

## Pathways' Housing First:

Ending homelessness and supporting recovery for people with psychiatric disabilities and addiction disorders

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Pathways to Housing, Inc.

# Housing First

- What is Housing First?
- Why was it developed?
- Who does it serve?
- When does it work?
- How much does it cost?

# What is Housing First?

- A consumer driven housing and support services that offers people who are homeless and who have psychiatric disabilities immediate access to an apartment of their own and the services needed for their recovery.

# What is Housing First?

- A practical, humane, and effective solution for people who cannot succeed in the traditional array of services

# Are they the mentally ill homeless or the homeless mentally ill?

- Do people who are homeless and mentally ill have more in common because they are homeless or because they are mentally ill?

# Brief Historical Context

- Early 80's: Visibility- disproportionately high numbers of people with mental illness on the streets
- Mid 80's: Increased frequency in newspaper reports of the words 'homeless' and 'mental illness'

# Homelessness contributes to:

- Poor Health<sup>1</sup>
- Increased use of acute care services<sup>2</sup>
  - MH
  - Substance abuse and detoxification
  - Emergency medical services
- Incarceration<sup>3</sup>

<sup>1</sup> Lee et al. 2005; Cheung et al. 2004; Hwang 1997

<sup>2</sup> Folsom et al. 2005; Kuno et al. 2000; McNiel & Binder 2005

<sup>3</sup> McNiel et al. 2005; HCH Clinicians' Network 2004

# Initial Housing and Service Models for the mentally ill homeless

- Outreach and Drop-In Centers
- Emergency/Temporary
- Transitional Housing
- Permanent Supportive Housing



# Current System

## Housing and service programs:

(most programs still use sequence approach to develop “housing ready”)

|                      |                        |                            |                         |
|----------------------|------------------------|----------------------------|-------------------------|
|                      |                        |                            | Permanent<br>Supportive |
|                      |                        | Emergency/<br>Transitional |                         |
|                      | Shelter/<br>Safe haven |                            |                         |
| Outreach/<br>Drop In |                        |                            |                         |

# Permanent Supportive Housing (retention)

Several studies found positive outcomes for residents in programs that provide permanent supportive housing:

- Maintain housing for some period of time
- Reduce use of emergency services,
- Express satisfaction with living situations

(Anderson, 2002; Mayberg, 2003; CSH/Burt & Anderson, 2005, Barrow, 2004)

# Evaluating permanent supportive housing (cont'd)

- Congregate arrangements & independent housing can both work effectively
  - Structure of the services must be optimized
  - *Bundling housing and services can jeopardize housing stability*
  - Increased choice associated with longer tenure in housing

Lipton et al (2000) Siegel et al (2006)

# Permanent Supportive Housing Effectiveness (cont'd)

Even though the housing is permanent,  
substantial numbers of residents do leave

- HUD-sponsored study of 'leavers' and 'stayers'  
in Philadelphia
- 28 programs; all for people with serious mental  
illness, research cohort entered in 2001

(O'Hara, 2007)

# Permanent Effectiveness (cont'd)

- About half stayed 3 years or more
- Only one-third of leavers went to stable alternative housing (“positive leavers”)
- “Negative leavers” had more severe levels of mental illness, greater incidence of substance abuse, higher supportive service needs

(Davis, 2006)

# Housing and service programs: for people who are mentally ill and homeless

|          |                     |                         |                      |
|----------|---------------------|-------------------------|----------------------|
|          |                     |                         | Permanent<br>Housing |
|          |                     | Transitional<br>Housing |                      |
|          | Drop-in,<br>Shelter |                         |                      |
| Outreach | homeless            | homeless                | homeless             |

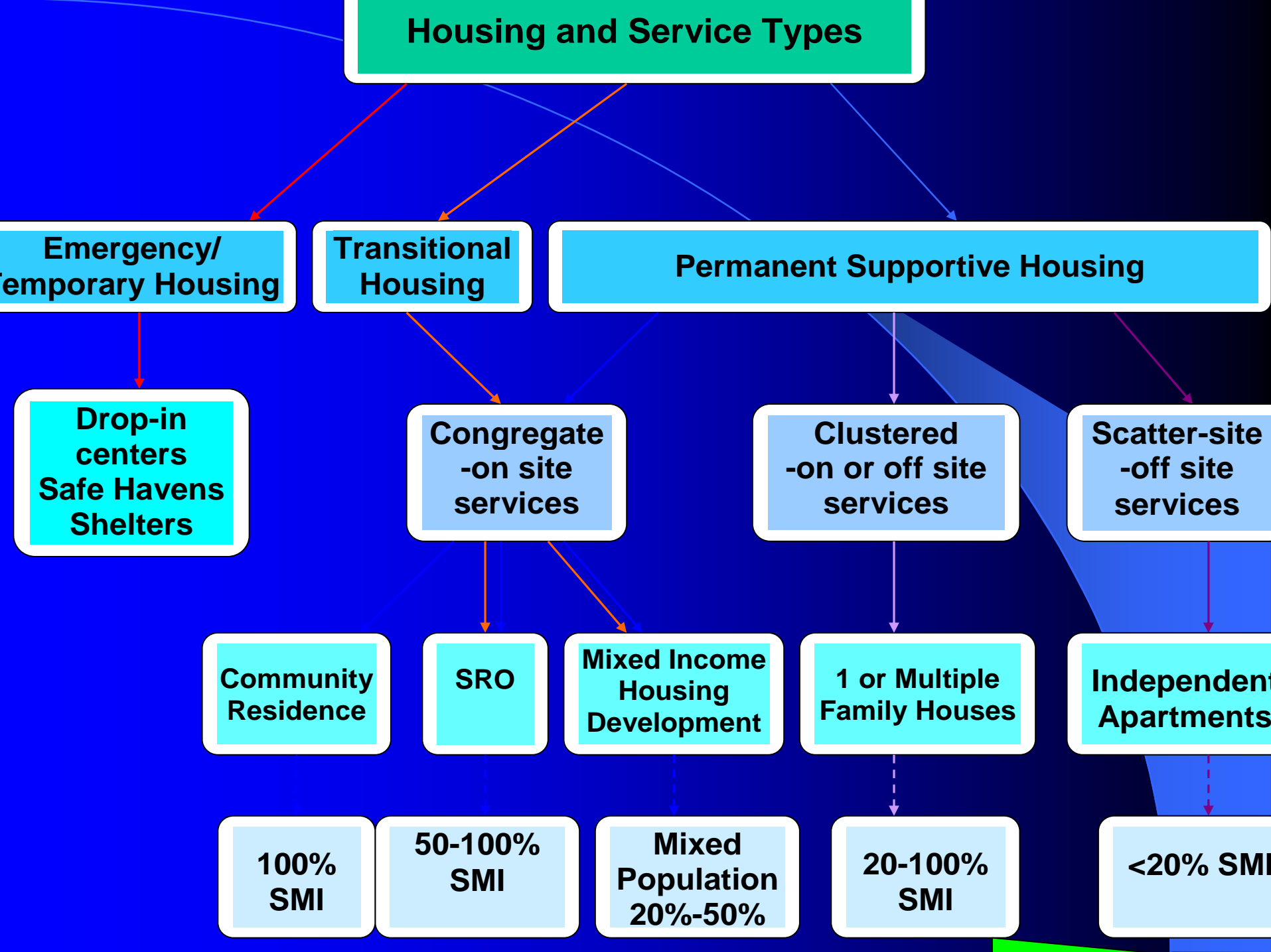
# MI and Vulnerability to Homelessness

Mental Illness and co-occurring substance use disorders may both contribute to individuals' risk of becoming homeless and their "often greater difficulty exiting homelessness on their own and [they] are more vulnerable to experiencing chronic homelessness...."

O'Hara, A (2007).

Access is the major hurdle for people who remain homeless for years:  
(DHS NYC Survey of psh providers criteria in 2005)

- **Clean time** – 92.5% of Providers require
- Methadone – 11 % exclude
- **Insight** into mental illness
- **Compliance with treatment**
- **Criminal background**
  - Sex offenders – 82% exclude
  - History of arson – 80% exclude
- Credit checks



# Effects of Client Characteristics on Housing Options

**Client Characteristics (Cumulative)**

Other Difficulties

Crim. Just. Involvement

Poor Phys Health

SA

MI

Likelihood of **rejection** from Housing Choices

More congregate & structured

More independent & less structured

**Continuum of Supportive Housing Types**



# For the mentally ill homeless; there is also enormous misuse of resources

- Shelters: 10% of the chronically homeless utilize 50% of the system resources
- Hospitals/Detoxes: 3% of clients use 28% of all Medicaid funding for these services
- Jail/Prison: High rates of incarceration and recidivism rates for people who are mentally ill and homeless
- *Million Dollar Murray* – M Gladwell
- Culhane et al, 1996; Millman et al, 2007

# What if system was designed for people who are *homeless* and *mentally ill*?

In 2006, based on data from HUD:

- ❖ given the national average for rental units
- ❖ a person with a psychiatric disability relying on SSI
- ❖ would need to pay 113% of his or her monthly income
- ❖ to rent a modest one-bedroom apartment....

# Housing First:

## A consumer based solution for people who are homeless (and mentally ill)

- Developed the program from the consumer's perspective (Who is this program for?)
- For people who are poor, tired, angry
- I want to live in ordinary housing, and go to treatment – maybe – don't want to live in treatment
- My mental illness and addiction were around long before I was homeless – right now, i just need a place to live

# Housing First:

A person centered approach that can accommodate individual needs

- My dog comes with me
- Me and Ana go together or we don't go at all
- Is it possible to get an extra room so my kids can visit?
- Don't want to hide my beer under the couch when you come to visit. Do you hide your beer under your couch when you have guests?

# From: *Crossing the Border*, Michael Rowe

- *“If we cannot trust another to know his or her own needs we will end by oppressing them”*

# 4 Essential Elements of Housing First

- 1. Consumer Choice
- 2. Separation of Housing and Services
- 3. Recovery Orientation
- 4. Community Integration
- (5. Program Evaluation)

# 1. Consumer Choice is the foundation of this program

Program started with an NIMH grant ‘taking psych rehab to the streets’ –(d shern, b anthony)

Learn to ask what consumers wanted

Discovered a huge disconnect between what providers offer and what consumers want

Essential learning for adopting this approach to housing and services

# What do consumers want?

## Housing, *first!*

- When asked, almost every person who is homeless (w or w/o mi) says they want housing *first*;
- Will accept housing and services on own terms
- Very effective with so called ‘hard to house’ and ‘treatment resistant’

# Housing First Honors Consumer Choice

- Choice usually begins with an exploration of housing options including neighborhoods, apartments, furniture, appliances, etc.
- Once housed, consumers **continue to choose** the type, sequence and intensity of services (or no services)
- All must agree to weekly visit

# Consumer choice as a continuous process in Housing First programs

- Choices include the **right to risk**; people make mistakes and learn from that experience, dignity of failure
- Continued practice in making choices leads to making the right choices and **the experience of success**

# Philadelphia's Housing First retention rates

- Two years after program start-up, 84% of consumers still in apartments:
  - 70/126 were successful in their 1st apartment (56%)
  - 24/47 were successful in their 2nd apartment (51%);
  - Cumulatively, 94/126 successful in their 2nd apt. (75%)
  - 12/14 were successful in their 3rd apartment (86%)
  - Cumulatively, 106/126 successful by their 3rd apt. (84%)

Dunbeck, D., 2006 (\*\*housing and services separate agencies)

# LIMITS to consumer choice: choice is also practical and clinically informed

- Choice is not absolute, there are clinical and legal limits to choice:
  - 1) Danger to self or others
  - 2) Must agree to weekly visit by support team
  - 3) Other limits (abuse, violence, legal issues)

## 2. Separation of Housing and Clinical Services

- **Housing Services:** To find apartments, sign lease, and maintain all aspects of housing including facilitating relations with building staff (intermediary between landlord and tenant)
- **Treatment and support services:** Offered not required; Relapse (SA or MH) is expected and does not result in housing loss and housing loss does not result in discharge from clinical services

# HOUSING FIRST PROGRAM

## Main Components

1. Housing: Scatter site independent apartments rented from community landlords (or other housing type)
2. Treatment: Treatment and support services provided using either Assertive Community Treatment (ACT) Teams, CM, and other off site services

# Treatment and support services: ACT teams

- Multidisciplinary team (MD, MSW, CSAC, RN, etc)
- Serves people with highest needs (severe mental illness; substance abuse; homeless, frequent or long periods of hospitalization, incarceration; involuntary commitment orders, etc.)
- Services are provided directly, about 70-80% of the time in the community
- 7-24 on call
- Team MUST have direct access to housing (rent stipends, section 8, SHP, S+C, other rental funds)

# Case Management teams: Brokerage Service Model

- CM services – higher case load ratios
- Must broker other needed services
- Follow through and continuity of care among systems
- 7-24 on call
- MUST have direct access to housing (rent stipends, section 8, SHP, S+C, other rental funds)

# Single Site Housing First Models

- Single site buildings
- Homogeneous population
- Services on site
- Use harm reduction approach and solve problem of access
- Severely restricted consumer choice
- For most people, it's a program not a home
- For some people this will be their home

# KEY is in matching support services with consumer needs

- Most people need the same things in housing (mih or hmi)
- Their service and support needs vary
- Ensure services are unlimited
- Ensure they are consumer driven and evidence based

# Housing Component: Independent apartments integrated into the community\*

1. Rental units available on the open market (normal rental housing; rented from community landlords)
2. Integration: Rent less than 20% of the total\* number of units in any one building
3. Permanence: Tenants have same rights and responsibilities as any other lease holder
4. Affordability: Apartments are subsidized; tenants pay 30% of income towards rent

# Landlords as program partners: Landlord, agency, and tenant have a common goal

- Landlord, agency, all want quality, safe, well managed apartments
- 1) Agency can ensure rent is paid on time
- 2) Communication: Agency responsive to landlord concerns
- 3) landlord has no rent loss for vacancies
- 4) Agency responsible for damages
- 5) Agency signs or guarantees lease if needed

# Tenant rights and responsibilities: Limits to consumer choice in housing issues

- There are limits to choice in these instances
  - 1) Must sign lease or sublease
  - 2) Pay portion of rent (30%)
  - 3) Observing the terms of the lease

# 3. Recovery oriented services

- People who are diagnosed with severe mental illness can live full and independent lives in the community (Nash and millions of others)
- Several WHO studies and Harding 25 year follow up: 5 point study definition
- How do we support more individuals to achieve this goal?

# Recovery focused support services

- *Provide services that support and emphasize recovery: supported employment, education, wellness management recovery, etc., (current spend far too much time policing of psychiatric and substance abuse symptoms)*
- Facilitate special interest groups, social events, etc

# Recovery focused services...

- **Convey hope**, offer choice after choice after choice –raise the ceiling...
- Are respectful, patient, nurturing, compassionate
- Seek to realize existing capabilities
- Seek to create new possibilities

## 4. Community Integration

- Design the treatment and housing services with a vision of recovery in mind
- Housing that accommodate positive life changes – better neighborhood, relationship, children begin to visit (portable rent supplements)

## 4. Community Integration (2)

- *Housing that is normal housing not a program*
- It's housing where the services can walk away from the person who no longer needs them (or return if necessary)
- At graduation the person gets to stay home

# 5. Effectiveness

CQI and documentation of Program  
Effectiveness

# Research Evidence: Building and evidence based practice

## New York Housing Study

*Funded by SAMHSA, CSAT and NYSOMH*

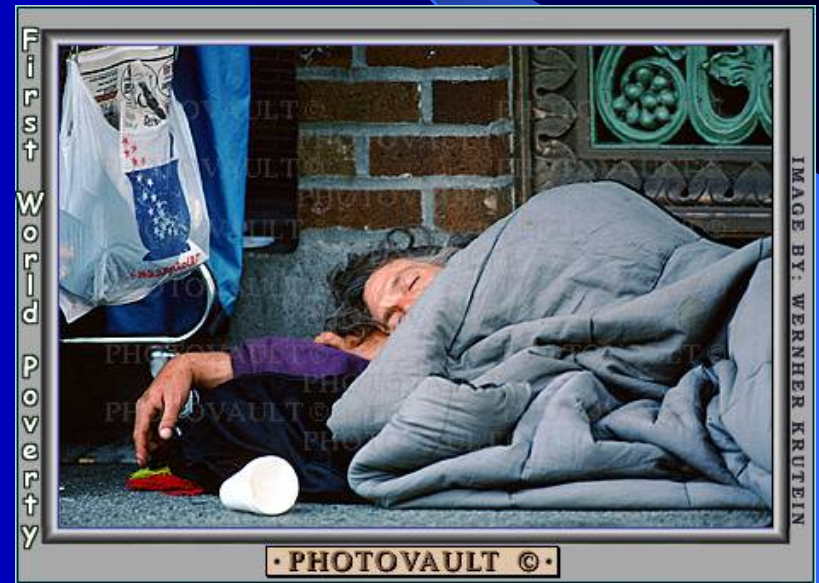
# Study 3: Comparing Pathways to Housing

with Standard  
Treatment-Housing  
Programs in NYC

36 month longitudinal  
randomized control trial

# Participants Inclusion Criteria

1. 15 days of the past month literally homeless
2. 6 months of housing instability
3. Major Axis I Psychiatric Diagnosis



# Study Design

- Longitudinal Random Assignment
  - N=225
- Experimental (Pathways) 99
- Control (Other NYC programs) 126

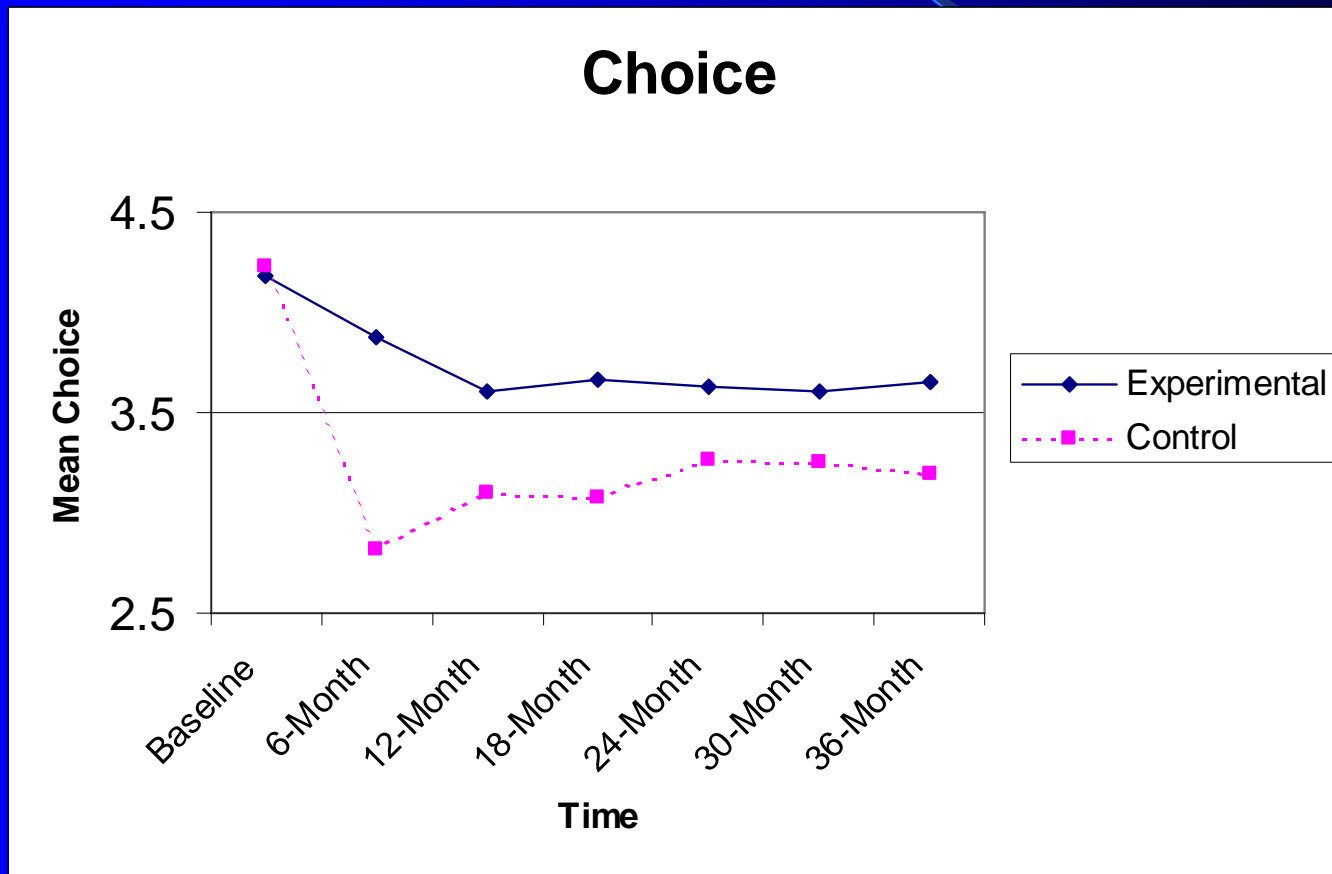
# Follow-up Rates Entire Sample

| 6-month | 12-month | 18-month | 24-month | 30-month | 36-month |
|---------|----------|----------|----------|----------|----------|
| 96%     | 94%      | 92%      | 90%      | 86%      | 86%      |

# 36-month follow up: Selected Domains

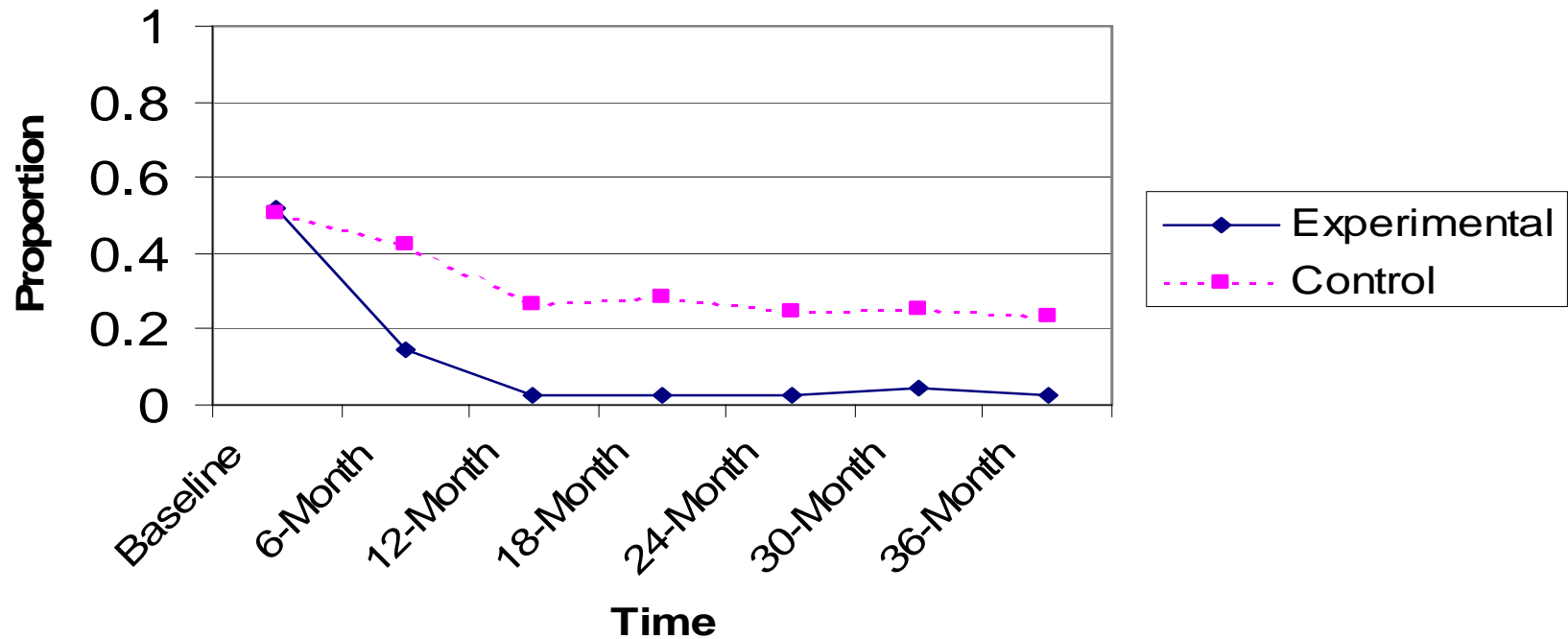
- Literal Homelessness
- Residential Stability
- Choice
- Psychiatric Symptoms
- Substance abuse

# HF experience significantly more choice



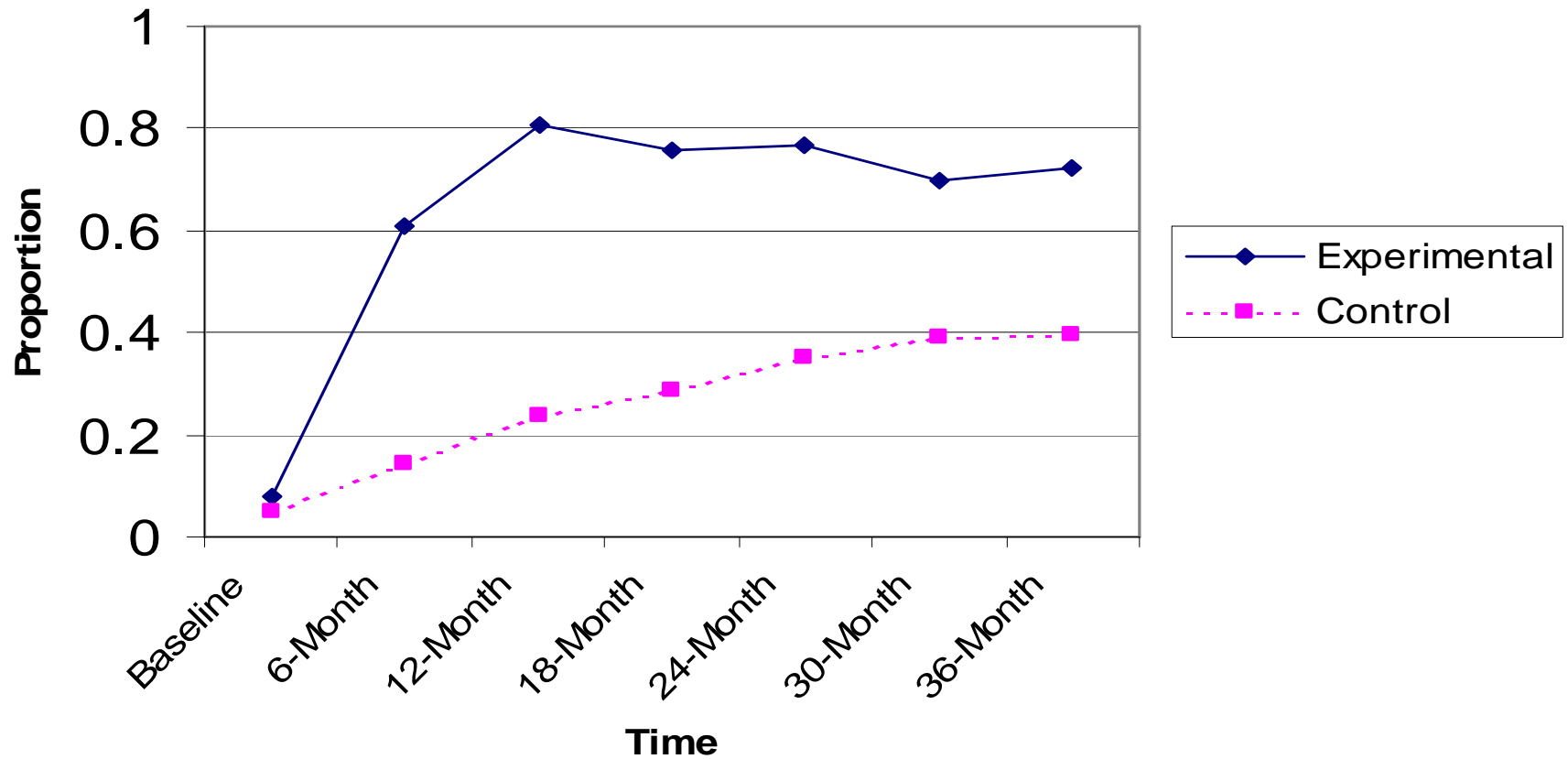
*Note.* Significant at 6-, 12-, 18-, 24-, 30-, and 36-month.

# Proportion of Time Literally Homeless



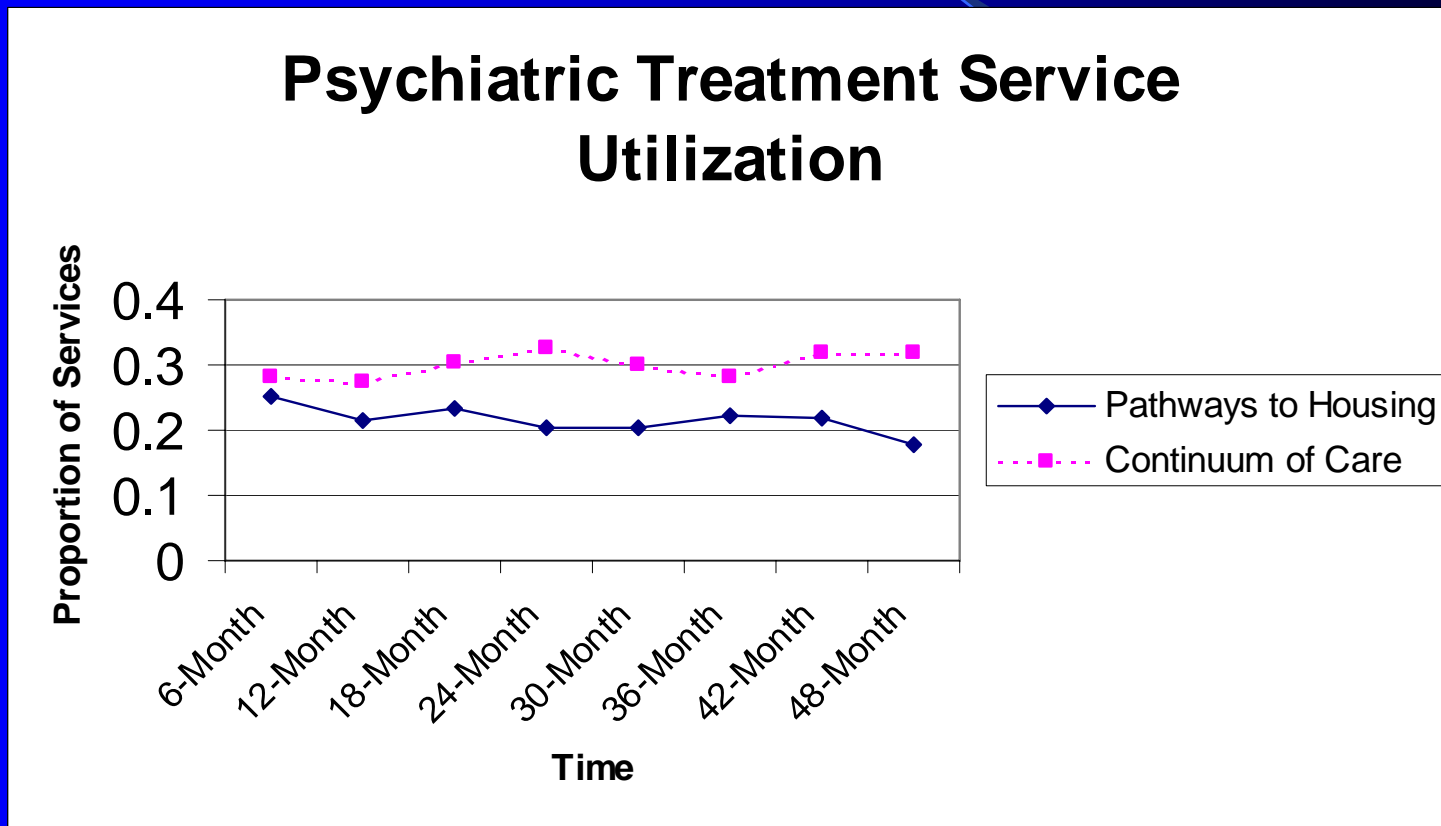
*Note.* Significant at 6-, 12-, 18-, 24-, 30-, and 36-month.

# Proportion of Time Stably Housed



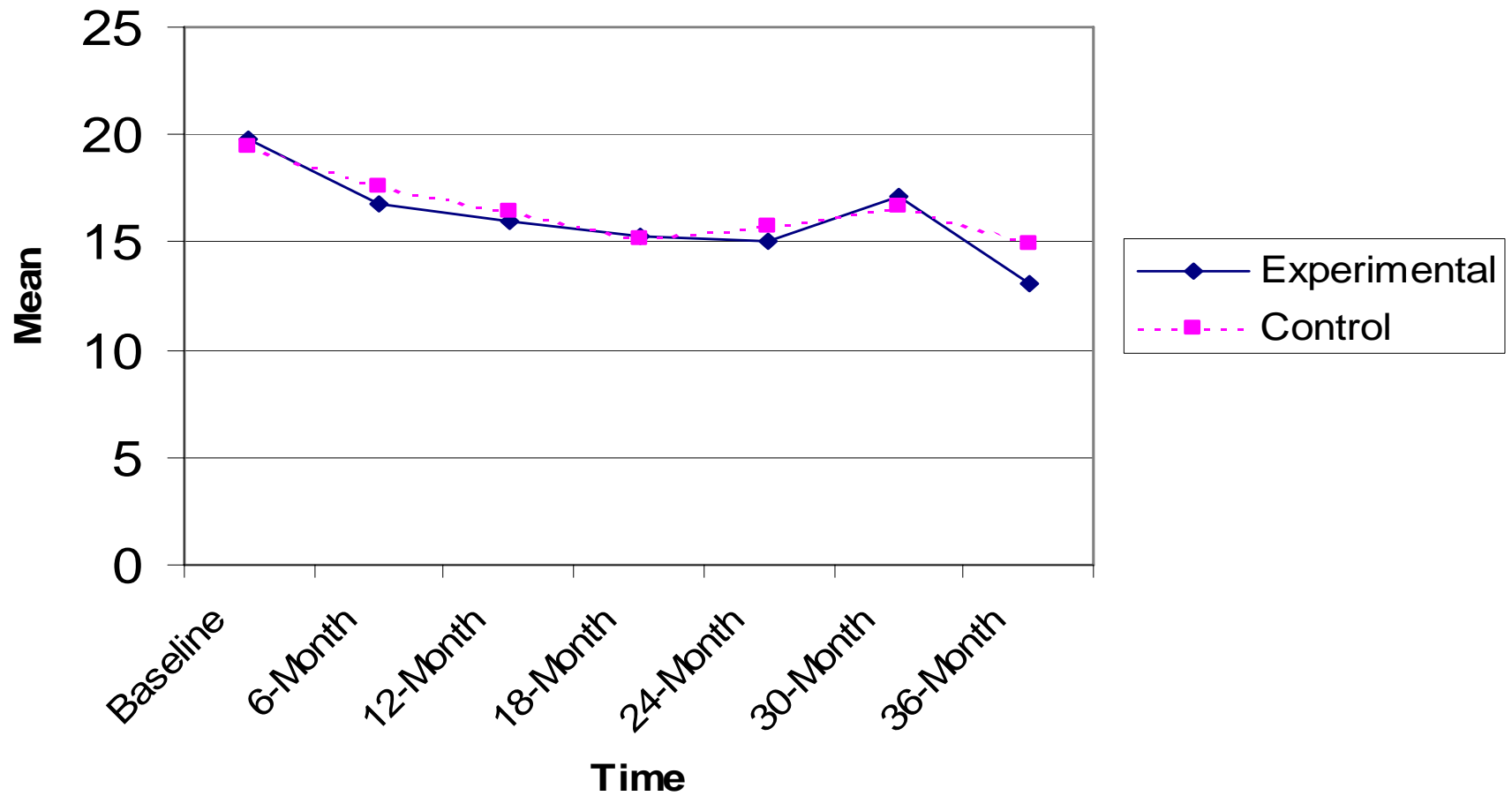
Note. Significant at 6-, 12-, 18-, 24-, 30-, and 36-month.

# Psychiatric Treatment Utilization in the Past 2 Weeks



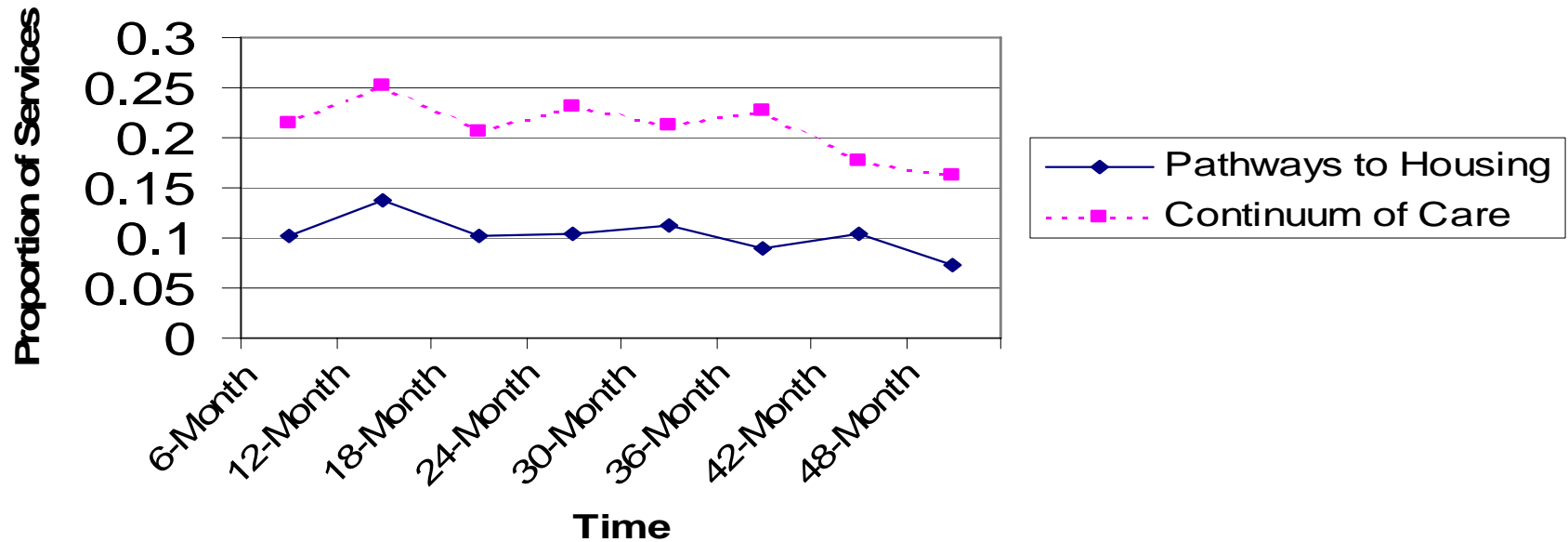
Note. Significant at 24-, 42- and 48-month.

# Colorado Symptom Index



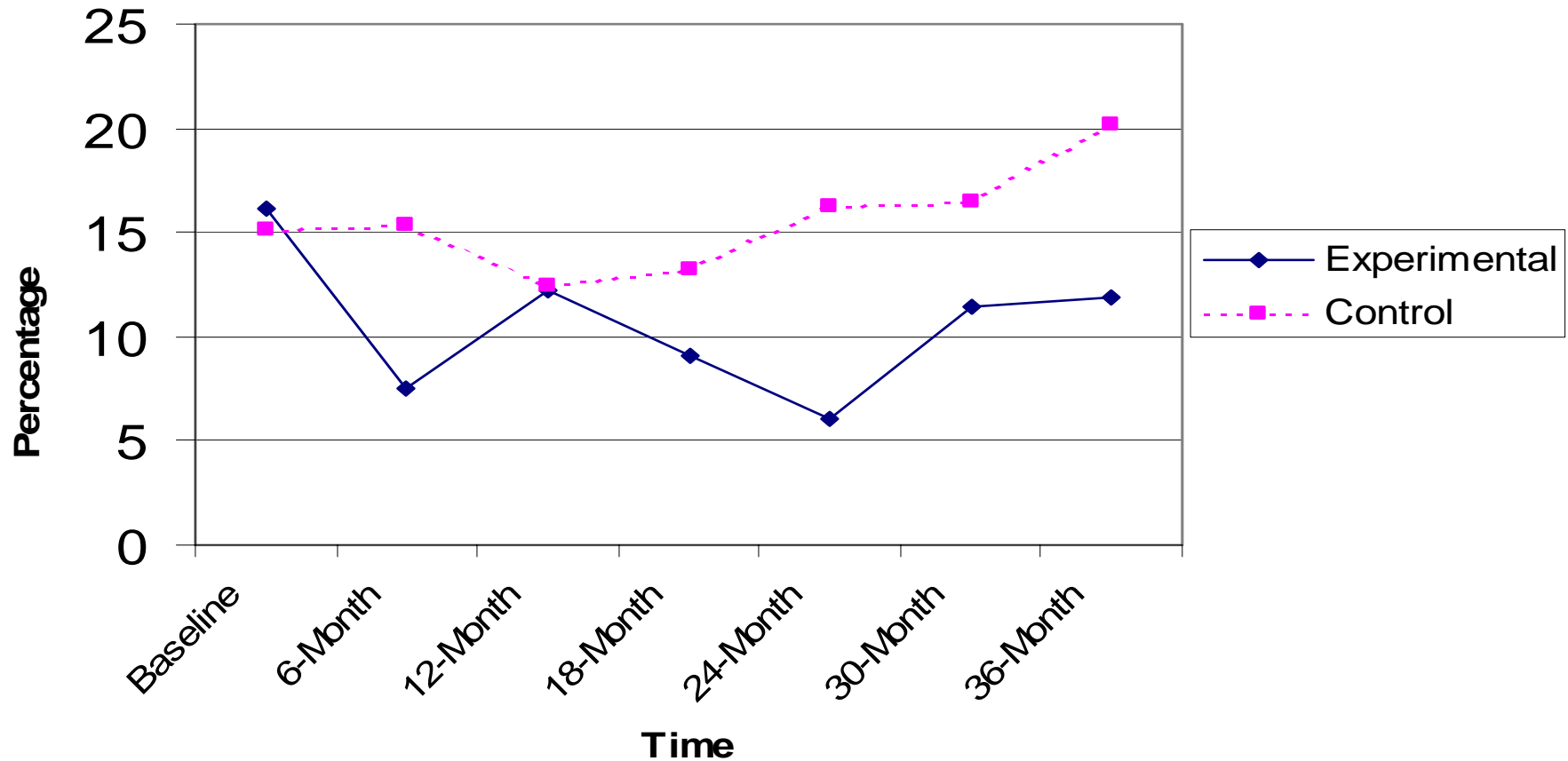
# Substance Treatment Utilization in the Past 2 Weeks

## Substance Treatment Service Utilization



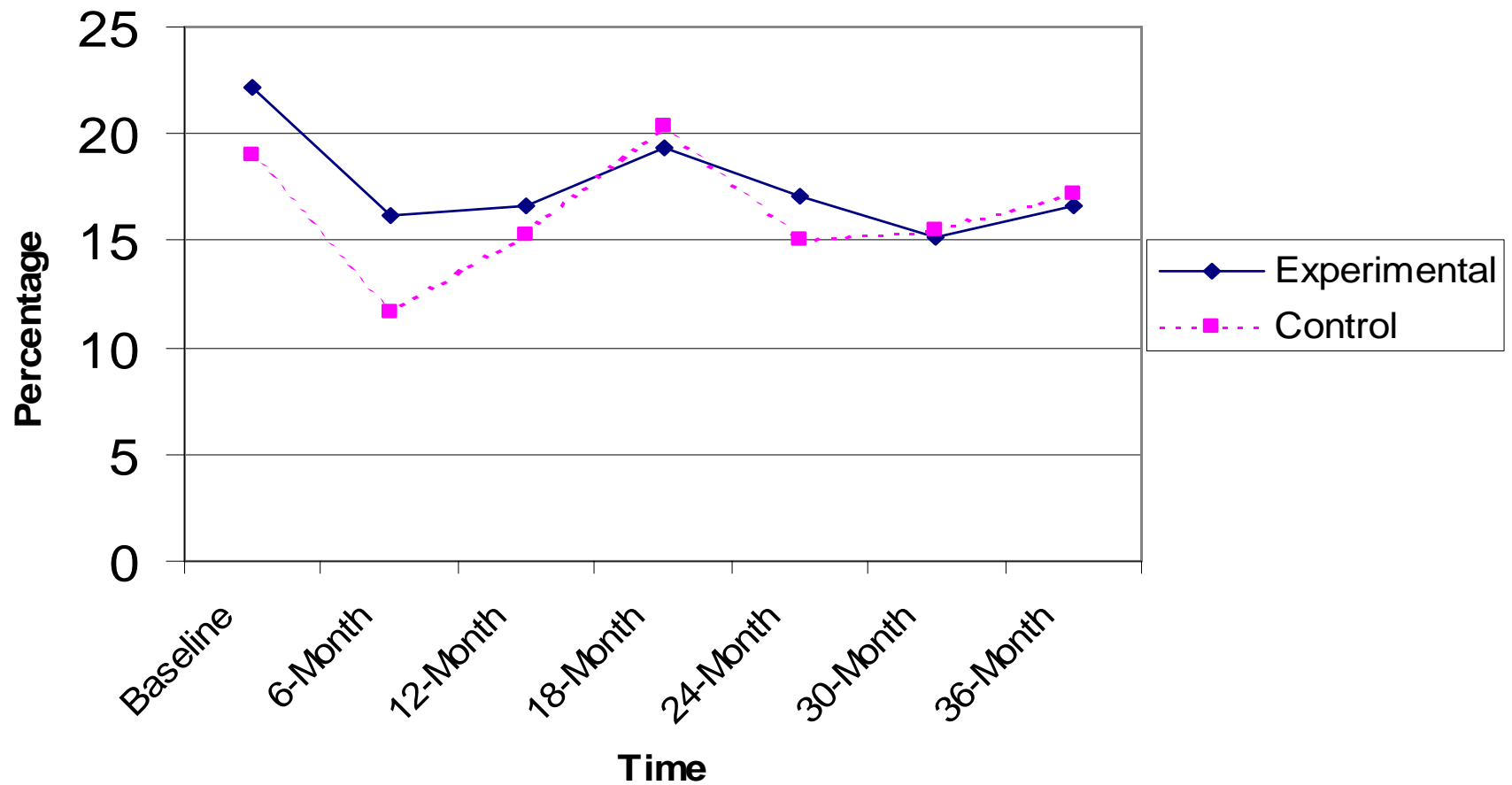
Note. Significant at 6-, 12-, 18-, 24-, 30-, 36-, 48-month.

# Percentage Heavy Alcohol Use

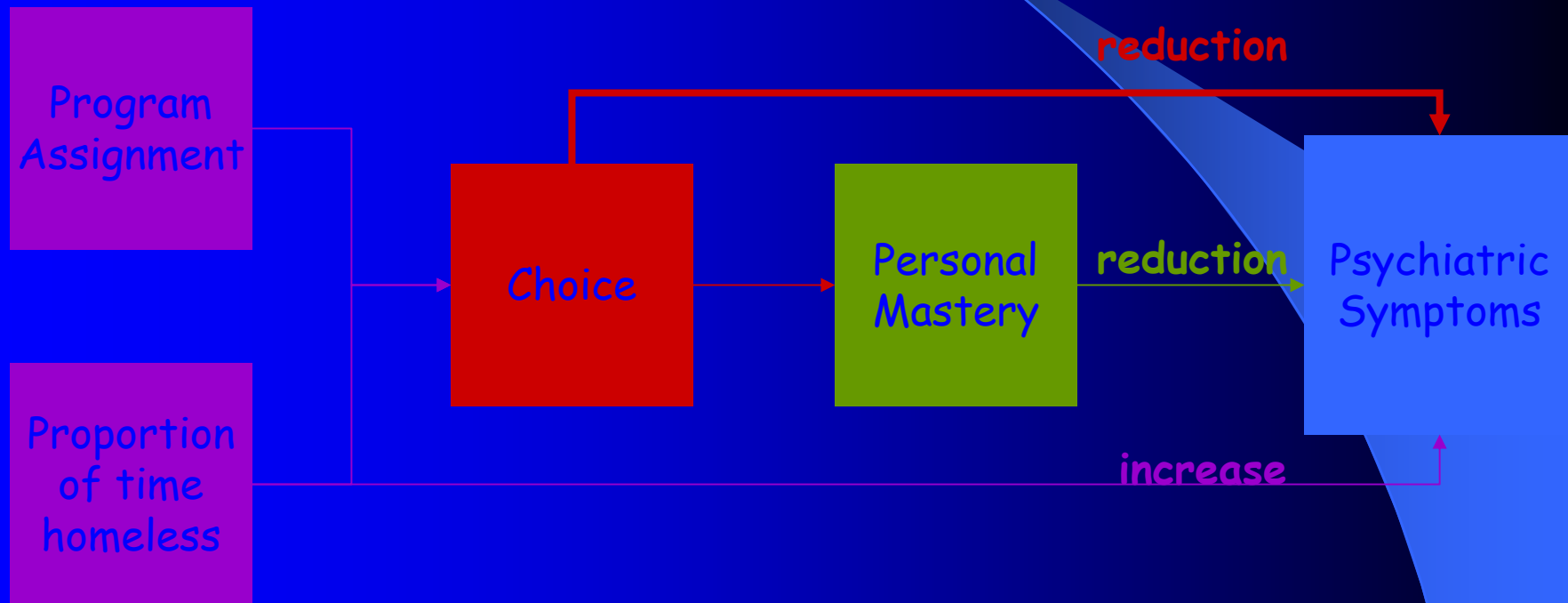


Note. Significant at 24-month.

# Percentage Heavy Substance Use



# Housing First Programs, Choice & Psychiatric Symptoms



Adapted from Greenwood et al, 2005.

# Current NYHS Research (with Sean Fischer)

- New research from the New York Housing Study examines two predictors of mental health and alcohol/substance use
  - Time spent in permanent housing
  - Perceived choice over residential and treatment decisions

# Time Lagged Analysis

- To assess for both immediate and delayed effects, housing and choice from the previous time period were entered with concurrent housing and choice
  - *Concurrent* housing and choice: Measured during the same observation period as the outcome of interest
  - *Time-lagged* housing and choice: Measured one interview period prior to the current assessment period
  - For example, psychiatric symptoms at 18-months was predicted by both 18-month housing and choice and 12-month housing and choice

# Hierarchical Linear Modeling

- Hierarchical Linear Modeling
  - Rather than averaging data over time, HLM allows researchers to examine changes within participants between observation periods
  - Can easily examine concurrent and time-lagged effects
  - Statistically more appropriate than traditional repeated measures analysis

# Research Findings

|                      | Housing | Choice |
|----------------------|---------|--------|
| Psychiatric Symptoms | -       | -      |
| Self-Esteem          | n.s.    | +      |
| Alcohol Use          | -       | +      |
| Drug Use             | n.s.    | +      |

*“-” = Negatively Correlated, “+” = Positively Correlated, “n.s.” = nonsignificant*

# Summary and Implications

- Two key components of program (permanent housing and choice driven services) are beneficial to mental health
- Permanent housing was associated with less alcohol use
- Although choice was associated with increased alcohol and substance use, actual usage was small (16% of assessments for both outcomes)

# How Housing First Relates to 10-Year Plans to End Homelessness

- The National Alliance to End Homelessness advocating for Cities and States to develop 10-year plans to END HOMELESSNESS
- The US Interagency Council on the Homeless focus on Ending Chronic Homelessness (\$35M Initiative)

# Housing First Programs in the USA & Canada



-  Mental Health Commission of Canada, upcoming sites
-  Housing First Sites that received technical assistance from Pathways to Housing, Inc
-  Housing First Single Site projects

# Cross site studies – 6 cities same measures: HUD commissions study to evaluate Housing First

- **HUD Housing First**: found 84% retention rate across six study sites
- (focus on ending chronic homelessness)

- Pearson, C., et al 2007; HUD, 2007

# CHI Cross site studies – 11 cities same measures: VA evaluates chronic homelessness initiative

- VA: 11 cities funded by ICH show  
about 85% housing retention rates  
after first year

Rosenheck et al., 2007

# Cost studies

- Using residential follow back from randomized control trial
- One year pre-post housing first programs in Denver and Providence
- Marc Fisher in Yesterday's Washington Post

# Pre Post Cost studies

## Denver's HF 24 mo pre-post

- Reductions (N=50) in institutional acute care:
- 73% ER use;
- 66% inpatient stays;
- 82% detox use;
- 76% incarceration
- Net per person cost while homeless  
\$31,765

# Pre Post Cost studies Denver's HF

- Factoring in cost of HF program Net cost savings of \$4,745 per person
- Projected savings for all 150 in HF program \$712K
- Project net saving for city chronic population of 513 is \$2.3 M

Perlman , J. & Parvenski,J., 2006

# Pre Post Cost studies Rhode Island HF program

- Total per client cost (N=18) of Housing First & other services received was \$22,778 per person per year.
- This is \$8,839 per person less than the institutional costs of \$31,617 per person while these individuals were homeless for a year
- Net project savings for 48 HF clients \$424K

# Replications and Dissemination

- Programs vary across the country
- Variations in service intensity, housing type, and philosophy
- Outcomes show much consistency in housing retention but variation in other domains
- Currently developing fidelity and other measures to examine cross site differences

# Pathways Housing First Critical Ingredients

30 Items developed through lit review, consulting relevant fidelity scales (DACTS, Supported Housing Scale), expert interviews, expert survey

## 5 Domains:

- 1) Housing Choice & Structure
- 2) Separation of & Treatment,
- 3) Service Philosophy
- 4) Service Array
- 5) Human Resources Housing

# Next steps research

- Program effectiveness assessment using fidelity scale
- Canadian study – 5 cities randomized control trial examining 2 variants of Housing First

# SAMHSA NREBPP

Pathways' Housing First

On

SAMHSA web site National Registry of  
Evidence Based Programs (NREPP)

THANK  
YOU!

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[www.pathwaystohousing.org](http://www.pathwaystohousing.org)