People Who Experience Long-Term Homelessness: Characteristics and Interventions

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Abstract

Carol Caton, Carol Wilkins, and Jacquelyn Anderson document the considerable efforts of the past decade to address the needs of people who are considered "chronically homeless; that is, unaccompanied adults with disabling conditions who experience long or numerous spells of homelessness. The authors detail the prevalence, characteristics, and service needs of adults who are chronically homeless and present a synthesis of recent research on service and housing interventions. Finally, they discuss the implications of the findings for services and for future research. The authors note that rigorous research on many interventions is lacking, but promising practices from the field may help guide the development of housing and services.

Introduction

In the early years of the 21st century, homelessness continues to be a social problem of enormous public health significance. In mid-20th century America, observed homelessness was rare. However, in the late 1970s, homelessness increased sharply and has persisted for nearly three decades.

The Department of Housing and Urban Development's Annual Homeless Assessment Report to Congress (HUD, 2007) indicates that on a single day in January, 2005 there were 754,147 sheltered and unsheltered homeless persons in the United States. This point-in-time estimate represents less than 0.3 percent of the total population. When contrasted with prior estimates, findings suggest that the size of the homeless population has not changed significantly in the past decade.

The majority of people who ever experience homelessness are able to return to conventional housing within a brief period of time. In a study of shelter use in Philadelphia, Metraux et al. (2001) found that three-quarters of the people who used emergency shelters were homeless only once or twice, and most stayed for less than 60 days. A smaller number of people, however, remain homeless much longer. At any point in time, this group comprises a large proportion of the homeless population. The one-week prevalence estimate in the National Survey of Homeless Assistance Providers and Clients (NSHAPC) indicated that about one-fourth of the homeless population experienced spells of homelessness lasting over four years or had numerous homeless episodes (Burt et al., 2001). These chronically homeless individuals present a huge challenge for providers and policymakers because they use a disproportionate share of public services but remain vulnerable to continued homelessness.

Despite the daunting challenges presented by chronic homelessness, there is a glimmer of optimism that the winds of change in policy and program development are thrusting new energy into the search for viable solutions. New approaches to service delivery and provision of housing targeted at this population have been developed. Some of these interventions are becoming widely recognized as "evidence-based." In the last 5 to 10 years, there has been a convergence of opinion among advocates and policymakers at all levels of government that chronic homelessness need not exist in the United States. Momentum around this issue started to build in 2000 when the National Alliance to End Homelessness (NAEH) released a plan to end homelessness in 10 years. Shortly afterward, Secretary Mel Martinez of the U.S. Department of Housing and Urban Development (USDHUD) endorsed the goal of ending chronic homelessness, and the Bush Administration affirmed this goal in its FY2003 budget. In 2002, the Millennial Housing Commission, appointed by a bipartisan committee in Congress, called for ending chronic homelessness through the creation of 150,000 units of supportive housing, and the Administration reactivated the federal Interagency Council on Homelessness (ICH). Beginning in FY2003, the Collaborative Initiative to Help End Chronic Homelessness was launched with funding provided by the HUD, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the Department of Veterans Affairs (VA), with coordination by the ICH. Policy Academies on Chronic Homelessness in which teams implement a plan to address chronic homelessness have been established in every state and territory (see www.hrsa.gov/homeless).

Since 2003, a growing number of communities have developed policy and program strategies that are informed by more rigorous local estimates of the number of homeless individuals and an increased understanding of the nature of chronic homelessness. These efforts are starting to bear fruit. There are early signs that the number of chronically homeless people in shelters and in the streets is declining in some localities (NAEH, 2006a).

This manuscript is focused on chronically homeless single disabled adults, clearly a most vulnerable segment of the homeless population. While it is likely that some youth under the age of 18 also experience long-term homelessness, the lack of information on the course of youth homelessness underscores the need for further study of this population. Here we describe the numbers, characteristics, and service needs of adults who are chronically homeless, present a synthesis of the research literature on service and housing interventions, and discuss the implications of research findings for services and for future research on preventing and ending chronic homelessness. As a caveat, we note that most of the research on disabled homeless adults does not specify the extent of residential instability of study participants, although undoubtedly chronically homeless people have been included in such investigations. We present findings from studies of chronically homeless people when available, and extrapolate from studies of homeless people in general when homeless chronicity has not been specified.

Chronic Homelessness Defined

It is widely agreed that chronically homeless adults constitute a small but significant subgroup of the homeless population. The federal government's definition of chronic homelessness (reflected in policies and programs adopted by the Interagency Council on Homelessness, HUD, HHS, and the VA) is as follows: *"An unaccompanied homeless individual with a disabling condition who has either a) been continuously homeless for a year or more OR b) has had at least 4 episodes of homelessness in the past three years."* This definition of chronic homelessness also has been adopted by many states, while some have expanded this definition to also include families that meet the same criteria. Disabilities or disabling conditions often include severe and persistent mental illness, severe and persistent alcohol and drug abuse problems, and HIV/AIDS. There is little information available about the prevalence or characteristics of adults who experience long-term homelessness but do not have any identified disabling conditions, who are therefore excluded from the most widely used definitions of chronic homelessness.

The Prevalence of Chronic Homelessness

Estimates of the prevalence of chronic homelessness vary depending on the definition used, the duration of time observed, and the method of data analysis. Based on applications for homeless assistance submitted to HUD from local areas across the country, the National Alliance to End Homelessness (2006a) estimated that there were 150,000 to 200,000 chronically homeless individuals nationwide as of January 2005.

Overall, about 20 percent of sheltered homeless adults would qualify as chronically homeless according to the federal definition, which combines single long spells of homelessness with episodic or recurrent homeless spells. Kuhn and Culhane (1998) studied shelter utilization patterns based on administrative data in New York City and Philadelphia. A cluster analysis of the New York City data revealed that approximately 10 percent of shelter entrants were chronically homeless, remaining in the shelter for an average of over 630 days and experiencing an average of 2.26 episodes over the three years of the study. This group consumed half the total shelter days, despite their small number. Another 10 percent were episodically homeless, shuttling in and out of shelters and other institutions such as hospitals, substance abuse treatment programs, and jails. A cluster analysis of the one-week estimate in the NSHAPC study classified 27 percent as chronically homeless (Burt et al., 2001). This group had an average duration of homelessness in excess of four years. Kertesz et al. (2005) classified 22 percent of study participants as chronically homeless in a two-year follow-up study employing the two-dimensioned federal definition of homelessness. Similarly, a New York City study of first-time homeless sheltered single adults (Caton et al., 2005) found that about 20 percent of study participants remained continuously homeless over a follow-up period of 18 months.

Chronic Homelessness: Characteristics and Risk Factors

Clinical Characteristics

Chronic homelessness and its attendant consequences are experienced more often by those with psychological, physical, and social vulnerabilities. Although there is considerable heterogeneity in the clinical characteristics of people who experience homelessness (Burt et al., 2001), the profile of disabled homeless individuals, the group most likely to fall into chronic homelessness, has not changed much in the last decade. Psychiatric disability, substance abuse, and medical co-morbidities are widespread in the

chronically homeless population. In fact, disability resulting from psychiatric and substance use disorders is greater among the chronically homeless population than among other single adults who experience homelessness on a transitional or episodic basis (Kuhn & Culhane, 1998; Burt et al., 2001; Kertesz et al., 2005). Lifetime mental health problems have been found in over 60 percent of chronically homeless people, and greater than 80 percent have experienced lifetime alcohol and/or drug problems (cross-tabulation estimate, Burt et al., 2001). Similar high rates of mental health and substance abuse problems have been reported from housing and service programs designed to serve chronically homeless people (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic Homelessness, 2006). Included among the psychiatric disabilities experienced by homeless people are violent victimization and posttraumatic stress disorder (Metraux & Culhane, 1999).

Medical co-morbidities are commonly found among people who use services designed for people who are chronically homeless (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic Homelessness, 2006). Indeed, the excess morbidity due to mental illness, substance abuse, and medical conditions place homeless people at higher risk of mortality than their housed counterparts. A New York City study found that age-adjusted mortality rates for homeless men and women were approximately four times greater than those found in the general population. Chronicity of homelessness was found to be a strong predictor of mortality among men, even when adjustments were made for age and disability (Barrow et al., 1999). Mortality is greater among younger homeless women compared to those over age 45 years (Cheung & Hwang, 2004). HIV/AIDS is a factor in the increased mortality found in homeless populations. A San Francisco study found that HIV seroprevalence was greater among homeless and marginally housed adults than in the city overall (Robertson et al., 2004). A recent New York City study of the health of sheltered homeless people revealed that the death rate from HIV/AIDS was nine times higher among sheltered single women than among the general population (Kerker et al., 2005). Further evidence comes from the study of Culhane et al. (2001) indicating that people admitted to public shelters in Philadelphia had a three-year rate of subsequent AIDS diagnoses that was nine times that of the city's general population. Other serious infectious diseases such as hepatitis-C (Gelberg et al., 2004) and tuberculosis (Zolopa et al., 1994) and chronic conditions such as asthma and hypertension (Schanzer et al., in press) are found among street and sheltered homeless people.

Social Characteristics

In addition to serious disability, the lives of chronically homeless people are compromised by persistent unemployment (Caton et al., 2005), forcing dependence on public entitlements for sustenance, health care, and an eventual exit from homelessness. Few can rely on support from family and friends (Kertesz et al., 2005; Caton et al., 2005), increasing their isolation and decreasing their opportunities for social inclusion.

Veterans constitute about 20 percent of service-using homeless people nationwide (Mojtabai, 2005). The Veterans Administration estimates that about 194,000 veterans were homeless in the United States on a given night in 2005 (GAO, 2006). Approximately 25–30 percent can be classified as chronically homeless (Dougherty, 2006).

The client characteristics of people enrolled in programs designed to serve the chronically homeless population indicate that about three out of four are men (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic

Homelessness, 2006). The predominance of men among the ranks of homeless single adults is underscored by the NSHAPC study, in which men outnumbered women by about 4 to 1 (Burt et al., 2001).

Although numerically a minority, single homeless women have been found to experience a greater number of stressful life events compared to homeless single men and women with children, and to more often report histories of foster care placement during childhood, domestic violence, psychiatric hospitalization, and sexual violence in adulthood (Zugazaga, 2004). The majority of homeless women are mothers, but many are considered "single" or unaccompanied adults because they are no longer living with their children (Burt et al., 2001). Mothers who are homeless for more than a year are more likely to lose custody of their children, and therefore they are less likely to qualify for public entitlements (welfare) or other forms of support that may be available to families with children. Compared to other homeless mothers, those living without their children are more likely to have a current substance use disorder (Zlotnick, Robertson, & Tam, 2003; Zlotnick, Tam, & Bradley, 2006). The accumulation of traumas experienced in adulthood by homeless women, including physical assault, rape, incarceration, and long-term homelessness, has been found to be associated with living apart from their dependent children (Zlotnick, Tam, & Bradley, 2006).

Racial and ethnic minorities are overrepresented among sheltered homeless individuals (see NYCDHS, 2006; Kuhn & Culhane, 1998) as well as among users of homeless services (Burt et al., 2001). The client characteristics of people enrolled in programs designed to serve people who are chronically homeless indicate that about half are African American (Barrow, Soto, & Cordova, 2004). Recent studies have underscored the overrepresentation of African Americans among people who are homeless and mentally ill (Whaley, 2002; Folsom et al., 2005), and among those who experience shelter reentry (Min, Wong, & Rothbard, 2004).

Programs designed to serve people who are chronically homeless report that the average age of program participants is the mid to late 40s (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic Homelessness, 2006). There are indications that the population with long-term spells of homelessness is growing older (North et al., 2004; Hahn et al., 2006). In a serial cross-sectional study of homeless adults recruited from San Francisco service programs over a 14-year period, Hahn et al. (2006) reported that over this time span the median age of homeless adults increased significantly from 37 to 46 years, accompanied by a significant increase in the median time homeless from 12 months to more than 39 months.

Risk Factors for Chronic Homelessness

Few long-term studies of the course of homelessness following initial housing loss have been carried out. However, available information on the characteristics of those who end up homeless for long periods of time indicates that older age, persistent unemployment, poor family support, arrest history, poor functioning and coping skills, a history of placement in the child welfare system, and recent victimization are important factors in determining the risk for chronic homelessness.

Caton et al. (2005) examined risk factors for chronic homelessness among newly homeless men and women admitted to New York City shelters for single homeless adults. Participants were interviewed upon entry into the shelter and followed for 18 months. A longer duration of homelessness was related to older age, past or current unemployment, a lack of earned income, poorer coping skills, less adequate family support, a history of substance abuse treatment, and an arrest history. The most important

predictors of long-term homelessness were older age and arrest history. Park, Metraux, and Culhane (2005) reviewed administrative data on a cohort of over 11,000 sheltered homeless adults from the New York City Department of Homeless Services, the agency that oversees the shelter care system, and the New York City Administration for Children's Services, the agency responsible for placement of children through the child welfare system. A history of placement in the child welfare system was associated with an increased likelihood of repeat stays in the adult shelter system. Importantly, Lam and Rosenheck (1998) found that recent victimization negatively impacts both duration of homelessness and quality of life, suggesting a critically important role for trauma-informed services in homelessness prevention as well as in interventions for people who are chronically homeless.

Further understanding of chronic homelessness risk can be gleaned from studies of homelessness onset in which homeless people are contrasted with people who have never experienced housing loss. These studies identify how the characteristics of homeless people differ from the characteristics of other people who have extremely low incomes but seem to manage without becoming homeless. It has been suggested that mental illness may play a role in initiating homelessness for some people, but it is not likely that mental illness alone functions as a risk factor for future housing loss (Sullivan, Burhham, & Koege, 2000). Among factors that distinguish homeless people from stably housed people, substance abuse ranks high (Drake et al., 1991; Susser et al., 1991; Caton et al., 1994; Caton et al., 1995; Goering, 1998; Caton et al., 2000; Winkleby & White, 1992; Early, 2005; Folsom et al., 2005; Whaley, 2002).

In a study contrasting homeless people with a matched, never-homeless sample, North et al. (1998) found that *chronicity* of homelessness was associated with symptoms of alcohol use disorder, schizophrenia, and antisocial personality disorder, as well as an earlier age of onset of drug use disorder and Axis I and Axis II psychopathology. The association of homelessness and Axis I disorder has also been reported by Folsom et al. (2005). For people suffering from illnesses such as schizophrenia, for which ongoing use of services is indicated, homelessness has been found to be associated with decreased use of needed services (Caton et al., 1994). Family experiences, such as out-of-home placement in childhood (Susser et al., 1991; Caton et al., 1994; Winkleby & White, 1992; Park, Metraux, & Culhane, 2005), parental and family instability (Caton et al., 1994), poor care from a parent (Herman et al., 1997), and inadequate family support in adulthood (Caton et al., 2000) have been found to be another domain that has distinguished homeless people from those who are stably housed. In the Zugazawa (2004) study, nearly one-third of single homeless women had histories of foster care placement in childhood.

Finally, characteristics reflective of opportunity differences, such as educational achievement (North et al., 1998; Caton et al., 2000), have been found to distinguish homeless individuals from never homeless people in cross-sectional studies. Mojtabai (2005) studied self-reported reasons for homelessness among people defined as mentally ill in the NSHAPC study and those not defined as mentally ill. Both groups attributed their homelessness to inadequate income support, unemployment, and the lack of appropriate housing. Findings underscore the important role of structural solutions, such as expanding the availability of adequate and affordable housing, creating job training and work opportunities, and ensuring that entitlement income is at a level to meet basic needs, in the prevention of long-term homelessness.

Patterns of Service Utilization Among People Who Are Chronically Homeless

The health, personal, and economic challenges that chronically homeless individuals face and the lack of effective, coordinated services to address these problems often lead to a vicious circle of housing instability and further deterioration of well-being. These individuals are often prevented from stabilizing in housing by their health conditions, while their persistent homelessness impedes their access to needed

health and employment services. Consequently, they cycle through costly emergency-driven public systems, including emergency shelters, hospital emergency departments, detoxification centers, and criminal justice facilities, without getting the ongoing care they need to address severe mental illness, substance use disorders, or chronic health conditions (Proscio, 2000; Kushel, 2003; Kushel et al., 2005; Thornquist, 2002).

High Rates of Shelter Use, Inpatient Hospital Stays, and Emergency Room Visits

As would be expected given their long-term homeless status, people who are chronically homeless spend a disproportionate number of days in the shelter system compared to those who are homeless for shorter periods of time. Chronically homeless people are likely to be about half or more of individuals included in cross-sectional samples of homeless people living in shelters or on the streets, while they only comprise about 20 percent of all the people who use shelters over a three-year period (Metraux et al., 2001).

In addition, people who are chronically homeless are high utilizers of emergency and inpatient hospital services for medical, substance use, and mental health conditions. In Philadelphia, homeless mental health patients used more psychiatric acute care hospital days, outpatient emergency-crisis intervention services, substance abuse treatment, and inpatient hospital care for medical conditions than non-homeless mental health patients (Kuno et al., 2000). In San Diego, Folsom et al. (2005) found that homeless patients with severe mental illness were ten times more likely than housed consumers with severe mental illness to use crisis residential treatment and four times more likely to use inpatient psychiatric hospitals and psychiatric emergency units; however, they were less likely to use outpatient mental health services. In the same study, it was found that homeless people with schizophrenia who have a physical illness are less likely to be admitted to a hospital during the early, less severe phase of their illness and more likely to be admitted when the disease is more advanced and severe.

As the chronically homeless population ages, individuals are increasingly likely to visit a hospital emergency department or to have experienced an inpatient hospitalization for a medical problem in the prior year, reflecting increasing rates of chronic medical conditions in addition to high rates of mental health and substance use disorders (Hahn et al., 2006). Garibaldi, Conde-Martel, and O'Toole (2005) found that homeless persons over age 50 were 3.6 times more likely to report two or more chronic medical conditions, 2.4 times more likely to be dependent on heroin, and 1.8 times more likely to abuse alcohol.

Studies of frequent users of health care services also provide some additional clues that homelessness may lead to frequent and inappropriate use of hospital services. As part of the Frequent Users of Health Services Initiative, six California communities developed data on the number and characteristics of their frequent users.[1] Each community identified a core group of individuals who repeatedly used hospital emergency departments (in some cases weekly), often for medical crises that could have been avoided with appropriate, ongoing care. Sometimes the presenting issue is not a medical crisis, but is related to a chronic health condition, mental illness, or a psychosocial issue, such as drug or alcohol use. Analyses of data related to these patients found that while the prevalence of patient characteristics varied from one county to another, high rates of mental illness, substance abuse problems, and homelessness were common. Among frequent user patients, 25 percent to 58 percent were homeless or lacked stable housing. Many were hospitalized but often failed to receive follow-up care and the social supports that could lead

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[1] The Frequent Users of Health Services Initiative is supported by grants from the California HealthCare Foundation and The California Endowment.

to genuine recovery (Corporation for Supportive Housing, 2005). In a study of frequent users of emergency department services at San Francisco General Hospital, 81 percent of study participants, who had five or more visits in the previous 12 months, were homeless. The majority had multiple serious medical illnesses that required ongoing health care (Shumway et al., in press).

Significant Involvement with the Criminal Justice System

Cycling through jail and prison is a common occurrence among people who experience chronic homelessness. Zugazawa's recent study (2004) of sheltered homeless adults, in which 82 percent of men and 52 percent of women had histories of incarceration, illustrates this fact. With changing patterns in systems of public mental health care for people with severe and persistent mental illness, the significance of the criminal justice system has grown more prominent (Freudenberg, 2001). Indeed, it has been suggested that jails are de facto assuming responsibility for the care of a seriously disabled group whose needs cross over multiple systems of care. Metraux and Culhane's (2004) analysis of administrative data on persons released from state prisons to New York City revealed that among persons released with a prior history of shelter use, 45 percent reentered the shelter system following release from prison. Most shelter reentries occurred within a one-month period following release. Homelessness occurring in the post-release period was apparent among former inmates with histories of mental health treatment. Kushel et al. (2005) have reported elevated health risks, including drug use, HIV infection, HIV risk behaviors, and mental illness among homeless and marginally housed former prisoners. McNiel, Binder, and Robinson (2005) have observed that incarcerated people with histories of homelessness, mental illness, and substance use disorders experience an increased duration of incarceration.

Low Rates of Engagement and Retention in Outpatient Mental Health Services, Substance Abuse Treatment, and Appropriate Health Care

While chronically homeless individuals have high rates of emergency service utilization, they are generally unable to access and engage in ongoing outpatient treatment for mental illness, chronic health conditions, and substance use disorders. According to Fortney et al. (2003), homeless people with mental illness are more likely than other mental health consumers to experience less continuity of care as measured by longer duration between encounters for mental health services, lower volume of service encounters, fewer types of services received, lower likelihood of receiving continuous care from the same facility/provider, and lower likelihood of having a case manager. The authors note that low continuity of outpatient care over time puts people who are homeless and mentally ill at risk for encounters with other less appropriate elements of the service system, such as hospitals and emergency departments, as well as placing them at risk for encounters with the criminal justice system. This is confirmed by other studies that consistently document inefficient patterns of utilization among homeless patients with mental illness—more days of acute psychiatric hospitalization, greater utilization of services in the psychiatric emergency units of hospitals, and more infrequent use of outpatient mental health services (Kuno et al., 2000; Rosenheck et al., 2003; Folsom et al., 2005).

Similarly, homeless individuals are more likely to cycle in and out of emergency and residential substance abuse treatment services and often find it difficult to maintain participation in outpatient settings. Homeless participants in substance abuse treatment services are more likely than other participants to receive detox or residential treatment and more likely to have had multiple episodes prior to the current treatment episode (Office of Applied Studies, SAMHSA, 2006). Homeless participants who enter substance abuse treatment programs are often unable or unwilling to complete the program. Studies of a range of treatment interventions found only about one-fourth (Castillo et al., 2005) to one-third (Orwin et

al., 1999) of participants complete substance abuse treatment programs, even when the programs are specifically designed for homeless people with serious substance use problems.

Providing housing in conjunction with treatment significantly increases client retention (Orwin et al., 1999) and improves treatment outcomes (Kertesz et al., 2006). The National Institute on Alcohol Abuse and Alcoholism Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Individuals tested 23 interventions in 14 sites. Eight of these sites offered some form of housing for one or more intervention groups, including residential treatment programs, supervised transitional housing, or other residential arrangements for treatment program participants. (This broad range of housing and treatment models included, but was not limited to, supportive housing, which is discussed later in this paper.) Discharge policies ranged from "zero tolerance to zero consequences" for relapse. Researchers found that all of the interventions lost two-thirds or more of participants prior to program completion, while residential interventions retained more individuals than nonresidential programs. In addition, homeless participants were more likely to complete treatment programs that are less intensive, more flexible, or designed as relatively brief (three to four months) interventions (Orwin et al., 1999). And while treatment-ready homeless clients may prefer intensive programs, others (the majority of chronically homeless people) are likely to stay longer in low-demand programs (Orwin et al., 1999).

In a study of long-term housing and work outcomes among homeless people who were using cocaine, Kertesz et al. (2006) compared outcomes for program participants who had been randomly assigned to live in a furnished apartment contingent upon drug abstinence, similar housing not contingent upon abstinence, and no housing during participation in a 6-month treatment program. Even though both housing interventions were available only during the 6-month period coinciding with treatment (a time frame significantly shorter than that allowed by most transitional housing programs), after 12 months participants who had received housing while in treatment had higher rates of both stable employment and stable housing, when compared to those who had not received housing assistance while in the same treatment program. Even so, the majority of treatment participants were unable to achieve stable housing after completing treatment.

Despite the individual barriers that homeless clients have, however, motivation may also play a key role in success in substance abuse treatment. Interventions to enhance motivation and readiness to change and seek treatment are likely to be helpful (Gonzalez & Rosenheck, 2002).

Among people living with HIV/AIDS, homelessness, active drug use, mental health problems, recent incarceration, and limited social support are all factors associated with an increased likelihood of delayed entry into appropriate medical care and dropping out of medical care, even after controlling for other demographic characteristics and risk factors. HIV-positive persons who are homeless are more likely to engage in high-risk sex and drug behaviors, and are more likely to have a high viral load, recent opportunistic infection, and hospitalization for HIV related disease (Aidala, 2006; Aidala & Needham-Waddell, 2006; Schubert & Botein, 2006).

High Public Costs for Ineffective Care

Emergency and inpatient health and psychiatric services carry a hefty price tag and are often more expensive than the ongoing outpatient and preventative treatment that people who are chronically homeless have a difficult time accessing. Including the costs of shelter use and incarceration, the public costs of chronic homelessness become exorbitant. Culhane et al. (2002) found that before placement into

permanent supportive housing, 4,679 homeless people with severe mental illness used about $40,451 per year per person in services. More than 85 percent of these costs were associated with health care and mental health services—primarily for care delivered in hospital settings. This is the largest study ever completed, but smaller studies in a range of communities found similarly high levels of costs for services to homeless (often chronically homeless) adults with disabilities.

A study of 151 homeless adults with serious mental illness in Baltimore found that total costs per person for in-patient and outpatient health care and treatment services averaged $26,193 to $33,827 (Lehman et al., 1999). Similarly, a pilot study of 35 chronically homeless adults with co-occurring mental illness and substance use problems in Portland, Oregon, estimated that pre-enrollment annual costs for health care and incarceration averaged $42,075 per person. More than 80 percent of total costs were associated with inpatient hospitalizations for medical care and emergency room visits (Moore, 2006). A study of Denver's Housing First Collaborative program (one of 11 projects funded in 2003 through the federal government's Collaborative Chronic Homelessness Initiative) found that the costs of health care services utilized in the two years before participants entered the program averaged $17,381 per participant, and 90 percent of these costs were associated with inpatient or emergency room care.

Studies of persons living on the streets and addicted to alcohol also show extremely high costs for health services (generally related to alcohol-related illness and injury), police intervention and incarceration, and detoxification services while homeless (Cox et al., 1998; Thornquist et al., 2002; Podymow et al., 2006). In San Diego's Serial Inebriate Program (SIP), rates of utilization of emergency room and inpatient hospital care among individuals served by the program were extraordinarily high. Charges for ambulance and hospital care provided to 529 SIP clients over a four-year period totaled $17.7 million, more than $8,000 per year per client (Dunford et al., 2006). Other studies of individuals among this population who were frequent users of detoxification services had very similar findings. In Seattle, medical charges for a sample of 298 people averaged more than $2.5 million per year during the three-year study, also more than $8,000 per year per person (Cox et al., 1998). In Minneapolis, Minnesota, the total annual charges for frequent users of detoxification services averaged $12,771 per person (Thornquist et al., 2002).

Research on Promising and Effective Strategies to Address Chronic Homelessness

The patterns of service use characteristic of chronically homeless people have prompted service innovation to improve the engagement of this vulnerable population in the treatment and housing support services needed to end their residential instability. Creative efforts directed at this objective have involved changing the locus of psychiatric and medical treatment from hospitals and clinics to the street, shelter, and housing settings where people vulnerable to chronic homelessness can be found. Outreach to homeless people living on the street and in shelters, delivery of case management and assertive community treatment services on site in shelters and community housing settings, integration of mental health and substance abuse treatment services, and permanent and transitional supportive housing are some of the innovative efforts to better meet the needs of this disabled population and engage them in a process of recovery and stable tenure in the community. As communities nationwide accelerate their efforts to address chronic homelessness, these innovative efforts can guide program development.

We note that some communities have already made significant strides in establishing a community-wide approach to program development for people who are chronically homeless. For example, the City of

Portland recently reported a 39 percent drop in the number of people sleeping outdoors (City of Portland, 2007). Other cities reporting reductions in street and chronic homelessness include Dallas; San Francisco; St. Louis; Atlanta; Norfolk, VA; and Quincy, MA (USICH, April 18, 2007). Communities that have made significant strides in reducing chronic homelessness have adopted clear goals that guide a communitywide approach that includes some or all of the following program elements, which are often implemented by multidisciplinary teams or multi-agency collaborative partnerships (Burt et al., 2004; City of Portland, 2007).

- **Outreach.** Outreach is a critical first step in connecting chronically homeless people with the services they need. Many communities have restructured these efforts to include multidisciplinary teams designed to increase engagement, develop positive relationships with clients, and more effectively link them with housing, treatment services, and other resources. A small but growing number of communities have empowered outreach workers to immediately offer chronically homeless people direct access to permanent housing, targeting housing opportunities to people who have been living on the streets or in shelters for the longest periods of time.

- **Housing.** Housing with attached supportive services is designed to help ensure residential stability for chronically homeless people coming directly from the streets or shelters. A range of different models provides this type of housing, including permanent supportive housing and Safe Havens. In addition, some housing is available for people who have not yet achieved sobriety or stability. These housing models do not require participation in treatment or other activities as a condition of entering or keeping housing if tenants are otherwise meeting the requirements of any leaseholder.

- **Discharge planning.** Given the frequency with which chronically homeless people cycle between institutions and life on the streets or in emergency shelters, effective processes for discharging people from jails, treatment facilities, and hospitals can provide opportunities for engaging chronically homeless people as well as preventing chronic homelessness for some of the most vulnerable homeless adults with disabilities. Effective strategies properly assess clients' service needs, help them make connections with service providers upon release, and arrange for appropriate post-release housing as an alternative to discharging people to the streets or emergency shelters.

In the following sections we describe the different approaches in services and housing that have been developed in the past decade and present findings on their efficacy.

The "Evidence-Based" Standard and the Quality of Available Evidence

Increasingly, policymakers have emphasized the value of research data on program efficacy as a necessary factor in the development of mental health services and systems of care. "Evidence-based care" is an approach to classifying research on service outcomes according to the amount and quality of evidence indicating that an intervention is effective (Sackett et al., 2000; Anthony, Rogers, & Farkas, 2004; Drake et al., 2003; Rog, 2004). Typically schemas for classifying evidence-based practices consider large, randomized clinical trials with adequate controls and unequivocal findings to be the highest standard of evidence required for an intervention to be considered evidence based. In fact, much of the recently published work on service innovation targeted at people who are homeless and severely mentally ill falls short of this standard, yet the relevance of the work is apparent in that it has emerged from practice experiences in response to sorely felt unmet needs.

Communities across the country have developed, implemented, and refined a wide range of program models and strategies to address chronic homelessness. Some of these models have been rigorously evaluated and others have been evaluated using less sophisticated methodologies. Some interventions have been implemented widely but little research exists to measure their effectiveness. New services for this population developed over the past decade include adaptations or modifications of established evidence-based interventions that were initially designed and tested for stably housed people with serious mental illness (Burns & Santos, 1995; Hwang et al., 2005), while other program innovations have shown promise based on non-experimental evaluations and have yet to be tested experimentally. Smaller studies of less rigorous design (e.g., comparisons of pre- and post-enrollment data for participants with no control group) and multiple case studies with reported outcomes, consensus of expert clinicians, and unpublished program evaluations, particularly when these sources produce a consistent pattern of findings, may also be considered as additional evidence to determine whether an intervention is considered evidence based (Rog, 2004). Accordingly, this paper will focus on a wide range of studies with relevance to the chronically homeless population, including studies with less rigorous methodologies and "practice-based evidence" emerging from the experience of providers and practitioners.

Effectiveness of Service Interventions in Breaking the Cycle of Homelessness

Outreach to People Who Are Homeless in Streets and Shelters

Outreach was one of the earliest strategies targeted at people residing in street locations, public parks, transportation depots, and other settings not meant for human habitation (Cohen, 1990). Street outreach teams employ an array of approaches to engage people who are mentally ill in a dialogue on eventual involvement in services (Tsemberis & Elfenbein, 1999). Despite anecdotal evidence of the value of street outreach in engaging people in needed treatment and support services and the widespread dissemination of street outreach services, there is as yet no specific strategy of engagement per se that can be considered evidence based. In many cases, repeated brief contacts to establish a relationship often precede an agreement to accept services. Strategies of initial engagement include the offering of food and other concrete services, medical care, and housing. Increasingly, outreach alone is viewed as having limited success potential unless it is combined with housing placement (Burt et al., 2004).

Lam and Rosenheck (1999) have reported that clients enrolled in the Access to Community Care and Effective Services (ACCESS) program (a multisite effort that evaluated the integration of service systems and its impact on outcomes for over 7,000 participants) initially engaged through street outreach, tended to be men with a psychotic disorder who were older and had longer durations of homelessness (living on the streets or in emergency shelter). Shern et al. (2000) conducted a randomized controlled trial to test a psychiatric rehabilitation program for street-dwelling homeless people that consisted of outreach and engagement; an invitation to join the "Choices Center," a low-demand day setting offering food, showers, socialization, and assistance combined with health, mental health, and other services if desired; respite housing in an informal church-based shelter or a staff-supervised YMCA room; and rehabilitation services both on site and in the community to assist individuals in finding and maintaining housing in the community. The control group had standard treatment that consisted of a range of programs including outreach, case management, drop-in centers, health and mental health services, and private and municipal shelters for homeless adults. Compared to the standard treatment group, those in the Choices Center program were more likely to attend a day program, spent less time in the streets and more time in community housing, had less difficulty meeting their basic needs, showed greater improvement in life satisfaction, and experienced a greater reduction in psychiatric symptoms. The research team found that housing was difficult to procure, forcing the Choices program ultimately to develop a supported

apartment program. A significant contribution of the Choices project was that it demonstrated a comprehensive approach to homeless people that began with the process of street outreach and was carried through until the person was successfully housed and off the streets.

Similarly, the provision of mental health and substance abuse treatment services "on site" in shelter settings as a means of engaging people in services has also gained wide currency. A recent study conducted by Bradford et al. (2005) focused on a shelter-based intervention targeted at homeless individuals with psychiatric and/or substance abuse problems. The program consisted of outreach by a psychiatric social worker and weekly visits by a psychiatrist. Findings revealed that individuals receiving the intervention were more likely to participate in substance abuse treatment services than subjects in the control group. Studies of outreach to homeless people living on the street and in shelters remain an important area for further research.

Services to Facilitate the Transition from Shelter to Housing

An innovative program for people who are homeless developed over the past decade, Critical Time Intervention (CTI), has focused on discharge planning for the shelter-based homeless population as a springboard for developing a more comprehensive package of services that includes housing placement and treatment support and post-release follow-up to assist program participants in working through issues in the transition from the shelter to a stable residence in the community. Susser et al. (1997) conducted a randomized controlled trial in which a 9-month time-limited case-management CTI intervention targeted at homeless men with severe mental illness was compared to usual care. Over the 18-month follow-up period, subjects in the CTI group had an average of 30 nights homeless, compared to 91 in the usual services group. The intervention was also found to be cost-effective, yielding a significantly greater net housing stability benefit compared to the control group (Jones et al., 2003). The success of CTI has led to its adaptation for other high-risk groups at critical junctures in their lives, such as discharge from mental institutions, jails, and prisons (Herman et al., in press). Controlled trials of adaptations of CTI are in progress.

Case Management and Assertive Community Treatment for Homeless People with Mental Illness

Various forms of case management and assertive community treatment have gained wide currency in the last quarter century (Morse, 1999). A common denominator of interventions classified as case management or assertive community treatment is that they all provide individualized treatment planning and long-term follow-up to clients with severe mental illness. However, there are important differences in how these programs are defined as well as the results they achieve. Traditional case managers are typically people with a bachelor's or master's degree in social work who provide limited direct care, brokering needed services on behalf of the individual from other providers in the community. In contrast, as originally developed by Stein and Test (see Morse, 1999), assertive community treatment (ACT) is characterized by comprehensive community-based treatment delivered *in situ* by a multidisciplinary team. The team is directed by a psychiatrist but other mental health care professionals provide vital elements of treatment and support. ACT teams have shared caseloads with a limited number of clients, and treatment is provided on a 24-hour open-ended basis, assisting the individual with symptom management, issues in the living environment, relationships with family and friends, and locating and maintaining stable employment.

Models similar to ACT, such as the Continuous Treatment Team (CTT) (see Johnsen et al., 1999), appear to share many elements in common. A study of the fidelity of four case management models to ACT

principles in the ACCESS study found that the four treatment variations were more alike than different (Johnsen et al., 1999). ACT has been studied experimentally and evidence has accumulated concerning its effectiveness in reducing hospitalization (Morse, 1999).

ACT has been applied to the management of people who are homeless and severely mentally ill. Morse et al. (1997) conducted a random assignment study focused on homeless mentally ill persons in which three types of case management were tried: broker case management in which the person's assessed needs were purchased from multiple providers, ACT alone in which services were provided by a treatment team for an unlimited period, and ACT with community workers who assisted with activities of daily living and were available for leisure activities. Findings revealed that both ACT interventions were superior to broker case management on a number of outcomes, including resource utilization, symptomatology, and client satisfaction. ACT alone was associated with longer time in stable housing. Further evidence for the usefulness of ACT for homeless mentally ill adults has been provided by Dixon et al. (1997), whose study demonstrated that this approach improved treatment compliance. In addition, Wolff et al. (1997), in a cost analysis of broker case management versus ACT, found that ACT has superior client outcomes at no greater cost than broker case management, and is therefore the more cost-effective of the two interventions. A meta-analysis of studies of assertive community treatment for homeless people with severe mental illness underscores its superiority over standard case management models in reducing homelessness and improving symptom outcomes (Coldwell & Bender, 2007).

Recent studies suggest that duration and intensity of services can be tailored to the clinical needs of the client. ACT is typically provided to all clients for an unlimited period of time. Rosenheck and Dennis (2001) conducted an analysis of the outcome of homeless patients with severe mental illness in the ACCESS study with varying durations of participation in ACT. Study findings suggested that clients could be discharged from the program to less intensive case management without losing gains in mental health status, control of substance use, housing stability, or employment. Min, Wong, and Rothbard (2004) found that use of vocational and rehabilitative services delivered through case management was associated with a lower probability of shelter reentry after termination in the ACCESS project, suggesting the need to emphasize rehabilitation in the prevention of recurrent homelessness. A study by Clark and Rich (2003) lends support to the notion that service intensity can be calibrated to the clinical needs of the individual without a negative result. This team studied a comprehensive housing program for people who were homeless and severely mentally ill, in which access to housing was guaranteed along with housing support services and case management. The comprehensive housing program was compared to case management only. This quasi-experimental investigation made use of propensity scoring to enable an analysis of how people with different levels of symptom severity fared in each type of program. Findings revealed that persons with high psychiatric severity and high substance use disorder achieved better outcomes with the comprehensive housing program. Persons with low to medium symptom severity and minimal alcohol or drug use did just as well with case management alone.

Adaptations of Assertive Community Treatment for People with Co-Occurring Mental Illness and Substance Use Disorders

Over time the ACT model has been adapted to better meet the needs of homeless people who have co-occurring mental illness and substance use disorders. The efficacy of integrated mental health and substance abuse treatment programs in the management of patients with co-occurring disorders is rapidly becoming established (Drake et al., 2004). Integrated treatment is characterized by treatment of the mental illness and the problem with substance abuse by the same clinician or clinical treatment team. This approach eliminates the need for the client to seek treatment for each disorder from different clinicians in

separate systems of care. Integrated dual diagnosis treatment would seem to be appropriate for people who are difficult to engage in services or who may have problems accessing services located in different sites. Morse et al. (2006) compared costs and outcomes of two types of assertive community treatment for homeless patients with dual disorders. In this investigation, ACT alone was compared to integrated ACT, a program in which treatment for severe mental illness and substance use disorders was provided by the same treatment team. Both treatments were compared to standard care. Patients in both types of ACT programs were more satisfied with their treatment and had more days in stable housing compared to controls. There were, however, no differences in psychiatric symptoms or patterns of substance use. The integrated ACT program had lower total costs than the ACT program alone, suggesting that the enriched ACT team approach is more cost-effective in treating homeless patients with dual disorders. In an another analysis from the same study, Calsyn et al. (2005) found that the treatment approaches had limited impact on criminal justice outcomes, suggesting the need for new, more specialized interventions to reduce criminal behavior among people with dual disorders.

Essock et al. (2006) conducted a random assignment study of two methods of community case management, ACT and standard case management, for delivering integrated mental health and substance abuse treatment services for consumers with dual disorders who were homeless or unstably housed. Clients receiving integrated dual diagnosis treatment in both the ACT and standard clinical case management venues showed steady reductions in substance use and improved in many areas over the course of the study, suggesting that integrated dual diagnosis treatment can be successfully delivered with either community case management approach.

Promising New Approaches to Managing Homeless People with Dual Disorders

In recent years new interventions for homeless people with co-occurring severe mental illness and substance use disorders have been developed. The very fact of their existence attests to the pressing need for approaches that can successfully engage clients in ongoing treatment of this devastating combination of afflictions. Three such innovative approaches, described below, are presented as promising new approaches despite the fact that they are not yet evidence-based.

Dyadic case management. Kirby et al. (1999) used a pair of case managers to address the service needs of homeless men and women with mental illness who were chronically debilitated due to alcohol and drug dependence. The dyadic case management model, developed by Denver's Arapahoe House, is geared to individual need and is characterized by techniques of recruitment and engagement, relationship and skills building, housing stabilization, and advocacy. It is contended that having two case managers builds on the professional strengths of two people rather than one, and that a duo of case managers can more readily ensure continuity of services and provide greater staff safety when carrying out street outreach. Although an evaluation of this intervention is planned, there is as yet no report of the program's efficacy in the scientific literature.

Modified therapeutic community. Therapeutic community models have achieved widespread utility in the treatment of people with serious problems with alcohol and drug abuse. Typically, therapeutic communities are residential settings in which a comprehensive array of services, including psychological, educational, medical, legal, and advocacy, are offered to facilitate a significant change in the lifestyle of the person afflicted with substance abuse and a concomitant reduction in substance use and criminality (De Leon, 2000). Skinner (2005) conducted a quasi-experimental study of a modified therapeutic community located in a homeless shelter serving men with mental illness and substance use disorders, comparing it with a general shelter program serving male veterans with the same co-occurring conditions.

Study data consisted of a retrospective review of closed case records for 70 subjects in each type of shelter. Although the modified therapeutic community showed no clear benefit in this analysis, the established success of this approach in other settings suggests that it may be promising and should be studied further.

Treatment as an alternative to incarceration. Collaborations involving mental health service providers, homeless services providers, and the criminal justice system are growing increasingly more common as it has become clear that these systems of care share a common caseload of clients who cycle among mental hospitals, emergency rooms, detox facilities, homeless shelters, and jails and prisons. San Diego's Serial Inebriate Program (SIP) targets individuals who are chronically homeless and intoxicated in public, often traveling a circuit from jails to emergency departments to a downtown "sobering" center. Service utilization costs for this population are extremely high. When police encounter intoxicated individuals who have had at least five transports to the local inebriate reception center within the past 30 days, they transport them to jail where, for each conviction after the first, they are given progressively longer sentences of time in jail (30 to 180 days). The SIP program offers an alternative to this experience. In lieu of custody, the client can participate in a six-month intensive outpatient clinical intervention program. While successful completion of the program satisfies the conditions of probation, clients who resume drinking or fail to complete treatment face a return to jail where they must complete their sentence. Dunford et al. (2006) conducted a retrospective review of health care utilization records of clients who did and did not participate in the SIP program. At the time of enrollment, the average participant had been homeless for more than 15 years. Treatment was offered to 268 individuals, but only 58 percent accepted. Clients typically accepted treatment only after repeated convictions with longer sentences. Participation in the SIP program was associated with a decline of more than 50 percent in utilization of ambulance, emergency room, and inpatient hospital care. Among those who rejected treatment, there was little change in patterns of health care utilization.

Housing Interventions

The social disability that often accompanies severe and persistent mental illness can interfere with the ability to sustain independent living. In recognition of this fact, supportive housing has evolved over the past two decades as a preferred housing approach for people with severe and persistent mental illness (Rog, 2004) and is now viewed as a best practice for ending chronic homelessness. Broadly defined, supportive housing is independent housing in the community coupled with support services (Rog, 2004). People who have been living on the streets or in shelters for long periods of time often need additional services to stabilize a psychiatric or substance abuse problem that, if left untreated, may inhibit residential stability. Moreover, chronically homeless individuals may find it extremely difficult to engage in a process of treatment without being housed. There is mounting evidence that the combination of housing and treatment is effective in facilitating both housing stability and treatment retention (Burt & Anderson, 2005) and that this approach is superior to treatment alone (Rosenheck et al., 2003). Housing and services combined appear to provide a synergy that helps people who have experienced chronic homelessness to achieve more stable and independent lives.

As defined by HUD's Homeless Assistance Programs, supportive housing includes both transitional and permanent supportive housing programs, as well as Safe Havens, which can function as either permanent or transitional housing. These programs are targeted to homeless individuals with disabilities, and many grants awarded in recent years are specifically targeted to projects that serve chronically homeless people. At this time only homeless people who are coming from the streets or emergency shelters are eligible to

move into permanent supportive housing that is funded through HUD's Homeless Assistance Programs, although supportive housing funded from other sources may have different eligibility provisions. Homeless people with disabilities and homeless families may be eligible for transitional housing. The Department of Veterans Affairs (VA) also funds transitional housing programs for homeless veterans, as well as supportive services coupled with HUD-funded rental assistance, in a program called HUD-VA Supported Housing or HUD-VASH. Other federal, state, and local government programs are also used to fund transitional or permanent supportive and affordable housing for people who are homeless or at risk of homelessness and for low-income people with disabilities or other special needs, including targeted programs that fund housing for adults with HIV/AIDS (often with co-occurring mental health and/or substance use problems).

Most frequently, research has focused on program models that combine housing and services that have been developed for adults with serious mental illness who are homeless or at risk of homelessness, and often study participants include people who also have co-occurring substance use problems or other health conditions. There is also some research that focuses on housing for adults with HIV/AIDS and housing for those with serious long-term problems with substance use, particularly a group that has been described as chronic public inebriates.

Increasingly, supportive housing programs have been adapted specifically to improve access and effectiveness for people who have experienced chronic homelessness. The housing models that are most directly relevant to the needs of chronically homeless people include transitional housing, permanent supportive housing, and Safe Havens. First, we describe these housing models and review their similarities and differences. Then we present evidence on their efficacy.

Common Characteristics of Supportive Housing Models

Supportive housing has become a key program model for homeless assistance and mental health systems throughout the country. Supportive housing can be provided in a single-site model where all or most of the units in an apartment or SRO building serve formerly homeless people and many of the services are provided on site; in a scattered-site model where tenants access rent-subsidized units on the open market and services are coordinated by case managers; and a hybrid model in which a single site mixes supportive housing with regular affordable housing (Corporation for Supportive Housing, 2004; Burt, 2005). Transitional and permanent supportive housing share the following characteristics:

- **Appropriate targeting.** Housing is targeted to people who are homeless or are at risk of homelessness and who are experiencing mental illness or other chronic health conditions or challenges that would affect their ability to achieve residential stability.

- **Affordability.** Tenants usually pay no more that 30-50 percent of their income in rent.

- **Range of services to meet a diversity of needs.** Services generally include coordinated case management, life skills, help in setting up a household, and tenant advocacy. Health and mental health treatment, substance use management and recovery, peer support, vocational and employment services, money management, and other supports may be provided directly or by facilitating linkages to appropriate community services.

Differences in Supportive Housing Models

Supportive housing models vary across a number of dimensions. Generally, variation along these dimensions exists between transitional and permanent models, although it often exists within models as well.

Housing first versus requiring housing readiness. The housing first model is generally defined as a program that places people directly into affordable housing without requiring that tenants be "housing ready" prior to entry. High-threshold housing readiness admission criteria require, for example, that prospective tenants demonstrate several months of sobriety, basic living skills and personal hygiene, and a high level of motivation to participate in treatment or case management services and to manage symptoms of mental illness. A known limitation of the housing readiness approach is that a majority of those who are chronically homeless, even among those who have participated in treatment or transitional programs that are intended to prepare them for housing, may not be able to meet these demands (Barrow & Soto, 2000; Barrow, Soto, & Cordova, 2004; Kertesz et al., 2006). Safe Havens use a housing first approach, and a growing number of permanent supportive housing programs are adjusting admission criteria to move toward a housing first approach (Burt et al., 2004; Burt, 2005; Tsemberis, 1999), although programs vary widely on this dimension.

The extent to which a "low demand" environment is created. Often implemented as part of a housing first model, a low demand approach does not place any requirements on a tenant that are outside of the normal conditions of tenancy, including paying the rent, not destroying property, and refraining from behavior that would harm other tenants. Housing programs that utilize a low demand approach strike a balance between helping individual tenants—even the most troubled—achieve housing stability, and enforcing rules that prohibit illegal activity and protect the safety of other tenants and their neighbors. This philosophy extends to the delivery of services in housing. Although participation is certainly encouraged in low demand programs, services are not mandatory and instead are based on consumer choice.

Some of the characteristics of housing-first/low demand models, in contrast to high demand housing models, are described in Exhibit 1. There is a wide spectrum of what constitutes "low demand." For example, some programs may require a low level of service participation (e.g., one or two meetings with a case manager every month), but not link that participation directly to tenants' ability to keep their housing. A low demand approach is used in Safe Havens as well as in many permanent supportive housing programs designed for people who are chronically homeless. There can be a range of approaches in permanent supportive housing (Burt, 2005; Lipton et al., 2000; Tsemberis, Gulcur, & Nakae, 2004). Transitional housing tends to be more structured and requires participation in treatment or work programs, regular appointments with case managers, and continued efforts to find permanent housing.

Intensity/richness of services. This dimension refers to the breadth and depth of services available to program participants and the staff/client ratios. Safe Havens tend to have a very rich set of services and low staff/client ratios, in part because of the small size of these programs. In permanent supportive housing and transitional housing models, service intensity can vary greatly from project to project depending on the target population, program goals, and service financing.

Permanency of housing. This dimension refers to whether participants/tenants may stay in housing indefinitely or whether they are encouraged or required to leave after a certain period of time. The goal of

Exhibit 1

Characteristics of Housing Programs That Serve Chronically Homeless Adults

Housing First/Low Demand	High Demand
1. How and when do chronically homeless people get into housing?	
• Sobriety and/or participation in treatment or other services *not* required as a condition of getting or keeping housing; consistent with consumer/homeless person's perspective that housing is an immediate need	• May require engagement with multiple programs at different stages as part of pathway out of homelessness; programs may be structurally segmented and/or transitionally oriented
• "(Pathways) posits that providing a person with housing first creates a foundation on which the process of recovery can begin. Having a place of one's own may—in and of itself—serve as a motivator for consumers to refrain from drug and alcohol abuse" (Tsemberis, Gulcur, & Nakae, 2004)	• Skills for independent living are developed in transitional settings; services focus on enhancing the homeless person's "readiness" for housing
• Helping consumers to get and keep housing is seen as the top priority for program/staff	• Screening for willingness to participate in treatment or supportive services and to comply with program rules as a condition of entering housing
• Minimize barriers to access (e.g., less complex application processes, no/few conditions impinge on autonomy); e.g., in some housing/Safe Havens programs designed for chronically homeless persons with serious mental illness or complex co-occurring health conditions, most tenants move into housing within 3 months of application	
• Tenants are assisted to develop skills for independent living while they live in permanent housing settings	
2. Service approach	
• Participation in services or structured activities not required	• May require participation in standardized program of services, or specified service intensity (e.g., frequency of contact with case manager or scheduled group activities or individual counseling)
• Services individualized and tailored to self-identified needs and goals using a "whatever it takes" approach	• Services may include monitoring and dispensing medications
• Assistance is offered for a range of needs and goals including practical material needs (food, clothing, etc.) before expecting that people will engage in more complex case management services (e.g., to establish eligibility for financial benefits) as well as clinical supports or treatment for health, mental health, substance use problems	• Services may be provided directly by on-site staff and/or by brokering linkages to other community service providers
• Continuity of relationships with primary service provider or interdisciplinary team that directly provides most services needed	• For persons with current or past substance use problems, participation in AA/NA groups may be strongly encouraged, with mandatory referral to detox or residential treatment programs in response to relapse
• Peer-based recovery services emphasize consumer empowerment and self-direction	• Peer-based recovery services emphasize sobriety
3. Housing characteristics and staffing	
• Legally binding leases	• Leases or occupancy agreements contain addenda that specify requirements for service participation, etc.
• Housing management and supportive services roles are clearly separate and performed by different staff or organizations	• Housing management and supportive services functions may be blended and performed by the same staff or organization.
• Housing usually individual units (SRO or apartments in multi-unit building, or scattered-site units in privately owned buildings)	• Housing is more likely to be licensed and/or exclusively serving people with identified special needs (e.g., serious mental illness)
• Buildings are more likely to have mixed tenancies (disabled and non-disabled tenants)	• Housing may be congregate (shared living arrangements) or rooms/apartments in multi-unit buildings
• Tenants prepare their own meals in private or shared cooking facilities	• Meals often provided
• Supportive services staff available during the day and some evenings and/or weekends; overnight staffing as needed for building security (not supportive services)	• Supportive services staff may be on-site 24 hours a day, 7 days a week

Exhibit 1 *continued*

Characteristics of Housing Programs That Serve Chronically Homeless Adults

Housing First/Low Demand	High Demand
4. Rules and requirements	

• High level of tolerance for behavior; responses to problem behaviors are graduated and individualized
 	
• Evictions or other sanctions for rule violations or problem incidents primarily focus on violence or threats of violence against staff or other residents, attempting to make drug transactions, illegal or criminal activity at (or nearby) the housing or program facility, property damage or destruction, violations of visitor-related policies, serious problems with hygiene (personal and/or housing unit)
 	
• Overnight guests permitted with limitations consistent with landlord-tenant law (e.g., limit number of days to avoid establishing occupancy/tenancy rights) and/or consideration of needs of other tenants
 	
• Visitor policies including sign-in procedures and limits on visitors (e.g., number of guests or limits on overnight guests) are intended to protect safety and quiet enjoyment of premises by other tenants
	• Adherence to behavioral norms and/or sobriety and/or completion of treatment or transitional program may be required as condition of eligibility for housing and/or other benefits or opportunities
	
	• Some/all the following restrictions may be imposed as condition of tenancy:
	  • Curfews
	  • Overnight guests not permitted
	  • Money management mandatory
	  • Medications dispensed or monitored
	  • Attendance at structured day activity (work, day treatment, educational program) required for 20–30 hours a week
	
	• Occupancy or program participation may be terminated if tenants (clients) possess or consume alcohol and/or other drugs either on-site in their residence or off-site in the community. In some projects, termination or eviction is the sanction for failure to maintain complete abstinence, while in other projects multiple relapses will lead to eviction or termination

5. Significant modifications in some programs	
• Participation in money management required and tenants must meet with a staff member a minimum of twice a month (Pathways) • Other supportive housing programs may offer representative payee or money management services to tenants but do not require participation, or participation requirements are limited (e.g., during the initial occupancy period or to resolve lease violations related to non-payment of rent) • A majority of Safe Havens programs (responding to national survey) prohibit use of alcohol or other drugs on-site, although most do not prohibit use off the premises • Staff may be available 24 hours a day, 7 days a week to manage safety and security for all residents in the building, strengthen tenant confidence in staff availability to manage crises and emergencies, facilitate engagement with residents, and provide informal support to those who are not actively following a treatment plan	• Some of these characteristics/rules exist but may be applied more flexibly • Multiple warnings are provided and/or multiple episodes of problem behavior (e.g., multiple relapses) are tolerated before tenants are evicted
6. When are tenants expected to move?	
• Tenants are not required to relocate as their service needs or willingness to participate in supportive services change; respite facilities may be available and used during crises or to meet short-term needs for more intensive supports, while preserving tenants' rights to return to their supportive housing unit	• Tenants may be expected to move to more independent housing as their needs for intensive services and/or structure diminish over time • Services and/or housing may be terminated for failure to participate and/or make progress toward service or treatment goals

Citations: Barrow & Soto, 2000; Lipton et al., 2000; Shern et al., 2000; Northwest Resource Associates, 2002; Barrow, Soto, & Cordova, 2004; Tsemberis, Gulcur, & Nakae, 2004; Burt, 2005; Ward Family Foundation; 2005.

Safe Havens and transitional housing is to eventually move people into permanent housing in the community. Safe Havens, however, may function as either transitional or permanent housing and are generally flexible about letting participants stay until they have found other options. In contrast, transitional housing models usually have stricter time limits. For example, HUD-funded transitional housing programs generally expect residents to move within 24 months. Some transitional housing programs offer tenants the opportunity to "transition in place," meaning that tenants may remain in the same housing unit after their participation in a transitional housing program ends, as they assume responsibility for paying rent, and in some cases qualify for other types of ongoing rental assistance from other housing programs. Permanent supportive housing does not have time limits or requirements that tenants move to other settings. Permanent supportive housing programs may allow tenants with the most severe mental health or substance use disorders to maintain a home they can return to after a temporary hospitalization or a stay in a treatment facility.

Exhibit 1 outlines major differences between housing-first/low demand and high demand supportive housing models, elaborating on what has been discussed above. The most well-known, rigorously evaluated and widely replicated housing first / low demand program is Pathways to Housing (Tsemberis et al., 2004), which uses a scattered site model. Other site-based housing first / low demand programs for chronically homeless adults have been described, including Seattle's Lyon Building and 1811 Eastlake projects, California's Health, Housing and Integrated Services Network, and San Francisco's Direct Access to Housing Program. As shown in Exhibit 1, these programs share many characteristics but there is some variability in the implementation of these approaches.

Research and published reports often highlight the differences between these two models, but in practice many supportive housing projects incorporate elements of both housing first/low demand and high demand approaches. For example, a housing program may target people who have been living on the streets for many years, but may require that they first engage in case management services for a period before being offered housing. Some programs may require a low level of service participation (e.g., one or two meetings with a case manager every month), but not link that participation directly to tenants' ability to keep their housing. Some programs offer tenants opportunities for repeated short stays in interim or transitional housing, which may require that tenants leave the housing if they are disruptive or use alcohol or drugs on site, but allow tenants to return to housing again when they are willing to comply with program rules, and move on to more permanent housing as they achieve greater stability. Low demand housing programs often use a variety of strategies to assertively engage tenants in supportive services and strongly encourage participation, particularly when a tenant's behavior is disruptive to others or may lead to eviction, or when there are concerns that symptoms or problems related to health, mental health, or substance abuse are worsening.

Efficacy of Housing Interventions

Transitional housing. Transitional housing programs funded by HUD serve more than 20,000 chronically homeless people each year, approximately 20 percent of those served by these programs. Most of HUD's transitional housing programs primarily serve homeless families or adults who have been homeless for shorter periods of time (Mark Johnston, personal communication, November 2006). To date, very little information is available on the efficacy of this program model for chronically homeless adults. It is not presently known, for example, how many chronically homeless people move from transitional housing to other stable permanent housing. Information is also lacking on the characteristics of those for whom this program model is successful in contrast to those for whom this model has failed. Nearly all of the research on transitional housing has focused on programs that serve homeless families.

While most transitional housing programs primarily serve people who are not chronically homeless, some transitional housing programs have been adapted to engage chronically homeless people who are ambivalent about services and pique their interest in seeking housing. Two transitions are involved in these programs. The first transition is from the streets or emergency shelters into the program, and the second transition is from the program into permanent housing. In settings where permanent supportive housing has high threshold housing readiness requirements, transitional housing programs may provide opportunities for people who are chronically homeless to demonstrate that they are ready to leave the streets and undergo a period of documented sobriety and participation in supportive services in preparation for permanent housing.

Because transitional housing programs are designed to help homeless people move toward more permanent housing, they often require residents to attend treatment or work programs, meet regularly with case managers, and make progress toward achieving goals related to "housing readiness." While this structure may be effective for some people who are chronically homeless, others may be unable or unwilling to accommodate to these demands and requirements.

Some transitional housing programs that have been specifically designed or adapted for people who are chronically homeless have incorporated low demand program models that use program strategies including:

- assertive but patient engagement to overcome barriers resulting from mistrust, isolation, and the symptoms of mental illness or addiction;

- identification of participants' unmet needs, preferences, and goals;

- establishment of trusting relationships, which often begins by providing concrete support for basic needs (food, clothing, etc.);

- training or coaching in basic living skills and personal hygiene;

- mental health and substance abuse treatment services (provided directly or through close linkages to community services);

- allowing a series of short stays or moves between programs that offer varying levels of support and requirements for participation and sobriety;

- assistance with accessing benefits or income; and

- encouragement and help to find and meet eligibility requirements for permanent housing (Barrow & Soto, 1996; Barrow & Soto, 2000).

The intention of transitional programs that use this approach is to build trusting relationships and engage even the most chronically homeless individuals in the service system, thus facilitating access to needed care and treatment and preparation for permanent housing (Barrow, Soto, & Cordova, 2004). Transitional housing has also been used as a technique to increase the effectiveness of substance abuse treatment programs, even when housing is not conditional upon abstinence (Kertesz, 2006). Transitional housing programs have limited effectiveness in helping participants achieve housing stability when permanent housing programs have complex and stigmatizing admissions procedures and program requirements that include evidence of sustained sobriety or a willingness to participate in treatment or other structured activities as a condition of tenancy (Barrow & Soto, 2000; Barrow, Soto, & Cordova, 2004; Kertesz, 2006).

Permanent supportive housing. Permanent supportive housing has gained considerable attention from practitioners and policymakers in the last 10–15 years, in part because of numerous research studies demonstrating its effectiveness in increasing housing stability (Barrow, Soto, & Cordova, 2004; Rog, 2004; Lipton et al., 2000; Shern et al., 2000; Tsemberis & Eisenberg, 2000) and decreasing shelter use, incarceration, inpatient hospital stays, and visits to the emergency room (Culhane, 2002; Martinez & Burt, 2006; Rosenheck et al., 2003).

Permanent supportive housing is the combination of permanent, affordable housing with supportive services aimed at helping residents maintain housing stability. While not all such programs are the same, the shared components that are most likely to distinguish permanent supportive housing from transitional housing include the following:

- *Voluntary services.* Participation in services is usually not a condition of ongoing tenancy in permanent supportive housing.[2]

- *Tenants hold a lease.* The tenant has a lease or similar form of occupancy agreement so as not to set a limit on the length of time a person can stay in housing.

- *Systems integration.* A working partnership exists between the service providers, property owners or managers, and/or housing subsidy programs.

The New Freedom Commission on Mental Health (2003) recommended the creation of 150,000 units of permanent supportive housing to end chronic homelessness among people with mental illnesses and their families, and HUD established the goal of creating 40,000 new units of permanent supportive housing for chronically homeless people during the five-year period from 2005 to 2009. As states and communities across the nation developed their own plans to end homelessness, they adopted ambitious goals for creating additional affordable and supportive housing, including (as of November 2006) a total of 80,000 units of permanent supportive housing (NAEH, 2006b).

From 1996 to 2005 the number of units of permanent supportive housing for homeless people in the U.S. nearly doubled, from 114,000 to 208,700 (HUD, 2007). Between 2002 and 2006, approximately 37,500 units of permanent supportive housing were created using funding provided through HUD's McKinney-Vento Homeless Assistance Grants Programs. Eligibility for this housing is restricted to homeless persons with disabilities, which may include mental illness or substance abuse.[3] In recent years new supportive housing created through this program has been targeted to people who are chronically homeless.

Permanent supportive housing is also funded from other sources (including other "mainstream" federal and state housing programs as well as targeted programs funded by states and local governments). Some of this supportive housing, particularly housing funded by state and local mental health authorities and mainstream housing programs, serves people with disabilities who are homeless or at risk of homelessness, but not chronically homeless. Reflecting this variability in eligibility and target

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[2] This is probably the most controversial component of supportive housing, and there are many philosophies about the best way to approach this issue and substantial variations in practice among permanent supportive housing programs.

[3] These include the Shelter Plus Care (SPC), Single Room Occupancy (SRO), and Supportive Housing—Permanent Housing (SHP-PH) Programs.

populations, survey results from a range of states and communities indicate that about a third of the permanent supportive housing units are occupied by people formerly chronically homeless (Burt, 2005).

1. *Housing stability outcomes*. Evaluations of permanent supportive housing have shown retention rates in the first year of 75–85 percent, even among chronically homeless adults with the most severe mental health and substance use disorders (Barrow, Soto, & Cordova, 2004; Burt et al., 2004; Martinez & Burt, 2006; Wong et al., 2006). About three-quarters of those who enter supportive housing stay for at least two years, and about half are still living there after three to five years (Wong et al., 2006; Lipton et al., 2000). Variability in retention rates reflects several factors, including characteristics of supportive housing tenants, housing, program structure, expectations, and requirements. Because most permanent supportive housing offers tenants the opportunity to return to a permanent housing unit (either the same unit or another apartment) after short stays in a hospital or treatment setting, and some chronically homeless people may return to spend time in shelters or on the streets for a few days as they become accustomed to living in housing, some researchers have also measured housing stability in terms of reductions in the number of days of homelessness or increases in the number of days in housing.

   The likelihood of moving out—often into unstable living arrangements—seems to be greatest during the first few months after tenants move into supportive housing, especially for residents who are living in supportive housing programs with a high degree of program structure and tenant expectations (Lipton et al., 2000). Older age seems to be associated with longer tenure in supportive housing. In some evaluations that consider a range of supportive housing program models, factors related to substance use, including a history of substance abuse and/or active substance use are associated with lower rates of housing stability, especially for homeless people who have moved into highly structured settings that are more likely to evict tenants for relapse in the use of alcohol or other drugs (Lipton et al., 2000; Wong et al., 2006).

2. *Outcomes on service utilization and cost.* Evaluations of permanent supportive housing have also attempted to measure changes in patterns of service utilization. Researchers from the University of Pennsylvania conducted a major study of the costs and utilization of public services, including hospitalizations and other Medicaid services, by more than 4,500 homeless adults with serious mental illness in New York City. The study included extensive regression analysis to determine both the costs of services used by homeless persons and the reductions that were attributable to placement in supportive housing. They found significant reductions in the total number of days that tenants spent in shelters (61 percent), inpatient psychiatric hospitals (61 percent), public hospitals (21 percent), VA inpatient hospitals (24 percent), prisons (85 percent), and jails (38 percent). While days in Medicaid-reimbursed inpatient services went down by 24 percent, the number of days of Medicaid-reimbursed outpatient services actually increased by 76 percent, which is probably a result of tenants having better access to more appropriate and preventive healthcare services while housed. Placement into supportive housing was associated with a reduction in services use of $16,281 per housing unit per year, and $14,413 of the service reduction savings resulted from the decrease in emergency and inpatient health and mental health services. The reduced costs associated with these changes in service utilization, when measured on a per diem basis, cover 95 percent of the cost of developing and operating supportive housing (Culhane, Metraux, & Hadley, 2002).

Other studies have shown similar findings:

- A study of two permanent supportive housing projects in San Francisco, targeted specifically to chronically homeless individuals, found significant reductions in the utilization of hospital emergency room and inpatient care. Study participants were 236 homeless adults who had been living on the streets or in emergency shelter for extended periods of time, a large majority (75 percent) of whom had co-occurring mental illness and substance abuse disorders. The study compared service utilization during the 12-month period before and after homeless persons moved into supportive housing. The researchers found a 57 percent reduction in the total number of emergency room visits for this group and a 45 percent reduction in the total number of inpatient admissions (Martinez & Burt, 2006).

- A study of the Connecticut Supportive Housing Demonstration Project also showed a reduction in Medicaid-reimbursed inpatient services while utilization of other services remained stable or increased (Arthur Andersen LLP, 1999).

- Total medical charges for residents in two Minnesota supportive housing programs for chronically homeless persons addicted to alcohol declined by 32 percent to 68 percent in comparisons between the year before and the year after program entry. Medical and hospital visits declined, particularly for visits related to alcohol or injury, and the median number of detox visits declined by 90 percent (Thornquist et al., 2002).

- Findings from Denver's Housing First Collaborative showed that utilization of emergency room services decreased by 34 percent in the two years after chronically homeless people entered the program, while the number of nights of inpatient hospitalization declined by more than 80 percent. Costs for outpatient care increased by 50 percent, resulting in a 45 percent net reduction in total health costs (Perlman & Parvensky, 2006).

- A random assignment evaluation of the HUD-VASH program found less robust reductions in service utilization. Overall the HUD-VASH program was 15 percent more costly than standard care—an average of $45 more for every additional day participants were housed. The program produced savings attributable to participants' decreased use of the shelter system and some changes in patterns of utilization of health services, but participants increased their utilization of mental health services, including homeless case management services provided as part of the program. Other positive outcomes for program group members included greater satisfaction with housing, higher housing quality, larger social networks, and reduced problems related to the use of alcohol or other drugs (Rosenheck et al., 2003; Cheng et al., in press).

3. *Other health outcomes*. Research on the impact of supportive housing on the health and well-being of chronically homeless people with disabilities has been limited, although some improvements in health may be inferred from the significant reductions in hospitalizations and emergency room visits that have been reported. To date most of the research on supportive housing has measured housing outcomes and utilization of other public services, while there has been little investigation of other impacts such as changes in psychiatric symptomatology or the use of alcohol and drugs. These issues require further study and evaluation. Compelling findings are emerging from research about the relationship between housing and HIV/AIDS, for which measurements of viral load and CD4 cell counts provide objective measures of improved health outcomes. Among homeless people with HIV/AIDS, access to housing is associated with significant improvements in entry into and retention in appropriate medical care, significantly

reduced viral load (increased viral suppression), and increased CD4 count (Schubert, 2006) as well as reductions in high-risk sex and drug behaviors that are associated with transmitting HIV to others (Aidala, 2006; Schubert & Botein, 2006).

4. ***How do outcomes differ among program models and participants?*** Practitioners and policymakers want to know "what models of housing and services work best—and for whom." While findings are far from definitive, available research provides some important clues.

    Importantly, housing retention appears to be greatest when housing is combined with services, regardless of the specific model of housing (Lipton et al., 2000; Rog, 2004; Siegel et al., 2006). However, the duration and intensity of services required to sustain housing requires further study and evaluation.

    It appears that consumers prefer to live in housing that offers opportunities for integration and independence, while service providers more often believe that staffed group homes or other housing with a higher level of support would be more appropriate for consumers with greater clinical vulnerability. Goldfinger et al. (1999) examined the influence of staffed group living sites versus individual apartments for formerly homeless people with mental illness in a random assignment study. Individuals assigned to independent apartments experienced a greater number of days homeless compared to those in staffed group homes—among members of minority groups only. Substance abuse was the strongest individual-level predictor of days homeless. Individuals whom clinicians determined would do best with group living experienced more days homeless, regardless of the type of housing they received. Findings suggest that housing type should be geared to the clinical and social characteristics of consumers in order to achieve optimal housing outcomes. Consumers living in independent apartments report greater satisfaction with their housing and autonomy, but Siegel et al. (2006) found that they also experience greater feelings of isolation when compared to consumers who live in site-based supportive housing with more intensive services.

    There is also evidence that the manner in which housing and services are organized has a significant impact on housing tenure. In a random assignment study of integrated (case management and housing services provided by teams within a single agency) versus parallel housing services (case management services provided by mobile assertive community treatment teams and housing by routine community-based landlords) for adults with severe mental illness who were at high risk for homelessness, McHugo et al. (2004) found that integrated housing services led to more stable housing and life satisfaction compared to parallel housing services, particularly for male participants.

Safe Havens

The vast majority of Safe Havens serve people who are chronically homeless and have been described as "service-resistant." More than 300 Safe Haven programs nationwide have received funding from HUD's McKinney-Vento Homeless Assistance Programs. Safe Havens are generally small programs (on average about 16 residents and generally no more than 25) that may be designed to operate as either permanent or transitional housing (Ward Family Foundation, 2005). Transitional programs generally do not set rigid time limits for exit. These programs are usually implemented by, or in partnership, with a mental health center or agency, and about half of these receive some mental health services funding through contracts or grants from state, county, or city agencies.

Evidence About Housing First/Low Demand Models

Evaluations of housing first and low demand service models have shown increased levels of housing stability when compared with other more high demand models. In one of the most rigorous studies, Tsemberis, Gulcur, and Nakae (2004) randomly assigned participants in New York City with an Axis I diagnosis, a 6-month history of homelessness, and recent street living to receive housing immediately without a treatment prerequisite (housing first group) or to receive housing contingent on sobriety ("continuum of care" control group). Over a 24-month follow-up period, the housing first group spent less time homeless and more time stably housed compared to the control group. The two groups did not differ on psychiatric symptoms or alcohol and drug use. Findings indicated that participants in the housing first group were able to maintain community housing without jeopardizing psychiatric stability or showing symptoms of substance abuse.

Despite the fact that there were no differences in alcohol or drug use, Tsemberis, Gulcur, and Nakae (2004) found that the control group reported significantly greater use of substance abuse treatment compared to the housing first group. This difference increased over time. While rates of participation in available supportive services may be lower when participation is voluntary, studies show tenants in many low demand programs are likely to participate at fairly high rates if supportive services are tailored to their needs. In the evaluation of the Closer to Home Initiative in New York and California, Barrow, Soto, and Cordova (2004) found that even when service participation was not required, supportive housing tenants were engaged in a wide variety of activities including health care services (81 percent), mental health treatment (80 percent), substance abuse treatment (56 percent), money management (65 percent), assistance in applying for benefits (51 percent), and employment services (41 percent). Similarly, an evaluation of the Choices program in New York City found high rates of participation in the voluntary day program services, which included assistance accessing health care and social services and provided an opportunity for participants to socialize (Shern et al., 2000).

Lipton et al. (2000) provides additional evidence that consumer choice and control has a positive impact on client outcomes. The study examined the effectiveness of a variety of different approaches to supportive housing in New York City. The study followed 2,937 tenants and described their outcomes based on whether they were placed into high-, moderate-, or low-intensity housing. Intensity reflected the amount of structure of the program and the degree of independence that tenants had. High-intensity programs were defined as having the most structure and least amount of tenant independence. Although people were not randomly assigned to the different housing models—and some selection bias certainly exists—the study found that those placed in the high-intensity models had the lowest level of housing retention—37 percent after five years compared with 56 percent for moderate-intensity programs (mostly women) and 54 percent for low-intensity programs.

Most Safe Havens have a daily structure and offer activities related to behavioral health, including 12-step meetings, counseling, training in daily living skills, medication monitoring and dispensing, and case management services. However, most programs do not require that residents participate. Safe Havens are generally staffed 24 hours a day, 7 days a week. Programs also offer opportunities for residents to participate in program governance through regular meetings or feedback sessions.

Safe Havens operate under a housing first, low demand philosophy. Nearly all Safe Havens have admissions criteria that are designed to target people who are most likely to be chronically homeless. As such, prospective residents generally are not required to be clean and sober, are not excluded if they have a criminal record, and are not required to participate in developing and carrying out an appropriate treatment plan. While nearly all Safe Havens prohibit the use of alcohol or illegal drugs on the premises, most do not prohibit the use of alcohol or illegal drugs away from the facility, and most expect that a significant number of residents will continue to have problems related to substance abuse. Some Safe Havens require that residents participate in weekly meetings, and some programs have more demanding

service participation requirements. Program rules also prohibit verbal or physical abuse, violence toward other residents or staff, and illegal or criminal activity.

A primary goal of Safe Havens is to connect consumers to permanent housing, avoiding a return to the streets, shelter, hospital, or jail. While outcome data on the efficacy of Safe Havens is limited, one report has indicated that slightly over half of Safe Havens residents exit to permanent housing (Ward Family Foundation, 2005). According to the Ward Family Foundation report, Safe Havens that have achieved higher rates of referrals into permanent housing, compared to Safe Havens with lower referral rates, are:

- smaller programs that provide private accommodations (usually a private room, and often a private bathroom), and they nearly always operate at full capacity;

- more likely to serve homeless people coming from the streets, more likely to require a diagnosis of severe and persistent mental illness plus a co-occurring disorder, and more likely to have no limit on length of stay;

- more likely to provide a psychiatrist at the program and to provide treatment and supports for mental illness at the program site; more likely to have a higher staffing level (on average .5 full-time staff and .3 part-time staff for every resident);

- more likely to provide linkages to vocational and employment services; and

- more likely to exclude individuals with sexual offender criminal records (and a small minority exclude chronically homeless people with felony criminal records) (Ward Family Foundation, 2005).

Discharge Planning

For people with severe mental illness, substance abuse problems, or other disabilities, who do not have a place to live upon discharge from a hospital, jail, or foster care setting, planning for needed housing, treatment, and support services prior to discharge is critically important. Discharge planning efforts often utilize a team or collaborative approach that includes a comprehensive assessment of each individual's needs in advance of the time of discharge, an assessment of housing needs and identification of multiple options, arrangement for follow-up appointments and medications, the engagement and active involvement of the homeless individual in identifying needs and preferences and considering options, a plan that delineates clear responsibilities, and back-up or contingency plans. However, discharge planning has no "teeth" unless the needed housing and services are available in the community (Semansky et al., 2004), and successful discharge planning is contingent upon effective linkages to community housing and services that are available and accessible at the right time (Moran et al., 2005). For some chronically homeless people, the time of discharge offers an important opportunity for engagement, enhancing motivation to change behaviors or circumstances that led to a health crisis or institutionalization, and establishing linkages to housing and ongoing care in the community that can help sustain recovery. Critical Time Intervention (CTI) (Herman et al., in press) discussed previously, is currently being studied in the transition from jail and state hospital settings to the community; findings are not yet available.

Respite or recuperative care is a promising approach to meeting the needs of chronically homeless people at the time of discharge from hospital or other health care facilities. For patients who are not homeless, our nation's health care delivery system has undergone significant changes in recent years. Increasingly surgery and other medical procedures may be performed on an outpatient basis, and hospital stays are shortened for all types of health care. Patients are frequently discharged from the hospital in

need of home-based rest and care (from family members or visiting health care providers) and compliance with complex instructions for wound care, medications, or post-surgery rehabilitation. Homeless patients are particularly vulnerable when discharged from hospitals after emergency or inpatient care, including surgery. A growing number of communities have established respite or recuperative care programs as an alternative to costly extended hospitalizations or discharging patients to the streets or shelters or a short-term stay in a motel room.

Respite or recuperative care programs serve homeless people who do not need to be hospitalized or in a nursing home, but are too ill to be on the streets or in shelters. Programs operate in a range of settings, including free-standing facilities, specialized shelters or transitional housing programs, and beds or units set aside in emergency or transitional housing programs with additional staffing and adaptations to requirements as needed For example, other shelter residents may be required to leave the facility during the day but those occupying respite beds may remain in the facility if they need bed rest. Generally these programs offer short-term housing (a few days or a few weeks) where participants can stay 24 hours a day as needed and receive meals and help with mobility and self-care. Some health care services are provided on site by nurses, a physician or mid-level practitioner, or other health care providers, but these services may be intermittent; for example, nurses may visit several times a day and be on call for emergencies, but limited health care staff are on site during much of the day. Programs also generally offer a range of supportive services and assistance with transportation to medical appointments, while seeking to facilitate long-term housing placements for clients.

One study of the effects of respite care (Buchanan et al., 2006) found a 49 percent reduction in hospital admissions among patients who received respite care, compared to similar patients who received usual care, after adjusting for gender, race, age, diagnosis, and previous utilization of health services. The average cost of respite per hospital day avoided was $706, approximately half the estimated cost of a day of hospital care.

Implications for "Best Practices" to End Chronic Homelessness

Across the country, the federal government, states, and communities have made a commitment to the goal of ending chronic homelessness. In so doing, a wide range of housing and service strategies tailored to the needs of people experiencing chronic homelessness have been developed.

Some important and influential research has been conducted in recent years, and a great deal of program development has been informed by evidence-based practice in the treatment of mental illness, co-occurring substance use disorders, and other health conditions. The development and implementation of innovative programs to address chronic homelessness, particularly for people with severe mental illness, substance abuse, and medical comorbidities, have outpaced the conduct of rigorously designed research studies that examine this population. As a result, while available research suggests promising approaches and implications for practice, it sometimes falls short of meeting the highest standards for defining evidence-based practice.

It will take a more substantial investment in research on homelessness to demonstrate with precision the efficacy of some of these promising practices, and to answer important questions about what works best for whom. Meanwhile, however, a growing number of practitioners and their partners in government and philanthropy are gaining experience in serving people who have had long and repeated spells of homelessness. In some cases consistent patterns and useful insights are emerging from available

information from research studies, administrative data, qualitative and quantitative program evaluations describing outcomes, and expert opinion to suggest "best practices" that can guide the development of housing and services for chronically homeless people. Formative evaluations of promising housing and services innovations can guide the development of randomized controlled trials to firmly establish their efficacy. Here we list best practices based on current evidence presented in prior sections of this manuscript.

Outreach to homeless people who are living on the street and in shelters is often a first step in the process of engagement in the service system for consumers with long histories of servicelessness, but outreach cannot end homelessness unless it is tied to housing placement and support. The transition process from chronic homelessness to permanent housing, however, is likely a critical period that requires further study and evaluation.

Discharge planning needs to be linked to appropriate short-term and permanent housing options and effectively targeted to those most at risk of long-term homelessness. While there is yet no evidence that adequate discharge planning can prevent long-term homelessness for people discharged from psychiatric hospitals, jails and prisons, or foster care settings, the critical juncture of institutional release remains an important area for research and for the development of effective interventions. As demonstrated by Critical Time Intervention, as well as emerging research on medical respite shelter linked to permanent supportive housing, a comprehensive program of housing placement and treatment combined with case management can assist in the transition from a shelter to stable residence in the community. Moreover, tenancy preservation efforts could be initiated in the discharge planning process to prevent homelessness onset when it is apparent that the existing living situation is unstable or inadequate.

Case management and assertive community treatment have been established as optimal techniques for the delivery of mental health and substance abuse treatment services to people with severe mental illness and histories of residential instability. Assertive community treatment that integrates the direct delivery of services to address substance use problems appears to be more cost-effective than assertive community treatment with linkages to parallel substance abuse treatment in the management of homeless people with dual disorders.

Permanent supportive housing increases housing stability and decreases use of costly institutional services such as shelters, hospitals, emergency departments, and jails and prisons.

Housing retention appears to be greatest when housing is combined with services, regardless of the specific model of housing. The needs and preferences of homeless people vary. Some will prefer to live in housing with on-site supportive services, while others may seek apartments that provide opportunities for community integration with people who do not have disabilities or recent experience with homelessness. Supportive services that are individualized and delivered to people in their homes and in community settings can help many people who were previously chronically homeless succeed in their own living setting, wherever that may be.

Housing type (e.g., supportive housing with on-site services or independent apartments) and program models (housing first/low demand or high demand) should be geared to the clinical and social characteristics and preferences of consumers in order to achieve optimal housing outcomes. People with long histories of homelessness, particularly men who have challenging behavior problems, may be more successful in supportive housing programs that are site based. The integration of housing and case management services (e.g., programs in which the housing provider shares the goal of helping program

participants maintain stable housing in spite of problems that might lead to eviction in private-market housing) may facilitate greater housing stability and life satisfaction, particularly for male consumers with greater clinical vulnerability.

Low demand models that include housing first (transitional housing, Safe Havens, and some permanent supportive housing) hold promise for engaging severely disabled chronically homeless individuals, who are often considered "service-resistant" and have longstanding substance abuse problems, in a process of recovery and eventual housing stability.

Recommendations for Future Research

The methodology of mental health services and housing research studies conducted over the past decade has grown increasingly more sophisticated. Several studies reported here illustrate the feasibility of conducting randomized controlled trials in real-world settings such as street outreach and engagement in housing and treatment support services (Shern et al., 2000), discharge planning and linking to community-based housing and treatment (Susser et al., 1997), assertive community treatment (Morse et al., 1997), and housing and treatment services (Rosenheck et al., 2003; McHugo et al., 2004). Fidelity measures have been developed to better describe an intervention and determine the degree to which a given program adheres to its critical elements. Strategies such as propensity scoring, which mimics randomization so that causal inferences can be facilitated, have been utilized when the study design is quasi-experimental (Siegel et al., 2006). Studies of housing programs that use lotteries to select tenants from a pre-screened pool of applicants can provide opportunities of de facto random assignment, with some homeless people randomly assigned to housing while others receive "usual care" but are likely to remain homeless (Martinez & Burt, 2006). Improved follow-up strategies have been implemented in longitudinal investigations to minimize attrition (Susser et al., 1997).

Despite these advances, empirical research on the efficacy of interventions targeted at chronic homelessness has lagged far behind the development of new interventions. As research on efforts to end chronic homelessness moves forward, a focus on the topics listed below would expand the science base on chronic homelessness.

The Characteristics and Needs of People Who Are at High Risk of Chronic Homelessness

New research efforts should distinguish prevention efforts geared toward people with mental illness or other disabilities who are *at risk of homelessness or who are newly homeless* from efforts addressed to those who are *already homeless or who have experienced long-stays in street or shelter locations.* Efforts intended for the latter will be most meaningful if they employ a consistent definition of chronic homelessness, such as the one recently adopted by the federal government for its interagency policy and program initiatives discussed previously in this report.

The overrepresentation of minorities, particularly African American men, among the ranks of people who are chronically homeless requires greater understanding to inform the development of appropriate, culturally competent, and effective housing and treatment approaches targeted for this group.

The high prevalence of childhood out-of-home placement among single homeless women, coupled with their greater exposure to victimization and violence, both in their childhood family histories and in

adulthood, suggests a need for research to document and evaluate the effectiveness of gender-specific interventions to ending and preventing homelessness for adult women. Recognizing that many single homeless women are mothers who have become separated from their children, research can guide the development of programs that preserve and reunify families.

More research is needed to better understand the dynamics and trends that are reflected in the increasing age of homeless single adults, and the factors that are influencing this trend. Additional research can help explain whether this pattern primarily reflects an aging cohort of adults who have been homeless for many years, or whether older adults are now at greater risk of becoming homeless for the first time, and remaining homeless for extended periods. A closer examination of this population could help identify risk and protective factors associated with homelessness among older adults and factors that may have influenced changes in this pattern over the past two decades.

A greater understanding of the impact of homelessness over the life course is needed to inform housing and service approaches specific to age groups, such as young adults with recent-onset severe mental illness and elderly people. As the population of people who end up chronically homeless is aging, more research is needed to better understand their health conditions and the costs and efficacy of health care and treatment approaches for this population.

More information is needed to examine the characteristics and needs of people who experience extended or repeated episodes of homelessness but who are not considered to be chronically homeless because they do not have identified disabilities.

A More Complete Understanding of the Outcomes Produced by Specific Housing and Services Interventions, and What Works Best for Whom

We know that for most people who are homeless today, rental assistance or access to affordable housing would end their homelessness. We also know that many people with disabilities can end chronic homelessness and overcome substantial barriers to housing stability if they receive supportive housing. But there is not enough research to guide practitioners and policymakers as they make assumptions about which homeless people with specific characteristics can achieve housing stability and other improved outcomes with rent subsidies or access to affordable housing alone, and which people are unlikely to end homelessness or achieve desired outcomes in other important areas of functioning without access to supportive housing. We do not know enough about how much service support is needed, and for how long, or which specific service strategies are most effective for which groups of homeless people. With limited research about which program models work most effectively for people with varying needs and challenges, decisions about which housing strategies and program options are most appropriate for individuals and communities are too often guided by assumptions and values instead of compelling evidence. Therefore, we recommend the following priorities for continued research:

It is apparent that strategies for eliminating chronic street homelessness are a high priority nationwide (USICH, 2003; USDHHS, 2003; Burt et al., 2004). However, there have been limited efforts to define evidence-based approaches to engaging street homeless individuals in the use of services to assist in coming in off the streets. Research efforts should be directed at this issue.

Research is needed to compare outcomes for homeless people with similar characteristics and needs who receive different well-defined types of housing and services interventions. In particular, more rigorous studies should compare the effectiveness of single-site and scattered-site supportive housing that use both

low demand and high demand service strategies. The studies should measure outcomes that include not only housing stability, but also improvements in employment, recovery from addiction, and health status, and examine whether outcomes vary by participant characteristics, including age, gender, race, and types of disabilities. More conclusive evidence about what works best for whom would help guide decisions that currently are too often shaped by value-laden assumptions.

There is a need for extended longitudinal follow-up of clients enrolled in various types of housing and treatment interventions targeted at people who are chronically homeless to gain a better grasp of the long-term effectiveness of the housing and interventions. For example, the typical duration of follow-up in the housing literature is one to two years. Program attrition at that point ranges from about 20 percent to 25 percent (Lipton et al., 2000; Martinez & Burt, 2006). Lipton et al. (2000) found that at the five-year mark, only 50 percent were still in supportive housing. More information is needed on people who move out (e.g., why they move out, where they go, whether they become homeless again).

There is a need to better understand the effectiveness of specific strategies such as "housing first" versus "treatment first" for engaging the most disabled homeless people living on the streets in the use of services and housing. While this is clearly a high priority among policymakers and many practitioners, investment in research that would define evidence-based practice in this area has been limited, and we need to better understand the characteristics and needs of those who have been unable or unwilling to enter available housing or residential programs as well as factors that contribute to motivation and readiness to change.

Outcomes in studies of the impact of housing and treatment services should be broadened to include cost outcomes, family relationships and child welfare, incarceration and public safety, high-risk behaviors and communicable disease, psychiatric symptoms, recovery from substance abuse, and social inclusion.

A Better Understanding of the Need for Ongoing Supportive Services and Long-Term Outcomes After Entering Housing

Research on promising efforts in the areas of supportive housing and Safe Havens should expand information on recruitment and tenant selection (e.g., who does and does not gain admission to the programs), program exits (e.g., who leaves and why), and transitions to other types of housing. More evidence is needed to better understand long-term needs for housing assistance, treatment, and supportive services for chronically homeless people who leave supportive housing.

Recent studies suggest that the duration and intensity of services can be tailored to the clinical needs of the client, and that some homeless people with disabilities who enter housing are able to maintain their housing and sustain other positive outcomes, with less intensive direct support and linkages to other community services, after a period of transitional support. However, the duration and intensity of services required to sustain housing requires further study and evaluation. The *Self-Sufficiency Matrix* developed by the Arizona Evaluation Project on Homelessness (Flaherty, 2004) could provide a useful tool in determining how clinical and support services can be tapered at the individual level without jeopardizing gains.

Better Information About How to Prevent Chronic Homelessness

A greater understanding of the role of family dynamics in the genesis of housing loss among people with mental illness or other disabilities that increase vulnerability could inform whether interventions

addressing the family unit could prevent the onset of homelessness, or prevent future adult homelessness among children living in high-risk families.

Research must be focused on dually disordered persons with criminal justice histories to assist them to better control their illnesses, remain stably housed, avoid recidivist involvement in the criminal justice system, obtain gainful employment, and be included in the life of society at large. Innovative efforts to link chronically homeless people with criminal justice involvement to treatment and housing services in the community at the point of release from jail or prison is needed to counteract repeated homelessness and dependence on institutional care.

Interventions designed to prevent homelessness among people with severe mental illness at risk but never homeless is an important and underdeveloped area. Issues to be considered include early preventive treatment of substance use disorders, treatment compliance, vocational and job training, socialization, and family support. Assisting people at risk for long-term homelessness to retain existing housing or obtain more appropriate housing should be part of a comprehensive strategy to ameliorate chronic homelessness. Such "upstream" interventions might include supportive housing for youth aging out of foster care (New York City Department of Health and Mental Hygiene, 2006), family-based interventions for people with mental illness residing with family members (Connery & Brekke, 1999), and tenancy preservation for those at-risk of homelessness to assist them in retaining existing housing through housing court and other advocacy measures (Burt et al., 2005).

In Sum

The last decade has seen a deliberate effort to focus service innovation on the small but significant group of people who experience chronic homelessness and consume a disproportionate share of public service dollars. Innovation in services and supportive housing has outpaced research designed to establish these efforts on a strong scientific basis. However, the practice-based evidence that has emerged from these creative efforts will inform the next generation of efficacy studies in this area. Expanded federal support for research on homelessness will be required to move the field forward in the next decade.

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