Permanent Supportive Housing

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Permanent supportive housing is more than simply a housing strategy – it is a combination of housing and services that include case management, substance use and/or mental health treatment, advocacy, and employment. It is typically summarized as permanent rental housing available to a given population where support services are available to residents. Permanent supportive housing is available to individuals and families with multiple barriers to attaining and maintaining housing, including those who are formally homeless or at risk for homelessness, and those with mental illness, substance use disorders, and/or HIV/AIDS (Minnesota Housing Benefits 101, 2017).

Permanent supportive housing is made to be affordable to residents, who pay a portion of income for rent and services. This occurs on a continuum such that housing and the accompanying services that support residents in improving their quality of life may be may be free for certain individuals (Minnesota Housing Benefits 101, 2017).

Supportive housing has a strong evidence base. Combining non-time-delimited affordable housing assistance with wrap-around supportive services has been demonstrated to be a cost-effective solution to homelessness, particularly for people experiencing chronic homelessness. Multiple studies have shown that supportive housing not only resolves homelessness and increases housing stability, but also improve health outcomes and lowers public costs by reducing the use of publicly-funded crisis services such as shelters, hospitals, psychiatric centers, jails, and prisons (United States Interagency Council on Homelessness, 2017).

Housing stability affects a number of health outcomes, both directly and indirectly. Direct effects of providing housing would include reducing exposure to the elements, environmental contaminants, and violent crime. Indirect health effects of providing adequate housing could include reducing stress and therefore blood pressure (Gove, Hughes, & Galle, 1979), more time and energy available to focus on addressing health needs and maintaining a healthy diet (Brickner et al., 1986), and more money available to cover vital needs such as food, utilities, and health related expenses (Lipman, 2005). For these reasons, residential stability can be a potent intervention for populations encountering complex health barriers such as health, mental illness, and substance use.

Housing stability is also intricately linked with employment, employability, and financial stability. According to the most recent annual survey by the U.S. Conference of Mayors, major cities across the country report that top causes of homelessness among families were: (1) lack of affordable housing, (2) unemployment, (3) poverty, and (4) low wages, in

that order. The same report found that the top four causes of homelessness among unaccompanied individuals were (1) lack of affordable housing, (2) unemployment, (3) poverty, (4) mental illness and the lack of needed services (City Policy Associates, 2014). In other words, all top four reasons for homelessness among families as well as three of the top four reasons for homelessness among unaccompanied individuals were – in short – inability to pay rent.

Housing instability is both a cause of, and result of, negative health outcomes and financial instability. While housing can help stabilize individuals encountering complex health barriers such as mental illness and substance use, the inverse is true as well: mental illness and substance abuse may be exacerbated by housing instability. Chronic stress - here, the experience of homelessness - can increase the chances of developing a mental health problem or exacerbate an existing condition (Mah, Fiocco, & Szabuniewicz, 2015). Individuals who previously used illicit substances - as well as those that did not - may turn to substances to cope with a stressful situation, while stress itself increases vulnerability to addiction (Sinha, 2008).

In Minnesota, 60% of homeless adults experience a significant mental illness and 21% suffer from a substance abuse disorder (Wilder Research, 2015). In general, there is a high rate of comorbidity between mental illness and substance abuse, but establishing causality or directionality is difficult for several reasons. However, it has been noted that drug use can cause abusers to experience one or more symptoms of another mental illness; mental illnesses can lead to drug abuse; and both drug use disorders and other mental illness can be caused by overlapping factors such as underlying brain deficits, genetic vulnerabilities, and/or early exposure to stress or trauma (US Department of Health and Human Services, 2008).

Similarly, while housing instability can be caused by unemployment, poverty, and low wages, encountering homelessness can make it difficult for an individual to achieve financial stability. Arriving to work on time, opening a bank account, completing employment paperwork, appearing professional, and being a productive worker is challenging in the face of homelessness. These challenges can be exacerbated if an individual struggling with mental illness and/or chemical dependency.

Due to the way housing stability is intricately tied to financial stability, mental health, and chemical dependency, permanent supportive housing has become a preferred method to 'interrupt the cycle' of homelessness in ways that single-minded programs cannot. By and large, permanent supportive housing uses the **housing first** approach. This is an approach that quickly

and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent a return to homelessness as opposed to addressing pre-determined treatment goals prior to permanent housing entry (US Department of Housing and Urban Development, 2014).

Permanent supportive housing can be a **polarizing topic** and it is viewed differently by service providers and the community-at-large. Public reaction to housing interventions can range from anger (*stop making poor decisions and asking me to pay for them*) to NIMBYism (*who wants to live next to poor people?)* to fatalism (*how can we hope to change an issue this big?)* to rejecting the need (*most people I know are doing okay, so it's not a problem*) (Frameworks Institute, 2016). When a housing intervention is intended to serve individuals with mental illness or chemical dependency – as is often the case with permanent supportive housing – these reactions can be amplified. For example, residents in Dallas appealed to City Council upon learning that permanent supportive housing was planned to be built in their neighborhood, saying "We do not appreciate being the dumping ground for the city of Dallas' homeless problem" (Horner & Appleton, 2010). In Columbus, similar concern was voiced when plans to convert a church into permanent supportive housing were announced, with one resident stating "None of us are opposed to helping these people, but we are concerned possible felons will be moving in. We don't want them placed smack dab in our area" (Webber, 2018). Noticeably missing from public opposition is supportive housing for seniors and individuals with physical and developmental disabilities, both of which typically enjoy popular support.

Public perception of what is adequate and healthy housing, as well as what is meant by *affordable*, may contribute the push-back frequently encountered by permanent supportive housing programs. The public generally considers housing a consumer good, while at the same time understanding housing in terms of basic needs. This results in the public view that those who cannot afford adequate housing are experiencing the result of natural market forces which cannot be altered, and that even the most minimal housing – simply providing shelter and heat – is sufficient (Baran, Kendall-Taylor, Haydon, & Volmert, 2016). Permanent supportive housing is then contrary to many community members' beliefs that in order to find improved housing, homeless individuals simply have to work harder or look elsewhere. For many community members, any living space that provides shelter from the elements is considered good enough and the wrap-around services provided through permanent supportive housing can be

perceived as excessive. In a community where middle-class affordable housing is scarce, these sentiments may be amplified.

Because public support for permanent supportive housing often hinges on the perceived morality of the service population, advocates for permanent supportive housing often find themselves framing their argument in terms of **cost reduction rather than improved outcomes**. While it is true that permanent supportive housing can reduce public costs (Perl & Bagalman, 2015) and programs have demonstrated positive returns on investment in Minnesota (Chase, Da'ar, & Diaz, 2012), the actual efficacy of a given program will vary depending on the demographics and specific barriers of the individuals served and how referrals are made to the program. As advocates and service providers are not generally driven by cost-reduction but by improved outcomes, framing support for their work in this way can cause friction between those who use the cost-reduction argument to gain support for their work and those who use the improved outcomes framework.

Despite public stigma around supportive housing efforts, the model continues to be employed in a variety of settings and serving a variety of populations. While the housing may be site-based, scattered, or clustered, it is best-used to serve individuals experiencing chronic homelessness. Generally speaking youth and single adults with severe mental health and/or chemical dependency issues need permanent supportive housing. Additional youth populations that benefit from PSH include youth with multiple placements and criminal offenders. Families most benefit from permanent supportive housing when they have experienced long-term homelessness, need more than 24 months of supportive housing, and could benefit from long-term services that are not tied to a specific program (Kadwell, Lawrenz, Nelson, & Zuleger, 2008).

Certain populations may benefit from transitional housing. This is an approach similar to permanent supportive housing in that housing support is incorporated with case management, but it is different in that it is time-delimited (typically, 24 months). These populations include foster youth, LGBTQ runaway youth, teen moms, single adults with a criminal record, victims of domestic violence, refugees, individuals working to maintain sobriety, and households with a parent pursuing educational or vocational training (Kadwell et al., 2008). These same populations are well-served by PSH, but the inverse is not true: populations best-served by PSH should not be served by transitional housing programs. Therefore, an important component of a community-level response to homeless is accurate intake and referral procedures for transitional programs, and sufficient PSH slots to accommodate individuals for home transitional housing is inappropriate.

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