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Supportive housing for chronically homeless individuals: Challenges and opportunities for providers

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Abstract

Chronically homeless individuals often have extensive health, mental health, and psychosocial needs that pose barriers to obtaining and maintain supportive housing. This study aims to qualitatively explore supportive housing providers' experiences and challenges with housing chronically homeless individuals and examine opportunities to improve supportive housing systems of care. In 2014, we conducted qualitative in-depth interviews with 65 program administrators and case managers of supportive housing programs in Chicago, IL. Data were analyzed using an inductive thematic content analysis. Analysis revealed four themes that capture the primary challenges faced by housing providers: housing priorities, funding cuts, coordinated entry, and permanency of housing. Housing for the chronically homeless has been prioritized, yet service providers are being expected to provide the necessary services to meet the needs of this population without commensurate funding increases or agency capacity. Additionally, case managers and administrators discussed the tension over housing tenure and the permanency of supportive housing. Findings provide qualitative insight into the challenges providers face implementing supportive housing for chronically homeless individuals.

Keywords

Chronic homelessness; case management services; Housing First; harm reduction; community-based services; Qualitative methodologies; Supportive Housing; Chronic homelessness

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According to the U.S. Department of Housing and Urban Development (HUD), there are over 560,000 homeless individuals in the United States on any given night, 83,000 of whom are chronically homeless (US Department of Housing and Urban Development, November

2015). Chronic homelessness is defined as individuals with a disabling condition (including serious mental illness or substance use disorders) who have been homeless for one year or longer, or had at least four episodes of homelessness in the last three years (US Department of Housing and Urban Development, July 28, 2014). These individuals exhibit long-term patterns of cycling in and out of shelters, jails, and hospitals (National Alliance to End Homelessness, February 2010), have a high chronic disease burden including co-occurring mental and physical health needs (Weinstein, Henwood, Matejkowski, & Santana, 2011) and are often labeled as a 'hard to serve' population (D. K. Padgett, Gulcur, & Tsemberis, 2006).

Given their vulnerability, HUD, the federal funding agency responsible for housing and homelessness services, has prioritized providing supportive housing to chronically homeless individuals since 2010, with a goal to end chronic homelessness by 2020 (US Department of Housing and Urban Development, July 28, 2014). Supportive housing is the provision of permanent, subsidized, independent housing coupled with social support services (Rog, 2004), with the goal of fostering independence and self-sufficiency (Wong et al., 2006). Participants pay 30% of their income (or pay nothing if they lack income) toward their rent, the rest of which is subsidized by the supportive housing agency. Although there are multiple approaches to supportive housing, Housing First has risen in prominence as an alternative to the traditional, abstinence-based approaches to housing. Often incorporating harm reduction, Housing First programs seek to minimize any potential barriers to housing, providing a rapid pathway to housing for some of the most vulnerable homeless individuals, including those with substance use disorders and untreated mental illness.

Research has consistently demonstrated the effectiveness of permanent supportive housing and Housing First at increasing housing stability and improving health and mental health outcomes (Leff et al., 2009; Rog et al., 2014). As a low-barrier approach to housing, Housing First addresses the needs of those with mental health and substance use disorders, minimizes program requirements, and more readily engages and moves people into housing (Srebnik, Connor, & Sylla, 2013). Individuals in Housing First programs demonstrate improvements in housing stability (Somers et al., 2017), psychological distress, quality of life, health service utilization (Whittaker, Dobbins, Swift, Flatau, & Burns, 2017), and access to medical care (Aidala, Lee, Abramson, Messeri, & Siegler, 2007). These programs have the potential to address chronic homelessness by reducing the overall cost to the community(D. Padgett, Henwood, & Tsemberis, 2015), successfully transitioning individuals from homelessness into stable housing, improving health outcomes, and increasing utilization of medical and mental health care (Parker, 2010).

Given the success of supportive housing, the number of permanent supportive housing beds available nationally increased by nearly 70% between 2007 and 2015 (US Department of Housing and Urban Development, November 2015), and supportive housing has been credited with helping to decrease chronic homelessness by 30% since 2007 (National Alliance to End Homelessness, 2015). In prioritizing the chronically homeless, HUD has encouraged supportive housing agencies to preferentially house individuals with the highest needs and most significant barriers to obtaining housing (i.e. the chronically homeless). Additionally, HUD has encouraged local Continuum of Care (local coordinated efforts of housing providers and nonprofits to oversee HUD funding and priorities) to establish a

single coordinated entry list, prioritizing chronically homeless individuals (US Department of Housing and Urban Development, July 28, 2014).

Yet, given their extensive homeless histories and mental and physical health needs, supportive housing agencies are facing new challenges in helping chronically homeless individuals obtain and maintain housing. Their long histories of homelessness, coupled with psychiatric and substance use disorders and complicated, untreated health issues, make the chronically homeless a difficult population to engage in housing programs. As such, one of the primary elements of supportive housing is provision of ancillary support and case management services. These support services, including case management, mental health and substance use services, and health care management help facilitate housing stability and independence among formerly homeless individuals (Cameron, Lloyd, Turner, & Macdonald, 2009).

In order to meet the needs of this vulnerable population, service providers have been expected to prioritize housing chronically homeless individuals, adopt a Housing First approach, and enhance efforts to help individuals maintain housing once they are in the program, often without commensurate funding increases. In fact, supportive housing agencies have had to manage a slow decrease in funding for supportive services over the last two decades. In 2000, nearly 60% of HUD funding was being appropriated for supportive services, while just 30% was available to cover the cost of rents. By 2009, just 33% of HUD funds were going to services to help keep people housed. This shift in funding allowed HUD to work toward their goal of reducing homelessness by creating over 40,000 new permanent supportive housing units with the expectation that other federal agencies would compensate for service funding lost through HUD (Burt et al., March 2010). For example, Medicaid can cover some of the services in supportive housing including case management, service coordination, and rehabilitative services. Yet, as a state-administered program, states have discretion over what services Medicaid covers, so the extent of coverage available is state-dependent (Corporation for Supportive Housing, May 2015; Wilkins, Burt, & Locke, July 23, 2014).

Previous research has demonstrated the effectiveness and importance of permanent supportive housing for chronically homeless individuals (Gilmer, Stefancic, Henwood, & Ettner, 2015; Henwood, Cabassa, Craig, & Padgett, 2013; D. K. Padgett et al., 2006; D. Padgett et al., 2015), yet more research is needed to understand the challenges and experiences of providing supportive housing faced by housing providers. This study aims to qualitatively examine supportive housing providers' experiences and challenges with housing chronically homeless individuals given the political and contextual environment, and explore opportunities to improve supportive housing systems of care. We begin by exploring HUD's goal of housing the chronically homeless and the challenges housing providers face in meeting this goal. We then explore how, despite the push to end chronic homelessness, housing providers often lack the resources and capacity necessary to meet the needs of the chronically homeless. Finally, we examine the tension providers face between the intent of supportive housing as permanent and the goal to move individuals into more independent housing.

Methods

This research was conducted in 2014 by a community-academic partnership between the Center for AIDS Intervention Research at the Medical College of Wisconsin, the AIDS Foundation of Chicago, and the Center for Housing and Health, a leader in supportive housing in Chicago, IL.. Purposive sampling was employed to recruit a diversity of permanent supportive housing agencies. Thirty agency Executive Directors were contacted directly by the community partner organization to explain study goals and methods and assess willingness to participate. No organizations refused to participate and Executive Directors provided names of potential housing administrators and case managers who were eligible to participate. We contacted administrators and case managers by email and a follow-up phone call to explain the study. They were informed that their decision to participate would not be shared with their employer and that they were free to refuse participation. No case managers or administrators refused to participate. Interested participants scheduled time for an individual face-to-face interview with a member of the research team trained in qualitative interviewing.

Written informed consent was obtained from all participants prior to the interview. Interviews lasted between 60 and 90 minutes and followed a semi-structured interview guide designed to better understand the history, structure, and funding of various types of permanent supportive housing (e.g. project-based, scattered site, harm reduction, sobriety-based, Housing First). The interview guide included questions about agency staffing and funding sources, a description of housing residents, case manager job duties, and challenges facing housing program providers. Interview guides were flexible and allowed interviewers to follow the lead of the participant on emerging topics. Interviews took place at participants' offices and were audio recorded and transcribed verbatim. All study protocols were approved by the Institutional Review Board at the Medical College of Wisconsin.

Data analysis took a collaborative approach. Interview transcripts were initially read by five members of the research team (from the academic and community partner organization) to come up with an initial list of codes. We constructed a preliminary codebook and collaboratively coded six randomly selected interviews. The codebook was refined through an iterative process of coding, discussion, examination of inter-coder reliability, and refinements until we reached consensus. The final codebook included a combination of a priori and inductive codes. Using MAXQDA Qaulitative analysis software, the final codebook was applied to all interviews by three members of the research team.

We took an inductive approach to thematic content analysis, which consisted of a continual development and refining of coding schemes used to identify themes, interactions among codes, and relationships among factors within each of the major themes. This process allowed for the identification and exploration of emerging relationships between themes, interactions, and patterns, and the identification of new and unanticipated relationships. The final themes were identified inductively through a process of open coding (Ryan & Bernard, 2003) and analytic memoing (Morrow & Smith, 1998). Analyses sought to understand the experiences and challenges of providing permanent supportive housing to chronically homeless individuals.

Findings

Characteristics of the Sample—We conducted 65 interviews with 32 administrators and 33 direct service providers from 30 supportive housing programs. At least one program administrator and one direct service provider from each site were interviewed. Administrators included program directors, case manager supervisors, and directors of clinical services. Most case managers and administrators had Master's degrees in social work or psychology. Nine case managers had bachelor's degrees in social work, psychology or education, and one case manager had an associate's degree. The amount of time participants had worked in supportive housing ranged from a couple of months to 32 years (mean 10.3 years, s.d. 8.9 years). Housing agencies in this study varied in the intensity with which they provided services. Most commonly, case managers had a caseload of 15–25 residents and provide services weekly to monthly depending on individual needs. Other programs provide low-intensity case management services, in which case managers have caseloads of up to 60 residents and see their clients monthly or quarterly for home visits. More information on the variation in housing agencies and types of housing in this study has been published elsewhere (Dickson-Gomez, Quinn, Bendixen, Johnson, & Nowicki, 2017).

HUD priorities: Housing for chronically homeless individuals—As the primary funder of supportive housing programs, HUD frequently dictated program goals, and local housing efforts were often driven by national priorities. Providers noted serving an increasing number of chronically homeless individuals in recent years, stemming from HUD's efforts to 'end chronic homelessness.'

> HUD has said that they want the services to be for chronically homeless. Well, when you are working with chronically homeless people you get many more severe disabilities. Some of this is a response to the research that we are seeing nationally and locally that the people who are chronically homeless with the most severe illnesses weren't getting off of the streets. [Case manager]

Given their long histories of homelessness and complex medical and social needs, case managers' narratives were filled with the challenges of helping some chronically homeless individuals obtain and maintain housing. Residents had long histories of homelessness coupled with untreated medical, substance use, and psychiatric disorders, and this created challenges for programs and case managers not used to serving a population with such high needs.

> A lot of programs in Chicago were creaming. And I can say that for our agency, that was definitely a problem. The only ones they would take were people who were sort of already stable and that makes it nice and easy. But really the goal of supportive housing is working with people who really need it. So how do we do that right? What you do is build up the capacity internally with your staff in order to be able to provide services to the population that really needs it. [Case manager]

Creaming, or the process of intentionally admitting individuals expected to have the best program outcomes, is a tactic used by service providers to improve program outcomes and ease the burden on service providers (Lipsky, 2010) Thus, the shift to prioritize chronic

homelessness was especially challenging for programs that were not used to serving a population with such high needs.

Case management and other ancillary services were seen as critical in helping the most vulnerable people maintain housing stability by managing mental health symptoms and substance use disorders, engaging individuals in employment and educational opportunities as appropriate, and offering the needed support of the case manager. Yet, in Housing First programs, residents' housing was not contingent on residents engaging in services. Despite understanding this philosophically, some case managers expressed frustration with residents who did not engage in services.

> I've just been doing this almost 3 years and I think the number one thing they need when they walk into the door is the services. So not just the housing but the services on site, if they don't want it in the first place they are not going to do well, they are not going to succeed, they are not because you know if they were desperate for housing but don't want a case manager, they will not do as well. [Case manager]

In line with previous research (Tiderington, 2017), case managers routinely acknowledged that resident participation in services was voluntary. While they respected residents' resistance to services, they believed that housing stability was predicated on an individual's engagement with services. Furthermore, lack of service utilization could result in cuts to the limited services that were available:

> We had a clinic coming in once a month, we have a therapist twice a week, an art therapist coming in, but they don't tap into those services even though they just have to come from upstairs. We just didn't get the amount of participants as we would need to keep certain services going. The services leave and it's hard to bring them back because we can't get the numbers we need. [Case manager]

Funding cuts for social services—While case managers tended to focus on the lack of resident utilization of available services, administrators felt strongly that the lack of funding for additional services was paramount. According to HUD, supportive services are essential in helping homeless individuals transition from the streets or shelters to permanent housing and achieve housing stability (US Department of Housing and Urban Development, 2008). Yet, despite the greater needs of the chronically homeless and the recognized importance of services, program administrators expressed frustration that increasing resident needs were not matched by an increase in the intensity of services.

> We're getting people who, who are, quote unquote, sicker as they come into housing which demands more resources than we actually have… They are very, very sick. You know, we would like a caseload level of 1 to 15, 1 to 20 people. Our caseloads are 1 to 40, 1 to 50 sometimes 1 to 60 in some buildings. It's crazy and you don't have the resources to hire more people. [Program Administrator]

In fact, at a time when housing providers were being asked by HUD to prioritize chronically homeless individuals with the greatest needs, they were facing significant cuts to supportive service funding from federal, state, and local funders, including HUD. Administrators also

noted a reduction in mental health services, substance use services, and ancillary services, and many agencies lost the ability to hire and retain the most qualified case managers, increasing caseloads. Not long before the interviews, several agencies experienced significant cuts in HUD funding for supportive services.

> [HUD] has drastically reduced the amount of dollars that go toward services. So HUD wants to pay for the subsides but they don't want to pay for the services that come along with it. So the salary for case managers, because they provide the services to the clients, has decreased over the last few years and supportive services programs. So [HUD] have expected other agencies or departments to pick up providing the funding for those types of services and it just hasn't happened. So there has been a decrease in supportive services for the clients. [Program Administrator]

Although HUD has continued to increase funding for the permanent supportive housing units to get more chronically homeless individuals off the street and into housing (US Department of Housing and Urban Development, November 2015), funding for the necessary services to keep those individuals housed has been cut. At the federal level, this stems, in part, from disagreements over which governmental agencies should be funding support services. In an effort to provide more housing and reach the goal of ending chronic homelessness, Congress has directed HUD to reduce allocation of their funds to services in favor of providing operating costs (overhead and rent subsidies) for new and existing housing units, hoping other agencies (e.g. Department of Health and Human Services) can provide funding for services (Burt et al., March 2010). While some cities and programs have been able to find alternate funding sources for services, others have struggled to fill those gaps. Without services available, agencies are less able to offer the depth and intensity of services needed by their residents. Participants expressed frustration feeling as though HUD and other funders failed to recognize the importance of service dollars to help individuals maintain their housing and reach other goals. One administrator described the most recent HUD funding cuts for services experienced by Chicago.

> These decisions were made in some group, in some room in Washington, but it's very, it's very disconcerting, it's disheartening, it just takes the wind right out of you. When you can work so hard to do something and you can see a vision and you can see because the people who need these services are right in front of you every day, you know to just have someone else, "they don't need that." [Program Administrator]

Coordinated entry: A discordance of residents and housing programs—Several housing providers noted challenges faced in Chicago while doing homeless outreach to identify and engage chronically homeless individuals. While some resided in homeless shelters or received social or medical services through local organizations, many chronically homeless individuals were disengaged from the homeless services available and thus, were difficult to recruit into housing programs.

> One of our homeless people once said it here in Chicago, 'you know, if you are homeless and you are trying to get housed, it's like winning the lottery. You have to

> be in the right place at the right time and know the right people' … and that was true because each agency got their own HUD grant and it was up to each agency to find their own candidates to put in there. And it did create an unfair situation where if you were just homeless out there and nobody has reached out to you or you didn't know how to navigate the system, your chances of getting housed were really limited. [Program administrator]

The recent efforts to streamline entry into supportive housing programs was seen as successful in helping house more chronically homeless individuals, yet its creation led to new challenges for supportive housing agencies. Chicago's Central Referral System (CRS) was designed to coordinate entry into supportive housing and prioritize the sickest and most vulnerable homeless individuals (often, the chronically homeless). As a result, individuals at the top of the list were housed with whichever agency had the next opening, and some residents were housed in agencies that could not meet their needs:

> Individuals are on one large waitlist and it ranks people based on their vulnerability index. So what we've noticed is now that once someone would reach the top of the list, they are now the most vulnerable person on that waitlist and not all housing programs are created equally. So if you're getting someone who's been chronically homeless for the last 12 years, has never held a lease in their life, and they're getting placed in a program that requires one home visit a quarter, one face-to-face meeting a month, and you've got the case managers got 25 individuals on her caseload, like if you do the math, you're not able to meet with that person as much as they may need it to make sure that they're going to be successful in their housing. [Case manager]

A coordinated entry system like the CRS can help ensure the most vulnerable homeless individuals (often the chronically homeless) have prioritized access to housing and reduce use of creaming tactics described earlier. Yet, as several case managers noted, the system often resulted in a mismatch of residents who had more needs than housing programs could meet. Furthermore, funding cuts for ancillary services meant programs were often not equipped with the resources (e.g. drug and alcohol counseling, mental health services, enough case managers) to house such a vulnerable population.

In addition to the mismatch of residents and housing programs, several case managers also noted that by prioritizing the chronically homeless, it was more difficult for other homeless populations (newly homeless individuals, individuals without disabling conditions) to access housing. One case manager said "I also feel like we are doing a disservice. I mean, we're limiting housing… right now you have to have a disability." Another case manager expressed similar frustrations:

> It makes no sense to me. I'll be honest, I wish we had more housing for everybody in general… it's super frustrating when folks are coming in the door and tell you, 'I'm 23. I'm just out of school and I don't have any income and I need housing.' And then you have to explain to them that this housing program is really not for them. They are not eligible. You have to meet these specific eligibility dictated by funders. We don't add anything to it, we just follow that. [case manager]

As a result, several case managers felt as though the system of prioritizing housing for the chronically homeless was actually contributing to chronic homelessness, as it forced individuals to remain homeless for longer periods of time in order to be considered 'chronically homeless' and eligible for housing.

The permanency of permanent supportive housing—Typically viewed as a long-term, 'permanent' approach to housing, supportive housing administrators and case managers noted a tension between the permanency of supportive housing and the goal of helping individuals 'graduate' into independent, affordable housing in the community. Historically, permanent supportive housing allowed individuals to remain in the housing program indefinitely and case managers generally worked to help residents maintain their housing, despite continued substance use or untreated mental illness. Yet, without a significant increase in funding to provide additional housing, the permanency of the program made it difficult to achieve broader goals of ending homelessness and getting more people off the streets. Waitlists for supportive housing were long and turnover of housing units was low.

> The last two years, HUD hasn't had any new money for any supportive housing, and with the state budget cuts, we have lost some of our support service dollars that would come from HUD dollars … our programs have 90 to 95% stability [of residents maintaining housing], and a lot of it had to do with the intensive case managers. [Program administrator]

Lack of HUD funding for new housing, coupled with high rates of housing stability (promoted and rewarded by HUD), made it difficult for agencies to house additional chronically homeless individuals and make progress toward local and federal goals of ending chronic homelessness. Agencies were proud of their housing stability rates and frequently cited residents who had been housed with them for up to a decade as examples of success.

Yet, the focus on moving people out of supportive housing and into independence had been a more recent goal for some administrators and case managers, especially long-term providers of Housing First.

> Two years ago, we had a program that worked with women as they move on. That's been a big shift for us and a shift in the way that we think about the permanency of our programs. Because we used to say when we first adopted Housing First you can stay here forever and that's not really the conversation anymore, you know? "What do you want for your life, where do you want to go next?" [Program Administrator]

Many providers noted that the combination of stable housing, intensive case management, and other ancillary services could help individuals achieve stability and get to the point where they no longer need supportive housing. Efforts to help residents graduate from supportive housing were seen as opportunities to help more people get off the streets and into housing.

> I believe a successful outcome would be the clients actually leaving the program. So, the clients here that we have now, once they get into these apartments and they

> receive the subsidy, they want to receive it forever, which limits other clients that may be in need of receiving this opportunity . … sometimes I see it as a crutch you know? And a lot of clients are a little less motivated to move on. [Case manager]

In this sense, supportive housing was seen as a transitional opportunity to move someone into their own, independent housing. Given HUD's goal of ending chronic homelessness, it is understandable that programs would want to move people toward independence, freeing space for other chronically homeless individuals still on the streets. Yet, as another administrator noted, while moving people out of supportive housing might be 'ideal,' it is not possible for many people in the program.

> Ideally, everybody should be able to leave those programs at some point. Ideally. But in reality, that's not the case. And depending on their disability, depending on many other things for the permanent housing programs, they may not be able to leave. They don't have to. It's permanent. But, I mean, you certainly hope that some people are able to achieve something so that they can go with less support and just get subsidized housing or perhaps not need subsidized housing. Most of 'em do need subsidized housing, though, because rent's high and income is difficult to get that will pay rent. So subsidies are important. [Program Administrator]

For the majority of supportive housing residents, high rents and limited employment opportunities made it difficult for residents to find housing on their own, when they no longer need the support services. Furthermore, other subsidized housing options, including Housing Choice Vouchers (often noted as the ideal housing option), had extremely long wait lists and greater restrictions (e.g. criminal background checks) that made them inaccessible for supportive housing residents. As a result, many residents may achieve stability and some level of independence but will be unable to leave supportive housing.

Discussion

The provision of permanent supportive housing has demonstrated effectiveness in reducing homelessness among a broad spectrum of homeless populations (Stergiopoulos et al., 2015). Yet, as our results make clear, there are numerous factors that make housing stability, and continuing efforts to reduce chronic homelessness, challenging. This study offers further contributions to the literature by using qualitative methods to explore the political and contextual challenges housing providers face in helping chronically homeless individuals achieve housing stability and meeting goals to end chronic homelessness.

Service providers who participated in this study overwhelmingly believed that housing stability was contingent on engagement in case management and other supportive services. The range of services and intensity with which those services were provided varied significantly by program, but supportive services were understood to be an important mechanism to help individuals maintain housing stability (Wong et al., 2006). Some researchers have argued that housing alone is insufficient in combating the health and social consequences related to homelessness and housing instability. Evans and Strathdee (2006), for example, argue that numerous structural and environmental factors lead to the conditions of housing instability that directly impact individual behaviors. Thus, social and medical

services, especially for those hardest to house, are seen as essential (Evans, 2006; Gilmer et al., 2015). Additionally, engagement in services may be one of the most important factors in predicting housing stability, leaving under favorable conditions (e.g. 'graduating' or moving on to other independent living situations) or, alternatively, getting discharged or evicted from a program (Wong et al., 2006). Nevertheless, residents prefer housing models that allow consumer choice over whether and in which services to engage (Rog et al., 2014) and such programs facilitate mental health treatment adherence (Robbins, Callahan, & Monahan, 2009). Furthermore, when given choices, residents are more likely to engage in services they need, including recovery-oriented goals (O'Connell, Rosenheck, Kasprow, & Frisman, 2006).

Although providers in this study ascribed to the idea of consumer choice theoretically, in practice, they often noted that engagement in services was essential for residents to be successful in housing and expressed frustration over lack of engagement in services. Simultaneously, several administrators and case managers noted a lack of available funding to provide needed ancillary support services. At a time when funders and policymakers were encouraging (and in many cases, requiring) agencies to prioritize housing for individuals with the greatest mental health, medical, and social needs, funding was cut for the services that support successful outcomes for these residents. As this study highlights, the shift in HUD resource allocation from services to rental costs has raised significant challenges for some housing providers and few agencies have found alternate sources of service funding. Providers have increased caseloads, decreased intensity of services, and decreased availability to provide ancillary services. Furthermore, without appropriate funding for services, it is difficult for providers to meet housing stability outcomes and other funder goals.

A lack of service utilization coupled with a lack of funding for needed services resulted in a tension among service providers over the permanency of supportive housing. Nearly all recognized that, per HUD guidelines, supportive housing was permanent and allowed individuals to remain in the program indefinitely, reducing the likelihood that someone would return to homelessness. Yet, this approach to housing could also interfere with agency and funder goals to end chronic homelessness. Keeping people housed indefinitely, rather than working to move individuals into other independent housing options, could result in a low turnover of housing units and an inability to get more people off the streets and into the limited number of supportive housing units available. Given few alternative affordable independent living options available to people, many residents of supportive housing were able to remain stably housed for many years. As has been found in previous research, in order for people to 'graduate' from supportive housing and live independently, there need to be more affordable housing options available, as it can be difficult for case managers to help residents move forward independence knowing there are few, if any affordable, independent living options available to them (Tiderington, 2017).

This research has limitations. First, as the research was conducted in a single city, the results may not be applicable to other cities. As noted in previous work, the cuts to services in supportive housing have affected cities in different ways and some have fared better than others (Burt et al., March 2010). Similarly, the Continuum of Care, coordinated entry,

availability of funding, and network of housing and service providers differs significantly across cities. Additionally, this research is from the prospective of providers and additional work is needed to understand the experiences of residents and their perceived barriers to success. A longitudinal survey with supportive housing residents is underway that will help discern some of the individual and program-level factors that promote or impede housing stability.

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What is known about this topic

- Chronically homeless individuals experience high rates of substance use and mental illness.
- Supportive housing is an effective intervention for improving the mental and physical health of chronically homeless individuals.
- Housing First and harm reduction approaches to housing offer the greatest opportunities for chronically homeless individuals to obtain and maintain housing stability.

What this paper adds

- Qualitative insight into challenges face implementing supportive housing for chronically homeless individuals
- Policy and administrative barriers housing providers face in achieving federal housing goals
- Insight into the tension over housing tenure and the permanency of supportive housing