Health Equity: Permanent Supportive Housing with Housing First (Housing First Programs)

Community Preventive Services Task Force
Finding and Rationale Statement
Ratified June 2019

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CPSTF Finding and Rationale Statement

Context
Each year in the United States, an estimated 1.4 million people stay in a homeless shelter at least once, and many others who are homeless do not use shelters (U.S. Department of Housing and Urban Development [HUD], 2018). Homelessness is associated with lower income and is more common among racial and ethnic minority populations (HUD, 2018).

Homelessness is associated with multiple health problems, increased mortality, and increased use of health care and other services (Caton et al., 2007). Approximately half (49.2%) of the people experiencing homelessness have a disabling condition, which the Department of Housing and Urban Development defines as having limitations in conducting daily life activities, or in working or living independently, or having a diagnosis of HIV infection (including AIDS; HUD, 2018).

In the United States, the standard approach to serving people who are experiencing homelessness and have a disability is referred to as “Treatment First,” or “continuum of care” (National Academies of Sciences, Engineering, and Medicine, 2018). The underlying premise is that, in the absence of treatment and sobriety, these individuals or families are not capable of maintaining a home, and their health and other conditions might worsen if given housing. Treatment First approaches maintain that clients must take steps, including treatment and sobriety, to become “housing ready” before they are given permanent supportive housing. Often with these programs, maintenance of housing is contingent on sobriety and treatment.

In contrast, Permanent Supportive Housing with Housing First (hereafter, the Housing First Program) proposes that homeless individuals or families (at least one of whom has a disability) are capable of maintaining a home when provided the opportunity along with a range of services (National Academies of Sciences, Engineering, and Medicine, 2018). It is assumed that once people are housed and offered services, their health, social situation, and quality of life will improve. The systematic review described below evaluated the effectiveness of the Housing First Program compared with treatment as usual and Treatment First.

Intervention Definition
Housing First Programs provide regular, subsidized, time-unlimited housing to individuals and families in which the head of household has a disabling condition, which may include mental health or substance use disorders, work-related disability, difficulties in independent living, and HIV infection. Clients are not required to be “housing ready,” i.e., substance free or in treatment. Once housed, they are encouraged, but not required, to maintain sobriety to keep their home. Clients may choose among housing alternatives and available services. Most options require meeting HUD housing standards as well as standards of accessibility and reasonable accommodation.

Housing First Programs offer clients a range of services to support housing stability, including one or more of the following: help with housing (e.g., assistance getting furniture and training in money management, including rent), health care, mental health services, treatment for substance use disorder, peer support, occupational therapy, and employment counseling.

Programs may vary in terms of types of housing offered (grouped vs. scattered), meeting requirements (client with case-worker), tailoring to client needs, and monitoring program fidelity.
**CPSTF Finding (June 2019)**

The Community Preventive Services Task Force (CPSTF) recommends Permanent Supportive Housing with Housing First (hereafter, Housing First Programs) based on strong evidence of effectiveness in decreasing homelessness, increasing housing stability, and improving the quality of life for people who are experiencing homelessness and have a disability. For clients living with HIV infection, Housing First Programs improve clinical indicators and physical and mental health, and reduce mortality. Housing First Programs also lead to reduced hospitalization and use of emergency departments for homeless persons with disabilities, including those with HIV infection.

Because homelessness is associated with lower income and is more common among racial and ethnic minority populations, Housing First Programs are likely to advance health equity.

**Rationale**

**Basis of Finding**

The CPSTF recommendation is based on evidence from a systematic review of 26 studies (in 65 papers, search period through February 2018) that met inclusion criteria. Included studies evaluated intervention effects on one or more of the following outcomes: housing stability, physical health, mental health, substance use, quality of life and community integration,* health care use, and mortality. Data for populations living with and without HIV infection were analyzed separately. All studies had a comparison group; 8 studies had randomized control design. Among the 16 studies reporting follow-up, the median duration was 24 months (interquartile interval: 12 months to 24 months). Table 1 shows results for outcomes assessed.

**Table 1: Depression and Anxiety Symptoms, Overall and U.S. Studies**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Relative Difference, Favorability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clients with a disability, not including those living with HIV infection</strong></td>
<td></td>
</tr>
<tr>
<td>Housing Stability</td>
<td></td>
</tr>
<tr>
<td>Compared with treatment as usual (8 studies)</td>
<td>128.1% (IQI: 27.0 to 632.2%), favorable</td>
</tr>
<tr>
<td>Compared with Treatment First (5 studies)</td>
<td>30.7% (IQI: 15.9% to 64.3%), favorable</td>
</tr>
<tr>
<td>Homelessness (5 studies)</td>
<td>-88.4% (IQI: -58.7% to -90.1%), favorable</td>
</tr>
<tr>
<td>Quality of Life (4 studies)</td>
<td>4.9% (Range: 2.0% to 9.9%), favorable</td>
</tr>
<tr>
<td>Community integration* (3 studies)</td>
<td>14.0% (Range: 1.4% to 227.3%), favorable</td>
</tr>
<tr>
<td>Physical health (2 studies)</td>
<td>1.6% (IQI: -0.2% and 3.3%), negligible change observed</td>
</tr>
<tr>
<td>Mental health (5 studies)</td>
<td>-2% (IQI: -5% to 4%), no change observed</td>
</tr>
<tr>
<td>Substance use</td>
<td></td>
</tr>
<tr>
<td>Alcohol use (5 studies)</td>
<td>10.0% (IQI: -66.0% to 46.0%), no change observed</td>
</tr>
<tr>
<td>Illegal drug use (3 studies)</td>
<td>10.9% (Range: -1.2% to 64.3%), no change observed</td>
</tr>
<tr>
<td>Alcohol use and drug use (1 study)</td>
<td>-71.0%, favorable</td>
</tr>
</tbody>
</table>
### Outcome and Relative Difference, Favorability

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Relative Difference, Favorability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Use</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Use (3 studies)</td>
<td>-5.0% (Range: -65.2 to 20.0%), favorable</td>
</tr>
<tr>
<td>Hospitalization (2 studies)</td>
<td>-36.2% and -6.8%, favorable</td>
</tr>
<tr>
<td><strong>Clients living with HIV infection</strong></td>
<td></td>
</tr>
<tr>
<td>Housing Stability (1 study)</td>
<td>63.0%, favorable</td>
</tr>
<tr>
<td>Homelessness (1 study)</td>
<td>-37.0%, favorable</td>
</tr>
<tr>
<td>Physical health (viral load or opportunistic infection; SF-36 physical health score; 2 studies with multiple measures)</td>
<td>-21.7 (Range: -31.8% to -4.3%), favorable</td>
</tr>
<tr>
<td>Mental health (perceived stress, depression scale score, mental health problems; 1 study with multiple measures)</td>
<td>-13.0% (Range: -21.7% to -10.0%), favorable</td>
</tr>
<tr>
<td>Mortality (2 studies)</td>
<td>-42.0% and -32.0%, favorable</td>
</tr>
<tr>
<td>Health Care Use</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Use (1 study)</td>
<td>-40.5%, favorable</td>
</tr>
<tr>
<td>Hospitalization (1 study)</td>
<td>-36.2%, favorable</td>
</tr>
</tbody>
</table>

IQI = interquartile interval  
Range = (when fewer than 5 studies, the range is reported)  
* Community integration: Extent to which an individual lives, participates, and socializes in his/her community, measured, for example, in the Wisconsin Quality of Life Index.

Among populations not living with HIV infection, there was no difference in mental health, physical health, and substance use outcomes between clients in intervention vs. control groups. Analysis of mental health changes in intervention and control groups showed comparable improvement for both. For these outcomes, there is no apparent incremental health benefit associated with Housing First Programs. However, for disabled clients, both with and without HIV infection, there were substantial reductions in emergency department use and hospitalization associated with Housing First Programs.

### Applicability and Generalizability Considerations

**Intervention Settings**

Studies of programs were implemented in urban (24 studies), suburban (1 study), or a mix of urban and suburban (1 study) settings across the United States (23 studies) and Canada (3 studies). Most programs were implemented in large cities (18 studies). None of the included studies were conducted in rural settings. Interventions were effective across settings examined.

**Population Characteristics**

Many of the programs evaluated in the included studies limited participation to those with a mental health disorder (13 studies) or substance use disorder (11 studies). Some studies limited participation to veterans with identified needs (2
studies), or people who had a diagnosis of HIV infection (3 studies), had a work-limiting disability (1 study), or were identified as having a highest level of need (4 studies).

Study participants had a mean age of 42.4 years (20 studies) and 74.0% were male (26 studies). Only one study examined a program targeted to homeless families. At the time of baseline assessment, the median duration of homelessness was 6.4 years. Of the 23 studies conducted in the United States, 20 reported race and ethnicity as follows: black (median 50.0%; 20 studies), white (median 32.4%; 18 studies), Hispanic (median 12.5%; 16 studies), Asian (median 1.4%; 6 studies), and other (median 7.1%; 15 studies).

Housing First Programs were effective for adult males from diverse racial and ethnic backgrounds. No study focused on females or racial/ethnic minority populations, and no study described results separately by sex, race, or ethnicity. One study found no difference in housing stability benefits for older and younger homeless clients. Women experiencing homelessness are often exposed to additional problems, such as sexual violence, and may thus have differing benefits from Housing First Programs. (Burt, et al., 1989; Lewis, et al., 2003).

**Intervention Characteristics**

Included studies evaluated interventions that offered scattered housing (17 studies), group housing (4 studies), or both (5 studies). One study that stratified by scattered vs. group housing reported similar improvements in housing stability for both types. The same study reported that participants in group housing had slightly better results in terms of community integration. Housing First Programs should be applicable for either scattered or grouped housing.

In addition to housing assistance, interventions offered the following services to support housing stability:

- Case management (11 studies)
- Mental health services (15 studies)
- Medical services (14 studies)
- Drug treatment services (14 studies)
- Employment assistance or vocational training (5 studies)
- Other, e.g., money management, food/grocery assistance, facilitation of family relations, recreational opportunities (8 studies)

Most studies provided minimal detail on services offered and did not report whether services were used, making it difficult to draw conclusions about the role of service utilization in outcomes.

Seven studies used the Assertive Community Treatment model, which includes a coordinated team of service providers who offer around-the-clock on-call services and maintain a low participant-to-staff ratio. One study used Intensive Case Management, which employs a case manager to refer clients out for care and is often used with clients who have less severe mental or physical health needs (Tsemberis 2010). Both forms of service delivery were found effective.

**Data Quality Issues**

Study designs included individual randomized control trials (8 studies) and pre-post studies with concurrent comparison groups (18 studies). Common limitations affecting this body of evidence were lack of description of the intervention and control group services that were available or used, selection bias due to self-selection, and participant loss to follow-up (particularly differential loss to follow-up between intervention and control groups).
Other Benefits and Harms
No additional benefits or harms were noted in included studies. The broader literature has suggested that the Housing First Program might lead to clients’ decreased motivation to work (Poremski et al., 2016); however, the same researchers (Poremski et al., 2016) report that 69% of this disabled population in one of the Canadian Housing First Programs wanted to work. Other literature suggests that providing housing may give clients a safe environment to continue substance use (Mares et al., 2011); our review of available studies indicates a negligible effect.

Considerations for Implementation
When implementing a Housing First Program, the following issues should be considered. These are drawn from studies included in the existing evidence review, the broader literature, and expert opinion.

- Resistance from community institutions to providing programs for people who are not “housing ready” (Tsemberis, 2003).
- Resistance from landlords. Unless there are regulations preventing this type of discrimination, landlords may reject rental applications from program participants (Nelson et al., 2014).
- Collaboration among agencies and coordination of services. People experiencing homelessness and living with disabilities commonly have multiple and diverse needs. Housing First Programs can benefit from collaboration among agencies and coordination of services (U.S. Interagency Council on Homelessness, 2016).
- Funding. At this time, there is no coordinated, single source of funding for Housing First Programs (National Academy Report, 2018).

Evidence Gaps
Several areas were identified as having limited information. Additional research would help answer questions and strengthen findings in these areas.

- How effective is the Housing First Program for the following population groups?
  - Families
  - Youth
  - Women and LGBTQ
  - Rural communities
- Which types of services do programs offer? Which ones do clients use and with what frequency? How does program effectiveness vary services available or used?
- What is the long-term impact of the Housing First Program on health outcomes?

References


Tsemberis SJ. Housing First: The Pathways Model to End Homelessness for People with Mental Health and Substance Use Disorders. Hazelden Foundation; Center City (MN): 2010.


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**Disclaimer**

The findings and conclusions on this page are those of the Community Preventive Services Task Force and do not necessarily represent those of CDC. Task Force evidence-based recommendations are not mandates for compliance or spending. Instead, they provide information and options for decision makers and stakeholders to consider when determining which programs, services, and policies best meet the needs, preferences, available resources, and constraints of their constituents.

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