

MEMORANDUM

TO: Regional Steering Committee on Homelessness and Housing

FROM: HomeBase

RE: HUD Research Briefing – “The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness”

DATE: October 19, 2007

Background

In recent years, responding to national advocacy groups and their contracted researches, Congress and the leadership of the U.S. Department of Housing and Urban Development (HUD) have encouraged the development of permanent housing for homeless people using targeted Homeless. Concurrently, there has been a shift toward committing a greater proportion of HUD McKinney-Vento Act funds toward housing as opposed to supportive services and an increase in attention toward the hardest-to-serve, chronically homeless population, a substantial number of whom are mentally ill. Because it addresses this population and its needs, the Housing First approach is currently experiencing increased attention as a method of serving this population consistent with these goals.

New Housing First Study

In September of this year, HUD released “The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness”. This report presents the findings from an exploratory study of the Housing First approach of providing permanent supportive housing to single, homeless adults with mental illness and co-occurring substance-related disorders.

The study identifies the existing variations of the Housing First approach, which appear to respond effectively to the needs of homeless people with serious mental illness. It examines and compares three programs that are implementing the Housing First approach in slightly different ways and describes the characteristics of programs that seem to be influential in housing tenure, stability, and other positive outcomes for clients.

The goals of the study were to provide an overview of Housing First programs in the United States that serve individuals with a serious mental illness, as well as a detailed analysis of the program characteristics and client outcomes at three of these programs.

Definition of Housing First

The study team identified variations in the Housing First approach through a telephone canvass conducted to identify existing Housing First programs across the nation and collected basic information on their program features. The results of the canvass indicated that the Housing First “model” is not a single model, but rather a set of general features and approaches that communities interpret somewhat differently. The study team observed wide variation among programs along several dimensions, including the populations served, the immediacy of placement, the type of housing offered, and the array of services available. Despite these variations, all 23 programs contacted shared the key feature of a commitment to offer housing *first* to hardest-to-serve homeless persons, rather than requiring a period of stabilization, sobriety, or commitment to treatment to demonstrate housing readiness.

Since Housing First programs may be constructed in a number of ways, this report describes Housing First as incorporating the following features:

- The direct, or nearly direct, placement of targeted homeless people into permanent housing. Even though the initial housing placement may be transitional in nature, the program commits to ensuring that the client is housed permanently.
- While supportive services are to be offered and made readily available, the program does not require participation in these services to remain in the housing.
- The use of assertive outreach to engage and offer housing to homeless people with mental illness who are reluctant to enter shelters or engage in services.
- Once in housing, the use of a low demand approach which accommodates client alcohol and substance use, so that “relapse” will not result in the client losing housing.
- The continued effort to provide case management and to hold housing for clients, even if they leave their program housing for short periods.

Three Study Sites

Downtown Emergency Service Center (DESC), Seattle, Washington

DESC started a permanent supportive housing program with a Housing First approach in May 1994. DESC serves more than 300 clients at one time. Approximately 30 percent of clients come directly from the streets, with the remainder coming from emergency shelters. The Annual Progress Report submitted to HUD in 2003 indicated that almost all of the new clients who entered DESC housing had a mental illness and the majority had a substance-related disorder. DESC maintains 306 units of permanent supportive housing in four buildings that it owns or controls. Each building serves slightly different populations and has 24-hour, on-site staff trained in property management and supportive services. All of the buildings provide private apartments with kitchenettes and baths, on-site meals, staff offices, and community rooms.

Pathways to Housing, New York City, New York

Established in 1993, Pathways to Housing serves 450 individuals with histories of homelessness, severe psychiatric disabilities, and co-occurring substance-related disorders. Clients are not required to be drug or alcohol free, acknowledge they have a mental illness, or participate in treatment programs. Clients must agree to two case manager visits per month and pay 30 percent of their income—usually Supplemental Security Income (SSI)—for rent. All housing units are privately owned, independent apartments in the community secured through Pathways to Housing’s network of landlords, brokers, and managing agents. Clients are offered a choice among up to three apartments. Pathways to Housing holds the lease and sublets the apartment to the client.

The program assumes that housing tenure is permanent. Housing rules resemble standard lease requirements. Pathways to Housing has six ACT teams that provide a range of intensive clinical, rehabilitation, and support services to clients in their neighborhood areas. These nine-person interdisciplinary teams consist of a substance abuse specialist, nurse practitioner, part-time psychiatrist, family systems specialist, wellness specialist, employment specialist, social workers, and an administrative assistant. Each ACT team is available 24 hours a day, seven days a week.

Reaching Out and Engaging to Achieve Consumer Health (REACH), San Diego, California

REACH was established in 2000 out of a \$10.3 million competitive state grant under California’s AB 2034 program. The grant gave the county the resources to design integrated services for seriously mentally ill homeless people. REACH requires that clients have an axis I diagnosis of mental illness, have been homeless at least 6 months during the past year, and want to be housed through REACH. While the REACH program offers placement into housing without requirements for treatment or sobriety, many of the housing options have strict requirements or rules restricting substance use. Most clients first enter either a safe haven or an SRO hotel. Most housing agreements have requirements regarding visitors, disruptive behavior, and substance use. Case managers assess each client, develop a service plan, and provide assistance to obtain medical and psychiatric services, crisis response, money management, self-help and community resources, substance abuse intervention, education and counseling, vocational services, assistance with entitlements, and support and education of family and significant others.

Key Similarities and Differences among Housing First Study Sites

The three Housing First programs selected for this study share a commitment to serve homeless individuals who are seriously mentally ill and have co-occurring substance-related disorders. A large majority of clients enrolled in the study had met the federal definition of chronic homelessness, though a portion did not technically meet that definition at entry, since they had at that point already spent some time in a setting other than the streets or in an emergency shelter. The programs also share a commitment to place people in permanent housing without service participation or sobriety requirements. The service approaches emphasize helping clients remain stably housed.

Pathways to Housing offers scattered-site housing secured through a network of private landlords and management companies. The Pathways to Housing model includes the ability to offer clients more choice in housing and neighborhoods. In addition, the program limits the number of clients housed in any given building, thus encouraging community integration. ACT teams are assigned to neighborhood-based offices so they can more easily maintain contact with clients and landlords and quickly resolve any issues that may arise.

DESC owns or controls the housing where its clients live and serves as the primary service provider. This approach allows staff to provide a high level of supervision and offers the greatest latitude among the three programs in responding to the challenges of housing this population. Staff are located on site and can respond immediately to issues that may arise. However, with housing located in a small number of buildings in a limited geographic area, this approach minimizes community integration and limits client choices in housing.

At REACH, separating housing assistance from the case management function helps create distance between lease enforcement—which a housing provider must pursue—and the case management support that may help clients address problems that could threaten their housing.

STUDY FINDINGS

Housing First programs are intended to target the hardest-to-serve homeless individuals who have a serious mental illness, often with a co-occurring substance-related disorder. Moreover, these programs are designed to increase housing stability for people who traditionally have been very difficult to house or have had difficulty maintaining their housing. The presumption is that once housing stability is achieved, clients are better prepared to address their mental illness and substance-related disorders. In addition, program housing combined with support services can stabilize a client's financial status and promote self-sufficiency.

The study sample included 25 clients at DESC, 26 clients at Pathways to Housing, and 29 clients at REACH for a total sample size of 80 clients. Study clients enrolled in the three Housing First programs between June 2003 and August 2004, with two-thirds entering between December 2003 and May 2004.

The clients enrolled in this study represent the severely impaired homeless population that Housing First programs intend to target. The majority of clients had been chronically homeless, had an axis I diagnosis, exhibited symptoms of mental illness or psychiatric problems, and were at least moderately impaired by their symptoms at enrollment. Three-quarters of the clients had a history of substance abuse, although only about one-half were using substances at the time of enrollment. In addition to their mental illness and substance abuse problems, these clients had limited work histories, low educational attainment, and a high incidence of criminal records.

Housing Tenure

The Housing First approach is designed to improve housing stability for people who traditionally have been very difficult to house or have had difficulty maintaining their housing. The primary indicator of a program's ability to improve clients' housing stability is the percentage of clients who stay in the program. The majority of clients tracked for this study remained enrolled in the Housing First program for 1 year following program entry.

- 84% of the clients tracked for this study remained enrolled in the Housing First program at the 12th month
- 43% of the clients remained in the Housing First program for a year and stayed in their housing unit for the entire time
- 41% remained in the program for a year and spent at least one night in some other temporary living environment
- The remaining 16% of the clients left the program or died within the first 12 months of enrollment.
- Clients with the lowest levels of housing stability were those who entered the program from the streets.
- Clients most likely to experience temporary program departures were those who entered the Housing First program from the streets.
- Clients with the highest levels of housing stability were those who entered the program from shelters, jail or a psychiatric hospital, or some other location, including crisis houses and living with friends.

Data indicated that Pathways to Housing clients had the greatest level of housing stability with 62% remaining in program housing for a full 12 months. Further, only 8% of its clients permanently left the program during the first 12 months.

Other Outcomes

Program staff in the three Housing First programs cautioned that, given the severity of their clients' symptoms, they would expect limited improvements in levels of impairment within 12 months. This was consistent with the findings from the study. Although clients may have experienced month-to-month variation in their levels of impairment, the data do not demonstrate any substantial trends in impairments related to psychiatric symptoms or substance use over the course of the first year in program housing. However, clients' incomes did increase slightly over the period (from non-employment sources), although their incomes were still well below the poverty line.

- Both intermittent stayers and leavers experienced higher levels of impairment related to psychiatric symptoms during their last month in housing compared to month 12 for stayers.
- While 69 percent of the study participants overall had a co-occurring axis I diagnosis and history of substance abuse, co-occurring disorders were even more prevalent among intermittent stayers and leavers.
- Overall, impairment related to substance use remained fairly stable, with a slight decrease in the number of clients who used substances during their final month.

Overall, there was a small increase in the number of clients with moderate psychiatric impairment and a corresponding decrease in the number of clients with severe psychiatric impairment, suggesting a small amount of improvement in the aggregate. Most clients who participated in the study had a psychiatric diagnosis, typically schizophrenia or another psychotic disorder. According to the case managers' reports, most clients' (72 percent) level of psychiatric impairment was different from baseline for at least one month (and usually more) at least once during the 12-month period. However, these data did not aggregate into a noticeable trend of improvement or worsening of psychiatric impairment over the 12-month study period because the positive and negative changes of individual clients offset each other in the aggregate. Overall, between baseline and month 12, there was only a slight decrease in the number of clients judged to have severe psychiatric impairments (from 21 to 18 clients). Across all three programs, the level of severity decreased at month 12 and fewer clients were using or impaired by using any substances.

Though not all incomes increased, the average monthly income of clients across the three Housing First programs grew from \$537 at baseline to \$610 during month 12.

These findings indicate that the Housing First approach is achieving considerable positive housing outcomes with a population with high service needs. Housing problems did occur, and some of them were serious. However, even at the Housing First program with the highest reported number of housing problems, the incidence of problems was less than one problem per client per month. Clearly, within the Housing First

approach achieving positive outcomes requires program policies and procedures that encourage working with clients and landlords to resolve housing problems when they arise and that enable programs to hold units for clients who leave temporarily.

Individual clients experienced small changes in several outcomes over the 12-month period of the study; however, these changes did not add up to trends illustrating major improvement or deterioration among clients. These findings are consistent with program staff expectations that few clients would experience substantial changes in their first year in program housing.

SUMMARY AND IMPLICATIONS

The study's findings lead to several conclusions about the program features that appear to promote housing stability and other positive outcomes and suggest implications for HUD policy.

Program elements that were important contributors to program success in the three study sites:

Access to a substantial supply of permanent housing: The dispersed housing and neighborhood-based ACT teams at Pathways to Housing offer consumer choice and intensive services, but require developing a large network of landlords and supporting the highly skilled professionals that comprise the ACT team. The DESC model, where the primary service provider owns or controls the housing and provides a high level of supervision, can respond to the challenges of housing this population, but this approach limits client choices in housing and seems to limit community integration.

Providing housing that clients like: Focus group participants at DESC and Pathways to Housing cited the privacy, independence, safety, and quality of their housing as positive features of their program experience. Clients' perceptions about the extent to which they have choices in their housing may influence their housing stability.

Wide array of supportive services to meet the multidimensional needs of clients: Wrap-around services include comprehensive mental health services, substance abuse treatment, medication assistance, as well as help with independent living skills, such as money management and housekeeping.

Service delivery approach that emphasizes community-based, client-driven services: The service approach includes a low demand approach to substance use, integrated substance abuse and mental illness treatment services, and a focus on helping clients develop skills for independent living. Clients take an active role in determining the timing, the nature, and the frequency of their service plan.

Staffing structure that ensures responsive service delivery: Staffing structure is designed to make sure clients' needs are met. The availability of staff response 24 hours a day is a key similarity among the sites. The use of daily team meetings and collaborative case planning further enhance coordination and consistency so that staff resources are immediately responsive to client needs.

Coordinating Services and Communication among Providers: Staff in each of the Housing First programs spend considerable time collectively reviewing the status of program clients. This review may take place during direct contacts at team meetings or telephone contacts.

Diverse funding streams for housing and services: To fund mental health case management services, each of the programs seek Medicaid reimbursement. All three programs also receive funding for clinical services from state or county sources. HUD programs subsidize a substantial portion—but not all—of the housing.

Policy Implications for HUD

The HUD priorities of addressing chronic homelessness and providing permanent housing are furthered by Housing First programs: The programs predominantly serve people who meet the HUD definition of chronic

homelessness and they are achieving a substantial level of housing stability for this population, although the most impaired clients are still the most likely to leave.

Lack of conditions on housing may be less important than the direct access: All three programs offer direct access to housing for a chronically homeless population and use a service approach that does not require sobriety or treatment compliance. DESC and Pathways to Housing offer direct access to housing without customary service requirements. At REACH, however, many clients enter housing at a safe haven with occupancy rules, including a prohibition on drugs and alcohol, a curfew, and assigned chores for all residents. Despite these requirements, clients preferred to accept this housing, rather than to continue the hardships of homelessness.

Housing stability does not come without challenges: Data collected during this study indicate that housing problems do occur, including problems that would result in the loss of one's housing in many programs. Housing stability requires a service approach that focuses on helping people keep their housing, as well as subsidy mechanisms that permit holding units for people who leave temporarily.

Tension Between HUD Policy and Low Demand: HUD resources are an important source of housing subsidies in these programs, but tensions exist between a low demand approach to substance use and HUD's concerns about any criminal activity, in particular drug activity, in HUD-supported housing.

Serving this population requires a long-term commitment to providing housing assistance: While the housing provided by the programs increased housing stability and afforded the opportunity to receive treatment, substantial progress toward recovery and self-sufficiency often takes years and is not a linear process.

Are you familiar with Housing First programs in your community? Does the analysis in this report seem similar to what you know about Housing First Programs?

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