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ORIGINAL PAPER

Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: Four-Year Study of Housing Access and Retention

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Abstract Housing First is an effective intervention that ends and prevents homelessness for individuals with severe mental illness and co-occurring addictions. By providing permanent, independent housing without prerequisites for sobriety and treatment, and by offering support services through consumer-driven Assertive Community Treatment teams, Housing First removes some of the major obstacles to obtaining and maintaining housing for consumers who are chronically homeless. In this study, consumers diagnosed with severe mental illness and who had the longest histories of shelter use in a suburban county were randomly assigned to either one of two Housing First programs or to a treatment-as-usual control group. Participants assigned to Housing First were placed in permanent housing at higher rates than the treatment-as-usual group and, over the course of four years, the majority of consumers placed by both Housing First agencies were able to maintain permanent, independent housing. Results also highlight that providers new to Housing First must be aware of ways in which their practices may deviate from the essential features of Housing First, particularly with respect to enrolling eligible consumers on a first-come, first-served basis and separating clinical issues from tenant or housing responsibilities. Finally, other aspects of successfully implementing a Housing First program are discussed.

Keywords Housing First · Homelessness · Mental illness · Choice

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Housing First

By operating housing services in a manner that is consistent with what consumers identify as their first priority—housing—Housing First engages persons whom traditional supportive housing providers have been unable to engage. Housing First programs offer immediate access to permanent independent housing, without requiring treatment compliance or abstinence from drugs or alcohol. The goals of Housing First are not only to end homelessness, but also to promote consumer choice, recovery, and community integration. Thus, Housing First programs offer housing in the form of scatter-site independent apartments in buildings rented from private landlords. Such residential arrangements honor the preference of consumers for apartments of their own (Goldfinger and Schutt 1996; Tanzman 1993) and afford people with psychiatric disabilities the opportunity to live in the community virtually indistinguishable from other residents, a fundamental aspect of recovery (Harding 1987a, b). To maintain this integration, the program does not lease more than 15% of the units in any one building. Units are rented from private landlords. This immediate offer of an independent apartment is a very powerful tool of engagement and consumers begin to recognize that the program is responsive to their needs and preferences. Addressing the consumer's needs first is the guiding principle for all subsequent services that are offered and is the foundation for building trusting and supportive clinical relationships, an essential component of Housing First that maximizes housing retention.

Although limited community resources and funding may titrate the intensity and breadth of treatment and support services that Housing First programs may provide, ideally, consumers will have access to integrated and comprehensive support, usually through multi-disciplinary Assertive Community Treatment (ACT) teams, with slight modifications (Stein and Santos 1998). ACT teams are located off-site, but are on-call 24 hours a day, 7 days a week, and provide most services in a client's natural environment (e.g., apartment, workplace, neighborhood) on a time-unlimited basis. Consumers are not discouraged, however, from visiting team members in their office. Teams are staffed with social workers, nurses, psychiatrists, and specialists in supported employment and peer counseling, and meet the national evidence-based practice standards for ACT (Phillips et al. 2001). Teams use a recovery-oriented practice philosophy that includes consumer choice as well as a harm reduction approach to substance use and mental health treatment. Teams offer consumers assistance with issues including housing, health care, medication, employment, family relations, and recreational opportunities (Tsemberis and Asmussen 1999). Service plans are not based on clinician assessments of consumers' needs; rather individual consumers choose the type, sequence, and frequency of services and have the option of refusing formal treatment altogether without compromising their housing. Such a flexible, consumer-driven approach to clinical practice helps ensure that consumers remain engaged with the team, particularly during crisis, and facilitates open rapport.

Though consumers can refuse formal clinical services, such as taking psychiatric medication, seeing a psychiatrist, or working with a substance use specialist, the programs have requirements for a minimum of one visit per week by the team. The

implemented by an agency that has previously practiced the traditional "housing readiness" approach to housing and treatment for the population.

Study Objectives

In the early months of 2000, a County Department of Social Services (DSS) contracted two organizations to provide Housing First services to consumers with psychiatric disabilities, and often co-occurring substance abuse disorders, who were chronic recidivists in the county's homeless shelter system. One provider was an agency with a long established record of operating Housing First programs but new to the county (Pathways to Housing); the other was a newly formed Consortium of treatment and housing agencies from within the county but with no prior experience operating Housing First. The study randomly assigned shelter users to one of the two Housing First programs as well as a "treatment as usual" control group. The housing status of participants in all three groups is presented at the 20-month follow-up point and housing retention rates for the two Housing First groups through just under four years. Additionally, because the goals of Housing First are to screen-in those clients considered "difficult to house," and to accept everyone from this targeted group who meets eligibility criteria on a first-come, first-served basis, we present data on the proportion of consumers outreached/engaged versus actually housed. We also discuss how the engagement and retention data suggest that the Housing First agencies may have taken different approaches to housing placement and discharge. Finally, in order to address the cost-effectiveness of the Housing First approach, we present the contractual per/client costs that were associated with each program.

Method

Procedures

Pathways to Housing (Pathways) and a Consortium of local agencies (Consortium) were contracted by the county to provide Housing First services, in the form of independent scatter-site apartments and ACT, to chronic shelter users with psychiatric disabilities. Each program was expected to house 60 individuals. The control group received the county's usual array of services that included shelter-based programs and transitional housing.

Data were collected from administrative records maintained by the Department of Social Services as well as the respective Housing First agencies. Each month, the two Housing First agencies submitted reports to the Department of Social Services indicating the number of consumers whom they had outreached/engaged, the number of consumers currently remaining in housing, and the number of consumers no longer housed. Residential data for Housing First consumers were available continuously for just under four years (47 months). Residential data for control participants were obtained through the county's computerized shelter tracking system, but were only available at the 20-month time-point. Because data were not

Table 1 Demographics, psychiatric diagnoses, and substance abuse disorders of originally assigned groups[a]

	Pathways (n = 105)		Consortium (n = 104)		Control (n = 51)	
	N	%	*N*	%	*N*	%
Sex						
Male	71	67.6	83	79.8	39	76.5
Female	34	32.4	21	20.2	12	23.5
Race						
African-American	63	60	56	53.8	28	54.9
Hispanic	8	7.6	13	12.5	7	13.7
Caucasian	30	28.6	29	27.9	14	27.5
Other	1	0.9	2	1.9	0	0
Unreported	3	2.9	4	3.9	2	3.9
Alcohol						
Dependence/Abuse	48	45.7	36	34.6	21	41.2
Dependence/Abuse in Remission	9	8.6	18	17.3	8	15.7
Unspecified	0	0	3	0	5	9.8
Drug						
Dependence/Abuse	54	51.4	33	31.7	20	39.2
Dependence/Abuse in Remission	8	7.6	19	18.3	8	15.7
Unspecified	3	2.9	3	2.9	3	5.9
Mental Illness						
Schizophrenia	48	45.7	45	43.3	16	31.4
Major Depressive Disorder	12	11.4	15	14.4	6	11.8
Bipolar Disorder	19	18.1	18	17.3	12	23.5
Shizoaffective Disorder	11	10.5	2	1.9	2	3.9
Other	10	9.5	15	14.4	11	21.6
Information unavailable	5	4.8	9	8.7	4	7.8

[a] Demographic characteristics were not available for participants who were randomly assigned to Housing First in the second and third rounds of the project

It was the responsibility of each agency to contact and engage participants once they received the list of consumers that were randomly assigned to them. The agencies could, therefore, conduct outreach and accept consumers from the list at their discretion. Additionally, because enrollment into the Housing First programs was staggered, participants entered into housing at various stages of the program's existence.

Results

Housing Status

Pathways housed its first consumer in early June of 2000 and the Consortium housed its first consumer the following month. Twenty months later, by February 2002,

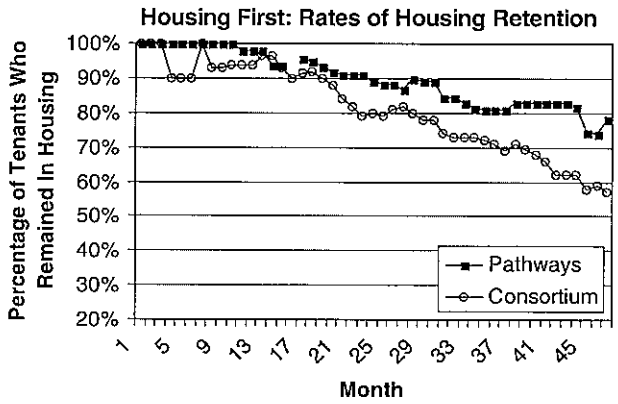

Fig. 1 Housing First: rates of housing retention

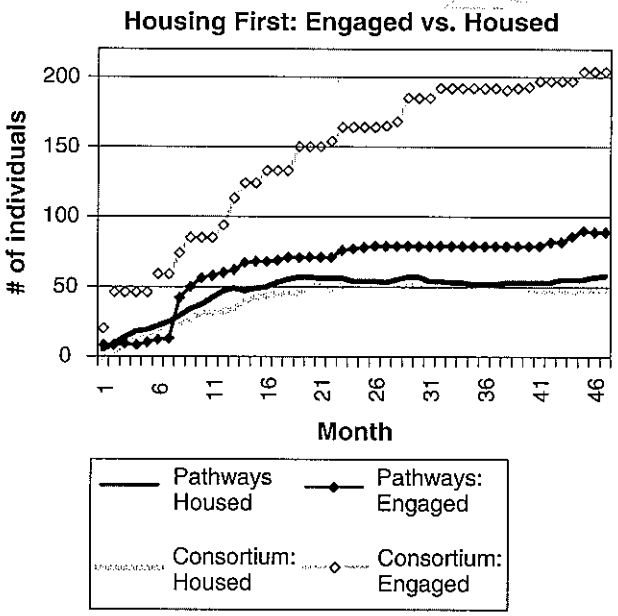

Fig. 2 Housing First: engaged/outreached versus housed

Cost

As Table 2 indicates, the per diem costs for Pathways and the Consortium, based on 2002 budgets, was $55.92, or $20,410 per client per year. Shelter reimbursement rates, meanwhile, ranged from a $66.49 to $119.26 per diem, or $24,269 to $43,530 per client per year. The Housing First costs included: staff salaries, operation costs, and funding for rents and property management.

Additionally, existing agencies and providers may be ill-prepared for the programmatic and systemic changes implied by adopting a Housing First approach that greatly reduces the need for shelters or other transitional housing programs. These providers may have very practical concerns, such as losing valuable shelter contracts, and by extension, jobs for shelter staff.

Providers new to Housing First must also be aware of ways in which their practices may deviate from some of the essential features and philosophy of Housing First. The Consortium's lower retention rate suggests that their discharge policies may not reflect the practice of separating housing from treatment. It is important to continue to provide services through housing loss and to assist consumers in finding new housing when they experience difficulties in one building or neighborhood, or upon their discharge from hospital or clinic-based treatment. Providers shifting to Housing First services must, therefore, be especially observant of the need to keep clinical matters separate from housing matters and to ensure that a clinical crisis results in the consumer receiving intensive clinical services, not being evicted from housing.

The disparity between the Housing First programs in the ratio of clients housed to those outreached/engaged suggests that the agencies used two different approaches to enrolling participants and placing them in housing. The large number of participants engaged by the Consortium may suggest that these agencies were extremely rigorous in their efforts to screen-out ineligible applicants. Also possible, however, is that the Consortium's selective enrollment was the result of clinicians turning down participants who were eligible but whom they did not consider appropriate for immediate placement in permanent housing. New Housing First providers may still be reluctant to work with consumers who are traditionally considered "difficult to house." One of the principles of Housing First is to target consumers who have had difficulty accessing traditional services and to then sequentially accept these consumers on a first-come, first-served basis. Providers who are shifting towards Housing First services must, therefore, be mindful of a long held but erroneous bias that equates psychiatric symptoms or substance use with an inability to maintain housing. Given that the Housing First Consortium had lower rates of housing retention despite carrying out a more extensive selection of consumers also reinforces the fact that housing providers and clinicians are not able to successfully predict which consumers among a chronically homeless pool of applicants will be able to successfully maintain housing.

With regard to implementing a Housing First approach based on a scattered-site, community integration model in a suburban or rural locale, service providers may encounter several challenges that could require slight modifications to the model. With regard to staffing, if sufficient resources for a full-scale ACT team operating within one agency are lacking, or if the number of consumers to be served is small, programs can create smaller sub-ACT teams that maintain low caseload ratios but must broker some services from agency or community providers. Another variant successfully implemented in some cities consists of 'composite teams' comprised of several staff members but each from a different agency (e.g., a mental health expert from the local mental health clinic, a substance abuse specialist from the drug treatment program, and a case worker from the shelter). Programs may also employ

this sample further confirm that Housing First approaches can be successful with persons who experience multiple impairments.

Nevertheless, the study also has considerable weaknesses. First, demographic data were only available for the first cohort of participants who enrolled into the study and so we cannot accurately describe the entire study sample. Second, despite employing random assignment, not all participants were enrolled by their respective Housing First agency. Though the initial groups were roughly equivalent after random assignment, unfortunately, individual-level data were not available to compare those who were actually housed within each study condition. Consequently, it was not possible to determine how comparable the groups of participants were who actually received housing. Further, the absence of such data made it impossible to determine whether there were any significant demographic differences between those who were housed and not housed within each condition. We cannot, therefore, identify the characteristics that are associated with entry into housing for each condition and across the sample as a whole. Further, almost half of the control participants' whereabouts were unknown at time of follow-up, resulting in substantial amounts of missing data. This weakens our ability to estimate the relative strength of the Housing First approach as compared to the usual sequence of services. Limited resources also did not permit continued follow-up of the control group over the entire 46-month study period. Though unlikely, it is impossible to determine whether the control group caught up with or exceeded the rates of permanent, independent housing reported here for the two Housing First groups after four years.

A final limitation is that the impact of specific agency support and treatment services that were received by participants and their role in maximizing housing retention, were not examined. Because both agencies were funded under the same mechanism, they were very similar in terms of their ACT teams' organizational structure, staffing, and general practices. Given the disparities in housing retention and selection outcomes across agencies, these structural similarities accentuate the potential impact that overarching agency philosophies and more informal, daily team support services may have on consumer outcomes. For example, the Consortium's affiliation with a medical center may have resulted in their ACT team having a lower threshold of tolerance for psychiatric symptoms and/or substance use among their clients. Such a service perspective may have led to greater residential instability if consumers were more abruptly removed from housing and their engagement with the team threatened by having their ability to exercise choice more restricted. Unfortunately, the current study was not able to examine these potential philosophical and services discrepancies between agencies in-depth.

Overall, Housing First has proven to be an effective and less costly alternative for housing chronically homeless individuals with psychiatric disabilities. This study demonstrates that the Housing First approach is effective in the long-term in reducing homelessness and can be successfully implemented in suburban areas and with populations of chronically homeless shelter users with multiple disorders. Other Housing First replication sites also report housing retention rates of 80% or better through 12–18 months (D. Dunbeck, personal communication, December

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