



# Supportive Housing Cuts Costs of Caring for the Chronically Homeless

Bridget M. Kuehn

IN THE LATE 1990S, SEATTLE LEADERS recognized the city had a problem. Homeless people with severe alcoholism consumed a tremendous share of public dollars, cycling in and out of emergency departments and the criminal justice system. The city's political, business, and hospital leaders joined forces with social service and substance abuse treatment agencies to adopt a new strategy not only to curb costs, but also to keep so many chronically homeless people from dying on the streets.

One of their first calls was to the Downtown Emergency Service Center (DESC), a group that ran housing projects targeting mentally ill and other vulnerable homeless populations. The city's leaders asked the DESC to take a "housing-first" approach by creating a new facility where chronically homeless people with severe alcohol abuse problems could find shelter without first having to stop drinking or enter treatment.

Bill Hobson, executive director of the DESC, explained that most shelters or housing facilities make treatment or abstinence a condition of housing. But the population Seattle was targeting included individuals who had repeatedly failed treatment programs—some as many as 20 times, Hobson explained.

"Let's accept that these individuals can't or won't stop drinking, and they are hurting the greater society with their use of crisis services," he explained.

The DESC adopted a "harm-reduction" strategy, which aimed to reduce the harmful effects of drinking on

the individual and on society, Hobson explained. The organization identified homeless people who incurred the greatest public costs because of their alcohol use problems and offered them individual apartments in a new facility at 1811 Eastlake. The facility opened in 2005 with a 24-hour staff of social workers and other clinicians.

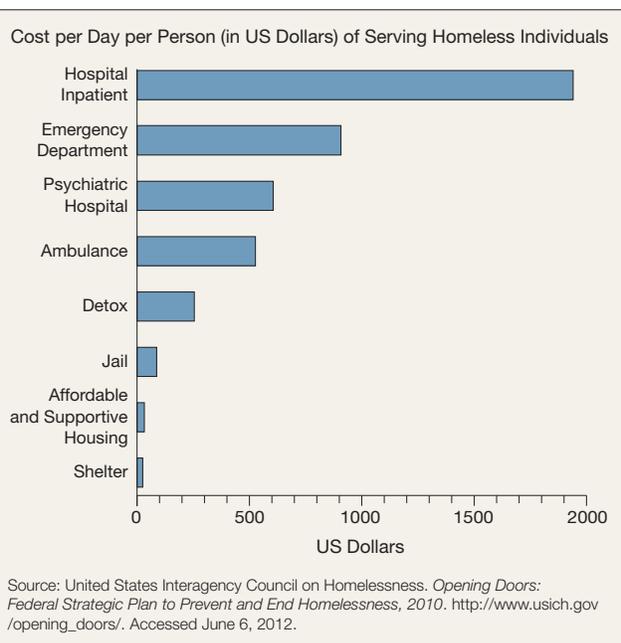
Staff helped residents access social and medical services and worked with them to address behavioral issues that had caused them to lose previous housing. Most residents continued drinking despite discussions with staff about the harmful effects of doing so.

"Harm reduction is about helping people prepare to change," Hobson said.

It was a radical experiment, with its share of critics. But it worked. The housing-first model used by the DESC

at 1811 Eastlake has been emulated by communities across the country working to eliminate chronic homelessness among individuals with severe substance abuse problems, mental illness, or other chronic diseases. Between 2006 and 2010, the number of beds in such supportive housing programs in the United States increased from 176 830 to 236 798. The United States Interagency Council on Homelessness (USICH) also has embraced the housing-first approach to chronic homelessness as a pillar of its plan to end homelessness in the United States.

"Chronically homeless individuals are extremely expensive for the taxpayer," said Barbara Poppe, executive director of the USICH. "[Supportive housing] benefits the entire community because people are not languishing on the streets."



A growing body of evidence suggests that it is more cost-effective to provide chronically homeless individuals with supportive housing than to allow these individuals to remain on the street, where they may require expensive public services.



## COST-EFFECTIVENESS

A growing body of literature verifies the cost-effectiveness of supportive housing.

A study of more than 10 000 homeless individuals in Los Angeles County found that those placed in supportive housing (1000 of the total) cost the public \$605 each per month, compared with \$2897 each for similar individuals who were not in such a program, according to a 2011 report from the USICH.

Supportive housing also appears to reduce the burden on the health care system. Researchers randomized 400 chronically homeless individuals treated at 2 Chicago hospitals between September 2003 and May 2006 to either supported housing or usual care (Sadowski LS et al. *JAMA*. 2009;301[17]:1771-1778). After 18 months, they found that compared with the controls, the individuals living in supported housing had 29% fewer hospitalizations, 29% fewer days hospitalized, and one-quarter fewer emergency department visits.

A statewide analysis of supported housing in rural areas of Maine found that supported housing virtually eliminated temporary housing and incarceration costs for participating individuals. It also reduced ambulance costs by a third and emergency department costs by 14%, according to the USICH report.

Cost reductions were also seen among the subset of chronically homeless individuals with severe alcohol use problems. Researchers compared the costs associated with 95 individuals with severe alcohol use disorders living at 1811 Eastlake in Seattle and 39 individuals on the waitlist for the facility between November 2005 and 2007 (Larimer ME et al. *JAMA*. 2009;301[13]:1349-1357). In the year before they entered supportive housing, individuals in the intervention group were responsible for \$8 175 992 in public costs, or an average of \$4066 per person each month. After 6 months in supportive housing, the individual per-month cost decreased to \$1492, and by 12 months it was below \$1000 per month. After factoring in the costs of the supportive housing program, the researchers calculated a savings of \$2449 per month per person in the program.

Additionally, the study found a 30% reduction in the number of drinks per day among housed individuals. Hobson said more recent data from 1811 Eastlake show drinking has declined 40% since the facility opened, suggesting that further improvements may be likely over time (Collins SE et al. *Am J Public Health*. 2012;102[3]:511-519). The authors note that individuals offered housing were highly likely to accept it (95%), while the acceptance rate was only 58% among individuals offered substance abuse treatment in lieu of incarceration. "Housing first is more acceptable to the target population than treatment, while resulting in similar benefits," the authors conclude.

Another study randomized 105 homeless individuals with HIV at a Chicago hospital to either usual care or permanent housing with case management (Buchanan D et al. *Am J Public Health*. 2009;99[suppl 3]:S675-S680). At 1 year, 55% of the intervention group were alive and had intact immunity compared with only 34% in the usual care group. Housed patients were also more likely to have undetectable viral loads, with 36% (17 individuals) in the intervention group achieving such status, compared with 19% (9) of the usual care group.

Poppe said the findings so far help debunk the idea that chronically homeless individuals are a lost cause. "We've proven it's possible to house anyone," she said.

## FUTURE DIRECTIONS

Although the cost savings and reduced homelessness associated with supportive housing have been impressive, improvements in clinical and psychosocial domains haven't been as dramatic as some advocates had hoped. Some experts note the need for greater efforts to improve overall quality of life among supported housing residents.

Robert Rosenheck, MD, a senior investigator at the Mental Illness Research Education and Clinical Center (MIRECC) of the VA New England and a professor at Yale University, summarized the results of some studies on supportive housing in a commentary in

*Psychiatric Services* (Rosenheck RA. *Psychiatric Serv*. 2012;63[5]:425-426). In recent years, he noted, mental health clinicians have set much more ambitious goals for success in the care of individuals with mental illness, substance abuse, and homelessness. He explained that the concept of recovery has been expanded to include improved quality of life, in addition to stable housing, an income, and access to health care and other social services.

"One of the major goals in helping them as human beings is to foster their participation in community life like any other citizen," Rosenheck said.

A study published by fellow MIRECC investigator Jack Tsai, PhD; Rosenheck; and Alvin Mares, PhD, of Ohio State University, found small but statistically significant improvements in measures of mental illness and substance use among 550 residents of a supported housing facility. However, these individuals remained socially isolated and reported low community involvement.

Tsai, who is also an assistant professor of psychiatry at Yale University, noted that loneliness is often a serious concern for mentally ill individuals. "There's a huge movement about housing first," said Tsai. "What's second?"

"We think the next step is to put more emphasis on socialization and mutual support, as well as on employment," Rosenheck said. He explained that housing alone can't resolve some of the complex medical and social challenges chronically homeless individuals face. In addition to dealing with chronic medical conditions, individuals with psychiatric or substance abuse problems face societal stigma and may be estranged from family. He and his colleagues are testing an intervention to encourage formerly homeless individuals to build peer support networks.

Hobson also said he'd also like to increase supported employment programs at the DESC's housing facilities. He said that about 100 residents are now enrolled, but he believes as many as a quarter of 1000 residents in the DESC facilities are capable of hold-



ing jobs in a competitive market. “I’m a big believer in the therapeutic value of work,” Hobson said.

Another area of concern for Hobson is helping residents manage end-of-life issues. The average age at death in the chronically homeless population is 62 years, and the average age of most chronically homeless individuals is 50 years.

Despite budget constraints, Poppe said the USICH will continue to work to increase the number of supported housing units. She noted that

more funding was allocated to the Department of Housing and Urban Development–Veterans Affairs Supportive Housing program to make another 1000 units available for homeless veterans.

Expansion of Medicaid in 2014 through the Affordable Care Act (ACA) may also help improve medical care for individuals in supported housing. Poppe explained that most individuals in supportive housing are not currently eligible for Medicaid because of

various exclusions, but most will be eligible under the ACA.

Poppe and her colleagues are also working with local communities to help them use their limited resources efficiently by targeting the neediest subset of chronically homeless individuals.

Hobson is optimistic that targeting resources for chronically homeless individuals will continue to pay off. “We never put the appropriate resources into seeing what these individuals are really capable of,” he said. □

## Prompt Response, Multidisciplinary Care Key to Reducing Diabetic Foot Amputation

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**I**NVOLVING A MULTIDISCIPLINARY TEAM of clinicians early in the care of patients with diabetic foot infections is crucial to preventing foot amputations, according to a new guideline from the Infectious Diseases Society of America (IDSA) (<http://tinyurl.com/bo5set7>).

Nerve damage and poor blood circulation to the extremities in individuals with diabetes can lead to foot injuries or ulcerations and subsequent infection and also impair healing of the foot, according to the US Centers for Disease Control and Prevention (CDC). The growing incidence of diabetes in the developed world, higher body weights, and greater longevity among patients with diabetes are all contributing to an increase in such infections, according to the IDSA. Figures from the CDC show that more than 111 000 individuals with diabetes required hospitalization for foot infections in 2003.

“Diabetic foot infections are a major health problem in the United States, with considerable morbidity and mortality,” said James Horton, MD, chair of the IDSA’s guidelines committee and chief of the division of infectious diseases in the department of internal medicine at the Carolinas Medical Center in Charlotte, NC. “Early identifica-

tion and treatment is key to addressing this problem.”

The guideline notes that 71 000 individuals were discharged after diabetes-related foot amputations in 2005.



Clinicians may help prevent diabetes-related foot amputations by ensuring proper care for foot infections, says a new guideline from the Infectious Diseases Society of America.

The amputation rate among patients with diabetes has actually been declining, from 11.2 per 1000 in 1996 to 3.9 per 1000 in 2008, but the guideline aims to further reduce that rate. Amputations contribute to poor quality of life for patients, and according to the IDSA,

about half of such patients die within 5 years of amputation.

“Lower extremity amputation takes a terrible toll on the diabetic patient,” said Benjamin A. Lipsky, MD, lead author of the guideline and professor of medicine at the University of Washington and VA Puget Sound, Seattle, in a statement. He explained that after amputation many patients can no longer walk and so are less able to work and socialize. These individuals are at risk of depression and subsequent amputations.

But as Lipsky and his colleagues write in the guideline, these amputations can often be prevented with proper care: “Properly managed, most [diabetic foot infections] can be cured, but many patients needlessly undergo amputations because of improper diagnostic and therapeutic approaches.”

The guideline, which replaces a version published in 2004, takes into account a growing body of literature about diabetic foot infections and how to care for them. It classifies the strength of each recommendation and the evidence base supporting it using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) system.

The guideline emphasizes the importance of establishing a multidisciplinary