

BRIEF REPORT

The Impact of Housing First and Peer Support on People Who Are Medically Vulnerable and Homeless

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Objective: The purpose of this study was to assess the impact of a local initiative, Project H3, which used housing first, harm reduction, and peer support models to provide housing for 47 homeless people who were medically vulnerable. **Method:** Comparisons of interviews with participants who were housed at the day of their move-in, and 6-months and 12-months after their move-in, were conducted. **Results:** Ninety-eight percent of the participants remained in housing after 12 months. Individuals who were housed reported significant increases in their access to and utilization of planned health care services and quality of life, and reductions in their involvement in the criminal justice system. **Conclusion and Implications for Practice:** Housing first, harm reduction, and peer support models demonstrate effectiveness in decreasing substance use and improving the quality of life of people who are homeless over time.

Keywords: homeless, housing first, harm reduction, peer support

People experiencing homelessness contend with mental illness, substance abuse, and serious physical ailments (Hwang, 2001; National Alliance to End Homelessness, 2007). Homelessness is a risk factor for death (Morrison, 2009). Housing-first, harm reduction, and peer support models, which are approaches often used together, have demonstrated efficacy in improving outcomes for people who are homeless (Padgett, Gulcer, & Tsemberis, 2006). The housing-first model ranks stable housing as the first and highest priority (Padgett et al., 2006). Harm-reduction aims to reduce adverse consequences of drug abuse, but does not require that people stop using drugs (Davidson, Chinman, Sells, & Rowe, 2006). Peer support uses specialists who have a history of homelessness, mental illness, or substance abuse and who are in recovery and offer supports to people who are not far along in their recovery (Besio & Mahler, 1993).

The 100,000 Homes Campaign, a national initiative to prioritize housing for the most medically vulnerable and homeless, inspired Project H3: Homes, Health, Hope in Phoenix, Arizona. Project H3 conducted surveys with 260 people who were living on the streets to assess for medical vulnerability, which was the presence of tri-morbidity (mental health problem, physical health problem, and

substance abuse problem), more than three hospitalizations in the last year or three emergency room visits in the past three months, aged 60 years or older, HIV/AIDS, cirrhosis of the liver, kidney disease/renal disease or dialysis, or cold weather injuries. These conditions are associated with premature death among people who were homeless (Hwang, 2001). Project H3 used housing-first, harm reduction, and peer support to provide housing for medically vulnerable people in scattered site apartments. In this article, we describe a longitudinal evaluation of Project H3, including housing retention and participants' self-report of quality of life, mental health, substance use, health care, and interactions with law enforcement over one year.

Method

The 47 participants who received housing and peer support by Project H3 completed structured surveys at the day of their move-in and 6-months and 12-months after their move-in. Measures on the survey are displayed in Table 2. Measures included the World Health Organization Quality of Life Scale (WHOQOL Group, 1998). The Phoenix Police Department also provided arrest data on the participants who completed a 12-month follow-up. Only participants who had either a move-in and 6-month survey completed ($n = 20$, 42.5% of all Project H3 participants), or a 6-month and 12-month survey completed ($n = 18$, 38.3% of all Project H3 participants), were included. Missing data are common for dually diagnosed clients and homeless individuals (Padgett et al., 2006). It should be noted that the sociodemographic characteristics of those who participated was very similar to those who did not participate. t tests and nonparametric sign tests were used to analyze changes over time. The Cronbach alpha measuring reliability on the quality of life scales ranged from 0.68 on the

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social relationships domain to 0.78 on the psychological domain, indicating medium to good reliability.

Results

Ninety-eight percent of participants remained in housing after 12 months. Descriptions of the participants are displayed

in Table 1. Table 2 displays results of the bivariate analyses between baseline and 6 months. Statistically significant changes in participants' report of substance use, quality of life, and use of primary care physicians were found between baseline and 6 months. Significant reductions in participants' report of going to jail and prison between move-in and 6 months were found.

Table 1
Description of Participants

| | Move-in and 6-month Sample (n = 20) | | 6-month and 12-month Sample (n = 180) | |
|--|--|---------------|--|---------------|
| | Mean (SD) | Frequency (%) | Mean (SD) | Frequency (%) |
| Age | 53.85 (7.03) | | 56.06 (6.04) | |
| Years homeless | 9.18 (7.26) | | 11.91 (9.89) | |
| Gender | | | | |
| Male | | 18 (90.0) | | 13 (72.2) |
| Female | | 2 (10.0) | | 5 (27.8) |
| Race | | | | |
| White | | 12 (60.0) | | 10 (55.6) |
| Black | | 4 (20.0) | | 4 (22.2) |
| Native American | | 3 (15.0) | | 3 (16.7) |
| Latino | | 1 (5.0) | | 1 (5.6) |
| Veteran | | | | |
| Yes | | 7 (35.0) | | 4 (22.2) |
| No | | 13 (65.0) | | 14 (77.8) |
| Brain injury | | | | |
| Yes | | 7 (36.8) | | 4 (22.2) |
| No | | 12 (63.2) | | 13 (72.2) |
| Missing | | | | 1 (5.6) |
| Sleep most frequently | | | | |
| Streets | | 14 (73.7) | | 13 (76.5) |
| Shelters | | 3 (15.8) | | 2 (11.8) |
| Other | | 2 (10.5) | | 2 (1.8) |
| Received treatment for mental health | | | | |
| Yes | | 7 (35.0) | | 9 (50.0) |
| No | | 12 (60.0) | | 8 (44.4) |
| Missing | | 1 (5.0) | | 1 (5.6) |
| Taken to hospital against own will | | | | |
| Yes | | 3 (15.0) | | 5 (31.3) |
| No | | 15 (75.0) | | 11 (68.8) |
| Missing | | 1 (10.0) | | 2 (11.1) |
| Abused drugs/alcohol | | | | |
| Yes | | 17 (85.0) | | 13 (72.2) |
| No | | 2 (10.0) | | 4 (22.2) |
| Missing | | 1 (5.0) | | 1 (5.6) |
| Consumed alcohol everyday for last month | | | | |
| Yes | | 4 (20.0) | | 1 (16.7) |
| No | | 16 (80.0) | | 5 (83.3) |
| Used injection drugs/shot | | | | |
| Yes | | 7 (35.0) | | 5 (27.8) |
| No | | 12 (60.0) | | 12 (70.6) |
| Missing | | 1 (5.0) | | 1 (5.6) |
| Received treatment for substance abuse | | | | |
| Yes | | 11 (55.0) | | 9 (52.9) |
| No | | 7 (35.0) | | 8 (47.1) |
| Missing | | 1 (10.0) | | 1 (5.6) |
| Times in the ER in the last 3 mos. | 0.94 (1.73) | | 1.52 (1.94) | |
| Times hospitalized as inpatient last yr. | 0.61 (0.84) | | 1.47 (1.84) | |
| Ever been to jail | | | | |
| Yes | | 16 (80.0) | | 14 (77.8) |
| No | | 3 (15.0) | | 3 (16.7) |
| Missing | | 1 (5.0) | | 1 (5.6) |
| Ever been to prison | | | | |
| Yes | | 8 (40.0) | | 3 (17.6) |
| No | | 11 (55.0) | | 14 (82.4) |
| Missing | | 1 (5.0) | | 1 (5.6) |

Table 2
Bivariate Analyses Between Self-Report Data From Baseline and 6 Months (n = 20)

| Variable | Baseline <i>M</i> (<i>SD</i>) | 6-month <i>M</i> (<i>SD</i>) | <i>t</i> | <i>p</i> | |
|------------------------------------|---------------------------------|--------------------------------|----------|----------|----------|
| QOL | | | | | |
| Physical | 3.08 (0.82) | 3.51 (0.65) | -2.96 | .008*** | |
| Psychological | 3.29 (0.87) | 3.66 (0.72) | -2.13 | 0.05* | |
| Social Relationships | 3.19 (0.98) | 3.62 (0.87) | -2.13 | 0.05* | |
| Environment | 2.75 (0.69) | 3.66 (0.67) | -4.16 | .001*** | |
| Health visit planned ahead of time | 3.05 (5.33) | 2.84 (4.21) | 0.17 | 0.87 | |
| ER visits | 1.63 (4.52) | 0.36 (0.68) | 1.32 | 0.20 | |
| Hospitalizations | 1.36 (4.56) | 0.16 (0.50) | 1.28 | 0.22 | |
| | <u>Baseline frequency (%)</u> | <u>6-month frequency (%)</u> | - | + | <i>p</i> |
| Diagnosed with a mental illness | 5 (25.0) | 8 (42.1) | 1 | 4 | 0.38 |
| Received mental health treatment | 4 (20.0) | 5 (25.0) | 1 | 2 | 1.00 |
| Taken to hospital against own will | 2 (10.0) | 0 (0.0) | 2 | 0 | 0.50 |
| Consumed alcohol everyday | 4 (20.0) | 2 (10.0) | 2 | 1 | 0.63 |
| Abused drugs/alcohol | 14 (70.0) | 5 (25.0) | 9 | 0 | .004*** |
| Used injection drugs/shots | 3 (15.0) | 1 (5.0) | 2 | 0 | 0.50 |
| Treated for substance abuse | 3 (15.0) | 5 (25.0) | 3 | 2 | 1.00 |
| Usually go for healthcare | | | | | |
| Nowhere | 6 (33.3) | 3 (21.4) | 1 | 7 | 0.07* |
| Hospital/ER | 6 (33.3) | 2 (11.1) | | | |
| HCH | 3 (16.7) | 1 (7.1) | | | |
| PCP/VA | 3 (16.7) | 8 (57.1) | | | |
| Been to jail | 19 (95.0) | 3 (15.0) | 16 | 0 | .000*** |
| Been to prison | 9 (45.0) | 0 (0.0) | 9 | 0 | .004*** |

Note. HCH indicates healthcare for the homeless.

* $p < .10$. ** $p < .05$. *** $p < .01$.

Parallel arrest data provided by the Phoenix Police Department showed statistically significant decreases in participants' arrests 12 months before receiving housing ($M = 2.05$, $SD = 1.04$) and 12 months after receiving housing ($M = 0.50$, $SD = 1.24$), $t = 3.24$, $p < .01$. Analyses between 6 and 12 months are not displayed, because no statistically significant changes occurred over that time.

Discussion

This report summarizes the process and results of a local manifestation of a national campaign to provide housing to chronically homeless individuals. The initiative conducted street surveys of approximately 260 chronically homeless and subsequently housed 47 of these individuals who were deemed to be the most medically chronically homeless. Individuals who were housed reported significant increases in their access to and utilization of planned health care services, enhancements in their quality of life, and reductions in their involvement in the criminal justice system. These outcomes were most pronounced during the first six months of housing, although nonstatistically significant trends continued to be observed during the 6–12 month period of housing. This indicates that intensive support for people who are homeless when they first move into scattered site housing may result in early client independence and positive outcomes. These findings provide evidence of and support for the service principles of housing first, harm reduction, and peer support.

Conclusion

Prioritizing housing for people who are medically vulnerable has the potential to improve people's health status, use of preven-

tative medical services, and interactions with law enforcement. In addition, housing first, harm reduction, and peer support models demonstrate efficacy of decreasing substance use and improving the quality of life of people who are homeless over time. Shelters and housing services could incorporate assessments of medical vulnerability to help prioritize housing placement. Future research should assess the efficacy of prioritization of housing people by medical vulnerability, housing first, harm reduction, and peer navigation with a control group and larger sample sizes.

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