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Barriers and Motivators to Deinstitutionalization in Narratives of Homeless- and Protected Housing Participants

Nienke Boesveldt[1],[2] and Chahida Bouhamou[3]

Abstract

Housing homeless people is widely seen as an important aspect of policies, and people living in institutions are increasingly encouraged to live independently within neighborhoods. Studies identify both positive effects of outpatient situations and barriers formed by self-stigma or financial cuts. Client-perspectives and policy outcomes for clients remain neglected topics, however. 160 semi-structured peer-to-peer interviews involving participants of shelter and protected housing (adults diagnosed with serious mental illness and with histories of substance use and institutionalization or homelessness, who use services) from a wide range of urban and rural settings, show the relative effectiveness of deinstitutionalization policies. Most participants exhibit limited support for direct housing policies, since preparation for re-housing and ongoing support are missing. Some participants experience clear motivators though, while others experience clear social and health-related obstacles. We conclude contexts should explicitly incorporate institutional change, including provision of preparatory and ongoing services meeting structural conditions, preventing recurrent homelessness.

Key words: Deinstitutionalization Policy, Homeless Persons, Protected Housing Services, Service User Perspective

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Introduction

This paper presents accounts of the personal experiences of users of homeless and protected housing services in the Netherlands, amid a broad deinstitutionalizing[4] policy trend (Benjaminsen 2013, Nichols and Doberstein 2016, Sylvestre et al 2017, Boesveldt, 2019). Since participation is highly valued, institutionalizing risks are identified (Goffman, 1961) and there is evidence that permanent housing can assist recovery for individuals experiencing homelessness and mental illness (Tsemberis & Eisenberg, 2000).

However, integrated recovery-oriented approaches still need explicit implementation (Kirst, Zerger, Wise Harris, Plenert, & Stergiopoulos 2014; Rapp & Goscha, 2006), with specific challenges emerging in the Dutch context (Bannink, Bosselaar, Van der Veer, & Trommel, 2014). As the neighborhood becomes a unit within which this support must be organized (Delespaul, Milo, Schalken, Boevink, & Van Os, 2016), through deinstitutionalization, discussions on social mixing, neighborhood livability and exclusion are increasingly being raised (Leidelmeijer, Frissen, & Van Iersel, 2020).

The purpose of this study is to articulate service user perspectives related to experiences with and opinions on deinstitutionalization and to identify service user perceived terms, motivators and barriers to their own deinstitutionalization from shelters and protected housing. It forms a deepening of theoretical knowledge and an explanation of the shortcomings of services and the resulting societal effects at client level.

At the same time, it acknowledges that in research (Solomon, 2004; Thomas, 2006), experience-led knowledge is increasingly being recognized as a valuable asset. In order to understand the service user narrative on deinstitutionalization, we proposed this explorative,

[4] The definition of deinstitutionalization contains three processes: 1) depopulation of state hospitals; 2) Diverging or deflecting potential institutional admissions to community-based service settings; 3) The decentralization, or the broadening of responsibility for patient care from a single service entity to multiple service entities and therefore also the fragmentation of authority (Bachrach, 1989).

qualitative study, using peer-interviews to investigate service user perspectives related to experiences and opinions and to identify service user perceived terms, motivators and barriers to their own deinstitutionalization from shelters and protected housing.

Personal experiences of users of homeless and protected housing services

The literature on the personal experiences of users of homeless and protected housing services[5] with deinstitutionalizing policy is heterogeneous, but with specific gaps. Kirst et al. (2014) show that homeless people feel socially isolated when housed, which may not be conducive to hopefulness and recovery. Furthermore, social psychological studies (Epel, Bandura, & Zimbardo, 1999) show that homeless participants with high self-efficacy are more inclined to search for housing and employment and thus to stay at the shelter for a shorter period, whilst participants with low self-efficacy are more likely to request an extension of their stay.

Self-efficacy revolves around people's beliefs in their ability to influence events that affect their lives. This core belief is the foundation of human motivation, performance accomplishments, and emotional well-being (Bandura, 1997). If people do not believe that they can produce desired effects through their actions, they have little incentive to undertake activities or to persevere in the face of difficulties. Whatever other factors may serve as guides and motivators, they are all rooted in the core belief that one can make a difference through one's actions.

In addition to self-efficacy, (self-perceived) stigma is also seen to impact the way clients perceive rehousing and their success in the undertaking (Epel et al., 1999). Goffman (1963) identified stigma as 'an attribute that is deeply discrediting' and that based on this attribute society discriminates against these persons which reduces their life chances. Self-stigma appears to negatively impact self-efficacy, whereas awareness of existing negative

[5] Both users of homeless and protected housing services are considered to be in a precarious housing situation that can also be categorized in wider definitions of institutional homelessness.

stereotypes is helpful in increasing one's self-efficacy and empowerment (Watson, Corrigan, Larson, & Sells, 2007). In this section, we discuss these factors in relation to deinstitutionalization.

Williams & Stickley (2011) show that for many homeless people, psychosocial barriers (stress, shame, stigma) derived from past experiences and stigmatized social status constitute a major barrier to asking for help or to (re)connecting with their social contacts. Previous experiences with stigmatization and societal rejection have negatively affected their sense of identity, or have led to an internalization of ideas that cause self-stigmatization. For many homeless people, stigma within society and a feeling of alienation when trying to fit in with 'normal' society act as barriers to them approaching new people, visiting new places and assuming new social roles (Williams & Stickley, 2011).

Research suggests that perceived stigma results in a loss of self-esteem and self-efficacy and in limited prospects for recovery (Link, 2001). Watson et al. (2007) show how group identification (GI) and the perceived legitimacy (PL) of mental illness stigma and discrimination may predict the extent to which individuals agree with stereotypes. They may apply these stereotypes to themselves and thus experience diminished self-esteem and self-efficacy or, conversely, more self-empowerment. As they explain, there are individuals who have positive examples for group identification (e.g. of people recovering from homelessness through direct housing) and a critical perception of the legitimacy of stigma and discrimination (e.g. of shelters as not legitimate emergency accommodation for homeless people). These people have a better chance of withstanding self-stigma (e.g. 'I am not the undeserving homeless, I deserve housing'). This implies that individuals who have fewer positive examples available to identify with (e.g. peers in protected institutions involved in unsuccessful recovery attempts) may be more susceptible to self-stigma (e.g. 'I expect my recovery to be unsuccessful').

Rapp & Goscha (2006) find that a requirement for empowerment of a person or group is an environment that provides options and gives a person the right to choose. This refers to the person's actual power to select from various alternatives, such as housing options. There are success stories of clients who have succeeded in living independently with floating support, having their own place with more privacy, and being able to control their life and having the opportunity to play a meaningful social role. This is a frequent outcome in studies on recovery, based on the expressed wishes of clients (Browne, Hemsley, & St. John, 2008; Van Hoof, Knispel, Van Wijngaarden, & Kok, 2009).

Reconnecting one's social network or approaching new people is not always easy or a matter of course. Kirst et al. (2014) reveal that most of their participants' narratives show a clear visualization of goals for recovery, which emphasizes the importance of housing as an integral factor facilitating hope and supporting dimensions of recovery. However, some Housing First participants had difficulty in adjusting to housing, and were concerned that feeling socially isolated could have negative implications for hopefulness and recovery. Galvin (2004) identifies how people with physical impairments who are reliant on their informal network experience feelings of shame, lack of independence and the obligation to be constantly grateful. The attitude of clients towards the policy intentions of reducing professional care while supposedly increasing informal care is not positive, and long-term care recipients in the Netherlands generally refuse an increase in dependence on their informal network. Consequently, clients who have less access to public long-term care do not seek alternative help and display limited self-efficacy (Grootegoed & Van Dijk, 2012).

For homeless families, self-efficacy and the time perspective have been shown to inform positive coping strategies in finding housing and work (Epel et al. (1999). The contrary was also found in this same study: "Those who distrust their ability to influence the course of events have little incentive to look to the future to set distant goals for themselves. They are more

likely to adapt a fatalistic present-oriented outlook in their everyday lives" (Epel et al., 1999, p. 579). Within the context of youth homelessness too, self-efficacy appears to predict rule adherence and to reaffirm the importance of incorporating notions of people's perceived ease or difficulty in performing actions in models of attitude–behavior prediction (Broadhead- Fearn & White, 2006).

For chronically homeless individuals with alcohol problems, it has also frequently been shown how multiple failed treatment attempts may erode self-efficacy and self-control for later behavioral change (Muraven, & Baumeister, 2000). Collins, Malone, and Larimer (2012) in a Housing First (HF) intervention show how both time spent and motivation to change (MTC) (rather than substance abuse treatment attendance) consistently predict improved two-year alcohol-use programs and alcohol-use outcomes among chronically homeless individuals with alcohol problems.

These studies show that there is quite some knowledge on how (self-)stigma and self-efficacy have a major impact on the lives of users of homeless and protected housing facilities, limiting them in different possibilities among which one of them is housing. However, there are still a few gaps in knowledge when it comes to the extent in which service user perspectives and experiences of deinstitutionalization within shelters and supportive housing programs vary.

Methods

Sampling and recruitment

A purposive sample of participants (adults diagnosed with serious mental illness with histories of substance use and institutionalization or homelessness, using services) N=160 were recruited through the associated Dutch regions' participation in a larger five-year study. This study examined professional (political, administration, housing associations, mental health and

addiction services, welfare, police) and service user participants' narratives on deinstitutionalization and decentralization of shelter and protected housing services. Dutch regions typically constitute one larger central municipality with five to eight smaller municipalities; since 2015, they have borne policy responsibility for shelters and protected housing.

Shelters usually take the form of a night shelter for the homeless that serves as emergency accommodation and where a variety of people are taken in who have become homeless for various reasons (e.g. evicted/asked to leave or discharged/expelled from an institution or prison). Night shelters usually only admit people during the night and stay is limited to a few nights. In '24-hour' shelters, homeless people can stay for longer periods and usually also during the day.

Protected housing is defined as a "community-proximate institution" (Novella, 2010, p. 233), intended for people with psychiatric support needs. Typically, a stay in protected housing will follow discharge from a mental health clinic, sometimes because the client has lost their previous housing during their stay in the clinic. In our research we saw a considerable overlap between the clients of protected living and of the shelter, with those who were expelled from protected housing ending up in the shelter, and those in the shelter waiting for placement in protected housing (Authors, 2019).

Independent housing is offered to some clients with special priority and as part of a program after a stay in a shelter or protected housing, or on a participant's own initiative. Participants reside in transitional housing: a room or an apartment that is rented from the landlord by the service for the first two years. After this time, if successful, the participants will enter into a direct rental contract with the landlord. Transitional housing is seen here as a shelter/ permanent housing service. Depending on the region, transitional and permanent housing can assume different and widely varied forms.

Inclusion criteria for service user participants included being over 23 years of age, single (not bearing responsibility on the reference date for underage children), entitlement to service provision within the Dutch social support act or health insurance and upon the service user's consent for their inclusion. Regardless of completion of the interview, participants received a €10 gift card.

To create a representative sample per region, an inventory of shelter and protected housing was made. Many participants were then recruited with the help of the services that provided them with housing. We also recruited participants 'on the spot' in drop-in centers or day activities centers (thus not directly through services).

Data collection

The explorative nature of this study demanded a qualitative approach (Denscombe, 2003) allowing sufficient scope for the sensitivity of the context to be investigated in a natural setting, using a semi-structured interview-questionnaire (interview questionnaire 1) taking context into account (Boeije, 2009). The interviews took place within a week of the service user's agreement to participate in the study, and a total of 160 service users participated in an interview.

All study protocols were approved by the authors' university medical and social sciences ethics committees. Each participant gave written informed consent prior to participation. Researchers explained the content of the informed consent and emphasized the voluntary nature of participation and that participants could decline to answer any particular question or stop their participation at any time. An audio recording of the interview was made with the written permission of the participants.

Ten trained duos of university interviewers with experience working in the shelter and protected-housing systems and interviewers with lived experience as service users in these same systems conducted the semi-structured interviews (using interview questionnaire 1) lasting approximately 45 to 60 minutes. It transpired that, thanks in part to the involvement of interviewers with lived experience, participants spoke with great openness about potentially delicate subjects such as substance use and mental illness (Devotta et al., 2016).

Interviews were scheduled at the service user's convenience and completed in a private office space or at their homes. Interviewers asked general questions about the policy development in the participant's own shelter or protected housing and posed specific questions about support or guidance for independent living (whether people were moving out). Interviewers also asked additional probing questions pertaining to service user perspectives. The questions included: How do you experience your current living situation? Could you tell us what the professional support that is provided does for you and what it means for you? The interviews were audiotaped and transcribed verbatim for entry into ATLAS/ti software.

Data-analysis

A two-stage content analysis of verbatim transcripts was utilized to (1) assign a deductive analysis using predetermined theory-based codes (Authors, 2018) perform an inductive analysis to generate emerging codes and to reduce the complexity of the data (Thomas, 2006). The initial codebook that was used for the independent coding of the first twenty transcripts held the codes for temporary (shelter and protected) and independent (permanent) housing. To support the development of ideas and to ensure analytic rigor, several strategies were employed, including peer-debriefing, independent and co-coding, prolonged engagement with study participants and memo-writing (Padgett, 2017).

When emerging categories had been developed by studying the transcripts repeatedly and considering possible meanings and how these fitted in with developing themes, three additional categories of participant opinions emerged: (PRO) 'pro deinstitutionalization', where the manner in which deinstitutionalization takes place at the present time is seen as positive and feasible; (TERMS) where deinstitutionalization is perceived as positive and feasible only if certain additional conditions or terms are met, and (CON) 'against deinstitutionalization', meaning that it should not take place under any circumstance and is not feasible. Five participants were classified as 'not available' as insufficient information was obtainable to unambiguously classify their opinions.

In the coding process, it emerged that it was important to get a good overview of the entire transcript before the code could be assigned. For example, a participant may at first be very positive, and during the course of the interviews present clear terms upon which leaving the institution is still felt to be a good idea. In this example, no other new codes emerge, suggesting that saturation has been achieved (Urquhart, 2013).

Compliance with Ethical Standards

Disclosure of potential conflicts of interest

Authors state that there are no known conflicts of interest and all authors certify responsibility.

Ethics approval on research involving human participants

All study protocols were approved by the authors' university medical and social sciences ethics committee at the time the data collection took place: Medical Ethics Committee of the University Medical Center Utrecht (18-144/C); Faculty of Social and Behavioural Sciences, Faculty Support Office, Ethics Committee (FETC18-022 (Authors); FETC18-123 (Authors).

Informed consent

Each participant gave written informed consent prior to participation. Researchers explained the content of the informed consent and emphasized the voluntary nature of participation and

that participants could decline to answer any particular question or stop their participation at any time. An audio recording of the interview was made with the written permission of the participants.

Results

Sample Characteristics

Regarding the demographic characteristics of the sample of 160 service user participants: 120 participants are male (75 %); 26 participants are aged under 35 (16%), 75 participants are between 35-55 (47%), 49 participants (30%) are over 55 years old and 10 participants (6%) are age unknown.

General opinions on deinstitutionalization

Table 1 (next page) shows that the majority of participants (n=101, 63%) set terms regarding deinstitutionalization or, in other words, are not overly positive about their own deinstitutionalization. These participants are still open to the idea and are clear about the terms that need to be met. Participants who are 'pro' deinstitutionalization (n=32, 20%) are mostly housed in shelters and, to a lesser degree, in permanent and protected housing. Participants who are 'con' deinstitutionalization and most hesitant about the idea due to social factors and health needs constitute the smallest group (n=22, 14%), and are mostly from protected housing, followed by permanent housing, and not from shelters.

Table 1

Clients classified according to opinion on deinstitutionalization

Category			
Housing Status	**Total Sample (%)**	**Opinion**	**Total sample (%)**
	160 (100)		160 (100)
Pro	32 (20)	**Shelter**	21 (13)
		Protected housing	6 (4)
		Independent housing	5 (3)
Terms	101 (63)	**Shelter**	23 (14)
		Protected housing	41 (26)
		Independent housing	37 (23)
Con	22 (14)	**Shelter**	0 (0)
		Protected housing	15 (9)
		Independent housing	7 (5)
N/A	5 (3)		5 (3)

Table 2 demonstrates broad thematic differences between ‘pro’ and ’con’ participants. ‘Pro’ participants' opinions relate to motivators such as the amount of time involved, the denial of perceived legitimacy of stigma and merits of self-direction and one’s own authority in decision-making. On the other hand, ‘con’ participants’ opinions indicate barriers such as habituation due to time spent, age, and the fear of social isolation and loneliness. They also mention, in relation to the participants' support needs, the virtue of stability, a lack of self-confidence and multiple failed treatment attempts by themselves or their peers.

Table 2

Social Psychological Motivators and Barriers related to Deinstitutionalization

	Motivators
Social aspects	
Time/ age	‘Four years is just too long to live here'
Denial of perceived legitimacy	‘These guys, no matter how strong you are, if you live here for three weeks, you get frustrated. You’re living here with several people, with multiple cultures in one place. You cannot escape, it’s just like in prison, for example.'
Authority	‘There are plenty of people who, if you encourage them enough, could live on their own, with or without support... I don't see the point of living in protected housing throughout your life.'
	Barriers
Social aspects	
Time/ age	‘Maybe for young people. But at my age, sixty-nine, we're not going to do that anymore.'
Fear of social isolation, loneliness	‘Then I would be alone all day, I couldn’t stand that. Then I’d kill myself.'

Support needs	
Stability	‘I loved those four years. I had almost no outliers. And other people also have problems, so you don't have to explain anything to each other.'
Lack of self-confidence	‘So I tried to see whether [living independently] worked, but it didn't work. I felt I needed more and more help, and at one point they also said "we cannot provide help day and night." I could call at night, but that was not enough.'
Repeated failed treatment attempts	‘I got caught with alcohol at one point, yeah, and then I had to go out for the night and then I decided: I’ll quit [treatment]. Then I'm done with it. And then I was off the radar [of professionals] for a month or two.’
The wrong policy-incentive	‘Because sometimes the authorities want you to live independently too quickly, because this naturally costs them money'

Setting Terms: Transition- and Continuity Oriented Support

The majority of shelter and protected housing participants do not take an explicit stance, and are in favor of deinstitutionalization, provided this is done under certain conditions, such as provision of increased ‘transition-oriented support’ and ‘continuity of support’.

Transition-oriented support

Participants indicate that a transition to independent housing would be accompanied by less fear and uncertainty if this transition were to be independent on whether or not support is extended, and if clarity is provided about what kind of support may be expected once the transition to independent housing has taken place. These participants regard their transition to

independent living important and desirable and wish to receive continued support during and after the transition, and to move-out at their own pace (and not hastily for reasons of efficiency). One of our participants states: “The support will have to keep coming. Then there’ll be a chance of success, but "work it out for yourself" just really doesn't work for me.”

In such a case, it would be appropriate to implement an intervention such as Critical Time Intervention (CTI), a time-limited case-management model used in preparation of and during the actual transition. It is designed to prevent adverse outcomes in vulnerable people at the time of a critical transition in their lives, such as after discharge from institutional settings (Herman, Conover, Felix, Nakagawa, & Mills, 2007). We also see this need for transition-oriented support and motivation to change in participants who have recently recovered from an active addiction, many of whom have made follow-up appointments with support services (e.g. urine or bladder checks) to protect themselves from relapse. Here, the importance of the availability of unconditional support irrespective of time-limitations is related to the Housing First method, where both time spent and motivation to change (rather than substance abuse treatment attendance) consistently lead to improved and continuity-oriented programs (Collins, Malone, & Larimer, 2012).

Continuity-oriented support

This majority of ‘terms-setting’ participants also state that it is not clear to them what exactly will happen when they actually move to independent housing. Participants expect that support will be available, but do not necessarily know the amount of support available to them, the organization that will provide this support, and whether their current support-worker will continue to be involved. This continuation of support work is important to the trust that has been built up, especially for care-avoiding (or particularly timid) participants. Protected housing participants do not know whether it would be possible to return or temporarily return to

protected housing if they relapse, which is important to them and could prevent them from losing their homes. The necessity of support provision outside office hours is also mentioned.

Participants also find it important to be able, once they have moved, to determine themselves how much support they want to continue with. One of our participants describes this balance of self-direction and support-need: "Of course, I would be happy if someone came by one a week. If only to check up on me. That's great, but I also want to be independent."

According to Rapp and Gosha (2006), the provision of such options as self-direction and ascribing authority to a person to choose what support to receive are requirements for a person or group to become empowered. Participants feel that long-term floating support would prevent them having to make use of institutional facilities once again and also that this would increase their social integration. Moreover, this finding shows how open participants are to receiving professional support, provided it is on their own terms, or 'tailor-made'. Participants emphasize the importance of making clear agreements and knowing whom they can contact when things are not going well. This familiarity lowers the threshold for getting in touch, which may also tempt those participants to become 'pro'.

Pro deinstitutionalization: Motivators and Risks

Participants who are pro deinstitutionalization are mostly from shelters (McDaid &Thornicroft, 2005) and, to a lesser degree, from protected (Bannink et al., 2014) and permanent (Rapp & Goscha, 2006) housing.

Social aspects

We see denial of perceived legitimacy with sheltered participants. Those participants support deinstitutionalization mainly because of the (negative) social aspects they experience

that make staying in a shelter for a longer period very difficult. A topic that emerges in almost all these interviews is that participants are not happy with the fact that they have to share the shelters with people who have very extreme and complex problems. One of our participants states: “You are among clients who have lost their way spiritually and psychologically. So a person who has never lived among such people, or has a more timid character, will not feel at home here. Drug users are very mixed up”.

This concerns, for example, people with psychiatric and substance-abuse issues who may have been expelled from protected housing. These sheltered participants do not see their fellow residents as conducive to their recovery. Participants express that being homeless does not mean that you are “crazy”, and actively refute the stigma associated with this as being applicable to themselves. This lack of identification with other residents can also be seen as a form of denial of the perceived legitimacy of residence in a shelter, and as increased stereotype awareness and the empowerment related to this (Watson et al., 2007). A number of residents with complex needs were also interviewed for this study, and results described here indicate their need for transition-oriented support and motivation to change. We do not see participants in shelters who dismiss deinstitutionalization, irrespective of the time they have spent there.

Time-related aspects we typically see with ‘pro’ participants. Those participants see a rapid outflow to transitional or independent housing as a necessity. This is also related to the individual risks they identify within the shelter environment. A participant relates: “They stay there for too long. They come in sober and go out addicted. I really believe that it often causes more harm than good.”

Therefore, according to these participants, a long-term stay in a shelter without the perspective of independent living can contribute to a client’s further decline and lead to dependence on other forms of care such as protected housing. A smaller group of protected-housing participants also mention that they have lived in the institution for too long.

Overall, these participants have succeeded in retaining a clear time perspective, which has been identified as contributing to greater success in finding housing and work (Epel et al., 1999), and is linked to authority.

We also noted the aspect of authority with the interviewed protected-housing participants who wish to rehouse because they feel that they receive a surfeit of care. In their view, an abundance of support can be detrimental to clients because it leads to dependence. One of our participants says: "Because I sometimes notice that people have more to offer and that their abilities don't get used. It is a kind of convenience just to rely on support."

The view of these participants emphasizes the importance of being in an environment that provides options and the authority to make one's own choices. Rapp & Goscha (2006) show that privacy, control and having alternative social roles (other than simply receiving protected housing) contribute to a successful independent life with floating support. This appears not to be quite the experience of those participants who do not support deinstitutionalization.

Not supporting deinstitutionalization, experiencing barriers

All the participants who are against deinstitutionalization (n=22, 14%), reside in protected housing (15) or have recently left and now live independently (7). Participants relate to social aspects, support needs and the wrong policy incentive.

Social aspects

Regarding the time aspect, protected housing participants in the Netherlands and elsewhere have, since the 1980s, been subjected to various developments in protected housing. We see the time dimension as a possible explanation for opposition to deinstitutionalization.

With two exceptions, the remaining 20 participants in this group are equally divided across the 35-55 and the over-55 age groups and expressed the experience of being ‘too old’ to make the transition to independent living. Another time-related dimension is that these participants indicate that it can be very hard to return to your own home after living in an institution for an extended period. It is for this reason that they state that it is important to limit new admissions to protected housing, simply because it is so hard to leave once you are there. One participant emphasizes: “I mean, you first have to look very carefully at what kind of help you can offer at home to prevent people from moving to an institution.”

This opinion can be explained by the combination of the time spent in protected housing and the age of the participants. Here we can see the time dimension as a manifold barrier. This group of participants strongly associates deinstitutionalization with the feeling of social isolation and the fear of loneliness. A participant shares with us the fear caused by the proposition of a transition to his own home: “Every day you hear "good morning" [from the staff and fellow residents]. Soon I'll be alone again. For me that's kind of scary.”

The fear of having to survive on your own and the loneliness of living in an independent home plays a major role. Participants indicate that they fear that the lack of clear structure in the course of the day will increase their personal risk of depression or suicidal thoughts.

Support needs

A need for psychiatric support increases the demand for stability and limits the desire for any change to the participants' lives, especially a major event such as a change in housing. For this reason, participants set great store by the peace and stability in their lives that they hope to gain by remaining in their protected housing facility. A participant expresses: “This [residing protected housing] was a godsend for me. Because suddenly there was a solution to my

problem. I just can't function on my own." An unannounced or short-notice offer of follow-up housing is not appreciated or accepted by these participants.

According to the participants who do not support deinstitutionalization, lack of self-confidence is caused by multiple failed attempts at independent living either by the participants themselves, or by peers in their institutions. It is for this reason that they do not want to leave their current living situation. One participant indicates: "Normally I'm quite assertive, but now I am quite insecure about myself. I need someone next to me to give me some support and some guidance, you know?"

The loss of self-confidence we see here is combined with a lack of positive examples for group identification. This leads to the perceived legitimation of negative stereotypes that participants begin to apply to themselves. The perceived stigma of being in the context of people and surroundings that negatively impact their own self-efficacy and self-esteem (Watson et al., 2007) is evident here as a barrier.

Multiple failed treatment attempts also play a role in blurring participants' perspective on deinstitutionalization. This is especially true for participants with an active addiction that still commands most of their attention. This makes it more difficult for them to articulate what they require in the long term. One of these participants shares what is needed: "The counselor has to have a conversation with you: Tell me what happened. And then they can still impose a penalty. Just listen please, because there is a story behind it."

Participants with substance use feel that the focus is on punishment rather than on understanding. This experienced lack of listening explains how multiple failed treatment attempts may erode self-efficacy and the necessary self-control for later behavioral change (Muraven & Baumeister, 2000). Harm reduction methods, such as Housing First, have been seen to attain better results in re-housing people with substance use, even though it remains a challenge (Kerman et al., 2020).

A final reason for participants to fall within the category opposing deinstitutionalization deals with perceiving the wrong policy incentive. In this case participants indicate feeling pressured and seeing deinstitutionalization primarily as a cost-saving measure. These participants feel that the transition towards independent living is being forced upon them, even if they are not ready for it, because it is cheaper than being housed in an institution. One of our participants shares: "Of course it all costs quite a bit of money, all the care. They want to cut the costs, one way or another. I do kind of get that. Only I think that there's such a risk for people who are really vulnerable." We sometimes also find a direct echo of a professional's resistance to policy change in the words of a participant. This is an example: "I hear from the staff that it should all be done more cheaply."

Participants indicate that there is an imbalance in the professionals' interest in their well-being. Therefore, they conclude that deinstitutionalization policy is based on the wrong incentive. Deinstitutionalization is seen by a number of these participants as a financial measure that does not always work in the interest of clients, and can even be counterproductive. This is mentioned most specifically in respect of people with substance use.

Discussion

The purpose of this explorative study has been to comprehend the narrative on deinstitutionalization. This narrative has been generally defined as the degree of support for social policy from the perspective of participants. The majority of the participants' responses (63%) show limited support for direct housing policies, and emphasize that whilst housing is an integral factor that can support aspects of recovery, additional conditions in offering support, need to be met. Such conditions or terms concern the degree to which current services are recovery-oriented and able to provide a continuity of floating support. If these terms are not met, then participants feel that the transition will progress too fast, and they are therefore not

inclined to move: *"Rather you than me*". Twenty percent (most of whom reside in shelters) support deinstitutionalization irrespective of the current terms and conditions; they are motivated by the detrimental social aspects of shelters and a desire to be self-supportive. Implications for behavioral health are an increased risk of recurrent homelessness. Fourteen percent (all currently or previously in protected housing) oppose living independently again due to age, psychiatric support needs, loneliness, multiple failed drug-treatment attempts, a lack of practical skills or the perception of re-housing as being based on 'the wrong incentive'.

In this study we have looked for explanations for the results from the perspective of social psychology. In our results section we have shown relevant correlations of our data with existing literature. We related Collins et al. (2012) in the context of Housing First to the setting of terms (terms) for deinstitutionalization and offering outflow and continuity-oriented support. We related findings on self-authority to Rapp & Goscha's (2006) emphasis on motivators (pro) such as setting privacy, control and alternative social roles for successful deinstitutionalization and that are mentioned by those who support the policy. Harm reduction and time spent have also been seen to increase successful deinstitutionalization (Collins et al., 2012), and additional motivators have been identified, such as the denial of perceived legitimacy (Watson et al., 2007) of shelter provision to people with unmet complex needs (Tsemberis & Eisenberg, 2000).

We have identified social psychological 'barriers'(con) in the narratives of participants opposing the policy goals that included social aspects such as the feeling of social isolation (Kirst et al., 2014; Verplanke & Duyvendak, 2010) and the need for stability rather than change. The latter is akin to Epel et al. (1999) who describe the clients' distrust of their own ability to influence the course of events, causing these clients to be more likely to adopt a fatalistic present-oriented outlook to everyday life. The lack of self-confidence (Watson et al., 2007) that participants relate to themselves or their peers' multiple failed treatment attempts supports the

idea that multiple failed treatment attempts may erode self-efficacy and self-control with respect to later behavioral change (Muraven & Baumeister, 2000).

The strengths of the study lie in the semi-structured peer-to-peer interviewing of 160 participants from a wide range of urban and rural settings, providing the insight into the level of support for deinstitutionalization policy that was necessary for this research. This wide range of settings ensures the transferability of the findings under discussion. Additionally, the interviews showed participants to be very capable of describing the tools they considered necessary to increase the chance of success of living independently, making the findings of this research as discussed above both credible and confirmable. The equal (and large) number of participants in shelters and protected housing enabled us to distinguish patterns in opinions that could clearly be related back to the housing type. While the perspectives and experiences of the shelter participants were fairly uniform, protected housing participants had more diverse experiences with regard to social needs, support needs and the experienced role of services in communicating policy incentives.

A limitation of this study is that it only considers service user perspectives. Whilst the broader study does consider management and executive perspectives, also the experiences of frontline staff could offer further insights. Furthermore, this study is potentially limited due to its location in Dutch regions where poverty is less often a cause of homelessness than in many other countries. However, the dependability of this study is bolstered by the finding of similar results in other, comparable international contexts such as in Denmark. The authors found service users expressing their opposition by stating: “Having to move out again can be seen as a punishment (…) wanting to save money [at our expense]” (Authors et al., 2018, p. 55). This shows a clear similarity to the experienced barrier ‘the wrong (policy) incentive’ discussed in this study.

Future research should take into account whether policy variation in both larger and smaller municipalities is an explanatory factor for the variation found in user-perspective. It is also important to include in future research the services and tools offered by the institutions.

Seeing the barriers experienced from the service user perspective in this study, for whom (various) institutions have been part of their precarious housing situation, we recommend that their value of permanency over moving out again is taken into account by policymakers. Examples of permanent and clustered, institutionalized contexts with permanency of tenancy and privacy are, for instance, part of the Finnish Housing First solution to homelessness.[51] This would mean conversion of existing protected housing units to rental-occupied settings, with support. The recurrence of homelessness, perceived low self-efficacy and self-stigma can be overcome by the provision of long-term and tailor-made support, resulting in the desired recovery and social integration without (self-) stigma.

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