Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities

Sam Tsemberis, Ph.D.
Ronda F. Eisenberg, M.A.

Objective: This study examined the effectiveness of the Pathways to Housing supported housing program over a five-year period. Unlike most housing programs that offer services in a linear, step-by-step continuum, the Pathways program in New York City provides immediate access to independent scatter-site apartments for individuals with psychiatric disabilities who are homeless and living on the street. Support services are provided by a team that uses a modified assertive community treatment model. Methods: Housing tenure for the Pathways sample of 242 individuals housed between January 1993 and September 1997 was compared with tenure for a citywide sample of 1,600 persons who were housed through a linear residential treatment approach during the same period. Survival analyses examined housing tenure and controlled for differences in client characteristics before program entry. Results: After five years, 88 percent of the program’s tenants remained housed, whereas only 47 percent of the residents in the city’s residential treatment system remained housed. When the analysis controlled for the effects of client characteristics, it showed that the supported housing program achieved better housing tenure than did the comparison group. Conclusions: The Pathways supported housing program provides a model for effectively housing individuals who are homeless and living on the streets. The program’s housing retention rate over a five-year period challenges many widely held clinical assumptions about the relationship between the symptoms and the functional ability of an individual. Clients with severe psychiatric disabilities and addictions are capable of obtaining and maintaining independent housing when provided with the opportunity and necessary supports. (Psychiatric Services 51: 487–493, 2000)
reach (17) to involuntary transportation to a psychiatric hospital (18). Some researchers argue that individuals in this segment of the population reject services because they distrust and are frustrated with the fragmented mental health, drug treatment, and medical care systems, which are unable to coordinate services to meet their needs, especially the need for housing (1,19).

Survey studies have shown that homeless consumers have different perceptions of their service needs than do providers. Consumers believe that meeting basic needs should come first, whereas providers emphasize mental health services (20,21). Several studies found that consumer self-determination predicts whether or not an individual will accept services (19,22). Other evidence suggests that many individuals who are labeled uncooperative by providers are willing to accept help if they view that help as relevant to them (23). Despite such consistent findings, mental health programs, especially those involving housing, have not been characterized by consumer-driven service approaches.

The linear residential treatment model

The design of New York City’s service system for individuals who are homeless and mentally ill is consistent with the recommendations of the Federal Task Force on Homelessness and Severe Mental Illness (24). The system consists of several program components, which as a whole form a linear continuum of care. The system is designed to assist clients through a step-by-step progression of services that begins with outreach, includes treatment, and ends with permanent housing (25).

In the first step, outreach programs engage the individual who is literally homeless and encourage him or her to accept a referral to low-demand second-step programs, such as drop-in centers, shelters, safe havens, or other transitional settings. These programs allow the person to remain indoors, usually for a specified period of time. They also provide assistance in obtaining entitlements and psychiatric or substance abuse treatment. These second-step programs are aimed at developing clients’ housing readiness so that they will be able to meet eligibility criteria required by housing providers. Complying with psychiatric treatment and maintaining periods of sobriety are frequently among such criteria.

Finding permanent housing is the third and final point on the continuum. Most providers use the linear residential treatment model to operate permanent housing programs. The programs consist of a wide assortment of congregate living facilities, such as group homes, community residences, and single-room-occupancy residences, with varying intensities of on-site services. The end point of this continuum is independent housing where the client can live in the community with few, if any, supports. The model combines treatment and housing under one program in an effort to match clients to the treatment residence best suited to their needs and capacities. Residents are placed in a variety of congregate living options with varying degrees of supervision.

In linear residential treatment programs, clinical status is closely related to housing status. To be admitted to the program, a client must agree to participate in psychiatric and substance abuse treatment. If he or she subsequently has a psychiatric crisis or relapses into drug abuse, the clinical team may move the client into a more intensely supervised housing setting. The programs also require clients to participate in ongoing psychiatric treatment and to maintain sobriety if they are to retain their housing. The overall goal of these programs is to stabilize clients and prepare them for independent living.

Consumers and advocates have identified several flaws in the linear residential treatment model. One serious problem is the lack of consumer choice and freedom in treatment or housing. Another is the stress that results from congregate living and frequent change of residence. A third problem is inferred from research on psychiatric rehabilitation that indicates that skills learned for successful functioning at one type of residential setting are not necessarily transferable to other living situations (26). A fourth problem is that it takes a substantial amount of time for clients to reach the final step on the continuum. Finally, the most important problem with the model is that individuals who are homeless are denied housing because placement is contingent on accepting treatment first (27).

The Pathways supported housing program

Pathways to Housing, a nonprofit agency in New York City, developed a supported housing program to meet the housing and service needs of homeless individuals who live on the streets and who have severe psychiatric disabilities and concurrent addiction disorders. The program is designed for individuals who are unable or unwilling to obtain housing through linear residential treatment programs. Founded on the belief that housing is a basic human right for all individuals, regardless of disability, the program provides clients with housing first—before other services are offered. All clients are offered immediate access to permanent independent apartments of their own.

Clients enter the program directly through outreach efforts of staff of the Pathways supported housing program or through referrals from the city’s outreach teams, drop-in centers, or shelters. Priority is given to women and elderly persons, who are at greater risk of victimization and health problems (28), and to individuals with other risk factors, such as a history of incarceration, that impede access to other programs.

When clients are admitted, the staff assists them with locating and selecting an apartment, executing the lease, furnishing the apartment, and moving in. Tenants select the location of their own apartments from available units on the open market. They decide whether anyone will live with them and who those roommates will be. Most apartments are owned and leased to clients individually by private landlords. If a suitable apartment is not found immediately, clients who are living on the streets are provided with a room at the local YMCA or a hotel until an apartment is secured.

The apartments are scatter-site stu-
Harm reduction also means that relapse does not remain an unmet goal. The approach can be obtained even if abstinence remains an unrealistic goal for individuals with a dual diagnosis (31,32).

Comparison of programs
Perhaps not surprisingly, the majority of clinicians have expressed doubts about the feasibility of supported housing in general (33), let alone a program offering immediate access to supported housing to individuals who are literally homeless. These clinicians argue that supported housing is, at best, suitable for a small, high-functioning group (34). Most service providers favor the linear residential treatment model that uses clinically managed residential treatment settings and that regards homeless mentally ill persons as too fragile and too clinically unstable to cope with “normal” life (35–38).

Proponents of the supported housing model regard consumer choice rather than treatment compliance as the necessary first step in the recovery process. Recent research findings support this view. In one study, clients who were given a choice among housing options reported greater housing satisfaction, improved housing stability, and greater psychological well-being (39). Consumer preference studies have found that the lack of consumer choice can actually accelerate homelessness, because consumers may choose the relative independence of the streets to the restrictions of a highly structured residential facility (40).

Several studies have found that many of the liberties taken for granted by most Americans—privacy, control over one’s daily activities, and choice about living alone or with others—are also ideas valued greatly by individuals with psychiatric disabilities (41–43). Furthermore, consumers regard their housing problems as more strongly related to economic and social factors than to psychiatric disability. They report that lack of income, rather than psychiatric disability, is the main barrier to securing stable housing (14,41,44–46).

The growing body of research and survey literature favoring the supported housing model, together with the limited effectiveness of traditional housing approaches based on the linear residential treatment model, has led to what some have described as a paradigm shift toward a new housing model (47,48). This shift entails a movement away from residential treatment guided by therapeutic principles to supported housing models guided by consumer preference (49,50). Despite state and national policy shifts favoring the new paradigm, the implementation of supported housing programs has been relatively slow because it entails dramatic changes in program philosophy and practice (48). As a consequence, the Pathways supported housing program is one of the few models available to advocates of supported housing.

Little empirical evidence directly compares supported housing and residential treatment programs. This study examined the issue of program effectiveness. It attempted to answer two major questions. First, can homeless individuals who live on the streets and who have psychiatric disabilities or substance addictions successfully obtain and maintain an independent apartment of their own without prior treatment? And second, do housing programs that require clients to participate in psychiatric treatment and maintain sobriety have a greater housing retention rate than a program that first offers clients access to independent living without requiring treatment?

Methods
The housing retention rate of the Pathways supported housing program was compared with rates of other New York City agencies operating linear residential treatment programs...
Table 1
Placement by year of clients in the Pathways supported housing program and in New York City linear residential treatment settings

<table>
<thead>
<tr>
<th>Year</th>
<th>Pathways program</th>
<th>Linear residential treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>1993</td>
<td>33</td>
<td>13.7</td>
</tr>
<tr>
<td>1994</td>
<td>42</td>
<td>17.4</td>
</tr>
<tr>
<td>1995</td>
<td>59</td>
<td>24.5</td>
</tr>
<tr>
<td>1996</td>
<td>68</td>
<td>28.2</td>
</tr>
<tr>
<td>1997</td>
<td>39</td>
<td>16.2</td>
</tr>
<tr>
<td>Total</td>
<td>241</td>
<td>100</td>
</tr>
</tbody>
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At the time the Human Resources Administration was contacted to provide data for this study, information was available on individuals placed through September 1997. Because Pathways was initiated in late 1992, individuals placed between 1993 and September 1997 were included in the analysis. As can be seen in Table 1, clients entered the two programs at comparable rates over the five-year period.

The Pathways sample consisted of the 241 clients who were housed at some point during the period from January 1, 1993, to September 30, 1997. A total of 4,102 clients were housed through the New York–New York Agreement program during the same period. As the majority of Pathways clients are referred from the streets (42 percent), drop-in centers (24 percent), and shelters (18 percent), only clients referred to New York–New York housing from outreach teams, drop-in centers, shelters, and reception centers were included in the housing tenure analysis. This approach was taken to reduce differences between samples. It resulted in a sample of 1,600 clients, or 39 percent of the total New York–New York sample.

The largest segment of the New York–New York sample, 55 percent, was initially placed in supportive single-room-occupancy hotels; 35 percent were placed in community residences, and the remaining 10 percent were placed in several other settings. Only eight of the 1,600 New York–New York clients (.5 percent), went directly into scatter-site apartments. The entire Pathways sample went directly into independent scatter-site apartments.

Table 2 lists the characteristics of the two samples, including age, gender, ethnicity, diagnosis, and substance abuse. The two samples differed significantly on all variables except age. Compared with the New York–New York sample, the Pathways sample had a greater proportion of women (33 percent versus 27 percent) and individuals with a substance abuse diagnosis (55 percent versus 49 percent). Also, the Pathways sample had a greater percentage of individuals diagnosed as having schizophrenia (52 percent versus 35 percent) and a smaller percentage of clients with a mood disorder diagnosis (26 percent versus 47 percent). The Pathways sample had a greater percentage of white clients (28 percent versus 20 percent) and a smaller percentage of Hispanic clients (13 percent versus 19 percent).

Survival analyses were used to examine tenure in housing. First, the survival variable, the number of days continuously housed from January 1993 through September 1997, was computed for each individual in the study. Those who remained housed were classified as “continuous.” Individuals who became homeless or moved into unstable housing situations during this period were considered “discontinuous.” A “failure” occurred when a person had a discon-
Results
Because the participants entered housing at different points during the study period, the Kaplan-Meier product-limit survival method for progressively censored data was used (52). Survival functions for the two samples are reported in Figure 1. Individuals from the Pathways group were more likely than those from the linear residential treatment sample to remain housed for up to four and a half years. After five years, 88 percent of those in the Pathways program and 47 percent of those in the comparison group remained housed.

To control for the effects of client characteristics that may have contributed to this housing tenure outcome, a forward stepwise Cox regression survival model was used (52). In this procedure, variables are selected into the equation in order of importance in predicting survival time. This procedure also provides risk ratios for all variables selected, adjusting for all other variables in the equation. Risk ratios greater than one indicate an increased risk, and ratios less than one a decreased risk.

Table 3 shows the results for those variables that significantly predict tenure in housing. Of the variables considered, type of program was the second most important predictor of housing tenure. Being older or having a mood disorder increased tenure in housing, whereas having a dual diagnosis and being white decreased housing tenure. Moreover, the results indicated that the tenants of the Pathways program achieved greater housing tenure than those in the linear residential treatment settings when the analysis controlled for the effects of the other client variables in the equation. Specifically, the risk of discontinuous housing was approximately four times greater for a person in the linear residential treatment sample than for a person in the Pathways program.

Further analyses included the interaction variables of gender by group, ethnicity by group, and dual diagnosis by group. None of the interaction variables were selected into the equation, which suggests that gender, ethnicity, and dual diagnosis operated similarly in both housing groups.

Discussion
The 88 percent housing retention rate for the Pathways supported housing program over a five-year period, together with the much lower risk of homelessness for Pathways residents than for linear residential treatment residents, supports a new model for effectively housing individuals who are homeless and living on the streets. The Pathways model blends elements of supported housing with assertive community treatment in a manner that effectively engages individuals who are homeless and have remained beyond the reach of traditional approaches. Supported housing offers the independence and privacy that most consumers desire. Most other programs, in contrast, offer supported housing as the last step on the continuum with minimal clinical support. Using assertive community treatment as the clinical component, supported housing can effec-

<table>
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<tr>
<th>Variable</th>
<th>Risk ratio</th>
<th>Significance</th>
<th>Step</th>
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<tbody>
<tr>
<td>Program(^1)</td>
<td>.235</td>
<td>&lt;.001</td>
<td>2</td>
</tr>
<tr>
<td>Mood disorder(^2)</td>
<td>.820</td>
<td>.038</td>
<td>5</td>
</tr>
<tr>
<td>Dual diagnosis(^2)</td>
<td>1.394</td>
<td>&lt;.001</td>
<td>3</td>
</tr>
<tr>
<td>Age</td>
<td>.958</td>
<td>&lt;.001</td>
<td>1</td>
</tr>
<tr>
<td>Ethnicity(^3)</td>
<td>1.319</td>
<td>.017</td>
<td>4</td>
</tr>
</tbody>
</table>

\(^1\) Linear residential treatment = 0; Pathways program = 1
\(^2\) No = 0; yes = 1
\(^3\) Nonwhite = 0; white = 1

Figure 1
Survival model of housing tenure for residents in the Pathways supported housing program and in linear residential treatment settings

![Figure 1](https://via.placeholder.com/150)
tively house and keep housed indi-
viduals with a dual diagnosis who en-
ter the program directly from the streets.

The housing retention results em-
phasize the importance of program
models. Of the several variables con-
sidered, type of program was the sec-
ond most important predictor of
housing retention, more predictive
than either diagnosis or substance
abuse. These findings support the as-
sumption that housing program char-
acteristics are more important than
most personal or clinical variables in
accounting for housing retention.
Findings are also consistent with re-
search from psychiatric rehabilita-
tion, which indicate that if the goal is
for the individuals to live independ-
ently in the community, the optimal
setting to learn the necessary skills is
the community. For the homeless
clients in these programs, living in
apartments of their own with assist-
tance from a supportive and available
clinical staff teaches them the skills
and provides them with the necessary
support to continue to live successful-
ly in the community.

These findings also challenge the
widely held assumption that a strong
relationship exists between psycho-
pathology and the ability to maintain
housing. The Pathways program ef-
effectively serves clients with severe
psychiatric disabilities and substance
addictions. Clients often labeled by
other programs “not housing ready” or
“treatment resistant” are capable of
choosing, obtaining, and main-
taining independent housing when
participating in the Pathways pro-
gram.

Furthermore, after clients are
housed and away from the war zone
of life on the streets, they are much
more likely to seek treatment for
mental health problems and sub-
stance abuse voluntarily. Clients have
reported that having an apartment of
their own, sometimes for the first
time, gives them something that they
want to hold on to. More than 65 per-
cent of the Pathways tenants in the
sample were receiving treatment
from the program’s psychiatrist. An-
other index of the effectiveness of
self-motivation is that 27 percent of
the tenants in the program were em-
ployed at least part of the time during
the 1997 calendar year.

Dually diagnosed clients are at
greater risk for housing loss in the
Pathways program, just as they are in
all other housing programs. The harm
reduction approach employed by the
program ensures that all possible
measures are taken to help the indi-
vidual move from high to low drug
use and from high-risk to low-risk be-
aviors (55). The program will also
use any means possible to reduce the
risk of eviction that often results from
drug use. The methods include strict
money management, relocation to
another neighborhood, or a contract
to hold the apartment if the client
seeks treatment. The practice of
harm reduction challenges staff to
maintain a consumer-driven stance
while working with a tenant whose
drug use is out of control. A basic
premise of all clinical interventions is
that the program will have a long-
term—lifelong if necessary—com-
mitment to every client.

Conclusions
The supported housing program de-
scribed here represents a significant
paradigm shift from the linear resi-
dential treatment model. Although
few would argue that residential
treatment settings have no place in
the new paradigm, the Pathways pro-
gram challenges popular clinical as-
sumptions about the limitations of
people with severe mental illness and
the type of housing and support that
is best suited to meet their needs.

Pathways to Housing was recently
awarded a two-year homelessness
prevention grant from the Substance
Abuse Services and Mental Health
Services Administration (SAMHSA)
to conduct a longitudinal study com-
paring tenants who have been ran-
domly assigned to the Pathways pro-
gram or to linear residential treat-
ment settings. The SAMHSA study, a
collaboration with eight other cities,
will provide additional data on pro-
gram outcomes, such as psychiatric
symptoms, drug and alcohol use, so-
cial networks, and housing satisfac-
tion. However, the findings reported
here highlight the importance of con-
sumer choice in operating effective
housing and treatment programs.

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