

Enhanced Supportive Housing as a Platform for Enhanced Recovery Outcomes

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Abstract

Supportive Housing is widely accepted as a best practice for individuals with behavioral health challenges as a service model to help individuals obtain and maintain housing in the community. The model was developed in New York City in the 1980s as a response to increased homelessness and the deficiencies of hospital deinstitutionalization. Supportive Housing has evolved into an Evidence-based Practice program model that lends itself to additional clinical and support, leading to improved recovery outcomes. This article describes the approach of one agency demonstrating how some enhancements lead to greater housing stability and improved health.

Introduction

Stable, affordable housing for individuals with a mental health and or substance use condition is a critical element in a person's recovery journey. Without housing, a social determinant of health, a person striving for change is severely challenged in attaining this goal. It is accepted that many individuals receiving services, carrying these diagnoses, have experienced trauma and disruptions to their healthy development and well-being. A stable, secure environment is essential as a foundation for developing supports and fostering skill development in the service of their recovery. While social service systems are comprised of diverse housing models, including transitional housing, Permanent Supportive Housing provides the most enduring, supportive environment for people to heal and grow. SAM-HSA, the Federal Substance Abuse and Mental Health Services Administration, an important funding source for research and service provision, has identified Permanent Supportive Housing as an evidence-based practice for enhancing recovery, employment outcomes, and improving housing stability.¹ PSH, as other Evidence-Based Practices, delineates fidelity measures, reflecting practices and principles that define a service model. Fidelity measures are extremely important in providing a frame for service delivery, and individual providers have the latitude to decide on clinical and supportive approaches to meet the unique needs of a community and target population. Bridgeway Behavioral Health Services, having 27 years of experience working within these parameters, has built upon the original supportive housing model to include additional evidence-based practices, enhancing recovery-based outcomes and community integration. This discussion will focus on the principles of the model and the enhancements that improve the lives of people served.

Supportive housing was founded in the 1980s as a New York City response to the growing homelessness challenges. The model was seen as more progressive than residential programs, which grew out of the hospital deinstitutionalization movement, serving to place people in the community. Supportive housing is valued as independent living with the resident holding the lease with tenant's rights. This feature is critical to community tenure since tenants cannot be easily removed from the place of residence and, in turn, perceive the apartment as valuable. Bridgeway Behavioral Health Services operates eight supportive housing teams in central and northern New Jersey. Currently, 515 individuals receive supportive housing services by multi-disciplinary teams, including licensed clinicians, wellness managers, and peer support staff, some of whom have lived experience with mental health conditions. The teams are geographically based and organized around acuity levels of psychiatric and medical status. The teams are staffed with specific disciplines based on the needs of the people served. Supportive housing in its early iterations was based on support, accounting for the individual's transition from being unhoused to living independently in an apartment. The introduction of Housing Firstⁱⁱ and Harm Reduction to the supportive housing philosophy impelled providers to respond to the social determinants and clinical needs of the residents. Clinical interventions provided within this structure have proven effective at enhancing housing stability and recovery outcomes for people served.

A variety of clinical interventions, provided by direct staff, are offered. The Transtheoretical Model of Change, also referred to as the Stages of Change, guides the approach toward engagement and work toward goal attainment. All staff are trained in Motivational Interviewing and Cognitive Behavioral interventions in the provision of counseling services. These core competencies for staff enable them to employ clinical strategies to match interventions to the individual's change process and goals. As Supportive Housing has evolved into a recovery model, the addition of Recovery Oriented Cognitive Therapy (CT-R) developed by the Beck Institute has helped individuals to "flourish in the lives of their choosing". CTR provides concrete, actionable steps to promote recovery, wellness, and resiliency for individuals experiencing behavioral, social, and other challenges. The approach cultivates connection, belonging, hope, purpose, and empowerment. CT-R aligns with the organizational mission and philosophy of inspiring and supporting individuals to become productive citizens fully engaged in their communities by creating opportunities for wellness, independent living, learning, and social inclusion. This organization's supportive housing model has added a wellness component, incorporating SAMHSA-endorsed Eight Dimensions of Wellness,ⁱⁱ developed by Dr. Peggy Swarbrick and her colleagues. The dimensions are: Physical, Spiritual, Social, Intellectual, Emotional/Mental, Occupational, Environmental, and Financial. The dimensions are interconnected, and the staff assesses each dimension and areas of need in each theme. With the enhanced training of staff and the addition of CTR, we witnessed a decrease in psychiatric hospitalization to 2%, as compared to a 13% rate in 2023. Competitive employment rates increased from an average of 13% individuals in FY'22 to 19% in FY'25.

An additional feature of the layering or scaffolding approach is the utilization of Measurement-Based Care, and specifically the PHQ-9 (Patient Health Questionnaire), for depression screening and the GAD 7 (General Anxiety) for anxiety screening.ⁱⁱⁱ Through utilization of the screenings

every six months and as clinically needed, staff are able to assess symptoms in these critical areas and assess the efficacy of their interventions. A strength of the model is that services take place mostly in the home, enabling staff to work with individuals in their natural environments. The screening tools help guide service, in particular for the Licensed Clinicians' interventions, who focus on symptom reductions and enhancing coping skills. Bridgeway started measuring a decrease in score from the first PHQ-9 to the last screening administered in FY'24. The organization exceeded the goal of 2% and the score saw a decrease for 8% of persons served. In FY'25, the goal was a decrease of 8% and was exceeded as 21% of persons served achieved a decrease in score. The support for individuals receiving counseling in their homes has been critical to reducing hospitalizations and enhancing recovery-based outcomes, including employment, education, housing stability, and wellness. A critical goal of housing stability is defined as the maintenance of an individual's housing of choice. The target for FY'22 of 98% was met since 98% of persons served stayed in their homes for the full fiscal year. The same target was achieved in FY'25 at 98%.

Forging an integrated care model incorporating behavioral and physical health is a systems goal for individuals with behavioral health challenges.^{iv} Although agencies confront licensing and billing challenges, Bridgeway has blended medical interventions, behavioral health, and stable housing in order to help individuals manage their overarching health. Early results show great promise in helping individuals manage diabetes and A1C levels.

To accomplish this goal, the organization has implemented a pilot population health program that focuses on diabetes. The first step was to obtain A1c levels for the target population to determine the incidence of diabetes and prediabetes. It is important to note that various methods were employed to obtain A1c levels that included point-of-care testing by agency RNs and LPNs, obtaining lab data from primary care providers, as well as through Health Information Exchanges. In the original sample, it was found that 15% of persons served are diabetic and 14% pre-diabetic. Once we determined who was diabetic or pre-diabetic, the teams developed individual goals for diabetes management. Examples include goals related to diet, physical exercise, weight management, medication adherence, and blood glucose monitoring. Based on an individual's goals, the team implemented a variety of interventions, which include health education, exercise, and diet plans. A dietician was hired as a consultant to provide group and individual counseling. Also, a medical APN who is on staff meets with each team monthly to review treatment plans, medications, and medical linkages. This has resulted in medication changes, referrals to specialists, and collaboration with psychiatrists. The teams help oversee the self-administration of medications.

The behavioral health and co-morbid medical conditions of the people served have improved in large part due to stable, affordable housing. Supportive housing providers have found that when individuals have a financial and emotional investment in their housing and are given choices around neighborhood, community, and treatment, they are more likely to be engaged in recovery-based options. When housing is seen as a right and not dependent upon an individual's adherence to treatment, with the right supports, individuals are most likely to opt for wellness

and growth. When practitioners provide options and embrace the concept of individual pace of change, people served perceive collaboration and the freedom to drive their own recovery.

References

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Endnotes

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