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# Housing First: permanent supported accommodation for people with psychosis who have experienced chronic homelessness

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## Abstract

**Objectives:** The objective of this study was to determine whether a 'housing first' permanent supported accommodation was effective in improving housing stability, continuity of care and reducing mental health admissions for persons experiencing chronic homelessness with psychosis.
**Methods:** A quasi prospective cohort study of 42 chronic homeless persons with psychosis accommodated in a new purpose built facility in central Melbourne. Accommodation stability, mental health service contacts and psychiatric admissions were compared across the 2 years prior, the first 2 years of placement and the 2 years after leaving.
**Results:** The mean number of mental health admissions in the first 2 years of accommodation was less (0.56, SD = 1.0) when compared with in the 2 years prior to accommodation (1.0, SD = 1.4, $p = 0.05$). There was an increase in the mean total number of days admitted in the 2 years after having left the supported accommodation, (33.3 days, SD = 86.7, $p = 0.043$)
**Conclusions:** The accommodation of chronic homeless persons with psychosis in a 'housing first' permanent supported accommodation lead to increased housing stability and optimism, improved continuity of care and reduced psychiatric admissions.

**Keywords:** homeless, chronic, psychosis, housing

People with psychosis are over represented amongst people experiencing chronic homelessness.[1] Predominantly men, they often use drugs and alcohol, and have histories of childhood trauma and incarceration.[2,3] Their involvement with mental health services are typified by cycles of crisis, admission, discharge and disengagement, despite access to extended inpatient rehabilitation, assertive outreach and complex care packages.[4] Supported housing using the traditional approach, in which housing is conditional on behaviour change, has not been fully effective.[5] An alternative approach, not previously available in Australia, is 'housing first' in which providing access to and maintaining accommodation is the primary aim.[6]

In Australia between 18%[7] and 29%[1] of the homeless population have psychosis, mainly schizophrenia. Over 5% of Australians with psychosis are currently homeless and 12.8% report homeless in the previous 12 months.[8] The chronic homeless are those who have multiple episodes of homelessness over at least 12 months or those who are continuously homeless for more than 6 months. In one Australian survey, 13% of homeless men with psychosis reported being chronically homeless.[9]

Up to 2010 the established approach in Australia for people with chronic homelessness was the 'continuum of care' model. According to this method, the homeless person enters and graduates from a series of programs

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(emergency accommodation, transitional housing) on their way to permanent accommodation, each step requiring improved function and living skills.[10] For a proportion of chronic homeless persons, including those with psychosis, this approach has not been effective, as they are unable to achieve the self-sufficiency required to reach permanent accommodation.[11]

Housing first refers to the rapid and direct placement of homeless individuals into permanent housing with supportive services available, but without service utilization or treatment required as a condition of receiving housing.[12] Housing first programs target individuals for whom 'continuity of care' has been unsuccessful.[13] Housing first emphasizes respect for homeless individuals as consumers entitled to make choices and sees homelessness a failure to meet a human right to housing.[12] Housing is not time limited.[14] Difficulties that may arise through substance use, mental disorder and behavioural disturbance are tolerated within the framework of harm reduction. Support is flexible, non-judgemental, tolerant, open ended and promotes choice, integration and autonomy.

Common Ground was developed in New York, using housing first principles, to provide permanent housing to people experiencing chronic homelessness.[15] The program led to a reduction in hospital admissions and incarcerations.[16] Elizabeth Street Common Ground (ESCG) was opened in Melbourne in 2010.[17] ESCG is a congregate service comprising 60 single independent units with facilities for support staff, in reach services and training. A survey of wellbeing conducted on 24 new clients in ESCG using the Cantril Self-Anchoring Striving Scale[18] determined that 63% considered themselves to be thriving and 92% were optimistic about the future,[19] levels similar to those found in the Australian housed population.

## Method

The study used a quasi prospective cohort method to determine differences in mental health service use before, during and after accommodation in ESCG.

The study was approved by the Melbourne Health Research and Ethics committee, approval number 2015002.

The study population was all clients accommodated in ESCG from 2010 to 2015. Entry criteria for ESCG were homelessness and housing instability extending over many years.

ESCG clients were matched with the state-wide public mental health operational data store (CMI). CMI, which has been in operation since 1986, records contacts between clients and mental health clinicians, mental health diagnoses and dates of admission to and discharge from acute mental health inpatient units. Diagnoses were made using ICD-10.[20]

The data was entered into SPSS.[21] The number of contacts and admissions were allocated to three 2-year periods: prior to entry to ESCG; housed in ESCG and; after leaving ESCG. For those clients resident for less than 2 years, an imputed figure was calculated. The mean contacts, number of admissions and duration of admissions were compared across the time periods using ANOVA. When testing the relationship between diagnosis and eviction, the chi squared statistic was used.

## Results

A total of 162 clients have been accommodation in ESCG, of whom 60 were current at the time of the study. Their mean age was 40 years and 78% were male. At the time of entry, 17% were shelterless, 43% in crisis accommodation, 12% in boarding houses, 24% had been released from prison and 4% were from non-homeless settings. The mean time spent in ESCG was 687 days (SD = 518). Of the 101 clients who had left ESCG, 29% had been evicted, 25% relocated voluntarily, 24% incarcerated, 12% left without notice and 10% had died. The majority of those evicted (72%) were for violence and anti-social behaviour.

Overall, 31% of ESCG clients had a current or past mental disorder recorded on CMI. The most common diagnoses were a substance abuse (73%), schizophrenia or schizoaffective disorder (71%), alcohol abuse (71%) and personality disorder (45%). They had been seen on average in 1.9 area mental health services (SD = 2.0) in the previous 2 years. Of the 42 clients with a psychosis, 81% had a substance use disorder, 50% had an alcohol use disorder, 33% had a personality disorder and 10% intellectual disability. Clients with a mental health history who had been evicted were more likely to have diagnosis of personality disorder ($p = 0.005$) than those who were still resident or had left due to other reasons. Clients with a diagnosis of schizophrenia were less likely to be evicted (9.5% vs 16.3%, $p = 0.002$) than those without a mental health history or those without a diagnosis of schizophrenia.

The average length of time spent in ESCG by clients with psychosis was 685 days (SD = 581, p = 0.13). The total duration of mental health admissions for clients with psychosis was less in the first 2 years of accommodation in ESCG (9.4 days, SD = 20.8) when compared with the 2 years prior to entry (17.3 days, SD = 34.6, p = 0.029) and the 2 years after leaving (33.3 days, SD = 86.7, p = 0.043) (Figure 1). The mean number of mental health admissions during the first 2 years at ESCG was less (0.56, SD = 1.0) when compared with in the 2 years prior to accommodation (1.0, SD = 1.4, $p = 0.05$). The mean number of mental health admissions in the first 2 years of after leaving ESCG was 1.25 (SD = 2.3, $p = 0.11$). The mean number of contacts with public mental health clinicians did not differ significantly pre (197, SD = 232), peri (224, SD=226) or post (196, SD = 203) entry to ESCG ($p = 0.84$).

## Discussion

Accommodation of persons experiencing chronic homelessness and psychosis in a 'housing first' permanent

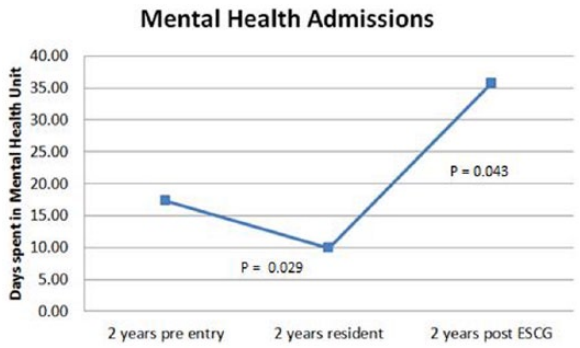


**Figure 1. Mean days spent in mental health inpatient unit before, during and after accommodation.**

ESCG: Elizabeth Street Common Ground.

supportive accommodation lead to a marked improvement in accommodation stability and client wellbeing. Continuity of care was achieved with no greater clinical resources than were used prior to entry. Admissions to mental health inpatient units were reduced by 50%. The evidence of this study supports the notion that the housing first approach is effective for those clients for whom the traditional continuum of care model has been unsuccessful.

The reduction in mental health admissions whilst resident in ESCG was due to improved mental health and increased tolerance of their disorders, disabilities and requirements for care. Stability allowed for the development of client clinician relationships through which treatment adherence was enhanced. Tolerance was reflected in the willingness to accept the clients in the first place and thereafter in the building of collaborative relationships and the development of complex strategies to deal with challenging behaviour. In particular, when difficulties arose, admission or eviction was not seen the default option, as might occur under other housing models.

Accommodation in ESCG did not lead to increased service demands on the mental health services. The resources required to provide adequate community care were no more than those previously expended in the previous cycles of crisis and admission. This finding was unexpected, given that homelessness is associated with disengagement and it may be assumed that re-engagement would lead to an increase in clinical contacts.[22] Of note, however, not all the past contacts occurred in the ESCG area mental health service. A requirement exists for the provision of new mental health resources to a housing first facility, but these should be in lieu of decreased demands elsewhere, including admissions.

A proportion of persons with psychosis left ESCG, despite its 'permanent' nature. A third of those leaving were evicted. This occurred despite assertive in-reach, advocacy, staged warnings and psychiatric inpatient admissions. Those evicted were more likely have a personality disorder. Those with a personality disorder often demonstrated anti-social or borderline behaviours, of which unpredictable verbal and physical aggression, intoxication, 'standing over' and drug dealing were the most difficult to manage. After leaving, the time spent in acute inpatient mental health services doubled. The increased admissions, commonly in other areas, reflected a return to itinerancy, crisis, reduced continuity of care and worsening mental health. The increased duration of these admissions may also have related to the absence of a suitable discharge destination.

For those evicted, the question must be asked 'what next?' Using the experience of ESCG, what alternative or novel strategies may be suggested? We know that their experience of housing was generally positive. Some of those evicted still returned to meet with residents and staff, indicating that some sense of attachment and community had developed. For those prone to interpersonal conflict, lower density scattered-site supportive housing[23] espousing 'housing first' principles might be better tolerated. For others, the availability of a 'sister' facility would allow for 'time out' or a 'second chance'. For those with persistently poor function, additional support packages such as those available through the National Disability Insurance Scheme may be required. On a broader level, there is a need for greater emphasis in on the long term homeless.

The strength of this study was in the quasi-prospective design, the unique characteristics of the program and the number persons introduced to the experimental condition around the same time. No similar services were available prior to opening, nor have others been developed subsequently. That said, the generalization of the key findings needs to be mindful that a program that works in one place will not necessarily work in another.

## Conclusion

The accommodation of people experiencing chronic homeless with psychosis in permanent supported accommodation espousing 'housing first' principles lead to housing stability, optimism, improved continuity of care and reduced psychiatric admissions. The cycle of crisis, admission, discharge and disengagement can be interrupted, but requires a different approach to housing for those for whom traditional approaches have been unsuccessful.

### Disclosure

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