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ENDING CHRONIC HOMELESSNESS FOR PEOPLE WITH MENTAL HEALTH AND ADDICTION DIAGNOSIS:

PATHWAYS' HOUSING FIRST

PROGRAM DESCRIPTION & EVIDENCE BASE

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PATHWAYS HOUSING FIRST: PROGRAM DESCRIPTION

Pathways Housing First is a humane, highly effective and cost efficient consumer driven, evidence-based program that ends homelessness for people diagnosed with psychiatric disabilities and/or addiction disorders. In 2007, this program successfully completed peer review and is listed on HHS/SAMHSA's National Registry of Evidence-Based Programs and Practices.

The Pathways' Housing First program is based on a philosophy that emphasizes consumer choice, rehabilitation, and recovery. Housing First is designed to address the needs of homeless individuals from the consumers' perspective, encouraging program participants to define their own needs and goals. The program provides what most consumers identify as their primary need -- immediate access to housing (a place of their own, a place to call home).

Independent, affordable apartments rented from community landlords is by far the most preferred housing option of all people who are homeless. Units are rented very quickly from the available housing rental market in normal integrated community settings by using rent subsidies such as Section 8 vouchers, shelter plus care funds or other permanent housing rent stipend. The program uses a 'scatter site' approach never renting more than 20% of the total number of units in a building. Program participants pay 30% of their income (usually SSI) towards their share of the rent. Thus supported housing program has a remarkably quick start up: it takes about 3 months from the time a program is funded to hire the support staff and begin moving people into apartments.

The program successfully removes the traditional barriers to housing for people who have disabilities. Notably, it does not place conditions such as achieving a period of sobriety or mandatory participation in psychiatric treatment as a precondition to housing. The program is

especially effective with people who are chronically homeless and cycling through expensive acute care services such as emergency rooms, shelters, hospitals, police and jails.

It is important to note that cycling through these acute care services is very costly and yet completely ineffectively for ending homelessness. By addressing the homelessness problem first and providing the person with a place to live and then the support services need to succeed in that housing we have been able to achieve enormous success in both ending homelessness and helping people with their recovery. And the cost of this permanent supported housing program – a section 8 voucher (or its' equivalent) and the support services component is significantly less than the cost of keeping the person in a hospital bed, jail cell, or even city shelter.

The clinical and support services of this program ensure that housing is found quickly and that it can be successfully maintained. The services include both clinical or case management staff and housing staff. We have found that housing is itself a stabilizing factor for program participants and allows them to move in the direction of treatment. The program fosters a sense of home (not simply providing housing) and belonging; being part of a building, neighborhood and community as well as a member of a treatment and support team. The way that the housing is integrated into the community promotes community integration, and empowers participants to define their own paths to recovery.

The Pathways Housing First program addresses housing and clinical issues as separate but coordinated domains. By providing housing first, the program effectively addresses a person's homelessness. By providing program participants with an apartment of their own and then, once safe and secure, they work with the support services team to address their other problems such as addiction, mental health, employment and so on. The program requires that all program participants agree to a home visit by a member of the support services team at a minimum of once a week. This visit assures the health and safety of the program participant and is the setting for developing the treatment and rehabilitation service plan.

Treatment and support services are provided by an Assertive Community Treatment (ACT) team [comprised of social workers, nurses, psychiatrists, employment specialists, substance abuse counselors, peer counselors, and other professionals] or an Intensive Case Management (ICM) team that provides support services but may broker other services including mental health, health, substance abuse treatment, supported employment, education, health and wellness to community based providers. ACT is the preferred support for persons with severe mental illness and ICM teams can be used for tenants with moderate mental health needs. ICM support can also be used when programs have a smaller census (less than 40 clients) and are not well suited to sustaining the staffing pattern of an ACT team. The housing component is always a community based apartment or equivalent depending on the housing stock available in the community and whether the participant is single, couple or family. The type and intensity of support services being provided to the participants is adjusted to meet their needs.

Over time, as individuals recover they can be referred to community-based providers that deliver needed services. Upon graduation, consumers do not have to transition into another housing program. They are already living in their own apartment with the subsidy still available if they need it. The only thing that changes at graduation is that the support services are reduced

or eliminated altogether and the person continues to live in the building and community to which they are accustomed.

The most remarkable and exciting discovery of this Housing First program concerns what we have learned about the capabilities of people who are homeless and have multiple disabling conditions. We have found that when given the right housing and support services people who we had previously considered 'hard to reach,' ' hard to house,' and 'not housing ready' are in fact capable of making and managing a home, successfully participating in treatment, reuniting with families, and getting a job. This remarkable success of the program's participants is the main reason that in a relatively short 10 year span, the Pathways Housing First program has grown from a small local program operating in one city to an internationally replicated model in hundreds of cities.

RESEARCH STUDIES AND DEMONSTRATED EFFECTIVENESS

There is an ever-growing body of research evidence for the effectiveness of the Pathways' Housing First program for ending homelessness, promoting housing stability, improving quality of life, reducing acute care service use and reducing costs. Results from some of the larger studies are summarized below.

I. Greater Housing Retention

Studies have shown that Housing First participants achieve stable housing faster & spend more time in stable housing.

1) A randomized controlled trial of persons who were literally homeless showed that after one year, participants in Housing First (experimental) spent 85% of their time stably housed, compared with less than 25% for participants in the services-as-usual group (control) (Tsemberis, Gulcur, & Nakae, 2004). After two years, Housing First participants still spent approximately 80% of their time stably housed, compared with only 30% for the control group (see Figure 1). Housing First tenants also reduced the proportion of time they spent homeless from approximately 55% at baseline to 12% at one year, and less than 5% after two years (see Figure 2). Reductions in homelessness were significantly slower and less drastic for the control group, who were homeless approximately 50% of the time at baseline, 27% at one year, and 25% after two years (Tsemberis, Gulcur, & Nakae, 2004).

Figure 1. Proportion of Time Spent in Stable Housing

Figure 2. Proportion of Time Spent Homeless

2) A randomized controlled trial of long-term shelter stayers found that participants assigned to Housing First obtained permanent, independent housing at higher rates than a services-as-usual control group. The majority of consumers housed by both Housing First agencies retained their housing over the course of four years with 78% of participants in the Pathways Housing First program remaining housed over that period (Stefancic & Tsemberis, 2007).

3) A randomized controlled trial in Chicago found that 60% of persons in Housing First were stably housed at 18 months, compared with only 15% of persons assigned to usual care (Sadowski, 2008; Bendixen, 2008).

4) Archival data was used to compare rates of housing retention for Housing First tenants to those of tenants in New York supportive housing programs that required treatment and sobriety as a precondition to housing. After five years, 88% of participants in the Housing First program remained housed, compared to 47% of participants in more traditional housing programs (Tsemberis & Eisenberg, 2000).

5) A cross-site study of programs funded by HUD, SAMHSA, VA and HHS and coordinated by the US Interagency Council on the Homeless (called the Collaborative Initiative to End Chronic Homeless) demonstrated that high housing retention rates could be achieved across the diverse contexts of the 11 cities funded by this initiative. At least seven of the eleven programs funded used the Pathways' Housing First model and approximately 80% of clients were stably housed after 1 year (Rosenheck, 2007).

6) A HUD cross-site study of six Housing First programs found that 84% of Housing First participants were in permanent housing at baseline and 1 year later (HUD, 2007).
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II. Reductions in Service Use

Studies have demonstrated that Housing First is associated with decreased use of emergency room visits, hospitalizations, incarcerations, and shelter stays, making Housing First a lower cost, more effective approach than traditional programs.

1) A randomized controlled trial found that persons assigned to Housing First spent significantly less time in psychiatric hospitals compared to participants assigned to services-as-usual (Gulcur et al., 2003).

2) A randomized controlled trial in Chicago found that persons in Housing First "used half as many nursing home days and were nearly two times less likely to be hospitalized or use emergency rooms" as compared to a usual care group over 18 months (Sadowski, 2008; Bendixen, 2008.).

3) A pre-post study in Denver documented reductions in institutional acute care subsequent to enrollment in Housing First. Housing First clients decreased emergency room use by 73%, inpatient stays by 66%, detox use by 82%, and incarceration by 76% (Perlman & Parvensky, 2006).

4) A pre-post study in Rhode Island documented decreases in hospital and jail stays, as well as emergency room visits, subsequent to clients' enrollment in Housing First. "In the year prior to entering supported housing, the formerly chronically homeless individuals spent a combined total of 534 nights in hospitals, 919 nights in jail, and had 177 emergency room visits. In contrast, the newly housed individuals had a combined total of only 149 nights in hospitals, 149 jail nights, and 75 emergency room visits in the first year of housing" (Hirsch & Glasser, 2007)

5) A pre-post study in Seattle, documented reductions in various services subsequent to enrollment in one of two Housing First programs. Compared to 1 year prior to admission, Housing First participants in one program decreased jail bookings by 52%, jail days by 45%, admissions to a sobering center by 96%, EMS paramedic interventions by 20% and visits to a medical center by 33% (DESC, 2007). Participants in the other Housing First program reduced medical respite days by 100%, inpatient visits to a medical center by 83%, emergency room visits by 74%, jail days by 18%, and admissions to a sobering center by 97% (Srebnik, 2007).

6) A pre-post study of Housing First in Massachusetts demonstrated that, compared to the year prior to enrollment, in the year after enrollment in Housing First, inpatient hospitalizations were reduced by 77% and emergency room visits by 83% (Meschede, 2007).

III. Decreased Costs

Studies have shown that Housing First is associated with decreased costs.

1) A randomized controlled trial of persons who were literally homeless showed that, from baseline to 2-year follow-up, participants in Housing First accrued significantly lower supportive housing and services costs than participants in services-as-usual (Gulcur et al., 2003).

2) A pre-post study in Denver estimated that enrollment in Housing First was associated with a net cost savings of $4,745 per person per year (Perlman & Parvensky, 2006).

3) A pre-post study in Rhode Island estimated that enrollment in Housing First was associated with a net cost savings of $8,839 per person per year (Hirsch & Glasser, 2008).

4) A pre-post study in Seattle estimated that enrollment in two of their Housing First programs was associated with an aggregate reduction in cost of services used by $1.7 million and $1.5 million, respectively (DESC, 2007; Srebnik, 2007).

5) A randomized controlled trial in Chicago concluded that “health care savings far exceed the costs of the Housing [First] intervention” (The National AIDS Housing Coalition, 2008).

In all there are more than 35 cost studies on this model, all showing similar results.

IV. Improvements in Quality of Life & Other Outcomes

Studies find that Housing First is associated with greater consumer choice, greater satisfaction, improved quality of life, and improvements in other clinical and personal domains.

1) A randomized controlled trial found that participants assigned to Housing First reported higher ratings of perceived choice compared to those in services-as-usual (Greenwood et al., 2005). Although program assignment did not have a direct effect on psychiatric symptoms, perceived choice significantly accounted for a decrease in psychiatric symptoms and this relationship was partially mediated by mastery (perceptions of personal control).

2) A qualitative study found that participants living in their own apartments through Housing First reported experiencing conditions that are indicative of a stable home that fosters a sense of control, allows for the enactment of daily routines, imparts a sense of privacy, and provides a foundation from which consumers can engage in identity construction (Padgett, 2007).

3) A Rhode Island study found that 93% of clients reported being "Very Dissatisfied" with their housing situation the year before entering their apartment. By contrast, 78% of clients reported being "Very Satisfied" and 12% "Somewhat Satisfied" with their housing situation at the time of first interviews…While homeless, nearly half of participants rated their health as "Poor" or "Very Poor" and two-thirds of participants said that physical or mental health disabilities had limited their ability to interact with those they felt close to. Once in the program nearly half rated their health as "Good or "Very Good" and only one third felt that their disabilities limited their social interaction (Hirsch & Glasser, YEAR).

4) A Housing First program in Massachusetts found that "overall quality of life improved dramatically for all Housing First residents after leaving the shelter, including increased sense of independence, control of their lives, and satisfaction with their housing" (Meschede, 2007).

5) Compared to participants in community residences, those in supported housing (Housing First and another supported housing program) reported greater satisfaction in terms of autonomy and economic viability over 18 months (Siegel, Samuels, Tang, Berg, Jones, & Hopper, 2006).

6) A qualitative study of participants in a randomized controlled trial found that, for most Housing First clients, entering housing after a long period of homelessness was associated with improvements in several psychological aspects of integration (e.g., a sense of fitting in and belonging) as well as feelings of being "normal" or part of the mainstream human experience (Yanos et al., 2004).

7) An evaluation in Philadelphia compared participants in Housing First to a group of persons receiving services but no housing. Of the participants in Housing First, 79% showed improvement in mental health (comparison group 20%), 57% showed improvement on substance use (comparison group 15%) and 84% showed improvement on overall life status (comparison group 50%) (Dunbeck, 2006).

CONCLUSIONS

The Housing First model has been replicated in over 40 cities throughout the U.S. and it is included as a program component in most city and county plan to end chronic homelessness.

• Housing First is a consumer-centered approach that ends homelessness for individuals who have remained homeless for years. From the point of engagement, it empowers consumers to make choices, develop self-determination, and begin their individual journeys toward recovery and community integration.

• Housing First has a 18-year track record of success. It results in better outcomes at significantly lower costs, creating a significant return on investment relative to other programs.

• Practically speaking, the program has a very quick start-up time since housing is rented from the existing rental market. Additionally, the program is extremely efficient in housing tenants, moving a person from homelessness into housing in two weeks, on average.

• Housing First eliminates costly transitional housing and treatment services that are aimed at preparing consumers to become "housing ready". The average cost of running a Housing First program is between $15,000 to $22,000 per person per year, depending on the intensity of services offered and local housing market rents. This cost compares very favorably with the cost of emergency room visits, jail stays, hospital stays, emergency shelter stays, and even the service and societal costs associated with street homelessness.

• Housing First promotes consumer choice, while encouraging use of mental health and other services. The provision of housing provides the environmental stability for consumers to participate in other services.

• Most importantly, the transformation of moving from homelessness into a home of one's own inspires physical and mental well-being and ignites hope in persons who had felt hopeless for years.