A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Facts for the Field

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PERMANENT SUPPORTIVE HOUSING:

An Effective Strategy for Ending Homelessness among Persons With Co-Occurring Disorders

Introduction

Persons who are homeless often have multiple and complex physical, mental, alcohol, and substance use conditions that strongly indicate the need for supportive services to help them regain lives in the community. Mayors of 25 U.S. cities report that substance abuse, lack of affordable housing, and mental illness are the top three causes of homelessness (U.S. Conference of Mayors, 2008). A 2008 U.S. Department of Housing and Urban Development (HUD) assessment finds that

- 26.3% of homeless persons are seriously mentally ill , and
- 36.5% of homeless persons are chronic substance abusers (HUD, 2009).

The comprehensive data sets compiled by HUD do not report specifically on co-occurring mental health and substance use disorders. Further, HUD's data on mental illness and substance abuse is limited to sheltered persons, and many shelters and transitional housing programs exclude people who are actively using substances. However, a number of sources suggest that about half of adults who are homeless and have a mental illness also have substance abuse issues. For example, the Metro Denver Homeless Initiative (2009) reported that 28 percent of homeless individuals and heads of households have a mental illness, and that half of these (14 percent) have a co-occurring substance use disorder. A compilation of State data submitted to SAMHSA in conjunction with Projects for Assistance in Transition from Homelessness (PATH, 2009), which funds services to people who are homeless and have a mental illness, reveals that 60 percent of PATH clients also have a co-occurring substance use disorder.

While persons who have co-occurring mental and substance use disorders may have health-related and other problems as well, SAMHSA's Center for Substance Abuse Treatment (CSAT) uses the term "co-occurring disorders" to refer specifically to co-occurring substance use (abuse or dependence) and mental disorders. As defined in Treatment Improvement Protocol (TIP) 42, "a diagnosis of co-occurring disorders (COD) occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder" (CSAT, 2005).

Permanent supportive housing (PSH) is a strategy that not only provides stable housing to persons with COD, but also offers services to help address these conditions. It is defined as "decent, safe, and affordable community-based housing that provides residents with the

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rights of tenancy under state/local landlord tenant laws and is linked to voluntary and flexible supports and services designed to meet residents' needs and preferences" (SAMHSA, 2002). PSH can make an important contribution to ending homelessness for persons with co-occurring disorders and help them recover.

Permanent supportive housing can be provided in a variety of settings. Many individuals with co-occurring disorders are best served in regular housing (similar to other housing in the community) where they can also receive intensive, coordinated supports and services. Housing should be affordable and chosen by the tenant, accessible to tenants with co-occurring disorders regardless of their readiness to change or their progress in recovery for either disorder, and combined with services that have sufficient depth to assist people with significant functional impairments.

PSH is most effective when delivered with fidelity to the best practice model developed from the SAMHSA Supportive Housing Study conducted in the 1990s (Rog and Hornik, 2002). The fidelity dimensions of PSH include choice in housing and living arrangements; functional separation of housing and services; decent, safe and affordable housing; community integration and rights of tenancy; access to housing and privacy; and flexible, voluntary, and recovery-focused services.

The Center for Mental Health Services has sponsored the development of the Permanent Supportive Housing KIT (Knowledge Informing Transformation). The KIT, one of a series that supports SAMHSA's science-to-services mission, is designed to encourage the use of recovery-oriented, evidence-based practices in meeting the housing needs of adults with serious mental illnesses. Use of the KIT will help service providers and communities improve the use of PSH and improve outcomes for persons with co-occurring disorders.

Epidemiology

Individuals who experience prolonged substance use disorders or psychiatric disabilities have a disproportionately high risk of homelessness and are greatly overrepresented among the population living in shelters and on the streets of America. The national estimate of persons who were homeless on a single night in January 2007 is 671,888 (HUD, 2008). Although estimates vary, it is clear that between 25 percent and 50 percent of the individuals who become homeless in any given year have substance use issues. The Department of Housing and Urban Development (HUD), using a different definition of mental illness, estimates that about one-third of people who are homeless in the United States have serious mental health problems or a history of psychiatric disability and institutionalization (HUD, 2007). People with both psychiatric and substance use disorders are at greater risk for homelessness because they tend to have more severe mental symptoms, to deny both their mental illness and their substance use problems, to refuse treatment and medication, and to abuse multiple substances (SAMHSA, 2003). Clearly, significant numbers of persons with co-occurring disorders lack housing and can benefit from the PSH model.

Positive Outcomes Attributable to PSH

PSH improves outcomes for persons with co-occurring disorders who are homeless. Specific and measurable improvements have been documented, such as increased residential stability, improved mental health, improved recovery from substance abuse, and reduced

costs of homelessness to the community (Hannigan & Wagner, 2003). An often-cited study found that people who are homeless with severe mental illnesses used an average of $40,451 per person per year in services. After placement in permanent supportive housing in New York City, these individuals used $16,281 less in services per year, with marked reductions in emergency room visits, hospitalizations, and incarceration (Culhane et al., 2002). Similar results have been reported in Portland, Oregon, and in Denver, Colorado, where a $15,773 per person per year reduction in services more than offset the $13,400 annual cost of the supportive housing (NAEH, 2007).

Key Issues Related to Housing

Many people live in housing that is overcrowded or substandard, and tenants are often at risk of losing access to housing because of poverty and the lack of affordable housing alternatives. While people with disabilities who are poor and who do not have a significant work history are eligible to receive Supplemental Security Income (SSI), those who rely exclusively on SSI will find it difficult to live in almost any community in the United States. *Priced Out in 2006* reports that the rents for modest one-bedroom apartments rose in the previous 8 years from 69 percent to 113.1 percent of SSI (O'Hara, A., Cooper, E., Zovistoski, A., & Buttrick, J., 2007). Many households in the United States live one paycheck away from serious economic problems. People on SSI are even closer to the edge: "Living precariously, people with serious mental illnesses are one small crisis—such as a rise in the cost of their medication—away from becoming homeless" (Pelletiere, 2006).

HUD helps communities identify the people in the greatest need of assistance with housing by providing the data required to compare their income with the fair market rent in their geographic area. Local data are published regularly on this Web site: http://www.huduser.org/datasets/fmr.html. Every household that depends solely on SSI has a severe cost burden (as defined by HUD), regardless of location. In 2003, there were 6 million rental units affordable for people at extremely low incomes (30 percent or less of area median family income), but 7.7 million households met these income criteria (SAMHSA, 2003). Alarmingly, the number of affordable units available to households with extremely low income is shrinking: a recent study estimates that approximately 200,000 affordable housing units will be lost over the next 10 years (Joint Center for Housing Studies, 2006).

Features of Successful PSH

PSH addresses two key issues of particular importance to people with co-occurring disorders: housing affordability and the need for flexible, comprehensive supports. PSH addresses the issue of affordability by providing rental subsidies that allow tenants to afford existing housing or by constructing affordable units, often made possible by "blending" multiple funding sources.

Experience suggests that PSH will be most successful when it offers tenants the following features:

- Choice: PSH can be provided in a variety of settings. Highly successful programs have been provided in scattered-site apartments (apartments that are located in different places throughout the community). Other successful programs are provided in one housing location, such as a multi-unit apartment complex where all the units are

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occupied by people with co-occurring disorders. The key seems to be consumer choice. Supportive housing programs should consider tenant preferences for type of housing at intake or program entry.

- Access: PSH programs are most useful for persons with co-occurring disorders when individuals are deemed eligible for the program without meeting numerous "readiness" criteria. Stable housing gives individuals an opportunity to make choices in keeping with their personal goals and their vision of recovery.
- Affordability: When a tenant pays 30 percent or more of his gross income towards housing costs (rent or mortgage, plus utilities), that tenant has a moderate cost burden (according to HUD); if the tenant must pay 50 percent or more, the cost burden is considered severe. PSH must make housing affordable, whether through rental subsidies or development of affordable housing units.

Key Issues Related to Services

PSH provides tenants with a flexible array of case management and other services that help them move towards recovery. These support services can include:

- Integrated treatment for co-occurring disorders;
- Inpatient, residential, and outpatient substance abuse treatment;
- Psychiatric assessment and treatment;
- Psychotropic medications;
- Health care, including dental care;
- Skills training;
- Habilitation and rehabilitation services;
- Case coordination services; and
- Direct provision of or links to additional services, such as
    - individual and family counseling,
    - HIV services,
    - crisis intervention,
    - child care,
    - medical care,
    - vocational counseling, and
    - job placement (CMHS, 2007).

Tenants in supportive housing are most likely to benefit from services when they see them as necessary. Consumers should be asked about their needs and preferences regarding program services, and the program should be prepared to deliver a sufficient number and variety of services to respond to the needs and preferences that are most important to the client. These services will be most effective when they are well coordinated and convenient for the client.

Although people with co-occurring disorders do want and use supportive services, many of them do not want to live in settings in which services are required or delivered as part of the housing program. They may prefer scattered site housing, in which staff travels to clients or vice versa. Whatever the physical configuration of PSH, services provided through the following methods have proved most helpful for persons with co-occurring disorders:

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- Intensive Case Management. The case manager can help coordinate multiple services in keeping with the client's needs and preferences. Intensive case management for persons with co-occurring disorders has been affirmed as an effective and recommended practice. Case management that includes an assertive outreach approach has been shown to engage and retain clients at a high rate, while case management that does not include outreach results in more "lost" clients. Meeting at the client's residence, for example, can be an effective strategy (NAMI, 2008).
- Integrated Dual Diagnosis Treatment (IDDT). IDDT refers to the integration of mental health and substance abuse treatments in one approach. The same clinicians or teams of clinicians, working in one setting, provide both mental health and substance abuse interventions so that the consumer does not get lost, excluded, or confused going back and forth between two different programs (CMHS, 2003). The coordinated approach also takes into account the interaction between these disorders. The multidisciplinary team approach is effective with individuals with co-occurring disorders and works well in conjunction with permanent supportive housing.
- Assertive Community Treatment (ACT). ACT is a team-based approach to delivering comprehensive and flexible treatment, support, and services. An ACT team consists of 10 to 12 staff with experience in psychiatry, social work, nursing, substance abuse treatment, and employment support. ACT teams can support individuals with co-occurring disorders in permanent supportive housing, serving as the first choice to meet the client's service requirements.

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