Evaluation of Pathways to Housing PA

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January 2011

FOREWARD

Philadelphia city government has long been in the vanguard nationally in addressing the needs of homeless people. In the early 1990's, the City established a "continuum of care" approach before the term was adopted by the federal Department of Housing and Urban Development and implemented nationwide. This service delivery model begins with outreach, includes treatment and transitional housing, and, in optimal cases, ends with permanent housing and needed supports for people who successfully progress through the system. Not intended to be a rigid or linear "one size fits all" approach, it was designed to promote flexibility based on the unique needs of each cohort of homeless people and the individuals within them. While the approach of providing permanent housing after other issues were addressed was effective for a wide range of those experiencing homelessness, there remained a segment of the homeless population for whom this model did not work.

One segment of the homeless population for whom this approach was typically less effective is people with chronic mental illness with personality disorders. These individuals find interacting with other people very challenging, inhibiting their willingness to participate in congregate housing or programming. Typically the hardest to reach and serve among the homeless, meeting the needs of this relatively small subset often incurs the highest financial cost to public systems. Recognizing that a continuum that begins with congregate housing and compliance with treatment objectives was ineffective to helping these people leave the street, the City of Philadelphia introduced a number of innovative approaches to serve them. Many of these efforts were successful, yet there remained a group that was not being reached.

In response, in 2008 the City government invited Pathways to Housing, a New York-based organization focused exclusively on this population, to bring its approach to "Housing First" to Philadelphia in order to reach this target group living on Philadelphia's streets. In tandem with the City of Philadelphia, Pathways to Housing-Philadelphia has been serving the chronically ill, seriously mentally ill throughout Philadelphia for the past three years.

This report is an evaluation of Pathways to Housing pilot program in Philadelphia. The data show remarkably better outcomes for the individuals served, with the potential to avoid substantial costs if this model is expanded in accordance with Pathway to Housing's approach to Housing First. So doing will achieve multiple goals: improve the life prospects of Philadelphia's chronically ill, seriously mentally ill while avoiding additional costs associated with police attention, emergency room care and other publicly administered systems. In these times of great budget austerity, it is heartening to identify an opportunity for multiple "wins": better outcomes for people with profound needs, costs avoided to the public sector, and a better environment for everyone. Philadelphia City government is to be applauded for inviting this best practice to Philadelphia: this report makes clear that this model should be expanded, whether by Pathways to Housing or other organizations, provided the model is properly adhered to.

We hope this report is the start of an important dialogue, and can bring Philadelphians one step closer to ending homelessness in our city.

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This evaluation was made possible through the financial support of the Center City District and the Thomas Scattergood Foundation for Behavioral Health.

I. Executive Summary

The 2009 One Book, One Philadelphia selection, Steve Lopez's The Soloist, introduced many Philadelphians to the inner life of a very troubled person, helping us better understand both the personal struggle of a man who was homeless and the policy choices we face as a society. The Soloist tells the story of Nathaniel Ayers, a talented musician who was driven to life on the streets by a mental illness that made it almost impossible for him to interact or live with other people. While Mr. Ayers does not typify every homeless person, his struggle with chronic mental illness and a personality disorder does typify a large segment of the homeless street population. These are individuals who we may see on the Benjamin Franklin Parkway, on Walnut Street, on East Market Street and in communities across the city. They have been extremely difficult to coax off the street using traditional outreach techniques and they often reject services even when placements are available.

By the end of Steve Lopez's story, Nathaniel Ayers is not "cured" of his mental illness, but he comes off the street into his own room, is reunited with his sister and is re-engaged with fellow musicians in Los Angeles. This paper evaluates the effectiveness of a seemingly counter-intuitive approach to reach out in a new way to help the Nathaniel Ayers' of Philadelphia.

In Philadelphia, homelessness has many faces. Official counts found that on a given evening[1], 6,304 people were homeless in Philadelphia. Of these, 3,250 were in families, all of whom were sheltered at the time. The remaining 3,054 were individual adults, of whom 506 were unsheltered on that night. On average, throughout 2009, there were 424 people living on the streets of Philadelphia on any given night, of whom approximately a quarter had a serious and persistent mental illness. For some portion of this population, their mental illness involves a personality disorder that makes them averse to being around and living with other people.

Traditional approaches to helping the homeless begin with engagement and the offer of group living situations with the goal of gradually progressing toward individual, independent housing. But this option rarely works for people with a chronic mental illness that includes a personality disorder. They require a different approach because their illness severely limits their ability to manage social interactions with people they do not know, let alone live among a group of "strangers." For this hard-to-reach group, other locales across the country, such as New York City, Denver, Seattle, San Diego, San Francisco, and Chicago, have implemented a different approach, known as Housing First.

The cornerstone of the Housing First approach is the direct placement of people who are homeless into permanent rental housing without first requiring a period of sobriety or the acceptance of a specific set of services after admittance. Recognizing the debilitating physical and mental effects of remaining on the street, the approach seeks to initially reduce harm. Clients agree to be visited by case managers regularly and are offered appropriate substance abuse and harm reduction counseling. However, they are not required to participate in

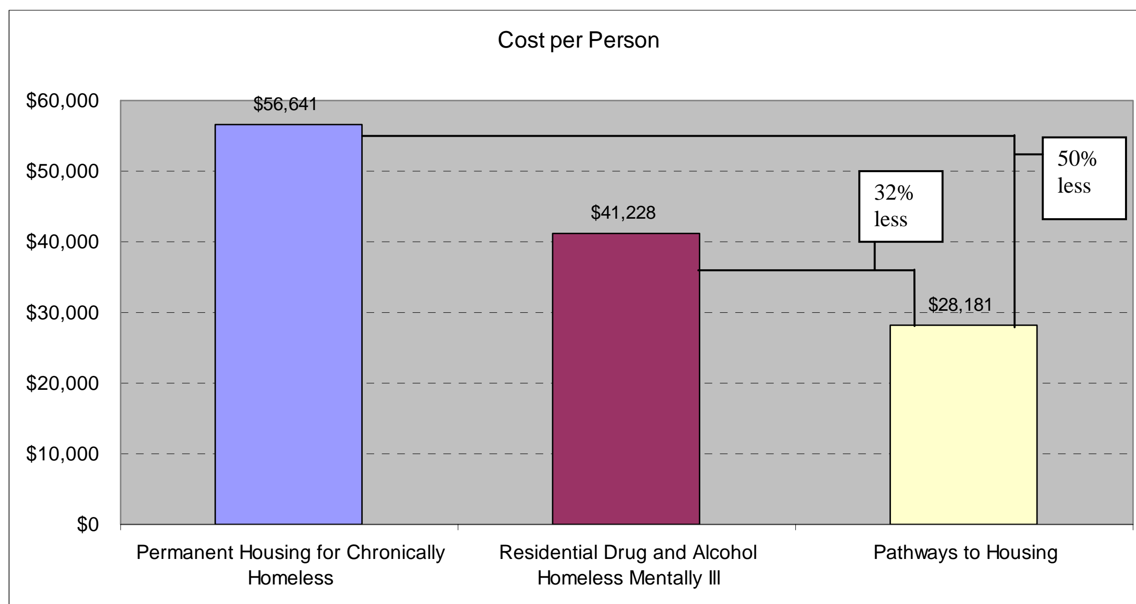
[1] January 2009

congregate living in order to have a place to call home. Even if a client lapses back onto the street, the housing is held for short periods. Rather than erect barriers to obtaining a roof and a bed, the program literally places *housing first*.

In 2008, the originator of the Housing First model, the New York-based Pathways to Housing, was invited to Philadelphia by city government. Pathways was given a list of 130 of the most difficult to serve people living on the street and asked to see whether this approach would prove effective here. As documented in this study, Pathways to Housing has succeeded in getting these hard-to-reach people to come off the street and improved their quality of life while reducing costs to the City's service systems.

What We Learned

Pathways to Housing PA is less expensive per person than comparable programs serving the same population. As shown below, Pathways is half the cost of other permanent housing programs for chronically homeless individuals and about two-thirds the cost of Residential Drug and Alcohol programs for chronically homeless mentally ill people.



Pathways also saves the City money by reducing the use of emergency services by the people it serves. This evaluation examined at the amount of services consumed by 51 people served by Pathways during the year before they entered the program and compared that with the amount used in the year after they entered the program and found that the use of publicly funded services decreased for every category:

- Shelter episodes decreased by 88%.
- Number of shelter nights decreased by 87%.
- Crisis Response Center episodes decreased by 71%.

- Mental Health Court episodes decreased by 11%.
- CBH hospitalizations episodes decreased by 70%.
- CBH hospitalization days decreased by 46%.
- Philadelphia Prison System episodes decreased by 50%.
- Philadelphia Prison System days decreased by 45%.

Considering the cost of these services, Pathways saves the City a substantial amount of money. Estimated savings for just the 51 people for whom data was available are summarized below:

Costs and Cost Avoided[2]

51 Study Subjects	Cost in year before entry	Cost in year after entry	Cost Avoided
Shelter Nights	$26,044	$3,434	$22,610
MH Hospitalizations	$317,680	$171,760	$145,920
Prison	$43,905	$24,179	$19,725
CRC Episodes	$38,025	$11,115	$26,910
Totals	$425,654	$210,488	$215,165

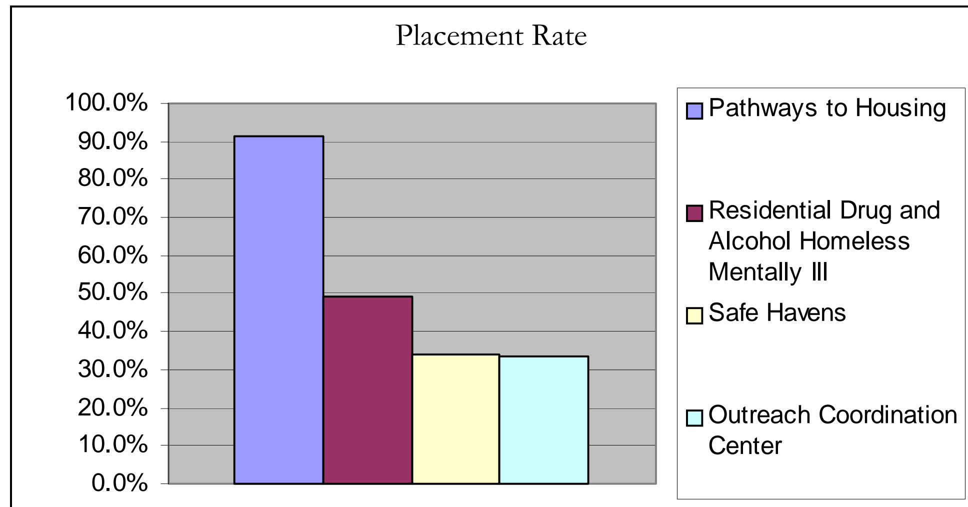
Assuming that Pathways houses approximately 100 people at any one time (average number of persons housed per month in the past 12 months was about 106) the program save the public a total of $421,893 per year, or $4,219 in cost avoided for each person it serves.

Costs and Cost Avoided

Per 100 Participants	Cost in year before entry	Cost in year after entry	Cost Avoided
Shelter Nights	$51,067	$6,733	$44,333
MH Hospitalizations	$622,902	$336,784	$286,118
Prison	$86,088	$47,411	$38,677
CRC Episodes	$74,559	$21,794	$52,765
Totals	$834,615	$412,722	$421,893

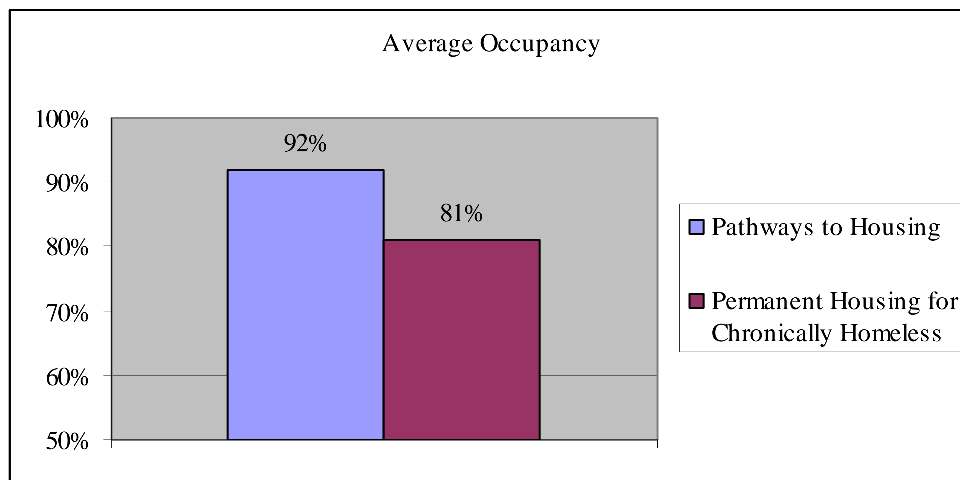
[2] NB: For the purposes of this report, cost savings associated with Pathways to Housing will be referred to as "cost avoided," since money is not "saved" but rather can be re-directed to other needed public services.

More important, Pathways improves the quality of life for those it serves. As shown above, access to permanent housing helps stabilize the lives of seriously mentally ill people as evidenced by a reduction in the use of emergency services. Stably housed people spend less time on the street, in shelter, in hospitals and in jail. Pathways was able to help 92% of the people it contacted move off the streets and into their own apartments, which is markedly higher than other outreach and placement efforts. Pathways is also more successful in helping clients stay in housing than other programs that provide permanent housing for chronically homeless mentally people.



Of the 128 people that Pathways attempted to engage and house, 117, or **92%**, were successfully placed into housing over an 18-month period from October 2008 to April 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.

By way of comparison, in 2009, the City of Philadelphia's Department of Behavioral Health spent $6,000,000 on outreach services. During that time, outreach workers made 30,202 contacts with 4,506 unduplicated individuals. These 30,202 contacts resulted in a 1,509 people being placed into various programs including shelter and detoxification programs. A number of people were placed multiple times, as the total placements during the time period was 2,424. This means that outreach workers contact each individual on the street almost seven times and that only **35.6%** of them choose to enter shelter given the options that traditional outreach offers.



Implications

- The people served by the program. i.e., seriously mentally ill people living on the street, represent a discrete sub-set of the homeless population, who are harder to reach and serve than most homeless people and, therefore, need a different approach to care.
- The Housing First approach as employed by Pathways to Housing PA is consistent with national best practices and has been proven effective in other cities by a number of evaluations.
- The Pathways to Housing PA approach to Housing First works well for chronically homeless mentally ill people, reduces costs across City service systems, and is an improvement over alternate approaches in terms of cost and outcomes for the people it serves.
- In order to reduce the number of people living on the street, get them the help they need sooner and in a more cost-effective manner than is currently provided, Philadelphia's homeless policymakers should recognize that their trial program has been a success and consider expanding the Pathways to Housing PA approach to serve even more people who remain on the street.
- The City of Philadelphia is currently operating in a framework that began in the mid-1990's, rooted in the Continuum of Care model, where people progress through the system based on success through various stages. Since that time, national policy, public policy funding and the environment have changed dramatically such that a careful evaluation and examination of these policies is warranted. This study thus aims to initiate the conversation around a more comprehensive analysis of the City of Philadelphia's homeless and mental health systems.

II. Introduction

A. Purpose

Societal approaches to the problem of homelessness have continuously evolved as new evidence has come forward over the past 30 years. In the 1980s, when homelessness first became an issue in the minds of most of the population, cities responded by creating emergency shelters in which the homeless people were kept off the street. Over time, it became apparent that shelter alone was not enough to truly address the problems of many types of homeless people. From this realization came the development of what has become the "Continuum of Care" approach to homelessness, which employs a series of services and housing models from prevention, through outreach, to shelter, then to transitional and permanent housing. People typically enter through outreach or shelter and move through the system to permanent housing as they are deemed ready for the next level of housing. This approach has proven to be effective for many homeless persons.

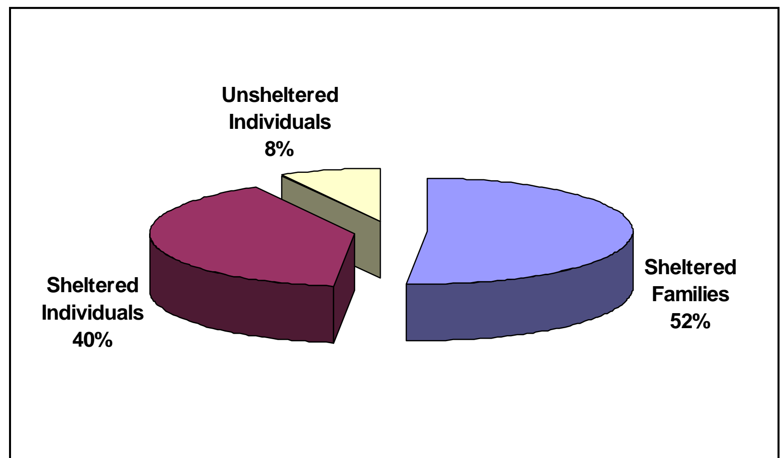
However, it has become clear that it does not work for many of the chronically homeless, seriously mentally ill people living on the streets. Many of these people, due to their illness, cannot function within highly structured shelter and transitional housing programs. Housing First is a harm-reduction approach to serving these people that focuses on moving them from the street into apartments as quickly as possible. While services are offered to clients, housing is not conditioned on acceptance of services. The original Housing First program, Pathways to Housing of New York, provides Housing First programming and technical assistance across the country. The program came to Philadelphia in the summer of 2008, targeting chronically homeless people with personality disorders who had previously resisted entering the traditional homeless service system. While studies in other cities across the country provide evidence that Housing First works, this is the first study of the effectiveness of this approach in Philadelphia. The purpose of this study is to evaluate the Pathways to Housing PA program to answer the following questions:

- How does the program work?
- How much does it cost?
- Is it effective?
- Is it worthwhile?

B. Background

1. Extent of Homelessness

Philadelphia's homeless population reflects that of many of America's large cities. According to the City of Philadelphia's Year 36 Consolidated Plan, on a given night in January of 2010, 6,304 people were homeless in the City. Of these, 3,250 were in families, all of whom were sheltered at the time. The remaining 3,054 were individual adults, of whom 506 were unsheltered on that night. The street population is made up almost exclusively of single adults, as emergency housing programs are utilized to a greater extent by families, especially single mothers with children. On average, throughout 2009, there were 424 people living on the streets of Philadelphia on any given night. Of these, approximately a quarter have a serious and persistent mental illness.



The causes of homelessness and the characteristics of the homeless differ greatly across subpopulations. Characteristics such as mental illness and substance abuse are often barriers to achieving stable, independent housing. The Philadelphia Office of Supportive Housing identifies these factors as some of the most challenging to overcome for homeless individuals. In FY2009, 31% of the heads of household in emergency housing disclosed a history of substance abuse, a probable understatement since the disclosure of information is not required. Data indicates that 26 percent of the unsheltered population in FY2009 had substance-abuse history as well.

Similar underreporting occurs with the disclosure of mental illness; during FY2009, 24 percent of those seeking emergency shelter disclosed a history of mental illness, and 19 percent of the unsheltered population had a serious mental illness. Those with both serious mental illness and substance abuse history are the "dually diagnosed." Those experiencing homelessness and who have dual diagnoses face two significant barriers in addition to their condition of homelessness. The Office of Supportive Housing indicates that 43 percent of the people engaged by street outreach teams in FY2009 were dually-diagnosed. In 2009, there were an estimate of 596 chronically homeless, 1,057 severely mentally ill, and 1,600 chronic substance abusers in Philadelphia. The Annual Plan for Mental Health Services for FY2011-2012, issued through the Department of Behavioral Health and Mental Retardation Services, estimates 5,150 unique homeless individuals, 20% of whom (1,030 individuals) were believed to be suffering from a mental illness, and an additional 40% who were dually diagnosed (2,060 individuals), suffering from both mental health and addiction disorders. The Consolidated Plan notes that subgroup of the homeless population is at a higher risk of becoming chronically homeless, and requires both long-term engagement and adequate attention to both of its dual diagnoses. It is this dual diagnosed, chronically homeless

population that Pathways to Housing PA seeks to engage in long-term, independent housing.

2. Frequent Service Users: the Chronically Homeless, Seriously Mentally Ill

As a small percentage of the overall homeless population in Philadelphia, the chronically homeless, dually diagnosed are often resistant to traditional types of homeless services. In lieu of homeless shelters, substance abuse treatment, and on-going psychiatric treatment, this population contains frequent users of emergency health, behavioral health and correctional services, reporting the same patterns of overlapping conditions: chronic illness, substance use illness, homelessness and mental illness. Some communities have begun to use administrative data to identify the overlap among frequent users of public systems. In New York City, administrative data matches have revealed a 30% overlap of persons with frequent admissions to public shelter and in correctional facilities.[3] This is confirmed in both Santa Cruz County (CA) and Seattle: data matches show that frequent users of emergency department and sobering centers were also frequently in jail.[4] Additionally, Dennis Culhane, in his landmark 2002 study of the NY/NY I Initiative, noted that as many as 112,000 single adults with serious mental illness are homeless in the United States on any given day, and as many as 280,000 single adults are chronically homeless and found that this population are extensive users of acute care health services, public shelters and criminal justice systems.[5]

For these users of multiple crisis systems, emergency and correctional systems can quickly become "de facto housing, health and mental health care systems."[6] Not only is this detrimental to the safety and well-being of the population, but having people rely only on emergency systems results in a significant strain on the system itself. Although "this chronically homeless group constitutes only a minority of the homeless population, these individuals can account for over half of all public shelter stays."[7] Exorbitant costs are born by the general public when this sector of the population, chronically homeless and dually diagnosed, are not provided with adequate care and appropriate support systems.

3. Philadelphia's Homeless System

The City of Philadelphia's current system is based on the concept of creating a "Continuum of Care," which seeks to help homeless people by moving them through a sequence of housing and service models in which consumers are gradually moved from shelter through transitional housing and, eventually, into permanent housing. The Continuum of Care has been the "predominant service delivery model designed to address the needs of this chronically homeless population."[8] While Continuum of Care has come to be used as a generic description of geographic cooperatives seeking to serve the homeless, for the

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[3] "Frequent Users of Public Services: Ending the institutional circuit." Corporation for Supportive Housing (2008), 63.
[4] Ibid, 9.
[5] Culhane, Dennis, et al. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." University of Pennsylvania School of Social Policy and Practice (2002).
[6] "Frequent Users of Public Services: Ending the institutional circuit." Corporation for Supportive Housing (2008), 11.
[7] Stefancic, Ana and Sam Tsemberis. "Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention." Journal of Primary Prevention (2007): 2.
[8] Tsemberis, Sam, et al. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." American Journal of Public Health (2004): 651.

purpose of this report, the term is used to describe linear, sequential residential programming, depending on some measure of the client's readiness. Moving through this continuum and into permanent housing requires consumers to meet the goals of each program in order to demonstrate that they are "ready" to progress to the next level. Independent, permanent housing is offered as a 'rewards' for more normatively acceptable behavior. This Continuum of Care approach has been successful in helping a significant portion of homeless households, generally single-parent families who need a safe, affordable place to live while they resettle their lives and gain additional skills and abilities that will allow them to support themselves.

Among those individuals that this system has been unable to help are service-resistant chronically homeless people with serious mental illness. While these people make up a relatively small proportion of the homeless population, they are the most frequent and expensive users of the system. Characterized by serious mental illness, substance abuse and personality disorder, this subset of the homeless population is adverse to being around and living with other people. For people suffering from personality disorder as part of their mental illness, living alone on the streets is preferable to being around other people, much less abiding by a strict set of externally imposed rules. Understanding this aversion to be around other people provides an opportunity to help them.

Nationally, there is a move away from the Continuum of Care approach to dealing with the service-resistant, seriously mentally ill homeless. This emphasis has led to interest among practitioners in the Housing First approach to serving this population. The City of Philadelphia has also moved in this policy direction by supporting initiatives to move individuals into permanent housing.

C. What is Housing First?

1. Overview

The Housing First method differs from the standard methods of treatment with regards to some key characteristics. Standard methods of treatment usually "require detoxification and sobriety before giving access to services such as independent housing."[9] By ensuring that tenants are sober, programs can help them work further towards success. For a large portion of the homeless population, this method is successful. There are mandatory supportive services; these treatment portions are used in tandem with transitional housing to prepare clients for independence and 'housing readiness' in permanent housing.[10] Progress is based on meeting treatment and sobriety goals set by the provider.

However, this method assumes that individuals with severe psychiatric and mental disabilities cannot be independent in permanent housing without prior stabilization of their clinical status.[11] Having a sobriety threshold and mental health treatment requirements are often the key determinants in pushing away the chronically homeless, mentally ill population. From the "perspective of a person who [is] dually diagnosed, living on the street, this

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[9] Padgett, Deborah, et al. "Housing First Services for People who are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse." Research on Social Work Practice (2006): 74.
[10] Tsemberis, Sam, et al. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." American Journal of Public Health (2004).
[11] Ibid, 651.

threshold for entry can seem daunting at best."[12] Program elements that are designed to promote independence in permanent housing for the general homeless population are often the same elements that deter the most service-resistant individuals from engaging.

In contrast, Housing First programs have no conditions of sobriety or supportive services. The key tenet of Housing First is that access to safe, affordable, quality housing is the driving element. 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 as a prerequisite."[13] This "low-demand" model maintains that abstinence is not required as a condition for obtaining or retaining housing. Access to housing can then help clients become less dependent on emergency systems and improve their mental health: "housing provides the essential baseline for accessing the health care and supportive services necessary for the appropriate management of chronic illness, mental illness, re-entry from prison and jail, substance use and other complex health and social issues."[14] Through the immediate stabilization of the frequent users of public systems, Housing First provides necessary supports for a population who often have no other methods of obtaining housing and separates access to housing from services.

Housing First programs offer the direct placement of targeted homeless people into permanent housing. Models vary slightly, but none require participation in supportive services as necessary to remain in housing. Psychiatric treatment or sobriety are never a precondition for tenancy. There is a continued effort to provide case management, and housing is held for the client, even if the individual leaves the housing for a short period of time. Clients are not considered to have left the program unless they are absent for more than 90 days. In other programs, absences lead more quickly to clients losing their housing. This emphasis on housing aligns in a way that is "consistent with what the consumers identify as their first priority: housing."[15]

2. Examples of Housing First in other cities

Over the past 20 years, Housing First-type programs have been initiated in many other cities to a great degree of success. A description of these programs follows (see Appendix A for greater detail).

In 1990, New York State and New York City agreed to jointly fund and develop 3,600 housing units for homeless individuals with serious mental illness in a program called the New York/New York Agreement to House the Homeless Mentally Ill (the NY/NY Initiative). The innovative program was designed to target the most difficult to service individuals, easing demand on shelters and psychiatric treatment centers. To be eligible for the housing, tenants must have a diagnosis of serious mental illness and have recently been homeless in shelters or on the streets. Although the NY/NY Initiative was not Housing

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[12] Padgett, Deborah, et al. "Housing First Services for People who are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse." Research on Social Work Practice (2006): 75.
[13] "Frequent Users of Public Services: Ending the institutional circuit." Corporation for Supportive Housing (2008): 17.
[14] Ibid, 16.
[15] Stefancic, Ana and Sam Tsemberis. "Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention." Journal of Primary Prevention (2007): 3.

First, it was a landmark study that sought to serve the same dual diagnosis population as most Housing First programs.

The Colorado Coalition for the Homeless created the Denver Housing First Collaborative (DHFC) in 2003. The program uses a Housing First strategy, combined with assertive community treatment (ACT) services, providing integrated health, mental health, substance treatment and support services. The DHFC began accepting referrals in January 2004; by the end of the year, there had been 739 referrals. Of these 739, all had at least one of substance use, mental health disability and physical health disability, with the vast majority indicating at least two and often three disabling conditions

The Downtown Emergency Service Center (DESC) in Seattle, Washington is a permanent supportive housing program with a Housing First approach. Serving as a demonstration program site for the US Department of Health and Human Services, DESC serves more than 300 clients, nearly all of whom have mental illness, the majority of whom have substance-related disorders, and 84% of those tracked met HUD criteria for chronic homelessness.

The San Diego Police Department-initiated Serial Inebriate Program (SIP) provides housing and treatment in lieu of custody to persons convicted of a criminal charge of public drunkenness or disorderly contact. This program was initiated in 2001, aimed at a group of homeless individuals "stuck in a revolving door between jail, emergency departments and the city's sobering center."[16]

In San Francisco, the Department of Public Health's *Direct Access to Housing* program accepts single adults into permanent housing directly from the streets, shelters, acute hospitals and long-term care facilities regardless of active substance abuse disorders, serious mental health conditions and/or complex medical problems. Established in 1998, it currently provides permanent housing with on-site supportive services for approximately 1,100 adults, most of whom have concurrent mental health, substance use, or chronic medical conditions.

The California HealthCare Foundation and The California Endowment created the Frequent Users of Health Services Initiative (FUHSI), a pilot program conducted in six counties in California. The program addressed avoidable emergency department use among patients with complex, unmet needs that were not dealt adequately in the acute care settings. The initiative was begun to relieve pressure on overburdened systems and to promote the more effective use of resources.

The Chicago Housing for Health Partnership (CHHP) is an integrated system of housing and supports for individuals with chronic mental illness who are homeless upon discharge from hospitalization. Working with partner hospitals, CHHP identifies those individuals with serious mental illness who are likely to be homeless upon leaving the program.

The New York City Departments of Corrections (DOC) and Homeless Services (DHS), with assistance from the Department of Health and Mental Hygiene (DOHMH) and the New York City Housing Authority (NYCHA), implemented the Frequent Users Service

[16] "Frequent Users of Public Services: Ending the institutional circuit." Corporation for Supportive Housing (2008): 15.

Enhancement Initiative (FUSE). There are also FUSE programs at various stages of implementation in Illinois, Minnesota, Connecticut and Washington, DC. This program had placed 100 individuals in permanent supportive housing as of 2009, in an effort to break the cycle between jail, shelter, emergency health and other public systems. A key feature of this program is the intensive services provided during the critical time from recruitment through stabilization in housing. Eligibility is determined through a data match between DOC and DHS to identify people with a certain number of jail and shelter stays in the last five years.

3. Pathways to Housing

The first and most well-known model of Housing First is Pathways to Housing. Founded in 1992 in New York City with the mission to serve people who are homeless, literally living on the streets, in transportation terminals and other public places, Pathways to Housing focuses on those who suffer from severe psychiatric disabilities and substance use disorders. These are the people who are unable or unwilling to engage in traditional behavioral health and housing systems.

Pathways developed a low-demand model of Housing First, reversing the usual standards of care "by offering immediate access to independent apartments in scattered sites around the city, along with [non-mandatory] case management."[17] Pathways has voluntary treatment programs, but acknowledges housing as a fundamental need and human right.[18] In New York City, Pathways provides scattered-site housing with on-site staff supervision. Pathways is based on the principle that housing is a basic right and can be a foundation for psychiatric and substance abuse rehabilitation; this is a model driven by the needs of the consumer, from the consumer's perspective.[19]

Pathways characterizes their philosophy of Housing First and optional supportive services as practicing 'harm reduction', rather than an abstinence-based treatment approach.[20] At the core of the harm reduction approach is the aim to reduce the adverse effects of drug abuse and psychiatric symptoms. In terms of supportive service, Pathways employs Assertive Community Treatment (ACT) services that work "in conjunction with housing staff and a nurse practitioner to address ongoing housing and health needs."[21] These ACT teams are made up of a team of professionals, including social workers, nurses, psychiatrists, vocational and substance abuse counselors. In other cases, Pathways employs Intensive Case Management (ICM) teams for clients who need more close supervision.

While the choice integrated in the program and the emphasis on harm reduction reflects the Housing First philosophy, there is still attention paid to mental health and substance abuse treatment. Clients agree to be visited by a case manager regularly, and are expected to contribute one-third of any income (usually a SSI disability check) towards their rent. Clients

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[17] Padgett, Deborah and Ben Henwood. "New Approaches in the Third Decade of the Homelessness "Crisis" in America: Innovation Inspired by Practice and Supported by Research." New York University, Silver School of Social Work (2008).
[18] Padgett, Deborah, et al. "Housing First Services for People who are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse." Research on Social Work Practice (2006): 76.
[19] Tsemberis, Sam, et al. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." American Journal of Public Health (2004).
[20] Padgett, Deborah, et al. "Housing First Services for People who are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse." Research on Social Work Practice (2006): 76.
[21] Ibid, 76.

who abuse drugs or alcohol are counseled by the clinical services staff, based on their readiness assessment of the stages of change, and harm reduction or integrated dual diagnosis support groups are available. Clients live on their own in scattered-site apartments throughout New York City; apartments are located within normal residential buildings and location is based on consumer choice.[22]

Pathways to Housing has filled a void in New York City's homeless programs, by recognizing consumer choice as a key notion in service provision for the hardest to reach, most service resistant individuals. Because "it does not refuse clients with histories of violence or incarceration, Pathways to Housing has accepted and housed the most problematic among persons who are homeless with mental illness, that is, those other programs would not take or had ejected."[23] By taking this population off the streets and into stable, safe housing, Pathways serves dual purposes: helping the population itself achieve independence, and relieving the public support systems of a disproportionally large burden from a small group of individuals.

4. Evaluation of other Housing First programs

A study of Housing First in NYC found 90-95% of the program's cost was offset by reductions in emergency service usage.

The effectiveness and impact of the Housing First model has been evaluated by numerous studies conducted across the country. In a landmark study, Dennis Culhane and colleagues tracked 4,679 homeless people with serious mental illness who were placed in supportive housing in New York City between 1989 and 1997. This study "was able to quantify for the first time in the published literature the extent of service use by homeless people with serious mental illness *before* housing placement."[24] It was found that the net annual cost of the program, after accounting for decrease in service usage in seven public service systems, was 5-10% of the overall cost of the program; 90-95% of the costs of supportive housing in the NY/NY Initiative were compensated by reductions in collateral service attributable to the Housing First placement. The NY/NY Initiative and the resulting analysis has "galvanized many cities and the country as a whole to adopt the goal of ending chronic homelessness."[25]

A cost-benefit analysis of the Denver Housing First Collaborative (DHFC) was conducted in December 2006 by the Colorado Coalition for the Homeless. The analysis examined the health and emergency service records of a sample of DHFC participants for the 24 months prior to entering the program and the 24 month period after entering the program. The study found an overall reduction in emergency service costs for the sample group, with total emergency related costs declining by 72.95%, or nearly $600,000.

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[22] Gulcur, Leyla et al. "Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness." Community Mental Health Journal (2007).
[23] Padgett, Deborah, et al. "Housing First Services for People who are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse." Research on Social Work Practice (2006): 77.
[24] Culhane, Dennis, et al. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." University of Pennsylvania School of Social Policy and Practice (2002): 138.
[25] Burt, Martha. "Assessing Public Costs Before and After Permanent Supportive Housing: A Guide for State and Local Jurisdictions." Corporation for Supportive Housing (2004): 1.

In 2009, researchers at the University of Washington performed a quasi-experimental evaluation of DESC's 1811 Eastlake location, comparing 95 of the housed participants with 39 wait-list control participants. They found that use and cost of public system services for Housing First participants had a total cost rate reduction of 53% as compared to the wait-list controls over the first six months, and that the costs of the program were offset at six months for those participating in the program. The total costs offsets were program participants relative to the control group averaged $2449 per person per month, after accounting for housing program costs.

An evaluation in Seattle found that the cost of services went down by 53% for Housing First clients.

The University of California, San Diego Department of Emergency Medicine conducted a retrospective review of health care utilization records among SIP program participants (emergency medical services, emergency department visits, and inpatient care) of 529 chronically homeless individuals. The study concluded that use of these three service systems decreased by 50% for clients who chose treatment, resulting in total medical charges avoided of almost $7,400 a month of the group of 155 who accepted services.

An evaluation of San Francisco's Direct Access to Housing program found that acute medical care reduced significantly after entry into housing as compared to the two years prior to housing placement. There was a 58% reduction in emergency department visits and a 57% reduction in inpatient episodes. Although 1/6 of residents had exacerbations in mental illness resulting in psychiatric hospitalization before and after tenancy, the number of days per hospitalization decreased significantly after being housed.

Participants in a San Francisco program reduced emergency department visits by 58%.

An evaluation of the Frequent Users of Health Services Initiative (FUHSI) found that a small number of patients drive a disproportionate use of emergency department (ED) visits. The identified frequent users made an average of 10.3 ED visits annually, with annual charges of $11,388 per patient, and an average of 6.3 inpatient days each, with average annual charges of $46,826 per patient. On top of the excessive cost, this frequent care was found to not meet the health care needs of these users appropriately.

An evaluation of the Chicago Housing for Health Partnership (CHHP) demonstrates that offering housing and case management to homeless adults with chronic illness creates stability and dramatically reduces hospital days and emergency room visits. After 18 months in the program, 66% of the intervention group reported stable housing as compared to only 13% of the control group. Controlling for a range of individual and service variables, housed participants had 29% fewer hospitalizations, 29% fewer hospital days and 24% fewer emergency room visits than their control counterparts.

The John Jay College Research and Evaluation Center conducted an initial evaluation of the Frequent Users Service Enhancement Initiative (FUSE) in New York using a quasi-experimental design, comparing those who were placed in housing with a control group. Days spent in jail and shelter before and after placement into supportive housing were reduced by 53% and 92%, respectively, for those who received FUSE housing and services,

whereas the comparison group in traditional methods of care decreased their shelter use by only 20% and 71%, respectively, in the year following placement.

Each of these evaluations found that the Housing First approach is effective in helping chronically homeless individuals enter and remain in housing. Moreover, the evaluations have found that Housing First helps reduce the usage of emergency services by the people it serves. The next section of this report evaluates the Housing First approach employed by Pathways to Housing PA.

III. Evaluation of Pathways to Housing PA

A. How does Pathways to Housing PA work?

Pathways to Housing was invited to Philadelphia by City of Philadelphia officials in the summer of 2008 to implement their Housing First, scattered-site housing model. By the end of that summer, Pathways had a program and staff in place and began serving chronically homeless Philadelphians with severe and persistent mental illness and co-occurring disorders. Pathways to Housing, originally developed and implemented in New York City, followed a Housing First approach, blending together Assertive Community Treatment (ACT) Team and Supported Housing models. This program was specifically designed to serve people who are chronically homeless. The cornerstone of this model is the emphasis on consumer choice: consumers choose the neighborhoods they want to live in, how their apartments are furnished, and all other decisions regarding the use of their homes. The housing is permanent and is held for the individual during relapse, psychiatric crisis or short incarcerations. Consumers also determine the frequency, duration, and intensity of the support and treatment services they receive.

Within two months of signing its contract with the City, Pathways to Housing PA was housing its first tenants. In Philadelphia, Pathways receive the majority of its referrals from the City's Department of Behavioral Health in cooperation with the Office of Supportive Housing and Project H.O.M.E.'s Outreach Coordination Center. The initial list of chronically homeless individuals with serious mental illness was generated for Pathways in October 2008. Since the initial list in October 2008, the Department of Behavioral Health has gradually provided Pathways with additional names, totaling 130 individuals. Upon contact with individuals, a psychiatrist contracted through Pathways confirmed the mental illness diagnosis of the individual.

Pathways currently operates with the following staff complement: 1FTE psychiatrist, 2 FTE registered nurses, 6 FTE service coordinators, 2 FTE certified peer specialists, 2 FTE program assistants, 1 FTE employment specialist, 1 FTE clinical director, 3 FTE housing and maintenance staff, 1 FTE executive assistant, 1 FTE chief operating officer. The agency also has a partnership with Thomas Jefferson University Health System and a primary care physician available one day per week to provide clients with an integrated healthcare team.

Outreach and engagement strategies are key to the effectiveness of the Housing First Model and training in fidelity to the model is provided. All referrals are authorized by the Targeted Case Management (TCM) Unit of the Department of Behavioral Health. Team members

meet and engage people where they are comfortable, to begin the relationship building process. The teams offer targeted case management, clinical, vocational, health, and other support services. The staff work collaboratively with clients to articulate goals that move the client towards recovery, as defined by the client. In addition to traditional treatment services, clients participate in wellness groups, have consultations around nutrition, family, therapy and vocational planning and services. There are recreational activities, Narcotics Anonymous and Alcoholics Anonymous and Double Trouble (a program for the dually diagnosed) meetings, Wellness Recovery Action Plan (WRAP) groups, cooking classes, and other client groups. A Tenant Advisory Council provides a forum for input into the program and solicits ideas for changes and to meet new needs. The team coordinates all of these services in an individualized Comprehensive Service Plan for every person in the program.

A key tenet of the Housing First philosophy, program participants are placed in independent, scattered-site housing throughout Philadelphia. Units are located in privately-owned buildings and only a small percentage of units in any one building are occupied by Pathways' clients, thereby integrating them into the community. This approach allows for rapid implementation as no new housing needs to be built and avoids "NIMBY" confrontations that often frustrate attempts to develop housing for homeless, mentally ill people. In order to locate suitable housing for tenants, Pathways to Housing PA sought units that were at or below fair market rent (FMR), interviewing landlords and explaining the arrangement. Pathways' Housing Department has working relationships with more than 150 landlords and housing management companies, and is currently expanding its scope in Philadelphia. Through consultations with Team Leaders, ACT team members help to match new tenants with apartments in the location of their choice and help to navigate clients through the move-in process.

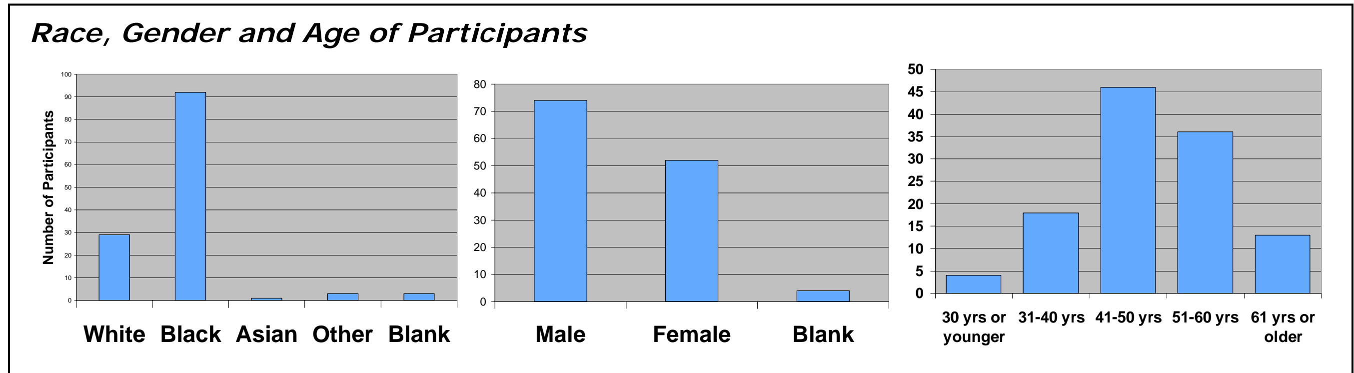
Apartments are leased to Pathways from private landlords. The clients then sign use and occupancy agreements with the agency. Apartments are primarily studio and one-bedroom units in affordable neighborhoods. All apartments are furnished by Pathways. In general, Pathways does not rent more than 10% of the apartments in any one building for program participants. After move-in, housing staff ensure that apartment repairs and emergencies are dealt with adequately and in a timely manner. Pathways also serves as a facilitator between landlords and clients on occasion, but with the ultimate goal of independent living, staff are continually encouraging participants to develop an independent tenant-landlord relationship to the extent possible. A long-term goal is for the lease to be signed over to the tenant's name.

The initial intake date, or "admissions date," marks the date the individuals are admitted to the Pathways to Housing PA program. Previous to the admission date, Pathways staff undertake outreach and engagement of the individual. This includes the participant's election to engage in the Pathways program, and their authorization by a Pathways targeted case manager (TCM) that they fit the criteria, namely, a psychiatric evaluation, for program participation. Once approved, Pathways staff seek appropriate housing for the individual; the move-in date is the first date the participant moves in to their independent housing.

Over the 18-month period from October 2008 to April 2010, Pathways to Housing PA was given a list with a total of 130 service-resistant, chronically homeless individuals in Philadelphia by the Department of Behavioral Health. The individuals were homeless with a

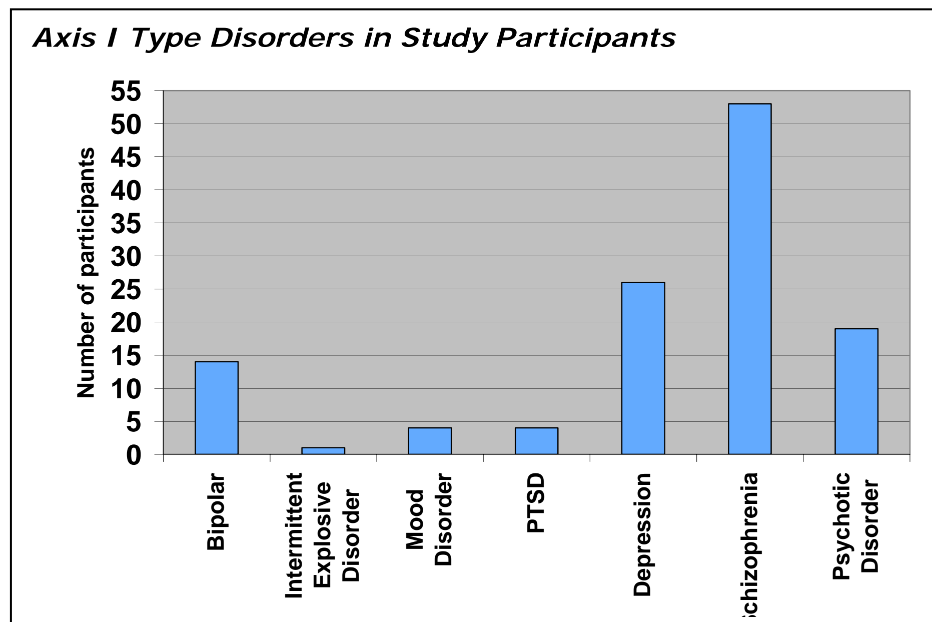
history of mental illness (evident either through hospital records, or familiarity with the individual within the Department), as reported by shelter networks and outreach staff throughout the city. As of April 2010, Pathways had placed 117 of these people, or 90%, into housing. Further details on the people contacted and placed by the program is provided in the following pages.

Demographics: Population Served



Upon intake, the 117 individuals placed into housing self-reported demographic information. Of these 117 individuals placed into housing , 26 identified themselves as Caucasian, 85 identified as African-American, one as Asian, three as "other" and two did not respond to the question. The average age of those placed was 48, with youngest member at 20 years, and the oldest 75. Females made up 39% of the group with 46 females, and 60% were male (70 individuals). One individual did not report gender.

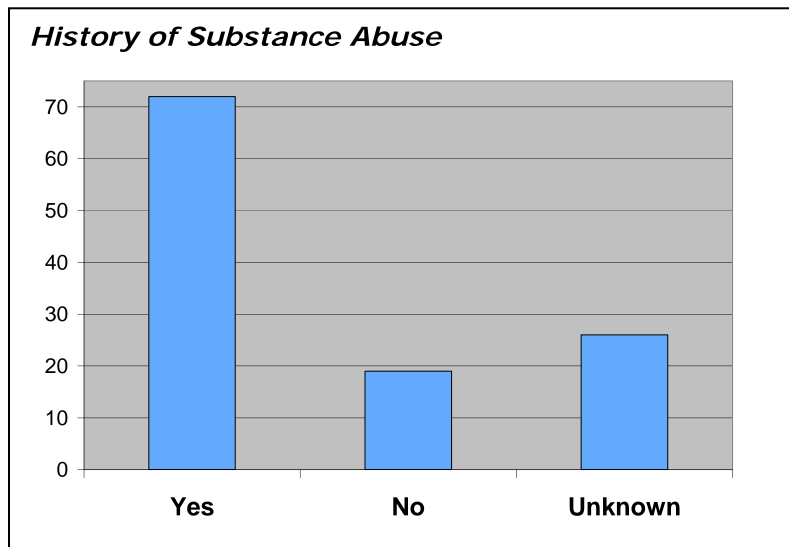
Mental Health: Axis I Type



A requirement of admission into the Pathways to Housing PA Program is diagnosis of mental disorder. Axis I is a coding that includes most types of clinical disorders. A Pathways to Housing PA psychiatrist evaluated participants upon intake to diagnose and confirm their mental health status. All 117 program participants in this 18-month study were thus diagnosed, with 4 of the 117 having two

different Axis I disorders. The following graph depicts the distribution of Axis I mental health disorders among the population studied.

As shown in Graph 2, the majority of participants were diagnosed with schizophrenia (53 participants). Schizophrenia, as an Axis I category, includes schizoaffective disorder, schizophrenia paranoid type, and schizophreniform disorder. The next most common mental illness was depression (26 participants), followed by psychotic disorder (19 participants), which included psychotic disorder, unspecified psychosis and severe psychosis. Fourteen (14) participants were bipolar, 4 had post-traumatic stress disorder (PTSD), 4 had mood disorder, and 1 had intermittent explosive disorder. Of the four participants who had two Axis I disorders, three (3) had both depression and PTSD and one (1) had depression and psychotic disorder.



Mental Health: Substance Abuse

Out of the 117 study participants, 72 reported either past or current substance abuse, including, but not limited to, alcohol, cocaine and/or marijuana. Due to the tendency of self-reporting for alcohol abuse to underreport addictions, this number is likely higher (especially with 26 of the 117 declining to respond to the question). With 62% (at least) of the studied population having engaged in substance abuse at some point, and 100% suffering from Axis I disorders, this "dual diagnosis" population is representative of the chronically homeless population across the nation.

B. Is Pathways to Housing PA effective?

Pathways to Housing PA is effective in placing people in housing

From a public policy perspective, people are better off in housing than they are living on the street. Thus, the most important measure of effectiveness for any program serving the chronically homeless is "How well does it move people from the street into housing?" Of the 130 individuals that Pathways was asked to serve, 117 were successfully housed at least once in the Pathways to Housing PA program. Pathways could not engage the remaining 13 individuals for a variety of reasons. Seven individuals refused services, one was incarcerated after Pathways made initial contact, Pathways was unable to locate two, one moved out of state and two moved into their own residential housing after Pathways contacted them effectively removing them from the population that Pathways is intended to serve.

Of the 128 people that Pathways attempted to engage and house (not including the two who moved into housing on their own), 117, or 92%, were successfully placed into housing over an 18-month period from October 2008 to April 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. By way of comparison, in 2009, the City of Philadelphia's street outreach efforts, which include the Outreach Coordination Center and Homeless Cafes made contact with 4,506 unduplicated individuals of whom approximately 33.5% were placed into shelter or another program.

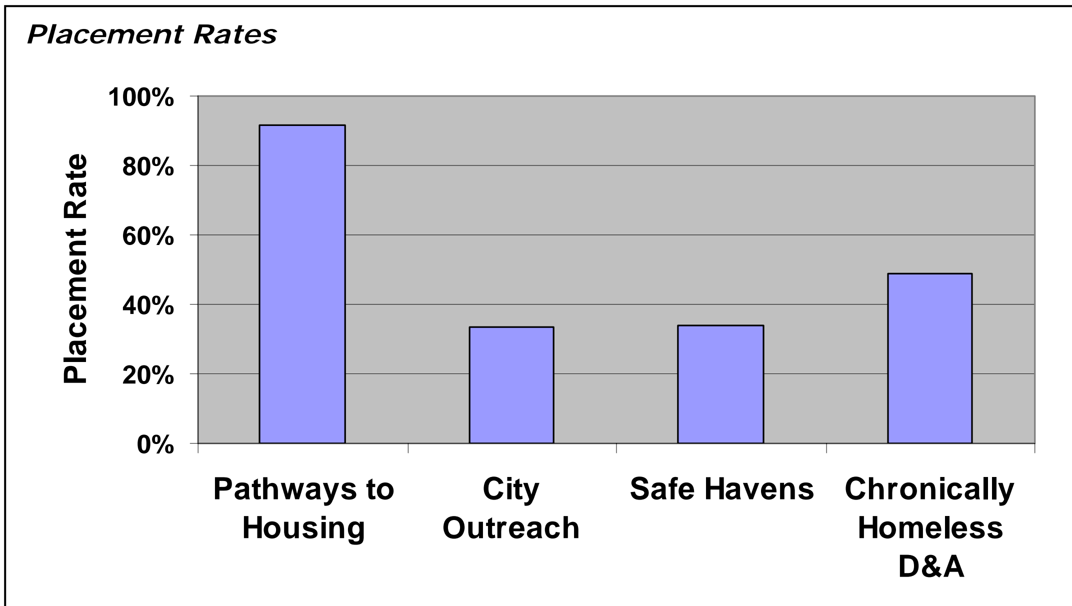
Status of Outreach Contacts	
Refused Services	7
Incarcerated	1
Unable to Locate	2
Moved out of State	1
Moved to own residential housing	2
Placed in Housing	117
Total	130

Pathways' 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 residence for individuals living on the street and access to services for those who want them. In FY 2009, the City had nine Safe Havens offering space to up to 204 people at any on time. In FY 2009, 566 people left Safe Havens. Of those, only 34% moved onto a positive situation including independent living, drug and alcohol or mental health treatment, moving in with supportive friends or family, and others.[26]

The City's Chronically Homeless Drug and Alcohol Treatment Programs provide residential substance abuse and co-occurring treatment services for up to 60 chronically homeless individuals at any one time. An individual's expected length of stay in the programs is six months to one year. Program graduates are eligible for subsidized permanent supportive housing. In FY 2009, 97 people left the program, of whom 49% moved on to a positive situation.

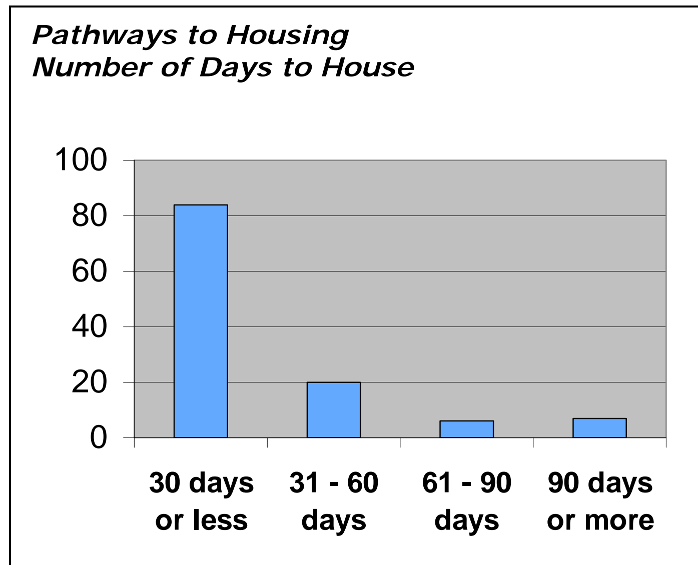
The following table compares Pathways placement rates with the programs described above:

[26] "DBH/MRS Plan to Support Behavioral Health Consumers Who Experience Homelessness." City of Philadelphia, Department of Behavioral Health and Mental Retardation Services (2010).



Pathways to Housing PA's placement rate compares well on a national basis. In San Diego's SIP program, treatment was offered to 268 individuals, 155 of which accepted (a 55% rate). Seattle's DESC program had 40% of their 80 clients stay the full 12 months, 40% stay intermittently (those who experienced at least one temporary departure from the program to another living environment) and 10% who left the program entirely. In the Connecticut program, 17% exited the program, 38% of which left under negative circumstances. In the NY/NY Initiative, after 1, 2 and 5 years, 75%, 64% and 50% (respectively) had retained their placement.

An important component of the Housing First approach is to move participants into housing rapidly. As evidenced from the graph to the right, the vast majority of Pathways to Housing PA individuals were housed in 30 days or less. The average number of days between admissions date and move-in for the 117 participants who were housed was 29 days. Excluding 7 outliers for whom number of days to house exceeded 100 days, the average drops to a more representative 19 days.



One of the key elements of success is the efficiency of the program and the ability to provide housing to participants as quickly as possible. In a report published by HUD, researchers

emphasize the importance of a staffing structure that ensures responsible service delivery.[27] Ensuring that clients' needs are met quickly is an essential metric of success. Additionally, the Corporation for Supportive Housing identified "removing barriers" as contributing substantially to effective interventions. By evaluating and addressing barriers to innovation, supportive housing programs can more quickly get housing and services to clients.

Pathways to Housing PA is effective in keeping people in housing

While getting people off the street and into housing is the primary goal of any program serving the homeless, keeping them in housing and breaking previously established cycles of homelessness is critical to long-term success. From October 2008 to July 2010, 117 individuals have been housed at least once through Pathways to Housing PA. Of these 103 remained stably housed with housed in the Pathways program, one person leaving the program to move in with family and another leaving the program to go into nursing care. Another two people are still participating in the program, although they sometimes return to the streets for short periods and one person remains in the program although currently incarcerated. The remaining 11 individuals have been discharged from the program for multiple reasons. Four individuals have died, three have been incarcerated long-term, one has elected to leave the program, and three have been discharged from the program and are currently homeless. Thus, 103 of the 117 participants who were placed in housing (or 88%) remain stably housed, either in Pathways housing, with family, or in an appropriate care setting. Discounting those who died while participating in the program, the housing retention rate would be 91% (103/117). Another three people remain in the program and have housing available to them. The programmatic retention rate is, therefore, 106/117, or 93.8%. In a study of Housing First models conducted by the founder of Pathways to Housing, Sam Tsemberis, he found that Housing First models in general reported housing retention rates of 80% or better through 12-18 months.[28] With a rate upwards of 88% to 93%, Pathways to Housing PA has had immense success with chronically homeless, mentally ill individuals in Philadelphia.

Status of 117 participants place in housing

Status	Number
Housed in Pathways to Housing Program	101
Housed in Nursing Care	1
Housed with Family	1
Incarcerated (remaining in program)	1
Intermittently homeless (remaining in program)	2
Died	4
Discharge - Homeless	3
Discharge - Refusing services	1
Incarcerated (long-term)	3
Total	**117**

An alternate way to evaluate the effectiveness of housing programs is to examine occupancy rates over time. This type of metric does not fit the Pathways model well, since the program

[27] Pearson, Carol, et al. "The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness." U.S. Department of Housing and Urban Development, Office of Policy Development and Research (2007): xxv.
[28] Stefancic, Ana and Sam Tsemberis. "Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention." Journal of Primary Prevention (2007).

does not have a set number of units it is trying to fill, but rather a number of people it is trying to serve. Nevertheless, the City of Philadelphia measures the effectiveness of programs on this scale, and it offers a way to compare other programs serving the population to Pathways. From 7/1/2009 through 6/30/2010, the number of people housed by Pathways ranged from 88 to 115. Using the maximum number housed as a proxy for the total number of housing units in the Pathways program, the monthly and average occupancy rates for that time period are as follows:

Pathways to Housing
Monthly and average occupancy rates

Total Units 115 (maximum occupancy)

Month	1	2	3	4	5	6
Rate	77%	83%	85%	89%	92%	100%
Number	88	95	98	102	106	115

Month	7	8	9	10	11	12
Rate	99%	97%	96%	97%	96%	93%
Number	114	111	110	111	110	107

	Average
Rate	92%
Number	106

As shown above, occupancy for Pathways during that time ranged from 77% to 100% with an average of 92%.

By way of comparison, the combined occupancy rates for the three permanent housing programs serving chronically homeless individuals are shown below. The following information is for the time period from February 2006 to January 2007, which was the most recently available:

Three permanent housing programs (aggregate)
Monthly and average occupancy rates

Total Units 107

Month	1	2	3	4	5	6
Rate	85%	86%	87%	89%	84%	82%
Number	91	92	93	95	90	88

Month	7	8	9	10	11	12
Rate	79%	76%	79%	79%	76%	72%
Number	85	81	84	84	81	77

	Average
Rate	81%
Number	87

Total occupancy rates for the three programs ranged from 72% to a maximum of 89% with an average of 81%.

Thus, as compared to other programs serving a comparable population, the average occupancy rate for Pathways is more than 10% higher and, in fact, exceeds the maximum rate achieved by the other programs.

Pathways to Housing PA is effective in reducing emergency service usage

Numerous studies have indicated that chronically homeless, mentally ill individuals use a disproportionate amount of publicly-funded emergency services such as emergency shelter, emergency medical care, emergency psychiatric care, etc[29]. Use of such services serves as a proxy for the lack of stability in a person's life: shelter episodes indicate a lack of stable housing; emergency room visits indicate a lack of stable medical care; psychiatric emergencies indicate a lack of stable psychiatric care; etc. In addition, the disproportionate use of such services also represents a drain on the public systems that fund them.

To determine the impact of the Pathways program on emergency service usage, an analysis of de-identified service usage data including shelter episodes, shelter nights, mental health hospitalizations, number of nights in mental health hospitals, mental health court episodes, encounters with the Philadelphia Prison System and number of nights spent in the Philadelphia Prison System was conducted. For each of these variables, Pathways provided aggregate usage data for 51 people who had been in the program for at least one year and who agreed to give Pathways access to their records. For each person, service usage was obtained for the first twelve months they were in the program and for a pre-admission look-back period of the same duration. The data was analyzed to determine if Pathways' clients

[29] Cite studies here.

decrease service usage as a result of participating in the program. Results of this analysis follow.

Shelter Episodes

Shelter Episodes			
There was an 88% decrease in shelter episodes in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.			
Number of Episodes			
Episodes	Pre-Entry	Post-Entry	Change
Total	191	22	(169)
Max	43	9	(34)
Average	3.75	0.43	(3.31)

Change in Usage After 1 Year		
People	#	%
Increased	3	6%
Decreased	25	49%
No Change	23	45%

Persons Who Used at All		
People	Pre	Post
Number	27	8
Percent of Total (n=51)	53%	16%

Pre/Post Usage		
People	#	%
Pre Only	21	41%
Post Only	2	4%
Both	6	12%
Neither	22	43%

Episodes per User		
	Pre	Post
	7.074074	2.75

In the year prior to Pathways housing, participants had a total of 191 shelter episodes, with the highest number of episodes per person at 43. The average number of shelter episodes per person was 3.75. After one year in Pathways housing, the total number of episodes dropped to 22, an 88 percent decrease. The most frequent individual user of shelters was substantially lower at 9 episodes, and the average dropped to 0.43 episodes/person. After one year in the program, three participants increased their usage of shelters, 25 decreased their usage, and 23 had no change in frequency of shelter usage.

A total of 27 individuals used shelters in the year prior to admittance, 53 percent of the study group. Post-usage, only 8 individuals, or 16 percent of the study group, used shelters at least once. In terms of overall usage (regardless of the number of episodes, simply if they had used at all), 21 individuals of the 51 used shelters in the year prior to entering Pathways, but did not use at all in the year after entering the program. Two individuals only used shelters after their tenure in Pathways; 6 individuals used both the year before and the year after admittance. Twenty-two individuals did not use shelters either in the year before or the year

after entering the program. The average number of episodes per user[30] was 7.07 in the year prior to entering the program, and 2.75 in the year following.

Shelter Nights

Distinguished from shelter episodes is shelter nights, the number of nights spent in Philadelphia's shelters. In the year prior to entering Pathways housing, a total of 766 nights were spent in shelters by the 51 person study group. A year into the Pathways program, this number decreased to 101 nights, a decrease of 87 percent. The maximum number of nights spent by an individual user decreased as well, from 166 to 58 (a 65 percent decrease), as did the average number of nights from 15.02 to 1.98 (a 87 percent decrease). After one year in the program, 1 person spent an increased number of shelter nights, while 26 decreased their number of nights, and 24 exhibited no change. Additionally, the number of people who had any shelter nights decreased from 26 people to 5 people, pre- and post-program participation, respectively.[31] Twenty-two individuals spent the night in shelters only before entering Pathways, 1 person spent the night in shelters only after entering Pathways, 4 people had shelter nights both before and after, and 24 did not have shelter nights at all in the year before and year after entering Pathways. For those who stayed

Shelter Nights
There was an 87% decrease in total shelter nights in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.

Number of Shelter Nights

Nights	Pre-Entry	Post-Entry	Change
Total	766	101	(665)
Max	166	58	(108)
Average	15.02	1.98	(13.04)

Change in Usage After 1 Year

People	#	%
Increased	1	2%
Decreased	26	51%
No Change	24	47%

Persons Who Used at All

People	Pre	Post
Number	26	5
Percent of Total (n=51)	51%	10%

Pre/Post Usage

People	#	%
Pre Only	22	43%
Post Only	1	2%
Both	4	8%
Neither	24	47%

Average Nights Per User

	Pre	Post
	29.46	20.20

[30] To be distinguished from the earlier "average," which includes all 51 individuals regardless of whether they had used shelters or not.
[31] NB: the difference in users "at all" between shelter episodes and shelter nights can be attributed to the fact that one can have a shelter episode without staying overnight.

in the shelter overnight at all, the average number of nights decreased from 29.46 nights to 20.2 nights.

Crisis Response Center Episodes

CRC Episodes			
There was a 71% decrease in Crisis Response Center episodes in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.			
Number of Episodes			
Episodes	Pre-Entry	Post-Entry	Change
Total	65	19	(46)
Max	20	5	(15)
Average	1.27	0.37	(0.90)
Change in Usage After 1 Year			
People	#	%	
Increased	3	6%	
Decreased	18	35%	
No Change	30	59%	
Persons Who Used at All			
People	Pre	Post	
Number	21	10	
Percent of Total (n=51)	41%	20%	
Pre/Post Usage			
People	#	%	
Pre Only	12	24%	
Post Only	1	2%	
Both	9	18%	
Neither	29	57%	
Episodes per User			
	Pre	Post	
	3.10	1.90	

Another measure of the effectiveness of Pathways would be a reduction in emergency psychiatric episodes. CRC episodes refer to the number of times an individual has visited a Crisis Response Center, a psychiatric emergency center. In the year prior to entering Pathways, there were a total of 65 CRC visits among the 51 individuals, which decreased to 19 visits after one year in the program, a decrease of 71 percent. The maximum number of episodes had by one person decreased from 20 to 5 (a 75 percent decrease), as did the average, from 1.27 to 0.37 (a 71 percent decrease). Three individuals increased their usage of CRC from the first year to the second, while 18 decreased their usage and 30 had no change. There were 21 people who had CRC episodes at all prior to entering Pathways housing, which decreased to 10 people in the year after. Twelve individuals had CRC episodes only prior to entering the program, 1 individual had episodes only after entering housing, 9 had episodes both before and after, and 29 had no episodes at all. Of those who had CRC episodes at all, the average number of episodes was 3.1 pre-Pathways housing and 1.9 after.

Mental Health Court Episodes

Mental Health Court Episodes			
There was an 11% decrease in Mental Health Court episodes in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.			
Number of Episodes			
Episodes	Pre-Entry	Post-Entry	Change
Total	27	24	(3)
Max	6	5	(1)
Average	0.53	0.47	(0.06)

Change in Usage After 1 Year		
People	#	%
Increased	6	12%
Decreased	9	18%
No Change	36	71%

Persons Who Used at All		
People	Pre	Post
Number	14	10
Percent of Total (n=51)	27%	20%

Pre/Post Usage		
People	#	%
Pre Only	8	16%
Post Only	4	8%
Both	6	12%
Neither	33	65%

Episodes per User		
	Pre	Post
	1.93	2.40

Mental Health Court episodes refer to the number of times a Pathways participant appeared before the Mental Health Court for an involuntary commitment hearing. In the year prior to entry into the program, there were a total of 27 episodes, compared to 24 in the year following entry, an 11 percent decrease. The maximum number of episodes experienced by any individual under study decreased slightly as well, from 6 to 5 episodes; the average number of episodes per person decreased from 0.53 to 0.47. After one year, 6 people increased their Mental Health court episodes, 9 decreased and 36 reported no change. There were 14 individuals who had Mental Health court episodes at all in the year prior to Pathways, and 10 in the year following. Eight people were reported to have used only in the year prior, 4 only in the year following, 6 during both years and 33 who had no Mental Health court episodes at all. The average among those who had at least one episode was 1.93 episodes in the year prior to Pathways and 2.40 episodes in the year following admission into the program.

Community Behavioral Health Hospitalizations Episodes

CBH Hospitalizations

There was a 70% decrease in Community Behavioral Health hospitalization episodes in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.

Number of Episodes

Episodes	Pre-Entry	Post-Entry	Change
Total	108	33	(75)
Max	26	9	(17)
Average	2.12	0.65	(1.47)

Change in Usage After 1 Year

People	#	%
Increased	2	4%
Decreased	16	31%
No Change	33	65%

Persons Who Used at All

People	Pre	Post
Number	19	10
Percent of Total (n=51)	37%	20%

Pre/Post Usage

People	#	%
Pre Only	10	20%
Post Only	1	2%
Both	9	18%
Neither	31	61%

Episodes per User

Pre	Post
5.68	3.30

CBH Hospitalizations refers to acute mental health hospitalizations, both voluntary and non-voluntary. The number of episodes refers specifically to the discrete number of times a client was admitted for acute care (as opposed to duration of stay in the hospital). For the 51 participants in the study group, there were a total of 108 episodes in the year prior to program entrance, which decreased to 33 episodes in the year following, a 70 percent decrease. The maximum number of hospitalizations of any one person decreased from 26 to 9 (a 65 percent decrease) as did the average, from 2.12 episodes to 0.65 (a 69 percent decrease). After one year in the program, 2 participants increased the number of CBH episodes, while 16 decreased their number of episodes, and 33 exhibited no change. There were 19 individuals who had a CBH hospitalization in the year prior to program entry, which decreased to 10 in the year following. Ten individuals had at least one episode only in the year prior, 1 had at least one only in the year following, 9 had episodes in both the year prior and year following, and 31 did not use have any CBH Hospitalizations at all. Of those who had at least one hospitalization in the two year period, the average number of hospitalizations was 5.68 in the year prior, and 3.30 in the year following entry into Pathways.

Community Behavioral Health Hospitalizations Days

CBH Hospitalizations Days			
There was a 46% decrease in the number of Community Behavioral Health hospitalization days in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.			
Number of Days			
Days	Pre-Entry	Post-Entry	Change
Total	418	226	(192)
Max	115	58	(57)
Average	8.20	4.43	(3.76)

Change in Usage After 1 Year		
People	#	%
Increased	6	12%
Decreased	14	27%
No Change	31	61%

Persons Who Used at All		
People	Pre	Post
Number	19	10
Percent of Total (n=51)	37%	20%

Pre/Post Usage		
People	#	%
Pre Only	10	20%
Post Only	1	2%
Both	9	18%
Neither	31	61%

Average Days per User		
	Pre	Post
	22	22.6

CBH Hospitalization days refers to the number of days in acute care experienced by the study group of 51 individuals. In the year prior to entry into the program, there were a total of 418 hospitalization days, which decreased to 226 in the year following entry in Pathways program (a 46 percent decrease). The maximum number of days spent in acute care by one individual fell from 115 to 58 (a 49.6 percent decrease), and the average number of days across the 51 individuals also fell from 8.2 days to 4.43 days (a 45.8 percent decrease). Six individuals increased their number of days hospitalized, while 14 decreased the number of days hospitalized and 33 exhibited no change. Nineteen individuals had at least one night in the year prior to Pathways, and 10 individuals had at least one night in the year following (matching the same statistics for CBH Hospitalization episodes). Ten individuals had CBH hospitalization days only before entering Pathways, 1 individual had CBH hospitalization days only after entering Pathways, 9 individuals had days both before and after, and 31 did not have any hospitalization days either before or after. The average number of days for those who had at least one hospitalization day was 22 days prior to Pathways and 22.6 days in the year following, remaining roughly the same.

Philadelphia Prison System Episodes

PPS Episodes
There was a 50% decrease in Philadelphia Prison System episodes in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.

Number of Episodes

Episodes	Pre-Entry	Post-Entry	Change
Total	16	8	(8)
Max	3	1	(2)
Average	0.31	0.16	(0.16)

Change in Usage After 1 Year

People	#	%
Increased	4	8%
Decreased	7	14%
No Change	40	78%

Persons Who Used at All

People	Pre	Post
Number	11	8
Percent of Total (n=51)	22%	16%

Pre/Post Usage

People	#	%
Pre Only	7	14%
Post Only	4	8%
Both	4	8%
Neither	36	71%

Episodes per User

Pre	Post
1.455	1.00

PPS Episodes refer to the Philadelphia Prison system, and the number of times an individual has entered the system regardless of the amount of time spent there. A total of 16 PPS episodes were reported in the year prior to Pathways for the 51 individuals, decreased to 8 episodes in the year following entry, a 50 percent decrease. The maximum number of days spent in prison by one individual decreased from 3 days to 1 day, and the average decreased from 0.31 days to 0.16 days. Four individuals increased the number of prison episodes from the year prior to Pathways to the year following, 7 individuals decreased the number of episodes, and 40 exhibited no change. Eleven individuals had at least one prison episode in the year prior, and 8 had at least one episode in the year following. There were 7 people who had at least one episode only in the year prior, 4 who had at least one episode only in the year following, and another 4 who had episodes in both the year prior and the year following. Thirty-six individuals did not have any PPS episodes. For those who had at least one episode, the average number of episodes was 1.455 in the year prior to Pathways, and 1 episode in the year following.

Philadelphia Prison System Days

PPS Days			
There was a 45% decrease in number of Philadelphia Prison System days in the twelve months after participants entered Pathways to Housing as compared to twelve months prior to program participation.			
Number of Days			
Days	Pre-Entry	Post-Entry	Change
Total	483	266	(217)
Max	167	129	(38)
Average	9.47	5.22	(4.25)

Change in Usage After 1 Year		
People	#	%
Increased	4	8%
Decreased	11	22%
No Change	36	71%

Persons Who Used at All		
People	Pre	Post
Number	11	8
Percent of Total (n=51)	22%	16%

Pre/Post Usage		
People	#	%
Pre Only	7	14%
Post Only	4	8%
Both	4	8%
Neither	36	71%

Average Days per User		
	Pre	Post

PPS days refer to the total number of days spent in the Philadelphia Prison System. In the year preceding Pathways, the 51 individuals under review spent a total of 483 days in prison. This number decreased to 266 in the year following, a 45 percent decrease. The maximum number of days spent in prison by one of these individuals was 167 in the year prior and 129 in the year following (a 23 percent decrease), and the average number of days spent decreased from 9.47 to 5.22 (a 44.8 percent decrease). Four individuals increased the number of days spent in the prison system, 11 individuals decreased the number of days spent, and 36 had no change in number of days spent. There were 11 individuals who had at least one day in the prison system in the year prior, and 8 in the year following (corresponding with the number of prison episodes). There were 7 individuals who had days in prison only in the year prior to Pathways, 4 who had days in prison only in the year following admittance into Pathways and 4 others who had prison days in both the year before and the year after admittance. Thirty-six did not have any prison days in either year (again corresponding with prison episodes). For the individuals who had at least one prison day, the average number of days in the year prior to admittance was 43.9 days, and the average in the year following admittance was 33.25 days.

As shown above, Pathways' clients decreased service usage as a result of participating in the program:

- Shelter episodes decreased by 88 percent.
- Number of shelter nights decreased by 87 percent.
- Crisis Response Center (CRC) episodes decreased by 71 percent.
- Mental Health Court episodes decreased by 11 percent.
- CBH hospitalizations episodes decreased by 70 percent.
- CBH hospitalization days decreased by 46 percent.
- Philadelphia Prison System episodes decreased by 50 percent.
- Philadelphia Prison System days decreased by 45 percent.

C. How much does it cost?

Pathways provided Fairmount with detailed monthly operating costs for the period from July 1, 2009 to April 30, 2010. Total program costs for this period were $2,700,685. Fairmount reviewed the budget data and worked with Pathways to determine which costs were attributable to housing clients (rent, utilities, etc.) and which were attributable to service provision and program administration. Of the total program costs, $1,867,003 were related to services and administration and $833,682 were related to housing. Projecting these costs to a twelve month basis, total annual costs would be approximately $3,240,822 with $2,240,404 of that amount attributable to services and $1,000,418 attributable to housing.

For that same ten month time period, Pathways served a total of 127 people of whom 115 were placed into housing. The total cost per person served during that time was $21,265 and the total cost per person housed was $23,484. Projecting the costs out to a 12 month period, but keeping the total number of persons served and housed constant, the total annual cost per person served would be $25,518 and the annual cost per person housed would be $28,181. Considering the annualized per person cost on a per diem basis, the total cost per client per day would be $69.91 and the cost per person housed would be $77.21.

D. Is it worthwhile?

Pathways to Housing PA reduces costs across service systems

As detailed previously, people who have been in the Pathways program for at least one year reduce their usage of emergency services as compared to the year before they entered the program. These reductions of service usage represent costs avoided to those systems. A recent study by Project HOME[32] gave the average cost per unit for a number of the services discussed previously including emergency shelter, prison, and mental health hospitalizations. Using these amounts and an estimate of the cost for crisis recovery center episodes discussed below, Fairmount estimated the cross-service cost reductions resulting from the reduction of service usage by Pathways participants.

[32] Saving Lives, Saving Money: Cost-Effective Solutions to Chronic Homelessness in Philadelphia. Project HOME (2010).

Shelter Nights			
Usage	**Pre**	**Post**	**Change**
Total Usage	766	101	-665
Average Usage	15.02	1.98	-13.04
Cost per Night	$34		
Total Cost Avoided	**Pre**	**Post**	**Savings**
Total	$26,044	$3,434	$22,610
Average (per person)	$510.67	$67.33	$443

As shown above, the 51 Pathways participants in the study group reduced total shelter nights by 665 nights or an average of a little more than 13 nights per participant. The average cost of a shelter night is $34. Pathways participants were, therefore responsible for $26,044 in shelter system costs in the year before they entered the program, but only $3,434 in the year after entering the program. Thus, Pathways to Housing PA avoids the shelter system a total of $22,610.

On a per person basis, average usage of shelter went from 15.02 nights in the year prior to entering the program to 1.98 nights in the first year of participation. Average costs were reduced from $510.67 to $67.33 representing savings of $443 per person per year.

MH Hospitalizations			
Usage	**Pre**	**Post**	**Change**
Total Usage	418	226	-192
Average Usage	8.20	4.43	-3.76
Cost per Night	$760		
Total Cost Avoided	**Pre**	**Post**	**Savings**
Total	$317,680	$171,760	$145,920
Average (per person)	$6,229	$3,368	$2,861

In the year prior to entering the program, Pathways participants used a total of 418 mental health hospitalization nights. In the year after entering the program, participants used a total of 226 nights, a reduction of 192 nights. With an average cost of $762 per night, Pathways participants accounted for $317,680 in mental health hospitalization costs in the year before they entered the program. In the first year of the program, these same participants accounted for $171,760 in mental health hospitalization costs, a reduction of $145,920.

Per person usage went from an average of 8.2 nights per person to 4.43 nights per person in the first year of participation. Average cost per person went from $6,229 in the pre- entry time period to $3,368 in the first year of participation, a reduction of $2,861 per person.

Prison			
Usage	**Pre**	**Post**	**Change**
Total Usage	483	266	-217
Average Usage	9.47	5.22	-4.25
Cost per Night	$91		
Total Cost Avoided	Pre	Post	Savings
Total	$43,905	$24,179	$19,725
Average (per person)	$861	$474	$387

Among the study group, nights spent in the Philadelphia prison system totaled 483 in the year prior to entering the program and 266 in the year after entry, a reduction of 217 nights. At $91 per night, total cost of the Pathways study group was $43,905 before entering the program and $24,179 in the first year of participation, for a total reduction of $19,725.

On a per person basis, average usage was 9.47 nights in the pre-entry period and 5.22 nights in the year after entry. Average cost per person was $861 for the pre-program period and $474 in the post-entry period representing an average reduction of $387 per person.

CRC Episodes			
Usage	**Pre**	**Post**	**Change**
Total Usage	65	19	-46
Average Usage	1.27	0.37	-0.90
Cost per Episode	$585		
Total Costs/Cost Avoided	**Pre**	**Post**	**Cost Avoided**
Total	$38,025	$11,115	$26,910
Average (per person)	$746	$218	$528

In the year prior to entering the program, the study group had a total of 65 CRC episodes. In the year after entry, they had a total of 19 CRC episodes, or a reduction of 46. To estimate the cost of each CRC episode, Fairmount used data from a 2000-2002 study on service costs provided by Steven Poulin of the University of Pennsylvania. In that data, the average cost of a visit to a Crisis Response Center was $475. To estimate the cost of a visit in 2009, Fairmount assumed a 3% annual increase in the cost from 2002 to 2009, which is conservative given the overall increase in health care cists during that time. The estimated 2009 cost of a CRC visit, shown above, is $585. Thus, CRC visits by Pathways participants cost $38,025 in the year before they entered the program and $11,115 in the first year of program participation. The total reduction in cost resulting from Pathways participation was $26,910.

Average usage of CRC in the year before entering the program was 1.27 visits per person. During the first year of the program, average usage was .37 visits per person for an average reduction of .9 visits. At $585 per visit, this represents a reduction of $528 per person per year.

As shown below, considering only shelter, mental health hospitalizations, prison, and crisis response center episodes, each person in the Pathways study group saved the public $4,219 in the year after they entered the program:

Overall Costs and Cost Avoided			
Per Person	Pre	Post	Cost Avoided
Shelter Nights	$511	$67	$443
MH Hospitalizations	$6,229	$3,368	$2,861
Prison	$861	$474	$387
CRC Episodes	$746	$218	$528
Totals	$8,346	$4,127	$4,219

Savings for all 51 persons in the study group totaled $215,165:

Overall Costs and Cost Avoided			
51 Study Subjects	Pre	Post	Cost Avoided
Shelter Nights	$26,044	$3,434	$22,610
MH Hospitalizations	$317,680	$171,760	$145,920
Prison	$43,905	$24,179	$19,725
CRC Episodes	$38,025	$11,115	$26,910
Totals	$425,654	$210,488	$215,165

Assuming that Pathways houses approximately 100 people at any one time (average number of persons housed per month in the past 12 months is approximately 106) the program would save the public a total of $421,893 per year:

Overall Costs and Cost Avoided			
Assuming 100 Participants	Pre	Post	Cost Avoided
Shelter Nights	$51,067	$6,733	$44,333
MH Hospitalizations	$622,902	$336,784	$286,118
Prison	$86,088	$47,411	$38,677
CRC Episodes	$74,559	$21,794	$52,765
Totals	$834,615	$412,722	$421,893

It is important to note that these figures do not include other costs that have been found to reduce significantly for chronically homeless persons in Housing First programs, such as medical emergency room visits, emergency medical transportation, in-patient hospitalizations, police time, detoxification programs, etc. Given the reductions in medical costs found by other evaluations of Housing First programs, it is likely that the total savings

are significantly higher than shown above. The focus of this study was on city-funded systems, so medical costs, which are funded outside of the city budget, were not considered. Other studies found significant savings on medical usage, so savings are likely understated. In an evaluation of San Diego's Serial Inebriate Program, it was found that for those who accepted services, emergency department and inpatient services declined collectively by 50%, resulting in an estimated decrease of total monthly average charges of $5,662 (emergency medical services), $12,006 (emergency department) and $55,684 (inpatient care).

Pathways to Housing PA reduces outreach costs

As noted previously, Pathways has a 92% success rate in placing the people it contacts on the street into housing, as compared to a 32% rate for traditional outreach. In addition to moving more people off of the street, Pathways also avoids the cost of repeated outreach to people living on the street. The City of Philadelphia's outreach system consists of the Outreach Coordination Center, which provides coordinated outreach to the City's street population and the City's Homeless Cafes, which provide overnight sanctuary to those who are unwilling to enter the shelter system. In FY 2009, the Department of Behavioral Health spent $6,000,000 on outreach services. During that time, outreach workers made 30,202 contacts with 4,506 unduplicated individuals. These 30,202 contacts resulted in a 1,509 people being placed into various programs including shelter and detoxification programs. A number of people were placed multiple times, as the total placements during the time period was 2,424. This means that outreach workers contact each individual on the street almost seven times and that only one-third of them choose to enter shelter given the options that traditional outreach offers. These figures are represented in the following table:

Outreach Costs (including cafes)		
	Cost (2009)	$6,000,000
	Contacts	30,202
	People Contacted	4,506
	Contacts/Person	6.702619
	People Placed	1,509
	Cost/Contact	$198.66
	Cost/Person	$1,331.56
	Cost/Person Placed	$3,976.14

Seen one way, the Pathways program saves the City $1,332 for every person it houses. However, each person contacted and not placed in stable housing represents a future cost to the outreach system as they will remain on the street and need to be contacted repeatedly (almost 7 times per year, on average). Thus, the more appropriate comparison is the cost per successful placement. Viewed that way, Pathways saves the City an additional $3,976 per person in its program.

Pathways to Housing PA is cost effective when compared to comparable programs.

As noted above, there are three programs in the City's Continuum of Care that provide permanent housing to chronically homeless, seriously mentally ill individuals. Fairmount

analyzed data available from the City's Continuum of Care application to HUD from 2007 to determine the costs of those programs so they could be compared to the costs of the Pathways program. The information available was for the 2006 program year. As shown in the following table, the first program, denoted as Program A, has 70 units of housing and spent a total of $3,055,360 on housing and services, or $43,648 per unit, during that time. Program B has 25 units and spent a total of $2,321,358, or $92,854 per unit, during the 2006 program year. Program C has 12 units and spent a total of $683,835, or $56,986 per unit in the 2006 program year.

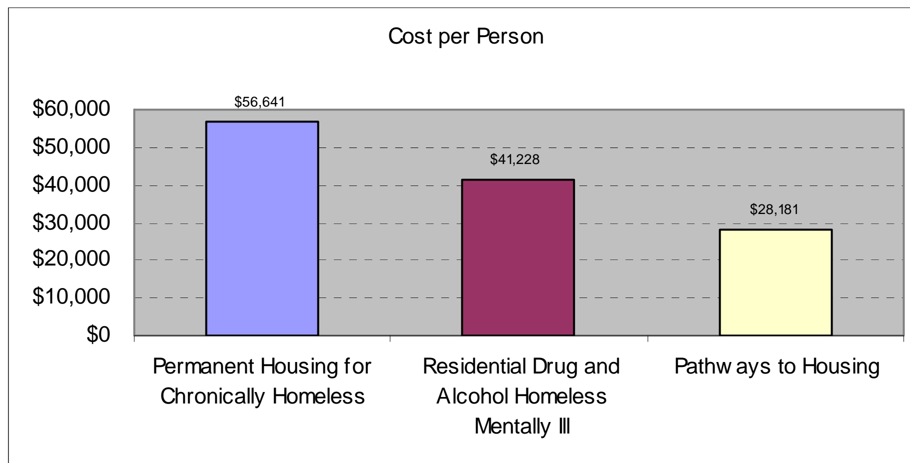
	Program A		Program B		Program C	
	70	Units	25	units	12	units
	Total Cost	Cost/Person	Total Cost	Cost/Person	Total Cost	Cost/Person
Housing	$591,360	$8,448	$209,358	$8,374	$78,799	$6,567
Services	$2,464,000	$35,200	$2,112,000	$84,480	$605,036	$50,420
Total	$3,055,360	$43,648	$2,321,358	$92,854	$683,835	$56,986

Altogether, the three programs contain 107 units and spent a total of $6,060,553, or $56,641 per person:

	Program Totals	
	107	Units
	Total Cost	Cost/Person
Housing	$879,517	$8,220
Services	$5,181,036	$48,421
Total	$6,060,553	$56,641

The City of Philadelphia's DBH/MRS Office of Addiction Services and Office of Supportive Housing also have four substance abuse programs that provide 60 residential treatment beds for chronically homeless individuals. In FY 2009, those programs cost a total of $4,700,000 or $41,228 per bed.

As noted earlier, the total annualized cost of Pathways to Housing PA is $3,240,822. As was done in calculating occupancy rates previously, using the maximum number of persons housed as a proxy for the number of units in the program, the cost per unit was $28,181. The cost of the Pathways to Housing PA Program is, therefore, considerably less than the cost of comparable residential programs in the City of Philadelphia.



Appendix A – Review of Selected Housing First Programs

The following is a description of other Housing First-type programs initiated in other cities.

In 1990, New York State (NYS) and New York City (NYC) agreed to jointly fund and develop 3,600 housing units for homeless individuals with serious mental illness in a program called the New York/New York Agreement to House the Homeless Mentally Ill (the NY/NY Initiative). The innovative program was designed to target the most difficult to service individuals, easing demand on shelters and psychiatric treatment centers. To be eligible for the housing, tenants must have a diagnosis of serious mental illness and have recently been homeless in shelters or on the streets. Application and assessment were performed by the NYC Human Resources Administration (HRA) to determine eligibility; the prospective tenant then applied through one of the nonprofit agencies that administered the funds of the program. The program provided housing and psychosocial services in two general configurations, known as NY/NY housing. The first model was supportive housing, including scattered-site units with community-based service support and single-room occupancy (SRO) housing. This model separated housing from supportive services, thus giving residents a sense of independence and choice. The second were community residence facilities, which included long-term treatment facilities and adult homes. These residences were more clinical in nature; supportive services were a necessary condition of housing.

The Colorado Coalition for the Homeless created the Denver Housing First Collaborative (DHFC) in 2003. The program uses a Housing First strategy, combined with assertive community treatment (ACT) services. The ACT model uses an intensive case management team that has the capacity to provide integrated support services including: health care, mental health care, substance treatment, psychiatric evaluation, medication management, benefits acquisition and supported employment and education opportunities. A major component of the ACT team is to deliver services directly to the consumer in the community as opposed to requiring them to come into an office. The DHFC began accepting referrals in January 2004; by the end of the year, there had been 739 referrals. Of these 739, all had at least one of substance use, mental health disability and physical health disability, with the vast majority indicating at least two and often three disabling conditions. Approximately 35% of the participants are housed in a supportive housing development, and the remaining live in scattered site apartments owned by private landlords. Tenants pay 30% of their income for rent, and the program pays the balance directly to the landlord.

The Downtown Emergency Service Center in Seattle, Washington is a permanent supportive housing program with a Housing First approach. Serving as a demonstration program site for the US Department of Health and Human Services, DESC serves more than 300 clients, nearly all of whom have mental illness, the majority of whom have substance-related disorders, and 84% of those tracked met HUD criteria for chronic homelessness. DESC's 1811 Eastlake project opened in December 2005. 1811 Eastlake, located just north of Seattle's downtown, is a Housing First program with onsite services

for 75 formerly homeless men and women living with chronic alcoholic addiction who are frequent users of crisis and emergency healthcare services. Nearly half of all residents have a co-occurring mental illness, and almost all others have chronic and disabling health conditions. Chemical dependency treatment and mental healthcare are provided onsite. Residents are encouraged, although not required, to participate in treatment. Sobriety is not required as a condition of tenancy. Residents of 1811 Eastlake have no treatment requirements but on-site case managers (24 hours a day, seven days a week) work to engage residents about substance abuse and other supportive services. DESC is the only provider in the Seattle area to have converted all of its housing stock to Housing First-type programs.

The San Diego Police Department-initiated Serial Inebriate Program (SIP) provides housing and treatment in lieu of custody to persons convicted of a criminal charge of public drunkenness or disorderly contact. This program was initiated in 2001, aimed at an estimated group of 300 homeless individuals "stuck in a revolving door between jail, emergency departments and the city's sobering center." (14, 15) SIP targets chronically homeless persons who are frequent users of jail, emergency health services and crisis alcohol treatment services. The program offers housing and treatment in lieu of custody to persons convicted on a misdemeanor criminal charge of public drunkenness. The program employs a coercive strategy for highly recidivist individuals. The program had early success, allowing it to expand citywide as a partnership between law enforcement, the fire department, emergency medical services, hospitals, the public defender, the city attorney, the courts, treatment providers and county alcohol and drug services. SIP aims to provide patients who have exhausted other treatment options with a living alternative, while reducing their adverse impact on the community-at-large. In this way, the judicial system is aligned with treatment, creating incentives for participation in outpatient recovery programs.

In San Francisco, the Department of Public Health (SFDPH)'s *Direct Access to Housing* (DAH) program accepts single adults into permanent housing directly from the streets, shelters, acute hospitals and long-term care facilities regardless of active substance abuse disorders, serious mental health conditions and/or complex medical problems. Established in 1998, it currently provides permanent housing with on-site supportive services for approximately 1,100 adults, most of whom have concurrent mental health, substance use, or chronic medical conditions. SFDPH operates a large public hospital, a publicly funded skilled nursing facility, primary care and mental health clinics, and contracts for a broad variety of services through community-based providers. The DAH program was developed as a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities. Residents are specifically referred to the DAH program if they are high users of the public health system and have on-going substance abuse, mental illness and/or medical programs. Many of these individuals have been be unwilling or unable to maintain permanent housing independently. Individuals are screened through a centralized intake process when potential residents are prioritized based on nature and severity of illness. The first DAH residents often came directly from the streets, and from emergency shelters. More recently, residents have come to DAH housing from medical

and psychiatric institutions that serve a high percentage of homeless people. The DAH program provides 1,100 units of permanent supportive housing in nine Single Room Occupancy (SRO) hotels, five newly developed properties, and one licensed residential care facility. In most of the buildings, residents live independently but support services are on site.

The California HealthCare Foundation and The California Endowment created the Frequent Users of Health Services Initiative (FUHSI), a pilot program conducted in six counties in California. Pilot programs were located in Alameda, Los Angeles, Sacramento, Santa Clara, Santa Cruz and Tulare Counties. The program addressed avoidable emergency department use among patients with complex, unmet needs that were not dealt adequately in the acute care settings. The initiative was begun to relieve pressure on overburdened systems and to promote the more effective use of resources by testing new models of care for "frequent users" of hospital emergency departments. The Initiative focused on building a more respective system of care to decrease these frequent users' use of avoidable emergency department visits and hospital stays. These frequent users were a small group of individuals with serious health conditions, who also have psychosocial risk factors, including mental health disorders, substance abuse and homelessness, and account for disproportionate costs and time for emergency departments. The Initiative pilot program employed various methods and strategies to target and engage program participants, including: electronic "flagging" of frequent users for automated referral process, program access to housing vouchers for permanent housing, ongoing case management by program staff, and co-location of program staff in the emergency departments for "real time" access. Through these features, the Initiative was to create a more responsive system of care that proactively address patient needs, produces better outcomes, and frees up emergency department resources for acute medical crises.

In 2002, a group of health care and housing providers in Chicago came together to serve homeless individuals with chronic medical health conditions. The Chicago Housing for Health Partnership (CHHP) is an integrated system of housing and supports for individuals with chronic mental illness who are homeless upon discharge from hospitalization. Working with partner hospitals, CHHP identifies those individuals with serious mental illness who are likely to be homeless upon leaving the program. The program was initiated to address the fact that one in every three inpatients (32.4%) at Chicago's Cook County Hospital was homeless or at high risk for homelessness during a study period in 2006. The CHHP intervention has three integrated components: expedited hospital discharge – participants receive hospital discharge planning from on-site supportive services providers, including plans for transitional care and permanent housing; housing first – placement in permanent, stable housing, and specialized case management services – delivered through a team of case managers from partner hospitals, respite programs and housing providers. This Housing First model places chronically ill homeless individuals in appropriate stable housing first. While case management and other supportive services are essential, the initial provision of housing provides permanency in the context of other change.

The New York City Departments of Corrections (DOC) and Homeless Services (DHS), with assistance from the Department of Health and Mental Hygiene (DOHMH) and the New York City Housing Authority (NYCHA), implemented the Frequent Users Service Enhancement Initiative (FUSE). This New York-based program was a central component of a larger, nationwide, "Returning Home Initiative" and the first FUSE program to be initiated. The FUSE approach integrates efforts of housing, human services, corrections and other public systems. In New York, this program had placed 100 individuals in permanent supportive housing as of 2009, in an effort to break the cycle between jail, shelter, emergency health and other public systems. The New York City Frequent User Service Enhancement Initiative provides 201 units of supportive housing for people leaving The program serves a small group of frequent users, 100% of whom or homeless, 30-50% of whom have mental health problems, 25-40% of whom have been diagnosed with a serious mental illness, and most of whom were arrested for "quality of life" crimes. A key feature of this program is the intensive services provided during the critical time from recruitment through stabilization in housing. Eligibility is determined through a data match between DOC and DHS to identify people with a certain number of jails and shelter stays in the last five years.

Appendix B – Review of Selected Housing First Evaluations

The effectiveness and impact of the Housing First model has been evaluated by numerous studies conducted across the country. In a landmark study, Dennis Culhane and colleagues tracked 4,679 homeless people with serious mental illness who were placed in supportive housing in New York City between 1989 and 1997. Data was collected and analyzed from a wide variety of public and private sources: utilization of public shelters, public and private hospitals and correctional facilities. Researchers used a matched group of controls, individuals who were homeless but were not placed in housing. They tracked service use for these individuals in comparison with those who had participated in the NY/NY Initiative in the two-year period immediately before and after NY/NY placement. This evaluation of the NY/NY Initiative "was able to quantify for the first time in the published literature the extent of service use by homeless people with serious mental illness *before* housing placement" (13,138) It was found that the net annual cost of the program, after accounting for decrease in service usage in seven public service systems, was 5-10% of the overall cost of the program; 90-95% of the costs of supportive housing in the NY/NY Initiative were compensated by reductions in collateral service attributable to the Housing First placement. Prior to placement, homeless individuals with severe mental illness used approximately $40,451 per person per year in services (1999 dollars). Placement in NY/NY housing was associated with a reduction in service use of $16,281 per housing unit per year. Annual unit costs were estimated at $17,227, a net cost of $995 per unit per year over the first two years. The NY/NY Initiative and the resulting analysis have "galvanized many cities and the country as a whole to adopt the goal of ending chronic homelessness." (11,1)

A cost-benefit analysis of the Denver Housing First Collaborative (DHFC) was conducted in December 2006 by the Colorado Coalition for the Homeless. The analysis examined the health and emergency service records of a sample of DHFC participants for the 24 months prior to entering the program and the 24 month period after entering the program. The study finds an overall reduction in emergency service costs for the sample group, with total emergency related costs declining by 72.95%, or nearly $600,000 in the 24 months of participation in the DHFC program compared with the 24 months prior to entry. The total emergency costs avoided averaged $31,545 per participant. Additionally, utilization of emergency room care, inpatient medical and psychiatric care, detox services, incarceration and emergency shelter were significantly reduced by participation in the program. Out outpatient health costs increased, as participants were directed to more appropriate and cost effective services through participation in the program. Fifty percent of participants documented improvements in their health status: 43% have improved mental health status, 15% have decreased their substance use, and 64% have improved their overall quality of life.

In 2009, researchers at the University of Washington, funded by the Robert Wood Johnson Foundation in a three-year study, performed a quasi-experimental evaluation of DESC's 1811 Eastlake location. Researchers compared 95 of the housed participants with 39 wait-list control participants between November 2005 and March 2007. Administrative data was collected from the King County Mental Health Chemical Abuse and Dependency Services Division, Washington Department of Social and Health Services, Harborview Medical Center (HMC), King County Correctional Facility, Public Health – Seattle & King County

and Downtown Emergency Services Center. Claims submitted to Medicaid were also obtained. They found that use and cost of public system services for Housing First participants had a total cost rate reduction of 53% as compared to the wait-list controls over the first six months, and that the costs of the program were offset at six months for those participating in the program. The total costs offsets of program participants relative to the control group averaged $2449 per person per month, after accounting for housing program costs. Overall, DESC's 1811 Eastlake project saved taxpayers over $4 million over the first year of operation. Additionally, alcohol use by Housing First participants decreased by about one-third. The median number of drinks for program participants dropped steadily: from 15.7 per day prior to move in, to 14, 12.5 and 10.6 per day at 6, 9 and 12 months in housing.

The University of California, San Diego Department of Emergency Medicine conducted a retrospective review of health care utilization records among SIP program participants (emergency medical services, emergency department visits, and inpatient care) of 529 chronically homeless individuals. Over a four-year period, 308 of the 529 (58%) individuals were transported by EMS 2,335 times; 409 0f 529 (77%) individuals amassed 3,318 emergency department visits, 217 of 529 (41%) individuals required 652 hospital admissions, resulting in 3,361 inpatient days. Health care expenses totaled $17.7 million ($1.3 million in emergency medical services, $2.5 million in emergency department, and $13.9 million in inpatient services). Treatment through the program was offered to 268 individuals, and 156 (58%) accepted. For the 156 who accepted services, the use of emergency medical services, emergency department and inpatient services declined collectively by 50%, resulting in an estimated decrease of total monthly average charges of $5,662 (emergency medical services), $12,006 (emergency department) and $55,684 (inpatient care). There was no change in services for the 112 who refused treatment in the program. Additionally, here was a significant trend towards acceptance of treatment in SIP as jail sentences lengthened.

An evaluation of San Francisco's Direct Access to Housing program found that acute medical care reduced significantly after entry into housing as compared to the two years prior to housing placement. Since first opening the site in 1998, almost two-thirds of the residents have remained housed in DAH. Of the remaining 1/3, half moved into other permanent housing. Only 4% residents were evicted from the housing facilities. Due to severity of mental illness, 4% of residents died. After placement, residents' use of services, specifically acute medical care, changed dramatically. There was a 58% reduction in emergency department visits and a 57% reduction in inpatient episodes. Although 1/6 of residents had exacerbations in mental illness resulting in psychiatric hospitalization before and after tenancy, the number of days per hospitalization decreased significantly after being housed.

The Lewin Group, a health care policy research and management consulting firm, conducted an external process and outcome evaluation of the Frequent Users of Health Services Initiative (FUHSI). In this evaluation, it was demonstrated that a multi-disciplinary, coordinated care approach can reduce emergency department visits and costs, while improving the stability and quality of life for patients. The Lewin Group found that a small number of patients drive a disproportionate use of emergency department (ED) visits. On top of the excessive costs, this frequent care was found to not meet the needs of these users appropriately. One of the sites, Project Connect in Santa Cruz, also had data which illustrated utilization across multiple systems. Results showed that enrolled clients had

declines in ambulance use (55%), jail bookings (51%) and jail days (37%). The analysis pointed to the significance of housing status. At enrollment, nearly half of all program participants were homeless. Given the propensity for these frequent users to be homeless, a key goal of the Initiative became to move clients quickly to housing. Connecting homeless frequent users to permanent housing made significant differences in frequency and expense of emergency room visits. Additionally, inpatient days and charges decreased by 27% for permanently housed clients, but for those who remained homeless, inpatient days grew by 26% and inpatient charges increased by 49%. The Initiative's ability to move participants into housing quickly was a key determinant of their continued abuse of the emergency department and inpatient hospital systems.

An evaluation of the Chicago Housing for Health Partnership (CHHP) demonstrates that offering housing and case management to homeless adults with chronic illness creates stability, dramatically reduces hospital days and emergency room visits. The evaluation followed 405 chronically ill homeless persons over an 18 month period following discharge from Chicago hospitals. CHHP researchers used a randomized control trial to study the number of hospital, emergency room, and nursing home visits were incurred by two groups: individuals who received CHHP supportive housing, compared to those who received "usual care," a piecemeal system of emergency shelters, family, and recovery programs. The information was used to track health outcomes and assess how much in avoidable medical expenses could be saved through stable housing and increased access to primary care. Participants had high rates of long-term substance abuse (86%), mental illness (46%), and medical issues such as HIV/AIDS (36%) and hypertension (33%). After 18 months in the program, 66% of the intervention group reported stable housing as compared to only 13% of the control group. Controlling for a range of individual and service variables, housed participants had 29% fewer hospitalizations, 29% fewer hospital days and 24% fewer emergency room visits than their control counterparts.

The New York Frequent Users Service Enhancement Initiative was the first to be implemented and operating long enough to produce concrete evaluation results. The John Jay College Research and Evaluation Center conducted an initial evaluation of FUSE using a quasi-experimental design, comparing those who were placed in housing with a control group. Provider housing data shows that NYC Fuse has a 91% housing retention rate for the first year following placement, and 85% housing retention for all placement raging up to 34 months in duration. Days spent in jail and shelter before and after placement into supportive housing were reduced by 53% and 92%, respectively, for those who received FUSE housing and services, whereas the comparison group in traditional methods of care decreased their shelter use by only 20% and 71%, respectively, in the year following placement. Cost-effectiveness analyses based on these data show a cost offset of the City's Department of Correction and Homeless Services of at least $2,953 per person, per year. A follow-up evaluation is being initiated to examine the impact and cost-effectiveness of the intervention, including the potential for the program to break even and perhaps generate public savings.

Appendix C - A Word About Approach

As the first study of the Pathways to Housing PA approach to housing first services conducted in Philadelphia, this evaluation was undertaken with three broad, but limited, goals. First, to evaluate the Pathways to Housing PA program in and of itself to see if it is effective in improving the lives of those it serves by moving them off of the streets and helping them stay housed. Second, to see if participation in Pathways reduced the use of City-funded services thereby reducing costs across systems. And, third, to see if Pathways is a cost-effective alternative as compared to other programs that serve a similar population. By focusing on this limited set of goals, the evaluation could be completed in a relatively short timeframe, using readily-accessible data gathered from Pathways to Housing PA and cooperating government agencies as well as publicly available information.

The Pathways program was evaluated using two sets of data for its participants. De-identified data containing information on intake, placement, current housing status, demographics, and mental health diagnosis for all participants was analyzed to describe the population served and determine housing and retention rates. De-identified data for a subset of participants who allowed Pathways to collect service usage data from the City of Philadelphia CARES database was analyzed to determine if service usage changed as a result of participation in the program. For this analysis, service usage for the year prior to program entry was compared with service usage for the first year of participation in the program.

As noted in Appendix B, other evaluations of have taken an expanded scope of inquiry. Some included matched-pair analyses to compare service usage of Housing First participants with control groups who did not participate in Housing First. Many focused on quantifying reductions in emergency medical costs resulting from participation in Housing First. Given the limited time and resources available for this evaluation, neither of these types of analyses could be included in the study. However, given the results shown by this evaluation, particularly the significant reductions in medical usage by Housing First participants found in other evaluations, both approaches offer promising avenues for additional study. It is hoped that more in-depth analyses of the Pathways to Housing PA will be undertaken in the future.

Appendix D - About Fairmount Ventures, Inc.

This evaluation was produced by Fairmount Ventures, Inc. (Fairmount), a Philadelphia based consulting firm consisting of sixteen (16) professional staff with diverse academic and professional experience. Formal academic training among the staff includes business and finance, city planning, public policy, social welfare policy, human service delivery, education, healthcare, communications and evaluation. Fairmount's inter-disciplinary team focuses exclusively on non-profit and public sector organizations working in the areas of human services, economic development, community development, behavioral and physical healthcare, and affordable and supportive housing. Since its inception in 1992, the firm has served more than 225 organizations and raised over $350,000,000. Clients range in size from small, community-focused organizations to large nonprofit institutions and public agencies.

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