Homelessness and Treatment Done Differently; or Why Housing First Works

Sam Tsemberis, Ph.D.

Pathways Housing First;

Department of Psychiatry

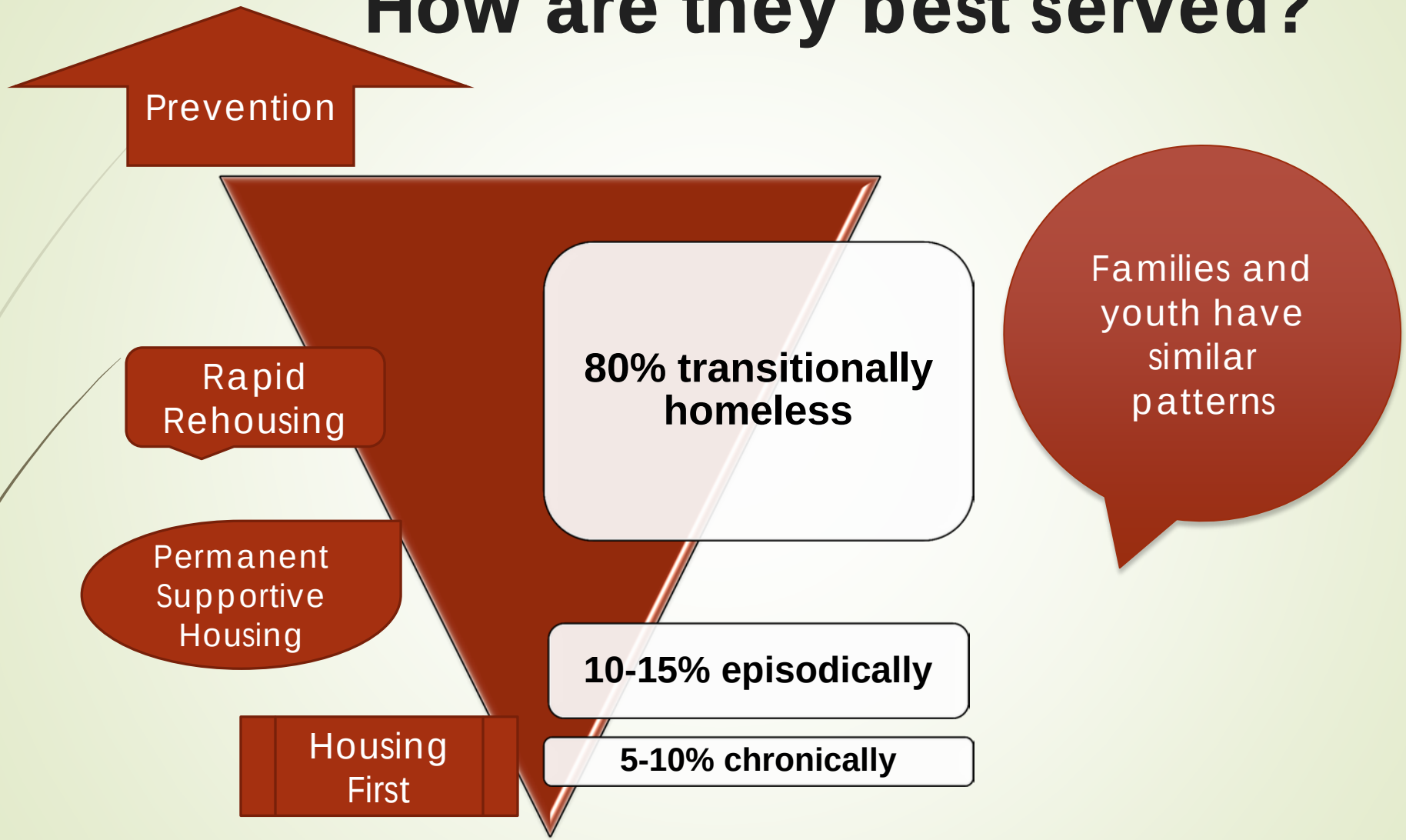
Columbia University Medical Center

sam@pathwayshousingfirst.org

Outline

- Root causes of homelessness
- Treatment as usual – treatment then housing
- Why focus on the chronically homeless?
- Housing First: program philosophy
- Issues in Program Operations
- Program evaluations
- Lessons learned
- Program fidelity and policy change
- System redesign and next steps

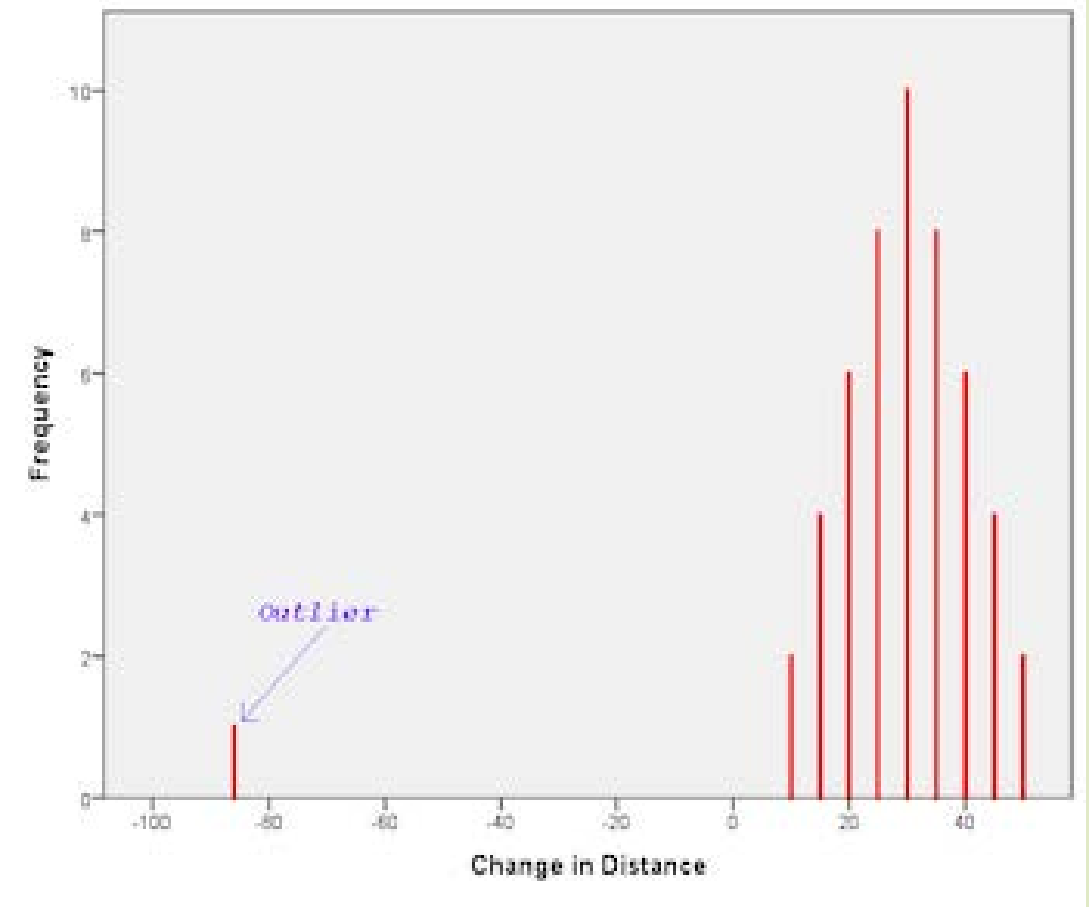
Who is experiencing homelessness? How are they best served?



10% of chronic service users utilize 50% of system resources

"Normals"
teach us rules;

"Outliers"
teach us laws



What are the root causes of homelessness?

Individual choices

System Dysfunctional

Philosophy One: Individual failings

- Beliefs about people in poverty are (unconsciously) internalized.
- Problems persist because we can deny them and they isolated and out of sight (except for the small numbers that are visible)
- Public perception and this determines our tepid policy responses.
- No Address? No respect. (No money, no mercy!)
- Far too many citizens regard our poor and homeless neighbors as drunk, lazy, and crazy
- "We blame – more often than we support – people with needs."
- We seem to prefer judgement and 'tough love' to support and meaningful institutional change.
- *Ending Homelessness: Why we haven't, how we can*

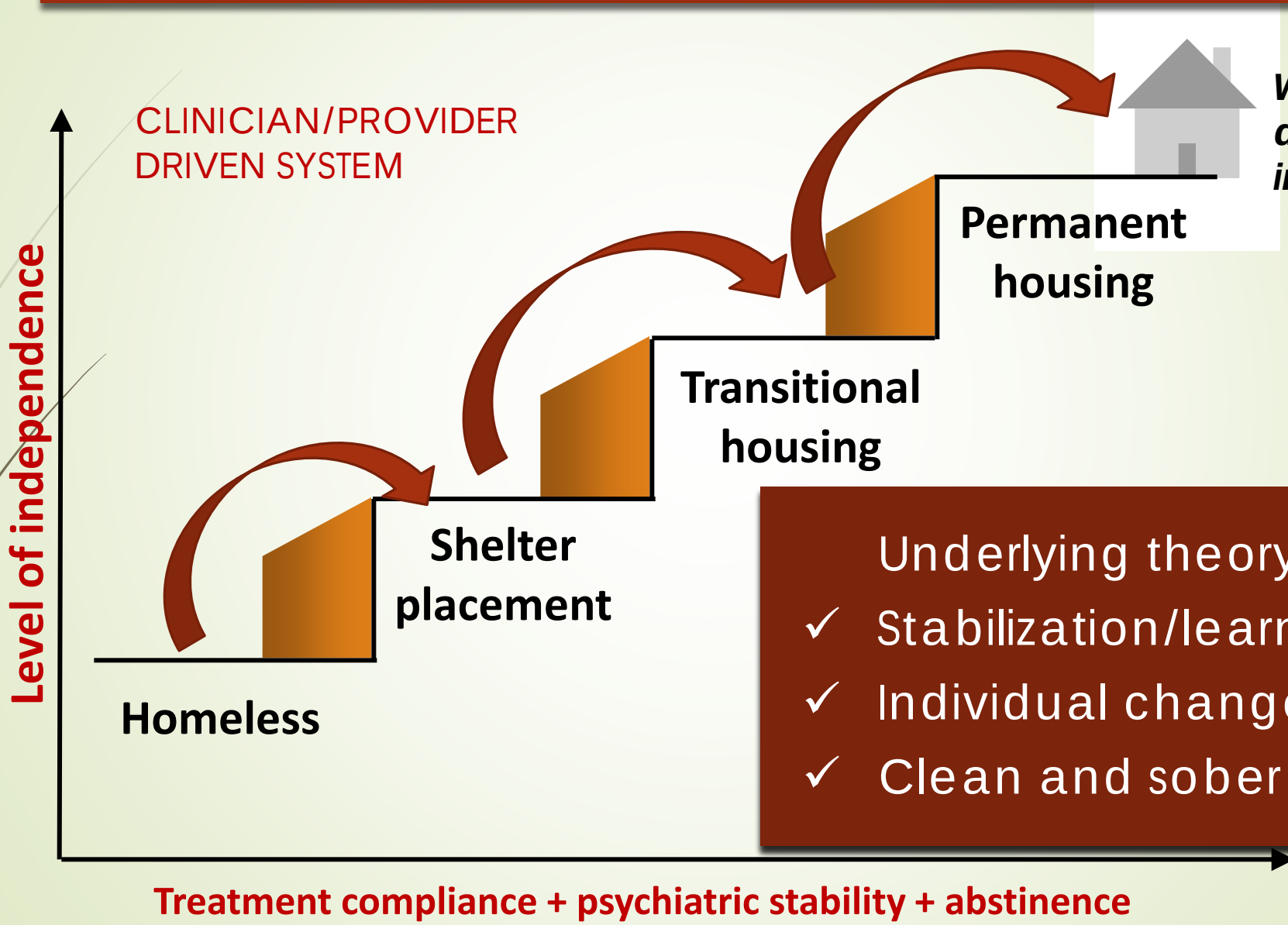
  (Burnes & DeLio)

Philosophy One:

"Root causes are personal issues"

- Beliefs and attitude of general public: homeless have made poor choices, or there because they choose to be, or mentally ill
- Poor response to personal crises, lack of social support, personal misfortune ("dealt a bad hand" M. Bloomberg)
- Programs provide 'tough love' or provide support and meaningful institutional change
- Enforcement of laws disadvantage homeless

TRADITIONAL STAIRCASE MODEL
HOUSING READINESS OR TREATMENT FIRST



The Mental Health and Addiction Treatment System and its Influence on Housing

Mental Illness and addiction traditionally regard individual as needing long term treatment, support and supervision

Group settings with 24-hr supervision; stay in tx keep housing

Assume mental illness and addiction must be cured in order to maintain independent housing

Relapse often means a return to homelessness

Why is it so difficult to stay in housing?

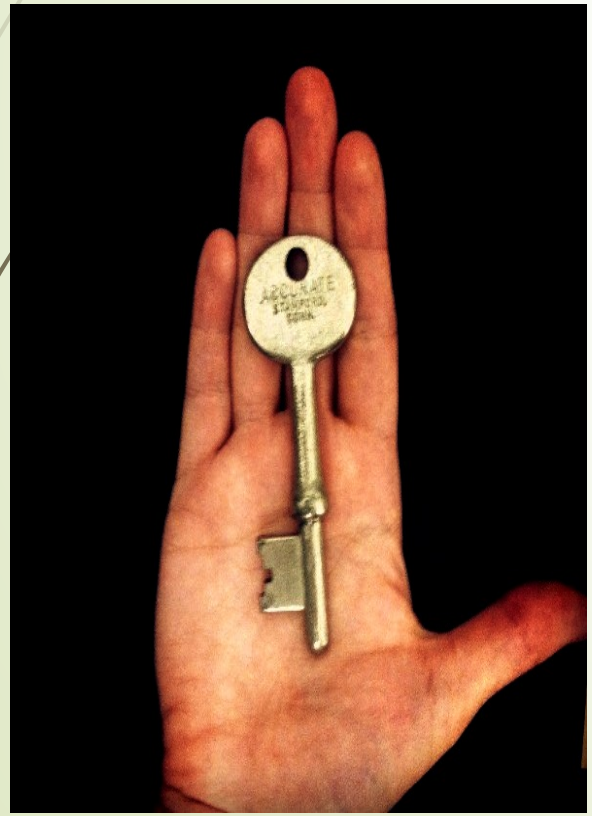
Consequences of staircase model?
"hard to reach" or "treatment resistant"
The focus on the "chronically" homeless

Philosophy 2:
Failings in systems and support

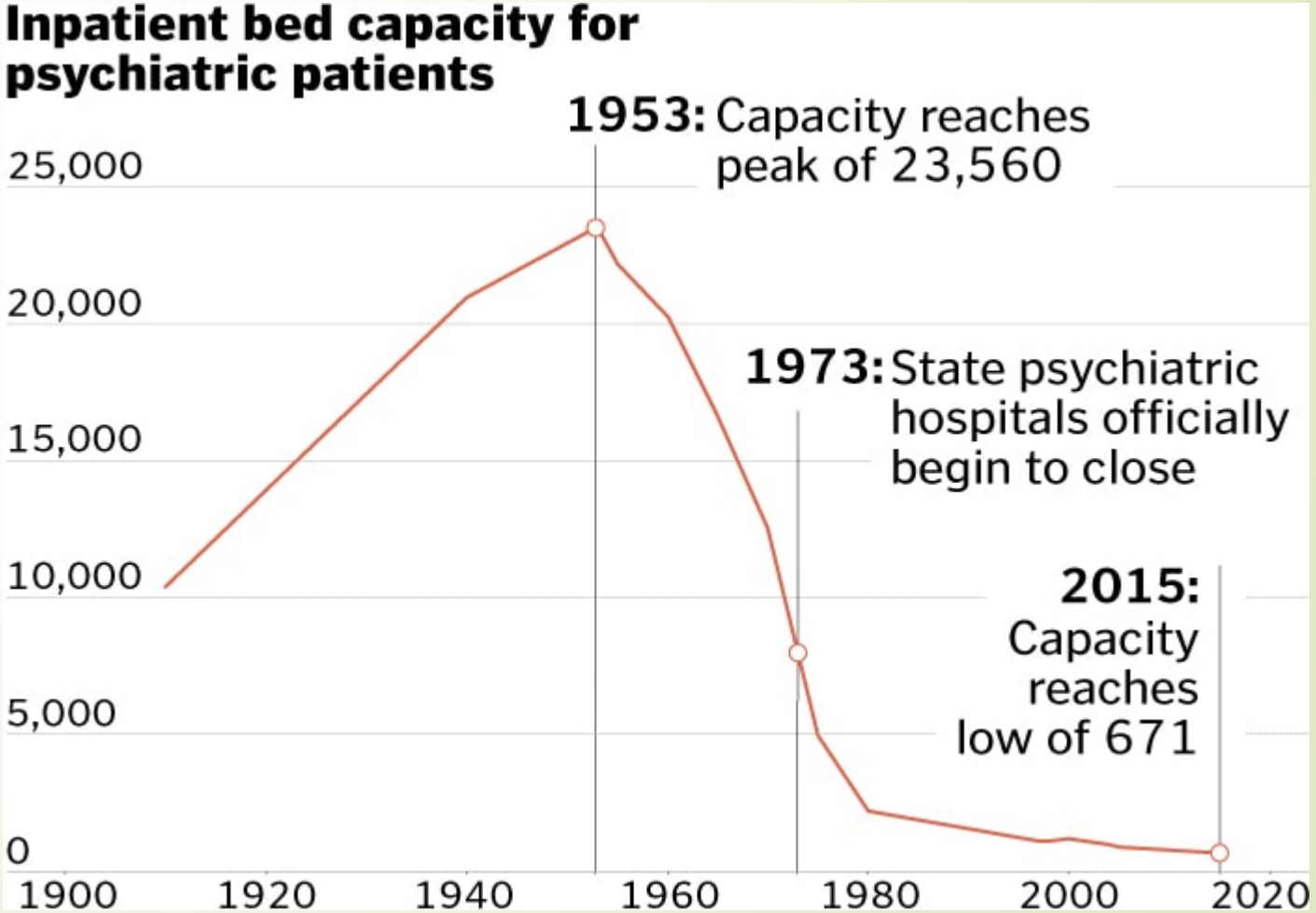
- System failures cause homelessness
- Educational System (early detection and prevention)
- Mental Health System focused on treatment
- Criminal Justice policy is essentially a war on people who use drugs
- Perspective that poverty is not about lack character, but a lack of cash!
- Minimum wage is not living wage
- The problem is not inside but outside
- No change in personal behavior is going to make affordable housing available or rents any cheaper

Mental health system policy change

Reduction in Inpatient Beds

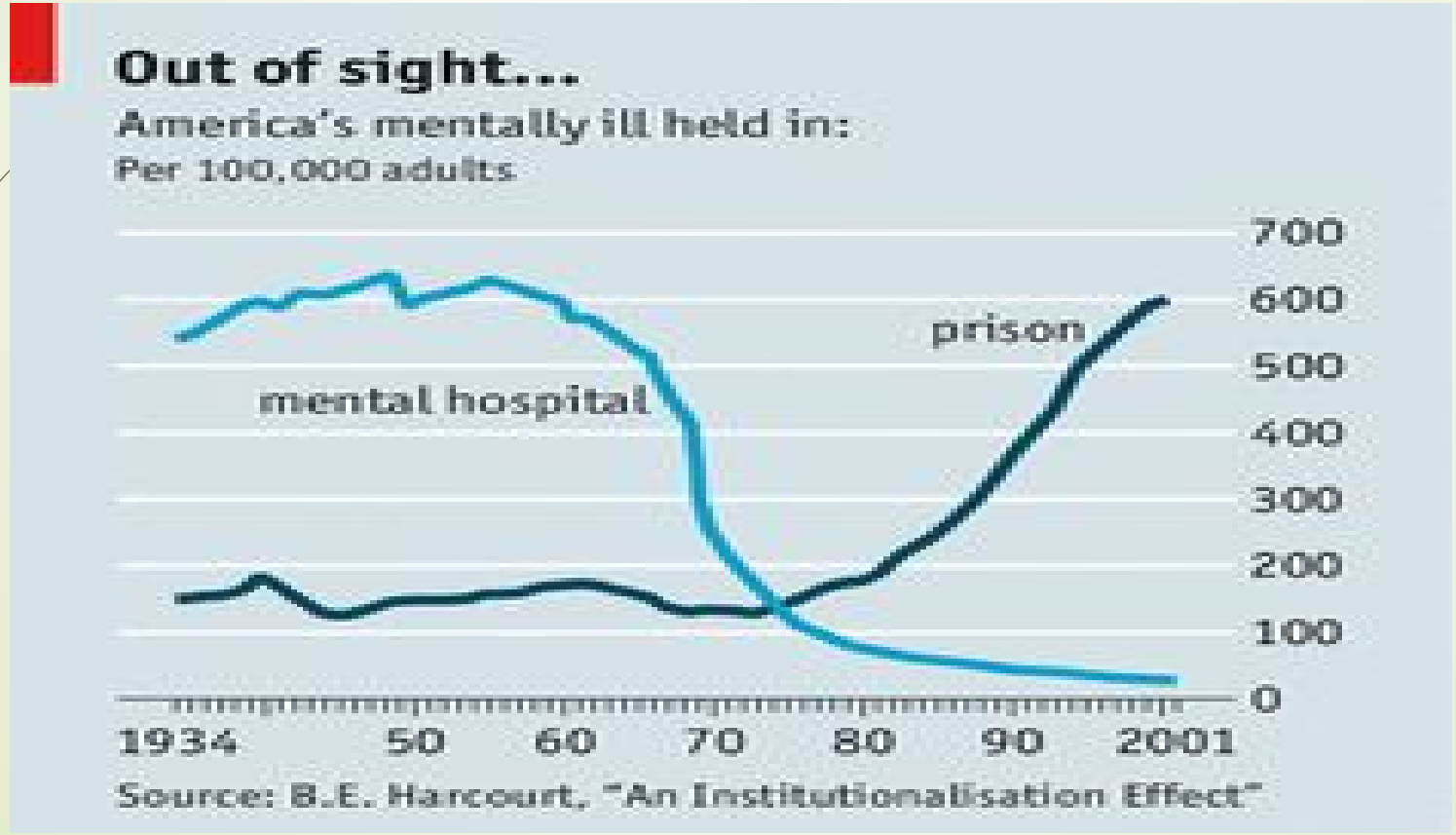


California Inpatient Beds



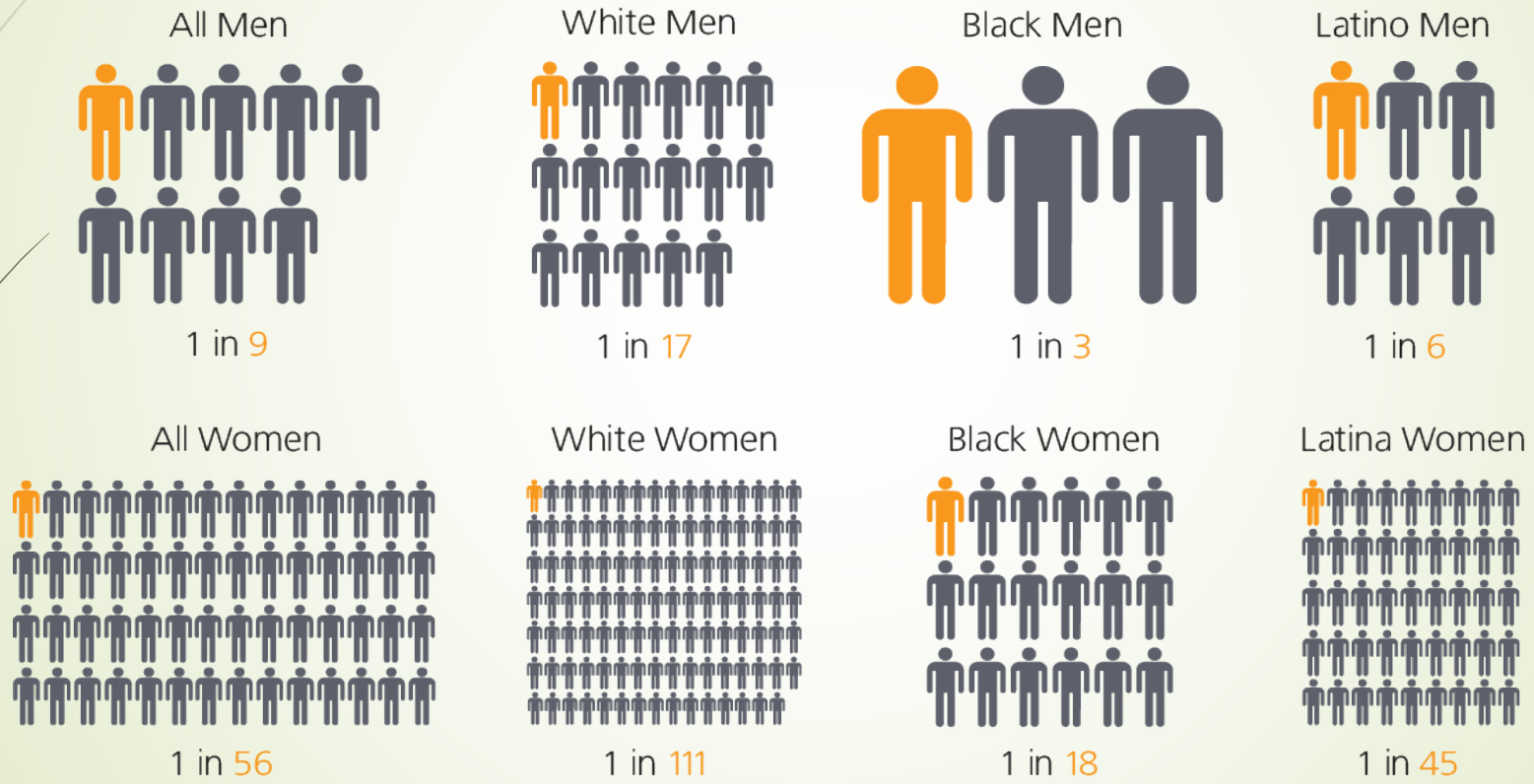
Mental Illness and criminal justice

- "I am tired of doing social work with a gun" Sheriff, Burlington VT



Incarceration and Racism

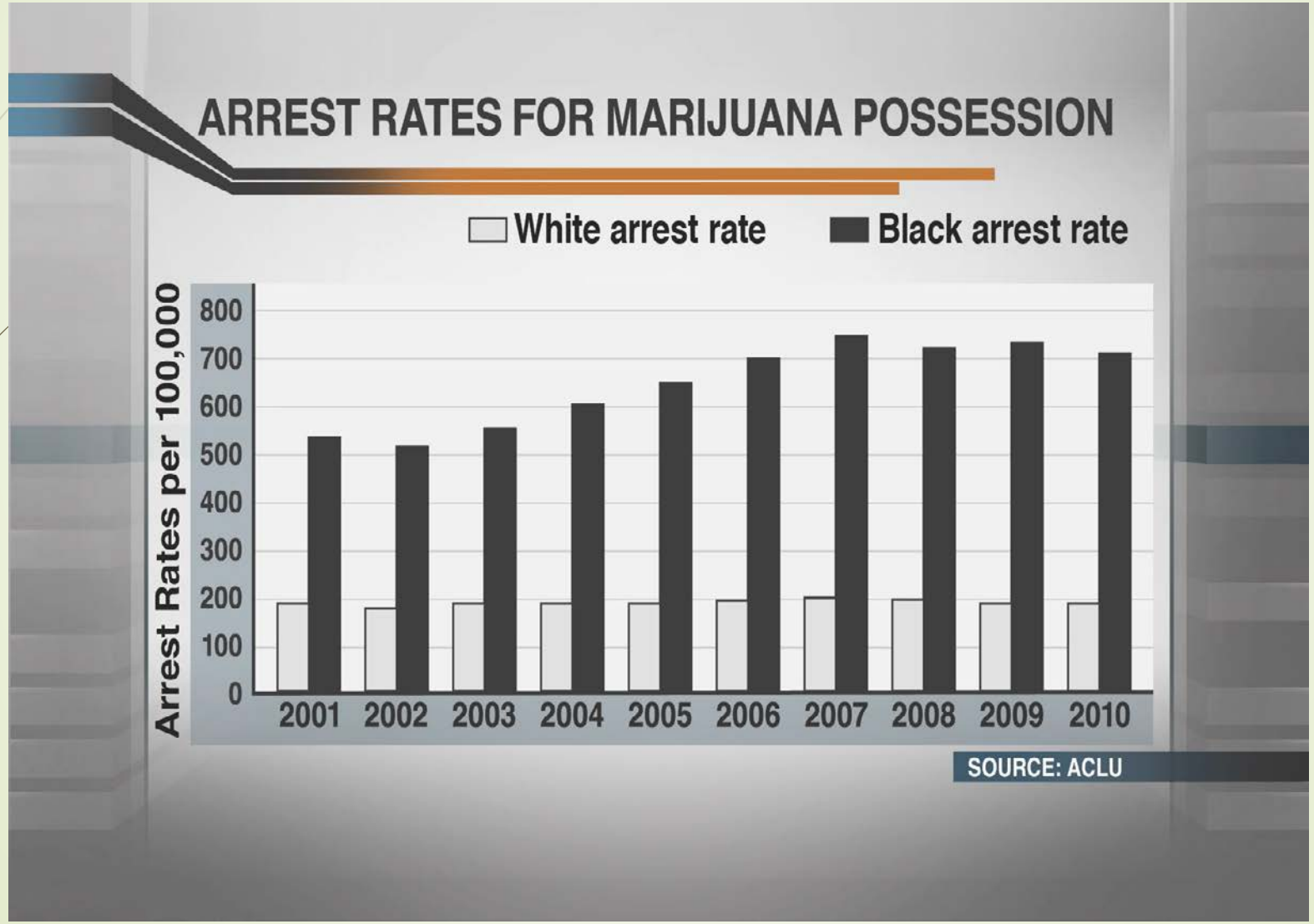
Lifetime Likelihood of Imprisonment of U.S. Residents Born in 2001



Source: Bonczar, T. (2003). *Prevalence of Imprisonment in the U.S. Population, 1974-2001.* Washington, DC: Bureau of Justice Statistics.

THE SENTENCING PROJECT

Race and Marijuana Arrests



“No money, no mercy”

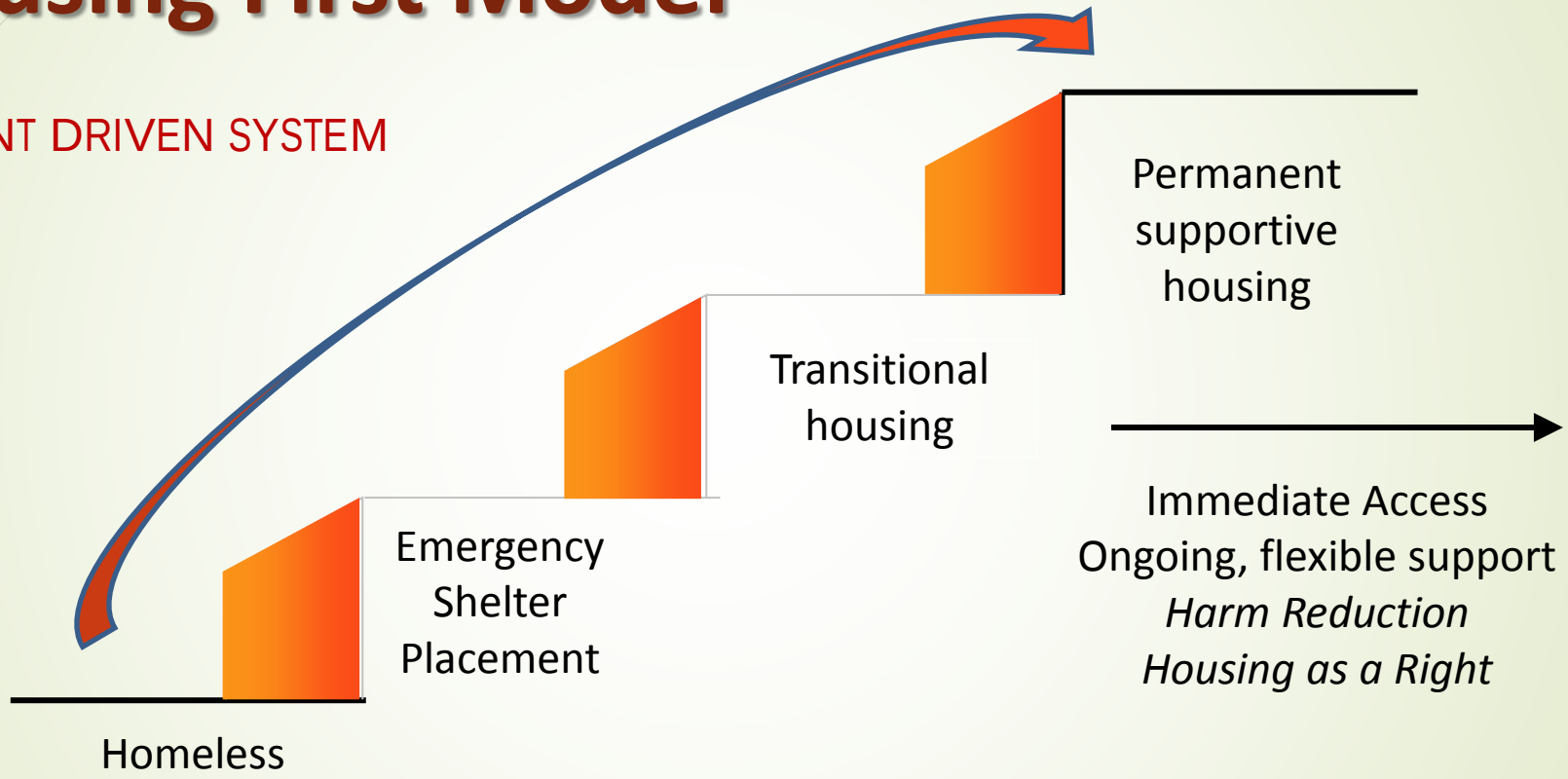
Ms. Willis

New York Times, Monday December 12, 2016

Pathways' Housing First Model

PARDIGM SHIFT

CLIENT DRIVEN SYSTEM



*Immediate Access to A Place to Housing
Support and Treatment to Follow

5 Principles of Housing First

1. Consumer choice
2. Separation of housing and services
3. Services array to match needs
4. Recovery focused practice
5. Program operations

Key Factors in the Paradigm Shift

- View of people served
- Program philosophy (recovery)
- Treatment practices
- Power relationships
- Commitment to ongoing support

PROGRAM CULTURE: *Welcoming*

- Welcoming at every level
- Trauma informed
- Expect and embrace complexity
- Respectful, hopeful, client directed

SERVICE CULTURE:
Empowerment (Rapport)

Empowerment: is the intervention intended to enhance the degree of control vulnerable individuals exercise over their lives?

1. Self determination

   'freedom is being able to choose your life'
2. Collaborative and democratic participation
3. Distributive justice

Choice in neighborhood location

CHOICE of neighborhoods in affordable areas

Integrated housing and private market

How much choice is real Choice?

Landlords as Program Partners

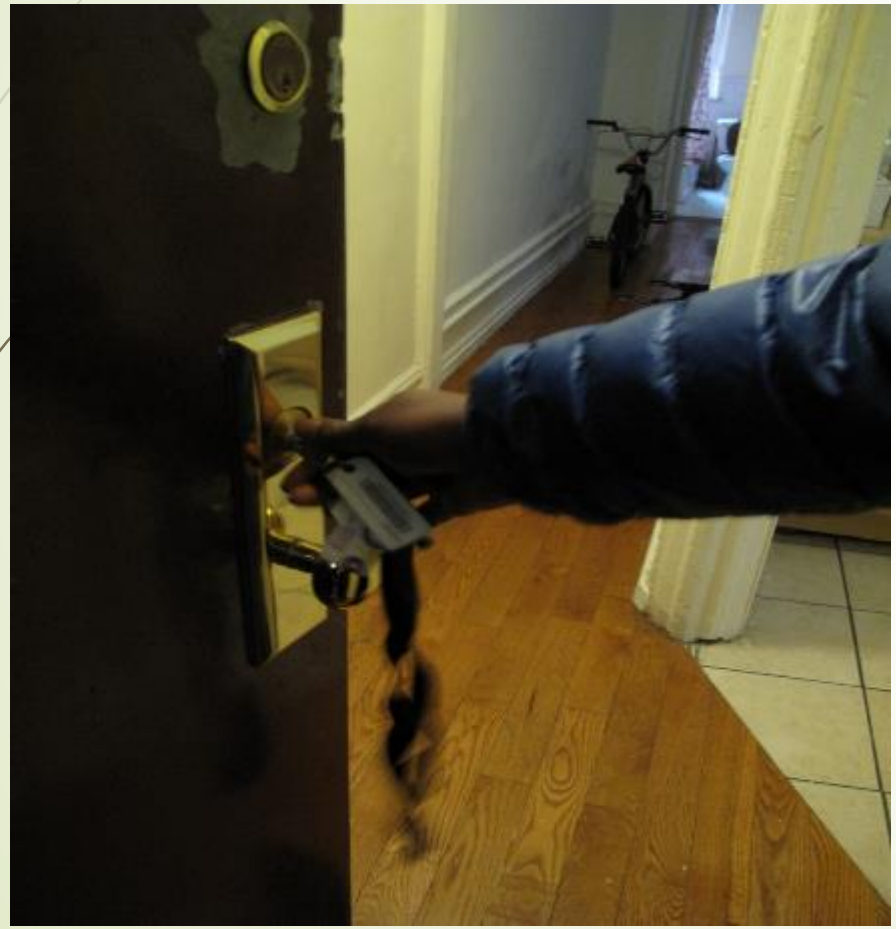
1. • Agency ensures rent is paid on time
2. • Agency and landlord communication
   • Responsive to landlord concerns
3. • Agency responsible for tenant damages
4. • Quick start up, relocation, expansion as needs change

Common Goal

Landlord, agency and participant–

All want safe, decent, well-managed housing

Housing First is the Cure for Homelessness



Immediate Access:

<u>2 Conditions one caution</u>:

1) **Sign standard lease and pay 30%**
2) **Home visit (1 x week)**
3) **Everyone gets a chance you can't predict!**

Must every client sign the lease?

Dimensions of Choice

- Housing Type
- Neighborhood
- Assist with furniture
- Affordable (30% of income)
- How long from admission/choice/ to move-in?

MATCHING SERVICE NEEDS

Community based, responsive, and flexible

Do I need an ACT or a FSP team to do HF?

High Need ACT (or ACT Like)

ACT – Multidisciplinary team and provides direct support and treatment

Caseload 1 to 10

Work as Team

Shared caseloads, participant driven,

includes prescriber, other clinical services, as well as peer and employment

Off site, on-call services 7-24

***FSP TEAMS + HOUSING ARE AN EXCELLENT OPTION**

Moderate Need (ICM +)

ICM - case management team provides support and brokers services

Case loads of 1 to 15/20

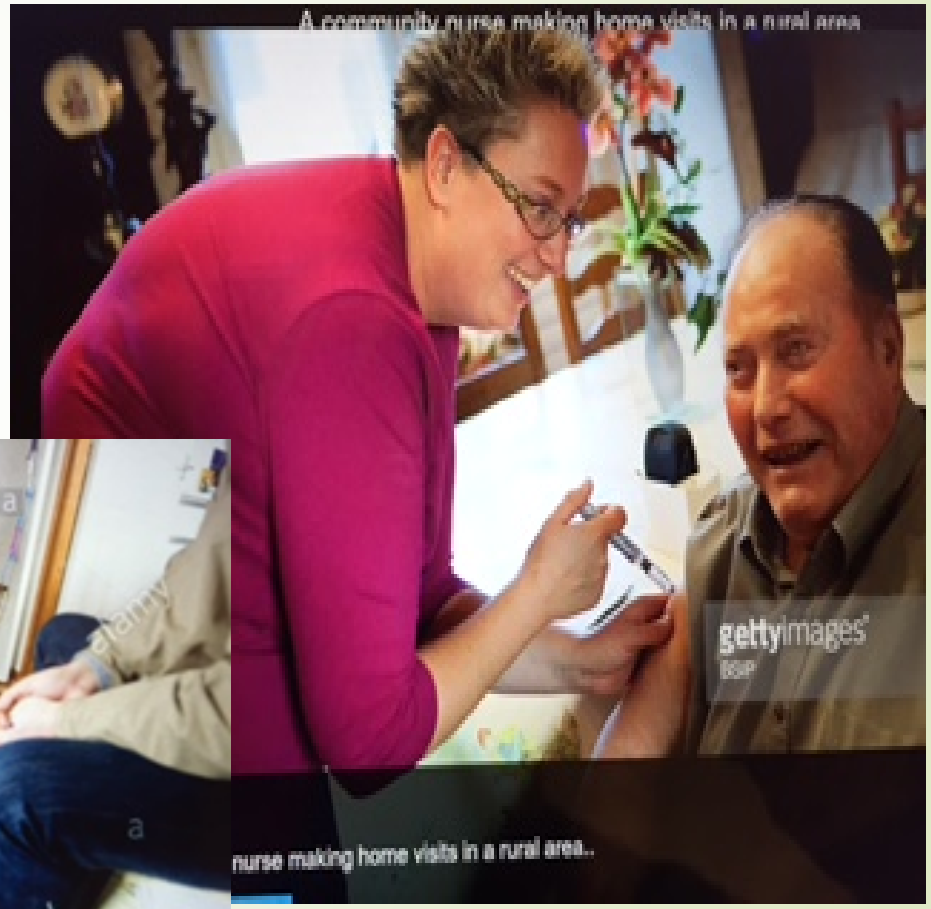
Blended team models

All teams use a recovery orientation

Client directed services - *"No wrong door"*

Bus ticket to Los Angeles or Intake for Housing?

Clinical and support services 70%-80% provide by home visits



Dimensions of Service Choice

- How does the program determine the type and sequence of services a participant needs?
- What are the requirements for participants with serious mental illness?
- What are the requirements for participants with severe addiction?
- What is the program's approach to substance use/abuse among participants?
- What activities does the program staff use to promote adherence to the treatment plan?
- What dimensions are typically included in a participants treatment plan?
- What types of services does the program offer and how are they offered: list from housing retention to psychiatric and medical treatment
- Does the program employee a peer specialist?
- How does the participant provide input into their plan?

HOME VISIT

The Art and Science of Home Visits

video

SOCIAL ISOLATION, SOCIAL INCLUSION & SOCIAL SUPPORT

“Looks like we have a guest!”

The pluses and minuses of social support

WHEN THE PERSON DOES NOT ANSWER

How assertive is assertive?

Keying in?

Mobile Crisis?

Key strategies

"Allow for the Dignity of failure"

Separation of Housing and Support Services

- Program commitment is to the ***person*** not the housing
- Eviction from housing does not mean discharge from the program (it may mean relocation) *** **no discharge policy**
- Service needs remain committed even if housing needs change
- Relapse is anticipated; relapse is a clinical problem not a housing problem
- Maintain focus and commitment through crises

Dimensions of Separation of Housing and Services

- What requirements do program participants have to meet to gain access to housing?
- What requirements do they meet to stay in housing?
- Do participants have a lease or use and occupancy agreement that defines their rights and responsibilities?
- What actions are taken if a participant loses their housing?

Goal of Housing First: Recovery

- People are more apt to change positively:

  A) in the context of a positive relationship;

  B) when they set their own goals;

  C) are taught skills;

  D) receive support;

  E) have positive expectations or hope for the future; and

  F) when they believe in their self efficacy.

Changing Thinking About What is Possible

Bellevue Psych Ward

Own Apartment

Beliefs and Attitudes About Addiction

- Broadly speaking there are two perspectives on addiction:
- 1) The brain has been chemically hijacked by drugs leaving the person no control over a chronic progressive disease.
- 2) The addict is a selfish criminal with little regard for others...

- #2 is what much of the public still seems to believe.

- When it's our own loved ones who become addicted we tend to favor the first explanation when it's someone else's we favor the second.

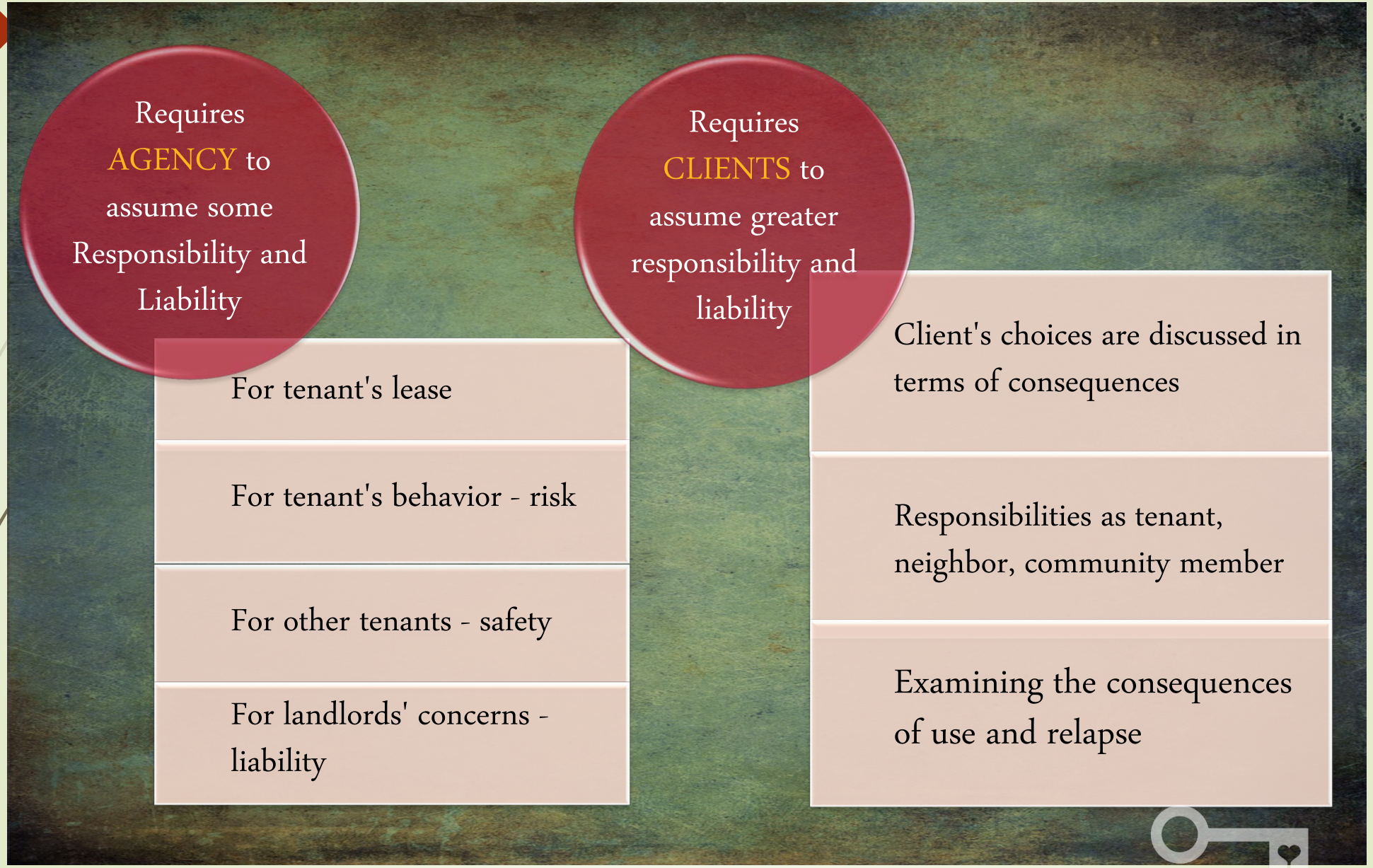
Dimensions of Service Choice

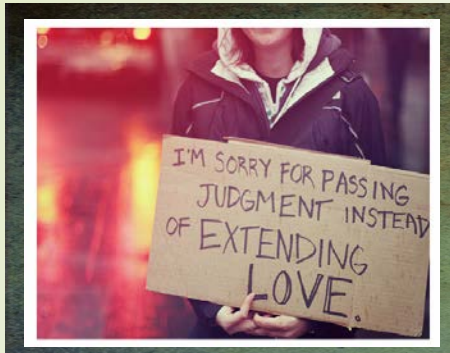
- How does the program determine the type and sequence of services a participant needs?
- What are the requirements for participants with serious mental illness?
- What are the requirements for participants with severe addiction?
- What is the program's approach to substance use/abuse among participants?
- What activities does the program staff use to promote adherence to the treatment plan?
- What dimensions are typically included in a participants treatment plan?
- What types of services does the program offer and how are they offered: list from housing retention to psychiatric and medical treatment
- Does the program employee a peer specialist?
- How does the participant provide input into their plan?

Differences from Traditional HF

What does “choice” mean for individuals involved in corrections?

Harm Reduction and Liability in Housing First Programs





**"What is addiction, really?
It is a sign, a signal, a symptom of distress, it is a language that tells us about a plight that must be understood."**

Alice Miller, *Breaking Down the Wall of Silence*

Principles of Harm Reduction - Intervention

Meet people where they are

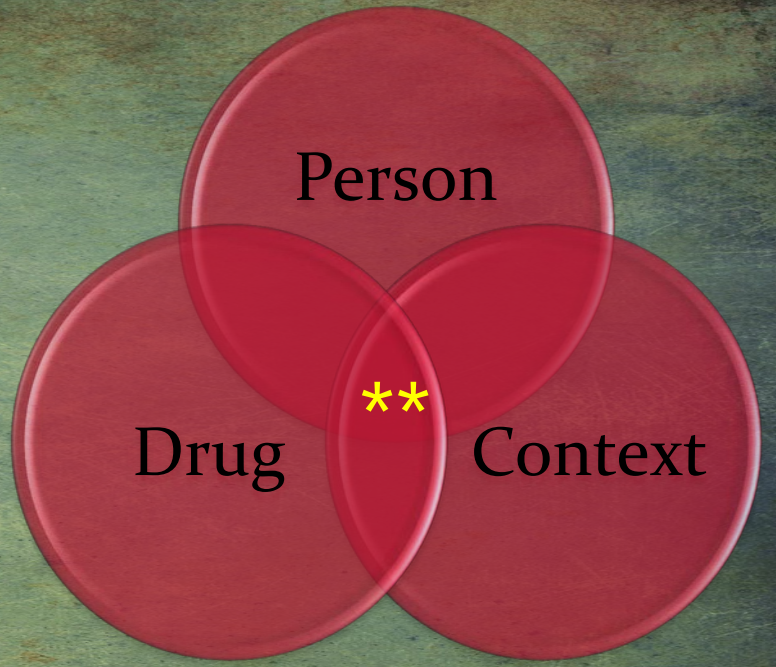
(but don't leave them there!)

Understand why they use

Understand under which conditions are they more prone to use

Relapse plans = expected part of recovery

Strengths based- gains rather than losses approach - noting time reduction or abstinence is maintained



** targeted behavior

Dimensions of Program Operation

- Where do program services generally occur?
- What is the staff/participant ration?
- Is there a policy regarding minimum face to face contacts?
- How often does the staff meet to plan and review services for participants?
- How does often does the team meet and what is the goal of the meetings?
- What types of opportunities are available for participant input?

When Housing First Doesn't Work

- The 10-20% who have repeatedly tried and failed in the scattered site model
- Single site options with control of entrance and exit
- Some recovery house options
- Other options in managed group setting need to be explored
- **Can you predict ahead of time?**

  (Aubry, et al., 2015)

Program Evaluation

- Quantitative
- Qualitative
- Large Scale Implementation
- Program Fidelity
- Lessons Learned

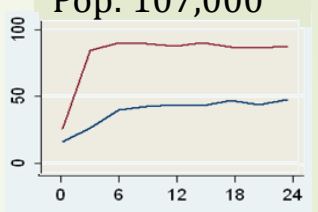
Housing First in 5 Cities: different sizes and composition across Canada

MENTAL HEALTH COMMISSION OF CANADA AT HOME/ CHEZ SOI

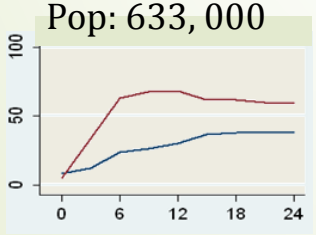
RTC

Vancouver
Pop: 578, 000

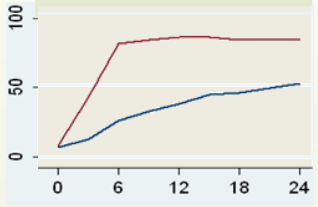
Moncton
Pop: 107,000



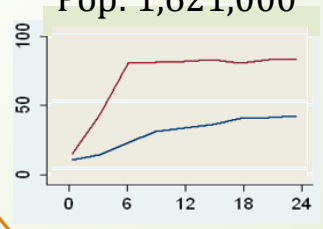
Winnipeg
Pop: 633, 000



Toronto
Pop: 2,503,000

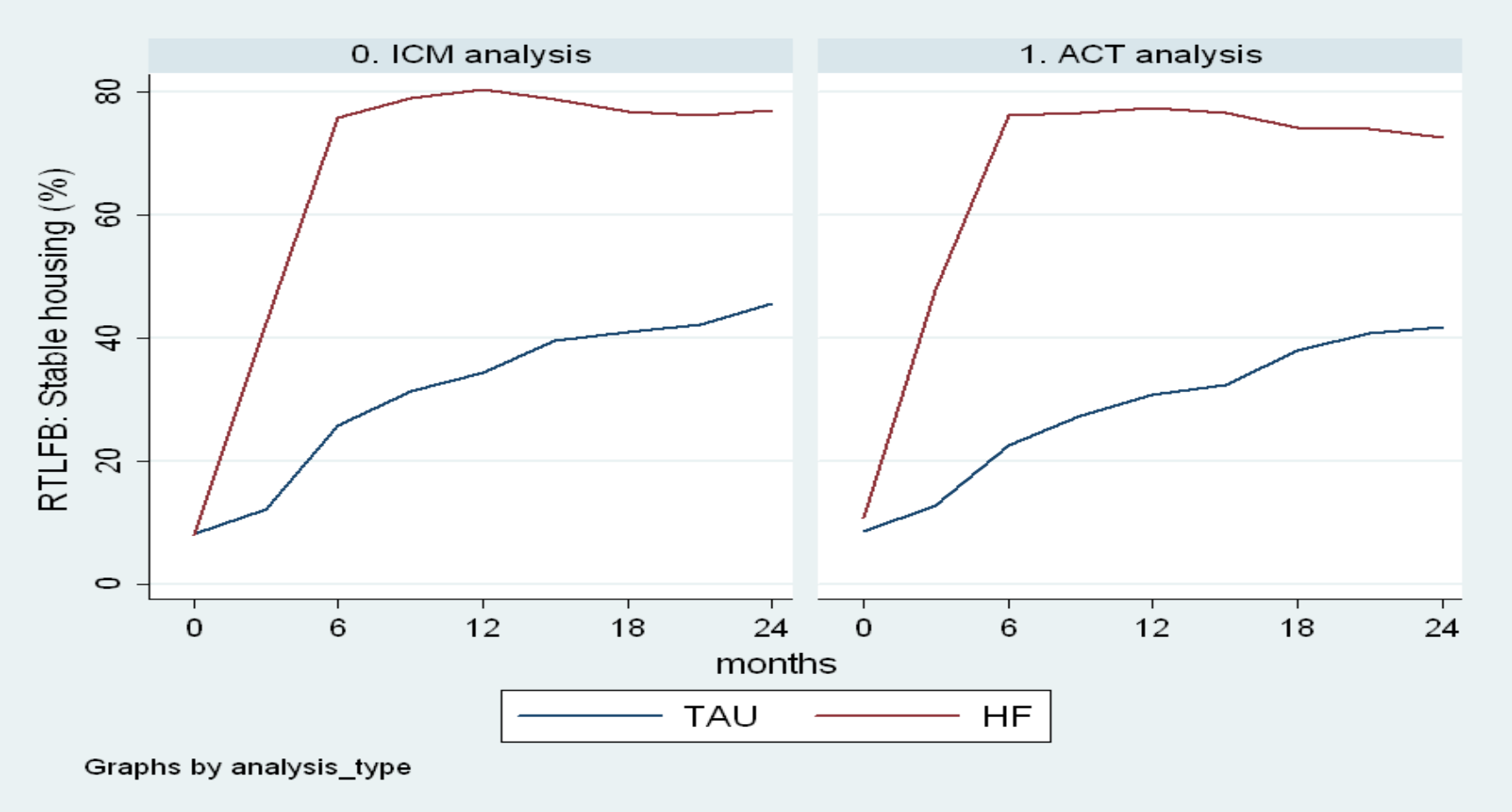


Montreal
Pop: 1,621,000



HF outcomes for moderate and high need participants

Percentage of time housed



Lessons Learned from Program Implementation and Research

- **Operations**
- -targeting,
- -outreach onus on providers to find clients ***("intent to treat"***)
- -expanding clinical services bridging health ministry and municipality
- Health services must conduct home visits (aim is no discharge policy)
- Culturally relevant adaptations

- **Need for Ongoing Staff Training and Support for Program Fidelity**
- "Why can't they do it themselves?" *How do we distinguish between helping and enabling?*
- "He said he doesn't want us to visit" *What are the limits of choice?*
- "How many chances?" *When do you decide housing first does not work?*

Qualitative findings

Overall, greatly preferred, sense f safety, quality of life, feeling “normal”

Having a place of one’s own can serve as a platform for other positive and challenging psychological effects;

Other goals are manifest;

Privacy and control to establish one’s own routine;

-Lonely, isolated, not fitting in;

-/+Housing stability and improved quality of life was retained despite continuing to experience symptoms or struggling with addiction (affirming the HF approach)

Mental health, addiction and discretionary income marginally improved

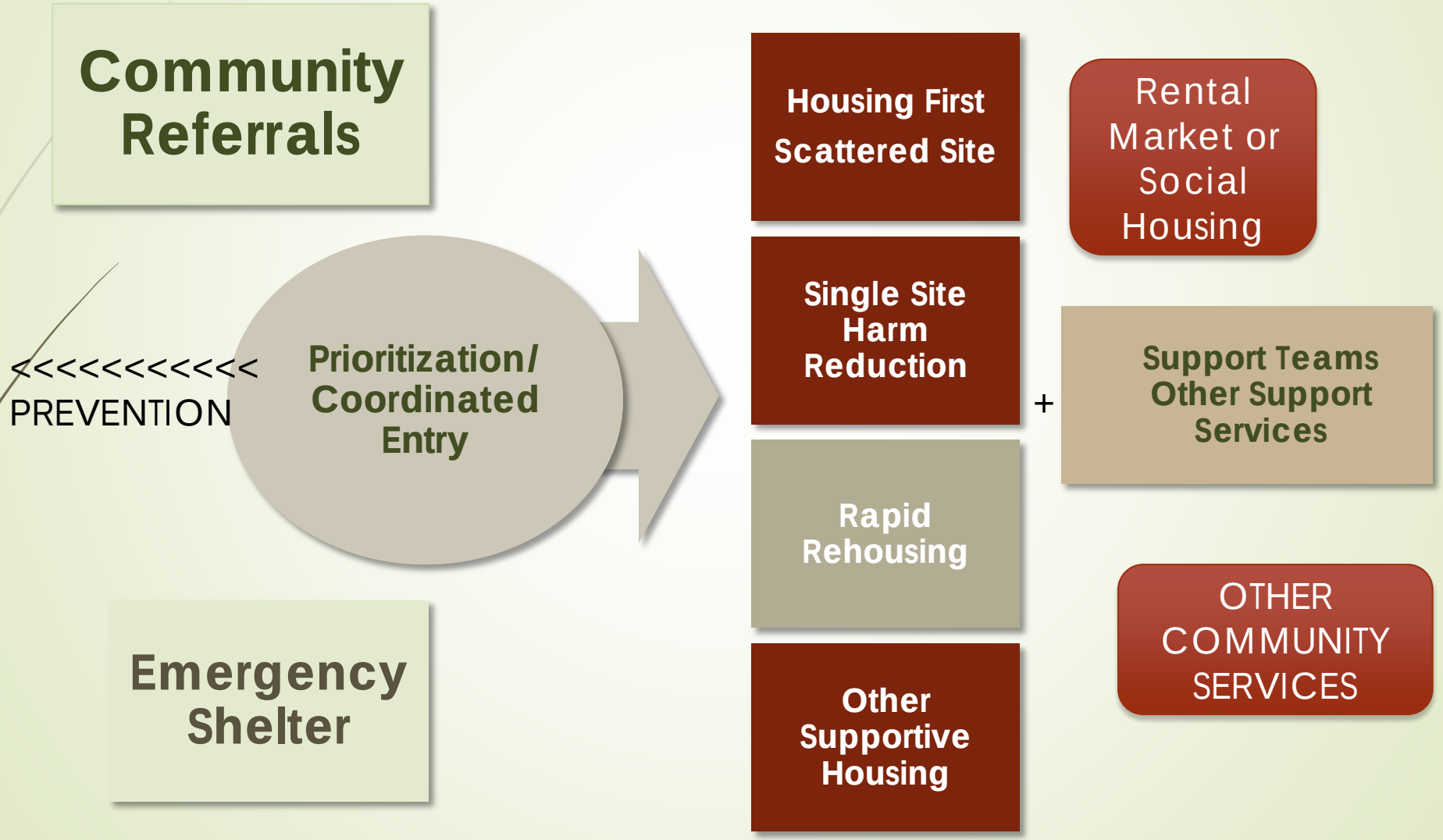
Systems change in housing policy and practice

- Private market community landlords
- Additional support for landlords
- Accept / share risk for clients (landlord, team/agency, neighbor)
- Allow accelerated access to some portion of public housing
- Expand dialogue about homelessness to lack of affordable housing or national affordable housing strategy

Housing First as a Community Approach

- **Target Population**: Set **priority** among homeless population
- **Collaboration**: **Partnership** among agencies (identification, data sharing, resource sharing, etc.)
- Lead Roles, Responsibility, Accountability
- Operations: Design or re-design system so there is a **clear map** for all providers and participants
- Measure: Set **specific targets** and **timelines** **and track outcomes** as a community (**transparency and accountability**)
- Leadership/Collaboration model

From HF Program to HF Systems Approach



Lessons from Research 2

- What is Housing First? Limits of federal definition
- Risk, liability, harm reduction and master leasing
- Three strikes and then what… ?
- Ignoring the extreme and going with the base rate
- Culturally relevant modifications over program fidelity
- Creativity and resourcefulness in partnerships

Keys to effective transition from demonstration to sustainable program

1. Funding for rent support and support services
2. Funding sources should not have a major impact of changing service delivery models
3. Anticipate different rates of recovery for mental health, addiction, health and poverty
4. Design programs that allow for continuation of services through improvement (step-down of other models of reduced support)
5. Anticipate graduation at point of admission

Why Does Program Fidelity Matter?

- Housing First is not Housing Only
- Housing is the first thing we talk about after they…"
- Choice is not laissez-faire
- Assertive engagement is not coercion
- Peer Specialists are not junior case managers

- **Understand current practice & make improvements**
- **The purpose is to maximize outcomes**

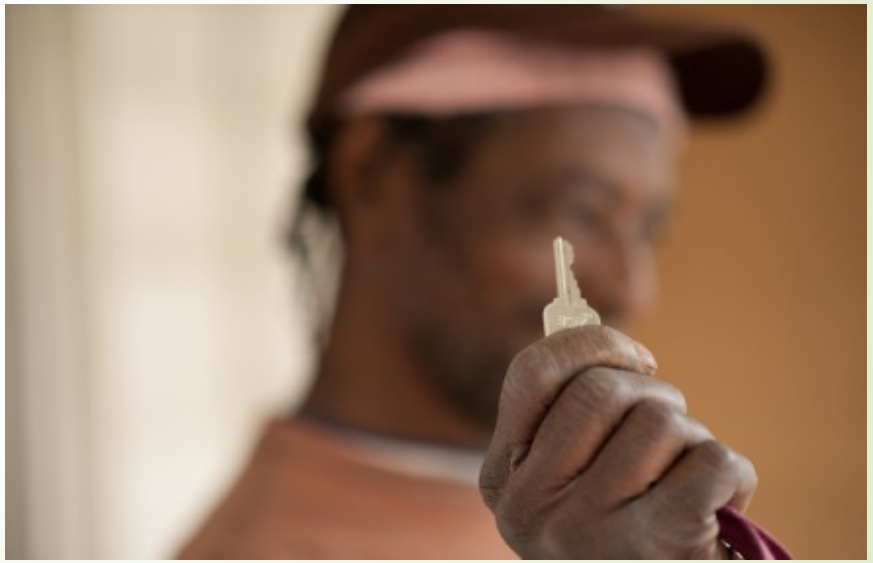
Fidelity Site Visit

Multiple Sources of Data

- **Before visit: collect basic info**
  - What types of housing do participants live in
  - How long did it take to get into housing
  - What percentage of participants have been discharged
- **Team meeting observation**
- **Individual interviews with staff**
  - All frontline providers; Each discipline
  - Team Leader
  - Program Director, Administrators
- **Focus group with program participants**
- **Chart review (random selection)**
- ***Optional: home visits***

Key Point

Higher fidelity to Housing First is associated with more recovery-oriented practice and improved outcomes.

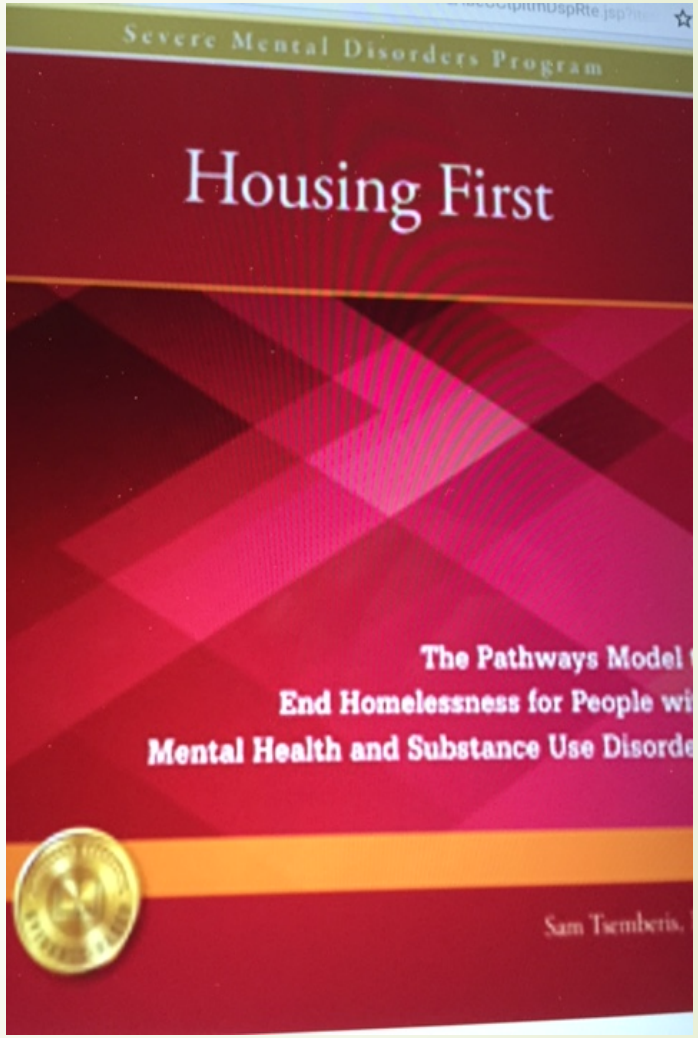


Program Fidelity and Outcomes for At Home/Chez Soi

- N=2,251 participants; RCT, 13 Teams
- High fidelity programs associated with participants' higher social functioning, increased quality of life and time stably housed
- Overall fidelity was correlated with direct service time (r= .55, p=.10), indirect service time (r=.58, p=.08), and number of contacts with providers (r=.60, p=.04)

(Paula Goering et. al, *Psychiatric Services, 2014*)

Thank You

Questions? Comments?

HOUSING FIRST
Program Manual
By Sam Tsemberis
Hazelden Publications
Or Amazon.com