# EVIDENCE-BASED INTERVENTIONS TO ADDRESS HOMELESSNESS

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ISSUE BRIEF

## INTRODUCTION

Details and evidence for several homelessness interventions are described below, with potential fiscal implications included for each. Overall, the provision of housing is an effective intervention for homeless individuals, including those with co-occurring mental illness and/or substance abuse. The provision of housing reduces substance use, increases abstinence, and reduces medical services utilization. Abstinence-contingent housing also appears to provide greater impact on sustained abstinence, sustained housing, and improved psychiatric outcomes than does non-abstinence-contingent housing[1].

*This brief is informational only, and does not require action by the committee.*

## INTERVENTIONS

- Housing First
  - Description
    - Designed to serve chronically homeless individuals with co-occurring mental illness and substance abuse disorders
    - Does not require abstinence from substance use or treatment/service compliance; focuses on harm reduction
    - Support services optional; participants are connected to services if they choose
  - Evidence
    - Studies of specific programs indicate an increase in housing stability, quality of life, and community functioning for program participants compared to treatment-as-usual individuals (Canada, Vermont, Denver, LA, etc.)[2]
  - Fiscal implications
    - Decrease in costs for emergency room care, inpatient medical and psychiatric care, detox services, incarceration, and emergency shelter
- Permanent supportive housing (PSH)
  - Description
    - Individuals participating in PSH generally have access to ongoing case management services that are designed to preserve tenancy and address their current needs
    - Tenants have full rights of tenancy, including a lease in their name
    - Housing is not contingent upon service participation
    - Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities
    - Housing is integrated; tenants live in scattered-site units located throughout the community or in buildings in which a majority of units is reserved for individuals receiving assistance
    - Housing is not time-limited

[1] Fitzpatrick-Lewis, D., Ganann, R., Krishnaratne, S., Ciliska, D., Kouyoumdjian, F., and Hwang, S.W. (2011). Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health,* 11(638).
[2] Aubry, T., et al. (2015). One-year outcomes of a randomized controlled trial of Housing First with ACT in five Canadian cities. *Psychiatric Services,* 66(5).

  - Evidence
    - For individuals with mental health and substance abuse disorders, PSH reduced homelessness, increased housing tenure over time, and resulted in fewer emergency room visits and hospitalizations, compared to normal treatment programs[3]
    - Two-year housing retention rates are above 80 percent[4]
    - Reduction in community-wide chronic homelessness
  - Fiscal implications
    - Cost of provision of PSH can be partially or completely offset by reductions in use of health, mental health, criminal justice, emergency shelter, and other public services following placement in housing[5]
  - Integration of Medicaid and supportive housing
    - In June 2015, the Centers for Medicare and Medicaid Services (CMS) enabled states to use Medicaid funds to help chronically homeless people and others with long-term disabilities to find and maintain permanent housing
    - Several states have integrated supportive housing with Medicaid services, in an effort to reduce health care costs and utilization
    - Examples
      - New York: rental subsidies, new capital construction, and pilot housing projects have resulted in a 40% reduction in inpatient days, a 26% reduction in emergency department visits, and a 15% reduction in overall Medicaid health expenditures since 2012 (average decrease of $6,130 per person per year)
      - States including California, Hawaii, New York, Texas, and Washington have included access to supported housing services in their 1115 Medicaid waivers
  - Utah
    - Palmer Court: 201 units for individuals and families (The Road Home)
    - Wendell Apartments: 32 units for individuals (The Road Home)
    - Grace Mary Manor: 84 units for individuals (Housing Authority of SL County)
    - Kelly Benson Apartments: 59 units for individuals (Housing Authority of SL County)
    - Sunrise Metro Apartments: 100 units for individuals (Housing Authority of SLC)
    - Freedom Landing: 109 units for veterans (Housing Authority of SLC)
    - 1,300+ scattered site placements with vouchers
- Rapid rehousing
  - Description
    - Move families into permanent housing as quickly as possible
    - Critical components, as defined by the VA and HUD
      - Housing identification services
      - Time-limited financial assistance
      - Case management services to address barriers affecting housing stability
        - Financial management, transportation, public benefits, health care, employment and job training
    - Reduce amount of time in homeless system (emergency shelter and/or transitional housing)

[3] Rog, D.J., Marshall, T., Dougherty, R.H., George, P., Ghose, S.S., and Delphin-Rittmon, M.E. (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services*, 65(3).

[4] Byrne, T., Fargo, J.D., Montgomery, A.E., Munley, E., and Culhane, D.P. (2014). The relationship between community investment in permanent supportive housing and chronic homelessness. *Social Service Review*.

[5] Ibid.

        - While rapid rehousing can lead to income gains, families must be able to afford their rent when they enter the program
    - Evidence
        - Rates of return to homeless system are low- between 4% and 14%[6]
    - Fiscal implications
        - Average per-household cost was $2,480 in FY 2013 through a VA-sponsored program[7]
- Diversion
    - Description
        - Prevent individuals and families from needing to enter the homelessness system
        - Trained staff identify realistic housing options based on individuals' resources rather than those of the system
        - May include one-time financial assistance to facilitate transition, conflict mediation, short-term case management, and/or connection to other services
        - Reduces rates of homelessness, demand for shelter beds, shelter waiting lists
    - Evidence
        - Low rate of diverted families/individuals return to seek shelter
    - Fiscal implications
        - Average cost per family housed was $1,668 in Seattle
        - In Connecticut, the average cost of shelter diversion was one-third the cost of sheltering and re-housing a homeless family
- Prevention[8]
    - Description
        - Low-cost, time-limited interventions for the majority of at-risk households
            - Time-limited housing subsidies, emergency cash assistance, mediation in housing courts
            - Assistance does not cover all needs, but acts as a means to leverage existing income and allows recipients to maintain housing
        - Extended interventions for households with more intractable problems related to their housing instability
            - Psychiatric disability, substance abuse, child welfare services involvement
            - Extended housing supports and ongoing support services
            - i.e. Housing First programs
    - Evidence[9]
        - Housing subsidies demonstrated 80-85% retention over 1.5-2 years
        - Mediation in housing courts preserved housing/avoided eviction
    - Fiscal implications
        - Lower-cost, and cost savings when homelessness is prevented

[6] Cunningham, M., Gillespie, S., & Anderson, J. (2015) Rapid rehousing: What the research says. *Urban Institute*.
[7] Ibid.
[8] Culhane, D.P., Metraux, S., and Byrne, T. (2011). A prevention-centered approach to homelessness assistance: A paradigm shift? *Housing Policy Debate*, 21(2).
[9] Burt, M.R., Pearson, C., and Montgomer, A.E. (2007). Community-wide strategies for preventing homelessness: Recent evidence. *The Journal of Primary Prevention*, 28(3-4).

- Critical time intervention (CTI)[10]
  - Description
    - Designed to reduce the risk of homelessness by enhancing continuity of support for individuals with severe mental illness (SMI) during the transition from institutions to community living
    - The period following institutional discharge involves high risk of homelessness, suicide, psychiatric rehospitalization, and violence against others for individuals with SMI
    - Post-discharge assistance provided by an employee who has an established relationship with the client during institutional stay
    - Three phases (across nine months)
      - Transition to the community
        - Provision of support and assessment of resources that exist for transition of care to community providers
        - High level of contact between patient and CTI worker
        - CTI worker introduces patient to new providers
      - Tryout
        - Assess whether support system is working
        - Modify system as needed
        - Regular contact, but less frequent
      - Transfer of care
        - Complete transfer of responsibility of care to community resources
  - Evidence
    - Statistically significant reduction in the risk of post-discharge homelessness
    - More days housed; fewer days in institutional settings; lower alcohol, drug, and psychiatric symptom scores
  - Fiscal implications
    - More cost-effective than usual care for homeless individuals, and reduces spending for shelter services due to more days housed

[10] Herman, D.B., and Mandiberg, J.M. (2010). Critical time intervention: Model description and implications for the significance of timing in social work interventions. *Research on Social Work Practice*, 20(5).