Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis

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Objectives. We examined the longitudinal effects of a Housing First program for homeless, mentally ill individuals' on those individuals' consumer choice, housing stability, substance use, treatment utilization, and psychiatric symptoms.

Methods. Two hundred twenty-five participants were randomly assigned to receive housing contingent on treatment and sobriety (control) or to receive immediate housing without treatment prerequisites (experimental). Interviews were conducted every 6 months for 24 months.

Results. The experimental group obtained housing earlier, remained stably housed, and reported higher perceived choice. Utilization of substance abuse treatment was significantly higher for the control group, but no differences were found in substance use or psychiatric symptoms.

Conclusions. Participants in the Housing First program were able to obtain and maintain independent housing without compromising psychiatric or substance abuse symptoms. (*Am J Public Health.* 2004;94:651–656)

Current rates of homelessness in New York City are the highest ever documented.[1] A small percentage of this population remains chronically homeless, either living on the streets or other public places or intermittently using emergency rooms, shelters, jails, and other short-term services, but never successfully ending their homelessness.[2] Members of this chronically homeless group typically have a history of mental illness,[3] compounded by substance use disorders.[4,5,6] Although much is known about the chronically homeless, these individuals continue to elude existing program efforts.

The predominant service delivery model designed to address the needs of this chronically homeless population, called the Continuum of Care, consists of several program components. It begins with outreach, includes treatment and transitional housing, and ends with permanent supportive housing. The purpose of outreach and transitional residential programs is to enhance clients' "housing readiness" by encouraging the sobriety and compliance with psychiatric treatment considered essential for successful transition to permanent housing. This approach assumes that individuals with severe psychiatric disabilities cannot maintain independent housing before their clinical status is stabilized. Furthermore, the model presumes that the skills a client needs for independent living can be learned in transitional congregate living. Research in psychiatric rehabilitation indicates, however, that the most effective place to teach a person the skills required for a particular environment is within that actual setting.[7]

Consumers' perception of the Continuum of Care offers another divergent perspective. Consumers experience the Continuum as a series of hurdles—specifically, ones that many of them are unable or unwilling to overcome. Consumers who are homeless regard housing as an immediate need, yet access to housing is not made available unless they first complete treatment. By leveraging housing on participation and treatment, continuum program requirements are incompatible with consumers' priorities and restrict the access of consumers who are unable or unwilling to comply with program terms.

In addition, most consumers prefer to live in a place of their own rather than in congregate specialized housing with treatment services onsite.[8,9] Most programs have rules that restrict clients' choices and that when violated are used as grounds for discharging the consumer from the program. For example, despite having attained permanent housing, clients who relapse and begin to drink mild or moderate amounts of alcohol, may be evicted if the program has strict rules about sobriety maintenance. The chronically homeless population is characterized by its frequent inability to gain access to existing housing programs. Individuals in this group often have multiple disabling conditions, especially psychiatric conditions and substance abuse.[10] Most programs are poorly equipped to treat people with dual diagnoses, let alone prepared to address their housing needs.[11] Treatment requires time and commitment and is often not available if a program is under pressure to move clients along a continuum.[12]

The loss of control over one's life resulting from housing instability, frequent psychiatric hospitalizations, and intermittent substance abuse treatment leaves some consumers mistrustful of the mental health system and unwilling to comply with demands set by providers.[13] Others prefer the relative independence of life on the streets to a fragmented treatment system that inadequately treats multiple diagnoses or addresses housing needs.[14,15] Paradoxically, consumers' reluctance to use traditional mental health and substance abuse services as a condition of housing only confirms providers' perceptions that these individuals are "resistant" to treatment, not willing to be helped, and certainly not ready for housing.[16]

The Housing First model was developed by Pathways to Housing to meet the housing and treatment needs of this chronically homeless population. The program is based on the belief that housing is a basic right and on a theoretical foundation that includes psychiatric rehabilitation and values consumer choice.[17] Pathways is designed to address the needs of consumers from the consumer's perspective.[18] Pathways encourages consumers to define their own needs and goals and, if the consumer so wishes, immediately provides an apartment of the consumers' own without any prerequisites for psychiatric treatment or sobriety. In addition to an apartment, consumers are offered treatment, support, and other services by the program's Assertive Community Treatment (ACT) team. ACT is a well defined community based inter-