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Quality of life after *housing first* for adults with serious mental illness who have experienced chronic homelessness



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ABSTRACT

This 1-year longitudinal study of adults who have recently transitioned from homelessness to Permanent Supportive Housing (PSH) focuses on quality of life as a primary outcome of interest. Eighty of 103 new tenants participated in structured interviews at the time of entry into their new home and at 12-months post-housing. *t*-tests assessed differences in community participation and quality of life measures at the 2 time points. Mixed effects models examined the impact of community participation on quality of life. Results show that time in independent housing was significantly associated with several domains of quality of life. Symptom severity was also significantly and negatively related to quality of life domains. Community participation was significantly related to frequency of social contacts only. These findings suggest that community participation is not critical to improving quality of life, and that despite concerns that individuals may feel isolated and lonely when living independently, satisfaction with one's living situation and family relationships nevertheless improves with housing tenure.

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1. Introduction

Permanent Supportive Housing (PSH) through a housing first (HF) approach has been recognized as the “clear solution” to chronic homelessness (U.S. Interagency Council on Homelessness, 2010), which is disproportionately experienced by adults with serious mental illness (Link et al., 1994). A HF approach refers to immediate access to affordable, permanent housing that is accompanied by supportive health and social services and has been credited for the decreased number of chronically homeless persons documented since 2006 (U.S. Department of Housing and Urban Development, 2010, 2013). HF embraces a harm reduction philosophy and stands in contrast to traditional approaches that typically require adherence to treatment and abstinence from substances before granting access to permanent housing options (Tsemberis et al., 2004). In addition to being effective at ending homelessness (Tsemberis et al., 2004; Pearson et al., 2009) and consistent with basic human rights (United Nations, 1976), studies have found that HF is cost-effective when targeting people with complex health and social needs (Culhane et al., 2002; Culhane, 2008).

Transitioning to permanent housing provides tenants a fresh start that they largely regard as positive at the outset particularly

given a poor quality of life experienced while homeless (Henwood et al., 2013). Whether quality of life continues to improve once one's basic need for shelter and health services has been addressed has not been widely reported on in the literature (Tsemberis, 2010; Tsai et al., 2012b). New challenges that tenants experience specifically around how to organize day-to-day life can make improved quality of life difficult (Padgett, 2007). Employment, for example, provides structure to life and is highly valued, but employment rates among individuals with psychiatric disabilities remain extremely low at about 15% (Mueser et al., 2011; Twamley et al., 2003), which negatively impacts quality of life (Marwaha and Johnson, 2004; Rüesch et al., 2004). Positive social relationships can also occupy one's focus and lead to improved quality of life yet formerly homeless tenants living in PSH often have depleted social networks (Hawkins and Abrams, 2007). High rates of co-occurring psychiatric and substance use disorder also present obstacles for improved quality of life (Xie et al., 2006). Nevertheless, results from a recent randomized control trial show that quality of life significantly improves when entering HF as compared to usual care over the course of a year, with the majority of change occurring within the first 6 months (Patterson et al., 2013).

A broader focus on community integration among individuals with serious mental illness living in PSH has often overshadowed basic questions about life satisfaction and quality of life (Mandiberg, 2012; Tsai et al., 2012a). Given limited employment

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and social relationships, participation in other forms of daily activities within one's community and neighborhood may be a more immediate or easily accessible way to improve quality of life (Eklund, 2009). In fact, researchers have found that the degree of movement within one's community may be a predictor of subjective quality of life (Townley et al., 2009). Yet concerns that PSH tenants may experience social isolation and lack of community have also been used as a rationale for a project-based or a congregate model of PSH rather than renting apartments from landlords throughout the community (Gilmer et al., 2010). This may have an unintended consequence of limiting quality of life since consumer preference research suggests that people are more satisfied and prefer to live in scatter-site settings (Schutt et al., 1997; Nelson et al., 2003; Nelson et al., 2007). Still, community integration, as a primary outcome of interest, has been found to be limited in this population. Research has shown that compared to a matched community sample of persons without psychiatric disorders, HF tenants participated in fewer community activities and had less social interaction with other community members (Yanos, Stefancic, & Tsemberis, 2012). In a longitudinal study of 550 formerly homeless individuals living in PSH, researchers found limited improvement in terms of overall community integration over the course of 1 year but did note an association between integration and life satisfaction (Tsai et al., 2012a).

The 1-year longitudinal study of individuals who have recently transitioned from homelessness to housing through a HF approach reported on here focuses on quality of life as a primary outcome of interest, referring to both subjective and objective dimensions of quality of life. We examine whether HF tenants' quality of life improves with the length of housing tenure and whether participation in daily community activities based out of one's new home is associated with quality of life. As noted, previous research would suggest that quality of life improves with housing tenure (Patterson et al., 2013). The notion that participation in community activities is associated with quality of life has not been investigated but is based on Padgett's (2007) findings that having one's own place provides HF tenants a sense of security through having constancy where daily routines can be enacted/carried out. Recognizing the limited employment rates, social networks, and levels of community integration that this population experiences, we hypothesize that participation in community activities will – through helping to establish daily routines and conferring what Padgett (2007) describes as “ontological security” – be positively related to quality of life.

2. Methods

2.1. Setting

This study began in the fall of 2008 and took place at an agency located in Philadelphia, PA that implemented an evidence-based model of HF. The HF program utilized scatter-site housing rented from private landlords along with multidisciplinary teams that delivered assertive community treatment (Tsemberis et al., 2004). Immediate access to housing came in the form of apartments that were generally one-bedroom units subleased to the tenant through the agency. The average number of days between admission to the agency's HF program and move-in was 29 days. Choice of apartment and location was based on availability and affordability. Tenants were expected to contribute 1/3 of their income for rent; the program assumed responsibility for the remaining portion of rent, paid security deposits, and initially furnished the apartments.

2.2. Recruitment

All new HF tenants were invited to participate in structured interviews at the time of entry into their new home (T1; mean=61.0 days from move-in date, S.D.=67.3) and at 12-months post-housing (T2; mean=362.6 days from move in, S.D.=60.3); 80 of 103 clients agreed and completed baseline and follow interviews (78%). A significantly higher percentage of participants than non-participants had a

primary diagnosis of a major mood disorder. However, no differences were found between participants and non-participants in terms of gender, race, primary diagnosis of a psychotic disorder and age at move-in ($p > 0.05$).

2.3. Data collection

Our primary outcome of interest, quality of life, was measured using Lehman's Quality of Life Interview (Lehman, 1988). Structured interviews included eight subjective quality of life scales and three quality of life objective scales. Subjective satisfaction with one's living situation (three items), daily activities (four items), family (two items) and social relations (three items), financial situation (three items), personal safety (three items) and health (three items) were measured on a seven-point “terrible” to “delighted” scale with a higher score indicating more satisfaction. Cronbach alphas for these seven domains, using T1 data, ranged from 75 to 91. The three quality of life objective scales included a measure of frequency of contact with family members (two items) and with non-family others (four items) measured on a five-point Likert scale with a higher score indicating more frequent contact and a set of six dichotomous items to assess adequacy of finances to cover certain expenditures. Cronbach alphas for these three domains, using T1 data, also ranged from 75 to 91. Mean scores were calculated for all quality of life scales to reflect each participant's a level of quality of life in each domain. In addition to these scales, the interview included a one-item general quality of life question that utilized the same 7-point response scale as above. Per instrument protocol (Lehman, 1988), this item is asked of respondents at the beginning of the Quality of Life Interview and again at its conclusion. These two score were averaged to provide an indicator of general life satisfaction.

Community participation was measured via a modified version of the External Integration Scale (EIS; Segal et al., 1980) that has been used in previous research with individuals living in PSH (Tsai et al., 2012; Tsai et al., 2012a; Yanos et al., 2012). The EIS provides the number of days over the past 2 weeks in which participants have engaged in each of 19 different activities outside of their home (e.g., gone to a park, gone to a shopping center, mall, or other retail store) as well as an indication of whether these activities were undertaken inside or outside of respondents' neighborhoods. The EIS also contains one item that asks participants the number of hours they spend inside their home during a typical day. Total activity days were calculated for each participant by summing the number of days they reported engaging in each of the 19 activities over the prior 2 weeks. Doing so provided participant scores that could range from 0 to 266 activity days (i.e., 14 days \times 19 activities).

In addition to age at move in, race (White/non-White), gender (male/female), and time, control variables included psychiatric symptoms, substance use, and percent of activities undertaken within one's neighborhood. This last control variable, which is included in the EIS, was included based on previous research found that the degree of movement within the community can be a predictor of subjective quality of life (Townley et al., 2009).

Given the variation in adaptive functioning that exists within classes of psychiatric disorders (Breier et al., 1991; Ciechanowski et al., 2000; Kroenke, 2003), psychiatric symptom severity experienced during the past month was included as a covariate rather than diagnostic category. Symptom severity was measured using the Modified Colorado Symptom Index (CSI; Conrad et al., 2001). Symptoms were measured on a 14-item, five-point Likert scale, with a higher score indicating more severe symptoms. Research has found the CSI to have strong reliability and validity and a score of 30 on the CSI to adequately discriminate between people with and without psychiatric disabilities (Boothroyd and Chen, 2008). Cronbach alpha for the CSI, using T1 data, was 84.

We also assessed participants' level of substance involvement at T1 and T2 using items from the Addiction Severity Index (Hodgins and el-Guebaly, 1992; McLellan et al., 1992; Zanis et al., 1997). Participants reported how many days, out of the previous 30 days, they had used each of 11 different substances (e.g., amphetamines, hallucinogens, and alcohol to the point of feeling “a buzz,” “high,” or “drunk”). Common “street” names of drugs (e.g., crank, acid, and smack) were included when exploring the various classes of drugs to facilitate understanding among respondents. Scores reflecting substance involvement could range from 0 to 330 (11 substances \times 30 days).

2.4. Data analysis

t-tests assessed differences in community participation and quality of life measures at the 2 time points (just following move in [T1] and 1 year post-move in [T2]). Where bivariate tests indicated significant differences in quality of life domain scores, mixed effects models were constructed with scores in each of the significant quality of life domains as the dependent variable and scores on the EIS as the predictor of interest. These models were run using the MIXED procedure in SPSS v.20 and also included time (as a repeated factor), basic demographics (i.e. age at move in, male/female, White/non-White), psychiatric symptom scores, substance use, and percentage of activities that participants engaged in within their own neighborhoods as covariates. The Housing First agency's Institutional Review Board approved all protocols.

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