Introduction to the Special Section: Toward Social Inclusion

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The ambitions of mental health providers for improving the lives of people with serious mental illness, addictions, and homelessness have grown seemingly exponentially in recent years. At the same time, the prospects for helping people overcome these adversities, which often occur in mutually exacerbating combinations and with diverse medical and social complications, have been worsened by the recent economic crisis. Obtaining housing, preventing hospitalization, or linking clients to income supports, medications, or social services no longer seems to be sufficient. With a new language of recovery, social inclusion, social integration, and citizenship, we increasingly seek to facilitate the achievement of a full humanity, a self-directed capability (1), or the full worth of freedom (2) in the lives we touch.

Care in conventional clinics is being supplemented by or replaced with increasingly diverse and imaginative processes directed at both consumers and the general public. In May 2011, the Columbia Center for Homelessness Prevention, directed by Carol Caton, Ph.D., gathered an international panel of scholars to review empirical, conceptual, and historical perspectives on our efforts to fulfill these ambitions. The seven articles in this special section represent the fruits of this gathering.

The first three contributions present recent empirical outcome data on state-of-the art programs that have sought to improve the lives of homeless persons with mental health problems. There is both good news and bad news, but the highest hopes seem to have been disappointed. In the first article, my colleagues Jack Tsai, Ph.D., and Alvin S. Mares, Ph.D., and I (3) present data from a federally funded, interagency collaboration to serve chronically homeless adults in 11 communities. The program achieved striking gains in reducing homelessness and improving housing stability but far more limited benefits in clinical domains, quality of life, and community participation. In the second article, Baumgartner and Herman (4) report on an experimental replication of the successful critical time intervention model with formerly homeless adults after discharge from inpatient psychiatric care. Participants experienced gains in housing and reduced hospitalization, but these outcomes were not associated with gains in social integration, which remained low. In the third study, Yanos and colleagues (5) compared the community integration of formerly homeless clients living in the Bronx in "housing first" supported housing provided by Pathways to Housing with that of other residents of the same neighborhoods. The clients in supported housing had lower community integration scores. However, length of time in the current residence was associated with better integration, which raises hope for improved social integration with greater community tenure.

The next three contributions to this special section move beyond the impact of service programs to identify the domains of greatest importance to consumers, to outline a novel group-centered approach to community development, and to evaluate the implementation of a communitywide education initiative designed to reduce stigma in the general population. Rowe and colleagues (6) used a multistage procedure to survey a wide range of consumers and found confirmation for a broadened conceptualization of service goals that center on citizenship and can be viewed as encompassing five Rs: rights, responsibilities, roles, resources, and relationships. Mandiberg (7) reconceptualizes the path to social reintegration, questioning the individualistic approach that has been dominant since the advent of community-based care models, such as assertive community treatment, in the 1970s. He advocates a diverse array of group programs, or enclaves, that directly foster the development of mutually supportive consumer communities. Henderson and colleagues (8) reframe the entire challenge of social reintegration with an intervention that is not directed toward consumers at all but rather toward education of the general public in London and the communitywide destigmatization of mental illness. The authors describe significant success in reducing discriminatory attitudes by 5%—perhaps a small absolute change, but one that has the potential to improve the sociocultural environment of far more consumers than any single service program.

Finally, Hopper (9) offers a broad historical perspective, commending

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the success of supported housing programs, such as those studied in the first triad of articles in this section, for their success in reducing homelessness among vulnerable citizens but lamenting the turn-away from the larger project of "rewriting cultural scripts" that continue to foster social suspicion and wholesale shunning of people with mental illness. Hopper cautions that the emphasis on recovery, peer support, and empowerment may inadvertently place the onus of responsibility too one-sidedly on stigmatized clients, letting the "1%" with the greatest access to power and resources off the hook. This concern is partially addressed in the public education work described by Henderson and colleagues (8), but Hopper urges a wider-ranging transformation of cultural values.

The contributions in this special section set a high bar for the future. The authors do not flinch from answering tough questions with "Why not?" and resist the all-too-common inclination toward triumphalism in the face of small, albeit statistically significant, gains. Such gains should not be undervalued, but neither should they be allowed to crowd out deeper aspirations.

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