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HOUSING STABILITY AMONG HOMELESS INDIVIDUALS WITH SERIOUS MENTAL ILLNESS PARTICIPATING IN HOUSING FIRST PROGRAMS

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This article presents findings from an exploratory study of three programs using the Housing First approach to provide permanent supportive housing for single, homeless adults with serious mental illness and often co-occurring substance-related disorders. This approach provides direct, or nearly direct, access to housing that is intended to be permanent without requiring sobriety or psychiatric treatment. Findings from the three programs examined for this study indicate that the Housing First approach may help the hardest-to-serve chronically homeless population achieve housing stability. Of the 80 participants tracked over 12 months, 84% remained enrolled in the Housing First program for 1 year following program entry. One half of those spent every night in their Housing First unit, while the others spent some time in other living environments. © 2009 Wiley Periodicals, Inc.

The U.S. Department of Housing and Urban Development (HUD) defines a chronically homeless person as an unaccompanied adult with a disabling condition—most commonly with a serious mental illness, substance-related disorder, developmental disability, or chronic physical illness or disability—who has been

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continuously homeless for one year or longer, or had at least four homeless episodes during the last 3 years (HUD, 2006). Estimates from applications for homelessness assistance submitted to HUD indicate that there were 150,000–200,000 chronically homeless individuals nationwide as of January 2005 (National Alliance to End Homelessness, 2006). To end homelessness, the needs of these individuals must be addressed.

Because the social disability that often accompanies serious mental illness is the inability to sustain independent living, permanent supportive housing has evolved as a preferred housing intervention for ending chronic homelessness. Broadly defined, supportive housing is independent housing in the community coupled with support services (Rog, 2004). Chronically homeless persons who have been living on the streets or in shelters for long periods of time often require services to help them stabilize a psychiatric or substance abuse problem that, if left untreated, can jeopardize housing stability. There is mounting evidence that the combination of housing and treatment is effective in facilitating both housing stability and treatment retention (Burt & Anderson, 2005; Culhane, Metraux, & Hadley, 2002; Martinez & Burt, 2006). However, chronically homeless individuals may reject or are unable to commit to a conditional offer of housing.

Chronically homeless individuals may find it extremely difficult to engage in a process of treatment without being housed. However, most chronically homeless individuals are unable to meet or commit to the demands related to housing readiness (e.g., sobriety, basic living skills, personal hygiene, commitment to engage in treatment) required to participate in many supportive housing models. For this reason, there has been increasing interest in the Housing First approach, which aims to move the most vulnerable homeless people directly to permanent housing without transitional placements. Tailored to the needs of chronically homeless individuals—typically with a serious mental illness and often a co-occurring substance-related disorder—the Housing First approach offers direct access to housing without sobriety requirements as well as voluntary participation in supportive services, based on consumer choice.

Housing First programs consider housing needs paramount and separate from treatment needs (Carling & Curtis, 1997; Tsemberis, 1999) in contrast to other types of programs that focus on a participant's mental illness or substance use, rather than homelessness, as the priority for service provision (Lipton, Siegel, Hannigan, Samuels, & Baker, 2000). The latter set of providers assume that homeless people with severe impairments require a period of structured stabilization prior to entering permanent housing, often involving stays in a series of housing settings along a continuum of increasingly independent living. Entering this continuum often requires that the homeless person commit to a service plan and agree to abstain from drugs and alcohol. Housing First programs target those unable to succeed in a more structured approach to services and those resistant to accepting services.

Research on permanent supportive housing has not focused specifically on the Housing First approach, with the exception of studies published on the first and most well-known Housing First model: Pathways to Housing in New York City (Shern, Tsemberis, Anthony, Lovell, & Richmond, 2000; Tsemberis, 1999; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004; Tsemberis, Moran, Shinn, Shern, & Asmussen, 2003). Established in 1992, this program offers homeless persons with mental illness direct access to scattered-site permanent apartments without requiring participation in psychiatric treatment or

sobriety. Neighborhood-based interdisciplinary Assertive Community Treatment (ACT) teams, modified from the original ACT team approach developed by Stein and Test (1980), work with participants to maintain their housing and offer additional, voluntarily available, supportive services. The Housing First model, as developed by Pathways to Housing, was recently identified as an evidence-based practice by the Department of Health and Human Services' National Registry of Evidence-based Programs and Practices.

Comparative studies of the Pathways to Housing model have shown increased levels of housing stability when compared with more high-demand models. One of the most rigorous studies compared the outcomes of street-dwelling homeless persons with serious mental illness who were randomly assigned to receive either (a) immediate housing without a treatment prerequisite (Pathways to Housing group) or (b) housing contingent on sobriety ("continuum of care" control group). This study found that, over the 24-month follow-up period, the Pathways to Housing group spent less time homeless and more time stably housed compared to the control group (Tsemberis et al., 2004). Findings indicated that the two groups did not differ in the extent of their psychiatric symptoms or substance use.

Further, in a study comparing the outcomes of homeless persons with serious mental illness placed in community residential treatment facilities and those in the Pathways to Housing program, the Pathways to Housing supportive housing approach resulted in increased housing stability. After 5 years, 88% of Pathways to Housing participants remained housed, whereas only 47% of the residents in the residential treatment system remained housed (Tsemberis & Eisenberg, 2000).

Although Housing First programs may be constructed in a number of ways, the distinguishing features of the overall approach are (a) direct, or nearly direct, placement of homeless people into housing with the program's commitment to ensure that the participant is housed permanently; (b) no requirement that participants use supportive services, although the program offers and makes services readily available; (c) 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 as well as use of a harm-reduction approach to substance use, which addresses the harms caused by risk-taking behavior without forcing elimination of the behavior altogether; and (d) continued efforts to provide case management and hold housing for participants, even if they temporarily leave program housing. Although Housing First programs incorporate each of these features, they may vary in the type of housing they offer (e.g., scattered site or project based) as well as the service model they make available to residents (Pearson, Locke, Montgomery, & Buron, 2007).

METHOD

This exploratory study, commissioned by HUD, examined and compared program characteristics and client outcomes in two Housing First programs, in addition to Pathways to Housing, that have adopted a Housing First approach. In late 2003, the study team canvassed Housing First programs nationally to select two study sites, in addition to Pathways to Housing, that were of sufficient size, had been in existence for a suitable period of time, and shared common features with Pathways to Housing though varying on certain key program characteristics that seem to be influential to housing tenure, stability, and other positive outcomes. The study team selected the

Downtown Emergency Service Center (DESC) in Seattle, Washington, and Reaching Out and Engaging to Achieve Consumer Health (REACH) in San Diego, California.

A sample of 80 study participants was selected from the Housing First programs, based on the order in which they entered the program. The study design called for the enrollment of the first 25 participants entering the Housing First programs during the 3-month enrollment period of April to June 2004. Because the Housing First programs have low turnover rates and a small volume of new enrollments each month, 52% of study participants were enrolled retrospectively. Therefore, to select study participants, the Housing First programs listed participants in chronological order by date of entry between June 2003 and June 2004. Each program selected 25 participants from this list, beginning with those who entered the program in June 2004. There were no statistically significant differences between the prospective and retrospective samples and the study participants were representative of the overall program population. Staff made every effort to enroll participants who left the program prior to the commencement of the study to ensure an accurate representation of the Housing First program. DESC enrolled 25 participants, Pathways to Housing enrolled 26, and REACH enrolled 29 participants.

Program case managers collected quantitative baseline, retrospective, and monthly data on housing status and location as well as other key outcome variables such as impairment level related to drug use, alcohol, and mental illness; temporary program departures; and service contacts. Basic participant characteristics were expressed as categorical variables; level of impairment related to psychiatric symptoms or substance use was reported using a 3-point Likert-type scale ranging from *none* to *severe*. Although the study population was small, chi-square analyses were performed to determine any statistical differences in sample characteristics across groups (i.e., Housing First programs and level of housing stability).

During an initial site visit, the study team collected qualitative information on program design, visited program housing offered to participants, and trained program staff to recruit study participants, obtain informed consent, and record baseline and monthly tracking data using instruments developed by the study team. For those study participants who left the Housing First program prior to 12 months of tenure, the study team hired local researchers at each program location to gather follow-up information.

To obtain participants' perspectives on the quality of their housing, satisfaction with their housing, and their quality of life experience with the Housing First program during their first year of placement, the study team conducted two focus groups at DESC and REACH and three at Pathways to Housing, with a total of 27 participants. The focus group participants provided insights on how participants enter the programs, whether participants had choice in their housing and services, and how satisfied they were with their program experiences. These data allowed the study team to interpret and triangulate quantitative findings.

RESULTS

Program Characteristics

The DESC's permanent supportive housing program with a Housing First approach opened in May 1994. The DESC serves more than 300 participants at one time and places two to three new participants each month. Approximately 30% of participants

enter the program directly from the streets, with the remainder coming from emergency shelters. The majority of DESC participants enter the program following engagement with DESC outreach workers. Because vacancies are rare, staff maintains a waiting list and prioritizes those at greatest risk due to mental illness and other vulnerabilities. The DESC owns or controls four buildings, each serving slightly different populations with 24-hour, onsite staff trained in property management and supportive services. Participants sign their own leases and may choose to participate in services coordinated through clinical case managers as well as housing-based case management. Residents do not have to agree to participate in services or maintain sobriety to receive or retain their housing.

Pathways to Housing, located in New York City, serves 450 individuals who have histories of homelessness, severe psychiatric disabilities, and co-occurring substance-related disorders. Acceptance of referrals depends on the referral source, availability of a housing subsidy, and ACT team capacity. Upon enrollment, participants may reside in a shelter or be placed in a hotel or other temporary housing while working with the housing department and ACT team members to secure an apartment. Participants are offered a choice among up to three apartments. All housing units are privately owned, independent apartments secured through Pathways to Housing's network of landlords, brokers, and managing agents. Pathways to Housing holds the lease and sublets the apartment to the participant. 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 participants in their neighborhood areas.

REACH was established in 2000 out of concerns that vulnerable homeless people risked displacement by the construction of a new sports stadium in downtown San Diego. The San Diego County Mental Health Services Division received a $10.3 million competitive state grant under California's AB 2034 program to engage, house, and provide case management within 6 months to 250 chronically homeless individuals with mental illness. The program has been fully leased since June 2001, and averages five or six new participants a month. REACH requires that participants have an Axis I diagnosis (American Psychiatric Association, 2000) of mental illness, have been homeless at least 6 months during the past year, and want to be housed through REACH. The majority of REACH participants enter the program directly from the streets through a Homeless Outreach Team sponsored by the San Diego Police Department and comprised of a police officer, benefits specialist, and mental health counselor. Most participants first enter either a safehaven or a Single Room Occupancy (SRO) hotel. Although the REACH program offers placement into housing without requirements for treatment or sobriety, many of the housing options located in the community have restrictions on substance use. REACH makes it clear to participants, however, that the program will help them maintain permanent housing through the team of case managers that coordinates services 24 hours a day, 7 days a week.

Table 1 summarizes the characteristics of the Housing First programs selected for study. The three programs share some common features: They serve participants with serious mental illness (including many with co-occurring substance-related disorders) and long histories of homelessness; offer direct or nearly direct placement into permanent housing with access to a wide variety of services, with voluntary participation; and make efforts to provide services even if the participant leaves program housing for as long as 90 days.

Table 1. Characteristics of Housing First Programs

Feature	*DESC*	*Pathways to Housing*	*REACH*
Year established	1993	1992	2000
Units	306	450	250
Housing types	Owned by DESC	Scattered site	SRO, safehaven, independent living facilities, scattered-site apartments
Colocation of housing and services	Yes—onsite staff provide property and case management	No—ACT team members visit participants in home	No—case managers visit participants in home
ACT team	Modified	Yes	Modified

Note. DESC = Downtown Emergency Service Center; REACH = Reaching Out and Engaging to Achieve Consumer Health; SRO = Single Room Occupancy; ACT = Assertive Community Treatment.

However, the three programs' housing and service types vary. Although Pathways to Housing leases scattered-site units in privately owned buildings, DESC offers housing in four buildings the organization owns or controls, providing 24-hour on-site staff trained in property management and supportive services. Pathways to Housing provides neighborhood-based interdisciplinary support teams available at all times to participants in their own homes.

REACH has access to (but neither owns nor controls) a variety of housing units funded by a combination of federal and state funds. Some of the units are clustered in a safehaven and several downtown SRO buildings; others are scattered-site apartments in complexes throughout the county. Although REACH does not require service participation, a number of the housing providers associated with the program do have occupancy rules regarding alcohol and drugs, curfews, noise, and other issues. Due to these strict occupancy rules in many of the initial housing placements, REACH was not the best fit with the Housing First model; however, REACH case managers often struggled but nonetheless were committed and successful in helping clients find alternative placements rather than return to homelessness.

Participant Characteristics at Enrollment

Housing First programs primarily target homeless mentally ill people considered "hard to serve," who are living on the streets or in emergency shelters. Table 2 lists the characteristics of study participants at enrollment. This summary indicates that the study participants represented the severely impaired homeless population that Housing First programs intend to target: the majority was chronically homeless, had a primary diagnosis of mental illness, and was abusing substances at the time of enrollment. More than two thirds of the sample had co-occurring mental illness and history of substance abuse.

Differences in participants' living situations immediately prior to program entry may explain some of the population differences across the three Housing First programs. Almost 60% of REACH participants entered the program directly from the streets, whereas 56% of DESC participants came directly from "wet" shelters, which do not require residents to discontinue drug or alcohol use. This may explain the higher levels of psychiatric impairment at enrollment among DESC and REACH participants. At Pathways to Housing, the largest proportion of participants came to the program directly from psychiatric hospitals, exhibiting characteristics of a previously

Table 2. Participant Characteristics at Enrollment (N = 80)

Characteristic	*DESC*	*Pathways to Housing*	*REACH*
Age			
Mean	47.9	47.0	39.7
SD	10.3	12.7	10.7
Gender: female	16%	15%	34%
Race*			
White	64%	31%	55%
Black	20%	50%	17%
Education less than high school diploma*	28%	62%	28%
No employment history*	8%	85%	17%
Axis I diagnosis*			
Schizophrenia or other psychotic disorders	52%	85%	59%
Mood disorders	16%	8%	41%
History of substance abuse	84%	77%	66%
Previous substance abuse treatment*	48%	100%	15%
Co-occurring disorders	68%	73%	66%
HIV/AIDS*	20%	4%	0%
Chronic homelessness	84%	92%	86%
Prior living situation*			
Streets	36%	19%	59%
Homeless shelter	56%	23%	7%
Psychiatric hospital	8%	42%	3%
Other, jail or prison, unknown	0%	16%	31%

Note. Previous substance abuse treatment only for those with a history of substance abuse. Race was recoded into three categories: White, Black, and other or unknown race. DESC = Downtown Emergency Service Center; REACH = Reaching Out and Engaging to Achieve Consumer Health. $^{*}p < .05$, $^{**}p < .10$.

institutionalized population; they had a diagnosis of schizophrenia, had lower educational levels and employment experience, and had previous substance abuse treatment.

Housing Stability

A key participant outcome for Housing First programs is to increase housing stability. Burt and Anderson (2005) found that homeless people with serious mental illness who have stable housing are more likely to stay enrolled in the program—that is, to stay engaged in mental health services. Because the Housing First approach is intended to first and foremost increase participants' housing stability by reducing the amount of time spent homeless, the study team tracked several indicators to determine what factors may be related to housing stability across the Housing First programs: how long participants were engaged with the Housing First program (housing tenure); the relationship between participant characteristics and housing tenure; the frequency of housing problems and temporary departures to other living environments during the course of the year; and how frequently participants moved among program housing units.

Housing tenure. The tracking of housing tenure patterns across the three Housing First programs revealed that, overall, the programs had similar outcomes: the majority of participants (84%) were still housed at the end of 12 months. The remaining 16% left or died during the follow-up period. Involuntary reasons for leaving program housing

within 12 months included death ($n = 4$), the need for more intensive care ($n = 2$), incarceration ($n = 2$), and loss of housing due to alleged assaults on other residents ($n = 2$). In addition, some participants left voluntarily ($n = 3$), due to resistance to obtaining identification to secure benefits or having a "wanderer" lifestyle, according to program staff.

Although not a statistically significant finding, there were differences in housing stability among the three programs. Pathways to Housing participants had the greatest level of housing stability with 92% remaining in program housing for 12 months ("stayers"), with only 8% leaving the program during the first 12 months. REACH and DESC both had 80% stayers, with 20% of participants leaving during the first 12 months. The most important feature of the Housing First programs is that the housing is permanent. Disruptions in housing may occur due to clients' behavioral problems resulting from substance abuse or psychiatric decompensation, but clients do not lose their housing as a result of these problems.

Participant characteristics related to housing tenure. As Table 3 indicates, participants' living situations immediately prior to program entry appear to have some impact on the differences in the level of housing stability among the Housing First programs. Participants who entered the Housing First program from the streets were most likely to leave the program within 12 months ($p < .10$). The participants with the highest levels of housing stability were those who entered the program from shelters, jail, or a psychiatric hospital, or some other or unknown location, including crisis houses and living with friends. Because almost 60% of REACH participants entered the program directly from the streets, this may explain their higher levels of temporary departures, most frequently back to homelessness. At Pathways to Housing, the largest proportion (42%) of participants came to the program directly from psychiatric hospitals, and were therefore somewhat stabilized before entering housing.

Other than prior living situation, characteristics of stayers and "leavers" were quite similar with the exception of gender (all women were stayers, $p < .05$), race (leavers were more likely to be Black), and education (stayers attained a higher level of

Table 3. Housing Program and Participant Characteristics Related to Housing Tenure ***(N = 80)***

Housing tenure	*Stayers*	*Leavers*
Housing First program		
DESC	80%	20%
Pathways to Housing	92%	8%
REACH	79%	21%
Gender: female*	27%	0%
Race		
White	60%	46%
Black	27%	39%
Education less than high school diploma**	32%	61%
Prior living situation**		
Streets	33%	69%
Homeless shelter	28%	23%
Psychiatric hospital	21%	8%
Other, jail or prison, unknown	18%	0%

Note. DESC = Downtown Emergency Service Center; REACH = Reaching Out and Engaging to Achieve Consumer Health. *$p < .05$, **$p < .10$.

education than leavers, $p < .10$). These characteristics demonstrate that the group of stayers was comprised of participants similar to the leavers.

Frequency of housing problems. The Housing First program staff indicated, each month, whether clients experienced any housing problems, and if so, described the problem. Housing problems reported most frequently included failure to upkeep the apartment or personal hygiene, flooding, hoarding, excessive noise, or other behavioral problems, such as imaginary fears due to hallucinations. On average, participants at Pathways to Housing reported less than one (0.46) housing problem during their tenure in the program; REACH participants reported 4.2 and participants at DESC reported 3.2. The report of housing problems was significantly greater at REACH and DESC, $F(2,77) = 13.367$, $p < 0.01$. In addition, leavers reported slightly more housing problems than stayers—3.1 compared to 2.6—although this difference was not significant.

Although housing problems may not be frequent, some are serious enough to jeopardize a client's housing in a less tolerant setting. For example, across all three Housing First programs, problem behavior linked to alcohol or drug use was reported for 17 participants, other behavioral issues were reported for 31 participants, 11 participants were abusive toward others, and 16 participants were cited for property damage or failure to upkeep their apartments. Table 4 lists the proportion of participants at each Housing First program that experienced the specified problem behavior. REACH participants were significantly more likely to take part in other problem behaviors, $F(2,77) = 4.107$, $p < 0.05$, whereas DESC participants were significantly more abusive to others, $F(2,77) = 3.836$, $p < 0.05$, and likely to damage property or not maintain their living quarters, $F(2,77) = 3.115$, $p < 0.05$. Leavers and stayers did not experience significantly different housing problems.

Duration in other living environments. An indicator of housing stability is the amount of time that participants spent in living environments other than program housing. Across the three study sites, clients experienced temporary program departures, most frequently for short stays in psychiatric hospitals or short periods of time on the streets. During these temporary departures, apartments were held for the clients' return. Over the course of the 12-month study period, stayers spent an average of 29.8 nights ($SD = 58.6$) in other living environments; leavers spent an average of 60.8 nights

Table 4. Proportion of Participants with Housing Problems by Housing Program ***(N = 80)***

	Housing First Program			*ANOVA Results*		
Housing problem	*DESC %*	*Pathways to Housing %*	*REACH %*	*df*	*F*	*p*
Behavior associated with alcohol or drug use	40	4	21	77	2.058	
Other behavioral issues	48	12	55	77	4.107	<.05
Abusive toward others	32	0	10	77	3.836	<.05
Property damage or failure to upkeep housing	28	23	10	77	3.115	<.05

Note. DESC = Downtown Emergency Service Center; REACH = Reaching Out and Engaging to Achieve Consumer Health.

($SD = 59.0$), $t(78) = -1.739$, $p < .10$. Note that leavers did not spend a full 12 months in the program.

Of the three programs, REACH participants experienced the greatest amount of time living in environments other than program housing. The DESC clients spent 25.2 nights ($SD = 44.1$) in other living environments, Pathways to Housing spent 22.5 nights ($SD = 49.2$), and REACH clients spent 54.4 nights ($SD = 74.3$) in other living environments. The relationship between Housing First program and temporary program departures was moderately significant, $F(2,77) = 2.553$, $p = 0.084$. This finding may be partially explained by the fact that some of REACH's program housing had strict occupancy rules. Temporary departures for DESC and Pathways to Housing participants were most frequently to medical and psychiatric hospitals.

Moves within program housing. In Housing First programs, participants may move to a different program unit for several reasons: dissatisfaction with current housing, a preference for living in a particular neighborhood, a perception that other housing is more independent or of higher quality, problems with neighbors or a landlord, or from a more temporary to permanent setting. Approximately the same proportion of stayers (33%) and leavers (31%) changed their Housing First unit during the study period. At the program level, few participants from DESC or Pathways to Housing moved from one program unit to another during the first 12 months, and none moved more than once. By contrast, 76% of REACH participants relocated within 12 months, and the average number of moves was almost two.

Client perspective on housing placement. The clients who participated in focus groups at each of the study sites made generally favorable comments about their housing. At DESC, clients liked tangible features, such as the privacy offered by individual apartments and amenities such as laundry facilities, television, and meals. They also cited less tangible features, such as feeling "at home," being independent, and having a social life. The negative comments came primarily from one focus group participant, a former state hospital resident, who did not like living with a large number of people with mental illness. "It's still a nuthouse," he complained.

During the focus groups at Pathways to Housing, clients reported that they would have been grateful to take anything as an alternative to living on the streets: "I thought it was too good to be true," or "If they had offered me an apartment where my life was in danger every time I opened the door, I would have taken it."

During the focus groups at REACH, clients indicated that there is a progression to be able to enter a scattered-site unit— "Something better is on the way… if you stick with it." This client described his experience of moving into housing as, "For me it happened really fast… I spent 2 weeks in a crisis house and then I went to the SRO for 3 months. It was noisy and I didn't like it, so I got independent living in a studio apartment in Old Town, but I still dream about sleeping on the streets." Most clients in the focus group said that there were few housing choices, but expressed little dissatisfaction. Only those living in one of the SRO sites expressed dissatisfaction.

Regarding housing choice, the responses of focus group participants were mixed. One client stated that his housing was "not imposed, but REACH directed me." Another stated, "I didn't care, I trusted REACH." A third client reported, "I took what was offered, but now I'm working on getting another place."

Table 5. Impairment Related to Psychiatric Symptoms and Substance Use at Baseline and Month 12 (n = 67)

	Psychiatric symptoms		*Substance use*	
Level of impairment	*Baseline %*	*12 months %*	*Baseline %*	*12 Months %*
No impairment	21	19	51	58
Moderate	48	52	6	3
Severe	31	27	19	25
Unknown	0	1	22	13

Note. For substance use category, level of impairment described as "no impairment" includes those who did not have a history of substance use. Sample does not include "leavers."

Change in Level of Impairment Related to Psychiatric Symptoms and Substance Use

Program staff in the three Housing First programs cautioned that, given the severity of their participants' symptoms, they would expect limited improvements in levels of impairment within 12 months. This was consistent with the findings from the present analysis. Although participants may experience month-to-month variation in their levels of impairment, the data do not demonstrate any significant trends in impairments related to psychiatric symptoms or substance use over the course of the first year in program housing. See Table 5 for a comparison of levels of impairment related to psychiatric symptoms and substance use between baseline and month 12 of participants' tenure in the Housing First program.

DISCUSSION

This is the first multisite study of the implementation and outcomes of the Housing First approach. Although the study is small and exploratory in nature, the findings from the three Housing First programs selected for study provide evidence that the Housing First approach, as implemented in these programs, can promote housing stability for homeless people with serious mental illness and substance-related disorders.

A large majority of the 80 participants tracked for this study met the HUD definition of chronic homelessness at some time during the last 3 years. In addition, participants were extremely poor and had limited work histories and low educational attainment, all of which can be significant barriers to obtaining and maintaining housing. Despite these challenges, the majority (84%) of the study sample remained engaged in program housing for 12 months. Although the housing tenure outcomes are promising, changes in participants' clinical status—level of impairment related to psychiatric symptoms and substance use—are limited during the first year.

The DESC, Pathways to Housing, and REACH were selected for this study, in part, because they share a commitment to serving homeless people with chronic mental illness. These programs emphasize direct placement into permanent housing and use a service approach that does not require sobriety or treatment compliance. The programs differed along several dimensions, however, including the type of housing utilized, the use of transitional placements, and the location and intensity of services. Participants' characteristics also varied across programs. These findings are suggestive of participant characteristics and program features that appear to promote housing stability.

The Housing First programs that offered a mixture of housing and services allowing the greatest flexibility in program rules and responsiveness to housing issues with this hard-to-serve population—Pathways to Housing and DESC—had greater levels of housing stability. The DESC owned or controlled the housing where its participants lived and had onsite staff to respond immediately to issues that arose with participants' housing. Pathways to Housing offered scattered-site housing in privately owned buildings, where neighborhood-based ACT teams could maintain contact with participants and landlords and quickly resolve any issues that might arise.

REACH participants experienced more housing instability, including more temporary departures, moves, and durations of stay outside of program housing. However, REACH had the highest proportion of participants who entered program housing from the streets, with severe psychiatric impairment, which were those more likely to be moved to maintain program housing or to experience temporary departures back to homelessness. This housing stability may also be attributed to REACH not being the best fit with the Housing First model because some of the housing providers that leased to REACH participants had strict lease requirements prohibiting drug or alcohol use. However, REACH case managers were committed to helping clients find alternative placements rather than return to homelessness.

An important lesson learned from this study is that housing stability in Housing First programs is an iterative process. Temporary departures from housing are not uncommon, but program staff continues to follow-up with participants even when they are away from their housing for lengthy periods. These episodic departures are part of a stabilizing strategy to ensure that clients maintain their engagement in housing and in treatment. 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. However, only Pathways to Housing and DESC offer housing without service requirements. At REACH, many participants enter housing at a safehaven that has a number of occupancy rules, including a prohibition on drugs and alcohol. Despite these requirements, most homeless people accept the offer of housing and express satisfaction once they are in it.

Based on limited evidence collected from follow-up interviews and focus groups conducted at each site, participants cite the privacy, independence, safety, and quality of their housing as positive features of their housing experience. Several REACH focus group participants noted dissatisfaction with the quality and safety of their housing, and participants experienced a higher incidence of program moves and temporary departures. Furthermore, though participants viewed their participation in services as voluntary, they understood that this participation would support their ability to retain housing.

The immediate advantage of the Housing First approach for the chronically homeless population is that direct placement in housing solves the problem of homelessness. The dilemma is that obtaining housing does not necessarily resolve other issues that may impede one's housing success. 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. Maintaining housing stability requires a flexible and responsive service approach that focuses on helping people keep their housing. It also requires subsidy mechanisms that permit programs to hold units for people who leave temporarily, as well as a housing supply and program policies that help people obtain a different unit if they cannot return to their unit following a departure.

The present study presents the first exploratory comparison of Housing First programs. The limitations of the study include the use of a partially retrospective sample as well as data collected through administrative sources and reported by case managers. Although important outcomes were measured in this study—housing stability and program tenure—the study was unable to uncover significant changes in impairments related to psychiatric symptoms and substance use. Limited inferences could be made due to the use of a limited 3-point Likert-type scale to measure impairments, data not collected directly from program participants, and short follow-up period. Specifically, an acknowledged weakness of this study was the inability to follow participants for up to 24 months following program entry to better measure the impact of service engagement on improvement in clinical outcomes such as psychiatric impairment and substance abuse over time.

The Housing First approach is a promising strategy for ending homelessness. Further research should focus on whether this approach is more effective than other permanent supportive housing models using quasi-experimental designs to determine the relative impact of housing and service delivery.

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