

The Applicability of

Housing First Models to Homeless Persons with Serious Mental Illness



U.S. Department of Housing and Urban Development Office of Policy Development and Research



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Housing First Models to Homeless Persons with Serious Mental Illness

FINAL REPORT

Prepared for:

U.S. Department of Housing and Urban Development Office of Policy Development and Research

Prepared by:

Carol L. Pearson, Ph.D., Walter R. McDonald & Associates, Inc. Gretchen Locke, Abt Associates Inc. Ann Elizabeth Montgomery, Walter R. McDonald & Associates, Inc. Larry Buron, Ph.D., Abt Associates Inc.

Walter R. McDonald & Associates, Inc., Rockville, MD

Abt Associates Inc., Cambridge, MA

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Foreword

Understanding homelessness is a necessary step toward ending it, especially for those persons living with a chronic condition such as mental illness, an addiction, or physical disability. Ending chronic homelessness remains a national goal for President Bush, the Department of Housing and Urban Development (HUD), and many within the homeless advocacy community.

In recent years, an approach known as Housing First has emerged as one model for serving chronically homeless people. HUD began this study as a first step in describing how Housing First programs actually work and what sorts of short term outcomes are realized by the people they serve.

This report, *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*, provides a basic description of several programs that represent a Housing First model. The report should help clarify the issues and inform the policy discussion about how best to address the most vulnerable in American society.

Darlene F. Williams Assistant Secretary for Policy Development and Research

Preface

This report presents the findings from an exploratory study of the Housing First approach of providing permanent supportive housing to single, homeless adults. Those served have mental illness and co-occurring substance-related disorders, and frequently come directly (or nearly directly) off the streets. Congress and the U.S. Department of Housing and Urban Development (HUD) have encouraged the development of permanent supportive housing for homeless people since the inception of the McKinney-Vento Act in 1987. In recent years, increased public attention has been focused on 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 has emerged as a favored policy response among many in the advocacy and practitioner communities.

Each of the three Housing First programs studied here use a low demand model to respond to substance abuse among their chronically homeless target populations.¹ What is low demand? This report defines it in this way:

The [low demand] approach addresses the harms caused by risk-taking behavior without forcing clients to eliminate the behavior altogether (Marlatt and Tapert, 1993). For example, abstinence is a form of [low demand] for those who want to quit using drugs, but for those who are not ready, case managers must start with interventions that can help a substance user improve his or her life. Interventions might include reminding the client to eat, drink water, sleep, pay rent and other bills before spending money on drugs, and to educate users about the negative effects of drugs and encourage them to use less frequently, if not quit using entirely.

One recent review of the literature indicates that the fundamental assumption of low demand "is that substance use falls along a continuum from abstinence to problematic use or abuse. While abstinence and a substance-free life represent long-term goals, any immediate step in that direction, such as reducing the quantity and/or frequency of use, should be viewed positively and reinforced." (Connors et al. (2001)

Clearly, any public program or policy that countenances the use of illegal drugs under any circumstance runs the risk of violating other Federal, state and local laws and policies. The Department then must weigh competing social values to arrive at a policy relating to low demand approaches.² This is not the place to set that policy, but we do believe that clarifying what is at

¹ Throughout this report and this preface we shall use the term "low demand" where others might use "harm reduction". As Zerger (2002) observes, "…[P]olitically, the harm reduction approach has been aligned with the contentious debate of drug legalization, resulting in rhetoric which has implications for the clarity of any pursuant discussion on which drug policies might actually work." In this regard, it is difficult, if not impossible, for the government to support a set of policies, some of which are objectionable on legal grounds, that have been grouped under the category of "harm reduction". Under the circumstances, it is necessary to use the less politically and emotionally freighted term "low demand".

² Recent studies document that keeping homeless people housed benefits society quite apart from the person directly assisted. For example, Kidder et al. (upcoming) find that keeping someone housed reduces the incidence of risky sexual behavior, thereby reducing significantly the risk of HIV/AIDS transmission. Graham et al. (upcoming) conclude that keeping an ex-offender housed after a stay in prison or jail reduces substantially the likelihood that

stake will further the debate and ultimately work to reconcile what might be preferred practice by some providers and public law.

Certainly current research challenges the presumption that substance abusers can't and won't change. Beyond that, though, the reasons why people change addictive behaviors are still not well understood. As one close observer writes, "The simplistic account that people change because they receive treatment is wanting in many ways. Many people who recover do so without formal treatment. Even relatively brief interventions seem to trigger changes, and the dose of treatment delivered is surprisingly unrelated to outcomes. Client compliance with many different approaches, including placebo medication, has been linked to better outcomes." [Miller (1998)] One of the most prominent theories outlines a series of phases through which addicts proceed. What is clear, though, is that the rehabilitative process is neither unidirectional nor regular. For the vast majority of those dependent on drugs and alcohol, in fact, the process of choice and change is characterized by fits and starts, occasional relapse and, for some, chronic failure. Substance abuse policies, to be effective, must accommodate these dynamics. Clearly existing research, divergent as it is, does not recommend a single program or policy.

On the other side are the realities of chronic homelessness. We know, for example, that a significant portion of those living on the streets use drugs and alcohol; frequently, they suffer from mental illness as well. We also understand that for some part of that number getting them off the street will require at least temporary accommodation to drug and alcohol use in the facilities in which they are housed. On the other hand, the statutory purposes of the McKinney Vento Act homeless programs are to move homeless people toward stable housing and the greatest independence of which they are able. Persistent dependence on drugs and alcohol, whatever it is, is not a manifestation of independence.

The McKinney-Vento Act provides for a variety of HUD housing options to help stabilize the lives of homeless persons. These include emergency, transitional and permanent supportive housing. The law further allows for tenant-based and project-based assistance. A common tie to all these housing options is the principle that HUD's homeless housing programs are intended to help persons through the provision of services to address their special needs in order to become more independent. For instance, in describing the purpose of the Supportive Housing Program (SHP), the McKinney Act states that the program is to "promote the provision of supportive housing to homeless persons to enable them to live as *independently as possible*." (Title IV, C Section 421; emphasis added.) This emphasis on assisting clients with housing and services in improving their lives is also highlighted in the Act's provisions for the Emergency Shelter Grants Program. By law, this program requires that applicants assist homeless individuals to obtain "appropriate supportive services, including permanent housing, medical and mental health treatment, counseling, supervision, and other services essential for achieving independent living...." (Title IV, B Section 415 (c) (3) (A)) (emphasis added). These provisions are mirrored in the Code of Federal Regulations. HUD further reinforces this principle in its program grant application and grantee performance reports.

he/she will return to a criminal justice facility. Culhane, Metraux and Hadley (2002) make a compelling case that providing appropriate housing and services is cost-neutral when the alternative is the street and all the public costs that entails.

With this focus on helping persons become more independent—emphasized in the law, regulation, application, and performance reporting—grantees are to assist clients in achieving this goal and to provide environments in which this progress can take place. By law, HUD's permanent supportive housing programs for homeless persons are designed to serve persons who are disabled, including those who are currently seriously mentally ill and/or who have chronic problems with alcohol, drugs, or both. For example, the fact that Shelter Plus Care statute specifies substance and alcohol abuse services as eligible supportive services for matching purposes presumes that some clients will be actively using drugs and/or alcohol at program entry, either before or during occupancy of the Shelter Plus Care housing.

Given these conditions that exist at the time of entry into housing, providers need to work individually with clients to address and resolve these issues. The law (SHP law) requires that the applicant "provide such *residential supervision* as the Secretary determines is necessary to facilitate the adequate provision of supportive services to residents and users of the project." Accordingly, HUD requires in its grant agreement that providers cannot knowingly allow any illegal activities, including illicit drug use, to be conducted in the project. This provision was added expressly to maximize the likelihood that clients struggling to overcome substance abuse addictions would have the most supportive environment possible in which to succeed in rehabilitating their lives. Many providers also prohibit the use of any alcohol while in a HUD homeless project and find this to be a necessary and effective approach for rehabilitation.³

It is important in this connection to distinguish Departmental policy related to public and assisted housing from that for McKinney-Vento Act homeless programs. Homeless people affected by substance abuse are a **target** population for the Department's homeless programs. They are **not** for the Public Housing or Housing Choice Voucher programs. When Congress sets forth a target population and the Administration subsequently proposes to end chronic homelessness, there is an underlying presumption that a not inconsiderable part of the target population will be using those drugs/alcohol at entry and perhaps for some time thereafter. Similarly, Congress has instituted such policy initiatives as safe havens as intentionally "low demand" alternatives to more orthodox approaches. [Note that safe haven is probably the closest statutorily-based conception to the Housing First concept]. The presumption is that such low demand programs will "do anything it takes" to engage chronically homeless people and then maintain them in housing. And, "doing anything it takes" presumes acceptance that some of those who are agreeing to come in off the street have not agreed or are not able to stop an existing addiction upon entering the program.

³ Illegal drug use is no guarantor of eviction even when that is the housing provider's intent. For example, the Corporation for Supportive Housing, in its *Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing*, comments, "The use of illegal drugs should generally be sufficient grounds for eviction; however, it is advisable that leases contain a provision prohibiting the use of illegal drugs so the eviction is based on a lease violation. Most jurisdictions allow eviction for criminal activity, including illegal drug use. Housing providers should be prepared for the resident to assert the need for a reasonable accommodation in any eviction. Although it is difficult to think of what the reasonable accommodation would be in the instance where the housing provider has clear evidence of illegal drug use, providers should be prepared for creative defenses asserted by tenants who are being evicted for drug use.

Housing providers may have difficulty obtaining convincing evidence of the tenant's drug use. Rarely will a tenant use drugs in front of staff and other tenants are often reluctant to testify against fellow residents. Evidence based on behavior may not be convincing or explained away by the tenant."

Even here, though, the statute specifically prohibits the use of illegal drugs and alcohol in a HUD-assisted safe haven: "The Secretary may not provide assistance under this [Safe haven] subtitle for any safe haven program unless the applicant agrees to prohibit the use of illegal drugs and alcohol in the facility."⁴

These instances constitute a contrast to HUD-supported public and assisted housing where the target population is low income families with no presumption of disability and where the multifamily setting and, in the case of assisted housing, the future of the program is bound up with the ongoing satisfaction of landlords. For example, the Housing Choice Voucher rules permit an owner to terminate tenancy for criminal activity or alcohol abuse by any household member or guest. Such activity includes: Criminal activity which threatens the health, safety or peaceful enjoyment of the premises by other tenants or by people residing in the immediate vicinity; or drug-related criminal activity on or near the premises. Likewise, if, among other reasons, any member of the family commits drug-related criminal or violent criminal activity, PHAs may deny or terminate for this reason if the preponderance of evidence indicates a family member engaged in the activity whether or not the member was arrested or convicted. If any family member is illegally using, or possessing a controlled substance for personal use within one year before the date the PHA provides the notice of termination, the PHA may terminate assistance.

- 86 percent of all surveyed providers received HUD funding for their safe haven programs;
- 79 percent of the responding providers indicate that they would accept residents who were active substance abusers;
- 47 percent of the providers reported low demand-oriented alcohol and drug treatment services were available on-site, and another 34 percent reported that, although they did not have such services on-site, they were committed to support them for their clients off-site;
- With all this in mind, 100 percent of the providers report that use of illegal substances on the safe haven premises is prohibited; 95 percent ban use of alcohol in the safe haven;
- 77 percent of respondents reported that they would terminate any client if they used drugs on-site; and 62 percent indicated that they would terminate any safe haven resident for use of alcohol on-site.

What appears evident from these numbers is that safe haven providers are faced daily with the task of reconciling house rules and expectations with the realities of the population they are serving and provider commitment, to the best they are able, to keep their clients from returning to the streets. In *In from the Cold: A Toolkit for Creating Safe Havens for Homeless People on the Streets*, a joint technical assistance document sponsored by HUD and HHS, the authors advise: "Safe Havens need to consider whether they will be a 'dry', 'damp', or 'wet' facility. While Save Havens do not assist or support residents in using alcohol or illegal drugs, some may have chosen to work with their residents toward a better understanding of their substance use and toward abstinence of reduced use and dependence."

⁴ The results of a recent survey of safe haven providers illustrate the paradoxes that pervade substance use in safe havens specifically and low demand programs generally. Based on returned surveys from 79 of 118 identified safe havens, the Ward Family Foundation found that:

We cannot deny the realities of homeless people abusing substances. The great majority of them, when sheltered, are going to be living in multi-unit buildings in which their ongoing substance use will affect others. Persistent drug use, for example, will offer an ongoing temptation to others who are themselves at various phases of change or recovery. Even if homeless clients do not sell illegal substances themselves, their use ensures that they are caught up in the crime and violence that accompanies drug and alcohol abuse. For many people, substance abuse brings changes in behavior (belligerence, noise, bizarre behavior) that undermine social/therapeutic health. Moreover, ongoing use of alcohol and drugs leads to progressive debilitation and adversely affects the capacity of those so afflicted to make good decisions. Acquiescence in active substance use does have consequences. On the other hand, as this study documents, some Housing First programs can ameliorate some of the worst social effects of persistent drug abuse through close and proactive contact with the client and steady commitment on the part of an interdisciplinary team to meet the needs of landlords as well as clients. On the other hand, there are certainly not enough cases in this research effort to conclude persuasively that the staff-intensity evident in these examples is widely replicable.

To the extent that projects using low demand acknowledge these social realities, then low demand may well comprise a feature of a viable response to chronic homelessness. However, the Department cannot in the name of low demand condone or acquiescence in the continued, unabated use of harmful substances or accept the ultimate expendability of people who do not recover.

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EXECUTIVE SUMMARY

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 cooccurring substance-related disorders. In recent years, 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. 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 the above-stated goals.

WHAT IS THE HOUSING FIRST APPROACH?

Housing First programs may be constructed in a number of ways, but share 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, a low demand approach accommodates client alcohol and substance use, so that "relapse" will not result in the client losing housing (Marlatt and Tapert, 1993).⁵
- The continued effort to provide case management and to hold housing for clients, even if they leave their program housing for short periods.

The first and most well known Housing First model is Pathways to Housing, located in New York City. Established in 1992, Pathways to Housing offers individuals, who are homeless and have psychiatric or substance-related disorders, direct access to permanent, independent apartments without requiring participation in psychiatric treatment or sobriety as a precondition

⁵ The low demand approach addresses the harms caused by risk-taking behavior without forcing clients to eliminate the behavior altogether (Marlatt and Tapert, 1993). For example, abstinence is a form of low demand for those who want to quit using drugs, but for those who are not ready, case managers must start with interventions that can help a substance user improve his or her life. Interventions might include reminding the client to eat, drink water, sleep, pay rent and other bills before spending money on drugs, and to educate users about the negative effects of drugs and encourage them to use less frequently, if not quit using entirely.

for entering housing (Tsemberis, Gulcur, and Nakae, 2004). Housing and treatment services are separated. Clients rent apartments—with the lease held by Pathways to Housing—from landlords who do not have a direct relationship with the treatment agency. The program uses a low demand approach that does not prohibit substance use as a condition for obtaining or retaining housing. The program requires that clients pay 30 percent of their income for rent and participate in two home visits by their case manager each month. Following housing placement, interdisciplinary Assertive Community Treatment (ACT) teams are available 24 hours a day, 7 days a week to provide treatment, support, and other needed services to the client in a neighborhood office or in the client's home.⁶

Previous evaluations of the Housing First approach have concentrated on Pathways to Housing and have been conducted by the originator and director of the program. Independent evaluations, of which the present study is one of the first, are appropriate to assess both Pathways to Housing's program and other ways to implement the Housing First approach.

This exploratory study identifies the existing permutations 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.

OVERVIEW OF THE METHODOLOGY

HUD contracted in 2003 with Walter R. McDonald & Associates, Inc. (WRMA), and its partner Abt Associates Inc., to conduct this study. 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. The overall approach to this study included the following research activities:

- Conduct a telephone canvass of Housing First programs in the United States that serve individuals with a serious mental illness and develop criteria to select two study sites, in addition to Pathways to Housing, for in-depth analysis of program characteristics and client outcomes;
- Explore program implementation at the three selected Housing First programs by conducting baseline and followup site visits, interviewing program staff, and gathering detailed information about the operation of the program; and

⁶ The ACT approach at Pathways to Housing is modified from the original ACT teams developed in Madison, Wisconsin, by Stein and Test (1980). The goals of the ACT teams are to enhance the client's community adjustment, decrease time spent in institutions, and prevent the development of a chronic "patient" role. Key features include small caseloads with low staff-to-client ratios, neighborhood proximity for client monitoring, and easy access for needed services or assistance with activities of daily living and community integration.

• Assess program outcomes in the three study sites by selecting and tracking 25 new or recently enrolled, formerly homeless study participants over a 12-month period at each site, engaging local researchers to interview the participants who left the program within 12 months of placement, and conducting focus groups with participants.⁷

HOUSING FIRST STUDY SITES

To identify variations in the Housing First approach, the study team conducted a telephone canvass to identify existing Housing First programs and collect basic information on their program features. Through this process, the study team contacted every agency that the study team, HUD staff, and advocates identified as operating a Housing First program for individuals with serious mental illness.

The canvass provided a wealth of information about the current status of Housing First programs across the country (as of late 2003). The study team conducted canvass discussions with 33 programs—nine incorporated the key features of the Housing First model and 14 incorporated many of the key features, but did not target single unaccompanied adults with a serious mental illness. The study team did not consider the remaining 10 programs to be examples of a Housing First program because clients were required to participate in treatment prior to placement, or because the program did not primarily serve homeless people.

The nine programs (including Pathways to Housing) that were found to incorporate the key features of the Housing First model were:

- Community Housing Network, Columbus, Ohio;
- Direct Access to Housing, San Francisco, California;
- Downtown Emergency Service Center (DESC), Seattle, Washington;
- Horizon House, Philadelphia, Pennsylvania;
- Lamp Community, Los Angeles, California;
- Pathways to Housing, New York City, New York;
- Reaching Out and Engaging to Achieve Consumer Health (REACH), San Diego County AB 2034, San Diego, California;
- Sunshine Terrace, Columbus, Ohio; and
- The Village, Los Angeles County AB 2034, Long Beach, California.

An important purpose of the nationwide canvass was to identify and recommend two study sites, in addition to Pathways to Housing, which met the criteria for the study. In addition to choosing study sites that incorporated the key features of the Housing First approach, the programs also needed to be large enough to meet the study's enrollment target of 25 clients within the 12-month period. The study team also excluded programs that were involved in another research

⁷ Study participants were not randomly selected. Instead, the study team instructed the three study sites to work backwards, beginning with the most recently enrolled clients, to select the first 25 homeless clients who entered the Housing First program and were unaccompanied (not part of a homeless family), seriously mentally ill, and willing to participate in the study. For further information on study enrollment, see Appendix A.

effort underway at the same time as this study. This was done to avoid over-burdening programs with two different data collection efforts.

The two programs most suitable for further study—DESC and REACH—had the most key features of the Housing First approach, the best comparability to the Pathways to Housing program model, and commensurability with the other study requirements. These three sites are briefly described below.

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 and places three to six new clients each month. 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.⁸ Of the 25 clients tracked for this study, 84 percent (n = 21) met the HUD criteria for chronic homelessness.⁹

The majority of DESC clients enter the Housing First program as a result of engagement by DESC's outreach workers. A worker may offer a client housing at any point during the engagement process. Because vacancies are rare, staff maintain a waiting list with the most impaired candidates (that is, those at greatest risk due to their mental illness as well as other vulnerabilities such as substance abuse or physical health problems) receiving the highest priority for housing. Applicants for housing do not have to agree to participate in services or maintain sobriety as a condition of receiving or retaining their housing.

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. Kerner-Scott House is a 25-unit safe haven for seriously mentally ill people referred through DESC's homeless outreach program. It serves the most impaired and least engaged of DESC's clients. The other three buildings are single room occupancy (SRO) hotels. The Morrison Hotel has 180 residential units and a 203-bed emergency shelter operated by DESC. The Lyon Building has 64 units and serves people with HIV/AIDS, mental illness, or a substance-related disorder. The Union Hotel is a 52-unit SRO building serving seriously mentally ill clients referred from Kerner-Scott House or DESC's outreach team. All of the buildings provide private apartments with kitchenettes and baths, onsite meals, staff offices, and community rooms. Units can be held for 90 days for residents who leave, but are expected to return. If the client returns after 90 days, DESC will place the client in another unit as quickly as possible.

⁸ Grantees operating HUD competitive homeless assistance programs submit annual reports that provide information necessary to assess project performance, including participant entry and exit information.

⁹ Chronic homelessness is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one year or more or has had at least four episodes of homelessness during the past 3 years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) or in an emergency shelter during that time. An episode is a separate, distinct, and sustained stay on the streets or in an emergency homeless shelter.

DESC case managers each carry a caseload of 34 people. DESC's service model emphasizes working with clients where they live, as well as coordinating between housing-based clinical service coordinators and the community case managers associated with DESC's licensed mental health and substance abuse treatment programs. Service plans are developed collaboratively by the housing-based staff, the community case manager, and the client.

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. Referral sources include several of New York City's outreach teams, drop-in centers, jails, hospitals, and shelters. Averaging three to five new enrollments per month, institutional discharges accounted for 50 of Pathways to Housing's new enrollments over the past 2 years and psychiatric discharges constitute 42 percent (n = 11) of the current study sample.¹⁰ Despite the large proportion of psychiatric discharges, Pathways to Housing staff reported that most of the clients who participated in this study met the joint federal definition of chronically homeless and 92 percent (n = 24) had met the definition at some point in the last 3 years.¹¹

Upon enrollment, the client may reside in a shelter or be placed in a hotel or at the Young Men's Christian Association (YMCA) while working with the Housing Department at Pathways to Housing to secure an apartment. Because Pathways to Housing was at full enrollment at the time of the study, referrals depended on the referral source, availability of a housing subsidy, and ACT team capacity. 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. Most clients agree to allow Pathways to Housing to act as representative payee for this purpose, but refusal to accept Pathways to Housing as a representative payee does not disqualify a person from the program.

All housing units are privately owned, independent apartments in the community secured through Pathways to Housing's network of landlords, brokers, and managing agents. Housing units are located in low-income neighborhoods in Queens, East and West Harlem, Westchester County, and Brooklyn. The Pathways to Housing Housing Department and ACT team members work with each client to find an acceptable apartment. 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

¹⁰ Pathways to Housing confirmed that the sample is representative of the larger program with the following exception: 42 percent of the sample entered the program from psychiatric hospitals, which reflects the addition of funding from psychiatric hospitals to provide housing to homeless patients upon discharge.

¹¹ Pathways to Housing reported that 24 clients in the study met the joint federal definition of chronically homeless. It should be emphasized, however, that this interpretation assumes that nine of the eleven clients who enrolled from psychiatric hospitals met the criteria for chronic homelessness prior to a short-term psychiatric hospital stay and were determined on a case-by-case basis most likely to become homeless upon discharge.

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 to monitor and respond to the needs of 60–70 clients. Clients choose the array and sequencing of support services offered by the ACT team. If a client requires inpatient treatment, Pathways to Housing will hold the apartment for 90 days; if the absence is longer, the apartment will be released and the client is guaranteed access to a new apartment upon program reentry.

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

REACH was established in 2000 out of concerns that vulnerable homeless people risked being displaced by the construction of a new sports stadium in downtown San Diego. In response, the San Diego County Mental Health Services Division successfully applied for 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.¹² The San Diego County Mental Health Services Division contracted with Telecare Corporation 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 now averages five or six new cases a month.

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. Eighty-six percent (n = 25) of program enrollees tracked for this study met HUD's definition of chronic homelessness. The majority of REACH clients come directly from the streets through a Homeless Outreach Team (HOT), which is sponsored by the San Diego Police Department and made up of a police officer, benefits specialist, and mental health counselor. REACH also has an outreach specialist who works with mentally ill people on the streets to help them move into housing. After the client agrees to come into housing and a unit is available, the HOT accompanies the client to REACH for screening and formal enrollment.

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.¹³ Most housing agreements have requirements regarding visitors, disruptive behavior, and substance use. REACH staff make it clear to clients, however, that the program will help them maintain permanent housing. Some clients who experience difficulty with the housing requirements may need additional case management support to either solve the problems or move to another housing location with fewer rules. Some clients demonstrate housing stability in the safe haven or SRO and may stay for long periods. Depending on housing stability, some clients are placed in scattered-site apartments within a few months of enrollment.

¹² California Assembly Bill (AB) 2034 allocated funds to expand and provide services for homeless persons, parolees, and probationers with serious mental illness. The California Department of Mental Health awarded funds to 32 counties to provide housing and supportive services to this population. After a demonstration year in three counties under AB 34, AB 2034 made funding available statewide to provide integrated services for homeless people with mental illness.

people with mental illness. ¹³ Out of a total of 29 REACH clients who participated in this study, 31 percent (n = 9) stayed in the safe haven for a range of five nights to up to 12 months, with the majority (n = 6) of clients staying less than 3 months.

One case manager is assigned to each client at enrollment. There are no treatment requirements other than meeting with the case manager biweekly. 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. Each case manager carries a caseload of 23 clients and works as part of a team dually certified in mental health and substance abuse treatment. Under a separate contract with the county, the Community Research Foundation provides employment, psychiatric, rehabilitative, and nursing services to REACH clients.

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. Case managers continue to followup with clients who leave program housing to maintain engagement in services and encourage them to return to housing. Key differences among the programs are the type of housing offered (including the use of transitional placements) and the structure for delivering services.

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. This approach is contingent on continued landlord willingness to lease to program clients. Pathways to Housing encourages landlord participation by holding the lease and subletting the apartment to the client. 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. REACH does not own or control any housing and staff are based in a central office, but work with sizeable caseloads that are geographically dispersed. However, a number of the housing providers that lease to REACH clients have strict lease requirements prohibiting drug or alcohol use, and therefore REACH clients experience frequent moves before achieving housing stability.

REACH case managers spend quite a bit of time addressing problems that occur due to substance abuse.

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.

This study collected information on demographic and client characteristics at baseline, as well as 12-month outcomes, including housing tenure, changes in impairment related to psychiatric symptoms and substance use, and changes in clients' income and self-sufficiency. Demographic and client background information was based on case managers' knowledge of the clients and administrative records. Case managers in each of the programs reported the outcomes data at baseline and each month during the 12-month study period.¹⁴ Although these data were subject to case managers' judgment, the case managers in all three programs gave every evidence of knowing their clients' situations very well and seemed to make informed judgments. Furthermore, the same case manager made the judgments over time for each client, diminishing any inter-rater variability issues (i.e., issues arising from different raters using different scales). Nevertheless, the judgments were necessarily subjective, and there is no guarantee that a case manager was entirely consistent across the 12-month period.

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 2004.¹⁵

Client Characteristics at Enrollment

The clients enrolled in this study represent the severely impaired homeless population that Housing First programs intend to target. The majority of clients were chronically homeless (88 percent), had a primary diagnosis of mental illness (91 percent), exhibited symptoms of mental illness or psychiatric problems (83 percent), and were at least moderately impaired by their symptoms at enrollment (97 percent of those with symptoms). Three-quarters of the clients had a history of substance abuse, and one-half of the clients were abusing substances at the time of enrollment. More than two-thirds of the sample (69%) had co-occurring mental illness and history of substance abuse. In addition, these clients had limited work histories, low educational attainment, and a high incidence of criminal records.

¹⁴ Case managers collected baseline data upon a client's enrollment into the Housing First program. For clients who were part of the retrospective data collection effort, case managers also collected their baseline information retrospectively using administrative records. Case managers collected data for month 1 following the end of the first month after the client entered the program. Case managers collected data for month 12 following the end of the client's 12th month in the program.

¹⁵ Much of the study data were collected retrospectively. Clients included in the study sample entered the Housing First programs as early as June 2003, but the programs reported baseline data during June and July of 2004.

Clients who entered the Housing First program from different living situations often demonstrated different service needs. Those entering the program directly from the streets were more likely to have criminal records and more severe levels of psychiatric and substance-related impairment. Clients from shelters also had a high frequency of criminal records, but were less likely to be currently abusing drugs or alcohol. These clients were also less likely to have a primary diagnosis of mental illness, possibly indicating a lack of psychiatric assessment, rather than the absence of psychiatric problems. Finally, those who entered the program from a psychiatric hospital were typically older, had little education and no employment history, and had severe psychiatric impairment, presenting unique challenges to increase levels of selfsufficiency. A large majority (86 percent) of those who entered the program from a psychiatric hospital were defined by their programs as having been chronically homeless.¹⁶

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. It is important to note, however, that in all three programs "staying in the program" meant that case managers and other program staff were in contact with the client, even if the client left the program housing for short periods. In most cases, a client was not considered to have left the program until he or she had been absent from their housing for 90 days. Thus, housing stability is viewed somewhat differently in Housing First programs compared to other homeless assistance programs where such absences would more quickly result in clients losing their housing.

The majority of clients tracked for this study remained enrolled in the Housing First program for 1 year following program entry. Of the total sample of 80 clients, 43 percent of the clients who stayed in the program were characterized as "stayers" because they spent the entire 12-month period in program housing. Another 41 percent of the clients who stayed in the program were characterized as "intermittent stayers" because they experienced at least one temporary departure to another living environment during the course of the 12-month period, but then returned to Housing First housing. The remaining 16 percent of clients left the program or died within the first 12 months—these clients were referred to as "leavers."

The differences in outcomes for stayers, intermittent stayers, and leavers were modest, but some patterns emerged. Clients who entered the Housing First program from the streets were most likely to leave the program within 12 months (69 percent) and were also most likely to experience temporary program departures (36 percent). The 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. Clients with the lowest levels of housing stability were those who entered the program from the streets and experienced higher levels of impairment related to psychiatric symptoms during their last month in housing.

While the majority (69 percent) of the sample overall had a co-occurring psychiatric diagnosis

¹⁶ These clients came from a short psychiatric hospital stay (less than one year) but were continuously homeless for a year or longer, or had at least four homeless episodes during the last 3 years before hospitalization.

and history of substance-related disorders, such dually diagnosed clients were even more prevalent among intermittent stayers (70 percent) and leavers (77 percent).

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 present analysis. Although clients may experience month-to-month variation in their levels of impairment, the data do not demonstrate any substantial trends in impairments related to psychiatric symptoms or related to 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.

SUMMARY AND IMPLICATIONS

Pathways to Housing, DESC, and REACH were selected for this study in part because they share a commitment to serving homeless people with chronic mental illness and emphasize placement into permanent housing without requirements for sobriety and treatment compliance. The programs differed on a number of dimensions, including the type of housing utilized, the location and intensity of services, and the use of representative payees. 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

With only three sites and broadly similar outcomes across sites, it is difficult to say definitively which program features are essential to program success. However, based on patterns in outcomes observed in the client-level data, interviews with program staff, and focus groups with program participants, a number of program elements emerge as important contributors to program success in the three study sites.

• Access to a substantial supply of permanent housing—The key similarity among the housing strategies at the three programs was access to a substantial stock of permanent housing for their clients. However, the three programs differed substantially in the types of housing offered to clients, and each approach offered benefits and challenges. 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. The REACH model poses certain challenges—the service provider does not own or control housing, case managers have sizeable caseloads, the program is geographically dispersed—but has the advantages of flexible state funding and Medicaid billable services that allow the program to provide housing assistance as well as community-based client support.

- **Providing housing that clients like**—Evidence from this study indicates that clients are satisfied with the permanent supportive housing offered in these programs. Forty-three percent of clients did not leave their housing at all during the first year and only a few of the leavers left voluntarily. 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. There were some complaints from focus group participants at REACH about the quality and safety of some of the housing locations, but REACH staff independently acknowledged these concerns and described how they were working toward possible solutions. Regarding the importance of housing choice, DESC and REACH clearly offer less choice than Pathways to Housing, but clients reported that the choice of housing over homelessness was important to them.¹⁷ Nevertheless, 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—Each of the three programs offers a wide array of supportive services to help clients maintain their housing and meet other needs. These 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.¹⁸ Staff are available around the clock to assist clients. At DESC, each housing location is staffed 24 hours per day and clinical staff are on call during overnight hours. Similarly, a staff member at REACH and Pathways to Housing is always on call to respond to issues that may arise.
- Service delivery approach that emphasizes community-based, client-driven services— Common features of service delivery across the three programs include 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. All three programs emphasize providing services primarily in the housing where people live. Program staff from all three programs emphasize the importance of client-driven service planning. Focus group participants expressed appreciation for the "do whatever it takes" attitude with which case managers approached their work.
- *Staffing structure that ensures responsive service delivery*—The staffing structure for delivering services differs across the three programs, but in all cases is designed to make sure clients' needs are met. Access to multidisciplinary staff is clearly important, but the experience of DESC and REACH indicate that services can be delivered using a service model different from the ACT teams used at Pathways to Housing. The nine-member ACT teams at Pathways to Housing include specialists in mental health, substance abuse, and employment who meet regularly to discuss clients' needs and decide how to respond most appropriately. REACH and DESC offer similarly diverse services, but do not use the ACT team model. Staff from REACH and DESC report that their service delivery structures offer

¹⁷ Additional research on client satisfaction in these three programs is currently underway, and preliminary results indicate that clients are very satisfied with their housing (P. Robbins and J. Monahan, Housing Leverage Pilot Study by the John D. and Catherine T. MacArthur Foundation on Mandated Community Treatment).

¹⁸ In the three study sites, the use of representative payees seems to be a useful tool for working with some clients, but programs do not require this and payees do not seem to be a mechanism for exerting leverage over clients. Roughly two-thirds of the sample had a payee for at least one month during the tracking period. Some 59 percent of those who had a payee had a staff member from the Housing First program as their payee.

a cost-effective alternative to the highly credentialed (and seemingly more costly) ACT team model. While caseloads differ across programs, 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.

• *Diverse funding streams for housing and services*—The three Housing First programs serve clients with extremely low incomes and limited resources to pay for housing, services, and other needs. The programs rely on a variety of funding streams to meet the needs of their clients. To fund mental health case management services, each of the programs seek Medicaid reimbursement, which requires licensing and administrative sophistication to document and bill for services appropriately. 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. Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation for SRO programs are used to assist clients.¹⁹

Policy Implications for HUD

The Housing First programs in this study achieved the important outcome of housing stability for a number of the clients in this hard-to-serve population. Although the authors understand that the limited sample of clients constrains the confidence within which we can draw policy implications, we would commend the following suggestions to the Department.

- The HUD priorities of addressing chronic homelessness and providing permanent housing are furthered by Housing First programs—The programs predominantly serve people who meet HUD's definition of chronic homelessness and achieve substantial housing stability for this population, although the most impaired clients, including persons coming directly from the streets, are still the most likely to leave.
- Lack of conditions on housing may be less important than the direct access—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. It is important to acknowledge, however, that all three programs use transitional stays for at least some clients.
- *Housing stability does not come without challenges*—The advantage of the Housing First approach for the chronically homeless people served is that direct placement in housing solves the elemental problem of homelessness. The dilemma is that it does not necessarily resolve other issues that may impede housing success. Findings from this study indicate that housing problems do occur, including problems that would result in the loss of housing in many programs. In addition, a substantial proportion of the clients tracked left their program

¹⁹ The scope of work for this study did not call for an analysis of program costs, but each of the three program sites were asked to provide a rough estimate of the annual per client cost of housing and services. The costs reported seemed low and likely understated services costs. Future research that would collect and analyze program costs would be very valuable in assessing the replicability of these programs.

housing for short periods during their first year. 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.

- *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*—This tension may be less pronounced in a program like DESC where the primary service provider also owns or controls the housing. It is more pronounced in programs like Pathways to Housing and REACH that lease housing from private landlords. Program staff in these programs work diligently with clients to show them how their behavior may jeopardize their housing. Pathways to Housing also works to normalize clients' living situations in scattered-site housing, ensuring that no more than 10 percent of a building is occupied by program clients. Responding to landlord concerns regarding housing problems is important to fostering good relationships and maintaining access to a supply of scattered-site apartments.
- Serving this population requires a long-term commitment to providing housing assistance—Provision of housing did not result in substantial improvements in mental illness or substance-related disorder symptomology within the 12-month study period. These clients have long-standing mental illnesses and, in most cases, co-occurring substance-related disorders. 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. Longitudinal tracking of clients both within and after leaving Housing First programs is needed to identify the factors that contribute to long-term housing stability of chronically homeless people with serious mental illness and co-occurring substance-related disorders.

CHAPTER 1: INTRODUCTION AND BACKGROUND

Since the mid-1990s, communities have come to recognize that addressing chronic homelessness is the cornerstone of an effective plan to end homelessness. Chronically homeless people are defined by the Interagency Council on the Homeless as disabled and continuously homeless for a year or longer, or having had at least four homeless episodes during the last three years. Disabilities, at least as they relate to homelessness, often include serious mental illness, substance abuse problems, and HIV/AIDS (Burt et al., 2004). Over the past decade, evidence indicates that housing with services, especially for homeless single adults with serious mental illness, increases housing tenure, reduces hospital stays, and reduces homelessness (Rog, 2004). Simultaneously, the research and practitioner communities have expressed interest in Housing First as a promising approach to assist the hardest-to-serve chronically homeless population to leave the streets by offering housing *first* without requiring treatment as a condition for entering or retaining housing.

In theory, the Housing First approach is quite different from approaches that transition people with serious mental illness from the streets to permanent housing. In these programs, 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 the continuum often requires that the homeless person commit to a service plan and agree to abstain from using drugs or alcohol. At times, clients' symptoms related to mental illness or substance abuse may worsen and require an increased level of service provision or even institutional care, temporarily halting, and possibly reversing, progress along the path toward independent living.

Some homeless people with mental illness and substance-related disorders are willing to accept these conditions, although not all are able to maintain their commitment to service plans and, as a result, may lose their housing. Other homeless people simply reject the offer and remain on the streets or in shelters. These two groups—those unable to succeed in a more structured approach to services and those resistant to accepting services—are the primary targets for the Housing First approach.

This study takes an exploratory look at whether the Housing First approach is a promising response to chronic homelessness and the needs of homeless people with serious mental illness. The majority of homeless assistance funding through the U.S. Department of Housing and Urban Development (HUD) that is directed toward permanent supportive housing would not be classified as Housing First. Although funding from the Supportive Housing Program and Shelter Plus Care may be used by Housing First programs, most projects that receive funding from these sources are not considered Housing First. This study provides some insight into whether the Housing First approach is an effective and appropriate model of response, as well as what constitute the key features of that approach.

WHAT IS THE HOUSING FIRST APPROACH?

During recent years, Congress and HUD leadership have encouraged the development of permanent housing for homeless people. Concurrently, there has been a move away from HUD-funded supportive services and an increase in attention toward the hardest-to-serve chronically homeless population, a substantial number of whom are mentally ill (39 percent of homeless individuals report some form of mental health problems and 20–25 percent of homeless individuals meet the criteria for serious mental illness).²⁰ At the same time, there has been interest among practitioners in the Housing First approach to serving this population.

Although the Housing First approach may be constructed in a number of ways, the distinguishing features of the Housing First approach are:

- 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 may 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, a low demand approach accommodates client alcohol and substance use, so that "relapse" will not result in the client losing housing (Marlatt and Tapert, 1993).²¹
- The continued effort to provide case management and to hold housing for clients, even if they leave their program housing for short periods.

Although Housing First approaches include programs serving families, this particular study focuses only on programs that target chronically homeless adult individuals with disabilities, particularly serious mental illness and substance abuse.

HOW AND WHEN DID THE HOUSING FIRST APPROACH COME ABOUT?

The first and most well known Housing First model to date is Pathways to Housing in New York City. Established in 1992, Pathways to Housing offers individuals who are homeless and have psychiatric or substance-related disorders direct access to permanent, independent apartments

²⁰ The incidence of mental illness among homeless individuals was obtained from the Substance Abuse and Mental Health Services Administration, National Resource and Training Center on Homelessness and Mental Illness at http://www.nrchmi.samhsa.gov/facts/facts_question_2.asp (accessed on 9/19/05).

²¹ The low demand approach addresses the harms caused by risk-taking behavior without forcing clients to eliminate the behavior altogether (Marlatt and Tapert, 1993). For example, abstinence is a form of low demand for those who want to quit using drugs, but, for those who are not ready, case managers must start with interventions that can help a substance user improve his or her life. Interventions might include reminding the client to eat, drink water, sleep, pay rent and other bills before spending money on drugs, and educating users about the negative effects of drugs and encourage them to use less frequently, if not quit using entirely.

without requiring participation in psychiatric treatment or sobriety as a precondition for entering housing (Tsemberis, Gulcur, and Nakae, 2004). Following housing placement, interdisciplinary Assertive Community Treatment (ACT) teams are available 24 hours, 7 days a week to provide treatment, support, and other needed services to the client in a neighborhood office or in their own home.²²

Pathways to Housing separates housing and treatment services. Clients rent apartments—with the lease held by Pathways to Housing—from landlords who do not have a direct relationship with the program.²³ Pathways to Housing ACT teams provide individualized support and treatment services in the community. The program uses a low demand approach, which does not prohibit substance use as a condition for obtaining or retaining housing. The only program requirements are that clients pay 30 percent of their income for rent, mostly through a representative payee money management program, and that they participate in two home visits by their case manager each month.

Since 1992, several programs based on the Housing First model have been developed and implemented. As a first step in this study, the study team conducted a nationwide canvass to learn more about the existence of programs that describe themselves as Housing First and serve homeless single adults with mental illness. The canvass findings indicate that there are many programs identifying themselves as Housing First that have several features of the Housing First approach—direct, or nearly direct, placement of a homeless individual into permanent housing without treatment requirements and the presence of a variety of service providers available to address client needs in the community. Chapter 2 summarizes the findings from the canvass.

WHY IS RESEARCH NEEDED?

Current trends in working with chronically homeless individuals with serious mental illness and often co-occurring substance-related disorders indicate that Housing First is recognized as a promising strategy to serve this population. The increased targeting of funding to address the needs of chronically homeless people has coincided with the development of this strategy across the country. For example, HUD has established the needs of persons who experience chronic homelessness as a priority in awarding funding for its competitive homeless assistance programs. In addition, the Interagency Council on the Homeless coordinated joint awards by HUD, Health and Human Services and Veterans Affairs, member agencies. Those awards totaled \$55 million in grants to 11 cities across the country as part of a Collaborative Initiative to End Chronic

²² The ACT approach at Pathways to Housing is modified from the original ACT teams developed in Madison, Wisconsin, by Stein and Test (1980). The goals of the ACT teams are to enhance the client's community adjustment, decrease time spent in institutions, and prevent the development of a chronic "patient" role. Key features include small caseloads with low staff to client ratios, neighborhood proximity for client monitoring, and easy access for needed services or assistance with activities of daily living and community integration. See Chapter 2 for more information.

²³ At Pathways to Housing, clients rent apartments in buildings that are not owned by the agency. Although Pathways to Housing does not initially have a direct relationship with the landlords, a positive and trusting relationship develops over time so that landlords continue to accept Pathways to Housing clients in their buildings. In addition, Pathways to Housing will only place clients in a particular building if the percentage of tenants who are also clients of Pathways to Housing is less than 10 percent.

Homelessness. The objective is to increase permanent housing solutions to address the chronically homeless population.²⁴

Evidence to date suggests that permanent supportive housing for homeless single adults with mental illness increases housing tenure, reduces rates of hospitalization and lengths of stay, and decreases homelessness. In addition, persons placed in supportive housing experience reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated (Culhane, Metraux, and Hadley, 2002). Evaluations that tested a range of housing types and services of the New York/New York Agreement found high retention rates in supportive housing, regardless of the particular configuration of housing and services, especially when compared to more restrictive environments.²⁵ Compared to those placed in community residential treatment facilities, the Pathways to Housing supportive housing approach resulted in increased housing stability. After 5 years in housing, 88 percent of Pathways to Housing clients remained housed, whereas only 47 percent of the residents in the residential treatment system remained housed (Tsemberis and Eisenberg, 2000).

To distinguish it from other "supportive" housing approaches in the homeless services continuum of care, the Housing First approach at Pathways to Housing is referred to as "supported" housing—permanent, independent housing with flexible, individualized service and supports that are integrated into the community and chosen by the consumer. Housing needs are considered paramount and separate from treatment needs (Tsemberis, 1999; Carling and Curtis, 1997). Treatment-oriented options constitute the remainder of the residential continuum (Lipton et al., 2000). While studies thus far do not provide clear direction on the level of service intensity needed to maintain this population in permanent housing, studies of supported housing models show improvements among homeless persons with mental illness (Tsemberis, Gulcur, and Nakae, 2004; Susser et al., 1997; Bebout et al., 2001).

Regardless of housing approach, those who stay in housing longer are older than those who leave the housing and are more likely to have mood disorders, rather than schizophrenia (Lipton et al., 2000; Tsemberis and Eisenberg, 2000).²⁶ Also, regardless of housing approach, those who exit housing earlier are more likely to have substance abuse problems (Tsemberis and Eisenberg, 2000; Lipton et al., 2000; Goldfinger et al., 1999; Hurlburt, Wood, and Hough, 1996). In addition to finding that those with a history of substance abuse have a shorter tenure in housing, Lipton et al., (2000) found that mentally ill substance abusers had a greater risk of leaving

²⁴ The Collaborative Initiative to End Chronic Homelessness is a joint initiative of the U.S. Department of Health and Human Services, Veteran's Affairs, and HUD. This initiative pooled funding for 11 community partnerships to provide housing and services to long-term disabled homeless people. See http://www.ich.gov/2003.html.
²⁵ Begun in 1989, the New York/New York Agreement was a supportive housing initiative struck between the

²⁵ Begun in 1989, the New York/New York Agreement was a supportive housing initiative struck between the governor and mayor, Mario Cuomo and David Dinkins, to build 3,600 units of housing specifically targeted to chronically homeless people with mental illness. The agreement provided housing and services through two general models: supportive housing, including independent apartments or SRO housing either with or linked to community-based service supports; and community residence facilities, including community residences, long-term treatment facilities, and adult homes. Supportive housing is independent housing linked to community-based or psychiatric-based service support while community residences integrate housing and service delivery with mandatory resident participation.

participation. ²⁶ Mood disorders include depressive disorders, bipolar disorders (characterized by depressive and manic episodes) and substance-induced mood disorders. Schizophrenia and other psychotic disorders include delusions or hallucinations.

housing during the first 4 months in more structured and restrictive housing models, whereas those placed in low or moderately structured settings displayed longer residential stability.

Research on permanent supportive housing has not focused specifically on the Housing First approach, with the exception of research conducted by the originator and director of Pathways to Housing (Tsemberis, Gulcur, and Nakae, 2004; Tsemberis, et al., 2003; Shern, et al., 2000; Tsemberis and Eisenberg, 2000; Tsemberis and Asmussen, 1999; Tsemberis, 1999). As more Housing First programs develop, they tend to vary in detail and emphasis. This exploratory study identifies the existing permutations of the Housing First approach that appear to respond to the needs of homeless people with serious mental illness. It describes the characteristics of programs that seem to be influential in housing tenure, stability, and other positive outcomes for clients.

WHAT ARE THE GOALS OF THE STUDY?

To learn more about the Housing First approach, HUD contracted in 2003 with Walter R. McDonald & Associates, Inc. (WRMA) and its partner Abt Associates Inc. to conduct this study. This study provides an overview of Housing First programs in the United States, which serve individuals with a serious mental illness, as well as a detailed analysis of the program characteristics and client outcomes of the three programs studied. Specifically, the goals of the study were the following:

- Identify Variations in the Housing First Approach. The study team accomplished this goal through a telephone canvass conducted to identify existing Housing First programs and collect basic information on their program features. A second purpose of the canvass was to identify possible sites for more intensive study. Through this process, the study team contacted every agency that the study team, HUD staff, and advocates identified as operating a Housing First program for individuals with serious mental illness. For the in-depth analyses of three Housing First programs, the study team interviewed program staff, tracked program participation and outcomes over a 12-month period at each site, and conducted focus groups with clients. The specific research questions addressed to meet this goal were:
 - 1. What are the features of the programs with respect to target population, housing options, and service models?
 - 2. What are the clients' characteristics (demographics, previous living situation, diagnoses)?
- Explore Outcomes for Clients who Participate in These Programs. The study team accomplished this goal by selecting three Housing First programs for the study and tracking the experiences and outcomes of clients for 12 months after they entered the program. The specific research questions addressed to meet this goal were:
 - 1. How long do the clients remain in program housing?
 - 2. Where do the clients go when they leave? Are they in stable housing situations?
 - 3. Why do some clients leave the program within 12 months of placement?

- 4. What are the clients' levels of engagement in services and do they increase the longer they are in the program?
- 5. How satisfied are the clients with their housing and other aspects of the program?
- 6. Are there differences in outcomes across the three programs? What program operations or client characteristics might explain the differences?

Outcomes of interest included housing tenure and stability, as well as changes in level of impairment related to mental illness and substance use, independence in financial and medication management, and frequency of housing problems.²⁷

OVERVIEW OF THE METHODOLOGY

The overall approach to this study included four main tasks:

- Canvass Housing First programs in the United States that serve individuals with a serious mental illness and develop criteria to select two study sites, in addition to Pathways to Housing, for in-depth analysis of the program characteristics and client outcomes;
- Engage the three selected Housing First programs by conducting baseline and followup site visits, interviewing program staff, and gathering detailed information about the operation of the program;
- Select and track formerly homeless study participants over a 12-month period at each site, engage local researchers to interview the participants who left the program within 12 months of placement, and conduct focus groups with participants; and
- Analyze tracking and focus group data to compare outcomes across sites.

See Appendix A for the specific methods used to conduct each of these tasks.

Identify Programs for Study

The canvass identified Housing First programs across the country. (See Chapter 2 for findings from the canvass and Appendix B for a summary table of Housing First programs.) In addition to addressing the research questions, the most important purpose of the canvass was to identify two sites, in addition to Pathways to Housing, that met the requirements for the study. These requirements included:

- The program had been in operation for at least one year;
- The program enrolled at least eight new clients per month or, alternatively, had enrolled at least 25 persons within the 6 months prior to data collection for the study;

²⁷ Outcomes related to client choice, satisfaction, and quality of life will be expanded upon in a separate study of this Housing First cohort, sponsored by the MacArthur Foundation, to be published at a later date. The MacArthur Foundation Grant-funded pilot study tests an instrument that collects quantitative data on client coercion, choice, and satisfaction in housing programs, including this Housing First study cohort.

- The program had good data collection and client tracking procedures; and
- The program indicated a willingness to participate in the study.

The most suitable sites for further study needed to serve a similar population with some operational differences from Pathways to Housing. In addition, the sites needed to present some variability to the "essential complements" considered important to clients' success:

- A strong emphasis on client choice in housing, resulting in clients living in dispersed apartments owned by private landlords;
- A service approach that did not co-locate housing and services; and
- Widespread use of the program as clients' representative payee.

The two programs most suitable for further study—Downtown Emergency Service Center (DESC) in Seattle, Washington, and Reaching Out and Engaging to Achieve Consumer Health (REACH) in San Diego, California—incorporated key features of the Housing First approach, were comparable to the Pathways to Housing program model, and commensurate with the other study requirements. Chapter 3 describes the rationale for selecting these programs for study and provides brief descriptions of each. (See Appendices C–E for detailed site descriptions.)

Engage Housing First Programs

Following the canvass and site selection process, the study team worked with each of the selected sites to secure its agreement to participate in the study. The program staff provided information about the operations of the Housing First programs, selected and tracked the study sample, and worked with the study team to ensure that the data were accurate. The study team visited each site twice during the course of the study—once at baseline and the second time following the conclusion of data collection activities.

Select and Track Study Participants

The study team worked with each of the sites to select and track program participants over a period of 12 months.²⁸ The study team also engaged and worked with local researchers to gather information about program leavers and conducted focus groups at the close of the 12-month data collection period to elicit feedback from study participants regarding the Housing First program.

The study team acknowledges several limitations of the data collection process. First, case managers at each of the study sites collected baseline and monthly client data from case records and other administrative data sources, not directly from clients. Second, given the low rate of new client enrollment at the study sites, a great deal of monthly tracking data had to be collected retrospectively as few new clients entered the programs during the study enrollment period. Finally, at one site the study team determined that the quantitative data collected through administrative sources did not reflect the anecdotal information gathered through focus groups and conversations with case managers. To ensure that these administrative data were accurate,

²⁸ Appendix A describes the sample selection and informed consent process, as well as the baseline, retrospective, and monthly data collection process.
case managers at this site retrospectively reported revised monthly data on the level of impairment related to alcohol and drug use and mental illness, temporary program leaves, and total service contacts.

REPORT ORGANIZATION

The six remaining chapters discuss the study's findings and implications.

- Chapter 2: Canvass of Housing First Programs—This chapter presents a summary description of the Housing First programs that the study team identified during a nationwide canvass in late 2003.
- **Chapter 3: Key Features of Housing First Study Sites**—This chapter presents the key features of the Housing First programs selected for this study. The chapter begins with a brief explanation of why the study team selected these sites, followed by brief overviews of each site, and concludes with a cross-site analysis of the key features.
- Chapter 4: Characteristics of Housing First Clients—This chapter presents the demographic characteristics of the 80 clients who enrolled in the study.
- **Chapter 5: Housing Tenure**—This chapter presents data regarding housing tenure for all clients who participated in the study, as well as additional information about those clients who left the program during the first 12 months.
- **Chapter 6: Outcomes**—This chapter presents the outcomes experienced by the clients who stayed in the Housing First program for at least 12 months.
- **Chapter 7: Summary and Implications**—This chapter presents the implications of the study findings for HUD and local communities in terms of policy, practice, and future research.

Appendices A and B describe additional information on the data collection and include charts with the findings of the canvass. Appendices C–E describe the three Housing First programs in detail. Each of these site Appendices includes:

- A brief description of the Housing First model;
- The background, population served, housing offered, and funding of the approach;
- How the approach transitions homeless people to housing;
- Services offered after enrollment; and
- Essential complements of the approach.

Finally, Appendix F supplies a glossary of acronyms used in the report, and Appendix G contains the list of references cited in the report.

CHAPTER 2: CANVASS OF HOUSING FIRST PROGRAMS

To document the key variants of Housing First programs across the United States and to identify sites for further study, the study team conducted discussions with prospective study programs between December 8, 2003, and February 3, 2004. The discussions addressed the basic features of each program, including type of housing offered, scale of the program, target population, referral source, and conditions that clients must meet for housing. Specifically, these discussions enabled the study team to identify programs that met the following criteria that define Housing First for this study.

- 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 may 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, a low demand approach accommodates client alcohol and substance use, so that "relapse" or increased substance use will not result in the client losing housing (Marlatt and Tapert, 1993).²⁹
- The continued effort to provide case management and to hold housing for clients, even if they leave their program housing for short periods.

In addition, the study team was particularly interested in identifying Housing First programs that serve unaccompanied adults with a serious mental illness and had some of the features of the Pathways to Housing model. The features of the Pathways to Housing model that the study team attempted to identify in other programs were: Community-based mental health treatment case managers; Assertive Community Treatment (ACT) teams; assertive outreach to work with hard-to-serve homeless mentally ill people who are reluctant to enter shelters or engage in treatment services; and use of a low demand approach to substance use.

To identify programs to participate in these canvass discussions, the study team contacted sources identified in Walter R. McDonald & Associates, Inc.'s (WRMA) and Abt Associates' previous studies of homelessness, as well as national experts in homelessness. These contacts included staff from the U.S. Department of Housing and Urban Development (HUD)

²⁹ The low demand approach addresses the harms caused by risk-taking behavior without forcing clients to eliminate the behavior altogether (Marlatt and Tapert, 1993). For example, abstinence is a form of low demand for those who want to quit using drugs, but for those who are not ready, case managers must start with interventions that can help a substance user improve his or her life. Interventions might include reminding the client to eat, drink water, sleep, pay rent and other bills before spending money on drugs, and to educate users about the negative effects of drugs and encourage them to use less frequently, if not quit using entirely.

Headquarters and field offices, the National Alliance to End Homelessness, Center for Urban Studies, Interagency Council on the Homeless Regional Coordinators, the Corporation for Supportive Housing, state and local departments of mental health services, housing developers, and mental health and homelessness consortia. As the study team identified Housing First programs, staff at some programs also offered additional contacts.

The canvass provided a wealth of information about the current status of Housing First programs across the country as of late 2003. The study team conducted canvass discussions with 33 programs—nine incorporated the key features of the Housing First model and 14 incorporated many of the key features, but did not target single unaccompanied adults with a serious mental illness. The study team did not consider the remaining 10 programs to follow the Housing First approach because clients were required to participate in treatment prior to placement, or because the program did not primarily serve homeless people.

This chapter describes the Housing First programs identified through the canvass and provides some generalizations about the implementation of the Housing First approach in the programs the study team contacted. Appendix B contains tables that summarize the key features of each program.

HOUSING FIRST PROGRAMS

Through canvass discussions, the study team identified 23 programs that could be classified in varying degrees as Housing First. Nine of the programs incorporated all of the key features of the Housing First model—direct, or nearly direct, placement into housing permanently, no requirements for clients to participate in services, and services provided in the community. The remaining 14 programs met some, but not all, of these criteria.

The nine programs (including Pathways to Housing) that incorporated the key features of the Housing First model were:

- Community Housing Network, Columbus, Ohio;
- Direct Access to Housing, San Francisco, California;
- Downtown Emergency Service Center (DESC), Seattle, Washington;
- Horizon House, Philadelphia, Pennsylvania;
- Lamp Community, Los Angeles, California;
- Pathways to Housing, New York City, NewYork;
- Reaching Out and Engaging to Achieve Consumer Health (REACH), San Diego County AB 2034, San Diego, California;³⁰
- Sunshine Terrace, Columbus, Ohio; and
- The Village, Los Angeles County AB 2034, Long Beach, California.

³⁰ California Assembly Bill (AB) 2034 allocated funds to expand and provide services for homeless persons, parolees, and probationers with serious mental illness. The California Department of Mental Health awarded funds to 32 counties to provide housing and supportive services to this population. After a demonstration year in three counties under AB 34, AB 2034 made funding available statewide to provide integrated services for homeless people with mental illness.

The additional 14 programs incorporated some of the Housing First features. However, most of the programs in this group did not recruit or enroll severely mentally ill homeless persons directly from the streets without an intermediary placement or did not target homeless people with mental illness. These programs were:

- Anishinabe Waikiagun, Minneapolis, Minnesota;
- Avalon Housing, Ann Arbor, Michigan;
- Canon Kip Community House, San Francisco, California;
- Chicago Housing for Health Partnership, Chicago, Illinois;
- Common Ground, New York City, New York;
- Commons at Grant, Columbus, Ohio;
- Contra Costa County Public Health Homeless Program, Contra Costa County, California;
- Dwelling Place, Grand Rapids, Michigan;
- Housing Initiatives, Madison, Wisconsin;
- Phoenix Programs, Inc., Concord, California;
- Project HOME, Philadelphia, Pennsylvania;
- Sacramento County AB 2034, Sacramento County, California;
- Tellurian, Madison, Wisconsin; and
- The Wintonia, Seattle, Washington.

The following sections provide a cross-site discussion of the Housing First approach in the programs the study team contacted. These sections describe the program scale and target populations as well as the primary features of the Housing First approach—identification of clients; immediacy of placement into permanent housing and the types of housing where the clients are placed; treatment requirements prior to and following program entry; and the Housing First programs' approaches to service provision, including use of an ACT team or assertive outreach and use of a low demand approach to addressing clients' substance use.

Program Scale

The Housing First programs identified through the canvass vary widely in size, from 40 clients to more than 400. The largest program is Pathways to Housing, serving 465 individuals. The Village reported serving 375 clients in permanent housing and Direct Access to Housing reported serving 393 clients at the time of the canvass. Some of the larger programs including Direct Access to Housing, Community Housing Network, Contra Costa County Public Health Homeless Program, and the Lamp Community anticipated increases in enrollments due to receipt of a Chronic Homeless Initiative grant in 2003. These grants, they proposed, would enable them to open new facilities to provide permanent housing for chronically homeless individuals.

Many of the Housing First programs reported limited turnover due to relatively high retention rates. Most programs reported retaining at least 90 percent of their clients during their first year of placement. As a result, most programs enroll as few as one or two new clients per month. Two other large programs with more than 300 residents each—Common Ground and DESC—reported enrollments of fewer than one or two a month because they do not admit new clients until a vacancy is available in their buildings. Contacts at the programs reported two basic responses to individuals who want to enter the program when there is not a vacancy: placing the client in an emergency shelter, transitional housing, or motel until there is a vacancy, and

maintaining a waiting list of individuals in the community who are interested in entering the Housing First program.

Populations Served

The main focus of the canvass was to identify Housing First programs that provided housing and services to homeless individuals with a serious mental illness. All of the programs serve homeless people as they define homelessness, although not all may meet HUD's definition of homelessness. For example, one program focused on serving only clients who were discharged from jail and were not homeless before entering jail, but had a pattern of episodic homelessness. Many programs primarily targeted individuals with mental illness, which is often associated with a co-occurring substance-related disorder. Three-quarters of the programs canvassed reported that a large percentage of their clients were mentally ill persons with co-occurring substance-related disorders.

Other programs did not focus specifically on mental illness, even though a large portion of their populations had a mental illness. For example, Anishinabe Waikiagun targeted persons with substance abuse issues, specifically chronic inebriates living on the streets, a percentage of whom were mentally ill. Approximately one-quarter of the clients at Avalon Housing and one-half of the clients at the Commons at Grant had neither a mental illness nor a substance-related disorder, but were homeless. The Chicago Housing for Health Partnership targeted individuals with at least one of 10 identified chronic illnesses; 80 percent of these individuals had a history of chronic substance abuse, and an estimated 20–30 percent had a mental illness.

Identification of Clients

Referral sources for clients varied widely among these programs. Only 10 of the 23 programs— Anishinabe Waikiagun, Canon Kip Community House, Contra Costa County Public Health Homeless Program, Direct Access to Housing, Horizon House, Lamp Community, Pathways to Housing, The Village, REACH, and Sunshine Terrace—recruited primarily from the streets. The majority of these were programs considered to be consistent with the basic Housing First model. DESC recruited the majority of its clients from emergency shelters where there are no sobriety requirements. The Chicago Housing for Health Partnership received referrals of homeless individuals with chronic medical conditions from three local hospitals. Several other programs recruited clients from local homeless shelters and drop-in centers.

In addition, nine of the 23 programs accepted formerly homeless individuals with mental illness or substance abuse problems upon discharge from jail, detoxification facilities, or psychiatric hospitals—Anishinabe Waikiagun, Chicago Housing for Health Partnership, Contra Costa County Public Health Homeless Program, Direct Access to Housing, Lamp Community, The Village, Pathways to Housing, Sacramento County AB 2034, and Sunshine Terrace. Several programs reported referrals from agencies for clients (whom no one else would serve) when the discharge plan would otherwise be to homelessness. Pathways to Housing had a higher than average proportion of clients from psychiatric hospitals during this timeframe because of a new contract with local psychiatric hospitals.

Immediacy of Placement into Permanent Housing

The greatest variation among Housing First programs was the speed of placement into housing. While programs prioritized placement into housing, very few of the programs achieved the goal of immediately placing clients into permanent housing, other than Pathways to Housing and Direct Access to Housing. Even these programs occasionally place clients in a very short-term placement before the permanent housing is located. Most Housing First programs directly place the client into some type of housing, with the understanding that the relationship between the client and program is permanent.

Representatives from several programs offered housing choice to clients through a range of housing options. Clients could choose among these options, which included board and care facilities, single room occupancy (SRO) hotels, and scattered-site housing. Most programs offering some level of choice ultimately placed clients in scattered-site housing—and some were able to offer choice among units—while some programs required intermediary steps to adjust from living on the streets to living in a home. For some programs, the use of transitional housing was a requirement to achieve permanent housing, while for others it was a matter of necessity as housing units were not available.

Several programs either required, or strongly encouraged, clients to participate in a transitional housing program. For example, in the Sacramento County AB 2034, two nonprofit agencies had the goal of placing homeless people with psychiatric disabilities in permanent housing. However, rather than placing clients directly in housing, most clients were placed in a transitional setting for one month while staff helped them identify housing that would best suit their needs. Another example was the Chicago Housing for Health Partnership that recruited homeless clients from local hospitals and required them to spend one to 12 weeks in an interim facility. This intermediary placement helped clients to stabilize from their hospitalization and determine the type of housing that would be most suitable for their needs.

Some programs placed clients in temporary or transitional housing first because the programs experienced low turnover rates and had to wait for a vacancy to occur before placing the individual. To address this issue, some programs used waiting lists. Avalon Housing advertised housing openings in the local newspaper. Once a waiting list was developed, the agency conducted a tenant selection process. While on the waiting list, potential clients typically secured services from local providers. A similar situation took place at the Canon Kip Community House, where clients from the waiting list eventually moved to permanent housing, but may have resided in a number of settings during the waiting period. At DESC, clients on the waiting list were prioritized by who needed the housing most.

Housing Types

A feature considered critical to the success of the Pathways to Housing model was offering clients "choice" in their housing. The Pathways to Housing program leases scattered-site apartment units from a variety of landlords, offering clients two or three apartments from which they may choose.³¹ Two other programs also offered clients choice in their housing—Horizon House and The Village. Most programs were not able to offer their clients "choice" in housing,

³¹ Clients at Pathways to Housing who participated in focus groups with the study team reported that the array of choice offered to them, in terms of their scattered-site apartment, was acceptable.

because the units offered were limited to units the program owned or leased. Due to low program turnover rates, programs offered clients whatever vacancy occurred during a given month.

Fifteen of the programs offered units where the entire building was master-leased or owned by the program—Anishinabe Waikiagun, Avalon Housing, Canon Kip Community House, Common Ground, Commons at Grant, Community Housing Network, Direct Access to Housing, Dwelling Place, DESC, Lamp Community, Phoenix Programs, Project HOME, Sunshine Terrace, Tellurian, and The Wintonia. Three programs offered housing choice, but only following a transitional stay in an intermediate housing facility or assessment of the type of housing need—Sacramento County AB 2034, Chicago Housing for Health Partnership, and Housing Initiatives.

Clients more often than not held their own leases for their permanent housing unit. In the instances when they did not, the Housing First program held the lease for the client—as is the case at Pathways to Housing—or the unit was part of a building owned by the Housing First program. At Housing Initiatives, the client holds the lease, but the Housing First program submits a letter to the landlord to guarantee that rent will be paid.

Treatment Requirements

Because the presence of treatment requirements prior to and following enrollment in the Housing First program was a primary criterion that made programs ineligible for further study, most of the programs described in this chapter did not require any mental health or substance abuse treatment prior to enrollment in the program. One program reported that clients would be required to participate in services if their housing were in jeopardy, while another "encouraged"—but did not require—clients to be clean and sober and medication compliant.

Approach to Services

The majority of programs reported service requirements regarding case management and lease agreements. One-half of the programs described case management as using an ACT team approach, primarily working on behaviors that jeopardize housing and secondarily working on issues to improve the tenants' quality of life. Case management services, whether located on or off site, were intended to ensure that the client did whatever was required to maintain housing. For example, Pathways to Housing required that most clients agree to participate in a money management program and that all clients agree to a minimum of two apartment visits per month by their case manager. Most programs assign a primary case manager to each client, with access to multidisciplinary teams, either on-site or within easy access for every client. Daily client contact was the norm in most programs, with goals of working with clients flexibly and at their own pace.

The study team did not specifically inquire about a low demand approach at each of the programs. This information was collected only for the three Housing First programs that were selected for intensive study. These programs reported utilizing a low demand approach to substance use and that program enrollment was not contingent on participation in treatment.

SUMMARIES OF PROGRAMS NOT SELECTED FOR STUDY

The study team selected Pathways to Housing, DESC, and REACH for further study. These programs are described in detail in Chapter 3, as well as in Appendices C–E. The following are brief descriptions of the programs that best fit the definition of Housing First but were not selected for study. Most of these programs were not selected for study because they had recently received grants as part of the Chronic Homeless Initiative and it was thought inadvisable to impose a second evaluation effort on them.

Community Housing Network, Columbus, Ohio

Established in 1987, the Community Housing Network began providing housing for individuals with disabilities related to addiction in 1998. During February 1999, the Community Housing Network opened its first project for street homeless individuals with co-occurring disorders. The Community Housing Network has 109 Housing First units in the Columbus area. The clients who live in these units have been diagnosed with a serious mental illness and many have a co-occurring substance-related disorder. Clients enter the program through shelters and are identified by a street outreach team. They move directly into permanent supportive housing units in buildings owned by the program and do not have to agree to a treatment regimen. The Community Housing Network was awarded a contract with the Community Shelter Board through the Chronic Homeless Initiative grant to develop 80 units of scattered-site housing for the Housing First program.

Direct Access to Housing, San Francisco, California

Established in 1998, the San Francisco Department of Public Health's Direct Access to Housing program provides permanent housing with on-site supportive services for approximately 400 adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. Targeted toward "high-utilizers" of the public health system, Direct Access to Housing is a "low threshold" program that actively recruits single adults into permanent housing directly from the streets, shelters, acute hospitals, or long-term care facilities. The program accepts residents with active substance abuse disorders, serious mental health conditions, or complex medical problems. The program provides some choice of permanent supportive housing in six SRO residential hotels and a licensed residential care facility, where the program holds the lease. Supportive services on site consist of case management, medical care, a roving behavioral health team, and property and money management. Since the opening of the first site in 1998, more than two-thirds of the residents have remained housed in the Direct Access to Housing program for up to 2 years.

Horizon House, Philadelphia, Pennsylvania

Horizon House runs a Housing First program called "New Keys" that targets individuals with cooccurring disorders of mental illness and substance abuse who are living on the streets. Forty people are in this program, which began in March 2003. Clients enter the program through a prioritization process on the homeless database maintained by various outreach teams that identify individuals with the longest times on the streets. This is a scattered-site program in which clients may select the neighborhood in which they want to live and staff choose two or three apartments from which clients may choose. Clients are not required to commit to treatment as a condition of housing, but some agree to treatment plans, which they complete before entering. Horizon House uses an ACT team approach, not case managers, and each client is required to meet with the ACT team at least twice per month, but may meet with them as often as several times per day. Horizon House recently received an Chronic Homeless Initiative grant to start a second Housing First program.

Lamp Community, Los Angeles, California

The Lamp Community serves 100 homeless adults with mental illness using a Housing First approach. Eighty percent of these adults also have substance abuse issues. Ninety percent of Lamp Community clients come from the streets or from jail, via the streets. Clients hold their own leases in Lamp Community's 50-unit building and in an additional 30 units through an agreement with a nonprofit developer. Lamp Community also has a 10-unit master lease through another nonprofit developer. Some clients choose to stay at the safe haven until they are ready for the responsibility of an apartment; others move from the apartments to the shelter when they need a break from the responsibilities of their apartment. Lamp Community's residences offer on-site, voluntary services. The Lamp Community received a Chronic Homeless Initiative grant and planned to use this money to place an additional 62 people in 2005.

Sunshine Terrace, Columbus, Ohio

Sunshine Terrace serves individuals with mental illness and co-occurring substance-related disorders, 90 percent of whom are from shelters, with the remainder coming directly from the streets. Sunshine Terrace uses a Housing First approach for permanent supportive housing in two locations—a building owned by the Young Men's Christian Association (YMCA) that has 65 SRO units, and a 180-unit building owned by the Columbus Metropolitan Housing Authority that has 65 Housing First units. Clients have no treatment requirements prior to or following enrollment in the program. On-site teams with community-based supportive services have daily contact with most residents.

The Village, Los Angeles County AB 2034 Program,

Long Beach, California

The Village, a program of the Mental Health Association of Los Angeles, is one of 19 programs funded by California's AB 2034 program in Los Angeles County. The Village houses approximately 400 individuals—all of whom have a serious mental illness—in permanent, scattered-site housing. The program identifies clients on the streets or in jails and gives them a range of housing choices, from board and care facilities to permanent apartments. Clients do not have to agree to a treatment regimen, but must be affiliated with a case manager prior to placement in housing. The program works with the client to identify services that he or she may want or need. Interactions between case managers and clients occur approximately once each week.

CONCLUSIONS

To conduct the national canvass of Housing First programs, the study team used the definition of Housing First described above, as well as some key features of the Pathways to Housing model, as the standard to identify other Housing First programs. Canvass findings revealed that 23 programs incorporated many, if not all, of the key features of the Housing First model.

The results of the canvass also 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 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.

The widest variation among the 23 programs identified as Housing First occurred in the immediacy of placement in a permanent housing unit. While programs expressed a strong commitment to direct placement into permanent housing, the study team identified only two programs for which this was the case: Pathways to Housing and Direct Access to Housing. Programs used a variety of approaches to move clients quickly from the streets and into housing, with the understanding that the program would permanently place the client. Given low turnover rates and limited funding for additional housing units, most programs could enroll only one or two new cases per month. Those programs with new grants, either from the Chronic Homeless Initiative or from other sources, were able to develop more housing and enroll many new clients to increase program size. For most programs, however, the availability of new units depended on a turnover frequency that is low, given the high housing retention rates.

Variation also appeared in the type of housing offered to clients at the time of program enrollment. Many programs offered very little choice in housing and many offered transitional placements until more permanent housing units became available. Most programs did make access to housing barrier-free, and the transitional placements did not have many requirements.

Through the canvass, the study team identified sites for study that exemplify existing permutations of the Housing First approach, with program characteristics that met the study criteria. The remainder of this report presents findings on the three intensive study sites.

CHAPTER 3: KEY FEATURES OF HOUSING FIRST STUDY SITES

This chapter briefly describes the rationale for selecting the three Housing First programs: Downtown Emergency Service Center (DESC), Pathways to Housing, and Reaching Out and Engaging to Achieve Consumer Health (REACH). Following the rationale for site selection, the chapter provides a brief overview of each of the programs. The overview places each program's activities in the context of the key features of the Housing First approach described in Chapter 1. Each program is described in terms of five main topics:

- Background—How the program developed its Housing First approach and obtained funding to provide housing and services;
- Population Served—How and why the program selected its target population, a description of the target population, and how the program identifies and enrolls the target population;
- Type of Housing Offered—The housing types offered to clients;
- Transition from Homelessness to Permanent Supportive Housing—How and when clients transition from homelessness into housing; and
- Housing and Services Following Enrollment—How the program organizes and provides services after the client is placed in housing.

The chapter concludes with a cross-site analysis of the Housing First programs selected for study. More detailed descriptions of the programs can be found in Appendices C–E.

RATIONALE FOR SITE SELECTION

An important purpose of the nationwide canvass of Housing First programs described in Chapter 2 was to identify and recommend two study sites, in addition to Pathways to Housing, that met the criteria for the study, incorporated key features of the Housing First approach, and offered some contrast to the Pathways to Housing approach. The two programs selected for further study—DESC and REACH—incorporated many of the key features of the Housing First approach. Both DESC and REACH served primarily homeless people with serious mental illness and emphasized placement into housing without requirements for sobriety and treatment compliance. Variation in key areas, including type of housing utilized, location and intensity of services, and representative payeeship, provided interesting contrasts to the model employed by Pathways to Housing.

DESC and REACH satisfied other important criteria for inclusion in this study. Both programs had been in operation for at least one year—DESC had been in operation since 1994 and REACH since 2000. Each program had sufficient size to collect data on a combination of new

client enrollments, in addition to those enrolled within the last year, to fulfill study sample requirements. Program staff indicated that they maintained databases of client characteristics and services provided and made efforts to continue contact with clients, even if the clients left program housing. Finally, both agencies were willing to participate in the study. The following sections provide a brief overview of each of the study sites.

DOWNTOWN EMERGENCY SERVICE CENTER (DESC), SEATTLE

Background

DESC began as an emergency shelter operator in 1979 and was certified as a licensed mental health provider in 1980. King County, Washington contracted with DESC to provide emergency shelter and case management to the chronically homeless population that increasingly was becoming a problem in the downtown business community. In 1994, the U.S. Department of Health and Human Services designated DESC as a demonstration program site in its Access to Community Care and Effective Services and Supports (ACCESS) program.³² Following the ACCESS demonstration, King County continued funding for DESC to find and engage homeless people with mental illness through its Homeless Outreach, Stabilization and Transition (HOST) Project.

Frustrated by the lack of an effective service system for homeless people with mental illnesses, DESC worked with the mental health and addiction treatment systems in Seattle to develop longterm housing for the mentally ill, chemically dependent, chronically homeless population. DESC started a permanent supportive housing program with a Housing First approach in May 1994. Outreach and engagement focus on the most vulnerable homeless people on the streets or in shelters. The program offers permanent housing without requiring that the client participate in services or maintain sobriety. The housing is located in four buildings that DESC either owns or controls. The housing is supported by funding from various U.S. Department of Housing and Urban Development programs, including the Supportive Housing Program (SHP) and Section 8 Moderate Rehabilitation Single Room Occupancy (SRO) Program.

Population Served

DESC serves more than 300 clients at one time and places three to six new clients each month. DESC staff estimate that approximately 30 percent of clients come directly from the streets, with the remainder coming from emergency shelters.

DESC's goal is to serve the most vulnerable homeless people. 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 a substance-related disorder.³³ Of the 25 clients tracked for this

³²One of the goals of the ACCESS program was to improve integration of service systems that provide housing and services for homeless people.

³³ Grantees operating HUD competitive homeless assistance programs submit annual reports that provide information necessary to assess program performance, including participant entry and exit information.

study, 84 percent (n = 21) had met HUD's criteria for "chronic homelessness" sometime within the past three years.^{34, 35}

Type of Housing Offered

DESC maintains 306 units of permanent supportive housing in four buildings that it either owns or controls. Each location serves slightly different populations and is staffed by 24-hour, on-site staff who are trained in both property management and supportive services. Clinical mental health and substance abuse services are coordinated by community case managers associated with DESC's licensed mental health and substance abuse treatment divisions.

Kerner-Scott House is a 25-unit safe haven for seriously mentally ill people referred through DESC's homeless outreach program. The safe haven serves the most impaired and least engaged of DESC's clients. Each safe haven resident has an efficiency apartment that includes a small kitchen, eating and sleeping area, and bathroom. Technically, the maximum length of stay at Kerner-Scott House is 24 months, but this is not strictly enforced. Unless they choose not to, Kerner-Scott House residents move on to one of DESC's other buildings. Program staff typically begin talking to residents about other housing options as clients express the desire to move.

The other three buildings are SRO hotels located within a three-block area in the Pioneer Square neighborhood. Residents may move to one of these buildings after a period of stay at Kerner-Scott House, or may be referred directly by DESC's outreach team. All of the buildings provide private apartments with kitchenettes and baths, on-site meals, staff offices, and community rooms. There are no time limits on stays in any of these buildings, and turnover is low. According to program data, more than 90 percent of residents housed in September 2005 had been in DESC housing (at one or more locations) for at least two years. The Morrison Hotel is the largest building with 180 residential units and a 203-bed emergency shelter, also operated by DESC. The Lyon Building has 64 units and serves people with AIDS and mental illness or a substance-related disorder. Referrals to the Lyon building come from DESC outreach, as well as from AIDS service providers. The Union Hotel is a 52-unit SRO building serving seriously mentally ill clients referred from Kerner-Scott House or DESC's outreach team.

Transition from Homelessness to Permanent Supportive Housing

The majority of DESC clients enter the Housing First program through HOST outreach workers. A HOST case manager may offer a client housing at any point during the engagement process. If the client seems ambivalent or unwilling, the HOST staff work with the client to learn more about the housing and become comfortable there. Because vacancies are rare, staff maintain a waiting list with the most candidates who display the most need receiving the highest priority for housing. In the interim, HOST staff maintain as much contact as possible with candidates where

³⁴ A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one year or more or has had at least four episodes of homelessness during the past 3 years. Because HUD defines homelessness as sleeping in a place not meant for human habitation or an emergency shelter, those coming into Housing First programs from a psychiatric hospital or jail had to have been previously homeless.

³⁵ The four individuals from DESC who were not identified as chronically homeless were homeless prior to enrollment, but did not meet criteria of being continuously homeless for one year or having had four episodes during the past 3 years.

they are living on the streets or in the shelter. Due to the lack of eligibility criteria for housing and intensive services, Kerner-Scott House serves the most vulnerable clients and those with whom the staff are least familiar. Clients who have a relationship with case management are more likely to be referred to one of the other buildings and to participate in discussions with housing staff and their clinical case manager to determine the appropriate living environment, beginning at enrollment.

Applicants for housing do not have to agree to participate in services as a condition of receiving or retaining their housing. DESC requires representative payees in a small number of cases (fewer than 10 percent) where the client has a history of rent payment problems. In addition, staff estimate that 30–40 percent of the agency's clients have representative payees mandated by the Social Security Administration or the state of Washington as a condition of receiving benefits.

Housing and Services Following Enrollment

DESC is staffed by 24-hour, on-site case managers known as clinical service coordinators, who carry caseloads of approximately 34 people. DESC's service model emphasizes working with clients where they live, as well as closely coordinating between housing-based clinical service coordinators and community case managers. Staff do not work as teams similar to the Assertive Community Treatment (ACT) team model; instead, clinical service coordinators take the lead in developing residential service plans with input from the community case manager and the client. The plans address several domains including housing retention, medical and mental health services, substance abuse treatment, education, vocational services, and reconnecting with family and friends. Housing and clinical case managers confer regularly in person and by telephone. In addition, a sophisticated on-line data system allows staff to log all contacts with clients. When a contact is logged into the system, an e-mail notification is automatically sent to the staff who work with the client to ensure adequate communication among all partners.

The intensive staffing in the buildings means that staff have frequent contact with most clients. DESC staff acknowledge, however, that housing a large number of people with serious mental health issues in close proximity to each other may create more problems than would occur if clients lived in dispersed areas. The important factor in DESC's model, staff add, is that on-site staff are available to address problems if they do arise.

Units can be held for residents who leave and are expected to return. In most cases, a unit is held for 90 days. If the client returns after 90 days, DESC will place the client in another unit as quickly as possible. The reasons for 73 program departures from the 306 permanent housing units over a recent 12-month period included reasons that could be considered positive, such as leaving for more appropriate housing (44 percent), and others: return to homelessness (14 percent) or an unknown location (15 percent), deaths (11 percent), or permanently moving in with family or friends (7 percent).

PATHWAYS TO HOUSING, NEW YORK CITY

Background

Pathways to Housing started in 1992 with 50 apartments in Hell's Kitchen and Harlem in Manhattan and a \$500,000 grant from the New York State Office of Mental Health. The Pathways to Housing approach was the response of Dr. Tsemberis, a clinical psychologist conducting outreach in New York City, to his frustration with the lack of an effective service system to house homeless mentally ill persons and to keep them housed. Since 1993, Pathways to Housing has provided outreach and housing placement to homeless persons with mental illness who dwell on the streets of New York City. Pathways to Housing offers clients independent, scattered-site apartments in privately owned buildings in affordable neighborhoods in New York City. Six neighborhood-based ACT teams provide support to clients living in their neighborhood.

Population Served

Pathways to Housing serves 450 individuals with histories of homelessness, severe psychiatric disabilities, and co-occurring substance-related disorders. Pathways to Housing gives priority to those whom other homeless assistance providers will not serve. Prior to program entry, many of these homeless individuals have been frequent users of crisis services, such as psychiatric hospitals, emergency departments, and the criminal justice system. Referral sources include several of New York City's outreach teams, drop-in centers, jails, hospitals, and shelters. Pathways to Housing staff also conduct some direct outreach.

Over the past 2 years the majority of new enrollees at Pathways to Housing have been referrals from outside agencies that have contracts to provide funding, such as the Westchester County Department of Social Services or state and county psychiatric hospitals. These contracts have infused much needed new funding for services and housing into the program but have resulted in an increase in new enrollments coming primarily from psychiatric hospitals. Averaging three to five new enrollments per month, institutional discharges accounted for 50 of Pathways to Housing's new enrollments over the past 2 years and psychiatric discharges constitute 42 percent (n = 11) of the current study sample.³⁶ Prior to enrolling in Pathways to Housing, these clients resided in psychiatric hospitals for an average of 6.8 months—five clients stayed in psychiatric hospitals for 3 months or less. Despite the large proportion of psychiatric discharges, Pathways to Housing staff reported that 92 percent (n = 24) of the clients who participated in this study had met HUD's definition of chronically homeless within the past three years.³⁷

³⁶ Pathways to Housing confirmed that the sample is representative of the larger program with the following exception: 42 percent of the sample entered the program from psychiatric hospitals, which reflects the addition of funding from psychiatric hospitals to provide housing to homeless patients upon discharge.

³⁷ Pathways to Housing reported that 24 clients in the study met the joint federal definition of chronically homeless. It should be emphasized, however, that this interpretation assumes that nine of the eleven clients who enrolled from psychiatric hospitals met the criteria for chronic homelessness prior to psychiatric hospitalization and were determined on a case-by-case basis most likely to become homeless upon discharge.

Type of Housing Offered

All housing units are privately owned, independent apartments in the community secured through Pathways to Housing's network of landlords, brokers, and managing agents. Housing units are located in low-income neighborhoods in Queens, East and West Harlem, Westchester County, and Brooklyn. The Housing Department at Pathways to Housing works with ACT team members and clients to find an acceptable apartment and typically offers clients up to three choices at enrollment. When housing moves occur due to lease violations or problematic behavior, clients may be offered fewer options, but the ACT team works with the client to find another apartment to suit the client's choice. Program units include studio, one-bedroom, and two-bedroom apartments with private baths. Pathways to Housing provides all essential furniture, such as a bed, mattress, bureau, table and chairs, as well as pots, pans, dishes, telephone, and television.

Pathways to Housing signs the lease and sublets the apartment to the client. The Housing Department at Pathways to Housing and ACT teams maintain relationships with landlords, ensuring that clients meet their lease obligations. The Housing Department also monitors repairs and lease renewals, and ensures that all essential services are provided and that tenants' rights are protected. The program assumes that housing tenure is permanent, with no actual or expected time limits. Housing rules resemble standard lease requirements.

Transition from Homelessness to Permanent Supportive Housing

Upon enrollment, the client may reside in a shelter or be placed in a hotel or at the Young Men's Christian Association (YMCA) while working with the Housing Department at Pathways to Housing to secure an apartment. Because Pathways to Housing is at full enrollment, referrals depend on the referral source, availability of a housing subsidy, and ACT team capacity. Westchester County Department of Social Services and the New York Presbyterian Hospital programs refer directly to the Westchester ACT team. Kingsboro Psychiatric Center and Kings County Hospital refer directly to the Brooklyn ACT team. All referrals are centralized through the two clinical program managers to prioritize enrollment. Pathways to Housing enrolls two or three new clients each month.

Pathways to Housing is designed to provide clients with immediate access to housing. Unless they choose to, clients are not required to be drug or alcohol free, acknowledge they have a mental illness, or participate in any treatment programs. The program has two requirements: clients have to agree to two case manager visits per month and pay 30 percent of their income— usually Supplemental Security Income (SSI)—for rent. Most clients agree to allow Pathways to Housing to act as representative payee for this purpose. These requirements are strongly recommended; however, refusal to accept Pathways to Housing as a representative payee does not disqualify a person from the program.

Housing and Services Following Enrollment

Pathways to Housing has six ACT teams, which provide a range of intensive clinical, rehabilitation, and support services to clients in their neighborhood areas. These nine-person interdisciplinary teams consist of social workers, a substance abuse specialist, nurse practitioner, part-time psychiatrist, family systems specialist, wellness specialist, employment specialist, and administrative assistant. Each ACT team is available 24 hours a day, 7 days a week to monitor

and respond to the needs of 60–70 clients. Clients choose the array and sequencing of support services offered by the ACT team.

Together, the ACT team and the client develop a Comprehensive Treatment Plan, in which the client identifies the goals and phrases them in his or her own words. Assessment begins at enrollment and forms the basis of the client-driven plan, which addresses ten domains including housing retention, medical and mental health services, substance abuse treatment, education, vocational services, and reconnecting with family and friends. The money management program allows Pathways to Housing to act as representative payee for clients until they demonstrate an ability to pay their rent, utilities, and food bills.

ACT teams spend 80 percent of their time in the community assisting clients to adapt to their homes and neighborhoods, emphasizing home visits and clinical interactions. The ACT team provides a range of services to help clients retain housing—one of the most critical factors is the integration of substance abuse and psychiatric services within each ACT team. Because clients enrolled in the program have a mental illness—and most have a substance-related disorder—they often experience symptoms that may lead to their loss of housing. The ACT team's collaboration assures that mental health and substance-related interventions appropriately address problems to help clients to remain stably housed.

Case managers help new clients move into their homes and acclimate to the neighborhood. Pathways to Housing clients may experience temporary program departures, most frequently for short stays in psychiatric hospitals or short periods of time on the streets. Following these short departures from their permanent housing, clients typically return to the same apartment. If a client requires inpatient treatment, Pathways to Housing will hold the apartment for 90 days; if the client requires a longer stay in inpatient treatment, the apartment will be released and the client is guaranteed access to a new apartment upon program reentry.

REACHING OUT AND ENGAGING TO ACHIEVE CONSUMER HEALTH (REACH), SAN DIEGO

Background

REACH was established in 2000 out of concern that homeless people were at risk of being displaced by the construction of a new sports stadium in downtown San Diego. In response, the San Diego County Mental Health Services Division successfully applied for 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.³⁸

³⁸ California Assembly Bill (AB) 2034 allocated funds to expand and provide services for homeless persons, parolees, and probationers with serious mental illness. The California Department of Mental Health awarded funds to 32 counties to provide housing and supportive services to this population. After a demonstration year in three counties under AB 34, AB 2034 made funding available statewide to provide integrated services for homeless people with mental illness.

The San Diego County Mental Health Services Division contracted with Telecare Corporation to engage, house, and provide case management to 250 chronically homeless individuals with mental illness within 6 months.³⁹ REACH experienced high turnover in the program during the early months. REACH staff explained that, due to the short timeframe for program startup, many of the individuals first enrolled had a more pronounced addiction problem, rather than a primary diagnosis of serious mental illness. As a response to these initial housing failures, REACH modified its intake process to improve screening for a primary axis I diagnosis of serious mental illness.

REACH adopted an approach of doing "whatever it takes" to end homelessness for this vulnerable population. The label of Housing First came 2 or 3 years later, when REACH staff realized that their approach of offering access to housing without requiring sobriety and treatment compliance resembled the Housing First model of supported housing. The program has been fully leased since June 2001, and now averages five or six new cases a month. Since achieving full enrollment, REACH does some outreach, but relies primarily on referrals from the community and the San Diego Police Department Homeless Outreach Team (HOT). The HOT consists of a uniformed police officer and a mental health counselor. The teams reach out to homeless, mentally ill people living on the streets and identify candidates for screening by a REACH outreach specialist.⁴¹ The Community Research Foundation partners with REACH to provide psychiatric services, medical care, and employment support.

Population Served

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 the REACH program. Some exceptions to these criteria are made for high priority vulnerable populations, including seniors and youth in transition from foster care. As of May 2005, two-thirds of the REACH population had co-occurring mental illness and substance-related disorders, and the remaining one-third had a diagnosis of mental illness only. Women comprise 43 percent of the REACH population. Program staff estimate that 70–80 percent of the population lived on the streets prior to program entry and that the remainder came from shelter or short-term psychiatric placement. Eighty-six percent (n = 25) of program enrollees tracked for the present study met HUD's definition of chronic homelessness.⁴²

³⁹ Telecare Corporation is a for-profit mental health services provider based in Alameda, California, that has operated AB 34 demonstration programs and AB 2034 programs in several counties in California. San Diego County Mental Health Services Division contracted with Telecare Corporation to develop and operate the REACH program.

program. ⁴⁰ The Diagnostic and Statistical Manual (DSM) of Mental Disorders, published by the American Psychiatric Association, describes the diagnostic categories of mental disorders and a multiaxial assessment that includes five axes. Axis I includes clinical disorders and other conditions that may be a focus of clinical attention—schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and other conditions.

⁴¹ Because the HOT is part of the San Diego Police Department, there is an inherent question about whether clients perceive they have a choice about entering housing when the offer comes from a uniformed officer. As one focus group participant noted, "HOT brought me here. I had been homeless off and on. They said they would bring me here or to jail." A former REACH mental health worker has joined the HOT, acting as a liaison between REACH and the HOT.

⁴² The four enrollees at REACH who did not meet the joint federal definition of chronic homelessness were referrals from other mental health providers that met the criteria for vulnerable populations. These individuals were homeless prior to enrollment at REACH, but had not been continuously homeless for a year or more or had not experienced at

Type of Housing Offered

REACH clients live in more than a dozen types of housing situations throughout the San Diego area, including a safe haven, a number of SRO hotels, and scattered-site apartments. 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. There is little housing choice at program enrollment—most residents enter either the safe haven or an SRO hotel at initial enrollment. The majority of clients stay at the safe haven for less than two weeks until a unit opens at an SRO, but others stay longer, some as long as 18 months.

Most housing agreements have requirements regarding visitors, disruptive behavior, and substance use. REACH staff make it clear to clients, however, that the program will help them maintain permanent housing. Some clients who experience difficulty with the housing requirements require additional case management support to either solve the problems or move to another housing location with fewer rules. Some clients demonstrate housing stability in the safe haven or SRO and may stay for long periods. Depending on housing stability, some clients are placed in scattered-site apartments within a few months of enrollment. The following sections describe these types of primary housing locations.

Safe Haven

The Episcopal Community Services safe haven occupies a 19-unit building operated with funding from the AB 2034 program. A resident assistant is on site 24 hours a day. Residents have their own apartment that can be locked, each with a refrigerator and sink, and share bathrooms and kitchen. Prior to entry, new residents must sign a rental housing agreement that includes: paying 30 percent of their income for rent; following the 10 p.m. weekday curfew, as well as restrictions on overnight visitors, alcohol or drug possession and use, and possession of weapons; agreeing to weekly room inspections; and signing in and out when entering or leaving the premises. If clients prefer the safe haven, they can stay up to 18 months. Occasionally, a REACH client will choose to remain in the safe haven for more than one year; most clients find alternative housing within 2 weeks.

SRO Hotels

The advantage to the SRO buildings, which are operated by private landlords, is that they provide relatively inexpensive apartments in downtown San Diego, with rents ranging from \$300 to \$600 per month, depending on the size and location of the apartment. Each unit has a sink, small refrigerator, and small kitchen area, and men's and women's common bathrooms are located on each floor.

Currently, the Metro Hotel provides the largest number of housing units for REACH clients. However, concern over the high density of clients in the building, client complaints, and numerous housing problems led REACH to administer a housing choice questionnaire to all clients at the Metro Hotel to help them relocate to other housing of choice. The goal is to reduce the client census at the Metro Hotel from a high of 55 units (of 200 total units) to a maximum of 15 units by December 2005. The other SRO hotels have a smaller number of program clients. The Plaza Hotel had 20 REACH clients (of 185 total units) and the Lynne Hotel had seven REACH clients (of 21 total units) as of May 2005.

least four episodes of homelessness during the previous three years.

Scattered-Site Apartments

As of May 2005, 56 REACH clients lived in scattered-site apartments—16 clients were paying their own rent, while the remaining units were subsidized through a variety of sources, including AB 2034 funds, HUD's Shelter Plus Care rental assistance, project-based Section 8 assistance, and Housing Choice Vouchers. Scattered-site apartments go to less-impaired REACH clients, usually those who have done well at the SRO hotels and require less staff overnight. A screening process is in place and includes an interview about what the client does with their day, their interest in scattered-site housing, level of independence, income, substance use, budgeting, ability to prepare food, and medication management.

Other Living Situations

Other living situations include ten clients residing in Independent Living Facilities, which provide one room and a shared bath for every three residents. These facilities are not licensed to distribute medications, but can remind people and support them. Nineteen REACH clients live in Board and Care Facilities, which house more impaired clients and are licensed by the state to distribute medications and to provide meals. Case managers work with clients to offer choice in housing. In some instances, housing with greater structure may be what the client prefers and needs.

Transition from Homelessness to Permanent Supportive Housing

The majority of REACH clients come directly from the streets through the HOT. In addition to the HOT, REACH has an outreach specialist who works with mentally ill people on the streets to help them move into housing. The REACH outreach specialist tracks by name in the program database clients who have received outreach and records the disposition of the encounter. The outreach specialist reports daily on the clients who are ready to enter the program, which must be coordinated with clients identified by the HOT. Openings occur frequently and clients can be housed temporarily in the safe haven while awaiting permanent housing. While REACH had an official waiting list in the past, staff found that many people moved on or received services. Staff report that they go "hunting" instead for the most vulnerable people who are not looking for services.

After the client agrees to come into housing and a unit is available, the HOT accompanies the client to REACH for screening and formal enrollment. Most clients stay at the safe haven during this assessment period, which typically takes no more than 2 weeks because most clients are well known to the outreach teams following several months of engagement. Some clients are immediately placed into an SRO. REACH case managers monitor vacancies and prioritize clients for movement from the safe haven to an independent apartment as soon as there is availability. Case managers work closely with each client to find his or her housing of choice. Infrequent program vacancies often mean that the outreach worker and the HOT must patch together resources and referrals until there are openings in the program.

Housing and Services Following Enrollment

One case manager is assigned to each client at enrollment. There are no treatment requirements other than meeting with the case manager biweekly. Case managers assess each client, develop a service plan, and provide assistance to obtain needed basic services, including 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. Each case manager carries a caseload of no more than 23 clients and works as part of a team of case managers dually certified in mental health and substance abuse. The Community Research Foundation provides employment, psychiatric, rehabilitative, and nursing services.

Case managers also help clients find housing of their choice. Because landlords or housing providers for the safe havens, SROs, or Independent Living Facilities have strict lease requirements regarding substance use, REACH clients experience frequent moves before achieving housing stability. Case managers work closely with landlords and clients to preserve housing whenever possible. If problems cannot be resolved, alternative housing is found. Once enrollment in REACH is accomplished, case managers work with clients to follow up with them regardless of where they move. Team members visit clients within 72 hours of a psychiatric placement and dispatch the outreach team to locate clients if they have returned to homelessness. Community Research Foundation staff work in the evenings to follow up with clients to ensure that their needs are met. If an absence lasts longer than 90 days, a client may be disenrolled from the program, but may return, although not necessarily to the same apartment or housing unit.

CROSS-SITE ANALYSIS OF HOUSING FIRST FEATURES

The brief site descriptions above provided information about each of the Housing First programs' background, the population they serve, the types of housing offered, clients' transitions from homelessness to living in permanent housing, and the provision of services to address mental illness and substance use, as well as to maintain housing after entering the program. Exhibit 3–1 provides a summary of program features across the Housing First programs. The following sections compare and contrast the features of the Housing First programs.

Feature	DESC	Pathways to Housing	REACH
Year established	1994	1992	2000
Population served	Serves 306 mentally ill, substance dependent, homeless individuals (50% co-occurring disorders). Majority of clients were chronically homeless. 30% from the streets, 70% from "wet" emergency shelters.	Serves 450 mentally ill, substance dependent, homeless individuals (90% co-occurring disorders). 25% from psychiatric hospitals, 75% from streets or shelters.	Serves 259 mentally ill, substance dependent, homeless individuals (70% co-occurring disorders). 90% from streets or shelters, 10% from crisis houses.
Outreach and referral	Outreach team identifies and places 2–3 clients per month. HOST works both streets and shelters. DESC maintains a waiting list.	Community referrals and Pathways to Housing outreach identify and place 5 or 6 clients each month. Funders identify referrals for Westchester County and Brooklyn ACT teams.	HOT and REACH outreach specialist identify and place 5 or 6 clients each month.
Housing placement	No sobriety or treatment requirements. Standard lease requirements. Client signs lease. SROs have no time limits. Safe haven has 18 month limit, but clients may move to an SRO. Units held 90 days for temporary absences.	No sobriety or treatment requirements. Standard lease requirements. Pathways to Housing signs lease. No time limits. Housing considered permanent. Units held 90 days for temporary absences.	No sobriety or treatment requirements. Landlords and leases have requirements. Safe haven has curfew and sobriety requirements. Client signs lease. No time limits. Housing considered permanent. Units held 90 days for temporary absences
Housing choice	Housing owned or controlled by DESC: 3 SRO buildings and 1 safe haven. Units are single occupancy apartments with private baths. Clients offered little choice in type of housing.	Scattered-site apartments in private buildings. Clients have choice of up to 3 apartments.	Various: SRO, safe haven, Independent Living Facilities, Board and Care, scattered-site apartments. Private landlords and community partners own or control housing. Clients offered some choice in type of housing.
Service model	Housing and clinical case managers coordinate services. Each housing- based case manager has caseload of 34 clients. Shift change meetings, telephone contact, and on-line data system coordinate services and track clients' status. Clinical case managers make referrals to DESC psychiatrist and substance abuse treatment professionals.	Neighborhood-based, 9-member ACT team carries caseload of 60–70 clients. Daily team meetings to discuss clients' status and determine which team member(s) should respond.	Team of case managers dually certified in mental health and substance abuse. Team meetings daily to coordinate services available 24/7. Case manager caseload is 23 clients. Nurse practitioner, psychiatrist, and vocational services provided by Community Research Foundation.
Separation of housing and services	No—on-site staff provide property and case management. DESC clients occupy all units in buildings. DESC owns or controls units.	Yes—ACT team members visit clients in home. Clients occupy no more than 10% of building. Private landlords own or control housing.	Yes—case managers visit clients in community. Safe haven is 100% REACH clients. REACH clients occupy 10–20% of SROs. Private landlords own or control housing.
Low Demand	Yes.	Yes.	Yes.
Representative payees	Not required.	Encouraged, with exceptions.	Not required, but common.
Program funding	Housing—HUD SHP, Section 8 Moderate Rehabilitation SRO Program. Services—HUD Service Coordinator, and HOPWA programs, PATH grants, Medicaid reimbursed through King County, Washington.	Housing—state rental subsidies, PATH grants, Shelter Plus Care, HUD SHP. Services—state-funded ACT team service dollars, Medicaid reimbursement, Westchester County Department of Social Services.	Housing—state-funded AB 2034 grant, 100 San Diego Housing Authority project-based assistance subsidies, Shelter Plus Care, tenant SSI income. Services— Medicaid reimbursement.

Exhibit 3–1. Program Features

Population Served

All of the Housing First programs selected for this study provide services for the hardest-to-serve segment of the homeless population—individuals with mental illness and often co-occurring substance-related disorders. The majority of these individuals also meet the HUD definition of chronic homelessness. Frustrated by watching these clients enter housing and then cycle back into homelessness, Pathways to Housing and DESC developed permanent supportive housing programs, in 1992 and 1994 respectively, and adopted their own treatment approaches. REACH, created in 2000 with state grant monies, arose as a collaboration with the San Diego County Mental Health Services Division to house homeless people with mental illness living on the streets, many of whom were at risk of displacement by the building of a new sports stadium in downtown San Diego.⁴³

The programs target individuals who have been living predominately on the streets or in other public spaces and have been frequent users of systems such as psychiatric hospitals, hospital emergency departments, and the criminal justice system. Program staff members describe their services as designed for "treatment resistant" clients.

Outreach and Referral

Each of the Housing First programs in this study provides some direct outreach to locate and engage potential clients. At DESC, the agency's own outreach workers identify the majority of enrollees, although a few come through AIDS services providers. DESC outreach workers look for the most impaired, most vulnerable people on the streets. A DESC staff member stated that, "HOST is looking for people who are *not* looking for us." Similarly, REACH referrals consist largely of persons identified by the San Diego Police Department HOT, which consists of uniformed police officers and mental health counselors who provide outreach services in the San Diego communities where homeless people congregate. Pathways to Housing staff provide some outreach, but most referrals to Pathways to Housing are from community agencies that have contracted with Pathways to Housing to provide housing to their homeless clients, such as Westchester County Department of Social Services and state and county psychiatric hospitals.

All three study sites were at full capacity at the time of this study. To address ongoing housing needs in the community, each program had some method to prioritize new referrals. REACH and DESC use a waiting list system whereby they identify clients who are living in shelters or on the streets and offer housing as it becomes available. During the study period, Pathways to Housing expanded to serve new enrollees under two HUD permanent supportive housing grants.⁴⁴ Psychiatric discharges also account for many of the new enrollments, particularly from Kingsboro Psychiatric Center and Kings County Hospital to the Brooklyn ACT team.

⁴³ Telecare Corporation provided integrated services for homeless people with mental illness in two of the AB 2034 pilot counties: Stanislaus County and Los Angeles County.

⁴⁴ Pathways to Housing provides supportive housing and services under two grants funded by HUD. Project Release provides permanent supportive housing for former inmates in a jail diversion program for the Center for Alternative Sentencing and Employment Services (CASES) Nathaniel project. The KEEPing Home program provides permanent supportive housing for former inmates who are sent to continue methadone treatment at the Key Extended Entry Program (KEEP) of the Narcotics Rehabilitation Center (NRC) of Mt. Sinai Hospital, located in East Harlem.

Housing Placement

The key feature characterizing housing placement in each of the study sites is that the programs offer housing *first* without requirements for treatment or sobriety. Moreover, this housing is viewed as *permanent*. Most housing agreements have requirements regarding visitors, disruptive behavior, or substance use; however, program staff make it clear to clients that the program will support them to maintain their housing permanently. In more traditional programs, clients may be required to demonstrate a period of sobriety or compliance with treatment in a transitional housing setting prior to entering permanent housing.

Enrollment occurs at the time that the client signs the lease and formally moves into a Housing First program unit. The timing of the lease signing and entering housing varies across programs and clients. For example, depending on level of functioning, clients at DESC may enter an apartment at the safe haven first and not sign the housing agreement until later. At Pathways to Housing and REACH, the availability of a funding source or new unit triggers the assessment process. Case managers conduct assessment interviews and secure client agreement to sign a lease before they move into their housing. At REACH and Pathways to Housing, this enrollment step is necessary because referrals come from outside agencies. Most of the referrals to REACH come from the HOT and REACH program staff must screen for severity of mental illness and determine if the client is agreeing to enter housing voluntarily.

A portion of new program enrollees at both DESC and REACH are placed first into safe havens.⁴⁵ Both DESC and REACH reported less choice and more structure in the housing offered at enrollment, but most clients who spoke with the study team reported that it was preferable to living on the streets. Even though the safe haven placement may be transitional, clients in both programs do move on to one of the permanent housing options offered by both programs. Thus, the housing commitment is permanent even if the initial placement is not.

The most important feature of the Housing First programs is that the housing is permanent. Disruptions in housing may occur due to a client's behavioral problems resulting from substance abuse or psychiatric decompensation; a client may lose his/her unit but not his/her housing as a result. Typical examples of housing problems include failure to upkeep the apartment or personal hygiene, flooding, hoarding, excessive noise, or other behavioral problems. In some cases, the client may request changing apartments due to drug activity in the apartment building or imaginary fears due to hallucinations. Across the three study sites, clients experience temporary program departures, most frequently for short stays in psychiatric hospitals or short periods of time on the streets. During these temporary departures, which usually do not exceed 90 days, apartments are held for the clients' return. (See Chapter 5 for a discussion of housing tenure for the study sample.)

⁴⁵ Out of a total of 29 REACH clients who participated in this study, 31 percent (n = 9) stayed in the safe haven for a range of five nights to up to 12 months, with the majority (n = 6) of clients staying less than three months. At DESC, five out of the 25 study participants stayed at the safe haven for an average length of stay of 10.2 months.

Client Perspective on Housing Placement

The clients who participated in focus groups during the site visits to each of the study sites made generally favorable comments about their housing.⁴⁶ At DESC, the features that these clients liked about their housing included tangible aspects, 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 two weeks in a crisis house and then I went to the Metro Hotel for three 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 the Metro Hotel, 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."

Housing Choice

Pathways to Housing places clients immediately (or nearly immediately) from the streets into permanent, scattered-site apartments. The program generally offers clients a choice among two or three apartments. However, Pathways to Housing may not be able to offer clients choice of neighborhood locations due to lack of vacancies or the program's determination that a client requires proximity to an ACT team office for monitoring.

Both DESC and REACH provide a contrast to the Pathways to Housing approach to housing choice. DESC maintains three SRO buildings and one safe haven. Because DESC owns or leases the program housing offered, DESC has greater control over the housing structure, but offers clients fewer housing choices. However, Pathways to Housing neighborhood offices and DESC's centralized location offer clients and case managers an ease of accessibility for monitoring and assistance that clients may want and need.

⁴⁶ The study team conducted two focus groups at DESC on May 23, 2005 and May 24, 2005; three focus groups at Pathways to Housing on June 1, 2005 and June 2, 2005; and two focus groups at REACH on May 18, 2005. The methodology for these focus groups and the discussion guide used to prompt the discussions may be found in Appendix A to this report.

When REACH enrolls clients, it places some of them immediately into a highly structured safe haven, which is not operated by REACH. From the safe haven, case managers work with the clients to help them choose among an array of housing options, including SRO units, Board and Care Facilities, Independent Living Facilities, or scattered-site apartments. While REACH offers some choice in housing options, the availability of independent scattered-site apartments is limited and turnover is infrequent. Because the REACH case managers are located in one centralized location and the clients' housing may be located throughout the city, transportation can be challenging. Clients are offered bus passes and case managers use their personal vehicles to visit clients in their housing units and to assist them in getting to needed appointments.

Service Model

The three Housing First programs provide coordinated and integrated case management services using somewhat different service delivery models. In each program, case managers provide services in the community where the client lives. While recovery from mental illness and substance abuse takes many years, staff at all three Housing First programs believe that recovery is possible. With their years of experience supporting the hard-to-serve mentally ill homeless population, staff believe that recovery is possible.

Only Pathways to Housing has ACT teams. These interdisciplinary teams are modified from the original ACT team concept to include a supported housing component based on the Housing First approach.⁴⁷ The primary goals of ACT are to enhance the client's community adjustment, decrease time spent in institutions, and prevent the development of a chronic "patient" role. Pathways to Housing has six ACT teams that provide a range of intensive clinical, rehabilitation, and support services to clients in their neighborhood areas. The interdisciplinary teams are available 24 hours a day, 7 days a week to monitor and respond to the needs of 60–70 clients. The ACT teams spend 80 percent of their time in the community assisting clients to adapt to their homes and neighborhoods and emphasize home visits and clinical interactions. The ACT team coordinates and monitors work with the clients through daily team meetings.

Achieving the ideal mix of professional staff required for a true ACT team model is challenging and costly. DESC and REACH use a team-based approach that replicates many of the strengths of the ACT team model. In both programs, the interdisciplinary services provided by an ACT team are available, but are not all provided by members of a treatment team. At DESC, clinical services are provided by the licensed treatment programs operated by other divisions. At REACH, another contractor provides these services.

The REACH model most closely resembles the Pathways to Housing ACT team approach in terms of providing services to the clients in their own homes at least twice a month. However, REACH caseloads are larger (23 clients per case manager) and the program covers a larger geographic area than Pathways to Housing ACT teams—REACH covers the entire San Diego area, while Pathways to Housing has a separate ACT team for each neighborhood. The Community Research Foundation partners with REACH to provide medication management and psychiatric and employment services. Because these services are provided through another contractor, case coordination is not a seamless process. Although REACH does not currently have an ACT team, it is striving toward that goal.

⁴⁷ The original ACT teams were developed in Madison, Wisconsin, and are described in Stein and Test (1980).

Clients in the focus groups expressed positive feelings for REACH case management services:

- "They want to know all your problems and then they deal with everything fast. They take over the thinking process. You don't have to think about it."
- "The others [programs] have too many rules. There are no threats here."
- "REACH told me I would never be homeless again."

Medication compliance is encouraged but not required in all three programs. However, the approach to medication management across the programs provides a useful comparison in an important area of client functioning. In both the Pathways to Housing and REACH models, a nurse practitioner, who is a member of the treatment team, assists the client in learning to package and then take the medications independently.⁴⁸ The process begins with the nurse assisting the client to package the medication and providing education about the medication, followed by frequent reminders to the client to take the medication. The level of assistance gradually decreases as clients become ready to package and take medication independently. In the Pathways to Housing and REACH models, improvement in medications independently and without reminders. However, if medication management becomes a problem, it may be several days or even weeks before the client's symptoms or behavior indicate that he or she is decompensating.

The advantage of the DESC model is that services are on site so that case manager and client contact can occur daily. At DESC, program staff oversee a similar process of increasing client independence in medication management, but the process can be much more closely monitored because staff are on site to witness medication compliance 24 hours a day, 7 days a week.

Monthly Service Contacts

Given the stress of entering housing from the streets or shelter, clients require considerable support in the community when they first enter housing. In all three Housing First programs, the average number of monthly service contacts was highest during the first 3 months following enrollment. It is expected that when a client is first enrolled there is a higher frequency of contacts, initiated by both staff and clients, to assure community adjustment. However, the data collection instruments used for this study did not collect information regarding the nature of the contacts. Clients at Pathways to Housing received the smallest average number of monthly service contacts because services are located on site. REACH clients made a greater number of temporary moves to other living environments, such as the streets or jail, and moves into other permanent housing, and, as a result. the average number of service contacts was higher than Pathways to Housing.⁴⁹ (See exhibit 3–2.)

⁴⁸ Packaging medications refers to clients' practice of keeping medications at an agency's office and visiting the office weekly or monthly to assemble enough medication for the following week or month. The client then takes the medication independently.

⁴⁹ Case managers at each of the Housing First programs reported the number and type of service contacts provided each month to clients enrolled in this study. Service contacts were counted by days—one service contact was



Exhibit 3–2. Average Service Contacts per Client per Month, by Program

Separation of Housing and Services

Although none of the Housing First programs requires treatment regimens as a condition of housing, the location of and type of services may affect a resident's success in permanent housing. Successful housing retention is predicated on the notion of offering a comprehensive array of supportive services that are individualized or client driven and provided within the community where the client lives. The functional separation between housing and services provides critical leverage in treatment to help the client work toward recovery and maintain his or her apartment. While the client will not be disenrolled from any of the Housing First programs for problems caused by behaviors related to substance abuse or mental illness, the client will suffer the consequence of losing the apartment due to landlord complaints.

In New York City and San Diego, the team approach is important to providing services effectively across widely dispersed housing units. In New York City, the six ACT teams associated with Pathways to Housing are located in the neighborhoods where clients live. REACH is headquartered centrally and must cover clients living throughout San Diego, but primarily downtown. Each morning teams at REACH and Pathways to Housing review the status of all clients and any emergencies that may have occurred overnight and determine the best way to address these issues.

For these programs, the separation of housing and services across large geographic areas is challenging, but the 24 hours-a-day, 7 days-a-week availability of the case management staff to solve problems in the client's housing helps to make it work. For example, when a client causes a housing problem, case management staff are committed to responding immediately to both

defined as one service provider having contact at least one time with a client during a given day. If the same provider had multiple contacts with a client during one day, the number of service contacts reported was one. Exhibit 3–2 displays the average number of monthly service contacts, per client, for the entire sample at each Housing First program. Data are presented for months one, 3, 6, 9, and 12 of client housing tenure. Each average was computed using the number of clients in each program during that particular month. In general, the average number of monthly service contacts who left the program within the first 12 months than for clients who remained in the program for 12 months at both DESC and Pathways to Housing. At REACH, the average number of monthly service contacts was greater for those who stayed in the program for 12 months.

landlord and client concerns, attempting to find a remedy. The fact that the housing is provided by private landlords, rather than the Housing First program, also means that case managers are not responsible for enforcing leases and can focus their efforts on resolving housing problems so that clients remain housed.

Landlord recruitment and retention largely hinges on successful and responsive attentiveness to landlords' concerns. This is particularly important to maintaining the safe haven, SRO, and scattered-site apartments in the San Diego area. The safe haven and the Metro Hotel have very strict lease requirements regarding substance use. In the case of the safe haven, which is funded by the AB 2034 grant, the landlord can be more lenient and will work with the client and case manager to resolve any housing problems that may arise due to substance abuse. A series of crises and the arrival of a new property manager at the Metro Hotel triggered an increased level of concern about problems stemming from substance abuse. In response to the new manager's strict "zero tolerance" policy, case managers moved several clients to other locations but kept them in the program.

Regarding scattered-site apartments, while a landlord may be supportive of REACH, housing complaints may escalate to neighborhood or community commissioners, resulting in political pressures to place clients in more restrictive housing when they in reality have a greater ability to function independently. Because there is a waiting list for scattered-site apartments, these units are occupied by less-impaired REACH clients, usually those who have done well at the SRO hotels. Program staff concede that, while they believe that clients who are not deemed ready for housing have the ability to function well in independent housing, "there is a worry about putting someone in an apartment with a landlord who has been open to housing clients and it not working out."

Landlord recruitment in the Pathways to Housing approach is predicated on the program signing the lease, so that the landlord can hold the program accountable to the lease requirements. The policy of Pathways to Housing is to be responsive to landlord concerns. Pathways to Housing staff also help clients learn to become good neighbors by taking them to meet the building superintendent and making the superintendent aware of numbers to call in case of any housing concerns.

DESC's model is quite different and arises from the housing type and the service resources DESC brings to the program. DESC controls the housing and provides on-site property case management to enforce lease requirements. The housing-based case managers develop service plans, with input from the client and the client's clinical mental health or substance abuse case managers. The service plans emphasize goals and outcomes that will help the client succeed in housing. These plans are meant to supplement, not duplicate, the clinical case manager's work with the client. In addition, clients usually have daily interaction with the housing-based case managers. While clients could lose their housing for lease violations, program disenrollments are rare and only for the most egregious of lease violations (e.g., physical violence or assault with a deadly weapon).

Low Demand

The Housing First model provides a range of services to help clients retain housing. For example, DESC case managers help new clients move into their homes and adjust to their new housing. REACH and Pathways to Housing also help clients acclimate to their new neighborhoods. These activities include showing clients where local markets are located, providing them with cleaning supplies, and introducing them to local transportation services. At each of the Housing First programs, case managers also intervene with clients to address behaviors that may lead to a loss of housing. These behaviors may be related to one's mental illness, drug or alcohol use, or lack of experience living indoors.

Low demand is a key attribute of the treatment approach utilized across all three Housing First programs. Low demand is an intervention designed to reduce harm, or risk of harm, associated with ongoing addictive behaviors, without requiring abstinence. Following are two examples of the low demand approach.

- During an apartment visit in response to a landlord complaint of suspected drug activity, the case manager may notice that a "friend" has moved in or is staying overnight with a client. The case manager might suspect that the friend is actively using or selling drugs. As a result, the case manager may visit the client more frequently to remind the client that overnight visitors are a lease violation that could jeopardize his or her housing.
- Drug use escalation may result in the client spending all of his or her money on drugs, leaving nothing for food. If the client has chosen the Housing First program as representative payee, the case manager may intervene as money manager, making food purchases and significantly reducing the client's access to cash until the drug use subsides.

Focus group participants confirmed that participation in services was not a condition of their staying in housing. When clients first enter the REACH program, placements in either the safe havens or the Metro Hotel involve adherence with rules regarding substance abuse. At REACH, the focus group participants indicated that case managers were supportive, even when you "relapsed." One REACH client indicated she felt really bad about relapsing, when they had helped her so much: "I feel guilty; I want an outside counselor so I don't have to tell REACH about relapses." At DESC, one client described his case manager's approach: "They listen, and then they watch you to see if you do what you said." Another commented on participating in Alcoholics Anonymous or Narcotics Anonymous meetings, noting, "They encourage you, but there's no pressure." Another, a long-time alcoholic, unapologetically asserted, "I've been drinking all my life…and I'm not going to quit."

Representative Payee

Representative payees can help clients better manage their money and ensure that rent payments are made on time. All of the Housing First programs have clients who have a designated representative payee. Among the clients who enrolled in this study, REACH clients have representative payees less frequently than clients in Pathways to Housing and DESC. Approximately 85 percent of clients at DESC (n = 21) and Pathways to Housing (n = 22) had a representative payee for at least one month during the first 12 months in the program compared with 35 percent (n = 10) at REACH. Further, clients at DESC (29 percent of those with a

representative payee) and REACH (50 percent of those with a representative payee) frequently designated a local nonprofit as their representative payee.

Most Pathways to Housing clients allow a program staff member to become their representative payee; however, it is not a requirement at program enrollment. Rather, it becomes a developmental step in recovery as clients demonstrate increasing ability to manage their affairs of daily living and independence. Many clients at Pathways to Housing have a representative payee at enrollment, but eventually manage their own money. Having the Housing First program as representative payee would appear to give the program leverage, however, many clients in the study had someone other than the program as their representative payee. Regarding of the influence of having a representative payee, research on this issue in the three study sites and other programs is underway.⁵⁰

The Pathways to Housing ACT team case managers use evidence-based practice tool-kits designed to help clients develop self-sufficiency skills to live independently, especially in the areas of activities of daily living, money management, and medication management. If a client does not have a representative payee, the case manager may initially provide a great deal of assistance in reminding clients to pay their rent with their monthly checks. As the client demonstrates progress in making good decisions, the case manager will gradually reduce the assistance to allow the client to assume increasing independence in money management.

Program Funding

All of the Housing First programs require a combination of funding sources to cover both housing and services. Sources of funding for housing consist of federal, state, local, and private funding. At DESC, the four housing locations are funded by HUD programs, including SHP, the Section 8 Moderate Rehabilitation SRO program, and the Low-Income Housing Tax Credit program. Services are funded through HUD's SHP, Service Coordinator grants, the Housing Opportunities for Persons with AIDS (HOPWA) program, and Medicaid funds administered by King County. Private fundraising also supports both housing and services. REACH receives both state and local funding for housing, through a state-funded AB 2034 grant and San Diego Housing Authority project-based housing subsidies. Services funds come through Medicaid reimbursement and state-funded AB 2034 funding.

Forty-two percent of the total program funding for Pathways to Housing comes through the New York State Office of Mental Health, which includes state-funded project-based Section 8 subsidies and state-funded ACT team service dollars, as well as federally-funded Projects for Assistance in Transition from Homelessness (PATH) grants and Shelter Plus Care. Certain ACT teams receive funding under special agreements or grants. The New York State Office of Mental Health subsidizes the Brooklyn ACT team, which is participating in a research study on ACT teams. The Westchester County Department of Social Services provides more than 10 percent of program funding for staff salaries and rental subsidies for the Westchester County ACT team. Sixteen percent of program funding for both housing and services comes from two HUD supportive housing grants for Project Release and the Center for Alternative Sentencing and

⁵⁰ P. Robbins and J. Monahan, Housing Leverage Pilot Study by the John D. and Catherine T. MacArthur Foundation on Mandated Community Treatment.

Employment Services (CASES) jail diversion program.⁵¹ Remaining program funding comes through the New York City Department of Mental Health and private donations.

All three Housing First programs reported that certification for Medicaid reimbursement is essential for program funding. Pathways to Housing became certified, most recently in 2003. REACH receives both state and local funding for Medicaid billable program and services, through the state-funded AB 2034 grant. DESC's clinical treatment programs are certified. The community case managers are Medicaid billable, but the housing case managers are not part of the clinical program and therefore are generally not Medicaid billable.

The scope of work for this study did not call for an analysis of program costs, but each of the three program sites offered a rough estimate of the annual per client cost of housing and services. The costs of services reported seemed low and not comparable. In addition, staff report that keeping people stably housed keeps them out of jails and hospitals and recent studies have found this to be generally the case (Gulcur et al., 2003; Davis, Johnson, and Mayberg, 2003). Therefore, the costs of Housing First programs may be offset by preventing the use of other more costly community resources, but these offsetting savings were not reflected in the cost estimates provided. Future research that would collect and analyze program costs and offsetting savings would be valuable to assess the replicability of these programs.

CONCLUSIONS

The three Housing First programs share a commitment to serving homeless individuals who are seriously mentally ill and have co-occurring substance-related disorders. They also share a commitment to placing people in permanent housing and do not have service participation or sobriety requirements. The service approaches emphasize helping clients remain stably housed.

Key differences among the programs are the type of housing offered (including the use of transitional placements) and the structure for delivering services. The dispersed housing and neighborhood-based ACT teams at Pathways to Housing offer consumer choice and intensive services, but require a large network of landlords and support from the highly skilled professionals that comprise the ACT team.

The DESC model, where the primary service provider also owns or controls the housing and provides a high level of supervision, offers considerable latitude to respond to the challenges of housing this population, but it minimizes community integration and limits client choice in housing.

The REACH model poses certain challenges—the service provider does not own or control any of the housing, case managers have sizeable caseloads, and the program is geographically dispersed. However, REACH has the advantages of flexible state funding and Medicaid billable services that allow the program to provide housing assistance, as well as community-based client support.

⁵¹ The housing and services provided through this program are for clients being considered on a case-by-case basis without a plan other than to be discharged into homelessness.

The following chapters review findings from client-level data collection at each of the three Housing First programs. These findings address: (1) client characteristics, (2) housing tenure, and (3) outcomes related to mental illness, substance use, and money management for a sample of clients during their first year in the Housing First programs.

CHAPTER 4: CHARACTERISTICS OF HOUSING FIRST CLIENTS

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, and typically are resistant to entering housing. As one program staff member said, "We are looking for the people who are *not* looking for us." This chapter describes the study sample's demographics as well as levels of impairment related to mental illness and substance abuse at the time of enrollment in the Housing First programs.

Case managers at the Housing First program collected information on clients' baseline characteristics and status. Demographic and client background information (e.g., family status, criminal history, and employment experience) were based on the case manager's knowledge of the client and administrative records. Clinical assessments of the client's mental health status and substance use were based on the case manager's professional judgment of each client's status at the time of entering the Housing First program.

The study sample included 25 clients at the Downtown Emergency Service Center (DESC), 26 clients at Pathways to Housing, and 29 clients at Reaching Out and Engaging to Achieve Consumer Health (REACH), for a total sample size of 80 clients.⁵² Study clients enrolled in the three Housing First programs between June 2003 and August 2004, with two-thirds entering between December 2003 and May 2004.⁵³ The chapter begins with a discussion of baseline characteristics by Housing First program, and then follows with a discussion of variations in baseline characteristics based on clients' living situations prior to enrolling in the Housing First program.

BASELINE DIFFERENCES BY HOUSING FIRST PROGRAM

The following sections address client characteristics at enrollment, client background, income and benefits, psychiatric diagnoses and symptoms, substance abuse and treatment, and clients' living situations prior to entering the Housing First program. Differences among the three Housing First programs in each of these areas are highlighted. In addition, some contextual

⁵² The exhibits in this chapter provide both numbers (N) and percentages (%) of clients. While discussions are based on percentages as informative groupings, the N's are relatively small. Any generalizations to the Housing First program as a whole should be made with caution. DESC confirmed the sample is generally similar to its overall client population with the following exceptions: the agency's overall population has a lower rate of previous incarceration (21% for the program compared to 40% for the sample); a lower incidence of co-occurring disorders (41% for the program compared to 68% for the sample); and a lower rate of substance abuse history (66% for the program compared to 84% for the sample). Pathways to Housing confirmed that the sample is representative of the larger program with the following exception: 42% of the sample entered the program from psychiatric hospitals, which reflects the addition of funding from psychiatric hospitals to provide housing to homeless patients upon discharge. REACH confirmed that the sample is representative of the larger program with the following exceptions: (25% of program compared to 17% of sample) and nonHispanic clients (95% of program compared to 93% of sample); and clients of the program are more likely to be employed than those in the sample (16% of program compared to 3% of sample).

employed than those in the sample (16% of program compared to 3% of sample). ⁵³ Although clients included in the study sample entered the Housing First programs as early as June 2003, the programs reported baseline data in June and July of 2004. Much of the baseline data was collected retrospectively.
information is provided by comparing several of the study's demographic findings with those obtained in the National Survey of Homeless Assistance Providers and Clients (NSHAPC). This survey, conducted in 1996, collected information from providers and clients across the country (Burt et al., 2001).

Client Characteristics at Enrollment

The typical client at the Housing First programs was a white male between the ages of 36 and 50 years. More than three-fourths of the clients in the sample were males. REACH had more female clients than the other programs—34 percent (n = 10), compared to 16 percent (n = 4) at DESC and 15 percent (n = 4) at Pathways to Housing. REACH also had more veterans than the other programs. (See exhibit 4–1.)

Client Characteristics	DESC (N = 25)		Pathways to Housing (N = 26)		RE <i>I</i> (N =		Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%
Gender: female	4	16%	4	15%	10	34%	18	23%
Client had children younger than 18 years	6	24%	2	8%	7	24%	15	19%
Veteran	2	8%	1	4%	5	17%	8	10%

Exhibit 4–1. Client Characteristics at Enrollment, by Program

Data source: Baseline Data Collection Instrument

Pathways to Housing had the oldest clientele—54 percent (n = 14) of its clients were 51 years or older. Not surprisingly, the clients at Pathways to Housing were also least likely to have children under the age of 18 years. REACH served the youngest population, as more than one-third (n = 10) of its clients were age 35 years or younger at enrollment. (See exhibit 4–2).

A comparison of findings related to age from the NSHAPC indicate that a larger percentage of the clients served by the Housing First programs in this study are older than the population of all currently homeless clients represented in the NSHAPC survey.⁵⁴

⁵⁴ The age categories used by the NSHAPC were different than those presented in exhibit 4–2. The study team conducted an additional analysis using the same age categories for the Housing First clients as those included in the NSHAPC. Clients included in the NSHAPC were in the following categories: 37 percent were age 34 years or younger, 55 percent were age 35–54 years, and 8 percent were age 55 years and older. For the present study, the percentages within the same age categories were 24 percent, 53 percent, and 24 percent.



Exhibit 4–2. Client Age at Enrollment, by Program⁵⁵ (N = 25 for DESC, N = 26 for Pathways to Housing, N = 29 for REACH)

Pathways to Housing had the highest percentage of clients who were members of minority groups—one-half (n = 13) were black and about one-fifth (n = 5) were Hispanic. At DESC, one-fifth (n = 5) of the clients were black and 4 percent (n = 1) were Hispanic. At REACH, 17 percent (n = 5) of the clients were black and 7 percent (n = 2) were Hispanic. More than one-half of clients were white at both DESC (n = 16) and REACH (n = 16). At these programs, clients of an "other" race who were non-Hispanic were Asian, Hawaiian, and Native American. (See exhibit 4–3.)





⁵⁵ Note that only three clients are older than 62 years, one at DESC and two at Pathways to Housing.

Client Background

In addition to homelessness, the clients enrolled in this study faced challenges including low levels of educational attainment, limited work histories, criminal records, and health problems. Across the programs, 39 percent (n = 31) of clients did not receive a high school diploma. This finding is comparable to that of the NSHAPC—38 percent of the population of service-using homeless people had received less than a high school diploma (Burt et al., 2001). Clients enrolled in Pathways to Housing had the lowest educational attainment among the programs— only one client continued his education past high school, and more than 60 percent (n = 16) of clients did not graduate from high school or receive their GED. (See exhibit 4–4.)

Across the three programs, about one-third of clients did not have a history of employment. Pathways to Housing clients were far less likely to have ever been employed than clients of the other programs—85 percent (n = 22) of Pathways to Housing clients had no employment history.

REACH clients were far less likely than clients at the other Housing First programs to have a chronic medical condition such as diabetes, heart disease, asthma, or a mobility impairment. This may be due to the fact that REACH serves a relatively younger clientele. Across the sample, only six clients were HIV-positive or had AIDS and related diseases—five clients at DESC (where one of the buildings serves primarily people with AIDS) and one client at Pathways to Housing.





Clients at DESC and REACH had similar incidences of previous arrests and incarcerations, while many fewer clients at Pathways to Housing had been arrested or incarcerated. A small proportion of clients were on probation or parole at the time of enrollment: 8 percent at Pathways to Housing; 12 percent at DESC; and 21 percent at REACH. (See exhibit 4–5.)



Exhibit 4–5. Client History of Arrest and Incarceration, by Program (N = 25 for DESC, N = 26 for Pathways to Housing, N = 29 for REACH)

The demographic and background characteristics of Pathways to Housing clients suggest a frequently institutionalized population. These clients are older, have less education and employment experience, and a lower incidence of prior arrest or incarceration. In fact, eleven (42 percent) of the Pathways to Housing clients came from institutions; however nine of these individuals were described by their case managers as being chronically homeless prior to hospitalization. (See exhibit 4-14.)

Income and Benefits

Most of the clients in the study had some income at baseline. Two-thirds (n = 54) of clients had gross monthly incomes greater than \$500 at enrollment, while 15 percent (n = 12) had no income at that time. Clients at REACH had the highest income at enrollment—55 percent (n = 16) of REACH clients made more than \$750 per month. (See exhibit 4–6.)



Exhibit 4–6. Client Monthly Income at Baseline, by Program (N = 25 for DESC, N = 26 for Pathways to Housing, N = 29 for REACH)

The incidence of clients' receipt of income and benefits from federal and state programs indicates some engagement with institutional support systems by the majority of clients at enrollment.⁵⁶ Across the sample, 45 percent (n = 36) of clients received Supplemental Security Income (SSI) at enrollment and 23 percent (n = 18) received Social Security Disability Income (SSDI).⁵⁷ Only one client was reported as having earned income at enrollment. However, the differences between categories of income are so narrow that it is impossible to draw any significant conclusions.

In terms of non-income benefits, 35 percent (n = 28) of clients received subsidized health insurance at enrollment, including Medicaid, Medicare, and veterans' health insurance—twice as many DESC clients received this benefit compared to clients at Pathways to Housing and REACH. About one-half (n = 12) of DESC clients were receiving food stamps at the time of enrollment, but this was less common at Pathways to Housing and REACH. DESC has an agreement with the state of Washington to expedite SSI eligibility determinations for its clients—DESC's outreach mental health program can submit applications on behalf of clients with state-approved assessment and diagnostic information. (See exhibit 4–7.)

Exhibit 4 7. Sources of income and benefits at Embinient, by 110gram												
		SC		to Housing		ACH	Total					
Sources of Income	(N = 25)		(N =	= 26)	(N =	= 29)	(N = 80)					
	Ν	%	Ν	%	Ν	%	Ν	%				
Income sources												
SSI	13	52%	10	38%	13	45%	36	45%				
SSDI	8	32%	2	8%	8	28%	18	23%				
Other	6	24%	0	0%	4	14%	10	13%				
Benefits sources												
Subsidized health insurance	14	56%	7	27%	7	24%	28	35%				
Food stamps	12	48%	1	4%	2	7%	15	19%				
Unsubsidized health insurance	0	0%	0	0%	5	17%	5	6%				

Data source: Baseline Data Collection Instrument

Notes: Other sources of income included welfare income, veterans' income, employment income, and income from a family member and lawsuit settlement. Subsidized health insurance included Medicaid, Medicare, and veterans' health insurance. Income and benefits sources are not mutually exclusive.

⁵⁶ At the conclusion of the 12-month data collection period, the study team requested that one of the programs provide revised data on total monthly income at baseline, month 1, and month 12. The study team did not request revised data for the sources of income and other benefits. The gross baseline income may not be correlated with the sources of income and benefits for all clients at this particular Housing First program; however, the sources of income and benefits reported by the programs at baseline provide an indication of the level of support that clients receive from federal sources and other entitlements.

⁵⁷ SSI is needs-based assistance for individuals with low or no income who are blind or disabled. SSDI is assistance for disabled workers. It is possible to receive SSI and SSDI simultaneously; however, SSI only pays the difference between the income one receives (including SSDI) and the benefit one is entitled to receive. Six clients in the study sample received both SSI and SSDI at baseline.

Psychiatric Diagnoses, Symptoms, and Impairment

Consistent with the Housing First priority of serving people with a serious mental illness, the majority of clients tracked for this study had a psychiatric diagnosis and experienced impairment related to psychiatric symptoms at the time they entered program housing. Across the sample, 91 percent (n = 73) of clients had an axis I diagnosis (five clients at DESC and two clients at Pathways to Housing did not have a diagnosis).⁵⁸ Of these, 65 percent (n = 52) had a diagnosis of schizophrenia or other psychotic disorders, with the highest incidence at Pathways to Housing (n = 22, 85 percent). Mood disorders were more common at REACH than at the other two sites.⁵⁹ In addition, DESC reported three clients with an axis I diagnosis other than schizophrenia and mood disorders, including oppositional defiant disorder and personality disorder. (See exhibit 4–8.)



Exhibit 4–8. Types of Axis I Diagnoses at Enrollment, by Program (N = 25 for DESC, N = 26 for Pathways to Housing, N = 29 for REACH)

The extent to which clients had received treatment for their conditions varied across programs. Nearly all Pathways to Housing clients with schizophrenia had been hospitalized in the past, reflecting the high percentage of clients who came to Pathways to Housing from a psychiatric hospital. DESC and REACH clients with schizophrenia were far less likely to have received past treatment for psychiatric problems. Across the sample, 78 percent (n = 62) of clients were taking psychiatric medications at the time of enrollment, with Pathways to Housing clients the most likely to be taking medications. While all REACH clients had an axis I diagnosis, only 79 percent (n = 23) were taking psychiatric medications at enrollment.

⁵⁸ The Diagnostic and Statistical Manual (DSM) of Mental Disorders, published by the American Psychiatric Association, describes the diagnostic categories of mental disorders and a multiaxial assessment that includes five axes. Axis I includes clinical disorders and other conditions that may be a focus of clinical attention—schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and other conditions. Axis II diagnoses include personality disorders and mental retardation. Axis III diagnoses include general medical conditions. Axis IV diagnoses include psychological and environmental problems. Axis V is a scale to measure global functioning.

⁵⁹ Mood disorders include depressive disorders, bipolar disorders (characterized by depressive and manic episodes), and substance-induced mood disorders. Schizophrenia and other psychotic disorders include delusions or hallucinations. Studies have found that homeless clients with mood disorders, rather than schizophrenia, have a higher success rate in housing (Lipton et al., 2000; Tsemberis and Eisenberg, 2000).

The majority of DESC and Pathways to Housing clients and all REACH clients experienced psychiatric symptoms at enrollment. Approximately one-half (n = 4) of the Pathways to Housing clients who did not experience any impairment related to psychiatric symptoms at enrollment entered the program directly from a psychiatric hospital. More than one-half (n = 16) of REACH clients were severely impaired by psychiatric symptoms.⁶⁰ (See exhibit 4–9.)

Psychiatric Symptoms and Impairments	DESC (N = 25)			to Housing 26)		ACH ⊧ 29)	Total (N = 80)		
and impairments	Ν	%	Ν	%	Ν	%	Ν	%	
Currently taking psychiatric medication	17	68%	22	85%	23	79%	62	78%	
Psychiatric symptoms	19	76%	18	69%	29	100%	66	83%	
Level of impairment related	to psychiatric	c symptoms							
None	6	24%	10	38%	0	0%	16	20%	
Moderate	13	52%	12	46%	13	45%	38	48%	
Severe	6	24%	4	15%	16	55%	26	33%	

Exhibit 4–9. Psychiatric Symptoms and Impairments at Enrollment, by Program

Data source: Baseline Data Collection Instrument

Notes: The "none" category under "level of impairment" includes clients with no psychiatric symptoms and clients with psychiatric symptoms, but no impairment. Pathways to Housing had two clients at baseline with psychiatric symptoms, but no impairment from those symptoms.

Substance Abuse, Treatment, and Impairment

Case managers at the Housing First programs reported information regarding their clients' history of substance abuse prior to enrollment (exhibits 4-10 and 4-11), as well as current substance abuse at the time of enrollment (exhibit 4-12). This section first discusses findings on the history of substance abuse, followed by substance abuse at the time of enrollment.

The majority (n = 60, 75 percent) of clients had a history of abusing alcohol or drugs prior to enrollment. Forty-five percent (n = 36) of clients across the Housing First programs had a history of abusing both drugs and alcohol, while about one-fifth (n = 15) abused alcohol only and about one-tenth (n = 9) abused drugs only. A history of dual alcohol and drug abuse was most common at DESC (n = 14, 56 percent) and least common at REACH (n = 11, 38 percent) (See exhibit 4–10.)

⁶⁰ The data collection instruments collected two types of information regarding level of impairment related to mental illness and substance abuse. The first type was whether the client experienced symptoms related to mental illness (or substance abuse). The second type was the severity of symptoms, ranked on a three-point scale—none, moderate, and severe. Case managers that worked with the clients reported each type of information, based on professional judgment. See Appendix A for additional information about study methodology and the data collection instruments.



Exhibit 4–10. Type of Substance Abuse Prior to Enrollment Across Programs (N = 80)

Among the entire sample, 40 percent (n = 34) had been treated at some point for substance abuse. At Pathways to Housing, all clients with a history of substance abuse had been treated for it, while only 14 percent (n = 4) of REACH clients had received treatment. DESC reported 40 percent (n = 10) of clients received treatment. These differences could be partially explained by the finding that the sample of Pathways to Housing clients were older and more likely to have been previously institutionalized. (See exhibit 4–11.)



Exhibit 4–11. History of Substance Abuse and Treatment, by Program (N = 25 for DESC, N = 26 for Pathways to Housing, N = 29 for REACH)

At the time of enrollment, one-half (n = 40) of clients were using drugs or alcohol, as shown in exhibit 4–12. More than one-half of DESC (n = 14) and REACH (n = 16) clients were using alcohol or drugs at the time of enrollment, while fewer Pathways to Housing clients were doing so (n = 10, 38 percent). Compared to the common history of the dual abuse of alcohol and drugs (45 percent across the sites), far fewer were doing so at enrollment (13 percent). Of those using

substances at enrollment, 40 percent were severely impaired, with REACH clients being the most impaired. A possible explanation for the lower reported engagement in substance use could be that these data were collected at program enrollment, when the case manager has the least knowledge of the client's typical behavior or level of impairment. An additional explanation could be that many clients were leaving institutional settings; however, as discussed later in this chapter, more than one-half (n = 9) of those leaving institutional settings were using substances at enrollment.

Exhibit 4-12. Substance Use and impairment at Enrollment, by i rogram												
Substance Use and Impairments	DESC (N = 25)			to Housing 26)		ACH ⊧ 29)	Total (N = 80)					
impairments	Ν	%	Ν	%	Ν	%	Ν	%				
Client used substance(s) at enrollment	14	56%	10	38%	16	55%	40	50%				
Substances used (of those who used substances at enrollment)												
Alcohol only	5	20%	4	15%	7	24%	16	20%				
Drugs only	2	8%	5	19%	2	7%	9	11%				
Alcohol and drugs	7	28%	1	4%	7	24%	15	19%				
Impairment from substance	use (of those	e who used s	ubstances a	t enrollment								
None	4	16%	1	4%	0	0%	5	6%				
Moderate	4	16%	6	23%	8	28%	18	23%				
Severe	5	20%	3	12%	8	28%	16	20%				
Unknown	1	4%	0	0%	0	0%	1	1%				

Exhibit 4–12. Substance Use and Impairment at Enrollment, by Program

Data source: Baseline Data Collection Instrument

Notes: Impairment from substance use shows, for all clients with substance use at enrollment, the level of impairment caused by that use. If a client used both alcohol and drugs, the higher level of impairment is noted.

Co-Occurring Disorders

Clients in the sample selected for this study had a mental illness and often a co-occurring substance-related disorder. These co-occurring disorders were prevalent within each of the Housing First programs. Across all programs, 69 percent (n = 55) of clients had an axis I diagnosis as well as a history of substance abuse. Pathways to Housing had the greatest percentage of clients with co-occurring mental illness and substance abuse at 73 percent (n = 19). Clients who did not have co-occurring disorders most often had an axis I diagnosis only and no substance abuse history (n = 18, 23%). (See exhibit 4–13.)

Exhibit 4–13. Co-Occurring Disorders, by Hogram													
Disorders	DESC (N = 25)			to Housing 26)		ACH ⊧ 29)	Total (N = 80)						
	Ν	%	Ν	%	Ν	%	Ν	%					
Axis I diagnosis and substance abuse history	17	68%	19	73%	19	66%	55	69%					
Axis I diagnosis only	3	12%	5	19%	10	34%	18	23%					
Substance abuse history only	4	16%	1	4%	0	0%	5	6%					
No axis I diagnosis or substance abuse history	1	4%	1	4%	0	0%	2	3%					
Total	25	100%	26	100%	29	100%	80	100%					

Exhibit 4–13. Co-Occurring Disorders, by Program

Data source: Baseline Data Collection Instrument

Compared to the entire service-using population identified through the NSHAPC, the clients at the Housing First programs tracked for the present study were more likely to have a mental illness, a history of substance abuse, and co-occurring disorders. Sixty-nine percent (n = 55) of the clients at the Housing First programs had a co-occurring mental illness and history of substance abuse, compared to 29 percent of the clients in the NSHAPC. In addition, 3 percent of the clients at the Housing First programs did not have a mental illness or history of substance abuse while 27 percent of the clients in the NSHAPC did not have these problems (Burt et al., 2001). These findings point to a relatively more impaired population of homeless individuals being served by the Housing First programs.

Prior Living Situation

Housing First programs primarily target homeless mentally ill people who are living on the streets or in emergency shelters. Overall, 67 percent (n = 53) of the clients lived on the streets or in a shelter immediately prior to entering the Housing First program. The remainder entered the Housing First program from a variety of living situations. (See exhibit 4–14.)

Living Situation	DESC (N = 25)			to Housing 26)		ACH ⊧ 29)	Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%
Streets	9	36%	5	19%	17	59%	31	39%
Homeless shelter	14	56%	6	23%	2	7%	22	28%
Jail or prison	0	0%	1	4%	0	0%	1	1%
Psychiatric hospital	2	8%	11	42%	1	3%	14	18%
Other or unknown	0	0%	3	12%	9	31%	12	16%

Exhibit 4–14.	Client Living Situation	Immediately Prior to	Enrollment, by Program
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Data source: Baseline Data Collection Instrument

Note: The living situation immediately prior to enrollment was unknown for only two clients (both from Pathways to Housing).

Most REACH clients entered the program directly from the streets, while most DESC clients came directly from shelters. At Pathways to Housing, 42 percent (n = 11) of clients entered their scattered-site apartments directly from psychiatric hospitals as part of a special grant to serve people who would otherwise become homeless upon discharge. Many clients served by this grant enrolled in Pathways to Housing during the study enrollment period. Another 23 percent (n = 6) of Pathways to Housing clients came from homeless shelters. Living situations categorized as "other" were most common at REACH and included a crisis house, living with friends, a hotel, and medical treatment facilities.

Although case managers did not report detailed housing histories, they did document whether the study clients met the U.S. Department of Housing and Urban Development (HUD) criteria for being "chronically homeless."⁶¹ Eighty-eight percent (n = 70) of the study clients had met the criteria within the past 3 years, 11 percent (n = 9) did not meet the criteria, and this information

⁶¹ A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one year or more or has had at least four episodes of homelessness during the past three years. Because HUD defines homelessness as sleeping in a place not meant for human habitation or an emergency shelter, those coming into Housing First programs from a psychiatric hospital or jail had to have been previously homeless.

was unknown for one client at Pathways to Housing. Due to the large difference in sample sizes between clients who were chronically homeless and those who were not, one cannot claim that differences between these categories are statistically significant.

Suggestive findings regarding the differences between clients who were chronically homeless and those who were not include the following: Chronically homeless clients were slightly younger, more likely to have children, had less education, and minimal employment experience. They were also more likely to have a chronic medical condition, a psychiatric diagnosis, and a co-occurring disorder compared to those who were not chronically homeless. Finally, chronically homeless clients were most likely to enter the Housing First program directly from the streets and to have no income at enrollment. (See exhibit 4–15.)

Characteristics	Hom	nically eless : 70)	Hom	onically eless = 9)		otal ₌ 80)
	Ν	%	Ν	%	Ν	%
Age 35 years or younger	18	26%	1	11%	19	24%
Age 36–50 years	31	44%	3	33%	34	43%
Age 51 years or older	21	30%	5	56%	27	34%
Children less than 18 years	14	20%	1	11%	15	19%
Less than high school diploma	28	40%	3	33%	31	39%
Chronic medical condition	29	41%	3	33%	33	41%
Ever employed	41	59%	8	89%	49	61%
\$0 income at enrollment	12	17%	0	0%	12	15%
Axis I diagnosis	65	93%	7	78%	73	91%
Co-occurring disorder	50	71%	5	56%	55	69%
Prior living situation: Streets	30	43%	1	11%	31	39%
Prior living situation: Shelter	17	24%	5	56%	22	28%

Exhibit 4–15. Client Characteristics, by Chronic Homelessness Status

Data source: Baseline Data Collection Instrument

Notes: Due to comparison of categories with significantly different sample sizes, percentages are for illustrative purposes only. Chronic homelessness status was unknown for one client at Pathways to Housing. The total column includes all 80 clients in the sample.

BASELINE DIFFERENCES BY PRIOR LIVING SITUATION

As previously discussed, clients enrolled in the Housing First programs from a number of different living situations. To learn more about the characteristics of people who live in various housing situations prior to enrollment, the study team compared baseline demographics across prior living situations. The study team placed each of the clients participating in the study into one of four groups, based on their prior living situations:

- Streets (n = 31);
- Homeless shelters (n = 22);
- Psychiatric hospitals and jail (n = 15);⁶² and
- Other locations (n = 12).⁶³

This section highlights the key demographic differences among the three primary prior living situation categories—streets, homeless shelters, jails/psychiatric hospitals. One cannot be certain that the demographics tell a real story for the category of other locations because it contains a number of different living environments; therefore, these data will not be explored separately. The exhibits inserted throughout this section provide detailed summary data for client characteristics, psychiatric diagnoses and impairments, and substance abuse history.

Client Characteristics at Enrollment

Clients who entered the Housing First programs from homeless shelters were much less likely to be female—only 9 percent (n = 2) of clients from shelters were female, compared to more than 23 percent (n = 7) of clients from the streets and 27 percent (n = 4) of clients from psychiatric hospitals or jail.

The study sample included a substantial number of clients (primarily at Pathways to Housing) who resided in a psychiatric hospital or jail immediately prior to entering the Housing First program. These clients were generally older than clients from other prior living situations, as 47 percent (n = 7) of them were age 51 years or older. (See exhibit 4–16.)

Age	Streets (N = 31)		Shelters (N = 22)		Psychiatric Hospital/Jail (N = 15)		Other/Unknown (N = 12)		Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%	Ν	%
35 years or younger	7	23%	5	23%	3	20%	4	33%	19	24%
36–50 years	16	52%	9	41%	5	33%	4	33%	34	43%
51 years or older	8	26%	8	36%	7	47%	4	33%	27	34%
Total	31	100%	22	100%	15	100%	12	100%	80	100%

Exhibit 4–16. Client Age at Enrollment, by Prior Living Situation

Data source: Baseline Data Collection Instrument

Client Background

Clients from psychiatric hospitals or jail were the least educated (53 percent had less than a high school diploma) and had the least employment history, compared to those from the streets and shelters. Almost three-fourths (n = 11) of clients from psychiatric hospitals or jail had no employment history, while these proportions were less than one-third for clients from the streets (n = 8) and shelters (n = 7). Clients from the streets were most likely to have been previously incarcerated (n = 14, 45 percent), although they did not have the highest incidence of previous arrest. Clients from shelters had the highest rate of arrests at 68 percent (n = 15), compared to

⁶² One client entered the Housing First program from jail or prison. That client was included with the group of clients who came from psychiatric hospitals—both living situations were fixed, controlled, and institutional environments.

⁶³ Other locations included a crisis house, living with friends, a hotel, and medical treatment facilities.

52 percent (n = 16) for those from the streets and 20 percent (n = 3) for those from psychiatric hospitals or jail. (See exhibit 4-17.)

Client Background	Stre (N =			Iters 22)	Psychiatric Hospital/Jail (N = 15)				Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%	Ν	%
Less than a high school diploma	11	35%	10	45%	8	53%	2	17%	31	39%
No employment history	8	26%	7	32%	11	73%	3	25%	29	36%
Previously arrested	16	52%	15	68%	3	20%	10	83%	44	55%
Previously incarcerated	14	45%	6	27%	2	13%	7	58%	29	36%

Exhibit 4–17. Client Background at Enrollment, by Prior Living Situation

Data source: Baseline Data Collection Instrument

Note: Client background characteristics are not mutually exclusive.

Psychiatric Diagnoses, Symptoms, and Impairment

More than one-quarter (n = 6) of clients from shelters did not have an axis I diagnosis—the lowest of any group. This finding is related to the smaller number of diagnosed schizophrenics among these clients. All clients from psychiatric hospitals or jail had an axis I diagnosis and were overwhelmingly diagnosed with schizophrenia or other psychotic disorders (n = 13, 87 percent). (See exhibit 4–18.)

Diagnoses	Streets (N = 31)		Shelters (N = 22)		Psychiatric Hospital/Jail (N = 15)		Other/Unknown (N = 12)		Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%	Ν	%
Axis I diagnosis	30	97%	16	73%	15	100%	12	100%	73	91%
Schizophrenia or other psychotic disorders	20	65%	11	50%	13	87%	8	67%	52	65%
Mood disorders	7	23%	5	23%	2	13%	4	33%	18	23%
Other disorders	3	10%	0	0%	0	0%	0	0%	3	4%

Exhibit 4–18. Axis I Diagnoses at Enrollment, by Prior Living Situation

Data source: Baseline Data Collection Instrument

While there were no major differences in axis I diagnosis for clients who entered the Housing First programs from the streets or from other housing locations, levels of psychiatric impairment were different. Clients from the streets experienced the highest levels of impairment related to psychiatric symptoms. All but one client from the streets (n = 30, 97 percent) had psychiatric symptoms at baseline while 68 percent (n = 15) of clients from shelters and 73 percent (n = 11) of clients from psychiatric hospitals or jail experienced psychiatric symptoms at baseline.

Only 7 percent (n = 1) of clients from psychiatric hospitals or jail and 9 percent (n = 2) of clients from shelters experienced severe impairment due to psychiatric symptoms. The lack of severity of psychiatric impairment among this population is very likely related to their recent receipt of longer-term psychiatric treatment or better medication management; however, 55 percent (n = 17) of clients from the streets experienced severe impairment related to psychiatric symptoms. This high frequency of severe impairment may be related to a lack of consistent service provision while living on the streets. (See exhibit 4–19.)

			NJ		ing bitt	auton				
Psychiatric Symptoms		eets 31)	Shelters (N = 22)		Psychiatric Hospital/Jail (N = 15)			nknown = 12)		
and Impairment	Ν	%	N	%	Ν	%	N	%	Ν	%
Psychiatric symptoms	30	97%	15	68%	11	73%	10	83%	66	83%
Level of impairmer	nt									
None	1	3%	9	41%	4	27%	2	17%	16	20%
Moderate	13	42%	11	50%	10	67%	4	33%	38	48%
Severe	17	55%	2	9%	1	7%	6	50%	26	33%

Exhibit 4–19. Psychiatric Symptoms and Impairment at Enrollment, by Prior Living Situation

Data source: Baseline Data Collection Instrument

Substance Abuse, Treatment, and Impairment

While clients coming from the streets were the least likely to have reported a history of substance abuse, they were also least likely to have received treatment. Only 26 percent (n = 8) of clients from the streets received treatment, compared to 50 percent (n = 11) among those from shelters, and 67 percent (n = 10) of those from psychiatric hospitals or jail.⁶⁴ The subsample of clients from the streets experienced the largest gap between history of abuse and history of treatment, indicating a possible lack of service utilization among this group. Clients from psychiatric hospitals or jail had the highest recorded incidence of a substance abuse history at 80 percent (n = 12). (See exhibit 4–20.)

Exhibit 4–20. History of Substance Abuse and Treatment, by Prior Living Situation (N = 31 for streets, N = 22 for shelters, N = 15 for psychiatric hospital/jail)



⁶⁴ Exhibit 4–20 indicates the percentage of all clients in the study sample, by prior living situation, whose case managers reported that they previously received treatment for a substance-related disorder. The incidence of previous treatment among clients with a history of substance abuse was greater than the incidence for the entire sample. Thirty-eight percent of past substance abusers from the streets had a history of treatment, 65 percent of past substance abusers from shelters had a history of treatment, and 83 percent of past substance abusers from psychiatric hospitals had a history of treatment.

Although the history of substance abuse did not vary much across the categories of prior living situations, substance use at enrollment was least common (n = 7, 32 percent) among clients from shelters. Clients from shelters who used substances at enrollment most commonly used both drugs and alcohol. Clients from psychiatric hospitals or jail had the highest incidence of drug use at 40 percent (n = 6).

Clients from the streets were more likely than clients from other prior living situations to experience impairment from substance use—55 percent (n = 17) of clients from the streets experienced moderate to severe impairment from substance use at the time of enrollment. In addition, clients from psychiatric hospitals or jail were less likely than other clients to experience impairment related to substance use (n = 3, 20 percent). (See exhibit 4–21.)

		Dyll		ing bitu	anon					
Substance Use and Impairments	Streets (N = 31)			Shelters (N = 22)		Psychiatric Hospital/Jail (N = 15)		nknown ⊧ 12)	Total (N = 80)	
-	N	%	Ν	%	Ν	%	Ν	%	Ν	%
Substance use at enrollment	19	61%	7	32%	9	60%	5	42%	40	50%
Substances used (of those who	used substar	nces at en	rollment)							
Alcohol only	7	23%	2	9%	3	20%	4	33%	16	20%
Drugs only	3	10%	0	0%	6	40%	0	0%	9	11%
Alcohol and drugs	9	29%	5	23%	0	0%	1	8%	15	19%
Impairment from substance use	(of those who	o used sub	ostances a	t enrollme	ent)					
None	1	3%	1	5%	3	20%	0	0%	5	6%
Moderate	10	32%	3	14%	4	27%	1	8%	18	23%
Severe	7	23%	3	14%	2	13%	4	33%	16	20%
Unknown	1	3%	0	0%	0	0%	0	0%	1	1%

Exhibit 4–21. Substance Abuse and Impairment at Enrollment, by Prior Living Situation

Data source: Baseline Data Collection Instrument

Notes: Impairment from substance use shows, for all clients with substance use at enrollment, the level of impairment caused by that use. If a client used both alcohol and drugs, the higher level of impairment is noted.

Co-Occurring Disorders

Clients who entered the Housing First program from a psychiatric hospital or jail (n = 12, 80 percent) or some other or unknown location (n = 10, 83 percent) most frequently had a cooccurring psychiatric diagnosis and substance abuse history. Clients from the streets were more likely to have an axis I diagnosis only (n = 10, 32 percent), while clients from shelters were more likely to have a substance abuse history but no axis I diagnosis (n = 4, 18 percent). (See exhibit 4-22.)

Co-Occurring Disorders		Streets (N = 31)		Shelters (N = 22)		Psychiatric Hospital/Jail (N = 15)		Other/Unknown (N = 12)		otal = 80)
	Ν	%	Ν	%	Ν	%	Ν	%	Ν	%
Clients with axis I diagnosis and substance abuse history	20	65%	13	59%	12	80%	10	83%	55	69%
Axis I diagnosis only	10	32%	3	14%	3	20%	2	17%	18	23%
Substance abuse history only	1	3%	4	18%	0	0%	0	0%	5	6%
No axis I diagnosis or substance abuse history	0	0%	2	9%	0	0%	0	0%	2	3%
Total	31	100%	22	100%	15	100%	12	100%	80	100%

Exhibit 4–22. Co-Occurring Disorders, by Prior Living Situation

Data source: Baseline Data Collection Instrument

SUMMARY OF BASELINE CHARACTERISTICS OF STUDY CLIENTS

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.

Clients who entered the Housing First program from different prior living situations often demonstrated different service needs. Those entering the program directly from the streets were more likely to have criminal records and more severe levels of psychiatric and substance-related impairment. Clients from shelters also had a high frequency of criminal records, but were less likely to be currently using drugs or alcohol. These clients were also less likely to have an axis I diagnosis, possibly indicating a lack of psychiatric assessment rather than the absence of psychiatric problems. Finally, those who entered the Housing First program from a psychiatric hospital or jail were typically older, had little education, no employment history, and experienced a moderate level of psychiatric impairment, presenting unique challenges to increase levels of self-sufficiency.

The demographic findings in this study point to a hard-to-serve population of homeless individuals with histories complicated by substance abuse and criminal activity. This population as whole is at a disadvantage regarding the tools and experiences needed to increase their levels of self-sufficiency, further complicated by current levels of impairment.

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CHAPTER 5: 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. Case managers at the Downtown Emergency Service Center (DESC), Pathways to Housing, and Reaching Out and Engaging to Achieve Consumer Health (REACH) work with clients to build skills to maintain their housing, address behavioral or substance abuse issues that may put their housing at risk, and work with clients to transition into new housing if problems arise. 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 at least one year following program entry. Among the 80 clients followed in this study 43 percent (n = 34) of the clients remained in the Housing First program for a year and stayed in their housing unit for the entire time; 41 percent (n = 33) remained in the program for a year and spent at least one night in some other temporary living environment; and the remaining 16 percent (n = 13) of the clients left the program or died within the first 12 months of enrollment.

This chapter will describe housing tenure—including housing stability, change in housing unit, and housing problems—for stayers (clients who remained in the Housing First program for 12 months without any time in temporary living environments), intermittent stayers (clients who remained in the Housing First program for 12 months, but spent some time in at least one temporary living environment), and leavers (clients who permanently left the program before 12 months). The chapter begins by describing stayers, intermittent stayers, and leavers and then compares them among a number of characteristics.

STAYERS, INTERMITTENT STAYERS, AND LEAVERS

An important feature of the Housing First approach is that housing is presumed to be permanent. Some clients do leave their housing for periods of time, but all three programs selected for this study try to reserve housing for clients who are expected to return. In most cases, the housing unit can be held for up to 90 days. If the client returns after 90 days, the client may not be able to return to the same unit, but the Housing First program will often give that client priority for an available unit. Case managers try to maintain contact with the client during these absences, wherever the client is staying.

Case managers at the Housing First programs reported, on a monthly basis, whether each client enrolled in the study spent any time in another living environment during the previous month and, if so, where and for how long the client was away from program housing. Locations where

clients temporarily lived included prison or jail, the streets, a homeless shelter, psychiatric or medical hospitals, inpatient substance abuse treatment programs, and other locations.⁶⁵ Case managers also reported when a client permanently left the program.

Level of Housing Stability

Because housing tenure and stability are key outcomes for Housing First clients, the study team grouped the sample of 80 clients into three categories based on level of housing stability.

- Stayers—Clients characterized as stayers remained in the Housing First program for a full 12 months and did not experience any temporary program departures to other living environments during that time. Stayers accounted for 43 percent (n = 34) of the study sample.
- Intermittent Stayers—Clients characterized as intermittent stayers were enrolled in the Housing First program for a full 12 months, but did experience at least one temporary program departure to another living environment during that time.⁶⁶ The study team did not consider these absences formal departures. Staff continued to contact clients to encourage them to return to program housing. This continued followup helped clients maintain some level of service engagement despite some instability in their housing situation. It is advisable to consider these episodic departures as part of a stabilizing strategy for program clients. Intermittent stayers accounted for 41 percent (n = 33) of the study sample.
- Leavers—Clients characterized as leavers were disenrolled from the Housing First program within the first 12 months of tenure. Disenrolled means that the client no longer lives in program housing, is no longer in contact with case management or other program staff, and is not expected to return. Although leavers left the program permanently, more than three-quarters (n = 10) of leavers had also experienced at least one temporary program departure to another living environment during their tenure in the program. Leavers accounted for 16 percent (n = 13) of the study sample.

Exhibit 5–1 shows the distribution of housing stability across Housing First programs in this study. REACH and DESC reported larger numbers of clients who spent some time away from their program housing compared to Pathways to Housing. Forty percent (n = 10) of DESC clients and 52 percent (n = 15) of REACH clients spent at least one night in a living environment other than program housing. In addition, DESC and REACH reported a higher percentage of leavers than Pathways to Housing with 20 percent (n = 5) at DESC and 21 percent (n = 6) at REACH.

⁶⁵ Temporary departures did not include vacations or visits to friends or family.

⁶⁶ For intermittent stayers, the total duration of temporary departures to another living environment was greater than one week, with the exception of three clients. For three clients, the total duration was less than three days. See exhibit 5–2 for duration in other living environments by level of housing stability.



Exhibit 5–1. Level of Housing Stability, by Program (N = 25 at DESC, N = 26 at Pathways to Housing, N = 29 at REACH)

Data indicated that Pathways to Housing clients had the greatest level of housing stability with 62 percent (n = 16) remaining in program housing for a full 12 months. Further, only 8 percent (n = 2) of its clients permanently left the program during the first 12 months. While these clients may in fact have had fewer temporary leaves, it is also possible that short-term absences were less likely to be known to Pathways to Housing staff. The data collected on service contacts indicate that Pathways to Housing clients have less frequent contact with program staff compared to the other sites—on average, Pathways to Housing had 8.8 contacts with each client during the first month of housing compared with 50.7 at DESC and 13.6 at REACH. (See Chapter 3.) It is possible that a client could leave a unit for a short period of time and Pathways to Housing staff might only learn of the absence if the client reported it.

Frequency and Duration in Other Living Environments

A second indicator of housing stability is the amount of time that clients spent in other living environments. Exhibit 5–2 indicates the number of clients who did not spend time in other living environments and the duration in other living environments for those who did. Stayers, by definition, spent no time in other living environments during the first 12 months. Despite their shorter tenure in the program, leavers spent more time than intermittent stayers in other living environments.

REACH clients spent the most time away from their housing—45 percent (n = 13) of REACH clients spent at least one month out of 12 in other living environments. Approximately 20 percent of clients at DESC (n = 5) and Pathways to Housing (n = 5) spent time in other living environments. Although temporary departures were numerous and some were lengthy, the absences did not seem to create a vacancy problem for the programs (or cause an inefficient use of program funds to cover vacancy losses). Program housing was only vacant for an average of

8 percent of available person-nights across all three programs.⁶⁷ The percentage ranged from 4 percent of person-nights at DESC to 6 percent at Pathways to Housing to 14 percent at REACH.

Duration in Other Living Environments	Stayers (N = 34)		Intermittent Stayers (N = 33)		Leavers (N = 13)		Total (N = 80)	
Environments	Ν	%	Ν	%	Ν	%	Ν	%
No time spent in other living environments	34	100%	0	0%	3	23%	37	46%
Less than 2 weeks	0	0%	7	21%	2	15%	9	11%
2 weeks to 1 month	0	0%	11	33%	1	8%	12	15%
1 to 3 months	0	0%	7	21%	2	15%	9	11%
3 months or longer	0	0%	8	24%	5	38%	13	16%
Total	34	100%	33	100%	13	100%	80	100%

Exhibit 5–2. Duration in Other Living Environments, by Level of Housing Stability

Data source: Monthly Data Collection Instrument

Note: The duration in other living environments for leavers does not include their final departure.

To analyze where clients stayed during temporary departures from the Housing First program, the study team looked at two variables: the frequency with which clients stayed in a particular living environment and the total number of nights that clients spent, in aggregate, at each of the living environments. Exhibit 5–3 lists the number of clients who stayed temporarily in each of the other living environments.

Exhibit 5–5. Frequency of	Other	Living i		ientes, by i		I IIUusi	ng Diai	miy
Other Living Environments		Stayers (N = 34)		nt Stayers = 33)		vers = 13)	Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%
Homeless			12	36%	4	31%	16	35%
Psychiatric hospital			11	33%	2	15%	13	28%
Substance abuse treatment or detox			6	18%	1	8%	7	15%
Medical hospital			8	24%	3	23%	11	24%
Jail or prison			6	18%	4	31%	10	22%
Other			5	15%	3	23%	8	17%

Exhibit 5–3. Frequency of Other Living Environments, by Level of Housing Stability

Data source: Monthly Data Collection Instrument

Average number of locations

Note: This table indicates the number of clients who spent at least one night in each of the other living environments and includes multiple responses. The shading of the stayers columns indicates that this category of clients did not experience any temporary program departures. Other living environments included skilled nursing facility and unknown locations. Frequency of other living environments for leavers does not include their final departure. The total percentages were calculated by dividing the total frequency by the number of intermittent stayers and leavers who had temporary program departures (n = 33 + 10 = 43).

1.5

1.3

1.4

⁶⁷ Total person-nights is the number of possible nights that a person could have stayed in a Housing First unit, multiplied by the number of units. For this particular analysis, the number of possible nights is 365 because the period during which these data were collected was 12 months; the number of units is the number of program stayers. For example, DESC had 20 stayers, so the number of person-nights at DESC was 7,300 (or 20*365). The percentage of unoccupied person-nights was determined by dividing the number of nights clients spent in other living environments by the total possible person-nights. For DESC, this is 4 percent (or 286/7300).

The average number of locations for intermittent stayers and leavers was similar at 1.5 and 1.3 locations each. Intermittent stayers were more likely than leavers to temporarily leave the program for a stay in a psychiatric hospital (n = 11, 33 percent), while leavers were more likely to have a temporary stay in jail or prison (n = 4, 31 percent). Overall, the most temporary departures were to homelessness. Some clients in the focus groups reported they had difficulty transitioning from sleeping on the streets to sleeping inside.

Across the Housing First programs, REACH clients who experienced temporary program departures lived in the greatest average number of other living environments at 1.6 compared to 1.3 at DESC and 1.1 of Pathways to Housing. DESC clients who experienced temporary program departures were most likely to stay in a medical hospital (n = 8, 50 percent). This is partially explained by the fact that four of the study participants lived at the Lyon Building, which serves clients with HIV/AIDS. Of the small number of temporary departures reported for Pathways to Housing clients, several entered psychiatric hospitals (n = 4, 36 percent). This may be explained partially by the prevalence of Pathways to Housing clients who entered the program immediately following a stay in a psychiatric hospital.

Temporary departures for REACH clients were most often to homelessness (n = 13, 62 percent), a choice made less threatening by the temperate climate in San Diego. Several REACH focus group participants also noted dissatisfaction with the quality and safety of their housing. Several of these comments came from residents of one of the single room occupancy (SRO) hotels that (at the time) housed a large number of REACH clients.⁶⁸ One resident stated that she would rather live outdoors than in her SRO unit. Residents of this SRO may be more likely to leave for periods of time.

Case managers also provided information about the duration of clients' temporary departures. Exhibit 5–4 lists the cumulative number of nights that clients at each program spent in other living environments. On average, leavers spent 79 nights in other living environments, while intermittent stayers spent 61 nights. Overall, clients spent most nights homeless—followed by stays in psychiatric hospitals—during temporary program departures. Despite the fact that they had shorter overall stays in the programs, leavers still spent the largest amount of time in other living environments, which included whereabouts unknown.

The 70 clients who were identified as chronically homeless spent the greatest average number of nights in another living environment—37 nights compared with 21 nights for those who were not chronically homeless.⁶⁹

⁶⁸ Program staff have since decided to reduce the number of REACH clients housed at this SRO.

⁶⁹ Chronic homelessness is defined as continuously homeless for one year or more prior to entering the program or had at least four episodes of homelessness during the previous 3 years.

	Stayers	Intermittent	Leavers	Total I	Vights
Other Living Environments	(N = 34)	Stayers (N = 33)	(N = 13)	Ν	%
Homeless		1,049	216	1,265	45%
Psychiatric hospital		361	75	436	16%
Substance abuse treatment or detox		115	5	120	4%
Medical hospital		134	72	206	7%
Jail or prison		251	120	371	13%
Other or unknown		89	302	391	14%
Total nights clients spent in other living environments		1,999	790	2,789	100%
Average nights clients spent in other living environments		61	79	6	5

Exhibit 5–4. Nights Spent in Other Living Environments, by Level of Housing Stability

Data source: Monthly Data Collection Instrument

Note: The shading of the stayers columns indicates that this category of clients did not experience any temporary program departures. Other living environments included skilled nursing facility and unknown locations. The average number of nights for leavers was calculated by dividing the total nights for leavers by the number of leavers who had temporary program departures (n = 10). The average number of total nights was calculated by dividing the total nights was calculated by dividing the total nights stayers and leavers who had temporary program departures (n = 33 + 10 = 43). Duration in other living environments for leavers does not include their final departure.

Movement within the Housing First Program

Most of the housing units offered at the three Housing First programs are considered permanent and there are no limits on length of stay. The exceptions are the safe havens at DESC, where clients are expected to move to other permanent supportive housing within 24 months, and REACH, where clients are expected to move within 18 months.⁷⁰ Other permanent housing options such as SRO units or scattered-site apartments are available to these clients when they move from safe havens.

In addition to moves from safe havens to other permanent supportive housing, clients may move to a different program unit for other reasons, such as dissatisfaction with current housing, a preference for living in a particular neighborhood, a perception that other housing is more independent or of higher quality, or problems with neighbors or a landlord. Intermittent stayers were by far the most likely to change their Housing First unit. Almost 50 percent of these clients (n = 16) moved from one Housing First unit to another at least once during the first 12 months of their housing tenure. Among the stayers, only 18 percent (n = 6) changed units, while 31 percent (n = 4) of leavers changed units prior to disenrolling from the Housing First program. (See exhibit 5–5.)

⁷⁰ Out of a total of 29 REACH clients who participated in this study, 31 percent (n = 9) stayed in the safe haven for a range of five nights to up to 12 months, with the majority (n = 6) of clients staying less than 3 months. At DESC, five out of the 25 study participants stayed at the safe haven for an average length of stay of 10.2 months.

Exhibit 5–5. Movement within the Housing First Program during First Year of Residence, by Level of Housing Stability



(N = 34 for stayers, N = 33 for intermittent stayers, N = 13 for leavers)

At the site level, few clients from DESC or Pathways to Housing moved from one program unit to another during the first 12 months in the Housing First program, and none moved more than once. One DESC client moved from an SRO to the safe haven following a period of inpatient treatment.⁷¹ Four Pathways to Housing clients moved from one program unit to another: the first client lost her initial apartment due to behaviors associated with alcohol use; the second client moved due to problems with the condition of her building; the third client requested to move to another borough in New York City; and the fourth client moved from a short stay at a hotel, while looking for housing to a permanent, scattered-site apartment.

By contrast, REACH clients moved more frequently. Some 76 percent (n = 22) of REACH clients relocated within 12 months, and the average number of moves was almost two. Some of these moves reflect positive movement to more independent housing (e.g., from the safe haven to an SRO or from an SRO to a scattered-site apartment). During the 12-month period, eight REACH clients changed housing units under what could be characterized as positive circumstances. For example, six clients moved from the safe haven to another program unit within the first three months of housing. Other moves, however, were related to housing problems at one location that resulted in the client moving before a threatened eviction. At least six clients moved under such negative circumstances. In the most extreme case, one client moved eight times during the tracking period—in each case, this client was asked to leave due to his disruptive behavior. Case managers reported that two REACH clients were moved to different housing as a result of disruptive behavior related to drug or alcohol use.

It is important to note that the REACH program is by far the youngest of the three sites selected for this study, and could be characterized as still undergoing development. REACH clients experienced the highest level of movement within and out of the program, and REACH is still

⁷¹ Program staff described this as an unusual case. More commonly, clients move from the safe haven to an SRO. Among the five clients tracked for this study who initially moved into DESC's safe haven, none moved to another program unit within 12 months.

working to develop its housing component. This work includes increasing the availability of housing options as well as clients' choice among these options.

Housing Problems

Given the history of homelessness and level of impairment from mental illness and substance use among the clients tracked for this study, the study team anticipated reports 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 were reported most frequently for intermittent stayers, and these problems were typically related to behavioral issues that included poor hygiene or clients' disruptive responses to hallucinations related to their mental illness. Problems for leavers and stayers were most often classified as other and included drug dealing, other criminal activity, medication noncompliance, failure to pay rent, and breaking other rules of the residence. (See exhibit 5–6.)

Housing Problems		Stayers (N = 34)		Intermittent Stayers (N = 33)		vers = 13)	Total (N = 80)	
	Ν	%	N	%	Ν	%	Ν	%
Property damage, failure to upkeep apartment	14	20%	9	5%	2	4%	25	8%
Drug or alcohol-related problem behavior	1	1%	17	9%	9	17%	27	9%
Alcohol or drug use	13	19%	38	20%	11	21%	62	20%
Abusive to staff, visitors, residents, neighbors	1	1%	20	11%	3	6%	24	8%
Other behavioral issues	18	26%	52	28%	10	19%	80	26%
Other problems	22	32%	51	27%	18	34%	91	29%
Total	69	100%	187	100%	53	100%	309	100%

Exhibit 5–6. Frequency of Housing Problems, by Level of Housing Stability

Data source: Monthly Data Collection Instrument

Note: Other problems include drug dealing, other criminal activity, medication noncompliance, failure to pay rent, and breaking other rules of the residence. Frequency of housing problems include multiple responses—some reported problems are counted more than once due to the categorization of problems.

At the site level, DESC had the highest average number of housing problems reported per client. However, with an average of 11 housing problems reported per client over one year, DESC staff reported fewer than one problem per client per month. Because DESC has the most intensive staffing of the three programs—and program staff are always present—it might be expected to have the highest rate of reported problems as staff have the greatest opportunity to observe problematic behavior.

While 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, there were 62 incidences of problem behavior linked to alcohol or drug use, 80 incidences of other behavioral issues, 24 incidences of abusive behavior toward others, and 25 incidences of property damage or failure of clients to upkeep their apartments.

Clearly, to keep clients stably housed and to maintain relationships with landlords, staff at REACH and Pathways to Housing in particular must have strategies to identify and respond to housing problems that may be severe. Strategies include frequent contact with clients, especially

in the first months after they move into their housing. Program staff also encourage landlords to contact the program if there are any concerns about a client's behavior or well-being.

DEMOGRAPHICS AND BASELINE CHARACTERISTICS

To explore factors that influence staying and leaving the programs, the study team explored client demographics, income and sources of benefits, prior living situations, co-occurring disorders, and baseline levels of impairment related to mental illness and substance use. Case managers at the Housing First programs reported this information for each client at baseline. Assessments of levels of impairment were based on the case managers' knowledge of the client and professional judgment. Although the small sample sizes (particularly for leavers) preclude drawing firm conclusions about predictors of housing stability, some patterns emerge between client characteristics and housing tenure outcomes.

Demographics

The demographic characteristics of the clients in the study sample revealed some differences among clients based on their level of housing stability during the first 12 months in the Housing First program. Women were more likely to experience temporary departures from program housing (n = 11, 33 percent) than to stay in housing every night or leave the program permanently. Intermittent stayers were also slightly younger and more likely than other clients to have children younger than 18 years (n = 9, 27 percent). More than one-half of stayers (n = 17) and intermittent stayers (n = 19) were white. There was a higher proportion of black clients among leavers (n = 5, 38 percent) than the other groups. (See exhibit 5–7.)

The majority of leavers had less than a high school diploma (n = 8, 62 percent) although they were more likely than stayers to have some employment history. Almost one-half of stayers (n = 16, 47%) did not have any history of employment. The most distinct similarity between intermittent stayers and leavers was their history of arrest and incarceration. This history was much more prevalent among these two groups than for stayers. Seventy percent (n = 23) of intermittent stayers and 62 percent (n = 8) of leavers had previous arrests, compared to only 38 percent (n = 13) of stayers did. Intermittent stayers and leavers were twice as likely as stayers to have been previously incarcerated. These variables may have had some impact on the level of housing stability as it is often more difficult for people with a criminal history to secure housing and one's status as an ex-offender may indicate additional behavioral or legal problems.

Intermittent stayers were slightly more likely to have chronic medical conditions (n = 16, 48 percent), which could explain their temporary leaves from program housing to enter a medical or psychiatric treatment facility. Finally, the majority of all clients was chronically homeless, and all groups were almost equally likely to be chronically homeless.

Characteristics		yers 34)		Intermittent Stayers (N = 33)		Leavers (N = 13)		tal 80)
	Ν	%	Ν	%	Ν	%	Ν	%
Gender: female	7	21%	11	33%	0	0%	18	23%
Has children younger than 18 years	5	15%	9	27%	1	8%	15	19%
Less than high school diploma	11	32%	12	36%	8	62%	31	39%
No employment history	16	47%	9	27%	4	31%	29	36%
Previously arrested	13	38%	23	70%	8	62%	44	55%
Previously incarcerated	7	21%	16	48%	6	46%	29	36%
Chronic medical condition	13	38%	16	48%	4	31%	33	41%
Chronically homeless	30	88%	29	88%	11	85%	70	88%
Age	-							
35 years or younger	7	21%	8	24%	4	31%	19	24%
36–50 years	14	41%	16	48%	4	31%	34	43%
51 years or older	13	38%	9	27%	5	38%	27	34%
Race and ethnicity	-							
White, non-Hispanic	17	50%	19	58%	4	31%	40	50%
Black, non-Hispanic	8	24%	10	30%	5	38%	23	29%
Hispanic (any race)	4	12%	2	6%	2	15%	8	10%
Other, non-Hispanic	5	15%	2	6%	2	15%	9	11%

Exhibit 5–7. Demographic Characteristics, by Level of Housing Stability

Data source: Baseline Data Collection Instrument

Note: Chronic homelessness was unknown for one Pathways to Housing client in this study, who was a stayer.

Benefits and Income

As reported in Chapter 4, most of the study participants had some income at baseline. At baseline, intermittent stayers had less income than stayers, but more income than leavers. In addition, intermittent stayers were more likely than stayers and leavers to receive Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). This may indicate that the population of intermittent stayers may be more disabled than the others, which is further bolstered by the fact that clients in this group had more temporary departures to medical and psychiatric hospitals during their first 12 months in the Housing First program. (See exhibit 5–8.)

Client Benefits and Income	Stay (N =		Intermittent (N = 3			vers = 13)	Total (N = 80)	
	N	%	Ň	<i>%</i>	N	%	N	<i>.</i> %
Income range	Income range							
\$0	2	6%	6	18%	4	31%	12	15%
\$1-\$599	14	41%	14	42%	4	31%	32	40%
\$600 or more	18	53%	13	39%	5	38%	36	45%
Income and benefits sources								
SSI	14	41%	17	52%	5	38%	36	45%
SSDI	5	15%	10	30%	3	23%	18	23%
Subsidized health insurance	10	29%	13	39%	5	38%	28	35%
Food stamps	7	21%	7	21%	1	8%	15	19%
Other	4	12%	4	12%	2	15%	10	13%

Exhibit 5–8.	Client Benefits and Monthl	v Income at Baseline, h	y Level of Housing Stability
L'Amore 5 0	Cheffe Denemis and Month	y meonic at Dasenne, s	y Devel of Housing Stubility

Data source: Baseline Data Collection Instrument

Notes: Other sources of income included welfare income, veterans' income, employment income, and income from a family member/lawsuit settlement. Subsidized health insurance included Medicaid, Medicare, and veterans' health insurance.

Prior Living Situation

Clients who entered the Housing First program from the streets were most likely to leave the program within 12 months (n = 9, 69 percent) and were also most likely to experience temporary program departures (n = 12, 36 percent). The clients 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.⁷² (See exhibit 5–9.)

Exhibit 5–9. Prior Living Situation, by Level of Housing Stability (N = 34 for stayers, N = 33 for intermittent stayers, N = 13 for leavers)



⁷² One client entered the Housing First program from jail and was included with the group of clients who came from psychiatric hospitals—both living situations were fixed, controlled, and institutional environments.

Co-Occurring Disorders

As reported in Chapter 4, 69 percent (n = 55) of the study participants had both an axis I diagnosis and a history of substance abuse at baseline. Clients who left the Housing First program permanently during the first 12 months were slightly more likely than other clients to experience co-occurring psychiatric diagnoses and histories of substance abuse (n = 10, 77%). The remainder of clients—approximately one-quarter of stayers (n = 9) and leavers (n = 3) and 18 percent (n = 6) of intermittent stayers—had a diagnosed psychiatric disorder only. (See exhibit 5–10.)

		yers	/	nittent		vers		otal
Co-Occurring Disorders		= 34)	Stayers (N = 33)			= 13)		= 80)
	Ν	%	N	%	Ν	%	Ν	%
Disorders								
Axis I diagnosis and substance abuse history	22	65%	23	70%	10	77%	55	69%
Axis I diagnosis only	9	26%	6	18%	3	23%	18	23%
Substance abuse history only	1	3%	4	12%	0	0%	5	6%
No axis I diagnosis or substance abuse history	2	6%	0	0%	0	0%	2	3%
Psychiatric diagnoses								
No axis I diagnosis	3	9%	4	12%	0	0%	7	9%
Has axis I diagnosis	31	91%	29	88%	13	100%	73	91%
Schizophrenia, psychotic disorders	25	74%	18	55%	9	69%	52	65%
Mood disorders	5	15%	11	33%	2	15%	18	23%
Other disorders	1	3%	0	0%	2	15%	3	4%
History of substance abuse		-		-		-		
None	11	32%	6	18%	3	23%	20	25%
Alcohol	4	12%	10	30%	1	8%	15	19%
Drugs	4	12%	3	9%	2	15%	9	11%
Alcohol and drugs	15	44%	14	42%	7	54%	36	45%
Prior substance abuse treatment	14	41%	15	45%	5	38%	34	43%

Exhibit 5–10. Co-Occurring Disorders, by Level of Housing Stability

Data source: Baseline Data Collection Instrument

Note: Other disorders include oppositional-defiant disorders and personality disorders.

All leavers in the sample, and most stayers and intermittent stayers, had an axis I diagnosis.⁷³ Intermittent stayers were much more likely than the other two groups to have a mood disorder (n = 11, 33 percent) and stayers and leavers were more likely to have schizophrenia or other

⁷³ The Diagnostic and Statistical Manual (DSM) of Mental Disorders, published by the American Psychiatric Association, describes the diagnostic categories of mental disorders and a multiaxial assessment that includes five axes. Axis I includes clinical disorders and other conditions that may be a focus of clinical attention—schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and other conditions. Mood disorders include depressive disorders, bipolar disorders (characterized by depressive and manic episodes), and substance-induced mood disorders. Schizophrenia and other psychotic disorders include delusions or hallucinations. Studies have found that homeless mentally ill clients with mood disorders, rather than schizophrenia, have a higher success rate in housing (Lipton et al., 2000; Tsemberis and Eisenberg, 2000).

psychotic disorders. In addition, intermittent stayers were most likely to have a history of substance abuse and were more likely to use alcohol alone than other clients. Further, intermittent stayers also received prior substance abuse treatment more frequently than other clients—45 percent (n = 15) of intermittent stayers received treatment compared to 41 percent (n = 14) of stayers and 38 percent (n = 5) of leavers.

Baseline Levels of Impairment

Clients in the study sample with higher levels of impairment related to psychiatric symptoms and substance use at baseline had lower levels of housing stability. Eighty-five percent of intermittent stayers (n = 28) and leavers (n = 11) had some impairment related to psychiatric symptoms upon entering the Housing First program, while 76 percent of stayers (n = 25) were impaired. (See exhibit 5–11.)

Exhibit 5–11.	Level of Impairment Related to Psychiatric Symptoms, Drug Use, and
	Alcohol Use, by Level of Housing Stability

Level of Impairment	Stayers (N = 34)		Intermittent Stayers (N = 33)		Leavers (N = 13)		Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%
Psychiatric impairment		-		-		-		-
No symptoms	7	21%	5	15%	2	15%	14	18%
No impairment	2	6%	0	0%	0	0%	2	3%
Moderate impairment	19	56%	13	39%	6	46%	38	48%
Severe impairment	6	18%	15	45%	5	38%	26	33%
Impairment related to drug use								
No drug use	28	82%	21	64%	7	54%	56	70%
No impairment	2	6%	0	0%	0	0%	2	3%
Moderate impairment	2	6%	8	24%	5	38%	15	19%
Severe impairment	1	3%	4	12%	1	8%	6	8%
Unknown impairment	1	3%	0	0%	0	0%	1	1%
Impairment related to alcohol use								
No alcohol use	27	79%	13	39%	9	69%	49	61%
No impairment	2	6%	4	12%	1	8%	7	9%
Moderate impairment	3	9%	7	21%	3	23%	13	16%
Severe impairment	1	3%	9	27%	0	0%	10	13%
Unknown impairment	1	3%	0	0%	0	0%	1	1%

Data source: Baseline Data Collection Instrument

Consistent with the hypothesis that increased levels of impairment related to psychiatric symptoms or substance use impact clients' levels of housing stability, the study team observed that clients with higher levels of impairment experienced less stable housing histories in the Housing First programs. The levels of impairment related to drug and alcohol use were higher for intermittent stayers and leavers than for stayers. While only 9 percent (n = 3) of stayers experienced impairment related to drug use, 36 percent (n = 12) of intermittent stayers and 46 percent (n = 6) of leavers were impaired as a result of drug use. Similarly, only 12 percent (n = 4) of stayers experienced impairment related to alcohol use, while 48 percent (n = 16) of

intermittent stayers and 23 percent (n = 3) of leavers were impaired. In addition, intermittent stayers were much more likely than other groups to use alcohol.

OUTCOMES

Although housing tenure and stability are the ultimate outcomes for Housing First programs, they are also factors tied to other outcomes for clients in the programs. One's housing stability during the course of the 12-month study may influence other outcomes, including level of impairment related to psychiatric symptoms and substance use, as well as monthly income and independence of money management. This section explores each of these outcomes for clients based on their level of housing stability.

Most of the outcomes explored in this study require comparisons between variables at baseline or month one and month 12. Baseline refers to the time when the client entered program housing and month one refers to the end of the first complete month in housing. Because leavers permanently left the Housing First program prior to the twelfth month, data reported for the final month of their tenure in the Housing First program are used for the comparison. In addition, some outcomes could not be evaluated for leavers. The final outcome to be discussed in this section is leave status and includes detailed information about the 13 clients who left the Housing First program prior to the twelfth month.

Impairment Related to Psychiatric Symptoms

Exhibit 5–12 compares the level of impairment related to psychiatric symptoms at baseline and after 12 months in the program for stayers and intermittent stayers and at the last month in the program for leavers. The columns list first the number of clients who had a given level of impairment and then the number of clients who experienced a change in impairment from month one to the final month (month 12 or the client's last month in the program). For example, at baseline seven stayers had no psychiatric symptoms and at 12 months that number changed by one so that eight stayers had no psychiatric symptoms.

······································									
	Stayers (N = 34)		Intermittent Stayers (N = 33)			vers 13)	Total (N = 80)		
Level of Impairment	N at baseline	Change in month 12	N at baseline	Change in month 12	N at baseline	Change at last month	N at baseline	Change in month 12	
No symptoms	7	+1	5	0	2	0	14	+1	
No impairment	2	-2	0	0	0	0	2	-2	
Moderate impairment	19	+1	13	+2	6	-4	38	-1	
Severe impairment	6	0	15	-3	5	+4	26	+1	
Unknown impairment	0	0	0	+1	0	0	0	+1	

Exhibit 5–12. Change in Level of Impairment Related to Psychiatric Symptoms, by Level of Housing Stability

Data source: Baseline Data Collection Instrument, Monthly Data Collection Instrument

Notes: The last known level of impairment for leavers was the level of impairment reported during their last month in the Housing First program. The level of impairment for stayers and intermittent stayers was that reported during month 12 of their tenure.

The level of impairment related to psychiatric symptoms for intermittent stayers appeared to improve. The level of impairment for one intermittent stayer was unknown during month 12, most likely due to lack of contact with the client during a temporary departure from the Housing First program. Between baseline and the month when the leavers permanently left the Housing First programs, four leavers experienced an increase in their level of impairment related to psychiatric symptoms from moderate to severe. This increase in impairment may have been related to the client's leaving the Housing First program.

Impairment Related to Substance Use

Exhibit 5–13 compares the level of impairment related to substance use at baseline and after 12 months in the program for stayers and intermittent stayers and at the last month in the program for leavers. The columns list first the number of clients who had a given level of impairment and then the number of clients who experienced a change in impairment from month one to the final month (month 12 or the client's last month in the program). For example, at baseline 24 stayers did not use substances and there was no change in that number at month 12.

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.⁷⁴ Level of impairment related to substance use increased for stayers and leavers, while it decreased for intermittent stayers.

by Level of Housing Stubility										
Level of Impairment Related to	Stayers (N = 34)Intermittent Stayers (N = 33)Leavers (N = 13)			Total (N = 80)						
Substance Use	N at baseline	Change at month 12	N at baseline	Change at month 12		Change at last month		Change at month 12		
No substance use	24	0	10	+5	6	+1	40	+6		
No impairment	3	-2	1	0	1	-1	5	-3		
Moderate impairment	4	+4	9	0	5	-4	18	0		
Severe impairment	2	-1	13	-5	1	+4	16	-2		
Unknown level of impairment	1	-1	0	0	0	0	1	-1		

Exhibit 5–13. Change in Level of Impairment Related to Substance Use, by Level of Housing Stability

Data source: Baseline Data Collection Instrument, Monthly Data Collection Instrument Note: Level of impairment is the highest level of impairment related to either drug or alcohol use.

Income and Representative Payee Status

At baseline, stayers were more likely to have a representative payee than intermittent stayers or leavers. Fifty-nine percent (n = 20) of stayers had a representative payee at baseline. Approximately 48 percent of intermittent stayers (n = 16) and 38 percent of leavers (n = 5) had representative payees at baseline and that percentage increased over time. Over 12 months, an additional 10 percent (n = 3) of intermittent stayers acquired representative payees and 16 percent (n = 2) of leavers acquired representative payees before they left the program.

⁷⁴ The study team analyzed change in impairment separately for drug and alcohol use. Impairment related to alcohol use shifted from none to moderate for stayers and intermittent stayers, while it shifted from moderate to severe for leavers. This increase in alcohol use may be related to the low cost to obtain it, its availability, and few consequences for drinking in program housing. The severity of impairment related to drug use increased slightly for leavers.

The accretion of representative payees during this time may indicate that staff at the Housing First programs perceived intermittent stayers and leavers to be in need of guidance regarding their finances. However, intermittent stayers experienced a greater increase in total monthly income between baseline and month 12 than stayers. (See exhibit 5–14.)

Change in Representative Payee Status and Income		yers = 34)	Stay	nittent yers = 33)		Leavers (N = 13)		Total (N = 80)	
	Ν	%	Ν	%	Ν	%	Ν	%	
Change in representative payee status between month 1 and month 12									
Representative payee at baseline	20	59%	16	48%	5	38%	41	51%	
Representative payee at month 12	19	56%	19	58%	7	54%	45	56%	
Change in monthly income between baseline	Change in monthly income between baseline and month 12								
Decreased at least \$100	6	18%	2	6%			8	12%	
Decreased \$50-\$99	0	0%	2	6%			2	3%	
Decreased \$1–\$49	2	6%	3	9%			5	7%	
No Change	12	35%	11	33%			23	34%	
Increased \$1-\$49	10	29%	6	18%			16	24%	
Increased \$50-\$99	0	0%	2	6%			2	3%	
Increased at least \$100	4	12%	7	21%			11	16%	

Exhibit 5–14. Change in Representative Payee Status and Monthly Income, by Level of Housing Stability

Data source: Monthly Data Collection Instrument

Notes: The last known status of representative payeeship for leavers was reported during their last month in the Housing First program. For stayers it was reported during month 12 of their tenure. The shading of the leavers columns indicates that 12-month outcomes could not be evaluated for this category of clients because they left the program prior to 12 months.

Leavers

This section provides additional detail on the circumstances of program leavers. Of the 80 clients tracked for this study, 16 percent (n = 13) left the program within one year of entry. The distribution of leavers across programs is as follows:

- Five clients left DESC;
- Two clients left Pathways to Housing; and
- Six clients left REACH.

Leaving the Housing First programs is not easy to do given the fact that program staff work with clients to keep them in housing, even if it requires moving them if there are problems. As discussed above, clients do continue to live in program housing even though many have significant behavioral issues that might threaten their housing elsewhere. The programs usually reserve housing for as long as possible for a client who leaves and will rehouse the client upon return. In addition, under most circumstances, case managers try to maintain contact with clients for at least 90 days after they leave program housing.

The program leavers in this study were primarily people who died (n = 4) or left involuntarily (n = 6). Only three clients left voluntarily, supporting the hypothesis that if housing is offered

without conditions and with support, most of the chronically homeless people with co-occurring disorders targeted by these programs will remain in the program, some with intermittent departures.

Reasons for Leaving

There was a range of reasons for leaving among the 13 clients who left program housing within 12 months. To protect clients' confidentiality—given the small number of cases—exhibit 5–15 summarizes the reasons for leaving across all programs.

Type of Departure	Reason for Leaving	Number of Clients	Comments
Involuntary	Death		1 died of AIDS
5		4	2 medication overdoses
			1 killed in confrontation with police
	Incarcerated	2	
	Institutional care	2	1 long-term drug treatment
		Z	1 skilled nursing facility
	Asked to leave by program	2	Both due to alleged assaults on other residents
Voluntary	Left voluntarily	1	Did not want to apply for Social Security Number
	Left without explanation	2	
	Total	13	

Exhibit 5–15. Reasons for Leaving Housing First Programs

Data source: Monthly Data Collection Instrument, followup by local researchers

Most leaves are categorized as "involuntary," including leaving housing for more intensive care, such as long-term drug treatment or skilled nursing. Two clients were incarcerated, one for attempted murder and the other on a drug charge. Two clients were asked to leave their programs due to alleged assaults on other residents. Among the voluntary leavers, one client left following resistance to obtaining identification to secure benefits and the remaining two were described by staff as "wanderers" who most likely left the cities where the programs were located.

While some research indicates that departures are more likely during the first few months after entering housing, among the study clients, the departures in this study occurred during months 3-11 after enrollment. Five departures occurred between months three and six and the remaining eight departures occurred during months 7-12.⁷⁵ (See exhibit 5-16.)

Months		SC = 5)	Hou	Pathways to Housing (N = 2) REACH (N = 6)		Total (N = 13)			
	Ν	%	Ν	%	Ν	%	Ν	%	
1–3 months	0	0%	0	0%	0	0%	0	0%	
3–6 months	2	40%	0	0%	3	50%	5	38%	
6–7 months	1	20%	1	50%	0	0%	2	15%	
8–9 months	2	40%	1	50%	1	17%	4	31%	
10–11 months	0	0%	0	0%	2	33%	2	15%	
Total	5	100%	2	100%	6	100%	13	100%	

Data source: Monthly Data Collection Instrument

⁷⁵ The deaths were distributed across the tracking period, occurring in months 4, 5 (1 death each), and 11 (2 deaths).

Other Circumstances of Leavers

As part of the data collection for this study, the study team hired local researchers to locate clients who left the programs. The researchers were experienced in working with homeless people in each city, but were not affiliated with the Housing First program. The purpose of the follow-up contacts was to determine where the clients were living, to ask why they left the Housing First program, and to obtain their views on their program experience. If the local researcher could not reach the client directly or the client had died, the local researcher contacted the case manager to learn as much as possible about the client's program experience and circumstances.

The local researchers obtained at least some additional information on the circumstances of the 13 leavers. The following summaries briefly recount the experiences of a these clients.

- The local researcher arranged to meet Client 1 at the mental health clinic where he receives services. Client 1 said that he left his program housing because he was involved in an altercation with another resident. He said he was provoked by the other resident, and that the altercation was "more of an impulse" resulting from his mental illness than a premeditated act. Program staff gave him the choice of leaving or being evicted from his housing, so he chose to leave. He said he had been happy with his program housing and services, that he had gotten the help he needed, and that he was working with his case manager to reenter the program. In the meantime, he was living in a homeless shelter.
- Client 2 had HIV and moved into a convalescent home during his first month in the Housing First program. Client 2 never returned to his Housing First unit and remained in the convalescent home, except for a stay in a medical hospital, until his death.
- Client 3 left the Housing First program and could not be located. Prior to leaving, he did not take medications regularly and staff indicated that Client 3 had untreated psychiatric symptoms. Client 3 also caused substantial property damage and staff believe that he may have left the Housing First program because he thought he would be evicted. He had indicated a desire to leave the program, but staff were not sure why he wanted to leave.
- Client 4 was an immigrant who lived in program housing for about eight months. Client 4 had both an axis I diagnosis and a history of drug use. He did not take his prescribed medications regularly, if at all, nor was he interested in drug treatment. His case manager said he was difficult to house because he did not have any immigration paperwork and lost one housing placement because he did not have proper documents. Client 4 would have qualified for a green card but refused to apply despite program staff's encouragement and assistance. According to program staff, he seemed unconcerned about whether he had housing or not and eventually asked to be disenrolled from the program. Client 4 occasionally stayed in a shelter until he was barred after a fight.
- Client 5 agreed to move out voluntarily following reports that he was involved in criminal activity. Client 5 refused to cooperate with the investigation, although staff made numerous attempts to encourage him to tell his side of the story.

- Client 6 was in the program for seven months before entering jail. He had been referred to the program from a psychiatric hospital, where he met a girlfriend. When his girlfriend decompensated (i.e., experienced a deterioration in psychiatric symptoms in response to stress), Client 6 did as well. He was then arrested for attempted murder and sent to jail.
- Client 7 disappeared from his program housing four months after entering and could not be located. The local researcher learned about Client 7 from an outreach worker who had worked with the client. Client 7 was described as "a wanderer" who did not talk much. He told the outreach worker he had come from another city several hundred miles away. He had been housed twice by the Housing First program, but had wandered away from both of these prior housing situations. The outreach worker described Client 7 as very compliant and good at taking care of himself, but he would never stay anywhere long enough to get the help he needed. His speech was disorganized and hard to understand, which may also have contributed to him not getting the help he needed.
- Prior to a worsening of his mental illness, Client 8 had held odd jobs, had been in a relationship, and had two children. As his symptoms worsened, however, he entered what his case manager described as a "vicious cycle" of institutionalization in a county mental health facility, jail, and homelessness. He spent almost a year in program housing. His case manager said he had discontinued his medications and was decompensating when he was admitted to a treatment facility. Shortly after returning to program housing from the treatment facility he overdosed on medication and passed away.
- Client 9 had HIV/AIDS, as well as a physical disability, a documented mental illness, and a history of alcohol use. As this client's physical symptoms worsened, he disenrolled from the Housing First program and entered a skilled nursing facility.
- Client 10 was a veteran who had been homeless for several years. He had an axis I diagnosis and reported extremely intrusive voices. He was also a drug user. He left one housing placement after an altercation with police during which he was injured. After he recovered, he moved to another building. While in his second placement, he died during another altercation with police after living in program housing for 10 months.
- Client 11 entered the Housing First program from an alternative sentencing program. During his eight months in the program, he entered detox for crack on multiple occasions and was caught carrying a knife. In lieu of time in jail, Client 11 entered a long-term treatment program and was disenrolled from the program after 90 days.
- Client 12 was a schizophrenic who was dependent on cocaine. He stayed in the Housing First program for three months until he was incarcerated for behavior related to drug and alcohol use.
- Client 13 died from a medication overdose. He was schizophrenic with symptoms of paranoia and auditory hallucinations. His case manager described him as timid. In addition, he did not speak English well and required an interpreter to communicate effectively. He lived in at least three housing program units over approximately 18 months, but he would
periodically disappear. His case manager said he was reluctant to discuss his symptoms, a response which may have been partly cultural.

CONCLUSIONS

Despite the history of homelessness and severe mental illness of the clients served in the three Housing First programs, 84 percent (n = 67) of the clients tracked for this study remained enrolled in the Housing First program at the 12th month. Forty-three percent remained in the Housing First housing for the full 12 months, 41 percent were "intermittent stayers" and left during the 12-month period but returned, and 16 percent left the housing or died within the first 12 months. Program staff made substantial efforts to maintain contact with clients even when they were not in their housing, making it more likely that clients would return from these temporary departures.

The differences among stayers, intermittent stayers, and leavers are modest, but some patterns emerge. Leavers and intermittent stayers more often entered the Housing First program from the streets and were more likely to experience temporary program departures. In addition, 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.

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.

CHAPTER 6: OUTCOMES

The presumption of the Housing First approach is that, once clients achieve housing stability, they are better prepared to address their mental illness and substance-related issues. In addition, program housing combined with support services can help stabilize a client's financial status and help promote self-sufficiency. As data presented in Chapter 5 of this report demonstrate, the Housing First programs have successfully increased housing stability for most of their clients. For some, that housing stability takes a more episodic form than perhaps most homeless providers and policy makers might have considered appropriate. This study suggests that intermittent stays may be a stage in the direction of more fundamental housing, social, and psychiatric stability.

In addition to housing stability, other important outcomes for Housing First programs would be reductions in the frequency and severity of psychiatric symptoms, the use of drugs and alcohol, the level of impairment related to substance use, as well as positive changes in the client's income and self-sufficiency. This chapter explores changes in these outcomes across Housing First programs for the 67 clients who were enrolled in the Housing First program for 12 months. This subsample includes stayers and intermittent stayers, both of whom were described in Chapter 5.⁷⁶

Case managers in each of the programs reported the outcomes data at baseline and each month during the 12-month study period.⁷⁷ Although these data were subject to the case managers' judgment, the case managers knew their client's situation better than other staff members and could make more informed judgments. Furthermore, the same case manager made the judgments over time for each client, so there is no inter-rater variability issue (i.e., issues arising from different raters using different scales). Nevertheless, the judgments were necessarily subjective, and there is no guarantee that a case manager was entirely consistent across the 12-month period.

Program staff at the three Housing First programs cautioned that, given the severity of their clients' symptoms, they anticipated limited improvements in levels of impairment within 12 months. This presumption is consistent with the findings from the present analysis. Although clients may experience month-to-month variation in their levels of impairment, the data do not demonstrate any substantial trends in either psychiatric symptoms or drug or alcohol impairment

⁷⁶ The study sample included a total of 80 clients across three Housing First programs. During the 12-month study period, 13 of these clients permanently left the Housing First program. Of the remaining 67 clients, 33 clients are characterized as intermittent stayers because they experienced at least one temporary departure to another living environment during the course of the 12-month period and returned to the Housing First program. The remaining 34 clients are characterized as stayers as they spent the entire 12-month period in the program without any temporary departures. This chapter describes outcomes for the combined subsamples of stayers and intermittent stayers for a total of 67 clients.

⁷⁷ Case managers collected baseline data upon a client's enrollment into the Housing First program. For clients who were part of the retrospective data collection effort, case managers also collected their baseline information retrospectively using administrative records. Case managers collected data for month 1 following the end of the first month during which the client entered the program. Case managers collected data for month 12 following the end of the client's twelfth month in the program. For more information about the data collection process, see Appendix A.

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 are still well below the poverty line.

CHANGE IN IMPAIRMENT RELATED TO PSYCHIATRIC SYMPTOMS

The Housing First programs in this study primarily serve formerly homeless individuals with a mental illness. Ninety percent (n = 60) of the clients who remained in the program for 12 months had an axis I diagnosis at enrollment—72 percent (n = 43) were diagnosed with schizophrenia or other psychotic disorders and 27 percent (n = 16) were diagnosed with a mood disorder.⁷⁸ This focus on mental illness points to an important service-related aspect of the three Housing First programs. Each of these programs provides treatment and service options to address their clients' mental illness.

Each of the three programs provides access to psychiatric services, although participation in services is not required in any of the programs. The Downtown Emergency Service Center (DESC) provides clients with access to clinical mental health and substance abuse treatment case managers. A psychiatrist also visits each of the program's buildings about every two weeks to meet with clients. At Pathways to Housing, each Assertive Community Treatment (ACT) team has a part-time psychiatrist who meets with the team on a regular basis to get feedback on the status of each client and determine which clients should be scheduled for appointments. At Reaching Out and Engaging to Achieve Consumer Health (REACH), a partner organization with offices in the same location as the service center provides psychiatric services after clients are referred by their REACH case managers.

Exhibit 6–1 compares the psychiatric symptoms of clients at baseline and after 12 months in the program as reported by their case managers. The columns list first the number of clients who had a given level of impairment at baseline and then the number of clients who experienced a change in impairment from baseline to month 12. Overall, there was a small increase in the number of clients with moderate impairment and a corresponding decrease in the number of clients with severe impairment, suggesting a small amount of improvement in the aggregate. There was also a small decrease in clients with no psychiatric impairment.

The aggregate change is primarily due to changes among REACH clients. In month 12, REACH had four fewer clients with severe psychiatric impairment, two more with moderate impairment, and one more with no impairment than at baseline. Relative to REACH, fewer clients at DESC and Pathways to Housing had severe psychiatric impairment at baseline and their clients experienced smaller changes in impairment during the first year in housing.

⁷⁸ The Diagnostic and Statistical Manual (DSM) of Mental Disorders, published by the American Psychiatric Association, describes the diagnostic categories of mental disorders and a multiaxial assessment that includes five axes. Axis I includes severe clinical disorders and other conditions that are expected to be the focus of clinical treatment. These diagnostic categories include schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and other conditions that may need clinical attention (e.g., anxiety or eating disorders). Mood disorders include depressive disorders, bipolar disorders (characterized by depressive and manic episodes), and substance-induced mood disorders. Schizophrenia and other psychotic disorders include delusions and hallucinations.

Level of Impairment Related to	DESC (N = 20)			to Housing 24)		ACH ⊧ 23)	Total (N = 67)	
Psychiatric Symptoms	N at baseline	Change at month 12	N at baseline	Change at month 12	N at baseline	Change at month 12	N at baseline	Change at month 12
No impairment	5	-1	9	-1	0	+1	14	-1
Moderate impairment	10	-1	11	+2	11	+2	32	+3
Severe impairment	5	+2	4	-1	12	-4	21	-3
Unknown level of impairment	0	0	0	0	0	+1	0	+1

Exhibit 6–1. Change in Level of Impairment Related to Psychiatric Symptoms Between Baseline and Month 12, by Program

Data source: Baseline Data Collection Instrument, Monthly Data Collection Instrument

Regardless of the level of psychiatric impairment at baseline, exhibit 6–2 suggests that for most clients (n = 48, 72 percent) the level of impairment changed during at least one month during the year. Only 28 percent (n = 19) of the clients had the same reported level of psychiatric symptoms every month during the year.⁷⁹ Of the 48 clients who had a reported change in psychiatric symptoms for at least one month, 33 percent (n = 22) showed improvement, 28 percent (n = 19) were worse, and 10 percent (n = 7) had at least one month when they were better than baseline and one month when they were worse than baseline. The variation in level of impairment related to psychiatric symptoms from month to month is reflective of the episodic character of serious mental illness.

Change in Psychiatric Impairment	-	otal = 67)
	Ν	%
No change in impairment from baseline	19	28%
Improved level of impairment at least one month (no months of worsened impairment)	22	33%
Fluctuating levels of impairment (improved at least one month and worsened at least one month)	7	10%
Worsened level of impairment at least one month (no months of improvement)	19	28%
Total	67	100%

Exhibit 6–2. Change in Level of Impairment Related to Psychiatric Symptoms

Data source: Baseline Data Collection Instrument, Monthly Data Collection Instrument

An analysis of changes in impairment levels by baseline impairment level indicated that most clients had an impairment level different from baseline for at least one month during the year. Only 21 percent (n = 14) of clients with no impairment at baseline, 34 percent (n = 23) with a moderate impairment at baseline, and 24 percent (n = 16) with a severe impairment at baseline had the same reported level of impairment each month of the year. This indicates that even though the aggregate levels of psychiatric impairments did not change much during the year, there was substantial movement of individuals across levels of impairment during the period.

⁷⁹ Of the 48 clients whose level of impairment changed from baseline, eight clients experienced a change for only one month. If these eight clients were added to the "no change" category, 40 percent of clients would be in the "no change" category.

While some of this movement across levels of impairment may be reporting error, the results from exhibit 6–1, showing little change in the aggregate between baseline and month 12, and exhibit 6–2, showing no clear direction of the changes for individuals at any time during the period, lead to the conclusion that there were no substantial changes in the level of psychiatric symptoms for clients during the first year in the program.

There are several reasons for a client's change in the level of impairment related to psychiatric symptoms. The level of stress in a client's life—often influenced by level of service provision and housing stability—can cause the symptoms to become more or less pronounced at any given time. The client may also have changed medication type or dosage or may have become more or less consistent in taking prescribed medications. Finally, because a client's level of psychiatric symptoms may fluctuate during the month, the case manager's reported level of impairment may depend on whether the case manager had contact with the client during good or bad periods.

Exhibit 6–3 indicates the aggregate number of clients with each level of psychiatric impairment by month. The graph shows that there is no clear upward or downward trend in the number of clients with no psychiatric symptoms during the period. As discussed earlier, there is a small decrease in the number of clients with severe psychiatric impairment and a corresponding small increase in clients with moderate psychiatric impairment, but the graph suggests that this finding is not necessarily part of a consistent trend. This graph demonstrates the variation in symptomology over time, which may impact the appropriateness of various housing situations and services over time.





⁸⁰ The chart does not include clients for whom level of psychiatric impairment was unknown. Month 0 refers to baseline.

PSYCHIATRIC MEDICATION MANAGEMENT

As reported in Chapter 4, the majority of study participants came from the streets or shelters and met the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness.⁸¹ Despite their history of homelessness, almost 80 percent (n = 53) of clients were already taking psychiatric medications when they entered Housing First housing. This finding indicates that a significant share of the clients enrolled in the Housing First programs had some amount of prior connection with service providers and perhaps had already achieved some stabilization in their psychiatric symptoms.⁸² Given that many clients were already taking medication. However, the extent to which case managers increase client access to psychiatric medications and improve the regularity and independence with which clients take their medications are potentially important outcomes. (See exhibit 6–4.)



Exhibit 6–4. Clients Taking Psychiatric Medications at Baseline, by Program (N = 20 for DESC, N = 24 for Pathways to Housing, N = 23 for REACH)

The regularity with which clients took their medications prior to program entry is unknown. However, once in the Housing First programs, case managers monitored client medication practices. For this study, case managers reported each month how regularly—never, sometimes but less than prescribed, or always as prescribed—clients took their prescribed psychiatric medications during that month. Exhibit 6–5 compares the frequency with which clients took their psychiatric medications, in aggregate, between month 1 and month 12. This graph shows

⁸¹ Of the 67 clients discussed in this chapter, 61 percent lived on the streets (n = 22) or in shelters (n = 19) directly prior to entering the Housing First program. In addition, 88 percent (n = 59) met at sometime during the last three years the joint federal definition of chronically homeless. Since almost all the stayers were identified as chronically homeless at baseline, the outcomes that look at the chronically homeless separately are almost identical to the outcomes reported in this chapter.

⁸² Of the 67 clients discussed in this chapter, seven had neither an axis I nor an axis II diagnosis at baseline. However, most of those not diagnosed at this stage were reported to have psychiatric impairment and to take medications to treat psychiatric symptoms during the study period.

the increase in percentage of clients who *never* took their psychiatric medications and the slight decrease in those who took their psychiatric medications *always as prescribed*.⁸³



Exhibit 6–5. Frequency with Which Clients Took Psychiatric Medications in Months 1 and 12 (N = 67)

The apparent decline in the regularity with which clients took psychiatric medications sometimes but less than prescribed may have resulted from a combination of factors. For example, clients may have taken their medications less regularly because they were experiencing improvements in level of impairment. Alternatively, clients may have taken medications with less regularity because they took them independently or may have made the decision to stop taking their medications. Case managers reported whether clients were supervised while taking or packaging psychiatric medications and whether the clients took the medications independently.

Case managers reported level of supervision and independence along the following continuum:

- Supervised by staff while client took medication;
- Staff packaged medications, but client took independently;
- Client packaged medication at agency's office and took independently;⁸⁴ and
- Client obtained and took medication independently.

Across the three Housing First programs, only 13 percent (n = 9) of clients were supervised by staff while taking medications while 34 percent (n = 23) of clients took medications completely independently. As shown in Exhibit 6–6, clients at DESC experienced the highest level of medication supervision during their first month in the program and clients at REACH experienced the most independence in medication management. Also, DESC not only knows

⁸³ Case managers' reports of the regularity that unsupervised clients (i.e., clients who the case manager or other staff person did not witness taking the medication) took medication were based on a variety of factors including clients' self-report, client behavior, and whether the client was timely in refilling the prescription or seeing the psychiatrist for a new prescription.

⁸⁴ Packaging medications refers to clients' practice of keeping medications at an agency office and visiting the office weekly or monthly to assemble enough medication for the following week or month. The client then takes the medication independently.

when people are not taking their medications, but the housing-based staff can more easily monitor whether a client's medication noncompliance poses a threat to the client or others, potentially making DESC better able to let people choose to not take their medications.

Level of Independence		SC = 20)			REACH (N = 23)		Total (N = 67)	
		%	Ν	%	Ν	%	Ν	%
Supervised by staff while client took medication		40%	1	4%	0	0%	9	13%
Staff packaged medications, but client took independently	4	20%	13	54%	0	0%	17	25%
Client packaged medication and took independently	0	0%	5	21%	3	13%	8	12%
Client obtained and took medication independently		10%	4	17%	17	74%	23	34%
Client did not take medication		30%	1	4%	3	13%	10	15%
Total		100%	24	100%	23	100%	67	100%

Exhibit 6–6. Independence of Medication Management in Month 1, by Program

Data source: Monthly Data Collection Instrument

Note: This information was not available at baseline.

Among the 52 clients who took psychiatric medications during both month 1 and month 12, 10 percent (n = 7) received higher levels of monitoring in month 12, and an additional 10 percent (n = 7) increased their independence. Most clients did not change their level of independence of medication management over the first 12 months in the Housing First program. (See exhibit 6–7.)

Exhibit 6–7. Change in Independence of Medication Management Between
Month 1 and Month 12, by Program

Month I and Month 12, by Hogham											
Level of Independence	DESC (N = 20)			to Housing 24)		ACH ⊧ 23)	Total (N = 67)				
	Ν	%	Ν	%	Ν	%	Ν	%			
Less independence	2	10%	1	4%	4	17%	7	10%			
No change	10	50%	16	67%	12	52%	38	57%			
More independence	2	10%	1	4%	4	17%	7	10%			
Clients not taking medications in month 1 and month 12	6	30%	6	25%	3	13%	15	22%			
Total	20	100%	24	100%	23	100%	67	100%			

Data source: Monthly Data Collection Instrument

Note: This information was not available at baseline.

CHANGE IN IMPAIRMENT RELATED TO SUBSTANCE USE

Substance-related disorders frequently co-occur with mental illness among the clients served by Housing First programs. All three programs in this study either provide substance abuse counseling and treatment or referrals to other providers for these services. At Pathways to Housing, a member of each ACT team specializes in substance abuse counseling. In addition, Pathways to Housing staff refer clients to substance abuse treatment programs and encourage attendance at Alcoholics or Narcotics Anonymous meetings. DESC and REACH staff also encourage participation in these meetings and provide related referrals. At REACH, substance

abuse specialists are available to clients by referral. DESC has certified substance abuse treatment staff at one of their buildings and a full staff of substance abuse treatment professionals in their licensed substance abuse treatment program division.

All three of the Housing First programs maintain a low demand approach to substance use and do not require that clients refrain from using drugs or alcohol to obtain or maintain housing. At DESC and Pathways to Housing, clients are not evicted because of alcohol or drug use, but staff make it clear to clients that behaviors associated with drug and alcohol use may threaten their housing.

However, some private landlords who provide housing for REACH clients do not allow drug or alcohol use on the premises and can evict clients for violating this rule. This is a tension in REACH's low demand philosophy. While the client may be threatened with the loss, or actually lose, his or her housing due to drug or alcohol use on the premises, the client is not disenrolled from the program. Instead, REACH case managers work with their clients to get a second chance in his or her current housing or to find alternative housing. This is one reason why some REACH clients have to make frequent moves before achieving housing stability.

Exhibit 6–8 compares the level of impairment related to substance use of clients at baseline and after 12 months in the program. The columns list first the number of clients who experienced a given level of impairment at baseline and then the number of clients who experienced a change in impairment from baseline to month 12. For each month of the study, case managers reported on the clients' use and level of impairment from alcohol use and from drug use. The impairment level reported here is the highest level of impairment from either alcohol or drug use. At baseline, 51 percent (n = 34) of clients did not use any substances and an additional 6 percent (n = 4) did not experience any impairment related to substance use. Across all three programs, the level of severity decreased at month 12 and fewer clients were using or impaired by using any substances.

Level of Impairment Related to	DESC (N = 20)			to Housing ₌ 24)		ACH = 23)	Total (N <u>= 6</u> 7)	
Substance Use		Change at month 12	N at baseline	Change at month 12		Change at month 12	N at baseline	Change at month 12
No substance use	9	+1	15	0	10	+4	34	+5
No impairment	3	-3	1	-1	0	+2	4	-2
Moderate impairment	2	+4	5	+1	6	-1	13	+4
Severe impairment	5	-1	3	0	7	-5	15	-6
Unknown level of impairment	1	-1	0	0	0	0	1	-1

Exhibit 6–8. Change in Level of Impairment Related to Substance Use Between Baseline and Month 12, by Program

Data source: Baseline Data Collection Instrument, Monthly Data Collection Instrument

Note: Level of impairment is the highest level of impairment related to either drug or alcohol use.

REACH clients were slightly more likely than clients from the other two Housing First programs to have impairments related to substance use at baseline, but were also the most likely to show improvement from baseline to month 12. For example, 13 REACH clients had moderate or severe impairments related to substance use at baseline, but only seven had such impairments at month 12. The number of DESC clients with impairment from substance use increased from seven to 10 between baseline and month 12 while the number of Pathways to Housing clients with impairment was virtually unchanged.⁸⁵

Exhibit 6–9 shows the aggregate trends over time for the 67 clients enrolled in the Housing First programs for 12 months. Between baseline (month 0 in the program) and month 12 in the program, most clients did not use substances. Among those who did, moderate impairment was most frequent and increased over time. The number of clients with severe impairment appeared to decrease over time, indicating some decrease in the level of impairment related to substance use over 12 months.



Exhibit 6–9. Level of Impairment Related to Drug or Alcohol Use, by Month⁸⁶ (N = 67)

CHANGE IN IMPAIRMENT RELATED TO CO-OCCURRING DISORDERS

The majority of Housing First clients tracked for this study have co-occurring psychiatric diagnoses and substance use. As described throughout this report, clients' levels of impairment related to psychiatric symptoms and substance use vary over time. Exhibit 6–10 compares level of impairment related to psychiatric symptoms between baseline and month 12 for those who

⁸⁵ The change in impairments from substance use is driven by changes in impairments from alcohol use, rather than from impairments in drug use. At baseline, case managers only reported that 18 of the 67 clients that stayed in the program for 12 months used drugs and this decreased to 17 by month 12. None of the impairment level categories related to drug use changed by more than two people. For alcohol use, 27 clients were reported to be using alcohol at baseline and this decreased to 23 by month 12.

⁸⁶ The number of clients with no impairments related to substance use included those whose level of impairment was unknown. This included one client in months 0–4. In addition, some clients were living in housing situations at REACH where there were sobriety requirements; however, not all clients had these requirements.

were currently using substances (either drugs or alcohol) and those who were not. Although level of psychiatric impairment did not shift a great deal between baseline and month 12, there was a slight improvement for clients who used substances, as well as for those who did not. Further, at both baseline and month 12, level of impairment related to psychiatric symptoms was greater for clients who used substances than for those who did not.

Loval of Impairment Delated to		Substar	nce Use		No Substance Use							
Level of Impairment Related to Psychiatric Symptoms	Baseline		Month 12		Bas	eline	Month 12					
r sychiatric Symptoms	Ν	%	Ν	%	Ν	%	Ν	%				
No psychiatric symptoms	4	12%	2	7%	8	24%	11	28%				
No impairment	0	0%	0	0%	2	6%	0	0%				
Moderate impairment	18	55%	18	64%	14	41%	17	44%				
Severe impairment	11	33%	8	29%	10	29%	10	26%				
Unknown level of impairment	0	0%	0	0%	0	0%	1	3%				
Total	33	100%	28	100%	34	100%	39	100%				

Exhibit 6–10. Level of Impairment Related to Psychiatric Symptoms at Baseline and Month 12, by Substance Use

Data source: Baseline Data Collection Instrument, Monthly Data Collection Instrument

CHANGE IN INCOME AND MONEY MANAGEMENT

One presumption of Housing First is that, if a client has stable housing, the client—with support from the program—will be in a better situation to receive the government benefits for which he or she is eligible, manage money more effectively, and may eventually be able to obtain employment. Each of the programs worked with clients to access benefits and to manage their money. All but 12 percent (n = 8) of the clients had some monthly income at baseline.

Income

DESC and REACH experienced increases between baseline and month 12 in the numbers of clients with total monthly income greater than \$250. Among the 67 clients, the total number of clients with no income dropped by two people from eight at baseline to six at month 12. However, between baseline and month 12, the distribution of incomes shifted toward having higher incomes. Exhibit 6–11 lists the number and percentage of clients at each Housing First program that had the indicated amounts of total monthly income at baseline and month 12.

Monthly Income		SC 20)	5	to Housing 24)		ACH = 23)	Total (N = 67)		
	Baseline	Month 12	Baseline	Month 12	Baseline	Month 12	Baseline	Month 12	
\$0	0%	0%	21%	13%	13%	13%	12%	9%	
	(0)	(0)	(5)	(3)	(3)	(3)	(8)	(6)	
\$1-\$250	0%	0%	13%	0%	9%	4%	7%	1%	
	(0)	(0)	(3)	(0)	(2)	(1)	(5)	(1)	
\$251-\$500	30%	10%	0%	0%	4%	0%	10%	3%	
	(6)	(2)	(0)	(0)	(1)	(0)	(7)	(2)	
\$501-\$750	60%	75%	58%	54%	17%	9%	45%	45%	
	(12)	(15)	(14)	(13)	(4)	(2)	(30)	(30)	
\$751-\$1000	10%	10%	8%	4%	57%	74%	25%	30%	
	(2)	(2)	(2)	(1)	(13)	(17)	(17)	(20)	
More than \$1000	0%	5%	0%	0%	0%	0%	0%	1%	
	(0)	(1)	(0)	(0)	(0)	(0)	(0)	(1)	

Data source: Baseline Data Collection Instrument, Monthly Data Collection Instrument

Note: The N's related to the percentages displayed in this table are indicated in the parentheses under each percentage. Percentages may not sum to 100 percent due to rounding.

At DESC, no clients had monthly income less than \$250 at baseline. In contrast, Pathways to Housing had eight clients and REACH had five clients with monthly incomes below \$250. 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. (See exhibit 6–12.) Overall, Pathways to Housing clients had the lowest average monthly income at baseline (\$473) and month 12 (\$537). REACH clients had the highest average monthly income at both points (\$610 and \$677). DESC clients experienced the greatest average change in monthly income at \$88 between baseline and month 12.

Exhibit 6–12. Average Monthly Income at Baseline and Month 12, by Program (N = 20 for DESC, N = 24 for Pathways to Housing, N = 23 for REACH)



Increased access to several sources of benefits, including Supplemental Security Income and Social Security Disability Insurance, may account for the increase in average total monthly income between baseline and month 12. At both DESC and REACH, the number of recipients of these benefit sources increased from baseline to month 12.⁸⁷ No clients reported employment income to case managers at baseline, month one, or month 12.

Although there was an overall increase in total monthly income between baseline and month 12, the clients in the Housing First programs still lived in extreme poverty by national standards. The Federal poverty guidelines published by the U.S. Department of Health and Human Services indicate that a single person would need to have a monthly income of \$798 to be at the Federal poverty line.⁸⁸ The data indicate that less than 30 percent of the clients have incomes above the poverty line and none have income more than 1.25 times the poverty line. Further, while the poverty line is set at the same level across the country, each of the Housing First programs selected for study are located in municipalities with high costs of living and high median family incomes. The Fiscal Year 2005 HUD income limits released by the Office of Policy Development & Research indicate that the clients in this study have incomes below 30 percent of the family-size adjusted median income in their metropolitan area. For HUD programmatic purposes, income below 30 percent of the area median is categorized as extremely low income.⁸⁹

Money Management

To help ensure that clients made staying housed a priority, case managers at each of the Housing First programs encouraged at least some of their clients to have representative payees. Representative payees could be a case manager or other program staff member, a family member or friend, or a nonprofit organization. Representative payees can help ensure that clients pay their rent and can help them develop money management skills.

At baseline, 54 percent (n = 36) of clients across the three Housing First programs had representative payees. By month 12, the share of clients with a representative payee was slightly higher than reported at baseline (n = 38, 57 percent). The program with the largest share of clients with payees was DESC, where 75 percent (n = 15) of clients had a representative payee at month 12. At baseline and month 12, more than 70 percent of these clients had DESC as their payee. In addition, 63 percent (n = 15) of Pathways to Housing clients had a representative payee at month 12. All of these clients had Pathways to Housing as their payee. In contrast, just 35 percent (n = 8) of REACH clients had a representative payee at month 12, distributed evenly among the program, relatives, and other nonprofit agencies. (See exhibit 6–13.)

⁸⁷ The data regarding change in benefit sources between baseline and month 12 are not displayed, because the benefit sources reported are not accurately linked to total monthly income for all of the Housing First programs. One Housing First program reported amended total monthly income for baseline, month one, and month 12 following the data collection period. This program did not report updated benefit sources at that time. See Appendix A for a further discussion of data collection methodology.

⁸⁸ *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373–8375.

⁸⁹ HUD publishes income limits for Section 8 and public housing. These data contain median family income, as well as incomes for one-person families. Measures are provided to determine if a person is low-income (annual income does not exceed 80 percent of the metropolitan area family-size adjusted income) or very low-income (annual income does not exceed 50 percent of median income), or extremely low income (annual income less than 30% of median income). A person is categorized as extremely low income in Seattle if monthly income is less than \$1363, in New York City if monthly income is less than \$1100, and in San Diego if monthly income is less than \$1208. For more information, see http://www.huduser.org/datasets/il/il05/index.html.





Although the prevalence of representative payees increased for DESC and REACH, monthly data indicated that some clients gained independence in making decisions regarding their money. Case managers reported the level of clients' money management skills each month along the following continuum: client managed own money for needs during the month; client identified the need and asked for money to purchase items; client identified the need and asked the program to purchase the items; and program identified the need and purchased items for the client.

Exhibit 6–14 presents the level of money management independence of clients at each Housing First program during months 1 and 12. At month 1, most clients (n = 47, 70 percent) either managed their own money or determined how they would use their money but requested money to purchase items, most likely from their representative payee.

Level of Money Management Independence	DESC (N = 20)		Hou	ays to sing 24)		ACH = 23)	Total (N = 67)	
	Month 1	Month 12	Month 1	Month 12	Month 1	Month 12	Month 1	Month 12
Client managed own money for	40%	40%	38%	42%	35%	57%	37%	46%
needs during the month	(8)	(8)	(9)	(10)	(8)	(13)	(25)	(31)
Client identified the need and asked for money to purchase items	30% (6)	50% (10)	33%	38% (9)	13% (3)	17% (4)	25% (17)	34% (23)
Client identified the need and asked the program to purchase the items	15%	6%	4%	4%	4%	4%	7%	4%
	(3)	(1)	(1)	(1)	(1)	(1)	(5)	(3)
Program identified the need and purchased items for client	15%	5%	4%	0%	30%	9%	16%	4%
	(3)	(1)	(1)	(0)	(7)	(2)	(11)	(3)
Client had no income	0%	0%	21%	17%	17%	13%	13%	10%
	(0)	(0)	(5)	(4)	(4)	(3)	(9)	(7)
Total	100%	100%	100%	100%	100%	100%	100%	100%
	(20)	(20)	(24)	(24)	(23)	(23)	(67)	(67)

Exhibit 6–14. Money Management Independence at Months 1 and 12, by Program

Data source: Monthly Data Collection Instrument

Notes: The N's related to the percentages displayed in this table are indicated in the parentheses under each percentage. This information was not available at baseline.

There was a notable increase in clients' independence in money management over the 12-month period at each Housing First program. When looking at money management independence in the aggregate, it is evident that the level of independence increased across all three programs. (See exhibit 6–15.)



Exhibit 6–15. Distribution of Money Management Independence at Months 1 and 12 (N = 67)

However, this increase in money management independence did not necessarily result in better money management ability (as rated by the clients' case managers, based on their professional judgment), as shown in exhibit 6–16. These data indicate a fairly static level of money management ability among clients between month one and month 12. At both DESC and Pathways to Housing, there was an increase between month one and month 12 in the number of clients who managed their money poorly—a 5 percent (n = 1) increase at DESC and a 13 percent (n = 3) increase at Pathways to Housing. Similarly, DESC and Pathways to Housing also decreased in the number of clients who were managing their money very well—a 15 percent (n = 3) decrease at DESC and an 8 percent (n = 4) of clients who managed money poorly and an increase of 22 percent (n = 5) of clients who managed money very well between month one and month 12.

Level of Money Management Ability		DESC (N = 20)		to Housing 24)	RE <i>I</i> (N =	ACH 23)	Total (N = 67)	
	Month 1	Month 12	Month 1	Month 12	Month 1	Month 12	Month 1	Month 12
Poorly	25%	30%	4%	17%	35%	17%	21%	21%
	(5)	(6)	(1)	(4)	(8)	(4)	(14)	(14)
Moderately	40%	50%	58%	54%	30%	30%	43%	45%
	(8)	(10)	(14)	(13)	(7)	(7)	(29)	(30)
Very well	35%	20%	25%	17%	17%	39%	25%	25%
	(7)	(4)	(6)	(4)	(4)	(9)	(17)	(17)
Client had no income	0%	0%	13%	13%	18%	14%	11%	9%
	(0)	(0)	(3)	(3)	(4)	(3)	(7)	(6)
Total	100%	100%	100%	100%	100%	100%	100%	100%
	(20)	(20)	(24)	(24)	(23)	(23)	(67)	(67)

Data source: Monthly Data Collection Instrument

Notes: The N's related to the percentages displayed in this table are indicated in the parentheses under each percentage. This information was not available at baseline.

CONCLUSIONS

This chapter explored five major types of outcomes for the Housing First programs that participated in this study: level of psychiatric impairment, frequency of psychiatric medication use, impairment related to substance use, impairment related to co-occurring disorders, and income and money management. Each of these outcomes was explored for those clients who remained in the Housing First program for at least 12 months.

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). Regarding the frequency with which clients took their psychiatric medications, most did not change their level of frequency over 12 months and they were equally likely to increase or decrease the level of independence with which they took the medications over the 12-month period.

Most of the clients reported not using substances at the time of enrollment in the Housing First program (73 percent did not use drugs and 60 percent did not use alcohol). Impairment related to both substances dropped slightly at REACH and either increased slightly or remained static at DESC and Pathways to Housing. For clients with co-occurring disorders, the level of impairment related to psychiatric symptoms appeared to increase between baseline and month 12. However, due to a great deal of fluctuation in use of substances and related impairment over 12 months, there was no clear trend to suggest overall improvement or deterioration.

Outcomes across the programs in helping clients achieve increased financial independence seem mixed. REACH clients seem to have achieved the most improvement in their financial situations: their incomes were highest, they managed their money most successfully, and they increased the independence with which they managed their money. Financial independence outcomes for Pathways to Housing and DESC were less evident. Pathways to Housing clients managed their money less well later in the study period but did experience modest gains in income and ability to manage their monthly purchases independently. Fewer clients at DESC managed their money very well in month 12 and more used representative payees, but average incomes increased and clients gained some independence in making purchasing decisions.

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. Housing stability is the major outcome that Housing First programs are able to realize with their clients.

CHAPTER 7: SUMMARY AND IMPLICATIONS

The key distinguishing feature of the Housing First approach, as described throughout this report, is a commitment to offer permanent housing *first* to hard-to-serve homeless persons, rather than requiring a period of stabilization, sobriety, or commitment to treatment to demonstrate housing readiness. This paradigm shift of viewing chronically homeless individuals who have serious mental illness and often co-occurring substance-related disorders as "housing ready" differentiates the Housing First approach. The Housing First approach is not a single model, however, but rather a set of general features that communities may interpret somewhat differently. This study identified a number of these features that appear to contribute to housing stability for the clients served.

This study is the first multisite study of the implementation and outcomes of the Housing First approach. While the study is small and exploratory in nature, the findings from the three Housing First programs selected for study—Downtown Emergency Service Center (DESC), Pathways to Housing, and Reaching Out and Engaging to Achieve Consumer Health (REACH)—provide evidence that the Housing First approach, as implemented in these three programs, can promote housing stability and other positive outcomes for homeless people with serious mental illness and substance abuse issues.

A large majority of the 80 clients tracked for this study met the U.S. Department of Housing and Urban Developments (HUD) definition of chronic homelessness at some time during the last 3 years. In addition, clients 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, a substantial proportion (43 percent) of our study sample remained in housing continuously for a full year. An additional 41 percent were still in the Housing First program after one year but had spent at least some time away (in some cases extended periods) from their program housing during that period. While the housing tenure outcomes are promising, changes in clients' clinical status—level of impairment related to psychiatric symptoms and substance use—are limited during the first year.

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, including the type of housing utilized, the location and intensity of services, and the use of representative payees. This chapter reviews and summarizes the program features that appear to promote housing stability and other positive program outcomes at the three Housing First programs and suggests implications for HUD policy.

WHAT MAKES HOUSING FIRST WORK?

With only three sites and broadly similar outcomes across sites, it is difficult to say definitively which program features are essential to program success. However, based on patterns in outcomes observed in the client-level data, interviews with program staff and focus groups with program participants, several program elements emerge as important contributors to program success at the three Housing First programs. Important elements of the Housing First approach include access to a substantial supply of permanent housing in which clients want to live and the provision of a variety of services—utilizing a flexible and responsive staffing structure—to help clients maintain this housing. To ensure that both housing and services resources are available, a diverse set of funding opportunities must be available to the program. These features are discussed in this section.

Access to a Substantial Supply of Permanent Housing

The key similarity among the housing strategies in the three Housing First programs was that each program has access to a substantial stock of permanent housing for their clients. However, the three programs differed substantially in the types of housing they offered to program clients. Each approach offers benefits and challenges.

Pathways to Housing offers scattered-site housing that is secured through a network of private landlords and management companies. The benefits of the Pathways to Housing model include the program's ability to offer clients more choice in both housing and neighborhoods. In addition, Pathways to Housing is committed to limiting the number of its clients housed in any given building to promote mainstreaming clients and encourage community integration. Benefits of this approach include greater opportunities for socialization and community involvement and reduction in the stigmatizing effects of large concentrations of people with disabilities in certain buildings. The Pathways to Housing approach is contingent on continued landlord participation with the program. Landlord participation is encouraged by the fact that Pathways to Housing holds the lease and then sublets the apartment to the client. This helps assure landlords that the rent will be paid and that program staff will be available to address any client issues that arise.

DESC owns or controls the housing where its clients live and also 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 onsite and can respond immediately to issues that may arise—from a client causing damage to his apartment to another who may need crisis mental health services. However, because all of the housing is located in a small number of buildings within a limited geographic area, this approach does not reduce the stigmatizing effects of concentrating large numbers of people with disabilities within the community.

The REACH program appears to pose the greatest challenges because the service provider does not own or control any of the housing, case managers have sizeable caseloads, and the program is geographically dispersed. In addition, a number of the housing providers that lease to REACH clients have strict lease requirements regarding substance use, which often result in these clients experiencing frequent moves before achieving housing stability. Case managers at REACH spend a lot of time addressing problems that occur as a result of substance use. Relocations from one program housing unit to another were more common at REACH than at the other two programs, due partly to the presence of rules in some of the housing options and the wide variety of program housing, giving clients a number of housing options from which to choose.

The functional separation between the lease enforcement activities of a housing provider and case management support may help clients address problems that could threaten their housing. However, the study team observed that this separation may also contribute to housing instability as some clients move because of housing problems. REACH clients were the least likely to remain stably housed for the full 12 month tracking period. Only 28 percent of REACH clients were continuously housed with no temporary departures compared to 62 percent at Pathways to Housing and 40 percent at DESC.

Providing Housing that Clients Like

This study did not focus heavily on collecting data on client satisfaction, but the limited evidence available indicates that clients are generally satisfied with the permanent supportive housing offered at the Housing First programs. Forty-three percent (n = 34) of the clients in this study did not leave their housing at all during the first year, and 41 percent (n = 33) only left their housing for temporary departures and then returned to the Housing First program. Of the 16 percent (n = 13) of clients who permanently left the programs during this time, only a few left voluntarily.

Focus group participants generally reported that they were satisfied with their housing. Clients at DESC and Pathways to Housing cited the privacy, independence, safety, and quality of their housing as positive features of their program experience. At REACH, some focus group participants complained about the quality and safety at some of the housing locations in the community, but REACH staff independently acknowledged these concerns and described their work toward possible solutions. Clients at REACH who had temporary program departures during the 12-month period spent most of that time homeless, which may be an indication of lack of satisfaction with housing.

Regarding the importance of housing choice, DESC and REACH clearly offer less choice than Pathways to Housing. However, clients who participated in focus groups said the choice of housing over homelessness is important to them. Additional research on client satisfaction in these three Housing First programs (as well as others) is currently underway.⁹⁰ Preliminary results from that study indicate that clients are very satisfied with their housing. Further, while clients view their participation in services as voluntary, they understand that their participation in services supports their ability to retain their housing. Housing may thus serve as leverage for service engagement.

Wide Array of Supportive Services

The Housing First programs offer an array of supportive services to help clients maintain their housing and meet their other needs, including comprehensive mental health services, substance

⁹⁰ P. Robbins and J. Monahan, Housing Leverage Pilot Study by the John D. and Catherine T. MacArthur Foundation on Mandated Community Treatment.

abuse treatment, medication assistance, as well as help with independent living skills, such as money management and housekeeping. Staff are available around the clock to assist clients. At DESC, each housing location is staffed 24 hours per day and clinical staff are on call during overnight hours. Similarly, a staff member at REACH and Pathways to Housing is always on call to respond to issues that may arise.

The use of representative payees seems to be a useful tool for working with some clients in the areas of independent living skills and money management, but is not as widely used as expected. None of the programs mandated that all clients have representative payees, although all strongly encouraged the practice in at least some cases. In theory, representative payees can help clients ensure that the rent is paid and that other expenses are met, while discouraging clients from spending their money in ways that may jeopardize their health or housing. Approximately two-thirds of the clients in the study (n = 53) had a representative payee for at least one month during the tracking period. Of those who had a representative payee, 59 percent (n = 31) had a staff member from the Housing First program as their payee. Stayers were more likely than intermittent stayers and leavers to have a representative payee at baseline, indicating that this support may help to maintain housing stability. Regarding the leverage of representative payeeship, a study on this issue in the three study sites and other programs is underway.⁹¹

Community-Based, Client-Driven Services

An important feature of a successful Housing First program is a service delivery approach that emphasizes community-based, client-driven services. Common features of service delivery across the Housing First programs include 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.

The Housing First programs emphasize providing services primarily in the housing and the community where clients live. This means visiting clients at least twice a month, but often more frequently. While all programs strive to offer services in the community, each program uses a different strategy due to the different housing types. Pathways to Housing provides services in the community where clients live through their neighborhood-based Assertive Community Treatment (ACT) teams. REACH staff have central offices located near downtown, however, service provision is more challenging because case managers have to cover a broader geographical area to visit their clients. Because DESC has housing-based staff, daily client contact is the norm and clinical staff are also based in the organization's administrative offices, which are housed in one of the housing locations.

Program staff from all three programs emphasize the importance of client-driven service planning. Clients take an active role in determining the timing, the nature, and the frequency of their service plan. Focus group participants expressed appreciation for the "do whatever it takes" attitude with which case managers approach their work.

⁹¹ P. Robbins and J. Monahan, Housing Leverage Pilot Study by the John D. and Catherine T. MacArthur Foundation on Mandated Community Treatment.

Staffing Structure that Ensures Responsive Service Delivery

The staffing structure for delivering services differs across the three Housing First programs, but in all cases is designed to ensure that clients' needs are met. Access to multidisciplinary staff is clearly important, but the experiences of DESC and REACH indicate that services can be delivered using a service model different than the ACT teams used at Pathways to Housing.

The nine-member ACT teams at Pathways to Housing include specialists in diverse fields, including mental health, substance abuse, and employment who meet regularly to discuss clients' needs and decide who on the team can most appropriately respond. REACH and DESC offer similarly diverse services, but do not use the ACT team model. Staff from REACH and DESC report that their service delivery structures offer a cost-effective alternative to the highly credentialed, and, they would argue, more costly, ACT team model.

Given the high service needs of program clients, maintaining manageable caseloads is an important program feature. Caseloads are considerably smaller at Pathways to Housing than at the other two programs; each nine-member Pathways to Housing ACT team carries a caseload of 60–70 clients, averaging no more than eight clients per ACT team member. In contract, DESC's case managers carry caseloads of about 34 clients, while each REACH case manager has a maximum caseload of 23 clients.

While caseload to case manager ratios differ across programs, 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. All three programs also have automated systems, both for documenting program activities and client status and, equally importantly, for collecting information on client outcomes. The Housing First programs make efforts to use outcomes information to inform adjustments in program service delivery. Pathways to Housing has conducted a substantial number of studies that document program outcomes, the most recent of which involved random assignment comparing Pathways to Housing with clients placed in traditional continuum of care settings (Tsemberis, Gulcur, and Nakae, 2004).

Diverse Funding Streams for Housing and Services

All three Housing First programs serve clients with extremely low incomes and limited resources to pay for housing, services, and their other day-to-day needs. Clearly, no single funding source provides sufficient resources to meet the housing and service needs of this population. Further, it is often the case that service provision is driven by the availability of

resources. The Housing First programs rely on a variety of funding streams to meet the needs of their clients.⁹²

All three programs seek Medicaid reimbursement for mental health case management services. Accessing Medicaid funds requires licensing and administrative sophistication to document and bill for services appropriately, but program administrators view the administrative demands as justifiable. All three programs also receive funding for clinical services from state or county sources—Pathways to Housing receives funding from the New York State Office of Mental Health, REACH receives funding from the California AB 2034 program, and DESC receives funding from the King County Human Services Office.

HUD programs subsidize a substantial portion—but not all—of the housing at these programs. Support from the Supportive Housing Program (including both Transitional and Permanent Housing), Shelter Plus Care, and Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) programs are used to assist clients. Other diverse funding sources allow expanded options to help cover housing costs on both short- and long-term bases. For example, state or local funds may cover short-term stays in a hotel while a client is searching for housing (Pathways to Housing), or rental assistance may be provided to clients who are not eligible for assistance programs through HUD (REACH).

POLICY IMPLICATIONS FOR HUD

The Housing First programs in this study achieved the important outcome of housing stability for a hard-to-serve population. This finding, along with the program features that supported this outcome, lend to the following policy-level implications for HUD.

Housing First Addresses HUD's Priorities for Homeless Programs

The HUD priorities of addressing chronic homelessness and providing permanent housing are furthered by these 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.

Transitional Stays Do Occur

Despite Housing First programs' commitment to place clients directly into permanent housing, it is important to acknowledge that transitional stays do occur under various circumstances. First, all of the programs in the study were fully leased. Thus, in some cases, clients are briefly housed in a hotel, at the Young Men's Christian Association (YMCA), or a similar setting until a unit becomes available. The safe havens in the REACH and DESC programs have no firm

⁹² The scope of work for this study did not call for an analysis of program costs, but the study team asked each of the three programs to provide a rough estimate of the annual per client cost of housing and services. The costs reported seemed low and likely understated services costs. In addition, staff reported that keeping people stably housed keeps them out of jails and hospitals and recent studies have found this to be true (Gulcur et al., 2003; Davis, Johnson, and Mayberg, 2003). Therefore, the costs of Housing First programs may be offset by preventing the use of other more costly community resources, but these offsetting savings were not reflected in the cost estimates provided.

time limits, but are viewed as transitional settings. In REACH, some clients stay briefly at the safe haven until a unit opens elsewhere while others stay longer. At DESC, the safe haven serves the clients who are least engaged and whom the staff know the least well. DESC's safe haven provides a longer-term transition to one of the agency's SRO hotels.

Lack of Conditions

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 DESC and Pathways to Housing offer housing without service requirements. At REACH, many clients enter housing at a safe haven that has a number of occupancy rules, including a prohibition on drugs and alcohol, a curfew, and assigned chores for all residents. Despite these requirements, many homeless people do accept the offer of housing. Moreover, significant numbers of those express satisfaction with their housing once they are in it. The clients who participated in focus groups preferred accepting housing to the continued hardships of homelessness. Consistent with the literature, client satisfaction with housing may affect the level of housing stability.

Tenure and Stability are Viewed Differently in Housing First Programs

An important lesson from this study is that "housing stability" is viewed differently in these Housing First programs than in most homeless assistance programs. In Housing First programs, clients' enrollment status is determined more by their continued contact with case managers and other service providers and less by whether they are continuously residing in their program housing. Temporary departures from housing (some of them lengthy) are not uncommon, but program staff continue to follow up with clients even when they are away from their housing. Programs hold units for up to 90 days and work with clients to encourage them to return to program housing. A client is not considered to have "left the program" until he or she has been gone for 90 days, are no longer in contact with program staff, and are not expected to return.

Housing Stability Does Not Come Without Challenges

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 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.

Tension Between HUD Policy and Low Demand

HUD resources are an important source of housing subsidies in the Housing First programs selected for this study. However, tensions do exist between a low demand approach to substance use—a prominent feature in these programs—and widely-shared governmental concerns about any criminal activity in HUD-supported housing. In particular, the tension lies with drug activity.

This tension may be less pronounced in a program like DESC where the primary service provider also owns or controls the housing. However, it is more pronounced in programs like Pathways to Housing and REACH where the program or clients lease housing from private landlords. Program staff in each of the programs work diligently with clients to educate them about how their behavior may jeopardize their housing, but staff also acknowledge that their goal is to keep clients housed.

Staff at Pathways to Housing and REACH also work hard to normalize clients' living situations in scattered-site housing, with Pathways ensuring that no more than 10 percent of the tenants in a given building are program clients and REACH moving toward that standard. In addition, the programs' responsiveness to landlord concerns regarding housing problems has also helped to foster good relationships and maintain ready access to a substantial supply of scattered-site apartments.

Long-Term Commitment

Housing did not result in substantial improvements in mental illness or substance use disorders within the 12-month study period. These clients have long-standing mental illnesses and, in most cases, co-occurring substance-related disorders. 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, rather it is a series of ups and downs.⁹³ Longitudinal tracking of clients both within and after leaving Housing First programs is needed to identify the factors that most contribute to long term housing stability of chronically homeless people with severe mental illness and co-occurring disorders.

RECOMMENDATIONS FOR FUTURE RESEARCH

This study was exploratory in nature and points to several areas for future research:

Longitudinal Research on Client Outcomes

This study only tracked a sample of clients during the first 12 months after placement in housing. Tracking longer-term client outcomes, as well as the patterns and impact of service provision, are areas for future research. Longitudinal research would help policy makers and program operators learn whether the Housing First approach results in longer-term gains. If so, the approach may be a cost-effective way of mitigating substance abuse and other risk behaviors compared to alternative treatment approaches or incarceration.

Comparative Research on Outcomes in Housing First Programs and Other Approaches

This study focused exclusively on three examples of the Housing First approach. The study team was therefore unable to make comparisons to program implementation or outcomes

⁹³ Substance Abuse and Mental Health Services Administration. Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders. DHHS Pub. No. SMA-04-3870, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

associated with other approaches to housing chronically homeless people. Such comparative studies would be valuable in determining whether Housing First programs have greater success with this population. Future research should also explore the relative importance of the use of a low-demand approach and the different uses of transitional placements before placement into permanent housing.

Detailed Research on Program Costs and Offsetting Savings

This study did not collect detailed data on program costs or offsetting savings that may occur because clients may be less likely to use costly services such as hospital emergency rooms, jails, or detox programs. In addition, the study did not determine the extent to which staff quality and profile is consonant with cost. More detailed research on program costs and offsetting savings will be important in assessing the efficiency and replicability of the Housing First approach.

Research on the Replicability of the Housing First Approach

This study identified the structural elements that make Housing First work. However, the study did not fully address the issue of what is required to replicate the Housing First approach in communities throughout the country. To address this issue, future research questions would include:

- How able are programs to identify and secure scattered-site housing in local housing markets?
- What type of leadership is necessary to make a program like this happen?
- What level of staff quality is essential to provide services that encourage clients to remain in their housing?
- How critical is the capacity to attract new funding sources to the sustainability of a Housing First program?
- How important is the research or outcome focus of a program like Pathways to Housing to sustainability and client or program improvements over time?

CONCLUSIONS

Housing First is a viable response to address the housing needs of chronically homeless individuals with mental illness and often co-occurring substance-related disorders. While the three Housing First programs selected for study all achieved positive outcomes in the areas of housing stability and housing tenure, with some exception for people coming directly from the streets, each program did so in a slightly different way. However, certain structures must be in place for this particular response to work. First, it may be that some clients require transitional or temporary transitional placements prior to entering their permanent housing. Second, providers and policy makers will need to acknowledge that housing stability for some demands periods of instability. Third, at least in the short run, stability in a safe and healthy environment is the sole positive outcome for the clients served by these Housing First programs. Overall, there were very few systematic improvements in client behaviors or benefit attainment during the first year.

By studying the operations of each of the programs and analyzing the data from the 12-month study period in this context, the study team has identified implications at both the program and policy levels. Program-level implications address the features of the Housing First approach that programs should consider implementing to assure high levels of housing stability among the target population. Policy-level implications address the issues that arise from the program-level implications, including the tensions between a low demand approach to substance abuse and requirements guiding the expenditure of HUD and other governmental funding. These implications provide a framework to guide future research and inform the debate regarding the effectiveness of the Housing First approach.

APPENDIX A: METHODOLOGY

This appendix presents a description of the data collection process for the current study. The overall approach to this study included four main tasks:

- Canvass Housing First programs in the United States that serve individuals with a serious mental illness and develop criteria to select two study sites, in addition to Pathways to Housing, for in-depth analysis of the program characteristics and client outcomes;
- Engage the three selected Housing First programs by conducting baseline and followup site visits, interviewing program staff, and gathering detailed information about the operation of the program;
- Select and track formerly homeless study participants over a 12-month period at each site, engage local researchers to interview the participants who left the program within 12 months of placement, and conduct focus groups with participants; and
- Analyze tracking and focus group data to compare outcomes across sites.

Standard data collection instruments are located at the end of the Appendix.

CANVASS HOUSING FIRST PROGRAMS

The canvass identified Housing First programs across the country. In addition to addressing the research questions, the most important purpose of the canvass was to identify two sites, in addition to Pathways to Housing—the first Housing First program and the most notable to date—that met the requirements for the study. These requirements included:

- The program had been in operation for at least one year;
- The program enrolled at least eight new clients per month or, short of that, could incorporate 25 retrospective placements from no longer than 6 months prior to the study data collection period;
- The program had good data collection and client tracking procedures; and
- The program indicated a willingness to participate in the study.

The most suitable sites for further study needed to serve a similar population with a minimal number of operational differences from Pathways to Housing. In addition, the sites needed to present some variability to the "essential complements" that the Pathways to Housing considered important to clients' success:

- A strong emphasis on client choice in housing, resulting in clients living in dispersed apartments owned by private landlords;
- A service approach that did not co-locate housing and services; and
- Widespread use of the program as clients' representative payee.

To identify programs to participate in canvass discussions, the study team contacted sources identified in Walter R. McDonald & Associates, Inc.'s (WRMA) and Abt Associates' previous studies of homelessness, as well as national experts in homelessness. These contacts included staff from the U.S. Department of Housing and Urban Development Headquarters and field offices, the National Alliance to End Homelessness, Center for Urban Studies, Interagency Council on the Homeless Regional Coordinators, the Corporation for Supportive Housing, state and local departments of mental health services, housing developers, and mental health and homelessness consortia. As the study team identified Housing First programs, staff at some programs also offered additional contacts.

The discussions addressed the basic features of each program, including type of housing offered, scale of the program, target population, referral source, and conditions that clients must meet for housing. Specifically, these discussions enabled the study team to identify programs that met the following criteria that define Housing First for this study.

- 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 will 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, a low-demand approach accommodates client alcohol and substance use, so that "relapse" or increased substance use will not result in the client losing housing (Marlatt and Tapert, 1993).
- The continued effort to provide case management and to hold housing for clients, even if they leave their program housing for short periods.

The canvass provided a wealth of information about the current status of Housing First programs across the country as of late 2003. The study team conducted canvass discussions with 33 programs—nine incorporated the key features of the Housing First model and 14 incorporated many of the key features---but did not target single unaccompanied adults with a serious mental illness. The study team did not consider the remaining 10 programs Housing First because clients were required to participate in treatment prior to placement, or because the program did not primarily serve homeless people.

The two programs most suitable for further study that were not also participating in the Initiative to End Chronic Homelessness—Downtown Emergency Service Center (DESC) and Reaching Out and Engaging to Achieve Consumer Health (REACH)—had the most key features of the Housing First approach, the best comparability to the Pathways to Housing program model, and commensurability with the other study requirements.

ENGAGE HOUSING FIRST PROGRAMS

Following the canvass and site selection process, the study team worked with each of the selected sites to secure their agreement to participate in the study. The program staff members were instrumental in providing information about the operations of the Housing First programs, selecting and tracking the study sample, and working with the study team to ensure that data were accurate. The study team visited each site twice during the course of the study—once at baseline and the second time following the conclusion of data collection activities. The work conducted during the site visits is described in this section. Prior to the site visits, the study team worked with the sites to develop a memorandum of understanding (MOU) to guide the research process over the next 12 months.

Memorandum of Understanding

During the site recruitment process, the study team developed a MOU with each of the study sites. The MOUs covered the roles and responsibilities of site staff as well as of the study team, the terms for incentive payments, and expectations for data collection, including initial and final site visits, client recruitment for the study, and monthly status reporting. Each MOU:

- Identified the key staff contacts at the site and at WRMA and Abt Associates;⁹⁴
- Described the sample selection and baseline data collection processes;
- Identified the data elements collected during monthly monitoring and how the information would be reported to WRMA and Abt Associates;
- Specified the process to track participants who left the Housing First program;
- Determined when and under what conditions the site would receive the incentive payment for participating in the study; and
- Described the process for recruiting focus group members and handling arrangements for the focus groups that were conducted during the final site visit.

Baseline Site Visit

The baseline site visits enabled the study team to gain a better understanding of the Housing First program and setting, build a relationship with program staff and address any concerns about the study, determine acceptable procedures for selecting and engaging clients, and solidify site-specific data collection procedures. The site visits lasted 2 days and included a senior researcher

⁹⁴ WRMA staff monitored Pathways to Housing and Project REACH, and Abt Associates monitored DESC.

from both Walter R. McDonald & Associates, Inc. (WRMA) and Abt Associates. The primary objectives of the site visits were:

- To collect information on program design to expand upon the information collected during the canvass of Housing First programs;
- To confirm the conditions stated in the draft MOU between the study site and the project team;
- To train program staff to recruit participants for the study, administer the informed consent process, and report monthly tracking data;
- To commence the process of selecting the sample of participants to be tracked during the course of the study;
- To collect baseline data on any available prospective or retrospective study participants; and
- To tour examples of the permanent housing offered to participants.

During the initial site visit, the study team trained staff involved with client recruitment and tracking on how to obtain informed consent and complete the monthly tracking forms. To minimize the differences in sample selection procedures across sites, the training focused on the selection of a retrospective sample as well as new client enrollment. The study team also worked with the programs to be as consistent as possible with program policies for obtaining clients' informed consent to agree to participate in the study, as well as assuring confidentiality of all information gathered for the study.

From the canvass calls and followup calls to selected sites, the study team already had some information about the selected programs. However, the study team used the site visits to obtain more information about how the programs operate and to analyze their outcomes. The site visit focused on the following topics:

- Client Population;
- Program Attributes;
- Housing Attributes;
- Supportive Services; and
- Data Collection.

Follow-up Site Visit

Prior to the follow-up site visits, the study team prepared preliminary analyses of the tracking data for each site to assess results regarding participant tenure, engagement in services, and reasons for departure and destinations for leavers. The site visit provided an opportunity to review the features of the program and discuss any changes with staff in greater depth, including why a change was made and what effect the changes have had on participants' program experience. In addition, the study team conducted several focus groups with program

participants during the follow-up site visits—the methodology for the focus groups is described later in this appendix.

The issues addressed during the follow-up site visits included the following:

- Changes in key program features since initial visit (e.g., changes in housing options, requirements for admission or continued occupancy, lease arrangements, location of services, and use of representative payees);
- Review of preliminary analyses of participant outcomes (participant tenure, engagement in services, reasons for leaving and destinations for leavers, and resolution of any outstanding data collection issues); and
- Themes elicited from focus groups with participants.

Based on the information collected during the site visits, the study team wrote site descriptions for each Housing First programs. Staff at each of the programs reviewed the descriptions to check for accuracy and completeness.

SELECT AND TRACK STUDY PARTICIPANTS

The study team worked with each of the sites to select and track program participants over a period of 12 months. This section describes the sample selection and informed consent process. The baseline, retrospective, and monthly data collection processes are described as well. The study team also worked with external trackers to gather information about program leavers and conducted focus groups at the close of the 12-month data collection period to elicit feedback from study participants regarding the Housing First program.

Sample Selection

During the baseline site visit to each of the sites, the study team instructed the sites to select the first 25 clients who entered the Housing First program between April and June 2004 and were unaccompanied (not part of a homeless family), severely mentally ill, and willing to participate in the study.⁹⁵ Staff at the Housing First programs confirmed that the clients included in the study sample are representative of the overall population of the programs. During the sample selection process, each program had a number of clients refuse to participate in the study or the program chose to skip them. Although human subjects research standards prohibit asking a prospective study participant why he or she does not want to participate, program staff subsequently offered possible reasons for such refusal.

• At DESC, five clients refused to participate in the study. DESC staff believe their refusal was related to mental illness, including suspiciousness and paranoia. One of these was a client who had entered the program and left before the study enrollment began. She was offered the opportunity to join the study, but declined.

⁹⁵ Two of the study sites recruited more than 25 participants to track over 12 months. The sample at Pathways to Housing was 26 and the sample at Project REACH was 29.

- At REACH, seven clients could not consent due to the nature or acuteness of their mental illness; five clients were not homeless; 10 clients would not be cooperative with the study, as determined by REACH staff; two refused to participate in the study; and one was missing from the program.
- At Pathways to Housing, there were no refusals and two skips because the clients were unavailable for enrollment, for unknown reasons.

Because the Housing First programs selected for study had a fairly low turnover rate and a small volume of new enrollments each month, the study relied on a largely retrospective sample. The balance of retrospective and prospective cases in the sample was determined by the volume of new placements entering the program during the 3-month enrollment period of the study. The study team also requested that program staff attempt to enroll participants who entered and left the program before study recruitment started—this was the case of one prospective study participant at DESC who refused to participate. Approximately one-half of the study sample was retrospective (i.e., enrolled in the Housing First program prior to the study enrollment period, which began in May 2004). (See exhibit A-1.)

Date of Enrollment	DESC		Pathways to Housing		REACH		Total	
	Ν	%	Ν	%	Ν	%	Ν	%
June 2003–August 2003	0	0%	6	23%	1	3%	7	9%
September 2003–November 2003	8	32%	1	4%	5	17%	14	18%
December 2003–February 2004	8	32%	5	19%	8	28%	21	26%
March 2004–May 2004	9	36%	10	39%	13	45%	32	40%
June 2004–August 2004	0	0%	4	15%	2	7%	6	8%
Total	25	100%	26	100%	29	100%	80	100%

Exhibit A-1. Enrollment of Study Sample

Informed Consent

The study team worked with the Housing First programs to consistently obtain clients' informed consent to agree to participate in the study, as well as to assure confidentiality of all client information gathered for the study. Informed consent covered information about the purpose of the study, use of the data, assurances of confidentiality, contact persons who would know the participant's location, and permission to obtain information about the participant from the service provider. (See exhibit A–4 at the end of this appendix for the Informed Consent Form.)

Data Collection

The study team tracked the full study sample of 80 cases on housing status, location, and other key outcome variables for the 12-month period following their program enrollment. To track these data, the study team relied on baseline and monthly data submitted by the Housing First programs. The study team trained staff at the programs to complete the baseline and monthly tracking forms. Because most clients stayed in the Housing First programs, this approach to data collection was feasible. If larger numbers of clients had left the Housing First programs, this approach might have been unworkable. The rate of departure for those clients at REACH who either refused participation in the study or were skipped was similar to that of the sample tracked

for the study. Of the 25 clients who refused or were skipped, four have left the program (compared to six clients leaving REACH of the 29 clients who participated in the study).

The study team relied on a number of different case managers as well as administrative data sources to collect the data. To ensure consistent reporting, the study team provided training and ongoing assistance; however, respondent variability constitutes a limitation of the methodology. The rationale for this method to collect data is the clear impression that case managers would provide more accurate information than self report for some variables such as level of impairment related to psychiatric symptoms or substance use.

An additional limitation of the study methodology was collecting participant data retrospectively. Such an approach requires case managers to recollect or reconstruct information, and it thus may result in less variation across months because data for several months are reported simultaneously. In addition, the study team requested that case managers consult case files and assessment instruments to establish the most accurate responses for each data item at each point in time. To address this limitation during the data analysis phase, the study team studied changes in monthly trends by quarter or across longer spans of time such as between the first month of tenure and month 12.

The study team provided two incentive payments to the sites to encourage timely submission of monthly tracking forms. The Housing First programs received the first payment after it enrolled its sample and the second payment after it collected a full 12 months of data on the members of the study sample who still remained in the Housing First program.

All data collection and participant tracking procedures were vetted with Abt's Institutional Review Board prior to implementation.

Baseline Data Collection

Once the sites selected the sample and the participants signed the Informed Consent Form, the sites collected baseline information on all participants. The study sites submitted baseline data shortly following the receipt of informed consent from each of the study participants. (See exhibit A5 at the end of this appendix for the Baseline Data Collection Instrument.)

Retrospective and Monthly Data Collection

For each month that a study participant was in the Housing First program, the study site submitted a standard set of monthly data. For retrospective study participants, the study sites submitted all retrospective months of data with the first prospective monthly data. These data were the same although the study team developed a retrospective data collection form so that sites could easily report 6 months of data on one form. The study sites typically submitted these data to the study team one month following the month for which the data were collected. The study sites submitted these data for every month that the study participant was in the Housing First program. (See exhibit A–6 at the end of this appendix for the Monthly Data Collection Instrument.)

Tracking Leavers

The study sites were unable to provide monthly tracking data for those study participants who left the Housing First program in less than 12 months. To gather information about the leavers, the study team hired local researchers at each of the program locations to gather information about the participants who left the program. The local researchers provided information about the circumstances of the participants' departures and, if the local researcher was able to find such information, where the participant was living following the leave from the Housing First program. (See exhibit A-2.)

Date of Enrollment	DESC		Pathways to Housing		REACH		Total	
LIIIOIIIIIEIII	Ν	%	Ν	%	Ν	%	Ν	%
Leavers	5	20%	2	8%	6	21%	13	16%
Stayers	20	80%	24	92%	23	79%	67	84%
Total	25	100%	26	100%	29	100%	80	100%

Exhibit A-2. Client Tenure in Housing First Programs

Focus Groups

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 several focus groups at each of the study sites. These groups elicited client opinion on components of each program, such as use of the representative payee strategies and the program's housing options, to address the question of why different approaches seem to work well. The focus group moderator asked clients how they came to the Housing First program and their satisfaction with the program, as well as their feedback on how the Housing First program compares to other programs. The rationale for using focus groups was based on the study team's past experience in utilizing this data collection methodology effectively with the target population of this study.

Several weeks in advance of the followup site visits, the study team sent invitations to the study sites for participants to attend focus groups. The hope was that the local trackers would be able to personally contact each client who left the program and invite them to a separate focus group; however, they were not able to do so and the study team was not able to conduct a "leavers-only" focus group. To increase focus group participation among the stayers, the study team provided food and offered participants a \$10 incentive. The study team conducted two focus groups at DESC and REACH and three at Pathways to Housing. The focus groups ranged in size from 1 to 11 participants, with a total of 27 participants. Pathways to Housing had the smallest number of participants, most likely because it took place at the first of the month when clients received their benefits. (See exhibit A–3.)

Exhibit A=5: Client I al ticipation in Focus Of oups							
Focus Group	DESC	Pathways to Housing	REACH	Total			
Focus Group 1	7	1	11	18			
Focus Group 2	2	3	3	8			
Focus Group 3		1		1			
Total	9	5	14	27			

Exhibit A–3. Client Participation in Focus Groups

The turnout for the focus groups was less than the study team had hoped, particularly at Pathways to Housing. However, the study team did take advantage of all opportunities to speak with clients about their program experience, whether in a focus group setting or in more informal discussions with one or two people. An experienced moderator from the study team led the focus groups and followed a discussion guide that included general questions as well as probes to stimulate conversation. The moderator was accompanied by a second person to take notes, help coordinate the event, and record the sessions.

During the analysis phase of the study, the study team reviewed the focus group notes and incorporated the focus group participants' opinions and observations in the site profiles prepared for each Housing First program. The focus group participants provided useful insights on how clients enter the programs, whether they had choices in their housing or services, and how satisfied they were with their program experiences. Large numbers of clients did not participate in the focus groups and the views of those present are not representative of all clients at each Housing First program, but their input provided useful "reality checks" for the information obtained from program staff. (See exhibit A–7 for Focus Group Discussion Guides.)

DATA ANALYSIS

The study team collected the baseline and monthly tracking data from each of the study sites and entered it into an ACCESS file. The members of the study team who entered the baseline and monthly data provided the first stage of the quality control review by reviewing the information provided by site staff for completeness and clarity. The study team worked with the study sites to resolve obvious problems with the data. The second stage of quality control was the validation process. The study team developed an automated program to identify inconsistencies with the data. The study team analyzed the data using SPSS. The analysis included only descriptive statistics as the sample sizes were not sufficient to run inferential statistics.
Exhibit A–4. Housing First Informed Consent Form

Two research firms, Walter R. McDonald & Associates, Inc. (WRMA) and Abt Associates, are doing a study for the U.S. Department of Housing and Urban Development. The study is about homeless assistance programs. They would like to learn about your experiences during the year after you enter [Housing First Program] housing.

We are asking you to participate in this important study. Your participation in the study will help us learn more about helping people in the same situation as you. Participating in the study involves several steps:

- Your service coordinator will share information about your housing services with the researchers, but the information will not have your name on it.
- Research staff will contact you if you leave [Housing First Program] housing during the next year. They will ask you about your current housing and why you left the program. It is up to you whether you answer their questions or not.
- You will be asked to take a survey that asks you what you think about [Housing First Program] housing and the choices you made about your housing and care while you were in [Housing First Program] housing. Your information will be shared with research staff from the University of Virginia so they can contact you for this survey and so they can analyze the survey responses. You may say yes or no when they ask you to take the survey. You will be paid \$10 if you take the survey.
- You will be asked to join a group to talk about your experiences in [Housing First Program] housing. This group will be held about one year from now. You can choose at that time whether or not you want to be in the group discussion. You will be paid \$10 if you are in the group discussion.

People involved with the research will follow strict rules to protect your privacy to the extent provided by law. Your name will not be in any reports about the study and your name and personal information will not be given to anyone who is not on the research team, unless you tell us something that makes us worry about your safety or the safety of someone else. We would ONLY do this if we thought you could be harmed or someone else is in danger. Even though we do many things to protect your privacy, there is still a small risk that someone not on the research team might find out information about you.

You may choose whether or not to be in this study. Your choice will not affect services you get now or in the future. You may stop taking part in the study any time you wish. If you choose to stop being in the study, please call a researcher using the toll-free phone number at the bottom of the page. □ YES. I have read this form and want to be in this study. I understand that personal information will be kept private. I understand that neither my name nor any other personally identifying information will be used in any study report or in any data set.

Name (print)	Signature	Date

Please feel free to call Dr. Carol Pearson at 1-800-570-0837 (a toll-free call) if you have questions about the study. Carol is the Project Director at WRMA. You may also call Marianne Beauregard with Abt Associates at 617–349–2852 (a toll call or call collect) if you have any questions about your rights as a study participant.

The consent is valid for 13 months after the date it is signed, unless you notify us to end the consent earlier. Please keep a copy of this form for your own records.

HOUSING FIRST CONSENT TO CONTACT SECONDARY CONTACT PERSON

If [Housing First Program] staff do not know where you live at some point during the study, we would still like to contact you. We will only ask these contact people where to find you. We will tell them you are participating in an important study and gave us permission to contact them. We will not provide any other information to the contact person on the study or your situation. Is there someone we can contact who will usually know where to find you? [Yes/ No] If Yes, Please provide the following information:

Name	
Primary telephone number	
Second telephone number	
Street address	
City	
State	
Zip code	
What is his or her relationship to you?	

Is there a second person who also usually knows where to find you? [Yes/ No] If Yes, Please provide the following information:

Name	
Primary telephone number	
Second telephone number	
Street address	
City	
State	
Zip code	
What is his or her relationship to you?	

MAY WE CONTACT THESE PEOPLE TO FIND OUT HOW TO REACH YOU?

U YES. You may contact the above named persons to find me during the study period.

Signature

Date

Please feel free to contact Carol Pearson, the Project Director at WRMA, at 1-800-570-0837 if you have questions about the study. You may also contact Marianne Beauregard with Abt Associates at 617-349-2852 (a toll call or call collect) if you have questions or concerns about your rights as a study participant.

The consent is valid for 13 months after the date it is signed, unless you notify us to end the consent earlier. Please keep a copy of this form for your own records.

DOCUMENTATION OF CAPACITY TO PROVIDE INFORMED CONSENT

The consent interviewer (the person presenting the informed consent document to the potential study participant) has to determine whether the potential study participant appears to have the decision-making capacity to provide consent for participation in the study. The attached sheet contains some questions the consent interviewer should ask the potential study participant to help determine whether the client appears capable of making the consent decision.

Specifically, the interviewer should assess a potential study participant for the ability to:

- Demonstrate evidence of making a choice; that is, to communicate a yes or no decision;
- Understand relevant information; that is the person can tell the interviewer what the research procedures involve and what the consent information includes (e.g., right to withdraw); and
- Appreciate the situation and its likely consequences. The person can understand what research participation involves for him or her and what the likely outcomes are, and he or she can apply the information to his or her own situation.

After the consent interviewer has determined whether or not the potential study participant appears to have the ability to make a consent decision, they should record their finding below and sign and date the form.

Interviewer's Assessment of the Apparent Capacity of Potential Study Participant To Provide Informed Consent

I examined <u>(name of client)</u> on <u>(month/day/year)</u> for the purpose of determining whether he/she is capable of understanding the purpose, nature, risks, benefits and alternatives (including non-participation) of the research, making a decision about participation, and understanding that the decision about participation in the research will involve no penalty or loss of benefits to which the patient is otherwise entitled, for the Housing First study.

On the basis of this examination I have arrived at the conclusion that: (Check appropriate box.)

- This person has the capacity at this time to make informed consent;
- There is a doubt about this client's capacity to make informed consent; or
- This client clearly lacks the capacity to make informed consent at this time.

Signature:

Date:

QUESTIONS FOR DETERMINING WHETHER THE CLIENT APPEARS CAPABLE OF PROVIDING INFORMED CONSENT

The following questions for the potential study participant will help the consent interviewer determine whether the potential study participant appears to have the decision-making capacity to provide informed consent. This is not a pass/fail test. It is perfectly acceptable for the consent interviewer to take on an "educator" role during this process and should continue to do so until the person understands the information and is able to provide correct answers, or it becomes clear that the prospective subject is decisionally impaired and cannot provide informed consent.

Questions should be open-ended and include:

- Can you tell me what will happen if you agree to take part in the study? (Example of information respondents should know.) Researchers will have access to some of the information you provide to the housing first program and will try to contact you in the future for a survey and a discussion group.
- Who will see the information you provide as part of the study? (Example of information respondents should know.) Only a small group of researchers. They will not share your information with anyone outside the research team, except in aggregate form so you cannot be individually identified.
- Will the study benefit you? (Example of information respondents should know.) There are no direct benefits to the study participants. However, the goal of the study is to learn more about how to help people in the future who are in a similar situation.
- Do you have to be in this study? (Example of information respondents should know.) No. Participation in this study is voluntary and won't affect the services or benefits you are eligible for or receive.
- Can you leave the study once it begins? (Example of information respondents should know.) Yes. You can stop participating in the study any time you want. Just tell any researcher who contacts you that you no longer want to participate or call the telephone numbers on the consent form.

Exhibit A–5. Baseline Data Collection Instrument

HOUSING FIRST STUDY CLIENT IDENTIFICATION INFORMATION

Client ID Number	
Site ID	
Client Name	
Date Information Collected	

Street Address	
Apt. Number	
City	
State	
Zip Code	

Primary Case Manager	
----------------------	--

HOUSING FIRST STUDY BASELINE INFORMATION

Client ID Number	
Site ID	
Date Information Collected	

- A1. Year of birth: ______
- **B1.** Gender (circle one)

Male	1
Female	2

C1. Veteran (circle one)

NO	0
YES	1

D1. Ethnicity: Hispanic or Latino? (circle one)

NO	0
YES	1

E1. Race (circle all that apply)

American Indian or Alaskan Native	1
Asian	2
Black or African American	3
Native Hawaiian or other Pacific Islander	4
White	5

F1. What was the prior living situation for the client? (circle one)

Streets or other places not meant for human habitation	1
Homeless shelter	2
Jail or prison	3
Substance abuse treatment facility	4
Psychiatric hospital	5
Unknown	6
Other (specify:)	7

G1. Does the client have children under age 18? (circle one)

NO [go to H1]	0
YES	1
DON'T KNOW	2

- **G2.** How many children under age 18 does the client have? # _____
- **G3–6.** What are the children's ages and with whom do they live? If client has more than one child under the age of 18, list the 4 youngest children. Do not include an address, but with whom the children live (e.g., foster care, other parent, relatives, friends).

		Age	Where living
G3.	Child 1		
G4.	Child 2		
G5.	Child 3		
G6.	Child 4		

H1–9. Types of income and benefits (circle no or yes for each option)

	Income or Benefit Sources	NO	YES
H1.	Supplemental Security Income (SSI)	0	1
H2.	Social Security Disability Income (SSDI)	0	1
H3.	Welfare (TANF, GA, State or City program)	0	1
H4.	Veteran's income benefits	0	1
H5.	Employment income	0	1
H6.	Subsidized health insurance (Medicaid, Medicare, Veteran's)	0	1
H7.	Unsubsidized health insurance	0	1
H8.	Food Stamps	0	1
H9.	Other (specify:)	0	1

- I1. Total monthly income: **\$_____.00**
- **J1.** Does the client have a representative payee?

NO <i>[go to K1]</i>	0
YES	1

J2. Who is the client's representative payee?

Housing First Program	1
Relative (specify:)	2
Other (specify:)	3

K1. Does the client have an axis I diagnosis? (circle one)

```
        NO [go to K3]
        0

        YES
        1
```

K2. What is the client's axis I diagnosis? (briefly describe diagnosis)

K3. Does the client have an axis II diagnosis? (circle one)

NO [go to K5]	0
YES	1

- **K4.** What is the client's axis II diagnosis? (briefly describe diagnosis)
- **K5.** Is the client experiencing symptoms related to mental illness or psychiatric problems? (circle one)

NO <i>[go to L1]</i>	0
YES	1

K6. What level of impairment is the client experiencing due to symptoms related to mental illness or psychiatric problems? (circle one)

None	1
Moderate	2
Severe	3
Unknown	4

L1. Does the client have a *history* of substance use? (circle one)

NO [go to M1]	0
YES	1

L2. What were the substances the client used? (circle one)

Alcohol	1
Drugs	2
Alcohol and drugs	3

L3. Was the client ever treated for substance abuse? (circle one)

NO	0
YES	1

M1. Is the client *currently* using drugs? (circle one)

NO [go to M3]	0
YES	1

M2. What is the client's *current* level of impairment as a result of drug use? (circle one)

None	1
Moderate	2
Severe	3
Unknown	4

M3. Is the client *currently* using alcohol? (circle one)

NO [go to N1]	0
YES	1

M4. What is the client's *current* level of impairment as a result of alcohol use? (circle one)

None	1
Moderate	2
Severe	3
Unknown	4

N1-6. Does the client have any other special needs? (circle no or yes for each option)

	Special Needs	NO	YES
N1.	Developmental disability	0	1
N2.	Physical disability	0	1
N3.	HIV/AIDS and related diseases	0	1
N4.	Victim of domestic violence	0	1
N5.	First language is not English	0	1
N6.	Other (specify:)	0	1

O1. Has the client ever been arrested? (circle one)

NO <i>[go to P1]</i>	0
YES	1
DON'T KNOW	2

- O2. Number of times the client has been arrested in past 3 years: #_____
- **O3.** Was the client ever incarcerated? (circle one)

NO [go to O5]	0
YES	1
DON'T KNOW	2

O4. Is the client currently on probation or parole? (circle one)

NO	0
YES	1
DON'T KNOW	2

P1. Is the client currently taking psychiatric medications? (circle one)

NO	0
YES	1

Q1. Has the client been hospitalized for psychiatric reasons? (circle one)

NO <i>[go to R1]</i>	0
YES	1

- Q2. Number of days client spent in psychiatric hospital in past 3 years: #_____
- **R1.** Has the client had other psychiatric treatment (e.g., outpatient therapy, short-term residential treatment, respite care)? (circle one)

NO	0
YES	1

S1. Does the client have chronic medical condition(s) such as heart disease, diabetes, mobility impairment, or asthma? (circle one)

NO	0
YES	1

T 1–5. Please tell us the client's residential history (including institutions and temporary situations) for the 30 days prior to placement.

Record the type of housing where the client was living. Types of housing may include homelessness, jail or prison, brief residential transitions with friends and family, and hospitalizations (indicate medical, psychiatric, or detox/rehab).

Record the duration (number of days) that the client lived in a type of housing during the 30 days. For example, if a client lived on the streets for the entire 30 days, type of housing would be "homeless" and duration would be 30 days.

	Type of Housing	Duration
T1.		
T2.		
T3.		
T4.		
T5.		

U1. What is the client's highest level of school completed? (circle one)

8th grade or less	1
Some high school (9th to 11th grade)	2
High school diploma or GED	3
Some college	4
College degree	5

V1. Has the client ever been employed? (circle one)

NO <i>[go to V1]</i>	0
YES	1

- V2. Last year of the client's employment: _____
- W1. Date of placement in Housing First program: ____/___/

Exhibit A–6. Monthly Data Collection Instrument

HOUSING FIRST STUDY MONTHLY DATA COLLECTION

Client ID Number	
Site	
Data Collector's Initials	
Month Covered by Report	
Date Information Reported	

This information is to be completed by the client's treatment coordinator or agency staff member who knows the most about the client. To the extent possible, it should be filled out on a monthly basis even for clients who have left the permanent supportive housing program.

A1–5. Please tell us the client's residential history (including institutions and temporary situations) for the past month.

Starting at A1 with the location at the most recent interview, record the type of housing, the location, and the duration in days for the last month. Watch for periods of homelessness, jail or prison, hospitalizations, and brief residential transitions. Determine if hospitalizations were for medical, psychiatric, or detox/rehab reasons.

	Location	Type of Housing	Duration
A1.			
A2.			
A3.			
A4.			
A5.			

B1. Did the client leave the program during the month? (circle one)

NO [go to C1]	0
YES	1

B2. Why did the client leave the program? (briefly describe)

C1–9. Estimate the number of contacts with supportive services providers, and who provided the services, during the month. A contact is any day that a client meets with any of the listed providers. Multiple meetings in the same day with the same provider are counted as one contact. If the client meets with multiple providers on the same day, each provider should be counted once for that day. For each provider, the maximum number of contacts for a given month is the number of days in that month. If there were no contacts by a particular provider or for a particular service, mark that cell with a "0."

	Service	Housing Staff	Other Staff	Other Agency
C1.	Case management			
C2.	Life skills training (outside of case management)			
C3.	Substance abuse counseling or treatment			
C4.	Psychological treatment or mental health services			
C5.	Other health care services			
C6.	Legal assistance			
C7.	Employment assistance			
C8.	Other (specify:)			
C9.	Other (specify:)			

D1. Did the client use alcohol this month? (circle one)

NO	0
YES	1

D2. What was the client's level of impairment as a result of alcohol use during the past month? (circle one)

No alcohol use	0
None	1
Moderate	2
Severe	3
Unknown	4

D3. Did the client use drugs this month? (circle one)

NO	0
YES	1

D4. What was the client's level of impairment as a result of drug use during the past month? (circle one)

No drug use	0
None	1
Moderate	2
Severe	3
Unknown	4

E1. Does the client have a representative payee?

NO [go to E3]	0
YES	1

E2. Who is the client's representative payee?

Housing First Program	1
Relative (specify:)	2
Other (specify:)	3

E3. Estimate how well the client managed his/her money this month. (circle one)

Poorly	1
Moderately	2
Very well	3

E4. Estimate the client's money management skills this month. (circle one)

Program identifies need; program purchases items for the client.	1
Client identifies need; client asks program to purchase items.	2
Client identifies need; client asks for money to purchase items.	3
Client managed own money for needs during the month.	4

F1. Is the client experiencing symptoms related to mental illness or psychiatric problems? (circle one)

NO <i>[go to F3]</i>	0
YES	1

F2. What level of impairment is the client experiencing due to symptoms related to mental illness or psychiatric problems? (circle one)

None	1
Moderate	2
Severe	3
Unknown	4

F3. How often is the client taking medication to manage symptoms related to mental illness or psychiatric problems? (circle one)

Never	0
Sometimes	1
Always	2

F4. How independently is the client taking medication? (circle one)

Supervised by staff while they take it	1
Staff package it, but client takes it independently	2
Client packages it at agency's office and takes it independently	3
Client obtains and takes medication independently	4

G1. Estimate the number of days that the client had contacts with the community (outside of the agency) during the month. A contact with the community is any transaction or interaction (e.g., shopping at the grocery or drug store, going to a restaurant, doctor visit, meeting with welfare or SSI officer, visiting relatives, other social activities) that takes place outside their buildings. A community contact does not include meetings with program staff. If client has multiple community contacts on the same day, count it as one contact day. (circle one)

Daily or almost daily (25+ days)	1
A lot (10–24 days)	2
Some (5–10 days)	3
A few (1–4 days)	4
None <i>[go to H1]</i>	5
Don't know <i>[go to H1]</i>	6

G2. If client had community contacts, was the client accompanied by program staff or other service providers for half or more of the community contacts? (circle one)

NO	0
YES	1

H1–9. What sources of income benefits did the client have at any point during the month? (circle no or yes for each option)

	Income or Benefit Sources	NO	YES
H1.	Supplemental Security Income (SSI)	0	1
H2.	Social Security Disability Income (SSDI)	0	1
H3.	Welfare (TANF, GA, State or City program)	0	1
H4.	Veteran's income benefits	0	1
H5.	Employment income	0	1
H6.	Subsidized health insurance (Medicaid, Medicare, Veteran's)	0	1
H7.	Unsubsidized health insurance	0	1
H8.	Food Stamps	0	1
H9.	Other (specify:)	0	1

- I1. What was the client's total income during the month? \$____.00
- **J1.** Were there any housing problems for the client during the month? (circle one)



J2. In general terms, what were the problems? (briefly describe)

Exhibit A–7. Focus Group Discussion Guide

Thank you for meeting with us today. My name is [name of moderator] and this is [name of note taker] and we are here as part of a study to understand how programs like [Housing First program] can help people who have been living on the streets for a long time find a place to live and stay off the streets. For this study, we are also talking with the people who plan, run, and pay for programs like this. We are also visiting two other programs to understand what they are doing to help people in need.

We would like to learn about your experiences in "getting off the streets" and your ideas about what programs or services are working well and what can be done better. There are no "right" or "wrong" answers, and we will not be using your names when we report what we have learned. We are really just interested in understanding how well programs like this work from the perspective of people who have experiences like yours.

[Name of note taker] will be taking notes as we talk about your experiences. We also will be tape recording the discussion, but that is only to provide backup to our notes, for example, to clarify something that is said when we review the notes later. We will not be associating any comments with anyone individually, so we hope you will feel free to respond candidly and honestly.

NOTE TO FACILITATORS

Pay close attention to the many themes of interest in this study and allow the participants to raise them before you bring them up explicitly. They include:

- Immediate placement into permanent housing;
- Availability of needed services;
- Voluntary versus mandatory nature of program services, experiences with each;
- Appropriateness of services/approach for various sub-groups of chronic homeless;
- Satisfaction with types of housing and range of housing choices offered;
- Preferences for types of services connected to housing, and how they are connected (required or voluntary); and
- Experience with the transition from streets to permanent housing.

ACCEPTING HOUSING

I'd like to begin our discussion by asking everyone how and when you first came in off the streets [or from a shelter] and into [Housing First program] housing?

• What made you decide to accept housing? (word on the street, another homeless person, specific service provider...?)

- What program or person first helped you? [We want to know what type of program this is/was so try to get exact name/s and confirm type/s later.]
- There must have been many times before you decided to "come in" that you thought about it, or that people asked if you wanted to "come in." What was different about this time?
- Were you just "ready?" Did [program/person] offer you something or some service in particular that made it okay for you to leave the streets?
- What did you know about this program/person before you came in? How did you know this?
- Were the program and the help you received what you expected? Any "surprises?"
- Did you get everything you needed when you first came in? Was there anything that you didn't need/want but had to do?
- Did you have a choice about where you would live? If so, what were your choices and what was important to you in deciding among your choices?
- How did [Housing First program] staff build trust with you in a way that helped you get services or stay in your housing?
- What do you like about the housing you have here? What do you not like about it?
- Overall, would you say you are very satisfied, somewhat satisfied, or not satisfied with the housing you obtained through this program?
- Was there anything that should have been done differently or better?
- Do you have someone who serves as representative payee for you—that is, receiving your money every month and paying your rent and other bills, and then giving you what is left over? If so, what do you think of this arrangement? Is this required by [Housing First program]?
- How well would this program work for other people you know who are still living on the streets? What do they need? How could they be helped off the streets and into housing?

STAYING OFF THE STREETS

The last topic I'd like to cover with you is what it takes to keep people who have lived on the streets for a long time from ever going back. What types of services and supports are important to helping people stay housed for a long time (forever)? What do you need, now that you have been off the streets for a while? What will you need in the future? What have your experiences been, both good and bad?

- What do you know about other housing programs in this community? How do you know about them (personal or friends' experiences, word on the street?) Do they work? All of them, or only some? If only some, which ones and why those? How good are they? Do they provide you with everything you need (or help you get what you need from other programs/places)? How do the other programs compare to this one in terms of housing? Supportive services? Rules? Respect for their clients?
- What are the most important things that will help you stay off the streets? Is there anything offered by permanent housing programs that you don't really need?
- In thinking about how this program can help formerly homeless people stay housed forever, is there anything that the program should be doing differently or better?
- What do you think people who are living on the street right now need in order to leave the streets and come to programs such as this one? Would this program work for all of them, or just some types of people who are now living on the streets?

Are there any other experiences or ideas you would like to share with us before we end our meeting? Does anyone have any questions for us?

Thank you all so much for your time and help. When we are finished visiting all the places we are studying, we will write a report with our findings. We hope that other communities will read this report and learn about what they can do to help other people like you. What you have shared with us today will help these communities as they develop programs like this. Thanks again.

Distribute payments in envelopes and have respondents sign receipts for project accounting.

APPENDIX B: CANVASS TABLES

The following tables display the findings from the nationwide canvass of Housing First programs conducted between December 2003 and January 2004. See table B–1 for characteristics of programs that the study team determined met the criteria for a Housing First model. See table B–2 for characteristics of programs that the study team determined met some, but not all, criteria for a Housing First model.⁹⁶

⁹⁶ Note that all information in the matrix may not be available for all programs for one of two reasons: due to the short timeframe of the study, some programs were unable to participate in a discussion of all aspects of their Housing First approach; and some programs were not eligible for this study so the study team did not discuss all aspects of the program's approach.

Table B–1. Housing First Programs

	Year First Client Placed		Population	s Served	Identification of Clients	Immediacy of Placement into Permanent Housing	Treatment Requirements	Approach to Services
Provider		Program Scale	Diagnoses	Living on Streets				
Pathways to Housing, New York City, NY	1992	 465 total enrollment 3 placements per month 6% turnover during first year of placement 	90% dual diagnosis	50% (50% institutional discharges)	Outreach teams from community agencies, hospitals, prison	Clients move immediately into a scattered-site apartment where Pathways to Housing holds the lease	No treatment requirements prior to enrollment; clients must agree to 2 home visits per month	ACT team with off- site services; low demand approach to substance use
Downtown Emergency Service Center, Seattle, WA	May 1994	 306 total enrollment 2–3 placements per month 6–7% turnover during first year of placement 	10% substance abuse only, 40% mental illness only, 50% dual diagnosis	30%	Case managers and self- referrals	Clients move from a transitional to permanent housing placement in one of three buildings; clients hold their own leases	No treatment requirements prior to or after enrollment	Modified ACT team with on-site services; low demand approach to substance use
REACH, San Diego, CA	December 2000	 250 total enrollment (200 in permanent housing, 50 in transitional housing) 2 placements per month 25% turnover during first year of placement 	30% mental illness only, 70% dual diagnosis	80%	Street outreach	20% of clients move into transitional housing prior to permanent placement, typically by choice; transitional housing is in the Metro Hotel, which may also serve as permanent housing for individuals who do not have Section 8 vouchers; clients hold their own leases	No treatment requirements prior to program enrollment; clients must meet with case manager twice a month	Modified ACT team; low demand response to substance use
Sunshine Terrace, Columbus, OH	July 2001	 130 total enrollment 16 placements per month 20% turnover during first year of placement 	20% mental illness only, 30% substance abuse only, 40% dual diagnosis	10%	Outreach, shelters, street, hospitals, jail, veterans' commission	Some clients have transitional moves prior to permanent placement in an SRO owned by the YMCA or other building owned by the Columbus Metropolitan Housing Authority; agencies that own the buildings hold the leases	No treatment requirements prior to or after enrollment	Teams with community-based support services on-site
The Village, Los Angeles County AB 2034, Long Beach, CA	1999	 400 total enrollment 8 placements per month 10% turnover during first year of placement 	100% mental illness	100%	Streets, jail; members must be connected with a case manager to enter program	Clients may choose among a number of housing options, including transitional housing at hotels or shelters; clients hold their own lease	No treatment requirements prior to or after enrollment	Community-based services that meet clients "where they are"
Community Housing Network, Columbus, OH	February 1999	 109 total enrollment 	All mentally ill, most dual diagnosis	Not available	Mental health agency, homeless outreach team, shelters	Clients move into permanent supportive housing in buildings owned by the agency	No treatment requirements prior to or after enrollment	Stages of change model to address substance use

Provider	Year First Client Placed	Program Scale	Populations Served		Identification of	Immediacy of Placement into	Treatment	Approach to
			Diagnoses	Living on Streets	Clients	Permanent Housing	Requirements	Services
Direct Access to Housing, San Francisco, CA	December 1998	 393 total enrollment 30–40 placements per month 33% turnover during first year of placement 	80% disabled (substance abuse, mental health, medical disorders)	90%	Street outreach teams, shelters, emergency department case management teams, primary care clinics, institutional settings	Immediate access to permanent housing in six facilities where the program holds the lease	No treatment requirements prior to or after enrollment	ACT teams with on- site services
Horizon House, Philadelphia, PA	March 2003	 40 total enrollment 5 placements per month No turnover during first year in placement 	100% dual diagnosis	100%	Outreach teams, database of homeless	Client chooses among several scattered-site apartments and clients hold their own leases	No treatment requirements prior to or after enrollment	ACT team with off- site services
Lamp Community, Los Angeles, CA	June 1991	 100 total enrollment 3-4 placements per month 1% turnover during first year in placement 	20% mental illness only, 80% dual diagnosis	90%	Street and jail outreach, safe haven project	Client chooses to move directly into an apartment or to stay in the shelter first; client holds the lease for some housing locations and program holds the lease for others	No treatment requirements prior to or after enrollment	ACT team with on- site services

Table B–1. Housing First Programs

Provider	Year First Client Placed	Program Scale	Populations Served		Identification of	Immediacy of Placement into	Treatment	Approach to
			Diagnoses	Living on Streets	Clients	Permanent Housing	Requirements	Services
Anishinabe Wakiagun, Minneapolis, MN	Not available	40 total enrollment	33% dual diagnosis, 67% substance abuse only	90%	Local detox center, walk- ins	No transitional moves	No treatment requirements prior to or after enrollment	ACT team with on- site services
Avalon Housing, Ann Arbor, MI	1992	 116 total enrollment 1 placement per month 2% turnover during first year in placement 	25% no diagnosis, 30% dual diagnosis, 45% mental illness only	<10%	Word of mouth, openings published in the paper, referrals from area service providers	Clients move directly into permanent housing owned by the program; clients hold their own leases	No treatment requirements prior to or after enrollment, unless housing is in jeopardy	On-site multidisciplinary treatment team
Canon Kip Community House, San Francisco, CA	1994	 103 total enrollment 1 placement per month <10% turnover during first year in placement 	75–80% dual diagnosis	90%	Referral by social services providers	Clients move from a waiting list into permanent housing provided through several city agencies; clients hold their own leases	No treatment requirements prior to or after enrollment	ACT team with on- site services
Chicago Housing for Health Partnership, Chicago, IL	2003	24 total enrollment	100% diagnosed with one of 10 identified chronic illnesses; 80% have a history of chronic substance abuse and 20%–30% have chronic mental illness	Not available	Referrals from three local hospitals	Clients must stay at an interim health facility for 1–12 weeks to stabilize following hospitalization and to determine the appropriate type of permanent housing, including scattered-site and group living	No treatment requirements prior to enrollment; clients must work with a case manager	Off-site services
Common Ground, New York City, NY	Early 1993	 270–350 total enrollment <1 placement per month <1% turnover during first year in placement 	60% dual diagnosis	Not available	Referrals from Human Resources Administration, Housing Resource Center, and self-referral	Clients enter permanent housing in one of two buildings following a stay in shelter or transitional facility; clients hold their own leases	No treatment requirements prior to or after enrollment	ACT team with on- site services

Table B–2. Possible Housing First Programs

Provider	Year First Client Placed	Program Scale	Populations Served		Identification of	Immediacy of Placement into	Treatment	Approach to
			Diagnoses	Living on Streets	Clients	Permanent Housing	Requirements	Services
Commons at Grant, Columbus, OH	June 2003	100 total enrollmentNo new placements	50% low- income wage earners, 50% homeless with one verifiable disability (mental or physical)	Not available	Not available	Not available	No treatment requirements prior to or after enrollment	Not available
Contra Costa County Public Health Homeless Program , Contra Costa County, CA	1997	 160 total enrollment 1 placement per month <10% turnover during first year of placement 	60% dual diagnosis	70%	Psychiatric facilities, hospitals, detox, jail, transitional housing, multi- service centers, streets	Clients have to wait 90–120 days to secure a housing voucher; clients hold their own leases	No treatment requirements prior to or after enrollment	Modified ACT team with a low demand approach
Dwelling Place, Grand Rapids, MI	May 2002 for Ferguson; 1987 for DPI	 189 total enrollment 25% turnover during first year in placement 	Ferguson— 20% mental illness only, 20% physical disability, 60% dual diagnosis; Dwelling Place Inn—25% mental illness only; 25% physical disability, 50% dual diagnosis	20%	Social service agencies and self-referral	Clients immediately enter one of the program's facilities where they hold their own leases	No treatment requirements prior to or after enrollment	ACT team with on- site services
Housing Initiatives, Madison, WI	January 1995	 64 total enrollment 1.5 placements per month <1% turnover during first year in placement 	33% dual diagnosis, 67% mental illness only	1%	Referrals by shelters and transitional housing staff, walk-ins	Clients move immediately into a program facility or scattered-site housing; clients hold their own leases and program writes a letter to landlords to guarantee rent	No treatment requirements prior to enrollment; clients must work with a case manager	ACT team with off- site services
Phoenix Programs, Inc., Concord, CA	Not available	20 total enrollment	Mental illness	Not available	Outreach, daytime homeless service centers	Clients move directly into shared permanent housing owned by the program; the program holds a master lease	Clients are encouraged to be clean and sober and medication compliant	Assertive case management

Table B–2. Possible Housing First Programs

Provider	Year First Client Placed	Program Scale	Populations Served		Identification of	Immediacy of Placement into	Treatment	Approach to
			Diagnoses	Living on Streets	Clients	Permanent Housing	Requirements	Services
Project HOME, Philadelphia, PA	1992	 98 total enrollment 5 placements per month 60% turnover during first year in placement 	100% mental illness, 32- 53% of which have a dual diagnosis	43%	Homeless outreach programs, Department of Mental Health	Clients experience transitional moves through the safe haven; clients do not hold their own leases	Substance abuse treatment required at one of the housing facilities	Case managers and psychiatrists
Sacramento County, California AB 2034, Sacramento County, CA	1999	 100 total enrollment <1 placement per month 	32% mental illness only, 68% dual diagnosis	Not available	Referrals by the larger homeless system of care, the mental health homeless system of care, jails, and mental health crisis units	Clients typically have a transitional stay at a room and board house or transitional housing unit	No treatment requirements prior to or after enrollment	Modified ACT team with off-site services
Tellurian, Madison, WI	January 1988	 12 total enrollment 2–3% turnover during first year in placement 	40% mental illness only, 60% dual diagnosis	15–20%	Self-referrals from street, police, cab drivers, shelters, and transitional housing	Not available	Not available	ACT team with on- site services
The Wintonia, Seattle, WA	1994	 89 total enrollment 2 placements per month 3% turnover during first year in placement 	10% either substance abuse or mental illness only, 90% dual diagnosis	65%	Clients are referred by other social service agencies and placed on a waiting list	Clients move directly into SRO housing, masterleased by the program	No treatment requirements prior to or after enrollment	On- and off-site services

Table B–2. Possible Housing First Programs

APPENDIX C: DOWNTOWN EMERGENCY SERVICE CENTER (DESC), SEATTLE, WASHINGTON

The Downtown Emergency Service Center (DESC) provides outreach, case management, and mental health and substance abuse treatment services. DESC also operates emergency shelters, a safe haven, and permanent supportive housing programs for homeless people with mental illness and substance-related disorders.

DESC maintains 331 units of permanent supportive housing in four buildings that DESC either owns or controls. Each building is staffed by 24-hour, on-site housing case management staff who work with clinical case managers to help residents adjust successfully to the housing environment. DESC also controls access to an additional 145 rent subsidies for use by agency clients in scattered-site housing in the community. This housing is typically used by clients who require lower levels of supportive services.

DESC initiated a permanent supportive housing program with a Housing First approach in May 1994. Most clients enter DESC's permanent supportive housing through other divisions within DESC. DESC's outreach program—the Homeless Outreach, Stabilization, and Transition (HOST) project—provides outreach and engages homeless people on the street and in DESC's shelter. Case managers from the clinical mental health services division of the agency refer homeless people on the street and in emergency shelters to DESC's housing programs.

BACKGROUND

For more than 20 years, DESC has specialized in serving homeless people with mental illness who congregate in the downtown Pioneer Square area of Seattle. Initially, DESC opened an emergency shelter to serve the mentally ill and substance abusing homeless population living on the street. DESC thus learned how to work effectively with the homeless people who other agencies would not serve.

To meet the needs of this treatment-resistant population more effectively, DESC has fostered strong partnerships with city and county government. DESC became certified as a licensed mental health provider in 1980. King County then contracted with the agency to provide emergency shelter and case management to the chronically homeless population that increasingly was considered a problem to the downtown business community. In 1985, through a Robert Wood Johnson Health Care for the Homeless grant, DESC secured on-site nursing staff in addition to mental health and drug and alcohol addiction services.

In 1994, the U.S. Department of Health and Human Services designated DESC as a demonstration program site in its Access to Community Care and Effective Services and Supports (ACCESS) program. One goal of the ACCESS program was to improve integration of service systems that provide housing and services for severely mentally ill homeless people. Following the ACCESS demonstration in 1999, King County continued funding DESC to find and engage the homeless mentally ill population through its HOST project. Also in 1999, DESC

became licensed in chemical dependency treatment, allowing the agency to integrate mental health and addiction treatment for homeless people who are dually diagnosed with substance-related disorders.

DESC staff found that they could effectively help homeless people move out of emergency shelters. Staff grew frustrated, however, that after leaving the shelters, they often returned to homelessness. Hindered by the lack of an effective service system, DESC decided to work with the mental health and addiction treatment systems in Seattle. Together, they developed long-term housing for homeless people with psychiatric disabilities and substance-related disorders.

DESC's overall housing program has not been evaluated. However, a study was conducted during 2002 on the Lyon Building, where 64 DESC clients live. The Lyon Building serves low-income people with HIV/AIDS and at least one other qualifying disability—typically mental illness or substance abuse, and frequently both. This study found that more than 90 percent of the Lyon Building's residents had been homeless at some time. Forty-six percent had been homeless for at least one-quarter of their adult lives. Despite the high past incidence of homelessness among these residents, 65 percent had lived there for more than three years. While living at the Lyon Building, residents reported increased access to services, better control over their lives, and improved overall quality of life. Fewer than 20 percent planned to leave. Physical health status deteriorated significantly during the study period, which was expected given the frail health of the residents at baseline. Service engagement and substance abuse impairment improved slightly (Northwest Resource Associates, 2002).

POPULATION SERVED

The agency provides emergency shelter, survival services, clinical programs, and supportive housing to more than 5,000 homeless people annually.⁹⁷ Staff estimate that DESC has at least some contact with most of the approximately 2,500 chronically homeless people in Seattle, because the agency's programs focus on people who are the most disabled and longest-term homeless.

DESC's Housing First program started in May 1994 and places approximately two or three clients per month. DESC staff estimate that about 30 percent of their clients come directly from the streets, with the remainder coming from emergency shelters. DESC operates a low-demand emergency shelter that prioritizes mentally ill and addicted individuals without sobriety requirements. This results in a fairly high proportion of Housing First clients using shelters at least some of the time. DESC's goal for its Housing First program is to serve the most vulnerable homeless people. Annual Progress Reports (APRs) submitted to the U.S. Department of Housing and Urban Development (HUD) in 2003 indicate that nearly all the new clients entering DESC's housing had a mental illness and the majority had a substance-related disorder.

⁹⁷For more information, see: http://www.desc.org/program.html.

The research on which this report is based tracked 25 of the agency's clients. Of those tracked, 21 met HUD's criteria for being "chronically homeless."⁹⁸

THE TRANSITION FROM HOMELESSNESS TO PERMANENT SUPPORTIVE HOUSING

The key feature of the DESC Housing First approach is that homeless people do not have to agree to sobriety or treatment as a condition of entering or retaining housing. According to DESC staff, a few other Seattle area programs serve people who are chronically homeless and have limited service requirements for clients. These programs do not require sobriety, but do require that clients be connected to case management. With its focus on providing permanent supportive housing to the most vulnerable and least engaged among the chronically homeless population, DESC staff believe their program approach allocates scarce housing resources to those who need them most, regardless of how connected the clients are to case management or other services. In the words of a senior staff member at DESC, the most important lesson learned from their experience is that "people can be housed the way they are."

DESC staff maintain that understanding the engagement, enrollment, and placement dynamic is an essential component of the Housing First approach:

The key to the approach is going at the client's own pace. It's about engagement, not outreach. It may start with going where people tend to go, but engagement continues throughout the process from streets, shelter, housing, and back. We work with the people who need it most. People who are more assertive in their needs are typically those who need it least; the onus is on us to make most resistant people want our services. (Interview with Dan Malone, Housing Program Director, April 2004)

Outreach

DESC's HOST project conducts outreach. Outreach workers engage homeless persons with mental illness on the street, in emergency shelters, and in drop-in centers. HOST outreach workers look for the most impaired, most vulnerable people on the street. A staff member reported that, "HOST is looking for people who are *not* looking for us." Outreach staff begin by meeting people where they spend time, starting with small talk, then offering tangible assistance (i.e., a sleeping bag, coffee, clothing). Once the homeless person accepts tangible items, the outreach worker may offer help with benefits, medical care, or other needs. HOST outreach workers carry caseloads of approximately 15 people.

Housing Placement

A HOST case manager may offer a client housing at any point during the engagement process. If the client seems ambivalent or unwilling, the HOST staff work with the client to learn more about the housing and become comfortable with the idea of trying the housing arrangement. Because vacancies are rare, staff maintain a waiting list of qualified homeless persons who are

⁹⁸ The present study included DESC staff tracking 25 clients over a 12-month period. The staff used standard baseline and monthly data collection instruments to gather data about the study participants through administrative information systems. See Appendix A for more information about the study methodology.

interested in entering housing. Staff explain that how long or how well they know an applicant has no bearing on the applicant's place on the waiting list. Instead, the lists are prioritized by level of need, with the most vulnerable and dysfunctional candidates receiving the highest priority for housing. About every two months, housing staff and HOST outreach workers meet to review where housing is available and who is at the top of the list to enter housing. In the meantime, HOST staff maintain as much contact as possible with candidates where they are living—on the streets or in the shelter.

Staff admit that setting priorities has been somewhat subjective in the past. To lessen subjectivity, DESC is in the process of implementing a standardized assessment form to be used with all clients. The form will assess functioning and vulnerability, yielding a score that will be used to rank housing applicants. Case managers will be able to see how their clients' scores compare to others on the waiting list.

When a housing opening occurs, DESC contacts the top applicant on the waiting list. Because vacancies are rare and are limited to the four buildings DESC owns or controls, client choice in housing is limited. Staff and residents confirmed that clients can choose between accepting a unit or remaining homeless, but do not really have a choice among housing units. Community integration is also limited. Each of DESC's buildings serves only (formerly) homeless people, the large majority of whom have a mental illness.

The nine clients who participated in focus groups during the site visit made generally favorable comments about DESC housing.⁹⁹ Clients liked tangible aspects of their housing, including the privacy offered by individual apartments and amenities such as laundry facilities, television, and meals. They also liked less tangible features such as feeling "at home," being independent, and having a social life. One focus group participant, a former state hospital resident, made most of the negative comments. He did not like living with a large number of people with mental illness, "It's still a nuthouse," he complained.

Residents in the focus groups verified, that applicants for housing do not have to agree to participate in supportive services to receive housing. Representative payees are rarely mandated by DESC, but approximately 30–40 percent of clients have them. DESC may initiate a representative payee arrangement if the resident has a history of nonpayment of rent. Staff estimate that this occurs in fewer than 10 percent of cases. More commonly, the Social Security Administration or the state of Washington requires that clients have a representative payee. In such a case, DESC often serves as representative payee for its clinical program clients. Eight of the clients who participated in the focus groups said they had a representative payee, and two said having a representative payee was a condition of getting their housing. One said he resented having a payee, but none of the others objected publicly to the arrangement.

In most cases, staff request that the client participate in an interview prior to admission, but this is not mandatory if the client is unwilling to participate. The Seattle Housing Authority (SHA) administers the Section 8 subsidies that are attached to some of the units in each of the four buildings operated by DESC. For the units that receive Section 8 subsidies, SHA must approve

⁹⁹ The study team conducted two focus groups at DESC on May 23 and 24, 2005. A total of eight clients participated in these groups.

new residents. Under certain circumstances, applicants with histories of sex offenses, arson, drug convictions, and evictions from SHA housing may be rejected, but DESC is permitted to apply their own criminal background criteria. More often than not, applicants with problematic criminal backgrounds can be housed, as long as it is not prohibited by the Federal regulations governing the Section 8 program.

HOUSING FOR DESC CLIENTS

DESC offers supportive housing at four locations, each serving slightly different populations. The common feature among the four locations is that homeless people do not have to agree to services as a condition of entering or retaining housing. Each location is described below.

Kerner-Scott House

Kerner-Scott House is a 25-unit safe haven for people with serious mental illness referred through DESC's HOST project. Located in the south Lake Union area, Kerner-Scott House is in a somewhat tucked away location. But it is near busy downtown streets and just off an expressway. The four-story building also houses offices for on-site staff, a 25-bed overnight shelter for women who are homeless and mentally ill, and a 15-unit "clean and sober" program.

Each safe haven resident has a studio apartment. Each apartment has a small kitchen, living and sleeping area, and bathroom. The street level includes a common living and dining area and staff offices. Kerner-Scott's on-site staff members include two clinical service coordinators and one or two residential counselors during the day. Staffing at night includes two or three overnight staff, and three swing shift staff. Clinical service coordinators provide clinical supervision of the residential counselors. They also are primarily responsible for administrative functions.

Eligibility criteria for Kerner-Scott House include homelessness, serious mental illness, and lack of other housing options. This safe haven serves the most impaired and least engaged of DESC's clients. There are no formal limits on length of stay, but residents are encouraged to move to one of DESC's other permanent supportive housing buildings within 24 months. DESC's other three buildings are located within a few blocks of each other on Third Avenue in the Pioneer Square area of downtown Seattle. Five of the clients tracked for this study lived at Kerner-Scott when they entered the study.

The Lyon Building

The Lyon Building has 64 units of permanent supportive housing for persons with HIV/AIDS and other disabilities. The building opened in 1997 after being renovated by another local nonprofit housing and services provider, AIDS Housing of Washington. DESC operates the building and provides services, but does not own the building. The first floor has a common area and staff offices.

Referrals to the Lyon Building come from DESC outreach, as well as Seattle area AIDS service providers. To live at the Lyon Building, applicants must be homeless, low-income, and require supportive services. They must have two of three qualifying disabilities:

HIV/AIDS, mental illness, or chronic substance abuse history. Applicants are assigned to a priority category for admission—applicants disabled by both HIV/AIDS and mental illness have top priority. Applicants who do not have HIV may be admitted, but this is only a small percentage of residents. Staff estimate that three-quarters of the building's residents have a mental illness, but not necessarily a "severe and persistent" mental illness. A slightly larger proportion—roughly

80 percent—have substance abuse histories. Many residents have all three disabilities, according to staff. Most also have criminal histories related to their substance abuse.

There are no time limits on stays at the Lyon Building. Compared to DESC's other permanent supportive housing locations, a smaller proportion of Lyon Building residents come from the streets or emergency shelters. According to staff, the HIV/AIDS services system has a more extensive stock of transitional housing relative to the need, so some residents come from such transitional settings.

The Lyon Building has four clinical service coordinators for its 64 residents, including one who is a chemical dependency specialist. Residential counselors provide additional on-site support. Four of the clients tracked for this research lived at the Lyon Building when they entered the study.

The Morrison Hotel

The Morrison Hotel was originally owned and operated by the SHA. The five-story building had 205 single room occupancy (SRO) units. Beginning in 1979, DESC leased additional space in the building for a 203-bed emergency shelter. Historically, the SRO units were mostly occupied; however, many residents were either frail elderly or had mental illnesses. Many had unmet service needs, criminal histories, behavioral issues, and other challenges. In 2001, a group of local stakeholders put pressure on SHA to address problems created by residents of the building, recommending that SHA sell it to DESC. SHA agreed. DESC purchased the building and assigned a project manager, program assistant, five clinical service coordinators, and nine residential counselors to the building. The building serves homeless individuals, disabled by mental illness or substance abuse, and some formerly homeless residents coming from Kerner-Scott House. Fifteen of the clients tracked for this study lived at the Morrison.

In addition to permanent supportive housing, the Morrison Hotel continues to house an emergency shelter for 203 men and women, including a 20-bed Crisis Respite Program. Shelter guests must either be women or people with disabilities. People are defined as disabled if they have a mental health problem or physical disability. During the day, the shelter space operates as a drop-in center staffed to provide medical care, mental health counseling, and chemical dependency treatment. Staff provide information and referrals. Visitors may obtain clothing and use hygiene facilities, as well as mail and phone services. These contacts allow homeless people to learn about DESC's permanent housing programs.

The Union Hotel

The Union Hotel, a renovated SRO hotel building, opened in 1994. It houses 52 mentally ill and formerly homeless residents in permanent supportive housing. Each resident has an independent apartment with a small kitchen area and bathroom. Some units do not have showers, so there are common showers in the hall. Turnover is extremely low (only four units in 2003). About one-half of the residents are former Kerner-Scott House residents who are ready for somewhat more independent living. Applicants must be homeless and disabled. Ninety-five percent have a primary diagnosis of mental illness, and roughly one-third have a history of chronic substance abuse. Staffing at the Union Hotel is somewhat less intensive than at the Morrison Hotel, with one residential counselor on duty at all times and one clinical service coordinator. There are no limits on length of stay at the Union Hotel. One of the clients tracked for this study lived at the Union Hotel.

Housing Agreements

When a client enters DESC housing, he or she signs a lease agreement and a clinical service coordinator is assigned. Residents of Kerner-Scott House sign a month-to-month agreement, while residents of the other buildings sign one-year agreements. Lease documents include provisions that the resident may be evicted for criminal activity, drug use, or violence in or near the property. Staff explain, however, that residents receive many warnings before the agency elects to move the resident to another DESC building or pursue an eviction. In addition, leases include a policy on visitors. Staff may limit or prohibit visitors on a case-by-case basis. One focus group participant was satisfied with his apartment, but objected to the restrictions on visitors. The restrictions were a condition of his own lease, due to his history of drug activity. Despite his objections, he conceded that, "If you live in your own place, you can make the rules. I'm living in someone else's place, so I have to live by their rules."

FUNDING SOURCES FOR HOUSING AND SERVICES

All four housing locations are funded by HUD programs. Kerner-Scott House receives funding under the safe havens component of the Supportive Housing Program (SHP). At the Lyon Building, 40 units are subsidized through SHP and the remaining 24 units are funded by Section 8 Moderate Rehabilitation SRO Program. The Morrison Hotel and Union Hotel are both funded by the Section 8 Moderate Rehabilitation SRO Program, as well. All four buildings used the Low Income Housing Tax Credit Program for capital development.

DESC funds services in its buildings through a variety of sources, including:

- HUD's SHP, tenant rents (the portion not needed for building operations);
- HUD Service Coordinator Program;
- Housing Opportunities for Persons with AIDS grants through local government;
- Other local government funds; and
- Private fundraising.

DESC's other mental health and substance abuse treatment services are funded primarily through Medicaid, which is administered by the county government. DESC also uses other Federal and state funds (including Projects for Assistance in Transition from Homelessness) for these services. But staff report that Medicaid is the predominant funding source. Clinical staff members associated with DESC's licensed treatment programs provide services that are Medicaid-billable. The housing-based clinical service coordinators are not considered part of the licensed programs and therefore are not generally Medicaid-billable.

HOUSING AND SERVICES AFTER ENROLLMENT

HOST staff continue to followup with residents as they settle into their housing, typically for several months. Residents are not pressured to complete forms or undergo assessments in the first few weeks of residency. Typically, staff administer an assessment scale a month or two after the client's arrival. As the client becomes settled in housing, a DESC community case manager takes over from the HOST staff as the primary case manager.

Service Model

DESC emphasizes providing services where their residents live. The agency does not, however, use the multidisciplinary teams that characterize the Assertive Community Treatment (ACT) team model. The DESC approach offers outreach, psychiatric and substance abuse treatment services, housing and life skills support, and case management. These services are handled by staff from different divisions of DESC. Both "human-to-human" and electronic systems— including a sophisticated on-line management information system (described below)—support coordination among staff providing different services to DESC's clients. Some clients receive case management or other services from outside organizations, but DESC typically takes the lead for residents of its buildings.

As noted previously, all of DESC's permanent housing locations have 24-hour on-site housing case management staff. These property-based staff members work with the agency's community case managers, who provide clinical services and supervision. The community case managers come from DESC's licensed mental health or substance abuse treatment divisions. DESC tries to integrate property management and supportive services seamlessly. Staff members believe this approach results in a better relationship between clients and workers, which fosters long-term success. The housing staff members, who usually have a social work background, are trained to handle both property management issues and supportive services. DESC management believes that it is easier to teach property management skills to a social worker than vice versa.

The average caseload for each housing case manager is 34 people. The program model provides "an easy entrance" and allows people to learn from their mistakes. Case managers are assigned to the clients and work with them to ensure housing success. Residents are still held accountable for their actions (often by fellow residents). DESC staff members work with the resident to address any problems. The intensive staffing in the buildings means that staff have frequent contact with most clients. This is reflected in the service contact data collected for this study. DESC service contact rates were far higher than in the other two programs where clients live in more dispersed housing. DESC staff acknowledge, however, that housing so many people with severe mental

health issues in close proximity may create more problems than would occur if clients were dispersed. The important factor in DESC's model, staff add, is that on-site staff are available to followup if problems arise.

Service Participation

DESC does not require that clients accept the services offered to be housed. The clinical service coordinators in each building take the lead in developing residential service plans for their caseloads. These plans are similar to individual service plans that would be developed by an outside case manager, but focus on issues that are most likely to affect the resident's success in housing. The clinical service coordinator consults with the community case manager and the resident if the resident is willing and able to participate. In cases when the client cannot or will not participate in the planning, the residential service plan generally focuses on engagement efforts. While DESC requires that program staff visit residents, the residents themselves are not required to agree to case manager visits.

The residential service plan identifies problems and issues. The plan then identifies objectives to be accomplished and methods for accomplishing the objectives. It also delineates the tasks that the housing staff, the community case manager, and the resident will undertake. The on-site support from the housing staff is intended to augment, not duplicate or replace, the community case manager's efforts. Clinical service coordinators are expected to contact community case managers as often as needed, minimally on a weekly basis. Clinical service coordinators update resident service plans quarterly in consultation with the community case manager and the resident.

While residents are not required to participate in mental health treatment or take medications, staff members encourage residents to do so. A psychiatrist visits each building approximately once every two weeks. The community case managers can also make referrals to the psychiatrists or chemical dependency specialists in the agency's licensed treatment divisions. If a resident's behavior poses a risk to self or others, staff may recommend commitment. In those cases when continued danger to others is present, staff may require medication compliance for a specified period (usually 90 days) following the resident's release from the hospital. Although drug and alcohol use are not grounds for eviction, staff make it clear to residents that the results of their drug or alcohol use may threaten their housing.

Unit inspections are required and are conducted weekly at Kerner-Scott House and monthly at the other buildings. Staff look for unacceptable conditions, such as fire hazards (loose papers or trash covering surfaces, excessive clutter making it hard to move around the room), and rotting food, heavy dirt, and damage. Staff work closely with residents to keep their apartments reasonably clean. As necessary, staff will help residents clean their rooms or arrange for a cleaning service to clean the room at the resident's expense.

Focus group participants confirmed that participation in services was not a condition of their staying in housing. One client described his case manager's approach: "They listen, and then they watch you to see if you do what you said." Another commented on participating in Alcoholics Anonymous or Narcotics Anonymous meetings, noting, "They

encourage you, but there's no pressure." Another, a long-time alcoholic, unapologetically asserted, "I've been drinking all my life... and I'm not going to quit."

Housing Tenure

With the exception of Kerner-Scott House, housing tenure is assumed to be permanent. As noted earlier, residents at Kerner-Scott House are encouraged to move on to other housing within 24 months although this guideline is not strictly enforced. The project manager at Kerner-Scott House said that getting residents to work with staff during their stay is the safe haven's "central contribution." Staff members' roles are "to be in people's lives, to set limits, to express concern and hope, and to inspect their rooms once a week." These interventions are intended to prepare residents for their next living situation. Case managers usually start talking to residents about leaving Kerner-Scott House once they have completed one year of residency. Most move on to one of the other three DESC buildings.

Program data confirm that most DESC residents stay in their housing. According to 2005 DESC data, more than 90 percent of residents in the agency's permanent supportive housing projects remained housed for two years. On average, Kerner-Scott House residents stay 1.14 years. Ninety-two percent of them achieve two years of housing success at Kerner-Scott House and the permanent housing they move on to from there.

DESC can hold units for residents who leave any of the buildings for inpatient treatment. Units may also be held for residents who go to jail, the streets, or a shelter if staff expect the client may return. Typically, DESC reserves a unit for up to 90 days. Residents absent for longer periods may also return, although the resident may not be able to return to the same unit they lived in before.

Among 73 clients who left DESC housing in a recent twelve-month period, 44 percent moved to other long-term housing. This group includes people who moved to other permanent housing (26 percent), skilled nursing (11 percent), or moved in permanently with family or friends (7 percent). Some 11 percent of all departures were due to death. Approximately 14 percent were known to have returned to homelessness and another 15 percent left for unknown destinations that may include homelessness. Long-term incarcerations accounted for 9 percent of departures and long-term mental health or substance abuse treatment for 7 percent.

Service Coordination and Monitoring

DESC staff communicate about clients and coordinate services by several means. Within buildings, shift change meetings are used to discuss any issues that came up on the previous shift. Clinical service coordinators and community case managers communicate by telephone, as well as face-to-face contacts when the community case manager visits residents in the buildings. More intensive "care conferences" may occur when the staff determine that new interventions are needed because the resident is not doing well.

Besides these conventional, person-to-person forms of communication, DESC has developed an in-house information system, known as the Client Housing and Services Entry and Reporting System (CHASERS). The system has detailed information on virtually everyone with whom DESC staff have contact, beginning with homeless people in the early stages of engagement. HOST outreach workers may enter information about these people under a pseudonym or nickname.

Housing and clinical staff enter information on all encounters with clients. The system automatically notifies the clinical service coordinator and the community case manager by

e-mail when new information has been entered on one of their clients. Most client files include a photograph of the client, address information, demographic data, any restrictions on their access to services and rent owed. The file also contains a comprehensive log of service contacts. Medication monitoring is not included in the system due to regulations that require paper files. CHASERS is controlled so that only appropriate staff have access to clinical or personal information.

Mechanisms are also in place to track clients who leave DESC housing. According to staff, DESC is able to track about 90 percent of those who leave their programs for six months after departure, primarily because most of them continue to receive services through DESC's shelter and clinical programs. In addition, King County's mental health division maintains a database of all clients enrolled in the publicly funded mental health system. This system helps notify mental health providers when a client receives services in another part of the system. The system sends automatic notifications to relevant providers, including DESC, if a client is jailed or admitted for services.

ESSENTIAL COMPLEMENTS OF THE DESC PROGRAM

Staff at DESC offered a variety of important elements they say are needed for a successful Housing First program. Elements of the service approach they use with their homeless, chronically mentally ill clients include:

- Flexibility in recognizing client problems and not insisting that the problems be fixed;
- Creativity in responding to behavioral problems beyond assessing penalties;
- Genuine positive regard for clients; and
- Assertive engagement efforts by staff while being cognizant of the pace at which clients can take the services being offered.

In addition to these elements, the key elements that seem to make DESC's program effective are:

• **Control of a Significant Stock of Permanent Supportive Housing Units**—DESC owns or controls more than 300 units of housing and more are being developed. This allows the organization to serve a large population of people who have traditionally been extremely difficult to house. Unfortunately, the need (an estimated 2,500 chronically homeless people) still surpasses even this substantial supply.
- **On-Site Support for Residents**—While housing this population together in larger buildings is challenging, the presence of staff trained in both property management and clinical interventions helps make it work. DESC does have scattered-site housing subsidized through the Shelter Plus Care and Section 8 programs, but these units are reserved for clients who are more "stable" than those served in the buildings described above. DESC staff believe there are advantages to scattered-site housing, but do not believe they could widely "sell" the Housing First approach to private landlords in Seattle's high-cost, low-vacancy rental market. To sell the approach would require substantially larger investments of rental subsidies, coupled with adequate resources for intensive *in vivo* support for clients. One DESC staff member explained that candidates for scattered-site housing are selected based on "the likelihood the person will make good choices in housing." Residents of Section 8 and Shelter Plus Care housing have much more freedom than in DESC buildings. DESC staff also say that residents who are likely to isolate themselves are better off in DESC buildings where staff can interact with them more easily.
- Access to a Wide Range of Clinical Mental Health, Physical Health, and Addiction Services within DESC—DESC's expertise in clinical services allows it to respond to the complex needs of chronically homeless people.
- Administrative Systems that Support Service Coordination within the Agency—At the time of the site visit in 2005, DESC was still adding new features to its management information system known as CHASERS, but it already appeared to provide an extremely important communication link among the outreach, clinical services, and housing divisions of DESC.

DESC staff explained that only a few other Seattle area providers offer a Housing First approach to homeless people who are mentally ill. A similarly small number of providers place a priority on serving people who are chronically homeless. According to DESC's executive director, many agencies and organizations in the Continuum of Care would prefer to focus on services for families, youth, and other subpopulations.

This trend seems to be reflected in DESC's experience with the 2005 McKinney-Vento funding competition. DESC was successful in getting funding for permanent housing for people who are chronically homeless in the 2003 and 2004 McKinney-Vento grant cycles. But the agency's proposed 2005 project was not prioritized and is unlikely to be funded. Despite this setback, DESC leadership continues to promote the Housing First approach. Several new projects are in the planning or early implementation stages, including a 75-bed facility for chronic inebriates and a second 75-bed facility with services funded by Medicaid.

Despite the concerns noted above about using a scattered-site approach for less stable clients, DESC is implementing a 60-unit expansion of its scattered-site program using a new SHP grant and an enhancement of service resources using private funds. The agency is also considering launching a capital campaign to provide working capital for new projects. DESC leadership expects these strategies will expand choice and opportunities for DESC's clients. This will allow DESC to respond to the needs of homeless people who are mentally ill or have substance abuse issues.

APPENDIX D: PATHWAYS TO HOUSING, NEW YORK CITY, NEW YORK

Pathways to Housing was founded on the belief that housing is a basic right. It offers homeless people with mental illness and concurrent substance-related disorders immediate access to housing in independent apartments scattered throughout affordable neighborhoods in New York City. The Pathways to Housing model is based on the following tenets:

- Housing and treatment services are separate—Pathways to Housing rents apartments from private landlords in the community;
- Assertive Community Treatment (ACT) team case management services are provided in the community and available 24 hours a day, 7 days a week, at a 10:1 client to case manager ratio¹⁰⁰;
- Pathways to Housing does not require that clients take medication, abstain from using drugs or alcohol, or participate in psychiatric treatment to enter or retain housing; and
- Service plans are individualized and client driven. Clients set the goals, sequence, intensity and duration of services. The service plan is done during the first 45 days following enrollment and renegotiated every 6 months.

BACKGROUND

Dr. Sam Tsemberis, a clinical psychologist, was providing outreach to homeless individuals with mental illness living on the streets of New York City in 1992. His frustration with the inability to house homeless mentally ill persons and to keep them housed led to the creation of a new approach. Dr. Sam Tsemberis started Pathways to Housing with 50 apartments in Hell's Kitchen and Harlem in Manhattan through a \$500,000 grant from the New York State Office of Mental Health (OMH). Since 1992, Pathways to Housing's contract with OMH has grown to more than \$5 million. These funds are used for clinical services and rental stipends for New York City's street dwelling homeless individuals with psychiatric disabilities and substance abuse problems.

Since 1992, Pathways to Housing has provided outreach to homeless persons with mental illness who dwell on the streets of New York. Most new enrollees now, however, are referred to the program from outside agencies, such as Westchester County Department of Social Services or state and county hospitals. Pathways to Housing serves homeless people with co-occurring psychiatric and substance-related disorders. The program also serves clients who exhibit violent behavior and those who rapidly relapse due to medication noncompliance and drug use. These

¹⁰⁰ Pathways to Housing uses a modified ACT team structure and model to provide intensive treatment services for clients in their own apartments and at the organization's neighborhood office sites. ACT teams are interdisciplinary, consisting of a psychiatrist, nurse practitioner, social workers, employment specialist, wellness specialist, substance abuse specialist, and administrative assistant.

characteristics make it particularly difficult to find supportive housing providers who will accept them.

The Pathways to Housing approach is "consumer-driven." According to an early mission statement, street life "renders people incapable of managing the most basic daily routines, and affords people little room to contemplate matters, such as treatment or recovery." For these reasons, Pathways to Housing provides people with an apartment of their own *first*, to provide immediate relief from the hardships of living on the streets every day. This client-driven model is based on the belief that symptoms of mental illness and drug use existed long before the client's homelessness. Treatment will not necessarily solve the problem of homelessness and working to build trust between the program and the individual. Staff members help new tenants move, become integrated into the community, and begin work on recovery and rehabilitation.

POPULATION SERVED

Prior to program entry, the 450 individuals served by Pathways to Housing had been living predominately on the streets and had been involved with multiple systems, such as hospitals, emergency rooms, and the criminal justice system. This program gives priority to those at high risk, including the elderly, women, or people with physical disabilities. Referral sources include several of New York City's outreach teams, drop-in centers, hospitals, and shelters. Pathways to Housing staff also provide some direct outreach.

Because the program is fully occupied, over the past two years the majority of new enrollees at Pathways to Housing are referrals from outside agencies that have contracts to provide funding, such as Westchester County Department of Social Services or state and county psychiatric hospitals. These contracts have infused much needed new funding for services and housing into the program but have resulted in an increase in new enrollments coming primarily from psychiatric hospitals. Averaging three to five new enrollments per month, institutional discharges accounted for 50 of Pathways to Housing's new enrollments over the past two years and psychiatric discharges constitute 42 percent (n = 11) of the current study sample.¹⁰¹ Prior to enrolling in Pathways to Housing, these clients resided in psychiatric hospitals for an average of 6.8 months—five clients stayed in psychiatric hospitals for three months or less. Despite the large proportion of psychiatric discharges, Pathways to Housing staff reported that 92 percent (n = 24) of the clients who participated in this study met HUD's definition of chronically homeless.¹⁰²

¹⁰¹ Pathways to Housing confirmed that the sample is representative of the larger program with the following exception: 42 percent of the sample entered the program from psychiatric hospitals, which reflects the addition of funding from psychiatric hospitals to provide housing to homeless patients upon discharge.

¹⁰² Pathways to Housing reported that 24 clients in the study met the joint federal definition of chronically homeless. It should be emphasized, however, that this interpretation assumes that nine of the eleven clients who enrolled from psychiatric hospitals met the criteria for chronic homelessness prior to a short-term psychiatric hospital stay and were determined on a case-by-case basis most likely to become homeless upon discharge.

Several contracts have been awarded to Pathways to Housing to service long-term psychiatric populations who cycle in and out of homelessness. These contracts include:

- Services for 30 individuals discharged from Manhattan and Rockland Psychiatric Centers;
- Support services and rent stipends for 14 individuals discharged from New York Presbyterian Hospital's Second Chance Program¹⁰³; and
- Services for 60 individuals discharged from city and state psychiatric facilities, such as Kingsboro Psychiatric Center and Kings County Hospital. The Pathways to Housing Brooklyn team is funded primarily to serve individuals discharged from the Kingsboro and Kings County facilities.

In addition, Pathways to Housing provides supportive housing and services under two grants funded by HUD. Project Release provides permanent supportive housing for former inmates referred from the Center for Alternative Sentencing and Employment Services' (CASES) Nathaniel project, a jail diversion program. The KEEPing Home program provides permanent supportive housing for former inmates who continue methadone treatment upon release at the Key Extended Entry Program (KEEP) of the Narcotics Rehabilitation Center (NRC) of Mt. Sinai Hospital. This program is located in East Harlem. The Westchester County Department of Social Services contracts with Pathways to Housing to serve homeless individuals with mental illness in Westchester County, New York.

PATHWAYS TO HOUSING CLIENTS

A fundamental underpinning of the Pathways to Housing program is the separation of housing and services. Private landlords, who are not affiliated with the program, own or manage the housing. All housing units are independent apartments in the community. Pathways to Housing secures the units through a network of landlords, brokers, and managing agents. To ensure that the type of housing meets client needs, the Pathways to Housing Housing Department maintains relationships with landlords. The ACT team case managers assure that clients meet their lease requirements. Pathways to Housing rules resemble standard lease requirements.

Pathways to Housing holds the lease and sublets the unit to the client. The program assumes that housing tenure is permanent, with no actual or expected time limits. The Housing Department monitors repairs and lease renewals, provides all essential services (e.g., hot water and heat), and protects tenants' rights.

Housing units are located in low-income neighborhoods in Queens, East and West Harlem, Westchester County, and Brooklyn. Case managers help clients select their apartments. They try to match the clients' choice of neighborhood or need for special accommodations. Pathways

¹⁰³ New York State's Second Chance initiative is a partnership between the New York State OMH and New York Presbyterian Hospital to improve the care of the state's long-stay inpatient population. Eligible individuals are those who have resided continuously in a state psychiatric center for more than five years and have the potential for partial recovery of functioning.

to Housing is at full enrollment. Acceptance of new referrals depends on the referral source, availability of a housing subsidy, and ACT team capacity. New clients are assigned to an ACT team case manager at the organization's neighborhood office sites. The program does not rent more than 10 percent of the units in any one apartment building so the client has the experience of living in the larger community. Generally, the units include studio, one-bedroom and two-bedroom apartments with a private bath. Pathways to Housing provides all essential furniture and other items, such as a bed, mattress, bureau, table and chairs, pots, pans, dishes, telephone, and television.

FUNDING SOURCES FOR PATHWAYS TO HOUSING

Pathways to Housing has a complex and diverse set of funding sources. Forty-two percent of the total program funding comes from the New York State OMH. This funding includes a combination of state-funded rental subsidies, Projects for Assistance in Transition from Homelessness (PATH) grants, Shelter Plus Care, and state-funded ACT team service dollars.

More than 20 percent of Pathways to Housing's funding comes through Medicaid reimbursement of four of the six ACT teams. The Brooklyn and Westchester team services are not reimbursed through Medicaid. The Westchester County Department of Social Services provides more than 10 percent of program funding for Westchester staff salaries and rental subsidies. OMH funding subsidizes the salaries of the Brooklyn ACT team, which participates in the National Fidelity Standards Project conducted by Dartmouth Psychiatric Center. The team is staffed to meet state regulations and national fidelity standards for ACT. This includes funding for a nurse practitioner and a job developer.¹⁰⁴

Sixteen percent of program funding for both housing and services comes from two HUD supportive housing grants. These funds provide permanent supportive housing to dually diagnosed mentally ill populations recently discharged from Rikers Island, New York City's largest jail. These grants serve former inmates through Project Release, awarded in 2003 and The KEEPing Home. (See previous discussion in the section on Population Served.)

The New York City Department of Mental Health (DMH) and private donations provide the remaining funding.

¹⁰⁴ To comply with national ACT standards, all Pathways to Housing ACT teams hired sufficient staff. They include employment specialists and nurse practitioners. There is a staff to client ratio of 1:10. They provide ACT training in evidence-based practice tool-kits and techniques. Program staff describe the development of the ACT team approach as a progression from cobbling together the services to ACT team certification and Medicaid reimbursement. The nurse practitioner and employment specialist are viewed as key catalysts on the team. They coordinate the client's medical regimen, increase medication self management, and integrate the client's vocational goals with all other team services.

THE TRANSITION FROM HOMELESSNESS TO PERMANENT SUPPORTIVE HOUSING

The transition from homelessness to permanent supportive housing begins with immediate placement into housing. It continues with the availability of an array of supportive services.

Housing Placement

Staff have routine contacts for all special programs where candidates are identified. Westchester County Department of Social Services and the New York Presbyterian Hospital program refer clients directly to the Westchester ACT team. Kingsboro Psychiatric Center and Kings County Hospitals refer clients directly to the Brooklyn ACT team. To prioritize enrollment, all referrals are centralized through the two clinical program managers. The criteria used to prioritize clients is largely driven by funding sources and vacancies. Pathways to Housing enrolls two or three new clients each month.

Upon enrollment, Pathways to Housing provides clients with immediate access to permanent, independent housing. There may be a 2-week period where the client stays in a hotel, shelter, or the Young Men's Christian Association (YMCA) until the client finds an apartment. Clients are not required to be drug or alcohol free, acknowledge they have a mental illness, or participate in any treatment programs. They are supposed to adhere to two requirements, Clients must agree to two case manager visits per month. They must also pay 30 percent of their income, which is usually Supplemental Security Income (SSI), for rent. Most clients agree to allow Pathways to Housing to act as representative payee for this purpose. Although these are supposedly requirements, refusal to adhere to them does not disqualify a person from the program.

HOUSING AND SERVICES FOLLOWING ENROLLMENT

Upon enrollment, while looking for an apartment, the client and a member of the ACT team complete a Comprehensive Treatment Plan. The client rates him or herself on a number of scales. These include family issues, personal relationships, employment, and substance abuse issues. The plan then sets goals for improvements clients would like to make. This helps the ACT team determine the client's most important criteria for selecting an appropriate apartment. Proximity to family, specific services such as medical or substance abuse treatment, and transportation are all potential considerations. Pathways to Housing also tries to find apartments that match the client's preference for location, size, and safety. In some cases, clients are encouraged to live in close proximity to a Pathways to Ho using neighborhood office to aid communication and service provision and to reduce client isolation.

Housing

Program staff report, and clients that we spoke with confirmed, that Pathways to Housing offers them a choice of up to three apartments. Clients reported in the focus groups 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."¹⁰⁵ If an initial housing placement does not work out, a client may ask to move. For example, one client reported that he was initially unhappy with his apartment located in the Bronx. He didn't know anyone or have any old friends in the neighborhood. He preferred to live in Harlem and his case manager was able to help him move to another apartment in West Harlem.

Services

People with serious mental illnesses and/or co-occurring substance use disorders who are homeless have complex problems that require comprehensive treatment and services. A multidisciplinary ACT team provides individuals with a type of "one-stop shopping" to arrange for or receive all needed services. The ACT team that serves the area in which the client is placed provides services following enrollment. Clients choose the array and sequencing of support services offered by the ACT team case managers.

ACT Teams

Pathways to Housing has six ACT teams that provide a range of intensive clinical, rehabilitation, and support services to clients in their neighborhood. Two teams are located in East Harlem. The West Harlem, Queens, Brooklyn, and Westchester County sites each have one team. These nine-person interdisciplinary teams of service coordinators have specialized roles. These roles include a team leader, substance abuse specialist, nurse practitioner, part-time psychiatrist, family systems specialist, peer counselor, wellness specialist, employment specialist, and administrative assistant. Each ACT team is available 24 hours a day, 7 days a week to respond to the needs of 60–70 clients. The case manager to client ratio is 1:10.

Housing is necessary, but not sufficient to help individuals with serious mental illnesses and/or co-occurring substance use disorders who have been homeless. To regain psychiatric and residential stability and maintain sobriety, they need unique and flexible supportive services. The services cannot a requirement to maintain housing. The Corporation for Supportive Housing defines such services as: designed to maximize independence; flexible and responsive to individual needs; available when needed; and accessible where the individual lives.¹⁰⁶

ACT teams spend 80 percent of their time in the community. They help clients adapt to their homes and neighborhoods through home visits and clinical interactions. The ACT team approach promotes the frequency and intensity of contacts. Teams meet each morning to coordinate case monitoring. The team reviews the entire caseload and discusses most recent client contacts, overnight emergencies, status changes, next steps, and which ACT team member should respond. ACT team services include:

- Psychiatric and substance abuse treatment;
- Help with shopping for groceries or doing laundry;
- Medication packing;
- Targeted primary health care;
- Intensive case management;

¹⁰⁵ The study team conducted two focus groups with Pathways to Housing clients who participated in the study. The study team moderated these groups on June 1, 2005 (n = 1) and June 2, 2005 (n = 3).

¹⁰⁶ Corporation for Supportive Housing, 1996.

- Money management;
- Vocational and educational counseling; and
- The provision of job opportunities.

One of the most important team functions is the integration of substance abuse and psychiatric services.

Case managers help new clients move into their homes and acclimate to the neighborhood. This helps them retain housing. Case managers introduce the client to the building's superintendent and encourage the development of a relationship. The case manager works with the client to learn and practice regular housekeeping chores and to meet the tenant responsibilities defined in the lease.

An apartment visit may reveal, for example, that a "friend" has moved in or is staying overnight with a client. The case manager may visit more frequently and remind the client that overnight visitors are a lease violation that could jeopardize their housing. Another example is when drug use escalates and may results in the client spending all of his or her money on drugs, leaving nothing for food. The ACT team then intervenes as money manager, making food purchases and reducing the client's access to cash until the drug use subsides.

Behavioral problems resulting from substance abuse may result in housing disruptions. Problems at Pathways to Housing primarily included failure to maintain the apartment and behavioral issues other than those related to substance use. In some cases, the client ask to change apartments due to drug activity in the building. Pathways to Housing clients may also experience temporary program departures. Most frequently these are for short stays in psychiatric hospitals or short periods of time on the streets. Following these short departures from their permanent housing, clients typically return to the same apartment. If a client is absent longer than 90 days, the apartment will be released. The client is still guaranteed access to a new apartment upon program reentry.

Client Choice

Pathways to Housing emphasizes a client-driven collaborative approach to match services to assessed and stated needs. Clients have the right to choose, refuse, and modify services and supports. The client may choose the ACT team members with whom he or she will work. In the Comprehensive Treatment Plan, the client identifies goals in his or her own words. Assessment begins at intake and forms the basis of the client-driven plan, which addresses 10 domains. These include housing retention, medical and mental health services, substance abuse treatment, education, vocational services, and reconnecting with family and friends.

Program Requirements

As noted earlier, clients are supposed to adhere to two requirements, although they are not disqualified from the program for failure to do so. During the focus groups, clients expressed mixed reactions to participation in the money management program, particularly when it involved a representative payee. Some were grateful that they did not have to budget or pay bills, Others wanted an increased level of freedom to manage their own money.

Also discussed previously, clients with psychiatric disabilities are not required to take medication or participate in psychiatric treatment, although these services are available to them. If a client requires inpatient psychiatric treatment, the apartment will be held for the duration of treatment. Likewise, clients with substance-related disorders are not required to abstain from alcohol or drugs, nor are they required to participate in substance abuse treatment, although these services are available and clients' housing would be maintained by the program if they choose to seek treatment. If the client is absent longer than 90 days, the apartment will be released, but the client is guaranteed access to a new apartment upon program reentry.

Employment Services

Pathways to Housing staff stress that having a job expedites recovery. The program is working toward increasing the range of vocational services offered by hiring a job developer. About 75 tenants work for Pathways to Housing as janitors, movers, painters, or in other jobs. Each job pays at least minimum wage. This employment can often be a stepping stone to a longer-term employment. The Career Club offers resume building, mock interviews, and other job search activities. Each team has a peer counselor or client advocate elected by the clients. The paid person in this position serves as a liaison between the staff and clients.

ESSENTIAL COMPONENTS OF THE PATHWAYS TO HOUSING PROGRAM

Essential features of the Pathways to Housing program are:

- Access to Housing First—The Pathways to Housing approach emphasizes that clients must first have housing. This provides the foundation from which to make the steps toward recovery. The streets are not a safe or supportive place for recovery. Clients are given immediate access to permanent individual housing, without requirements for sobriety or treatment participation. Pathways to Housing separates the housing issues from the treatment issues by bringing people into housing first and then working with them where they are.
- ACT Team Services Provided in the Community—Pathways to Housing uses the ACT team structure and model to provide intensive treatment services for clients. Clients receive services in their apartments or in the neighborhood offices in which the teams are located. These interdisciplinary teams are modified from the original ACT teams to include a supported housing component based on the housing first approach.¹⁰⁷ The primary goals of ACT are to enhance the client's community adjustment, decrease time spent in institutions, and prevent the development of a chronic "patient" role. The ACT team services meet local and national fidelity standards. Clients determined the frequency and intensity of services. The services are integrated for effective mental health and substance abuse treatment. They offer evidence-based practice tool-kits for case managers to help clients become self-sufficient and live independently. Efforts to improve client skills focus especially on activities of daily living, money management, and medication management. The Pathways to Housing' ACT team model includes small caseloads with staff to client ratios of 1:10. It is

¹⁰⁷ Stein, L.I., & Test, M.A. (1980). Alternative to mental hospital treatment: A conceptual model, treatment program, and clinical evaluation. *General Psychiatry*, 37, 392–397.

neighborhood-based for client monitoring, and for the provision of needed services. It promotes community integration.

• Housing and Treatment Services Provided Separately—Pathways to Housing rents apartments from private landlords in the community. The program tries to not rent more than 10 percent of the units in any one building in order to minimize the number of clients with mental illness in that building. When clients relapse into substance abuse or if psychiatric symptoms increase, their housing status remains constant. They are not required to leave their apartments. The team and client manage relapse crises collaboratively and services often intensify during such periods. Decisions about intervention are up to the client, unless the client presents a danger to self or others. This housing policy contributes to clients' success in maintaining stable housing as it reduces the frequency of periods of homelessness. A client may temporarily leave the housing for a short stay in a psychiatric hospital or detox center without losing his or her permanent housing.

APPENDIX E: REACHING OUT AND ENGAGING TO ACHIEVE CONSUMER HEALTH (REACH), SAN DIEGO, CALIFORNIA

The San Diego Reaching Out and Engaging to Achieve Consumer Health (REACH) program is a county and city collaborative. This program coordinates housing, intensive case management, employment, and mental health and substance abuse services for mentally ill homeless individuals living on the streets. San Diego County Mental Health Services Division (CMH) is the parent agency for REACH. CMH is a California AB 2034 program intended to bring homeless adults with mental illness into permanent supportive housing.¹⁰⁸ The San Diego Housing Commission (SDHC) is an important partner. SDHC supplies subsidies to pay for housing provided by a network of community partners, including nonprofit organizations and private landlords.

Most homeless mentally ill clients who come to REACH are brought from the streets into housing by the Homeless Outreach Team (HOT) of the San Diego Police Department. Each HOT consists of a uniformed police officer teamed with a mental health counselor and an income maintenance worker. The teams reach out to homeless, mentally ill people living on the streets and identify candidates for screening by a REACH outreach specialist. REACH and its partners provide supportive services and housing to 257 homeless mentally ill persons through a variety of housing options. These options include a safe haven, single room occupancy (SRO) hotels, Board and Care facilities, Independent Living Facilities (ILFs), or scattered-site apartments in San Diego. Once a client agrees to enter housing, REACH case managers provide or coordinate the necessary supports and services to help the person stay housed.

BACKGROUND

REACH launched its program in 2000 with plans to move homeless people with mental illness from the streets into housing quickly. During the late 1990s, concerns about the potential displacement of homeless individuals by a downtown stadium construction project led to the creation of the Ad Hoc Committee on Downtown Homelessness. This committee developed a five-part Special Needs Homeless Initiative that included plans for housing and supportive services. REACH was born when the Ad Hoc Committee applied for and received a three-year, \$10.3 million competitive state grant under California's AB 2034 program.¹⁰⁹ The grant gave the county resources to design integrated services for seriously mentally ill homeless people.

¹⁰⁸ California Assembly Bill (AB) 2034 allocated funds to expand and provide services for homeless persons, parolees, and probationers with serious mental illness. The California Department of Mental Health awarded funds to 32 counties to provide housing and supportive services to this population. After a demonstration year in three counties under AB 34, AB 2034 made funding available statewide to provide integrated services for homeless people with mental illness. ¹⁰⁹ AB 2034 expanded to new counties under a pilot program to integrate services for homeless adults with serious

mental illness.

Following the grant award in December 2000, San Diego CMH contracted with two behavioral health companies experienced in providing supportive services to homeless people with mental illness. Telecare Corporation provides outreach and mental health case management services. Community Research Foundation (CRF) provides employment, mental health, and substance abuse services.

Telecare, a for-profit agency based in Alameda, California, previously operated demonstration programs in two of three AB 2034 pilot counties in California. The agency brought a track record of keeping homeless mentally ill people housed. Other agency outcomes included decreases in jail time, psychiatric placements, and homelessness. San Diego CMH charged Telecare with engaging, housing, and providing case management to 250 homeless, mentally ill, and dually-diagnosed individuals within 6 months.

By June 2001, REACH met enrollment goals ahead of schedule. Initially the REACH program conducted extensive traditional outreach by contacting individuals at emergency shelters, day centers, and food lines. Once REACH had its full contingent of clients, outreach dropped off considerably. Now most new referrals come from HOT teams. REACH program staff still do some outreach to crisis houses and short-term psychiatric placements.

REACH experienced high turnover in the program during the early months. More than half of the initial 250 individuals enrolled in the program left their permanent housing within the first 6 months. Many of these failures resulted from clients refusing to pay the required 30 percent of their income for housing. This resulted from rapid enrollment of people due to the short time to become operational. Over time, the substance abuse issue began to emerge as dominant in what was often a cloudy clinical picture. Many of the individuals enrolled initially did not meet the criteria of having an axis I diagnosis of serious mental illness.¹¹⁰ In response to the initial housing failures, REACH modified its intake process to improve screening for the primary axis I diagnosis of serious mental illness.

Initially, REACH program staff relied on offering clients SRO hotel units in large downtown San Diego buildings. This over reliance on certain SRO hotels resulted in a high density of REACH clients in some buildings. Gradually, REACH forged relationships with other housing providers and private landlords. They provide scattered-site, independent apartments that are geographically dispersed across the San Diego area.¹¹¹

REACH and HOT have continued to engage individuals and provide outreach. Each new vacancy in the program is rapidly filled. Since June 2001, REACH has remained at full enrollment. It increased in size from 250 at program inception to 257 clients in May 2005.

¹¹⁰ These individuals could be characterized as having a less severe mental disorder and more severe substance abuse disorder. This is Quadrant III in the Quadrants of Care system developed by the National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Program Directors. For more information, see: http://ncadi.samhsa.gov/media/prevline/pdfs/bkd515.pdf.

¹¹¹ Many of these original housing partners have rented to REACH clients for more than 5 years. They have long track records of partnering with the program to house homeless adults with mental illness. Recently, REACH hired a housing specialist to develop more independent housing options for REACH clients. REACH intends to reduce the density of their clients in all SRO buildings to no more than 10 percent of the tenant population by the end of 2005.

During the one-year period of this study, REACH enrolled 60 unduplicated homeless individuals with severe mental illness into the program. The average enrollment was five or six individuals each month. Simultaneously, the average number of clients leaving the program was five each month. While people left for variety of reasons, most frequently clients dropped out of the program or moved out of the area. Clients average 965 days or about 2.6 years in the program. More than 80 percent of clients have been enrolled at least one year.¹¹²

REACH has had the following impacts, annualized to compare the 12 months before enrollment to the 12 months after enrollment. The 257 clients enrolled as of May 2005 have had:

- 88 percent fewer homeless days;
- A 59 percent decrease in incarceration days and 65 percent decrease in incarceration episodes;
- A 41 percent decrease in hospital days and 52 percent decrease in hospitalization episodes; and
- A 98 percent increase in receipt of cash and other public benefits, usually health insurance, food stamps, Supplemental Security Income (SSI), other cash assistance.¹¹³

POPULATION SERVED

Eligibility criteria for REACH clients include: an axis I diagnosis of mental illness; 6 months of homelessness during the past year; and a desire to be housed through the REACH program. REACH makes exceptions to the length of time spent homeless criteria to serve high priority vulnerable populations. This includes seniors and young adults in transition from foster care.

As of May 2005, two-thirds of the REACH population had a dual diagnosis of mental illness and substance abuse. The remaining one-third of the population had a diagnosis of mental illness. Women comprise 43 percent of the REACH population. Program staff estimate that 70–80 percent of the people they house lived on the streets prior to program entry. They also estimate that the other people come from shelters or short-term psychiatric placements. Twenty-five of 29 (86 percent) clients tracked for this study met HUD's definition for being chronically homeless.^{114, 115} The four enrollees who did not meet the definition of chronically homeless were referred from other mental health providers. They were high priority, vulnerable people,

¹¹² Data obtained from AB 2034 statewide outcomes collection and reporting system, found on www.AB34.org.

¹¹³ These benefits and assistance do not include housing subsidies, which most REACH clients have.

¹¹⁴ For the current study, staff at REACH tracked 29 clients over a 12-month period using standard data collection instruments. The methodology for the study is more fully described in Appendix A to this report.

¹¹⁵ A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who meets one of two criteria. The person has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past 3 years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) or in an emergency shelter during that time. An episode is a separate, distinct and sustained stay on the streets or in an emergency homeless shelter.

including homeless and disabled young adults, one older veteran, and one woman.

THE TRANSITION FROM HOMELESSNESS TO PERMANENT SUPPORTIVE HOUSING

Most referrals to REACH are through HOT, which engages the hardest-to-serve street homeless people with mental illness. HOT assesses the needs of potential clients, qualifies them for services, and helps place them in suitable programs. Other referrals come from hospitals, crisis houses, and self-referrals. In addition, other outreach programs make referrals. Examples include the cold weather program outreach (December–March), Rachel's Center (emergency drop-in for women), and Friend to Friend Clubhouse.

More than 1,383 people are identified as chronically homeless in the San Diego area. HOT has identified and visit a subset daily at known locations within the city. Increased enforcement of San Diego's "illegal lodging" law may be encouraging homeless people to seek shelter. This law allows police to cite and arrest homeless people for sitting or sleeping in public places. Each year the police arrest or ticket several thousand people.

Housing Placement

Most REACH clients come directly from the streets through HOT. The HOT may have been working with a homeless person for many weeks to convince the person to come into housing. The HOT focuses on people who are more likely to have mental illness as a primary problem and are not likely to get arrested. When HOT encounters alcoholics, it offers rehabilitation and help getting into appropriate care if they are interested.¹¹⁶

HOT is part of the San Diego Police Department. Thus, there is an inherent question about whether clients believe they have a choice about entering housing. One focus group participant noted, "HOT brought me here. I had been homeless off and on. They said they would bring me here or to jail." A former REACH mental health worker has joined HOT, acting as a liaison between REACH and HOT.¹¹⁷

Besides the teams, REACH has an outreach specialist who works with mentally ill people on the streets. This specialist tracks clients, by name, when they receive outreach. They are tracked in a program database, which includes the disposition of the encounter. The outreach specialist reports daily on the clients who are ready to enter the program. This must be coordinated with those that HOT identified as being ready to enter the program. Openings occur frequently and clients can be housed temporarily in the safe haven while awaiting permanent housing. While REACH had an official waiting list in the past, staff found that a lot of people moved or received other services. Staff report that, instead, they search for the most vulnerable people who are not looking for services.

¹¹⁶ The Serial Inebriates Program is based on a "drug court" type of model targeted to chronic alcoholics. It forces them to choose between extended time in jail or treatment and social services.

¹¹⁷ On May 18, 2005, the study team conducted two focus groups with REACH clients who participated in this study. Eleven clients participated in the first focus group and three in the second group. The methodology for these focus groups and the discussion guide used to prompt the discussions may be found in Appendix A to this report.

After the mentally ill homeless person agrees to enter housing and a unit becomes available, the individual accompanies HOT members to REACH for screening and program enrollment. If the client was previously unknown to the outreach staff, screening involves confirming that the client meets enrollment criteria. After learning a client's name, the outreach specialist gathers pre-enrollment information. This includes verification of the client's mental illness diagnosis and any records on previous hospitalizations, incarcerations, and benefits. For those brought by HOT, REACH confirms that the client is voluntarily agreeing to enroll in the program rather than feeling coerced by a police presence.

Most transitional or permanent supportive housing programs in San Diego's continuum of care have strict prohibitions against drug and alcohol use. The REACH outreach specialist and HOT recruit homeless mentally ill persons directly from the streets into "housing." Housing most often means placement in a safe haven funded by AB 2034 funds and operated by Episcopal Community Services (ECS). The safe haven plays an important role in the REACH program because there are not sufficient permanent supportive beds available.

Some people need less structure and more in services than what is offered by the safe haven and existing service programs. REACH staff may use the many other housing options described earlier, in addition to scattered-site apartments.

REACH recently reimplemented a Housing Committee. This Committee meets weekly to make policy decisions and evaluate individual cases. The Committee tries to ensure fair and equitable distribution of the limited housing resources. It also endeavors to provide choices, empowering clients to obtain housing at the highest possible level of independence. The Housing Committee includes a Member Forum and an Apartment Living Support Group. The Member Forum provides a venue for REACH clients to discuss and make suggestions about housing. Clients may also discuss challenges, fears, successes, and questions related to housing. The Apartment Living Support Group provides support for clients currently living independently in apartments and those who may be considering living independently. This group allows clients to share their positive experiences and challenges and offer support to one another.

HOUSING FOR REACH CLIENTS

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. REACH staff make it clear to clients, however, that the program will help them maintain permanent housing. Some clients who experience difficulty with the housing requirements require additional case management support to either solve the problems or move to another housing location with fewer rules. Some clients demonstrate housing stability in the safe haven or SRO and may stay for long periods. Depending on housing stability, some clients are placed in scattered-site apartments within a few months of enrollment. The following sections describe these primary housing locations.

Safe Haven

The ECS safe haven occupies a 19-unit building. It is operated with funding from the AB 2034 program. A resident assistant is on-site 24 hours a day. Residents have their own apartments, which includes a door that can be locked, a refrigerator, and a sink. Residents share bathrooms. Meals are prepared for the residents or they can prepare their own food in shared kitchen facilities.

The ECS safe haven has more extensive requirements for entry and occupancy than most safe havens. Prior to entry, new residents must sign a rental housing agreement. Rental agreements require that clients pay 30 percent of their monthly income for rent. They must adhere to a 10 p.m. weekday curfew. They may not have overnight visitors. Clients must agree to weekly room inspections (more frequently if needed). In addition, there can be no violence or verbal aggression, no weapons, and no alcohol or drug possession or use. Residents must sign-in and sign-out whenever entering or leaving the premises.

REACH places clients least known by the REACH case managers in the safe haven for an assessment periods. However, the length of stay varies. If clients prefer the safe haven they can stay up to 18 months. Occasionally, a REACH client will choose to remain in the safe haven for more than one year. But most clients find alternative housing within two weeks.

Single Room Occupancy (SRO) Hotels

The primary housing resources available prior to REACH were the safe haven and 100 projectbased, Section 8 subsidies used for rental units in old SRO hotels in the downtown area. Many of the hotels are located around downtown San Diego near the new ballpark. These hotels used as SROs are the Metro Hotel, the Plaza Hotel, and Island Village. The advantage of these older SRO buildings is that they provide relatively inexpensive downtown apartments. Rents range from \$300–\$600, depending on size and location. Such affordable housing is extremely scarce in the San Diego area. New condominiums under construction in the area around the ballpark start at prices as high as \$600,000.

The Metro Hotel provides the largest number of housing units for REACH clients of any of the REACH housing providers. Clients currently rent 38 of 200 units in this SRO building. Operated by a private landlord, each unit has a sink, a small refrigerator, and a small kitchen area. Men's and women's common bathrooms are located on each floor. There are common areas for socializing, television viewing, and computer use. Coin-operated laundry facilities are located on the main floor. The building is older, and many of the units are in need of extensive repairs. As units turn over, the landlord is refurbishing them with new countertops and tile flooring. Despite these improvements, many focus group participants who were current or prior residents at the Metro Hotel complained about the small units and deteriorated facilities.

The landlord provides property management services on site, primarily to provide security in the building. The Metro Hotel has a zero tolerance policy for alcohol use and drug activity on the premises. Signs posted in the lobby clearly state that drugs and alcohol are prohibited in the building. Both REACH staff and clients confirmed problems with living conditions at the Metro Hotel, including concerns about safety and housing quality. A client who previously lived outside at Balboa Park stated, "I would rather be in the park. It's a battle to dodge the drugs."

Another client commented, "Sometimes it feels like I'm living in a jail cell...my room at the safe haven was twice as big." Clients expressed fewer concerns about other housing situations.

Some problems with vandalism, crime, drug activity, and prostitution have been linked to REACH clients. Local respondents all acknowledged, however, that some problems were due to the transient nature of the building's other tenants. REACH clients are often vulnerable to illegal traffickers and drug addicts on the streets. Sometimes they fall prey to allowing this activity in their apartments. The landlord closely monitors visitors and illegal activities in the building. He can contact the REACH case managers when they suspect that a REACH client is in trouble or causing a disturbance.

As of May 2005, concern over the high density, client complaints, and numerous housing problems led REACH to administer a housing choice questionnaire to all clients at the Metro Hotel. This was designed to help them relocate to their housing of choice. REACH's goal is to reduce the number of clients in the Metro Hotel to a maximum of 15 units by December 2005. The other SRO hotels associated with REACH have a smaller number of program clients, resulting in a lower density of mentally ill clients. The Plaza Hotel had 20 REACH clients. According to REACH staff, the on-site property manager at the Plaza Hotel is a former convict who reformed his life. He is more tolerant and understanding of REACH clientele. Seven clients lived at the Lynne Hotel.

Scattered-Site Apartments

As of May 2005, 56 REACH clients were living in scattered-site apartments. Most scattered-site apartments are located in the eastern part of the city where rents are more affordable. Many REACH clients are in apartment buildings that are managed by landlords who collaborate with REACH. Sixteen clients were paying their own rent while the remaining units were subsidized through a variety of sources. (See page 8.) One housing developer and manager specifically allocate units for REACH clients. A total of 16 clients are in the Delmar Apartments, Reese Village, and Paseo Glenn.

Because there is a waiting list for scattered-site apartments, these units go to less impaired REACH clients. Usually these clients have done well at the SRO hotels. During the screening process, case managers interview clients about their daily activities. They also assess client interest in scattered-site housing, level of independence, income, sobriety, budgeting, ability to prepare food, and medication management.

Clients in the focus group understand that they must progress to be able to enter a scattered-site unit. One client described his experience of moving into housing. "For me it happened really fast.... I spent two weeks in a crisis house and then I went to the Metro Hotel for three 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 street." Most clients in the focus group said that there were few housing choices, but expressed little dissatisfaction unless they were living in the Metro Hotel.

The responses of focus group participants about housing choices were mixed. One client stated that his housing was "not imposed, but REACH directed me." Another said, "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."

Other living situations include ILFs. An ILF provides a one-room rental with one shared bath for every three residents. These facilities are not licensed to distribute medications, only to remind people and support them. There are no "house rules" but many landlords have strict provisions against substance use. Another type of placement is a Board and Care facility. These facilities are licensed by the state to distribute medications and provide meals. Nineteen of the more impaired REACH clients were in Board and Care facilities.

Housing Agreements and Leases

When REACH houses a client, a case manager is assigned and the client signs a lease. Residents at the safe haven sign a housing agreement with the assistance of their HOT member or REACH case manager. The safe haven housing agreement and lease documents do include provisions that the resident may be evicted for criminal activity, drug use, or violence in or near the property. To a certain extent, the program pays the rent, but the client typically pays a portion. For some, the client pays all of their rent and receives help with food and transportation vouchers. Clients are fully responsible for following through on paying rent but the program will remind them. If the client has not paid rent and the program knows the landlord, the landlord will call REACH to report that a client has not paid rent.

Telecare sometimes acts as the representative payee for clients. One other organization—The Organizer—also act as representative payee for some REACH clients.

FUNDING SOURCES FOR HOUSING AND SERVICES

SDHC provides 100 project-based Section 8 subsidies for REACH clients. The Association for Community Housing Solutions (TACHS) provides Shelter Plus Care rental assistance at three different housing complexes. TACHS also provides rental assistance for other scattered-site housing. The Tom Behr Foundation provides scattered-site apartments using project-based Section 8 and Shelter Plus Care subsidies at four complexes.

SDHC and TACHS fund the housing portion of the program. The state-funded AB 2034 program, operating through San Diego CMH, funds mental health and other program services. REACH is able to finance a significant portion of services through Medicaid (Medi-Cal in California) billing after clients begin receiving SSI and Medi-Cal. The additional Medi-Cal revenue pays for staff positions, services, and housing for more clients. SDHC participation allows San Diego to use most AB 2034 funding for supportive services that serve more people, rather than devoting most state funding to housing. Case managers use program funding to house those clients that have zero income. Once clients secure SSI or employment income, they can use it to offset rental expense.

HOUSING AND SERVICES FOLLOWING ENROLLMENT

The outreach specialist at REACH screens homeless people in the community. The specialist also acts as a liaison to HOT and identifies and prioritizes mentally ill clients most in need. REACH case managers assess each client's needs, develop a service plan, and help clients obtain basic services, such as clothing, food, and medical treatment. As noted earlier, most clients stay at the ECS safe haven during this assessment period. Some assessments may take up to 30 days, but some clients are immediately placed into an SRO apartment. REACH case managers work with clients to find housing of choice as soon as they are "ready." A San Diego County probation officer assigned to REACH helps to resolve any outstanding warrants, illegal lodging tickets, or other issues that could prevent a client from obtaining housing.

REACH case managers consider several factors when placing clients in housing. These include the client's level of functioning, client resources, the degree of impairment, need for psychiatric services, and behavioral difficulties. If clients have resources, such as SSI or Medi-Cal, they may be able to pay part or all of their own rent. Sometimes clients must be prioritized for moves due to landlord complaints. Case managers work closely with each client to find his or her housing of choice. Most clients who attended the focus groups, however, felt that they had very little choice in housing.

Housing Moves

Approximately half of REACH clients experienced frequent moves following enrollment. Reasons included temporary periods of homelessness, emergency psychiatric placements, shortterm drug or alcohol treatment, and time spent in jail or prison. Some clients experienced permanent housing moves to more or less supportive environments.

Once enrolled in REACH, case managers followup with clients regardless of where they move. Team members visit clients within 72 hours of a psychiatric placement. They dispatch the outreach team to locate clients if they have returned to the streets and homelessness for a period of time. CRF staff members followup with clients in the evenings to ensure that their needs are met.

Housing moves may be related to specific housing problems. Regardless of when housing problems occur, the case management team responds to the problem with the best solution for the client and for the landlord. Most housing problems identified during the study were related to drug or alcohol use and other behavioral problems. Most clients are diagnosed with schizophrenia or other psychotic disorders. Many, if not most, suffer from years of substance abuse. REACH clients are very impaired when they first enter housing. Symptoms from these serious disorders often result in disturbances or housing problems that are not tolerated within private market housing.

Depending on the nature of the housing problem, particularly if it involves a lease violation, behavioral intervention may be needed to preserve the client's housing. For example, housing problems may be solved by removing a friend who is temporarily staying with the client. It may be necessary to clean or repair problems caused by hoarding, fire setting, or flooding. The client may need to be placed in a short-term more supportive environment. In the most extreme cases, the client may be moved to other housing.

REACH clients experience moves for positive reasons as well. Improvements in functioning, employment, and independence can result in housing placements in scattered-site apartments, with or without on-site case management. In the focus groups, one former resident of the Metro Hotel, now living in a scattered-site apartment, remarked "Something better is on the way if you stick with it." One of the clients from the study sample who left the program during the first 12 months now lives in independent housing in Las Vegas. This client reported that "The Metro Hotel got me ready for where I live now. If I hadn't been living there, I don't know if I could live where I am living at now."

REACH Case Management Services

Within the REACH program, one case manager is assigned to each client at enrollment. There are no treatment requirements other than meeting with the case manager two times per month. Service plans are client-driven and adjusted, as needed, each time the case manager meets with the client. At 6 months, service plans are formally reviewed with the client.

Clients expressed positive feelings for REACH case management services. One client said, "They want to know all your problems and then they deal with everything fast. They take over the thinking process. You don't have to think about it." Another client reported that, "The others (programs) have too many rules. There are no threats here." A third client stated that "REACH told me I would never be homeless again."

The relationship between case managers and clients is a key component in the rehabilitative process. The case manager offers support and guidance as the individual works to achieve his or her life goals. Program services are client-centered and highly individualized, emphasizing personal choice and empowerment. The REACH case manager helps clients obtain a full range of services, in addition to the basic necessities of food, clothing, and stable housing. These services are designed to help clients retain housing and reduce the risk of harm associated with ongoing addiction. These services may include:

- Medical and psychiatric services;
- Crisis response;
- Case management;
- Money management;
- Connections to self-help and community resources;
- Substance abuse intervention;
- Education and counseling;
- Vocational services;
- Help obtaining entitlements;
- Assistance in the development of peer relationships; and
- Support and education of family and significant others.

Appendix E: Reaching Out and Engaging to Achieve Consumer Health (REACH), San Diego

Each case manager carries a caseload of no more than 23 clients. The REACH program is currently divided into two teams. Each team consists of a supervisor and six case managers serving a caseload of 130 clients. To serve so many clients over such a broad range of housing types, REACH adopted a team approach. The Telecare team provides clinical case management services to the client in the community. Other services such as employment, psychiatric, rehabilitative, and nursing services, are provided through another contractor, CRF. CRF is located in the same central administrative office location with Telecare, but case managers must make a formal referral to obtain CRF services for their clients. Two separate systems of record keeping must also be maintained to assure client confidentiality and to meet federal regulations for medical information sharing.

Recently improved communications between the two separate contractors have resulted in better case collaboration. The CRF director now meets with the Telecare teams during their morning team meetings. The CRF director updates all staff on key changes and informs them about which clients saw the nurse or medical doctor and what was done. The CRF director also collects information on any major client status changes reported by Telecare case managers.

Each day starts with a team meeting where the team reviews all clients to identify major changes or emergencies from the previous day and night. These meetings allow supervisors to collect information needed for AB 2034 program reporting. This includes jail or hospital admissions and contacts with clients (required at least once every two weeks). The meetings also provide an opportunity for case managers to share information and request assistance. For example, if a case manager plans to visit a particular apartment complex where several clients live, that case manager may help another case manager's client. The case manager may take a client to an appointment or bring back information to the client's assigned case manager.

An example of team coordination can be seen in REACH's approach to medication management. The CRF nurse practitioner member of the treatment team first helps the client package the medication. Then the nurse educates the client about the medication and when the client should take it. This is followed by frequent reminders to the client to take the medication. The level of assistance gradually decreases as clients become ready to package and take medication independently. Clients demonstrate improvement in independent medication management with this approach and no longer need reminders. However, if medication management becomes a problem, it may be several days before the client's symptoms or behavior indicate that he or she is decompensating.

Staff estimate that fewer than 10 percent of cases require staff to initiate a representative payee arrangement. When a payee is required, REACH will often serve as the representative payee for clients. None of the clients in the focus groups who said they had a representative payee objected publicly to the arrangement.

ESSENTIAL COMPLEMENTS OF THE REACH PROGRAM

Staff at REACH identified the key elements they say are needed for a successful Housing First program:

- **Direct Placement into Housing**—REACH separates the housing issues from the treatment issues by bringing people into housing first and then working with them where they are. Although clients have immediate access to housing without program requirements for sobriety or treatment participation, REACH clients sign leases with private landlords requiring case managers to develop collaborative relationships with landlords to support clients in their housing in the community. When a client causes a housing problem, case management staff attempt to find a remedy that responds to both the landlord and the client concerns. If necessary, case managers will help clients find alternative housing, doing "whatever it takes" to help the client maintain permanent housing in the community. REACH and its service provider partners' clinical expertise allows it to respond to the complex needs of chronically homeless people.
- Mental Health Case Management Services in the Community—Regardless of the degree of impairment, individuals have the potential to live successfully in the community when the necessary supports are available, according to REACH. The mental health case management teams have three primary goals. The first is to enhance the client's community adjustment. The second is to decrease time spent in institutions. And the third is to help clients live independently, especially in the areas of activities of daily living, money management, and medication management.
- Housing and Treatment Services Provided Separately—REACH staff acknowledge that housing this population across a large geographic area is challenging. However, the 24 hours a day, 7 days a week availability of case management staff makes it work. When clients relapse into substance abuse or experience increases in psychiatric symptoms, their housing status remains constant. The team and client manage relapse crises collaboratively and services often intensify during such periods. Decisions about intervention are up to the client unless the client presents a danger to self or others. This housing policy contributes to clients' success in maintaining stable housing as it reduces the frequency of periods of homelessness. Although a client may temporarily leave housing for a short stay in a psychiatric hospital or detoxification center, the client does not lose his or her permanent housing. Nor is the client discharged to homelessness upon completion of treatment.
- **Careful Monitoring of Outcomes**—Telecare is a licensed, for-profit provider of mental health services under contract with county government. As a private contractor, Telecare must meet high performance standards to receive contract renewals. Therefore the focus is on the impact of services on client outcomes. REACH tracks this performance data over time. This data and prior experience helps REACH effectively monitor clinical and financial risk. Mental health service delivery has long emphasized outcome tracking and practice evaluation. The more recent attention to the bottom line is a matter of survival in a competitive service industry. REACH supportive services are Medicaid-billable and regulations specify minimum standards of practice.

• New Directions for REACH—The REACH program is the newest program of the three sites selected for this study. Staff are still determining how to enhance their program and services to improve outcomes for people with mental illness living on the streets. During the last year, REACH hired a housing specialist to develop more housing options for clients, including options funded through the Mental Health Services Act. This will help to move clients out of the downtown SROs into more independent housing.¹¹⁸

¹¹⁸ Mental Health Services Act—MHSA (Proposition 63) passed in November 2004 and became effective January 1, 2005. The MHSA assures state funding for the planning and implementation of new and innovative children, adult, and older adult mental health services and programs in California counties. For more information see www.sandiego.networkofcare.org/mh.

APPENDIX F: GLOSSARY

ACCESS	Access to Community Care and Effective Services and Supports Program
ACT	Assertive Community Treatment
APR	Annual Progress Report
CASES	Center for Alternative Sentencing and Employment Services
CHASERS	Client Housing and Services Entry and Reporting System
CMH	San Diego County Mental Health Services Division
CRF	Community Research Foundation
DESC	Downtown Emergency Service Center
DMH	New York City Department of Mental Health
DSM	Diagnostic and Statistical Manual
ECS	Episcopal Community Services
GA	General Assistance
GED	General Educational Development
HOPWA	Housing Opportunities for Persons with AIDS
HOST	Homeless Outreach, Stabilization, and Transition Program
HOT	Homeless Outreach Team
HUD	U.S. Department of Housing and Urban Development
KEEP	Key Extended Entry Program
ILF	Independent Living Facility
KEEP	Key Extended Entry Program
MOU	Memorandum of Understanding
NRC	Narcotics Rehabilitation Center
NSHAPC	National Survey of Homeless Assistance Providers and Clients
OMH	New York State Office of Mental Health
PATH	Projects for Assistance in Transition from Homelessness
REACH	Reaching Out and Engaging to Achieve Consumer Health
SDHC	San Diego Housing Commission
SHA	Seattle Housing Authority
SHP	Supportive Housing Program
SRO	Single Room Occupancy
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TACHS	The Association for Community Housing Solutions
TANF	Temporary Assistance for Needy Families
WRMA	Walter R. McDonald & Associates, Inc.
YMCA	Young Men's Christian Association

APPENDIX G: REFERENCES

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