

HOUSING FIRST/HARM REDUCTION MODEL:

THE PHILADELPHIA PROJECT

by

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ABSTRACT

Philadelphia is one of several cities in the United States that has a disproportionately high rate of homeless adults. In 2009 the Office of Supportive Housing reported that on any given night, 6,304 people were homeless in the city of Philadelphia (Kligerman, Darling & Schaffer, 2010). Many of these homeless individuals have substance abuse or mental health issues. In the past the city has primarily used conventional methods to address this very serious problem, but recently efforts have been made to adopt an innovative method of housing for those who are considered chronically-homeless, the Housing First model. This paper will take a comparative look at the “Housing First” model, and the more traditional modality, commonly called “Continuum of Care”. The primary focus of this paper is to determine the effectiveness of the “Housing First” and “Harm Reduction” models on providing permanent supportive housing for homeless adults suffering with serious mental health and co-occurring substance abuse problems in the city of Philadelphia. This paper presents empirical evidence about the effectiveness of the overall services provided to the homeless population in Philadelphia, with a specific focus on Pathways to Housing, Philadelphia.

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INTRODUCTION

Homelessness is defined as the state or condition of having no home (especially the state of living in the streets). The homeless are often labeled vagrants, hoboes and other derogatory descriptive words. A great majority become transients, lack any stability, wandering from place to place; having no permanent home (American Heritage, 2000). An article in the *Journal of Community Psychology* noted that the U. S. Department of Housing and Urban Development (HUD) defines a chronically homeless person as an unaccompanied adult with a disabling condition- most commonly with a serious mental illness, substance-related disorder, developmental disability, or chronic physical illness or disability-who has been continuously homeless for one year or longer, or had at least four homeless episodes during the last 3 years (Pearson, Montgomery & Locke, 2009). The number of individuals that fit this description is disproportionately higher in large urban areas in the United States.

This study will make some comparisons of both treatment modalities, to help determine what method of care is the most effective way to address the chronic homelessness problem in the city of Philadelphia. The data collected in this synthesis will attempt to support the hypothesis that the Housing First/Harm Reduction model is one of the most effective ways to provide homeless services to adult individuals who suffer from chronic mental health, substance abuse and co-occurring problems. This will be evidenced by cost effectiveness, the level of affordable housing that has been provided, and client access to 24 hour supportive services. Considering the cost of these services, Pathways to Housing, Inc. saves the city a substantial amount of money (Kligerman, Darling & Schaffer, 2010).

In Philadelphia, the homeless problem is multifaceted. In 2009 the Office of Supportive Housing (OSH) reported that on any given night, 6,304 people were homeless in the city of Philadelphia. Of this number, 3,250 were families, all of whom were sheltered at the time. The remaining 3,054 were individual adults, and 506 of them were unsheltered. On the average, throughout 2009, there were 424 people living on the streets of Philadelphia on any given night and a quarter of these individuals had a serious and persistent mental illness (Kligerman, Darling & Schaffer, 2010). Many of these individuals have varying mental health diagnoses which make them less likely to adapt to a congregant living situation like a shelter or a safe haven. The Fairmount Ventures, Inc. a Philadelphia based research group, in a recent evaluation of Pathways to Housing-Philadelphia noted that, certain portions of this population, have a personality disorder that makes them feel anxious living with other people (Kligerman et al., 2010). In response to this difficulty, the mental health homeless service agencies have developed two primary service models to provide homeless services to individual adults who also suffer from chronic mental illness: the Residential Continuum and the Housing First models of care. The predominant approach to date that characterizes the majority of services is the residential continuum approach (Leff, Chow, Pepin, Conley, Allen & Seaman, 2009). In order to reach a certain sub-group of homeless chronically mentally ill that continuum of care models could not reach the Housing First/Harm Reduction model was implemented in 1992. This study will evaluate the effectiveness of both models.

PROBLEM STATEMENT

In 1983 Dan Aykroyd (Louis) and Eddie Murphy (Billy Ray) starred in a movie titled “Trading Places”, directed by John Landis. Two wealthy brothers embark on an experiment that would change two lives forever. Randolph and Mortimer Duke own a successful commodities brokerage. Randolph believes they can take a common criminal and make him a successful businessman in their company and at the same time take a wealthy and successful businessman and strip him of all of his money, his career and his home and he will most likely resort to street survival behaviors. The criminal and street person, Billy Ray, is given the job and home of Louis; the successful business man is framed for crimes he didn't commit, to see if he will resort to criminal activity once he lost his rich environment and friends. Mortimer held opposing views on the possible outcome, so they make a wager and agree to conduct an experiment switching the lives of two people at opposite sides of the social hierarchy and observing the results (Landis, 1983).

Initially Billy Ray continued to demonstrate the same behaviors associated with his previous lifestyle, but somewhere in the process he begins to adapt to his new role in life and begins to take advantage of the opportunity he had been afforded. Marked changes in his behavior and confidence lead him to take pride in his possessions, be successful in business, and to become a productive member of society in a short period of time. This work of fiction is a metaphor that parallels the Housing First philosophy which proposes that recovery begins with a permanent housing opportunity and then expands from there to other lifestyle changes. The reason so many homeless individuals stay homeless is because the opportunity to obtain housing evades them because of all of

the conditions attached. Housing First offers the same opportunity to homeless individuals that the Dukes offered Billy Ray, immediate housing without condition. The Duke brothers didn't send Billy Ray to edict school or behavior modification classes, but trusted that the changes in his environment and lifestyle would generate changes in his behavior and transform him from relying on past street behaviors i.e. drug usage, criminal activity etc. to a honest and productive person in society. The experiment proved to be successful for Billy Ray. Similar outcomes can be achieved for homeless individuals who are afforded a housing opportunity without treatment conditions. This is the primary goal of the Housing First model of care. A pure Housing First program's main priority is to address the issues of homelessness; instead of focusing on what is wrong with an individual's lifestyle, they simply remove the individual from living on the street to an independent living situation. This may sound like an incredulous expectation, but Housing First programs in various cities have made this a reality for thousands of homeless men and women. Housing First programs place the homeless individual into an apartment without treatment conditions, providing them with the kind of support that will eventually allow them to change their behavior and with the right type of nurturing and support; the individual will be more motivated to make significant behavioral changes when afforded with a housing opportunity (Torrey, 1997).

The prevalent system, Continuum of Care, is system motivated, not consumer motivated. The underlying assumption in the Continuum of Care is that the client must change his behavior and adhere to specific behavioral guidelines before independent housing will be provided. The presumption that all homeless mental health consumers can succeed in this model of care has resulted in frequent poor outcomes for homeless

consumers. This type of stereotyping is a major problem and has become a stumbling block to the goal to end homelessness. There is a need for an alternative system such as Housing First to meet the special needs of such a diverse population. This paper will take an exploratory look at the Housing First approach to determine the effectiveness of this model in relation to the established conventional methods of providing services to homeless individuals in the city of Philadelphia. It will also identify the approach that will best meet the needs of the individual who is experiencing chronic homelessness coupled with mental health and substance abuse problems. The question addressed by this paper is how do you provide housing without condition, and still provide an acceptable level of psychiatric care and substance abuse interventions and treatment options to the participant?

POLICY ALTERNATIVES

Philadelphia has a large and diverse population of homeless individuals, and clearly it would be prudent for the city to have several streams of homeless services in place that are tailored to fit the varying needs of this population. The Continuum of Care, sometimes referred to as “treatment first” model, has been the primary method of care used in homeless service agencies in the city of Philadelphia for many years.

This model’s approach highlights ‘treatment first’ (Padget, Gulcur & Tsemberis 2006) and the need for a phased ‘staircase of transition’ that deals with individual problems and needs, leading eventually to resettlement in a secure environment (Atherton & Nicholis, 2008). The process to housing begins with placement in some form of group living situation, with the goal to gradually progress toward an independent housing opportunity. If the homeless individual is willing to comply with mental health treatment and in many cases substance abuse treatment, then independent housing becomes a reality. In this system of care, housing becomes the end goal to be achieved rather than a component in a person’s recovery. For housing to be provided, the client must maintain a period of continuous sobriety from alcohol and drugs for a minimal of three to six months, and if medication is prescribed for the consumer, he or she must remain in compliance with medication regimens that are recommended by the clinical staff. The continuum of care model uses housing as the leverage to force compliance to treatment mandates. The model promotes the belief that an individuals’ problems are the key issues i.e. get clients off drugs and alcohol, medicate those who need anti-depressants and psychotropic drugs, and assist them to learn life skills. Only then will the consumer be in a position to successfully maintain an apartment of his or her own. The fundamental

value of this model is that the cessation of problematic behavior and compliance to treatment must be apparent before someone is deemed ‘housing ready’ (Sahlin, 1998). This structure can be effective in some cases, but unfortunately this option is not always effective with clients who have been diagnosed with a chronic mental illness. This model of care has come under a great deal of scrutiny in recent years because of apparent failure in many instances (Sahlin, 1998). With the emergence of more effective models of care it has created alternatives on how to provide services to chronic homeless mentally ill individuals. The research supports that to provide housing to this diverse population of homeless consumers requires a different approach, because their illness severely limits their ability to make rational decisions about adhering to treatment mandates. In most cases, the coercive treatment recommendation often exacerbates the client’s resistance to conforming to these conditions. In addition, many are unable to manage social interactions with people they do not know, let alone live among a group of strangers (Tsemberis & Eisenberg, 2000). For this unique group, cities in various parts of the country have implemented a seemingly counter-intuitive approach known as Housing First.

The Housing First approach has become synonymous with the work of Pathways to Housing, Inc., an agency based in New York City. The Housing First approach to providing housing to the chronically homeless and mentally ill individual is based on providing access to an independent tenancy first without treatment conditions. The Housing First approach is direct placement of the homeless individual into “permanent rental housing” without requiring a period of sobriety or acceptance of specific services (Kligerman et al., 2010). This system of care advocates for every human being’s right to

be provided with safe and affordable housing, regardless of where they may fall in the continuum of care. The first priority in this model is based on the harm reduction or low demand model of care. The client is at greater risk of harm from the devastating physical and mental effects of homelessness. Housing the client without condition reduces the dangers associated with living on the street. The housing is provided first with various supports given, and then treatment becomes the next priority.

The support provided is based on the Assertive Community Treatment (ACT) model. This type of support was designed specifically to serve people who are chronically homeless. The ACT team consists of 1 psychiatrist, 2 registered nurses, 6 service coordinators, 2 certified peer specialists, 2 program assistants, 1 employment specialist, 1 clinical director, 3 housing and maintenance staff, 1 executive assistant, and 1 chief operating officer. The Philadelphia agency also developed a partnership with Thomas Jefferson University Health Systems and has a medical doctor available one day a week to provide clients with “an integrated healthcare team” (Kligerman et al., 2010). The client agrees to be visited by service coordinators on a regular basis and is offered the opportunity to get substance abuse and other psychiatric treatment. However, this is not a mandatory requirement that the client has to agree to in order to keep their housing. The foundation of the Housing First model is the emphasis on consumer choice: they choose the neighborhoods they want to live in, how their apartments are furnished and all other decisions regarding the use of their home (Kligerman et al., 2010). The program provides the consumer with the basic items needed when they first move in, including furniture, food, utensils, pots and pans, but the client has the freedom to add furniture and decorate their apartment as they see fit. The housing is permanent and is held for the

individual during relapse, psychiatric crisis or short incarcerations. The low demand and harm reduction concept is designed to remove the former obstacles which caused many individuals to be denied housing in the established conventional homeless service systems.

BACKGROUND

Homelessness is a problem that has been with mankind since the beginning of time. In one creation manuscript, there is a particular story that indirectly introduces the concept of homelessness and being displaced. The biblical story of creation, in Genesis 1:1 details the creation of the earth, the plant life, and all living creatures, and finally the creation of human beings. It further details the placement of humans in a utopian place called the Garden of Eden. After an unspecified period of time, the man and the woman violate a specific term of their lease, “Do not eat from the tree that is in the midst of the garden” (Holman Bible, 1999). They chose to ignore this specific term of their lease and this resulted in the forced removal and lock out from their home. This creation account may very well be the first example of a tenant’s eviction proceeding. Ironically the story depicts the guidelines and principles that govern the way housing operates in modern times. Theoretically, these biblical characters were the first humans to experience the devastating effects of homelessness and displacement for behaving in a manner that was unacceptable to the owner of the property. Therefore homelessness is not a new phenomenon, but it has evolved into one of the major social problems in society today. The same principles of right behavior, following specific rules and guidelines to obtain housing and to maintain one’s residency found in this biblical story, are still applicable today. Over the years homelessness was primarily considered to be a problem that individual families, religious based institutions, and communities would solve. Many towns and cities had an area which contained the poor, the transients, and afflicted often called ‘skid row’. The development of rescue missions and other religious based organizations sprung up in these areas to provide food, clothing, and shelter. Initially

these avenues proved to be fairly effective and many of the homeless and displaced individuals were able to receive some relief from the devastating affects of this social malady. However, as homelessness began to rise due to varying factors i.e. high unemployment, mental illness, substance abuse and the decline of the economy, other types of interventions beyond the local community had to be developed to address this growing issue on a larger scale.

History of government involvement

In response to the homeless population, the government created various programs to provide affordable housing to low income and poor individuals. One primary agency that was developed to target this problem was the Department of Housing and Urban Development (HUD). It was established in 1934 as two separate entities, the Federal Housing Administration (FHA) and Public Housing Administration (PHA). It was primarily established to deal with the devastating effects of the Great Depression. During the Great Depression and ending at the height of the Nixon Presidency, the history of HUD consisted of new programs, new missions and the molding of the organization (Thompson, 2006). During the early developmental years the agency developed five core missions:

1. Increasing Homeownership (1934)
2. Assisting Low Income Renters (1937)
3. Improving the Physical, Social, Economic Health of Cities (1949)
4. Fighting discrimination in Housing Markets (1968)

5. Assisting Homeless Persons (1987)

(Thompson, 2006)

The federal government has funded subsidized housing for low income renters since the inception of the Housing Act of 1937, but the efforts to assist the homeless weren't implemented until 1987. Under the subsidized housing programs, qualified households typically pay 30% of their incomes toward their rent. The Federal government, through a HUD program, pays the rest. To be eligible for programs, people must meet applicable income limits, which vary by household size. Housing is subsidized when the government pays part of the tenant's rent or mortgage. To obtain subsidized housing, households must have a low or moderate income. Once an applicant is approved for the program, they will generally be put on a waiting list for assistance. The wait for a slot in the program can vary from two to four years (Thompson, 2006). A similar system developed to provide affordable housing was public housing. This type of housing is owned and run by a governmental body, such as a local Housing Authority. To be eligible to live in public housing, a person or family must have a low income and meet certain other stringent requirements. Rent and utilities are generally lower than in private housing, but the stringent restrictions and eligibility requirements keep certain segments of the population from being able to benefit from this service. Thus, another stream was implemented to provide housing to poor, elderly and low income applicants. It was developed under the HUD Housing Choice Vouchers program and the Rural Economic and Community Development Rental Assistance Program. In this program part of the rent of qualifying lower income households is paid by the government with the same income stipulations. The creation of the Housing Choice Vouchers can be project based

(e.g., a housing development where some or all units are partially paid by Housing Choice Vouchers) or client based where the voucher moves with the household. In this case, the voucher holder finds a private landlord willing to accept the certificate and work with the program (HUD.gov, 2006). There is a difference between 'subsidized housing' and what is referred to as 'affordable housing'. While subsidized housing involves monetary assistance with paying rent, the term affordable housing is used to describe housing that has been developed or purchased in a manner which allows rental costs or mortgage payments to stay at a lower rate. The various programs developed by HUD had merit and have been effective tools to provide housing for certain individuals who qualify based on income. However, these programs are not suitable for individuals who have no income and those who suffer from chronic homelessness with serious mental illness and in many cases substance abuse as well. Therefore, this type of housing remains affordable to households with lower incomes, but eludes those who are suffering from chronic mental illness and substance abuse.

The need for affordable housing continues to be problematic for homeless individuals. In the early 1980's the troubling social problem of homelessness increased and became highly visible in several cities throughout the United States (Thompson, 2006). So it became obvious that there was a need for a program that could address the unique service needs of this hard to reach population. This recognition of homelessness as a major social problem ushered in the type of homeless services that are presently being used today.

Martha R. Burt in her testimony to the Senate Banking, House and Urban Affairs Committee in 2006 observed that policy-oriented research on homeless populations and

homeless services systems in the early 1980's led to the implementation of the first Emergency Food and Shelter Program legislation passed in 1983. Since that time, homeless assistance has evolved, evidenced by three milestones of public policy making (Burt, 2006).

The first legislative action to impact homeless services was the passage of the Stewart B. McKinney Homeless Assistance Act of 1987. This act provided communities federal resources for transitional and permanent supportive housing and codified Emergency Shelter Grants and the Emergency Food and Shelter Programs. This led to the development of new programs like Shelter Plus Care and other resources under what eventually would become the McKinney-Vento Act. Burt further observes that the second legislative milestone came in 1996 when the 'Department of Housing and Urban Development of Special Needs Assistance Programs' established its Continuum of Care approach to disbursing the homeless assistance resources under its control. This policy had a major influence on the growth and integration of homeless services in communities throughout the United States. The third milestone, according to Burt's (2006) testimonial report, came in 2001 when the federal government adopted the goal of ending chronic homelessness in 10 years. This policy stimulated production of more permanent housing in every Continuum of Care program. Implementation and mobilization steps were activated in over 200 communities creating resources and structures targeted toward the chronically homeless population. The 2005 enactment of provision S 1801, The Community Partnership to End Homelessness Act, was implemented to move the country closer to achieving the goal to ending chronic homelessness (Burt, 2006). So what are the

reasons for the disproportionate rise in homelessness? And, what are some of the factors that have hindered the resolution of this problem?

Rise of Homelessness

Homelessness in the United States increased significantly in the late 1970's through 1980's due to housing and social service cuts. But the primary factor that resulted in the increase in chronic homelessness was Deinstitutionalization, a concept which was designed to move severely mentally ill individuals out of the large state hospitals and back into the community. This allowed for the closure of the large state mental hospitals, with the expectation that community services would be developed to provide follow up care for these patients. Deinstitutionalization began in 1955 with the widespread introduction of Thorazine, the first anti-psychotic medication (Torry, 2005). Many of the individuals who were treated with Thorazine and subsequently released from state facilities had chronic severe mental illnesses. Thus, this process perpetuated a mental health crisis in local neighborhoods and community mental health systems which lacked the infrastructure to provide the proper follow up rehabilitative services necessary to help reintegrate these consumers back into their communities.

Deinstitutionalization was one of the largest "social experiments" in U.S. history (Torry, 2005). The motivation behind this movement was a response to the deplorable conditions of state institutions and neglect of patients who were housed in state hospital wards. President John F. Kennedy's proposal for a national community mental health program was the catalyst behind the acceleration of this alternative for care. The number of inpatients in U.S. public mental health hospitals declined from 559,000 in 1955 to

approximately 110,000 in 1990 (see Appendix A). Deinstitutionalization was initiated in an era of social reform to protect the rights of the mentally ill. It was based on the principle that severe mental illness should be treated in a less restrictive setting. So this move toward community based psychiatric care became a reality, but it did not result in the outcomes policy makers expected. Deinstitutionalization actually further exacerbated the situation because once the state hospitals beds closed they were no longer available for people who later became mentally ill (Torry, 2005). The establishment of community care alternatives was highly inadequate leaving many severely and persistent mentally ill people without essential services. This referendum to close the state hospitals caused a fracture in the continuum of care that this author calls ‘the domino effect’.

The release of large numbers of patients from the state facilities back to an unsuspecting and unprepared community, helped to create a sub-culture of mentally ill individuals who were either under medicated or not medicated at all. This created an unbalanced level of care for the patient, a disservice to the community at large, and an increase in the chronic homeless population. As mental health care shifted from state psychiatric hospitals to the community, “the mental health system became inevitably involved in housing as it strove to meet the broader psychosocial needs of consumers” (O’Hara, 2007).

One study that was sponsored by Thomas Jefferson Hospital in Philadelphia, examined the mental health service utilization and costs of 321 patients discharged from state hospitals. Over a 3 year follow-up period they compared the costs after discharge to the cost to care for the same patients, if they had remained in the hospital. The study found that after a 3-year period following discharge, 20%-30% of the patients required

re-hospitalization, on an average of 76-91 days per year. All of the discharged patients received case management services, and a majority also received outpatient mental health care (66%-70%) and residential services (75%) throughout the follow-up period. The total treatment cost per person was approximately \$60,000 a year after controlling for inflation, with costs rising slightly over the 3-year period. The estimated cost of state hospitalization, with the use of 1992 estimates, would have been \$130,000 per year if the patients had remained institutionalized (Rothbard, Kuno, Schinnar, Hadley, Turk, 1999). The cost to deinstitutionalize the individuals overall was lower, but the resultant costs to the patient and to the community were high. Early attempts to provide services to the homeless had some major limitations:

1. A strong research base was absent and led to major flaws in policy implementation.
2. The chronically mentally ill are frequently poor advocates for themselves and without even the simplest needs fulfilled, end up homeless.
3. The homeless mentally ill require comprehensive support systems with assured continuity of care (Riesdorph, 1989).

The community mental health hospitals and the small number of established mental health centers were not prepared to handle the 'domino effects' created by the deinstitutionalization process, in which the number of patients released was greater than could be cared for with community resources. In addition to being unable to provide the appropriate level of care needed to treat the chronic mentally ill, the community service agencies also had to find appropriate housing for this population. Unfortunately, the community resources were limited in what they could offer and many of the homeless

had no family support, so many of these individuals fell through the cracks and usually ended up in what has become the “new asylum” (Torry, 2005). These patients ended up living on the street trying to find refuge on sidewalks, building steps, under bridges, in subway tunnels, train stations, bus stations, airports, etc. Some were able to find refuge in city shelters, safe havens, drop in centers and crowded tenements, but a disproportionate number of these vulnerable adults found themselves in jail/prison systems. The prison system very quickly became the major stream that the displaced severely mentally ill population had to navigate. An article in *Psychiatric Services* characterizes this phenomenon as the “institutional circuit” (Hooper, Jost, Hay, Welber & Haugland, 1997). The prisons inadvertently became the new lock wards for these consumers, birthing another ineffective alternative for many of the chronically homeless and mentally ill in cities across the nation.

The numbers of these severely mentally ill and now homeless individuals continued to grow at such a large rate, especially in the inner cities, that it became imperative that services had to be developed that could alleviate the great deprivations associated with being homeless, i.e. inappropriate clothing, lack of adequate shelter, poor nutrition, etc. In addition, limited access to medical and psychiatric treatment created a population of men and women who are poor physically and mentally. The causes of homelessness and the characteristics of the homeless differ greatly across subpopulations (Kligerman et al., 2010). Characteristics such as mental illness and substance abuse are often barriers to achieving stable, independent housing. In fact it is common to find that many of the street dwellers suffer from some sort of mental health diagnosis (Tsemberis,

1999). The Philadelphia Office of Supportive Housing (OSH) identifies these factors as some of the most challenging to overcome for homeless individuals (OSH, 2009).

In response to this larger mandate, the mental health system developed the plan that was based on the Continuum of Care. The continuum approach is not always the most effective method to meet the needs of these specific individuals, basically because “success is defined by treatment compliance, psychiatric stability, and abstinence from substance abuse, and is attributed to effective treatment (Henwood Stanhope & Padgett, 2010). Chronic homeless individuals with severe mental health problems have never been very successful in navigating a system solely based on behavior changes, thus the majority of these individuals will fail at some point during the continuum process and are at high risk of returning to the streets for refuge. This system is often referred to as the ‘Treatment First’ model. “Chronically homeless individuals may find it difficult to engage in a process of treatment without being housed” (Henwood et al., 2010).

In many cases, homeless adult individuals who participate in this model of care are often unwilling to stay on their psychiatric medications and are more likely to use drugs or alcohol again. The consequence for relapse in most cases results in the loss of their housing. Thus, this in many cases perpetuates a revolving door phenomenon, which thrusts the consumer into a continuous cycle from homelessness to housing and back to homelessness. In addition to creating a high recidivism rate, it also causes the consumers to distrust the very systems that were specifically designed to help alleviate the devastating effects of homelessness with the ultimate goal of providing permanent housing. This is just one of many reasons there has been increasing interest in the Housing First approach to homelessness, which aims to move the most vulnerable

homeless people directly from the street to permanent housing, without the transitional placement requirements.

In contrast, the Housing First model utilizes a supportive housing approach in which consumers begin their road to recovery with placement in permanent supportive housing (Henwood et al., 2010). After the consumer is placed, then a team of mental health professionals are assigned to provide psychiatric and medical services as needed. Clients who are resistant to services are still provided the housing, and the treatment efforts are tailored to fit the individual's willingness and readiness to participate in various treatment modalities. The Housing First model was designed to remove barriers to housing for the most vulnerable homeless individuals. Housing First programs consider housing needs paramount and separate from treatment needs (Pearson, Montgomery and Locke, 2009).

The Housing First/Harm Reduction model was first implemented in New York City in 1992. The name of this program is Pathways to Housing, Inc. The founder of Pathways to Housing, Dr. Sam Tsemberis, implemented this model of care in West Harlem. This program adapted the same treatment modality and principles that are associated with the Housing First model. The response and results were so effective, that the services quickly expanded to all five boroughs in New York City and later into Westchester County. The program has over 500 apartments that now house the same number of former homeless individuals. This same model was implemented in other cities that also had disproportionate numbers of homeless adult men and women. A program was established in Washington, DC in 2004 and Philadelphia in 2008. Most recently Pathways to Housing, Inc. was also established in the state of Vermont.

However, the focal point of this study is the Philadelphia chapter of Pathways to Housing, Inc. (PTH). The Philadelphia-PTH project has taken on the challenge to implement a plan to help alleviate the treatment obstacles and other problems that have prevented many chronically homeless mental ill consumers from receiving permanent housing in the city of Philadelphia.

OBJECTIVES

The city of Philadelphia is on the cutting edge of expanding its homeless services to reach the chronically homeless mentally ill individuals who have failed to succeed in the traditional models of care. This paper's primary goal is to compare the Housing First model to the Continuum of Care model, and evaluate which method of care is more effective in improving the lives of those it serves by moving them from the streets to housing; by helping them to stay housed and to non-intrusively connect them with the mental health services they need. Secondly to reduce the number of people living on the streets and to get them the help they need as soon as possible. Thirdly to examine the data to see if participation in Pathways to Housing – Philadelphia reduces the use of city-funded services thereby reducing cost across the systems. And, finally, to see if Pathways to Housing is a cost effective alternative as compared to other programs that serve a similar population.

OPTIONS

The city of Philadelphia's primary system of providing supportive housing is based on the concept of creating a 'Continuum of Care,' which seeks to help homeless people move through a sequence of stages before accessing permanent housing. For example, stage one is usually placement in an emergency homeless shelter for a designated period of time. The next stages toward permanent housing may vary in structure, but all are high demand and very structured. The limitations of this type of system are high demand expectations, overcrowding, hostile and unsafe environments, and the punitive consequence of not receiving or losing housing if they fail to meet all of the mandates. These variables alone would be a deterrent to anyone in need of shelter care, but for an individual who is homeless and is suffering from severe mental illness these types of shelter based programs become insurmountable obstacles. Many mental ill consumers have entered into a Continuum of Care system in hope of obtaining a safe and affordable housing opportunity. However, the disturbing news is that only a very small percentage will be able to navigate this high demand system and receive the prize, permanent housing.

Pathways to Housing established homeless services in Philadelphia in the summer of 2008. The mayor of Philadelphia, Michael Nutter, heard about the success of Pathways to Housing in New York, so he invited Pathways to Housing, Inc. to set up a similar model of care in the city of Philadelphia. Mayor Nutter realized there was a need to move people off the street to safe and more permanent housing (Kligerman et al., 2010). Dr. Sam Tsemberis and Christine Simiriglia, the Chief Operating Officer for Pathways-Philadelphia, collaborated with city agencies and mental health professionals to establish

Pathways to Housing, Inc. in Philadelphia. The initial contract with the city was to provide 125 chronic homeless adult individuals with scattered housing throughout the city.

The first Philadelphia client was housed October 2008, and from that first placement to now the response and outcomes have been phenomenal. Pathways to Housing-Philadelphia, has successfully housed over 118 single male and female clients, and a little over 85% of those housed remained in their apartments for an average of one year or more. The Housing First method differs from the conventional methods of providing housing with regards to some key characteristics. Housing First programs have no conditions of sobriety or supportive services. The key tenet of this method is that access to safe housing is the driving force. A central premise of Housing First is the acknowledgement that people will typically remain homeless, if access to housing is contingent upon completing treatment or programs (Stefancic & Tsemberis, 2007).

This model uses a method embedded in the concepts of the “low demand” philosophy that maintains that abstinence is not required as a condition for obtaining or retaining housing. Access to housing can then help consumers become less dependent on emergency systems and improve their mental health. Housing First provides necessary supports for a population that often has no other method of obtaining housing and it separates access to housing from services (Kligerman et al., 2010). In addition to improving consumer’s mental health, the Housing First program has also impacted consumer’s physical health awareness.

Pathways to Housing- Philadelphia developed a partnership with Thomas Jefferson University Health Systems and from that union were able to hire a medical

doctor one day a week to provide clients with medical consultations and an integrated healthcare team (Kligerman et al., 2010) to begin to look at consumer's medical awareness and care. The partnership with Jefferson revealed that the consumers had little knowledge of their own health care needs and this addition to the team has yielded some amazing results worth mentioning.

The clients who participated in a health care group expressed great benefit from the group experience. The research yielded data that can be used to improve the participants' personal health care and encourage other consumers to be more health conscious. This project yielded some fascinating truths that were captured in a video production, "Housing as a Road to Health Care" (Bones, 2010). A few select consumers who participated in this research project agreed to share their personal stories. Dr. Laura Weinstein MD, Ben Henwood, Clinical Director, an outside group counselor and a media production company worked closely with this group to help them identify their particular health needs.

The video production revealed how effective Housing First is not only to the participant's physical health, but how it helps promote healing mentally, emotionally and spiritually. Ben Henwood, Pathways to Housing's Clinical Coordinator, commented on the video, "I believe in the right to housing, but housing also functions as a health intervention that helps people maintain their health better" (Bones, 2010). Consumers are living on the streets with major health and psychiatric disorders. However, the time spent in just trying to survive the streets, the majority of the consumers are unable to maintain consistent medication regimens, keep doctor appointments or access the limited social service agencies that could offer some solutions to their dilemma. Providing permanent

supportive housing has proven to be an effective agent of change in this area. One participant in the video production encapsulated the essence of Housing First's primary care goal when he stated, "I was sick when I was in the street. You gave me a key and I'm still sick, but in a better place to do something about it. The healing starts every time I put that key in the door" (Bones, 2010). This statement captures the essence of Pathways to Housing mission to provide safe and affordable housing without condition.

ANALYSIS OF OPTIONS

Fairmount Ventures, a Philadelphia research team, found that Pathways to Housing- Philadelphia is less expensive per person than comparable programs for the same population. Pathways reduced the use of emergency services for the clients that are enrolled in the program resulting in significant savings for the City. In addition, the study found that these same clients had significant decreases in the following treatment areas:

- (1) Shelter episodes decreased by 88%.
- (2) Shelter nights decreased by 87%.
- (3) Crisis Response Center (CRC) visits decreased by 71%.
- (4) Mental Health Court petitions decreased by 11%.
- (5) Psychiatric hospitalizations decreased by 70%.
- (6) Psychiatric and Substance Abuse treatment days decreased by 46%.
- (7) Philadelphia Prison System incarcerations declined by 50%

(Kligerman et al., 2010)

In addition to major financial savings to the city, the establishment of Pathways to Housing, Philadelphia has helped to reduce the number of individuals living on the streets. It has created a safer environment for the homeless individual and has been instrumental in getting these consumers to participate in mental health and substance abuse treatment. It has proven to be more cost effective than the Continuum of Care model that is the primary model of care used by the majority of the homeless service providers in the city. The 125 clients targeted for service are minimal compared to the number of clients that remain on the streets. With expansion of the services, it will open

the door to offer the same opportunity and level of care to those who are still living on the streets of Philadelphia.

The city of Philadelphia's dominant homeless services system has been rooted in the concepts of the "Continuum of Care model since mid-1990. As mentioned before, this system requires that housing can only be obtained when an individual successfully moves through a sequence of housing and service models. In this system, consumers are gradually moved from shelter housing to a transitional housing situation and eventually into permanent housing. In marked contrast, the Housing First program reviewed in this study, Pathways to Housing-Philadelphia, provides consumers with immediate access to independent apartments and supportive services "without prerequisites for sobriety or participation in psychiatric treatment" (Tsemberis & Asmussen, 1999). Making independent housing the first service offered to consumers' leads to better engagement and retention because consumers receive the assistance that they feel is most relevant to resolving their problem (Howie the Harp, 1990).

Philadelphia was given a list with a total of 130 "service resistant", chronically homeless individuals in Philadelphia by the Department of Behavioral Health (DBH). The individuals were homeless with a history of mental illness as reported by shelter networks and outreach staff throughout the city. As of April 2010, Pathways had placed 117 of these targeted individuals into housing (Kligerman et al., 2010). This rate is impressive especially since this population of chronically homeless, dually diagnosed individuals are recognized as the most difficult to engage and hardest to house (see Appendix B).

By way of comparison, in 2009, the city of Philadelphia outreach efforts which include the Outreach Coordination Center and Homeless Cafes made contact with 4,506 unduplicated individuals of whom 33.5% were placed into a shelter or another program (DBH-MRS, 2010). Pathway's placement rate also compares favorably to the city of Philadelphia's Safe Haven and Chronically Homeless Drug and Alcohol Treatment Programs. Safe Havens offer low-demand residences for individuals living on the street and access to services for those who want them. In fiscal year 2009, the city had nine Safe Havens offering space to up to 204 people at any one time. In the same fiscal year, 566 people left Safe Havens. Of those only 34% moved into a positive situation (DBH-MRS, 2010).

The city's Chronically Homeless Drug and Alcohol programs provide residential substance abuse and co-occurring treatment services for 60 chronically homeless individuals at any one time. However, to qualify for services an individual must stay in this type of program for six month to one year. This is a perfect example of a high-demand program, because in order to receive "subsidized permanent housing" the individual must successfully graduate from the program (see Appendix C).

The results of the Philadelphia- Pathways to Housing program in providing permanent supportive housing to adult homeless individuals in Philadelphia are very impressive. However, the other streams of homeless service providers and mental health professionals in the city initially were apprehensive about Pathways to Housing's mission of providing consumers with permanent housing without condition. This author was also skeptical about this system of care, after being trained and working in the Continuum of Care service model for a number of years. Despite the initial skepticism, after being

introduced to the ideals of the Housing First model and the success that had already been achieved in New York City and other cities; I was offered and accepted a position in the Pathways to Housing-Philadelphia pilot program. I joined the staff at the inception of the program in 2008, and over the past two years I have become a believer, and am now a passionate advocate of the Housing First model of care. The lives that have been changed and the positive results I have personally observed outweigh the negative experiences that come naturally with this diverse group of individuals. Despite some failures for a small percentage of the consumers assigned to this unique service model, the success stories are amazing and cannot be minimized.

The cost effectiveness is another compelling reason to maintain this program's funding stream. When compared to other streams of care Housing First is a cost effective model. The average cost to house one consumer is approximately \$57.00 per day (see Appendix D). The expansion of this program could very well be the catalyst that could help this city to achieve the legislative policy goal stated in 2001, which was to "end homelessness in 10 years" (Burt, 2006). In order to successfully reach this goal, Pathways to Housing, Inc. role as a 'Housing First' provider in the city of Philadelphia must play an intricate part. .

RECOMMENDATIONS

The research confirms that Pathways to Housing has been successful, but it would be incorrect to imply that 'Housing First' is the best system of care for all adult homeless individuals who are mentally ill and have a co-occurring drug addiction diagnosis. I contend that there has to be a cooperative use of all the services to generate the best outcomes. In both Housing First and Continuum of Care programs, housing and services have to come together in order to improve client outcomes (Henwood et al., 2010). This is an attitude that has to become an important part of the entire process. Since no one has all the answers, inter-agency sharing of ideas and experiences will help providers to identify what methods are working and what are not. . The wall of separation created by differing opinions has created an obstacle of tunnel vision that ultimately affects recovery outcomes. The ability to draw from both models will enhance the homeless services' ability to provide the level and quality of care to the consumers that require these services. The results of the Philadelphia- Pathways to Housing program in providing permanent supportive housing to adult homeless individuals in Philadelphia cannot be disputed. The present Housing First services must be maintained to make sure that the participants who have improved their quality of life not be catapulted back into a state of homelessness. In addition, there is a definite need to plan for future expansion without jeopardizing other homeless services in the city.

In recent years research has proven that no one system of care to provide permanent supportive housing to all people is a viable expectation. We are all individuals and to try and lump everyone into the same system expecting the same results is not realistic. The reasons why one method of care may be effective with one group and fail to

impact another group is most likely related to varying backgrounds, diagnoses, and cultural diversity (Tsemberis, 2004). In many cases different goals and expectations may be a determining factor. So it seems reasonable to say that there needs to be other streams of care available to meet the individual needs of each person suffering the varying ill effects of homelessness and mental illness. Pathways to Housing methods are only one of the treatment streams that can provide an effective intervention for individuals that suffer from chronic homelessness. It is imperative that the other treatment streams continue be maintained and their funding remains intact.

It is a fact that not every consumer will benefit from Housing First. So to address this problem effectively, the homeless care services will need to work together. Both models will need to function like primary doctors and specialists do in the medical system. When a patient presents a medical problem beyond the primary caregiver's scope of practice, they immediately make a referral to a specialist. I believe that the Continuum of Care and Housing First models can co-exist together and together can impact the lives of individuals that are still on the streets and in need of permanent housing. The diversity of the homeless population in Philadelphia demands that both systems remain intact.

The statistics presented earlier confirm that the "Continuum of Care" model works for a certain section of the homeless population and also confirms the effectiveness of "Housing First" in engaging those individuals that have resisted or just couldn't survive in a system that is based on merits and rewards. The expansion of funding for Pathways to Housing is imperative to fulfill the Mayor's vision to eradicate homelessness in Philadelphia, but it must be additional funding, because cutting one program's funding to increase another will only weaken the city's homeless services structure. Expanding

both the homeless service models in the city of Philadelphia would better equip mental health professionals to house more of the chronic adult individuals who are still caught in the complex net of homelessness. However, there are some other ideas that apply directly to the Housing First model that could be instrumental in attaining even greater success helping consumers maintain their housing over longer periods of time.

The need for more support once the consumer is housed is a consideration that must be explored. Both housing streams would benefit by adding a service that specifically addresses the various problems consumers struggle with around Activities of Daily Living (ADLs). ADLs consist of the routine activities that an individual does for himself during the course of the day, such as eating, drinking, washing, cleaning, medication management, and the managing of finances (Geron, 2002). It is not uncommon to find that individuals who suffer from chronic homelessness and mental illness lack many of these life skills. Consequently, the absence of these basic skills becomes an obstacle for many consumers who are placed into permanent supportive housing situations; and in many cases they end up losing their housing. The use of Service Coordinators (Case Managers) to provide the client with this level of care is not a reasonable expectation. The reason being that due to the varied type of clients served by Housing First programs, Service Coordinators are continually dealing with one crisis situation after another, and that doesn't leave much time to focus on assisting clients' with their ADLs. This lack of attention to these life skill areas creates an environment where many consumers live in conditions that are not sanitary or healthy for the participant. This type of service is something that has to be implemented initially and continued throughout the placement process.

The Continuum of Care model already has a mechanism in place to provide this type of pre-housing education to consumers as they naturally move through the various stages of the continuum. However, it is still an issue that many of the consumers struggle with even after they come to the end of the continuum and are finally placed in an independent housing situation. Housing First consumers face this dilemma more frequently because most of the consumers targeted for supportive permanent housing are too sick to manage their own ADLs or in many cases do not possess the adequate skills. One reason that many of the chronic homeless individuals lack ADL skills is because many have never had the experience of living alone in an independent housing setting. The reality is that the skills the client used on the street to survive often follow them into their housing placement. Many of them have no reference point to draw from in the area of maintaining an apartment, so in many cases the mentality of life experienced on the street follows the consumer into their new environment. One example of this is evidenced in one Pathways to Housing- Philadelphia participant's experience.

This particular consumer has been successfully housed for 23 months, but the participant has never slept in the bed provided by the program, and has preferred to sleep on the floor on a stack of folded cardboard boxes. In addition to this behavior, whenever the clinical staff transports the same participant to the store or to a doctor's appointment the participant will not leave the apartment unless they can take all of their belongings with them (PTH-Phila., 2010). This example clearly demonstrates how certain street survival behaviors remain intact and in most cases becomes an obstacle to change. This true life scenario is indicative of many other participant experiences that demonstrate the various difficulties many consumers face when they try to change how they think and

behave in a new environment. Unfortunately, these types of behaviors are sometimes so deeply embedded that it will take a lengthy period of time to help motivate lifestyle changes in this area. So, the implementation of another stream of service designed to teach ADLs could be the catalyst to help the participant to successfully transition from the familiar street lifestyle to appropriate behavior that will help the participant maintain their apartment in a safe and sanitary condition. Having worked in both streams of care, this is a problematic area of concern that creates a fracture that will affect treatment outcomes in a negative way; and only by closing this gap will we be able to see greater results overall.

The final option to be proposed is the development of a few scattered temporary placement sites that could be designated as interim housing options. The reason this type of option is important because the process of securing permanent supportive housing is subject to several variables that could negatively affect placement. Some of these variables are related to landlord preparation time, followed by a city inspection to determine the safety and condition of an apartment. This process could take a week or more in some cases. Then there is a period of time needed for lease signing, furniture delivery, etc. and all of these factors can delay the process even longer. During this transitional period too much time passes between engagements, and the consumer may disappear and cannot be located when the targeted apartment is ready for habitation. So, when a consumer is engaged on the street and agrees to participate in the Housing First program, it is imperative that a place is available that could be offered as a temporary placement. Without this type of option, this could cause the consumer to become suspicious of the program's intentions and they may end up refusing the services.

Many of the consumers engaged are too sick to comprehend the bureaucratic intricacies associated with obtaining and securing an apartment, and will not always understand the reasons for the delay. This time gap could deteriorate future relationships with the consumer. The development of temporary transitional apartments allows the mental health professional to offer the consumer another option for housing that will immediately remove them from the street into a safe and secure environment. It will keep them connected to the program until their permanent apartment is ready for habitation. It will also provide the stability of a secure apartment and the independence afforded when one has their own place (Atherton, Nicholisis, 2008). With this option the reality of permanent housing is realized, even during a temporary housing experience.

Additionally, these interim sites could also be used to house consumers temporarily who have to move due to certain behavior problems that have been identified as being disruptive or destructive. This becomes more relevant when the landlord is aware of these problems and will not renew the lease or moves to terminate the lease by filing for eviction. The program data collected, between October 2008 to October 2010, supports the need for a temporary housing option plan. The data shows that of the 118 consumers placed during this period of time, 40 consumers were moved at least once. Of the 40 who were moved during this two year period, 12 were moved two times or more in the same period (PTH-Phila., 2010). So, considering the particular challenges this population of homeless individuals face in maintaining their housing a transitional site would be useful on both ends of the process.

These recommendations should be taken into consideration when these policies are reviewed and discussed in budgetary review meetings. It is imperative that the city

extend and expand the funding for Pathways to Housing Inc., and at the same time continue funding for the existing traditional models of care. This will insure that a holistic system of homeless services are accessible to all chronic homeless individuals regardless of where they are positioned on the continuum of care scale.

Appendix A

APPENDIX A					
STATE	Patients in Public Mental Hospitals Dec. 31, 1955	Patients in Public Mental Hospitals Dec. 31, 1994 +	Actual Deinstitutionalization Rate (percent)	Theoretical Number of Patients in Public Mental Hospitals in 1994, Based on Population Change since 1955 #	Effective Deinstitutionalization Rate (percent)
Rhode Island	3,442	63	98.2	4,156	98.5
New Hampshire	2,733	137	95	5,514	97.5
Arkansas	5,086	183	96.4	7,203	97.5
Vermont	1,294	63	95.1	1,975	96.8
Massachusetts	23,178	793	96.6	23,889	96.7
West Virginia	5,619	224	96	5,410	95.9
California	37,211	9,814	89.8	91,641	95.8
Wisconsin	14,981	891	94.1	20,680	95.7
Ohio	28,663	1,849	93.5	35,273	94.8
Colorado	5,720	775	86.5	13,470	94.2
Oklahoma	8,014	675	91.6	11,575	94.2
Illinois	37,883	2,845	92.5	47,153	94
Idaho	1,221	138	88.7	2,225	93.8
Kentucky	7,700	645	91.6	10,108	93.6
Arizona	1,690	462	72.7	6,947	93.3
Missouri	12,021	1,109	90.8	15,339	92.8
Montana	1,919	196	89.8	2,579	92.4
Connecticut	8,668	958	88.9	12,324	92.2
South Carolina	6,042	830	86.3	10,052	91.7
Texas	16,445	2,930	82.2	34,883	91.6
Washington	7,631	1,330	82.6	15,060	91.2
Indiana	11,151	1,320	88.2	14,706	91
Louisiana	8,271	1,091	86.8	12,084	91
Florida	8,026	2,766	65.5	29,857	90.7
Oregon	4,886	855	82.5	9,066	90.6

1A

Minnesota	11,449	1,593	86.1	16,469	90.3
Tennessee	7,693	1,142	85.2	11,629	90.2

Iowa	5,336	513	90.4	5,217	90.2
Utah	1,337	326	75.6	3,257	90
New York	96,664	11,286	88.3	109,980	89.7
North Dakota	1,993	213	89.3	2,057	89.6
New Mexico	950	209	78	1,984	89.5
Nebraska	4,788	599	87.5	5,662	89.4
New Jersey	22,262	3,405	84.7	31,976	89.4
Pennsylvania	40,920	4,787	88.3	45,072	89.4
Maryland	9,273	1,820	80.4	17,236	89.4
Maine	2,996	440	85.3	3,995	89
Virginia	11,303	2,540	77.5	20,796	87.8
Michigan	21,798	3,711	83	28,415	86.9
North Carolina	9,960	2,703	77.9	16,608	86.7
Georgia	11,701	3,239	72.3	22,663	85.7
Wyoming	655	147	77.6	1,014	85.5
Kansas	4,420	883	80	5,393	83.6
Alabama	7,197	1,649	77.1	9,934	83.4
Mississippi	5,295	1,208	77.2	6,837	82.3
South Dakota	1,603	317	80.2	1,749	81.9
Delaware	1,393	539	61.3	2,536	78.7
Washington, DC	7,318	1,148	84.3	5,280	78.3
Nevada	440	760	72.7	2,658	71.4
Totals	558,239	71,619	82	821,586	91.3

*Table shows the variation in state and county hospitalizations between December 31, 1955 to December 31, 1994 in 48 states and the District of Columbia.

Extracted from article "Deinstitutionalization: special Reports: A Psychiatric Titanic on November 28, 2010.

<http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html>

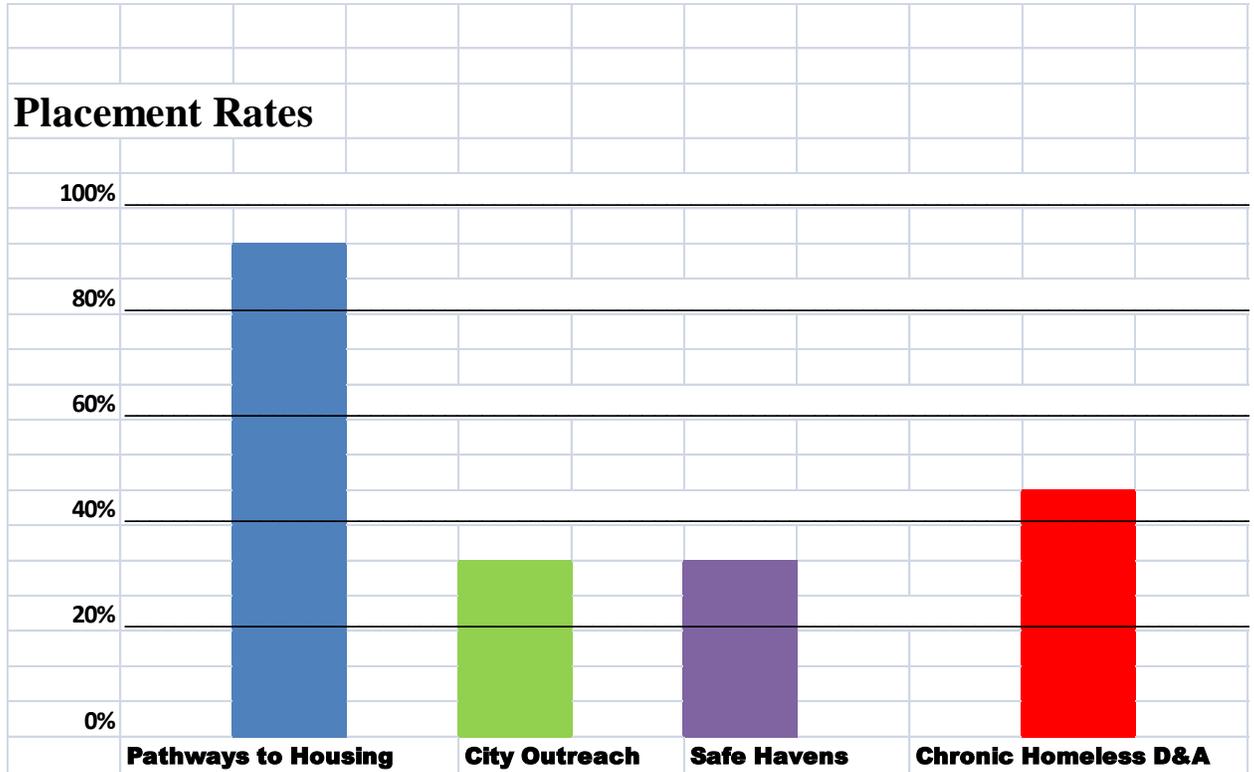
Appendix B

Status of Outreach Contacts

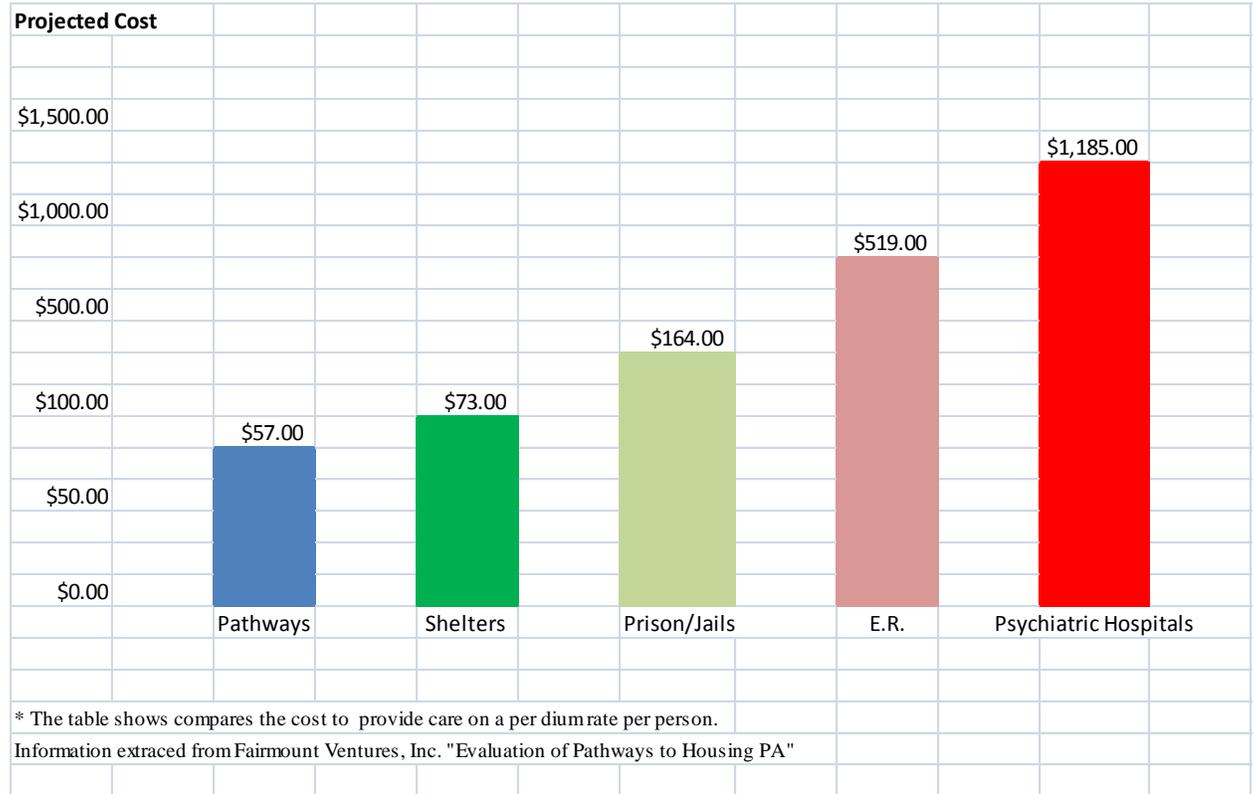
Refused Services	7
Incarcerated	1
Unable to Locate	2
Moved out of State	1
Moved to Residential Housing	2
Placed in Housing	117
Total	130

*Extracted from Fairmount Ventures, Inc. Evaluation of Pathways to Housing, Inc. PA

Appendix C



Appendix D



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**Some statistical information and client information were obtained directly from Pathways to Housing, Inc., Philadelphia staff and program client data bases. This information will be cited as (PTH-Phila., 2010).*