Life Changes Among Homeless Persons With Mental Illness: A Longitudinal Study of Housing First and Usual Treatment

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Objective: This study compared the life changes of homeless people with mental illness participating in Housing First or treatment as usual and examined factors related to various changes.

Methods: Semistructured narrative interviews were conducted with 219 participants in five Canadian cities at baseline; 197 were interviewed again at 18 months after random assignment to Housing First (N=119) or treatment as usual (N=78). Interviews were coded across 13 life domains, and each participant was categorized as reporting positive, mixed-neutral, or negative changes. Housing First and treatment as usual participants were compared with respect to change patterns. Thematic analysis was used to examine factors related to various changes.

Results: The percentage of participants in Housing First reporting positive changes was more than double that for participants in treatment as usual, and treatment as usual participants were four times more likely than Housing First participants to report negative changes. Factors related to positive changes included having stable good-quality housing, increased control over substance use, positive relationships and social support, and valued social roles. Factors related to negative changes included precarious housing, negative social contacts, isolation, heavy substance use, and hopelessness. Factors related to mixed-neutral changes were similar to those for participants reporting negative changes but were less intense.

Conclusions: Housing First with intensive support was related to more positive changes among homeless adults with mental illness across five Canadian cities. Those with poor housing or support, more common in treatment as usual, continued to struggle. These findings are relevant for services and social change to benefit this population.

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Homelessness among people with mental illness and addictions has emerged as a significant health and social issue in North America (1,2). Various approaches have been developed to support this population, including assertive community treatment (ACT) (3) and intensive case management (ICM) (4). However, unless these programs are paired with permanent housing, their effectiveness in reducing homelessness and improving mental health and psychosocial outcomes is limited (5).

Pathways to Housing developed Housing First, a novel approach for this population (6). In contrast to "treatment first" approaches, Housing First provides immediate access to housing in the community with rent supplements and with no requirements for a person's housing readiness. Housing First combines ACT and ICM with permanent housing, typically apartments, located throughout the community, rather than placing people in congregate housing with on-site staff. Recent reviews of controlled studies of Housing First have shown that it is effective in reducing homelessness, emergency room use, and hospitalization and increasing housing stability and consumer satisfaction (7,8). However, the effectiveness of Housing First in regard to psychosocial outcomes, such as recovery and community integration, is less clear. Standardized measures may not adequately capture such outcomes and thus they may not fully assess the impacts of Housing First on this population.

Qualitative research may shed more light on psychosocial outcomes. In one qualitative study, 20 formerly homeless people with mental illness reported positive personal and interpersonal changes (for example, more independence and improved or renewed relationships) and greater resource acquisition (for example, employment) after obtaining permanent supportive housing (9). Similarly, a qualitative study in which 12 formerly homeless people with mental illness were interviewed during their first six months in permanent supportive housing reported an overall theme of "moving

on," suggesting positive changes for participants (10). Another study compared 27 Housing First participants with 48 "treatment first" participants at baseline and at six and 12 months after program entry and quantified narrative data on substance use (11). Over time, Housing First participants were significantly less likely than "treatment first" participants to use substances and more likely to participate in substance use treatment. These studies suggest that Housing First can catalyze positive changes for formerly homeless people with mental illness.

Little research has examined factors related to persons who benefit the most from and those who struggle in Housing First programs. Some research suggests that people with high levels of substance use have worse outcomes (12). Again, qualitative research may reveal personal and contextual factors that are related to changes after entry into Housing First.

AT HOME/CHEZ SOI

At Home/Chez Soi is a research demonstration project for homeless people with mental illness in five cities across Canada: Moncton, Montreal, Toronto, Winnipeg, and Vancouver. The project is a randomized controlled trial (RCT) of Housing First versus treatment as usual (no housing or support provided through the study) (13,14). In the Housing First group, high-need participants receive ACT and moderate-need participants receive ICM. A Housing First fidelity assessment showed high levels of fidelity to the model across programs and sites (15). Treatment as usual varied because of the complex array of mental health and housing services available in the five communities (16). Across sites, the average number of times per year that moderate-need participants in treatment as usual used services over the two-year study period was as follows: shelters, range of 16 to 88 times; drop-in or meal centers, range of 38 to 164; and psychiatric hospitalization, range of one to five.

This study compared the life changes of participants in Housing First and in treatment as usual from baseline to 18-month follow-up and examined factors related to various changes.

METHODS

Sample

The sampling method for the larger RCT is described elsewhere (13). Institutional Research Ethics Board approval was obtained at all five sites. A total of 2,255 participants were recruited and randomly assigned to treatment conditions at each of the five sites. Recruitment and initial interviews began in October 2009 and ended in June 2011, and follow-up interviews ended in June 2013. A subsample was selected from the larger trial for narrative interviews ("narrative subsample"). For the first few interviews, one of every ten participants per treatment condition was selected to be interviewed. As subsample selection progressed, sites shifted to more purposeful selection to ensure that the subsample was representative of the larger sample.

At baseline, the narrative subsample (N=219), 10% of the total sample, was compared on more than 50 demographic, diagnostic, and outcome measures with participants who were not selected to participate in a narrative interview (N=2,036). In the subsample, the proportion of persons who identified as female or transgender (32%, N=219) was significantly greater than in the larger sample (28%, N=2,036) (χ^2=7.47, df=2, p=.02). Also, a significantly smaller portion of participants in the subsample (32%, N=214) had three or more symptoms on a measure of substance use compared with the larger sample (36%, N=1,940) (χ^2=9.80, df=2, p=.01). Finally, participants in the subsample had a significantly higher level of income in the past month (mean=$781.00± $839.70) than those in the larger sample (mean=$681.00± $660.30) (t=2.07, df=2,253, p=.02). Given that only three significant differences were found for more than 50 variables, the subsample appeared to be representative of the larger sample.

Overall, attrition rates were low: 90% of participants were retained at the 18-month follow-up interview (attrition rates across sites ranged from 0% to 20%). Reasons for attrition included inability to locate the participant and participant refusal, incarceration, or death. A total of 197 participants completed both the baseline and 18-month follow-up narrative interviews (Housing First, N=119; treatment as usual, N=78). No significant differences were found between those who completed the 18-month interview and those who did not on a number of demographic, diagnostic, and outcome variables at baseline.

Interviews

Baseline qualitative interviews focused on life before enrollment in the study, and the 18-month narrative interviews focused on changes that participants had experienced since the baseline interview (17). A common protocol was used at each site for both the baseline and 18-month interviews. [The protocols are available in an online supplement to this article.] Open-ended questions were used to elicit data about 13 domains: life changes, typical day, education, work, general medical health, mental health, substance use, relationships, housing and living situation, finances and material situation, mental health services, other services, and hopes for the future (11). Participants provided informed consent for each interview and were reimbursed between $20 and $50 Canadian for each interview (rates varied by site). Forty-five interviews (23%) were conducted in French, and 152 interviews (77%) were conducted in English. All interviews were digitally recorded and transcribed.

Data Coding and Analysis

Following methods used by Padgett and colleagues (11), each transcript was coded on 51 categories of change that were grouped within 13 larger change domains. Coders examined each participant's baseline and 18-month follow-up interviews.

TABLE 1. Baseline demographic and diagnostic characteristics of the 211 participants in the narrative sample

Variable	N	%
Need level		
High	92	44
Moderate	119	56
Gender		
Male	132	63
Female	74	35
Other	5	2
Aboriginal (First Nations, Metis, Inuit)	49	23
Ethnoracial minority group	49	23
Employment		
Unemployed	198	94
Employed, volunteer, or in school	13	6
Education		
Less than high school graduate	119	56
High school graduate	34	16
More than high school graduate	58	28
Marital status		
Single, never married	140	67
Separated, divorced, or widowed	68	32
Married or cohabiting	3	1
Disorder		
Major depressive episode	111	53
Manic or hypomanic episode	34	16
Posttraumatic stress disorder	58	28
Panic disorder	53	25
Mood disorder with psychotic features	48	23
Psychotic disorder	67	32
Alcohol dependence	72	34
Substance dependence	106	50
Alcohol abuse	40	19
Substance abuse	56	27
Age (M±SD)	41.3±11.2	
Last month's income (M±SD Canadian$)	781.0±839.7	
Lifetime months of homelessness (M±SD)	68.0±102.7	
N of children under 18 (M±SD)	1.0±6.7	

On the basis of this analysis, each participant was given a code of positive, mixed-neutral, or negative change for each of the 13 domains. Each domain was weighted equally. An example of a positive housing change was: "This is the first time, you know, that I've had a home . . . that I actually feel, like I've had supportive housing before, but I didn't feel like I was safe. And, this is the first place like I . . . feel like I love to go home. . . . I feel so safe. And . . . being safe is a major issue for me, you know?" An example of a negative change was: "They discharged me to a hotel. I left the next day. It was noisy, bug-infested, full of drugs." An example of a mixed-neutral code was: "That's what life is, cause it's just like I said, like picking up, losing it all, picking up, losing it all, picking up, losing it all."

If more domains were coded positive than negative or mixed-neutral, the participant was given an overall code of positive; if more domains were coded negative than positive or mixed-neutral, an overall code of negative was assigned; and if the number of domains with positive, negative, and mixed-neutral codes were mostly equal or if mixed-neutral predominated, then an overall code of mixed-neutral was given. A second coder, who was blind to treatment conditions, independently coded 20 of the transcripts in the same way (four per site). A high level of interrater reliability was obtained after one training session (κ=.77). Next, matrix displays were created to compare positive, mixed-neutral, and negative changes by Housing First and treatment as usual for each site and overall. A Mantel-Haenszel chi square test was used to test the association between treatment group and the change codes (positive, mixed-neutral, and negative) across sites (18). Finally, factors uncovered through thematic analysis that were related to changes were examined, again by using matrix displays. Qualitative themes constituted one dimension of the matrix, and type of change (positive, mixed-neutral, and negative) was the other dimension. Several methods were used to establish the trustworthiness of the qualitative data and analysis (19), including member checking, team coding, and triangulation (16).

RESULTS

Differences in Changes Between Groups

Table 1 summarizes the characteristics of the subsample. As shown in Table 2, the percentage of participants in Housing First who described positive changes was more than double the percentage of participants in treatment as usual (Mantel-Haenszel χ^2=28.5, df=1, p=.001). Conversely, participants in treatment as usual were four times more likely to report negative changes.

Factors Related to Various Changes

Several factors were important for positive changes across the Housing First and treatment as usual groups. Stable housing, together with the hopefulness it catalyzed for most participants, was an important factor. The acquisition of stable housing gave most participants hope and confidence and provided opportunities for them to take on or reclaim valued social roles. For example, one participant emphasized the value of providing housing in a "normal environment," as opposed to being offered a "room" in a chaotic social environment. He went on to explain how that motivated him to participate in an environmental rally because he felt "like a member of the community."

A second factor was positive social contacts. In Toronto, participants who had social support through positive relationships with friends and reconnection with family tended to report positive changes. The same was true of Aboriginal participants in Winnipeg who connected with their cultural traditions and communities. One participant said, "Yeah, I've made friendships in this, in the program, new friends." Supportive social contacts were associated with reduced substance use. "I don't sniff any more. I don't hang around with . . . street people, I don't hang around with the people I used to hang around with before that, that made me unhealthy cause I was getting myself really unhealthy." Finally, new social roles were important for positive changes across sites. Many participants began pursuing activities such as

volunteering, coaching sports, working, attending school, or becoming peer support workers. These endeavors gave participants opportunities to take on valued social roles that expressed a positive social identity.

TABLE 2. Participants reporting positive, mixed-neutral, and negative life changes at study sites in five cities, by treatment group

	Housing First (N=119)						Treatment as usual (N=78)					
	Positive		Mixed-neutral		Negative		Positive		Mixed-neutral		Negative	
Site	N	%	N	%	N	%	N	%	N	%	N	%
Moncton	6	75	2	25	0	—	1	13	3	37	4	50
Montreal	19	70	2	7	6	23	5	28	1	5	12	67
Toronto	20	65	8	26	3	9	7	37	5	26	7	37
Winnipeg	12	48	12	48	1	4	6	33	9	50	3	27
Vancouver	15	54	13	46	0	—	3	20	10	67	2	13
Total	72	61	37	31	10	8	22	28	28	36	28	36

A number of factors were related to negative changes. Precarious housing—losing housing, living in shelters, poor-quality or unstable housing, or negative experiences with housing—was related to negative changes. One participant commented, "It is a very old building, and it is dirty and my window is dirty, you know. And I don't have energy to clean it, and on the floor I see a lot of insects, you know. And since I moved here, I see a lot and I'm scared of this."

Negative social contacts and isolation were also associated with negative changes. Although negative social contacts affected both housed and unhoused participants, isolation was typically more common among housed participants. Isolated participants lacked the supportive social contacts that are important in helping to make changes. One participant stated, "Because of my loneliness I tend to bring in strangers thinking they will be my friend and be good to me but they're not, they're not my friends at all. They're trying to use me or to hurt me somehow. I think . . . I am an easy target . . . maybe it's my own fault. I don't know, maybe it's the choices I am making or my loneliness. Like I get so lonely I let people in."

Increased or continued heavy substance use was associated with negative changes and was related to participants' remaining involved in social groups that use substances. Finally, hopelessness was an important factor linked to negative changes. Hopelessness presented across sites as the pervasive belief that life would not improve for the individual. In some cases, participants remained hopeless despite being offered housing. For others, their prevailing sense of hopelessness was rekindled after losing their housing. According to a Vancouver participant who faced eviction, "I'm an addict. I screwed up. I was clean for eight months and then I relapsed. . . . Maybe I'm not good enough to have an apartment. I'm thinking that now."

Those with mixed-neutral changes made uneven progress, with a split of roughly equal positive and negative changes or of little to no change. Similar to those who reported negative changes, participants who reported mixed experiences showed sustained substance use and setbacks resulting from relapse. Perceived failures and disappointments were a salient factor associated with mixed changes. As with participants who reported negative changes and hopelessness, participants with mixed-neutral changes often tried to make changes but had difficulty following through when faced with setbacks. A salient example of a mixed-neutral change was for a Vancouver participant who attempted to return to school and resume contact with his family. Both pursuits did not go well, leaving the participant feeling depressed and hopeless.

DISCUSSION

This study used longitudinal, narrative data from a large sample of homeless adults with mental illness from five cities across Canada. No previous RCTs of Housing First have included longitudinal, narrative data with such a large and diverse sample. Overall, participants assigned to Housing First reported stability in their living situation that allowed them to progress in various aspects of their lives. In contrast, participants assigned to treatment as usual typically continued to struggle with numerous challenges related to housing, health, substance use, and community functioning. The findings are consistent with previous qualitative research with this population (9–11). However, use of an RCT design provides stronger evidence of the causal impacts of Housing First on participants' changes.

Positive changes were significantly more common among Housing First participants. Offering immediate, good-quality housing, with no preconditions for readiness, provided a secure base for participants to explore new daily routines and new social networks and roles. The combination of stable housing and support services appears to have provided a foundation and "fresh start" (20) for a range of positive events, including renewed connections with family and cultural communities, reduced substance use, and feelings of self-worth. Our findings support Laing's (21) construct of ontological security, the psychosocial sense of safety associated with stable housing that provides a basis for identity reconstruction and recovery (22).

Housing enabled people to move from a mode of survival to a place of security and future orientation, and the intensive support services that were provided with housing helped participants to gain greater control over their social relationships, mental health, and ability to maintain housing. Housing alone was insufficient for facilitating an exit from homelessness. Support services that follow individuals even if they are evicted or otherwise lose their housing may be critical, especially in the early phases of stabilization when relapses are common (3,4).

Unstable housing, negative social contacts, isolation, heavy substance use, and pervasive hopelessness characterized negative changes. In participants' narratives, cumulative trauma and adversity were often common factors underlying barriers to recovery, such as substance use and social isolation. Most participants had experienced repeated, long-standing trauma and marginalization, resulting in a level of psychosocial disorganization that pervaded multiple aspects of their lives. Substance use was pervasive on the streets and in shelters and often served as a form of social currency, facilitating interactions with others and often forming the basis of relationships (23).

Considerable variability was observed in the narratives of participants in treatment as usual compared with those of Housing First participants, which was expected given the variability in housing and support services across the five cities. Nevertheless, across sites, very few participants in treatment as usual were able to effect positive changes. A relative lack of good-quality stable housing and access to adequate support services was consistently observed among participants in treatment as usual across sites. Cultural belonging was an important facilitator of change for many participants, particularly Aboriginal participants in Winnipeg and members of ethnoracial minority groups in Toronto. Among Housing First participants in Winnipeg, opportunities for cultural healing and connection to Aboriginal heritage were noted as significant in facilitating recovery across a wide range of life domains.

Classifying participant narratives into three categories across two time points was challenging, particularly given the volatility and multidimensionality of people's lives (19). However, it is telling that similar patterns of positive, mixed-neutral, and negative changes were observed by independent coders within and across the sites. Mixed-neutral changes were inherently more variable than positive and negative changes. For example, the mixed-neutral category could reflect no change or various combinations of positive, negative, and mixed-neutral experiences.

CONCLUSIONS

Access to stable housing and adequate resources to engage in supportive relationships are critical for all communities. Our research highlights that Housing First needs to move beyond a primary focus on clinical and housing stability to include opportunities for social integration (24), including participation in employment (25), education (26), and other valued social roles. Once people achieve stable housing, they face the question "What's next?" Opportunities for social integration are needed to combat the social isolation that we observed in the consumer narratives. Despite their experiences of cumulative trauma and adversity, many participants retained a sense of optimism and hope for the future. Breaking the cycle of poverty, gaining education and employment, giving back to the community, reconnecting with family and friends, pursuing romantic relationships, and achieving greater well-being were all recovery goals voiced by participants. Like many people, individuals with lived experience of homelessness and mental illness want and deserve opportunities to contribute to society and live fulfilling and productive lives in the community.

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