housing, education, employment, and friends as essential to the recovery process. Supported approaches to helping them to achieve these goals share several features. They begin with the consumer's perception of needs, goals, and preferences. They offer consumers choices in terms of pathways, timing, steps, and types of supports. They aim directly and rapidly at integrating in one's community and using natural supports. They encourage independence from the mental health system.

People from many different backgrounds, including people in recovery, can deliver supported services. To ensure that different types of supports are combined, individually tailored, and linked with other services, team-based approaches are usually optimal. The consumer is always the central member of the team as the director of services. The variety of supported service models usefully informs the recovery vision and outcomes.

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