CENTRAL CITY CONCERN
HOMES HEALTH JOBS

Engaged Supportive Housing: Sustainable Models for Housing and Clinical Services in Supportive Housing

Andrew B. Mendenhall, M.D.
Brooke Goldberg, J.D.
Rose Goren, MPH
Juliana Wallace, LCSW
Sarah Holland, MSW, MPH
Mary-Rain O'Meara, MURP

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Executive Summary

The Portland, Oregon metro region continues to face a persistent and worsening crisis of street and unsheltered homelessness fueled by:

- A chronic shortage of deeply affordable and permanent supportive housing (PSH).
- Large, core populations with high prevalence of severe substance use disorders (SUD).
- Large, core populations with co-occurring severe and persistent mental illness (SPMI), including substance-induced psychosis and decompensated schizophrenia.
- A system of behavioral health care that has, for decades, been under-resourced, and even with some new resources from the state coming online, it will continue to be under-resourced.
- An acute behavioral health continuum that does not empower meaningful civil commitment, stabilization, and subsequent community re-entry for a core population repeatedly cycling through healthcare and housing systems.
- An entire network of affordable housing, including PSH, operating within an environment lacking a behavioral health system of care sufficient to meet identified population health needs.

Individuals with high acuity behavioral health needs are disproportionately represented among those who are chronically houseless (San Francisco Benioff Homelessness and Housing Initiative, 2025). Some of these individuals are too clinically unstable to benefit from housing alone, resulting in eviction and return to unsheltered homelessness. Assessed as individuals who are highly vulnerable with qualifying barriers to housing, these individuals are often prioritized by our region's Coordinated Entry System (CES) for Housing First oriented placement with the belief they will seek services and, through engagement, clinically stabilize.

The experience of Central City Concern (CCC) and other affordable housing and PSH providers is this subset of individuals often decline engagement with clinical services. Lack of service engagement in these populations often results in ongoing and persistent behavioral challenges which negatively impact the clients, staff, and neighbors within their housing communities. For housing providers like CCC, the behaviors resulting from severe and untreated behavioral health conditions often result in costly and lengthy eviction in response to client behavior. The volume of housing client "churn" contributed to by these challenges has recently been identified as a system stressor by our regional housing authority. During a time of affordable and supportive housing scarcity, our system of affordable housing and behavioral health services must be realigned to demonstrate strategic stewardship of scarce resources. It is critical to ensure the clinical acuity mismatch of clients to housing is minimized as much as possible. This mismatch is worsened by a CES system that allows individuals to self-attest to their level of behavioral

health acuity. For individuals with anosognosia (a lack of insight into their illness), this makes it likely they will not receive a suitable level of service to help them be successful in housing. The CES within our region must also be revised in order to support an improved service coordination structure. It is time to acknowledge some clients placed in this region through the CES are not stabilized enough to succeed in a housing placement and individuals who are service-engaged and more clinically stabilized are more likely to benefit from housing placement. Our region faces difficult ethical decisions for funders and service providers as affordable housing operational sustainability continues to show industry-wide risk for housing resource loss and ongoing strain related to the burden of untreated behavioral health needs.

Since the loss of access to the Oregon State Hospital (OSH) for civilly committed individuals in early 2020 and the introduction of fentanyl and P2P methamphetamine in 2021, achieving a successful treatment outcome for clients has become more difficult and relapse more common. Although Portland has embraced a Housing First approach (prioritizing immediate, low-barrier housing for individuals with high behavioral health needs), limited treatment infrastructure, with little or no access to the clinically appropriate level of service or client engagement as necessary support, results in outcomes one might expect if it was 'Housing Only.' As described, these outcomes include clinical deterioration, eviction, and a return to street homelessness. In more severe cases, they can escalate to criminal offenses and eventual placement in the forensic psychiatric care system as the final pathway to client engagement. Within this region it has been estimated that this population is less than 20% of individuals who are houseless, according to unpublished data from Health Share of Oregon (HSO). However, the disproportionate amount of resources and staff time needed to support them without the appropriately matched services available is proving to be unsustainable for operators, including those with expertise and commitment in serving this population.

Individuals with SPMI, particularly those suffering from anosognosia, often face challenges in engaging in treatment and medication adherence and may not be effectively reached by current housing and service delivery models. In the absence of intensive community-based service models like Assertive Community Treatment (ACT) or Intensive Case Management (ICM), affordable housing providers, including PSH programs, try to serve individuals who are non-stabilized without access to the support necessary to achieve consistently successful outcomes. These circumstances can create a cascade of negative impacts for the client and community. This is compounded by limits to our region's treatment capacity and thresholds for civil holds and civil commitments.

This executive summary asserts that this population with the highest levels of non-stabilized clinical acuity is at the greatest risk of not having their needs met in their housing environments. This is driven by the inability of our region's system of behavioral health and SUD care to support a successful and scaled Housing First model with a functional, acute psychiatric support system. Moreover, due to the profound shift in behavioral health acuity within our region's populations who are unhoused or housing insecure and the persistent

lack of behavioral health service capacity, the economic and operational risks of housing this population have been inadvertently shifted to affordable housing providers within this region. Prioritizing individuals leaving higher acuity clinical environments for housing placement with coordinated behavioral health support will result in increased capacity in the psychiatric acute care system by improving downstream clinical and housing outcomes. Such a structured coordination of behavioral health and housing resources also relieves pressure on the housing providers, reducing cycles of eviction and negative impacts on affordable housing communities, providers, and system sustainability.

It is time to address this unsustainable risk shifting and commit to designing and aligning housing and behavioral health resources to meet the needs of individuals more effectively with high acuity behavioral health and SUD conditions.

This white paper describes and advocates for **Engaged Supportive Housing**, a reimagined service model that integrates housing resources and behavioral health services with an expectation of service engagement. This approach restores housing and treatment as interdependent elements of client recovery and stability for those with high acuity behavioral health needs. Our region's truth is that the practice of Housing First without ready access to the appropriate behavioral health services is failing our sickest, most vulnerable people.

1. Housing First: The Practice Versus Reality in the Portland Metro Region

1.1 Origins and Principles

The Housing First model, developed by Dr. Sam Tsemberis of Pathways to Housing, Inc., emphasizes immediate housing access without preconditions like sobriety or treatment participation. Randomized controlled trials and literature reviews provide strong evidence that Housing First programs substantially improve housing stability, reduce time spent unhoused, decrease reliance on shelters and emergency systems, and reduce associated costs. Research has shown that while most participants maintain housing successfully, a subset of individuals with high acuity or ongoing psychiatric instability are at greater risk of eviction or cycling back into homelessness (Jacob et al., 2022; Aubry et al., 2015; Aubry et al., 2016; Stergiopoulos et al., 2015; Ly & Latimer, 2015; Tsai, 2020; Baxter et al., 2019).

Evidence remains mixed or limited regarding Housing First's impact on employment, mental health, and substance use outcomes compared to treatment as usual or treatment-first (Tsemberis, n.d.; Tsai, 2020; Hanson, 2024; Baxter et al., 2019; Leclair et al., 2019; Jacob et al., 2022; Poremski et al., 2016; Saldanha et al., 2024). Additionally, fidelity of Housing First implementation varies, and clients in programs with greater fidelity related to participation were associated with improved housing and high-risk substance use outcomes (Davidson et al., 2014; Gilmer et al., 2015). The Substance Abuse and Mental Health Services Administration (2021) underscores this by stating that “*recent*

research suggests that Housing First programs prioritizing housing placement without concurrent treatment engagement and adherence have not been effective in reducing homelessness." While there is some evidence that the model supports mental health benefits, ongoing research is needed to examine its broader system-level impacts, including health-related outcomes and long-term outcomes (Baxter et al., 2019; Aubry et al., 2020).

The Housing First model is grounded in the following five principles of fidelity:

- **Separation of housing and treatment:** Access to housing is granted without preconditions such as sobriety or participation in treatment. Supportive services and treatment are delivered independently of housing, following the individual regardless of where they live. Housing is typically scattered site and integrated into the community, with no more than 20% of units in one building dedicated to Housing First participants.
- **Consumer choice:** Individuals can select their housing options and decide which supportive services they wish to engage in, except for a minimum of weekly face-to-face meetings and bi-weekly unit check-ins, which remain a required component.
- **Recovery orientation:** Services are grounded in a philosophy of harm reduction, hope, resilience, and positive reinforcement, aiming to support long-term recovery and personal growth.
- **Provide services to match needs:** Supportive services are tailored to the priorities and self-identified goals of the participant and may include nursing, social integration, supportive employment, integrated substance use treatment, psychiatric treatment, motivational interviewing, and housing supports.
- **Social and community integration:** The model encourages tenants to build meaningful connections with the broader community, fostering social integration and reducing isolation (Stefancic et al., 2013; Tsemberis, 2010; Pathways Housing First Institute, n.d.).

As described by Dr. Tsemberis (2010), successful Housing First implementation relied on intensive, community-based psychiatric support; ongoing assessment and intervention to maintain clinical stability; and the provision of rental subsidies. Fidelity to the model required more than simply providing permanent housing but included extensive outreach and access to a continuum of treatment and services based on individual choice, delivered through high-touch, well-resourced multidisciplinary psychiatric teams.

While the model emphasized compassionate, low-barrier access, it was not without structure or limits. Tenants still had to uphold standard lease agreements, such as paying rent, not endangering others, and maintaining the unit (Tsemberis, 2010; Stefancic et al., 2013). The model assumed that, over time, continued practice in decision-making fosters greater self-regulation and long-term success (Tsemberis, 2010). In all of these examples,

the client is clinically competent to make decisions and consent to everything from their lease agreement to their choice of service engagement.

The Housing First model recognized that some individuals, when destabilized and experiencing behavioral health conditions that impair their capacity to make safe decisions, required higher levels of care and secure settings (Tsemberis, 2010). This is facilitated by a functional system of psychiatric response such as holds, short-term civil commitment, psychiatric hospitalization, mandated pharmacological treatment, and post-hospital secure residential environments to both restore and preserve individual capacity and stability. Most notably, a functional system of acute behavioral health services empowers individuals to re-enter the community within a pre-defined, appropriate supportive housing environment. Generally, these post-hospitalization solutions are long-term transitional or PSH communities resourced and assertively connected with behavioral health services. These housing and clinical resources are strategically linked and co-managed, with the 'back-up' of a functional and responsive acute system of psychiatric care.

As we consider the persistent systemic barriers for creating success for clients and sustainability for programs within PSH programs within the Portland Metro region, it is valuable to define these regional variances that exist and compare them to the Housing First framework. It is important to consider these gaps through the frames of system change experienced by the population of individuals with SPMI, severe SUD, and co-occurring SPMI and SUD from 2020 to the present for the region.

1.2 Portland Metro Variances

It is necessary to examine the "vision vs. reality" of the Housing First model as it is delivered in the Portland Metro region. While fidelity to the model calls for permanent housing paired with regular engagement and access to a continuum of treatment and services, the region faces (and will continue to experience) a critical shortage of prompt and effective acute behavioral health and SUD treatment, including psychiatric care.

All the elements of a psychiatric continuum of services are lacking at-scale within the Portland Metro region and across the State of Oregon *and will continue to remain in scarcity for the next three to five years* (Oregon Health Authority & Public Consulting Group, 2024). To meet today's estimated system demand, the Portland Metro region requires an additional 42 inpatient psychiatric beds, 95 secure residential treatment facility (SRTF) beds, 80 mental health residential beds, 494 SUD residential treatment beds, and 94 withdrawal management beds (HSO, 2024). While there are shovel-ready projects identified to partially address these gaps, the total funding needed to bring these projects online is approximately $183.9 million (HSO, 2024).

Additionally, critical behavioral health components of a Housing First model, such as ACT teams, are limited. According to HSO, Portland Metro ACT team capacity supports 406

clients, and capacity is declining due to staffing challenges. Regional partners estimate an additional 150–200 ACT or ICM slots are needed to meet the needs of the region's high acuity population. Even with recently approved legislative funding, capacity shortfalls will persist without further significant investments and strategic system-level interventions.

These regional shortages worsened in 2020 due to the loss of the OSH as the primary location of services for civilly committed Medicaid recipients from this region. This population historically numbered (in 2018-19) more than 450 individuals per year based on a claims-based review conducted by HSO. Objectively, there is no current evidence that OSH or the region's psychiatric hospitals will, in the next several years, be capable of fully serving the population who need to be civilly committed to begin their recovery journey and access this level of psychiatric service. Based on the Oregon 2025 long legislative session, the Portland Metro region will not be receiving funding to support expansion of the acute inpatient psychiatric continuum, and the modest, planned increase to the regional inventory of SRTF beds will likely continue to be utilized to meet the needs of a growing population of forensically committed individuals as a pathway for discharge from OSH for the next couple of years.

Access to services and investments reflected in the Housing First model has not been realized in the Portland Metro region. Below are some examples of the variations:

HF Principle	Observed Variance in Portland Metro
Separation of Housing and Treatment	Affordable and program housing supply is severely limited. Clients who are non-stabilized with unmet high acuity needs negatively impact communities and drive client "churn," insurability, and portfolio challenges. Regional behavioral health treatment capacity is insufficient for both treatment seeking and non-treatment seeking individuals. Investors/operators are less engaged in developing affordable housing due to generalized portfolio and sustainability concerns.
Consumer Choice	HUD has historically prohibited mandating treatment, but at the same time defines a frame for clients to sign lease agreements even when the provider observes the client's lack of capacity. Anosognosia is not systematically addressed, and there is chronically insufficient access to inpatient and outpatient behavioral healthcare care for all who need it. Clinical instability significantly increases the risk of eviction and other program sustainability problems as a final pathway. CES rubrics are at risk of exacerbating level of service and housing mismatch if reliant on client self-report and/or choice to not engage in services among clients who lack agency or capacity.

HF Principle	Observed Variance in Portland Metro
Recovery Orientation	De-prioritized locally over the past five to six years and more difficult to support within the Portland Metro region's chronically houseless population. Former HUD guidance emphasized engagement for individuals seeking permanent housing in Alcohol and Drug Free Communities (ADFC). Support for ADFC housing has been reduced over the past several years but is now a renewed priority focus of our federal HUD partners. Our region uses Project Based Section 8 ADFC housing to great success and stability for these programs and clients. Funding constraints on supportive services (high caseloads, reimbursement model challenges) have decreased these programs' ability to respond to a population with higher acuity due to the changes in the region's illicit drug supply.
Provide Services to Match Needs	The behavioral health system lacks adequate capacity to offer timely, individualized services. Overemphasis on client choice ignores those unable to make informed decisions, e.g. those who lack competency or have anosognosia. There is a lack of access to medication management necessary to maintain clinical stability. For the identified population of high acuity clients, prioritization of housing placement for this population has demonstrated inconsistent service coordination.
Social/Community Integration	Social integration depends on clinical stability and prosocial behaviors which are often missing from those with unmanaged schizophrenia and/or co-occurring stimulant induced psychosis. These individuals with untreated behavioral health conditions experience isolation themselves, and due to the behaviors associated with their untreated behavioral health conditions may cause fear, isolation, and non-desirability of living in the community itself for their fellow residents.

The inability of the region's behavioral health continuum to provide the right level of access and support at all levels of service has undermined the region's Housing First strategy. This leads to a system of chronic service level mismatch and the inability to retain many clients in affordable housing and drives the churn noted by our region's housing authority. The burden on housing services providers to address client instability, which is out of their operational scope, has created a perfect storm of acuity risks in housing. These acuity levels and unmet needs, combined with high housing costs, and the arrival of fentanyl and the pandemic, have all contributed to an increasing inflow to homelessness and unsheltered homelessness over the past six years.

2. Behavioral Health Landscape and Impact for Affordable Housing Services and Programs

2.1 Regional Medicaid Data: Health Share of Oregon Regional High Acuity Behavioral Health Analysis

Over the past three years, HSO, a Coordinated Care Organization (CCO) which administers the Medicaid benefit to nearly 85% of the Oregon Medicaid population within the Portland Metro region, has been conducting a behavioral health ecosystem analysis to better serve those with high acuity behavioral health needs. This involved retrospective analysis of the Medicaid paid-claims database for HSO members. Findings from 2024 data for the Portland Metro region indicate:

- Approximately 26,000 adults in the Portland Metro region had a paid claim for psychosis, opioid use disorder, stimulant use disorder, or overdose.
- This group represents 8% of Medicaid adults and accounts for 24% of total healthcare expenditures (approximately $550 million per year) and around 40% of total adult, inpatient hospitalization bed-days.
- Approximately 7,600 of these individuals also had indicators of homelessness or housing instability.
- Individuals within the high acuity group experiencing housing instability had twice the medical hospital utilization compared to those with stable housing (indicating the value of being housed, but housing characteristics and retention has not yet been assessed in these groups).
- 8,212 individuals had a claim for psychosis, 1,319 had a paid claim for psychosis *and* stimulant use disorder, and 895 had a paid claim for *all three*: co-occurring psychosis, opioid use disorder, and stimulant use disorder. These groups represent the highest acuity needs requiring intensive behavioral health intervention for which our regional continuum of services generally lacks capacity to provide.
- Service engagement analysis including long-term pharmacotherapy and behavioral health utilization analysis for these identified groups remains pending at this time (Livingston, 2024).

In 2025, regional data sharing from the Homeless Management Information System (HMIS) began between regional county partners and HSO. At the time of the publication of this paper, the initial analysis of these groups, their intersection, and subsequent analysis of service utilization and housing placement outcomes remain pending. Additional Medicaid claims analysis is being conducted by HSO and will provide evidence of the level of healthcare utilization and behavioral health service engagement for these populations. These data will establish the first set of benchmarks allowing us to evaluate the success or failure of the Portland Metro region's homeless and healthcare systems outcomes for specific populations with high acuity behavioral health needs. Most importantly, benchmarking becomes an anchor for strategic system redesign and evaluation of performance.

2.2 Behavioral Health Acuity and the Impact on Affordable Housing Programs

As previously stated, clients with high acuity behavioral health needs—particularly those who are untreated, and those who begin to become stabilized but are unable to receive the necessary services to re-stabilize quickly and efficiently when destabilized— create significant challenges for affordable housing providers. Below are just some of the complications and challenges impacting affordable housing providers within our region:

- Residents reporting reduced quality of life due to the distress occurring within the property.
- Higher facility maintenance and security needs.
- Staff workplace physical and emotional injury, burnout, and high rates of turnover.
- Unmanaged behavioral health acuity among tenants with no meaningful "next step."
- Cycles of eviction as a final pathway coupled with administrative burden and added cost for property management and housing providers.
- Housing operator financial sustainability challenges and financial compliance risk.
- Insurance and liability issues for housing operators.
- Reduced risk appetite to develop new affordable and PSH programs.
- Diminishing underwriting potential from lenders/investors into new projects.
- Higher than average vacancy rates across the affordable housing continuum.

The following scenario represents a common and recurring pattern of service mismatch relating to the level of clinical acuity and highlights the criticality of timing in the clinical cycle of treatment engagement and stabilization for individuals with SPMI and their housing placement. The authors suggest this scenario demonstrates poor human and service stewardship during a time of housing unit and behavioral health program scarcity and strain. This elevates the need for redesigning different entry points for housing and strategically prioritizing the connection of housing resources with behavioral health service access.

The scenario illustrates the ongoing need for intentional improvement of flow from the acute psychiatric system of care to better leverage the available affordable and PSH housing continuum. The authors propose intentional prioritization of housing and service coordination for the population who receive acute psychiatric care as their first step in becoming housing ready will empower our region's acute psychiatric care system to serve more individuals and improve outcomes for clients and housing providers. Creating capacity within the acute psychiatric care continuum in this manner will decompress the shelter, shelter alternative, and streets of our region by allowing more individuals to flow via holds and civil commitment into the acute psychiatric care system as the necessary first step to clinical stabilization.

One key lesson of this scenario within the Portland Metro region is the process of client housing prioritization, creating worse outcomes for both clients. It is important to note that

in August 2025, an interdisciplinary group convened by Homeless Systems Initiatives and attended by key regional partners who operate our region's psychiatric hospitals estimated that an average of one person per day (365 per year) leaves our regional inpatient psychiatric continuum to shelter or homelessness.

Scenario: John is an individual with SPMI admitted to Unity Center for Behavioral Health for 30 days following acute psychiatric decompensation and would benefit from placement in secure residential treatment as part of a comprehensive discharge plan. Due to our region's lack of behavioral health residential service access capacity, John can only be placed in affordable housing or a shelter, when they would be more clinically appropriate for a residential treatment facility or psychiatric group home. Because John is stabilized and service connected, they are defined as having fewer barriers to housing by the CES and are prioritized for shelter rather than PSH or other affordable housing placements. This level of service is inadequate for John's needs, increasing the likelihood that they will decompensate or disengage with services, resulting in a repeated cycle with a poor outcome.

Bill is a person with untreated psychosis who has limited capacity and anosognosia. Bill is considered to have significant barriers to housing and is therefore given priority placement in affordable housing or PSH. Bill repeatedly declines engagement in services and engages in unmanaged hoarding behavior leading to public hygiene and pestilence issues within the housing program. Upon having an internally managed housing intervention with supportive housing staff, Bill becomes agitated resulting in increasing paranoid ideation and isolation. Later the same week, a neighbor confronts Bill about unit odor and cockroach infestation resulting in Bill assaulting their neighbor. The assault leads to Bill's arrest and release, followed by a 24-hour eviction and re-cycling to unsheltered homelessness or, at-best, the shelter system.

John leaves the hospital environment to a congregate shelter with a high risk of immediate relapse on methamphetamines, stops their psychiatric medication, and is lost to follow-up within the homeless services continuum.

Bill receives housing, but gains a record of eviction, returns to being unsheltered, and faces possible criminal charges. The unrealized hope of our current system is that Bill and many hundreds of individuals with similar conditions will engage in treatment services once placed in an affordable housing or PSH unit. This results in harm to the client and housing service provider when an adequate level of care is not available and assertively engaged in. Closing the clinical service gap for Bill requires active, community-based engagement by street or shelter-based outreach and treatment teams specifically dedicated to the group of individuals with untreated SPMI or dual-diagnosis, with or without anosognosia. This population is large enough within our region that the preferred front door should be admission from the street or shelter to the psychiatric acute care system, facilitated through a hold or civil commitment process and followed by housing placement (due to our region's lack of residential treatment bed capacity) with affirmative

connection to community based behavioral health support. For both Bill and John, restoration of their capacity to make decisions through engagement with pharmacotherapy is the intervention they both deserve, and which will facilitate more effective housing placement and longitudinal engagement. For both individuals and the nearly two thousand individuals in our region who have paid Medicaid claims for psychosis and/or psychosis and stimulant disorder (Livingston, 2024), their most reliable and effective pathway to recovery and sustained housing placement will occur through medication initiation within the acute psychiatric system, which also facilitates a disruption in the cycle of stimulant use. Alternatively, engagement in a dedicated street to transitional housing with a behavioral health program which requires service engagement could be another entry pathway for Bill and could be a post-hospital discharge option for John. The authors offer a description of this form of program later in this document. Our region simply does not have enough of these treatment and housing program spaces to meet our region's population need.

2.3 Improving Outcomes in a Time of Persistent Scarcity

Service providers and regional government partners must acknowledge the Medicaid dollars spent to stabilize John only to have that clinical stability undermined by a release to the street or congregate shelter within this region. The same providers and partners must call into question and systematically revise our approach to Bill, who is also failed by the inadequate system of behavioral health services and the need for improved service connection and a reimagined CES. Bill is also set up to fail and faces personal risk of harm while creating a profound negative impact (due to their behavior resulting from untreated clinical conditions) on their housing community.

While HUD strongly encourages prioritization of people with the most severe needs and highest vulnerabilities, local entities have flexibility to define what that prioritization looks like and are not required to rely solely on a vulnerability index or single numeric score (Homeless Strategic Initiatives and Corporation for Supportive Housing, 2024). Prioritization for the CES can occur in several ways, including based on who would most benefit from a housing and/or services intervention. Currently, prioritization is given to those with the highest number of barriers to housing. While this is an answer to systemic deficits and disproportionate impacts on certain populations, it does not adequately ensure that those placed in housing with unmet high acuity clinical needs of any demographic will be set up for success. Our system can benefit from a placement process honoring both the needs and access to appropriately matched levels of service available for individuals in addition to other criteria.

Service providers are acknowledging that our regional and state behavioral health continuum and housing programs must adapt rapidly to make better use of scarce resources and simultaneously respond to the operational sustainability challenges driven by our current system. Revision of the current CES will be required to meet those

challenges. Additionally, several critical questions are posited for our regional leadership partners to act in response:

1. What does a coordinated system of transitional and permanent housing with supportive housing and clinical services look like to meet the needs of clients like John and Bill?
2. While waiting for needed capacity, how does service coordination and the CES rapidly transform to ensure clients who have high acuity needs but are stabilized like John are given priority housing support and placement over clinically similar individuals who are not service engaged? And at what downside cost(s) to other individuals, must we accept?
3. How is housing and healthcare information seamlessly shared and tracked to ensure clients like Bill are engaged and offered the opportunity to stabilize within shelter or a temporary alternative shelter site and offered the opportunity to receive a housing placement once a base of clinical stability has been achieved?

2.4 Sustainability Challenges for Programs, Staff, and Community

Affordable housing supply is inadequate to close the gap for thousands of individuals who are unsheltered, houseless, and low-income in the Portland Metro region (City of Portland Bureau of Planning and Sustainability, 2023). The planned development of additional units is well below the need for the region, resulting in scarcity which will persist for the next five years, and likely longer.

There is also a significant challenge we face in our region of long-term economic viability. The lack of financial sustainability for affordable housing providers is clearly shown in a recent report by the Network of Oregon Affordable Housing (Table 1).

Table 1. *Summary of Distressed Affordable Housing Properties in Oregon, 2018-2023*

	Projects	Units	Loan Balance
Projects at Risk of Loss			
Metro	27	1,785	$85,607,633
Balance of State	9	336	$10,281,081
Total	36	2,121	$95,888,714
Projects Draining Cash			
Metro	53	4,181	$197,705,768
Balance of State	23	792	$20,214,621
Total	76	4,973	$217,920,389
Grand Total – At Risk			
Metro	80	5,966	$283,313,401
Balance of State	32	1,128	$30,495,703

Total	112	7,094	$313,809,104

Note. From Network for Oregon Affordable Housing. (2025). *NOAH portfolio operating analysis 2018–2023* [PowerPoint slides].

Statewide, 2,121 affordable housing units are at risk of foreclosure. 7,094 are at risk, in total, and represent a material risk to the continuum of affordable housing, particularly within the Portland Metro region. Primary drivers of financial losses are 1) insurance cost, 2) onsite management cost including security, and 3) repairs and maintenance of facilities. Claims loss histories among affordable housing providers related to behavioral incidents are significantly different over the past five years at CCC and among partner organizations within this region. Increases in both insurance and repair costs are related to damage and incidents caused by clients with unmet high acuity behavioral health needs. Increased staffing and security are cost drivers for onsite management in response to increased behavioral health acuity.

At CCC, the total cost of insurance has risen by more than 580% over the past six years due to CCC's claims history for property and indemnity coverage. Significant fire, flood, and facility damage incidents have become normalized, regular events based on the frequency of their occurrence. These incidents are primarily driven by the shift in clients with unmet behavioral health needs.

CCC data on significant building loss incidents over a period from 2023-early 2025 showed that behavioral health factored into causality for nearly 60% of the events. The total cost of damages for these events was $1.443 million cumulatively. These damages occur at an equal rate throughout the CCC housing portfolio, regardless of housing typology, indicating a broad and consistent mismatch between clients with unmet behavioral health needs and housing placement.

CCC is also experiencing higher than typical vacancies across parts of our affordable housing portfolio due to lack of desirability of specific properties. Some individuals who are houseless are declining placement within several of CCC's buildings due to the reputations of certain buildings related to unmanaged behavioral health acuity among our clients. To address this, CCC has self-funded an internal security response team and is deploying a grant-funded team to engage clients more intentionally in eviction prevention activities. There are other regional affordable housing providers who would like to have these options but do not have the budget or funding to consider this level of support for their staff and clients.

Within CCC, the topic of safety within the workplace related to clients with untreated behavioral health needs has become the primary workforce concern across our housing and healthcare divisions. Client-facing staff in our housing and healthcare settings have been turning over at more than 50% annually. In addition to turnover, persistent staff vacancies drive overwork due to the understaffing of teams. Moral injury due to lack of resources to stabilize clients is also included in this list of factors driving employee and

team burnout and turnover. CCC staff report deep emotional burden, “watching people get more ill,” and feeling helpless to get clients the psychiatric services they need to prevent eviction.

These issues, driven by our region’s chronic, service-level mismatch, are not unique to CCC but are the primary area of discussion and focus for affordable housing, PSH and Medicaid service providers across the region.

3. Existing Models of Services, Design Opportunities, and Recent Challenges

3.1 Community Engagement Program and Shelter Plus Care Vouchers

Several models for short-term transitional programming which require service engagement by housing clients have shown significant success within CCC and other housing service providers. CCC’s Community Engagement Program historically provided transitional housing for clients with high acuity needs, SPMI, and/or dual diagnosis in an affirmative high-intensity model with success in transitioning a high proportion of clients to PSH. The Community Engagement Program has been defunded from a peak of four separate teams supporting more than 300 clients annually (in the early 2000’s) to one team supporting approximately 90-110 unique clients per year. The dollar cost per annum per client is roughly $14,000 for FY25. Scaling up the number of participants would require increased financial investment for both clinical services and consistent access to subsidized housing vouchers. Retention outcomes for FY25 are 100% for six months and 91% for twelve months.

This program has success in housing placement and retention based on several factors: 1) individuals are able to participate in the program based on their own perceived behavioral health and medical needs, rather than sobriety requirements or other treatment compliance and, 2) individuals can be placed immediately into a unit with an emergency shelter voucher which is located in the same building as their behavioral health clinic, which helps with intensive stabilization, document readiness, and keeping clients consistently located.

The Community Engagement Program historically had discretion with respect to which housing subsidy/voucher is most appropriate to apply to a given client's situation, depending on several factors that our region’s CES is unable to accurately assess for or track (type of support needs versus level of independence, readiness for independent housing, geographic considerations, and ongoing access to Federally Qualified Health Center services through CCC among many others). CCC’s Community Engagement Program no longer has this degree of decision making due to changes made to the CES in 2024-25.

The Community Engagement Program often waits for a minimum of six months before beginning the housing and subsidy search with a participant because that timeline allows

for more stabilization, better decision making on the part of the participant (through maintenance of psychiatric competency), and a higher degree of informed consent from the participant as they enter into a binding legal agreement (a lease). The Community Engagement Program team approach varies from the way our region prioritizes Housing First and rapid admission to a lease-based setting using the CES.

Currently, the Community Engagement Program relies on a number of non-CES subsidized housing pathways (e.g. Old Town Collaborative with Outside In and NARA, Katherine Gray Rental Assistance Demonstration Voucher program) to effectively house individuals who are highly vulnerable, but for reasons which are not transparent, did not score highly enough on the CES assessment to enter the priority pool.

Scaling and expanding the Community Engagement Program model to a 24-month emergency shelter to permanent supportive model would demonstrate a significant strategic improvement over our region's current approach to management of this population when they are healthier and prepared for a permanent housing transition.

The Community Engagement Program model of service is a proven model of stabilization and transitional housing service for part of the population with very high acuity behavioral health needs. Expansion of this model could meet the needs of more clients who are extremely vulnerable but would require commitment to aligning dedicated coordination of subsidized housing vouchers with our region's high acuity care teams across multiple service providers who are able to bill Medicaid for the behavioral health elements of their services. It should be noted that Shelter Plus Care vouchers are not funded to the level of need in the Portland Metro region.

3.2 Cedar Commons Overview

Cedar Commons is a 60-unit permanent housing building with integrated clinical behavioral health services on-site, which has led to improved housing retention rates. 30 units are funded with Regional Long-Term Rent Assistance (RLRA) vouchers, 10 are CHOICE/SPMI PSH units, and 20 are affordable fair market units. However, Medicaid billing alone cannot cover the full costs of the supportive *and* clinical housing services needed for individuals who use them. The building is also running at an operational deficit due to higher than projected expenses that are not covered by rental income alone.

While designed as a low-barrier housing community for individuals with SPMI, co-occurring SUD, and a history of chronic houselessness, credentialed providers also deliver Clinically Supported Living Services to residents who are not enrolled in formal behavioral health treatment. These services fall under Medicaid-covered categories and are offered under CCC's Federally Qualified Health Center. However, due to the requirement of formal enrollment and engagement in behavioral health treatment (which cannot be compelled

under HUD compliance requirements), these informally provided clinical engagements are delivered as unfunded, non-compensated care.

Retention rates at Cedar Commons are 95% at 6 months and 88% at 12 months, which is remarkable given the very high acuity needs of the residents compared to other PSH programs. Cedar Commons achieves these outcomes because behavioral health services are offered to all residents, regardless of CCC's ability to receive reimbursement. Typically, about 20% of residents are enrolled in CCC's outpatient mental health services which does not drive the volume of billable services to support the sustainability of a co-located behavioral health team, when clients are empowered to choose not to take part in services. Many of the activities which promote engagement and support long-term tenancy are non-compensable and therefore require a different model of service, one which ensures client engagement as enrolled participants within the on-site program, in order to recoup the cost of meeting client needs with a level of service (co-located, Master's level, behavioral health services) which meets the needs of the clients residing in this PSH program.

4. Strategic Key Priorities for Change

4.1 Immediately Invest in Additional Behavioral Health System Capacity

The most salient change for the region which can empower improved stabilization and outcomes for the thousands of individuals experiencing psychosis, with or without SUD, is scaled investments in the region's acute system of behavioral health care. The Oregon Health Authority and Public Consulting Group's 2024 report and the published response to this report by HSO in 2024 identified a cascade of scaled investments which are required to meet the region's identified need for acute behavioral health and SUD treatment. Focus on building capacity for the acute psychiatric system of care, including the OSH, is foundational to shifting the balance of acuity and risk for housing, supportive services, shelter providers, and the public safety system, alike.

It is critical to ensure acute psychiatric treatment access for individuals who require the initiation of psychiatric medication as the first step to experiencing the restoration of capacity, social re-integration, and successful housing placement and retention. This type of focused investment strategy, while expensive, will yield significant decompression of psychiatric acuity across our region's entire human service sector. This investment is a long-term dependency to better meet the needs of our region. While the region waits for additional scaled investments to meet the needs of this population, we must improve our approach to service coordination and coordinated entry to facilitate flow and improve stability within the existing structure and service capacity of our regional continuum.

4.2 Implement a Population Segmentation Strategy

Stakeholders have recommended a population segmentation approach to strengthen homeless system effectiveness (Homeless Strategic Initiatives & Corporation for Supportive Housing, 2024). This involves developing targeted strategies to identify and prioritize groups such as individuals discharged from healthcare or justice settings and those exiting interim housing programs. By focusing on specific groups and specific clinical needs, our housing and behavioral health system can drive a strategy to match scarce services more precisely to needs and reduce the likelihood of individuals cycling back into homelessness. Our regional HSO high acuity behavioral health data inform us of the size of these populations and will also inform the rate of engagement in treatment-related services for these conditions. Considering the highest acuity behavioral health group (individuals with SPMI and/or dual diagnosis), continuity of treatment is a primary determinant in a favorable housing outcome. The synthesis of this data and understanding outcomes are straightforward and represent a significant opportunity for our region to thoughtfully inform population-specific strategies which demonstrate improved housing and service coordination.

4.3 Improve Coordination of Behavioral Health, Homelessness, and Housing Systems

A more coordinated system requires integrating health and housing assessments, aligning behavioral health services with the CES, and expanding individualized matching strategies. The CES should incorporate physical and behavioral health evaluations to ensure service alignment. Stabilization supports, at shelter or shelter alternative sites and transitional supportive housing programs, must also be available before permanent (PSH or subsidized affordable) housing entry, with pathways for individuals to re-engage in stabilization services after housing placement, as needed. Up-front permanent housing placement without the appropriate clinical support for a population who lack capacity to make decisions is not an effective alternative. To sustain this alignment, behavioral health funders should be encouraged to invest directly in supportive housing programming and units as needed infrastructure. Our region cannot, however, wait for the latter during this time of resource compression.

Housing placements should reflect a balance of individual preferences and community integration needs. While some individuals thrive in scattered-site settings and others in single-site or community-based environments, placements should also consider opportunities for connection by situating people near peers with shared lived experiences to reduce isolation. Placements must also consider the risk of a single individual having an outsized, negative impact on their housing community.

Achieving this level of tailored matching, however, requires stronger system infrastructure. The region’s lack of a shared database continues to limit coordination between healthcare

and housing services, creating persistent gaps that undermine efforts to align placements with both personal needs and community support services.

4.4 Empowerment of Cross-Sector Case Conferencing

Developed by HSO, and supported by Portland Metro in 2023, county-specific case conferencing began with the vision of meaningfully coordinating individuals with high clinical acuity and barriers to services and care. Each Metro County's Continuum of Care service entity and a core team of behavioral health providers began meeting twice monthly and have served 275 individuals over the past 18 months. Early unpublished data reported by HSO has shown significantly reduced emergency department utilization by individuals served by these case conferencing teams. This effort requires trust and willingness to bridge the gap which has sometimes existed between housing services and behavioral health providers and represents a methodology which is starting to have modest impact. This form of collaborative partnership, empowered with housing vouchers, short term rental assistance, and behavioral access is a necessary solution during a time of increasing scarcity. Our region's partners have demonstrated flexibility with resource allocation and approach to coordinated entry, which is a solid starting point.

Targeted investment to scale capacity of these cross-sector teams with the resources they need to drive clinical stabilization and flow of clients is the most important action which elected leaders and other regional stakeholders should prioritize. Timely, ongoing analysis of client engagement and impact should be a requirement for these teams in support of these investments.

Data-driven accountability for outcomes and system performance is also essential to overcoming these gaps. The region should immediately and aggressively begin tracking population outcomes through HSO's Medicaid claims-based analytics and continue to cross-reference with HMIS data. Interdisciplinary case conferencing for specific populations, real-time client and program monitoring, transparent performance reporting, and shared metrics will allow providers, funders, and community partners to measure and improve system effectiveness. These interventions must also be executed consistently and at-scale.

Finally, the CES should prioritize placing individuals in "the right place" first. The decision to place a person in a housing setting that is a mismatch with their needs can have significant adverse impact, not just to the person themselves, but also to other vulnerable people and to affordable housing provider sustainability. This requires creating off-ramps to a range of options and factoring clinical acuity into prioritization.

4.5 Expand and Integrate High Acuity Behavioral Health Team Supports with Program Housing

Dedicated ACT/ICM teams in PSH were central to the success of Dr. Sam Tsemberis's original Housing First model. These teams helped residents stabilize in housing by reducing reliance on inpatient psychiatric care, while still recognizing that higher levels of care remain an essential component of the broader behavioral health system. To replicate such outcomes, system leaders must acknowledge the inadequacy of our current system for individuals with the highest acuity needs and commit to the necessary reforms. System leaders must also not wait for behavioral health service capacity to come online before engaging in meaningful, tactical service and system redesign. Improved flow from the acute psychiatric system of care must be leveraged as a foundation for long-term successful housing outcomes. If the psychiatric care continuum can decompress the shelter, shelter alternative, and streets of our region by allowing more individuals to flow into the acute psychiatric care system as the necessary first step to clinical stabilization, individuals will be on a path to better housing outcomes, thereby reducing cyclical housing failures.

The most promising option to achieve this outcome is to create a scaled structure of transitional housing vouchers coupled to the region's existing continuum of supportive services which follow the client and affirmatively ensure a next step handoff voucher or support is reliably guaranteed. A commitment to supporting long-term stabilization and outflow to stable housing is a transformative design which ensures the right bed is more available than simply the next available bed. Prioritizing the service-engaged and initially stabilized population first will empower improved sustainability for housing and supportive service providers and amplify the value of the active engagement of limited behavioral health supports within this region.

Stabilizing the service portfolio also requires expanding acute crisis stabilization and inpatient psychiatric capacity. Oregon has not invested sufficiently in these resources, and this shortfall increases the urgency of adopting assertive housing models and programmatic reforms that can better support individuals with the most complex behavioral health needs.

4.6 Transform and Expand Affordable and Supportive Housing

Accelerating affordable and supportive housing development, particularly for populations with high acuity needs, requires improvements in both the care system and financing structures. Success will depend on strategies that stabilize properties, strengthen financial proformas, and most importantly sustain healthy communities. One priority is addressing the historical exclusion of ADFC recovery-based PSH from state-level funding,

despite local, historical commitments secured by providers such as CCC in Multnomah and Clackamas Counties.

At the same time, programmatic and economic restructuring of existing affordable housing portfolios is necessary, given that more than 2,000 affordable units statewide are at risk of imminent foreclosure in 2025. Preserving these homes is essential to prevent displacement of thousands of residents, many of whom are medically vulnerable, disabled, or exiting homelessness. Preservation can often be achieved at up to 50% less cost than new construction (Public and Affordable Housing Research Corporation & National Low Income Housing Coalition, 2024).

Funding mechanisms must shift to preserve existing inventory while also creating new units. These mechanisms include:

- Sustainable bond funding.
- Insurance pool subsidies, nondiscrimination clauses for low-income property owners, and premise liability reform.
- Reforms to tax credit structures to allow for more uses.
- Increased capital funding from state and federal health agencies for non-Low-Income Housing Tax Credit, mental health focused housing development.

These investments are critical alongside providing sufficient supportive services and engagement in clinical services that help people retain their housing in their communities.

5. Reform Priorities: Engaged Supportive Housing

Engaged Supportive Housing proposes a shift from our region's incomplete fidelity to the Housing First model toward fully integrated housing and treatment systems which affirmatively allocate behavioral health service engagement concurrent with the housing resource. Funding for housing and supportive services for individuals with SPMI and/or dual diagnosis is directly connected *to and for* service-engaged individuals, *by priority and by-design*. Meeting this need includes providing highly flexible, client-centered rental support/vouchers into environments which best meet the supportive needs of the individual client and the community they live within. Whether developed as a long-term (24 month) transitional housing program or an expanded approach to PSH, the authors propose this as an alternative to our region's current approach for clients with very high acuity behavioral health needs. We are at a historic time when adaptation and design of new service models for this population is a required strategy.

A service design committed to improved prioritization of outflow (of frequently unsheltered houseless individuals) from higher acuity clinical environments to housing programs designed to affirmatively promote consistent engagement after initial stabilization will

simultaneously ensure improved inflow to acute psychiatric services and dual diagnosis services. This strategic design is critical for the large population served in shelters who will continue to require a psychiatric hold or civil commitment as their first (or next) step for clinical stabilization (or re-stabilization) and sustained service engagement. This model will open upstream capacity in today's regional, psychiatric acute care system through improving downstream clinical and housing outcomes via structured coordination of behavioral health and housing resources.

An Engaged Supportive Housing model of service seeks to maximize both individual and community-level benefits derived from our region's limited resources and simultaneously protect access to affordable and program housing due to unmet, high acuity behavioral health needs driving the well-described sustainability concerns across our region. Engaged Supportive Housing prioritizes access into affordable housing settings for service-connected and moderately stabilized individuals with SPMI and/or high acuity SPMI/dual diagnosis and requires active and ongoing client engagement as a condition of continuation of the housing resource. This model will likely demonstrate better outcomes for most individuals with high acuity needs who receive housing and services after they have achieved a restoration of capacity and agency through the behavioral health treatment system. Measurement of impact and outcome is straightforward and has simply defined and measurable outcomes. These include month-to-month tenancy stability, consistent treatment engagement, and Medicaid claims–based return-on-investment analyses of service utilization and cost savings.

Engaging members of this population will require the same, trauma-informed, client centered approaches as best practices, but the systemic commitment will require the intentional scaling of ICM or co-located supportive housing and behavioral health clinical service teams. It will require connecting housing vouchers affirmatively to behavioral health services and supports. Expanding the co-location of those services within housing facilities which are re-purposed, or purpose built to create and sustain relationships and community is a needed service improvement change and can be achieved through a braiding of existing HUD and Medicaid service dollars within the region's existing service providers. Prioritizing inflow into transitional and permanent housing from hospitals and residential programs will require the de-prioritization of less stable individuals within our region. A vision within the region's current service design to maintain client choice regarding clinical service engagement upon housing placement when clients lack capacity is a model which cannot continue within this region. The authors emphasize the ethical tension of this too-frequent truth and the well-intended aspirations of our region's approach to Dr. Tsemberis' Housing First model.

6. Conclusion

The time has come to rapidly adapt our region's existing, interdependent behavioral health and affordable housing service access model. Within a persistently resource constrained system of behavioral healthcare and affordable housing services, we must modify service models to better meet the needs of individuals with high acuity behavioral health conditions by housing stabilized or stabilizing, service-connected individuals with capacity to make decisions, as a first priority. Taking these actions will unlock existing acute psychiatric service capacity and empower improved flow of clients.

Engaged Supportive Housing, as described, upholds a core intention of Housing First by assertively coupling access to both housing and necessary clinical support. However, the Engaged Supportive Housing approach maximizes impact for clients and the community despite the persistent gaps in the psychiatric continuum of care which will remain for years. Reconfiguring our region's approach will improve outcomes for the large regional population who deserve housing stability but also require behavioral health treatment to sustain recovery and avoid repeated cycling through shelters, emergency rooms, and hospitals.

The authors see progress through our region's cross-sector case conferencing, but know these teams are under-resourced locally and still require an expanded acute psychiatric system of care and service to better meet the needs of the population characterized in this paper. This transformation is also essential to protect the affordable housing continuum itself, which is already in financial and operational distress from serving populations without the infrastructure needed to support them.

The Portland Metro region will reduce homelessness, save lives, and build a more sustainable, cost-effective, and humane system through scaled and resourced inter-disciplinary teams empowered to deliver an adapted CES, intentional service modification of behavioral health, realignment of housing strategies, and assertive client engagement.

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