Pathways Housing First: A person-centered approach

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What Works and What Needs to Change

- I) What is Housing First?
- II) What beliefs, attitudes and practices underlie the most homeless service programs?
- III) What are the principles and major components of Housing First? Defining Program Fidelity
- IV) Program Operations: Team operations, coordination with housing, home visits
- V Lived experience
- VI) Research, Policy and Systems Change

I) Housing First: Distinguishing between HF models

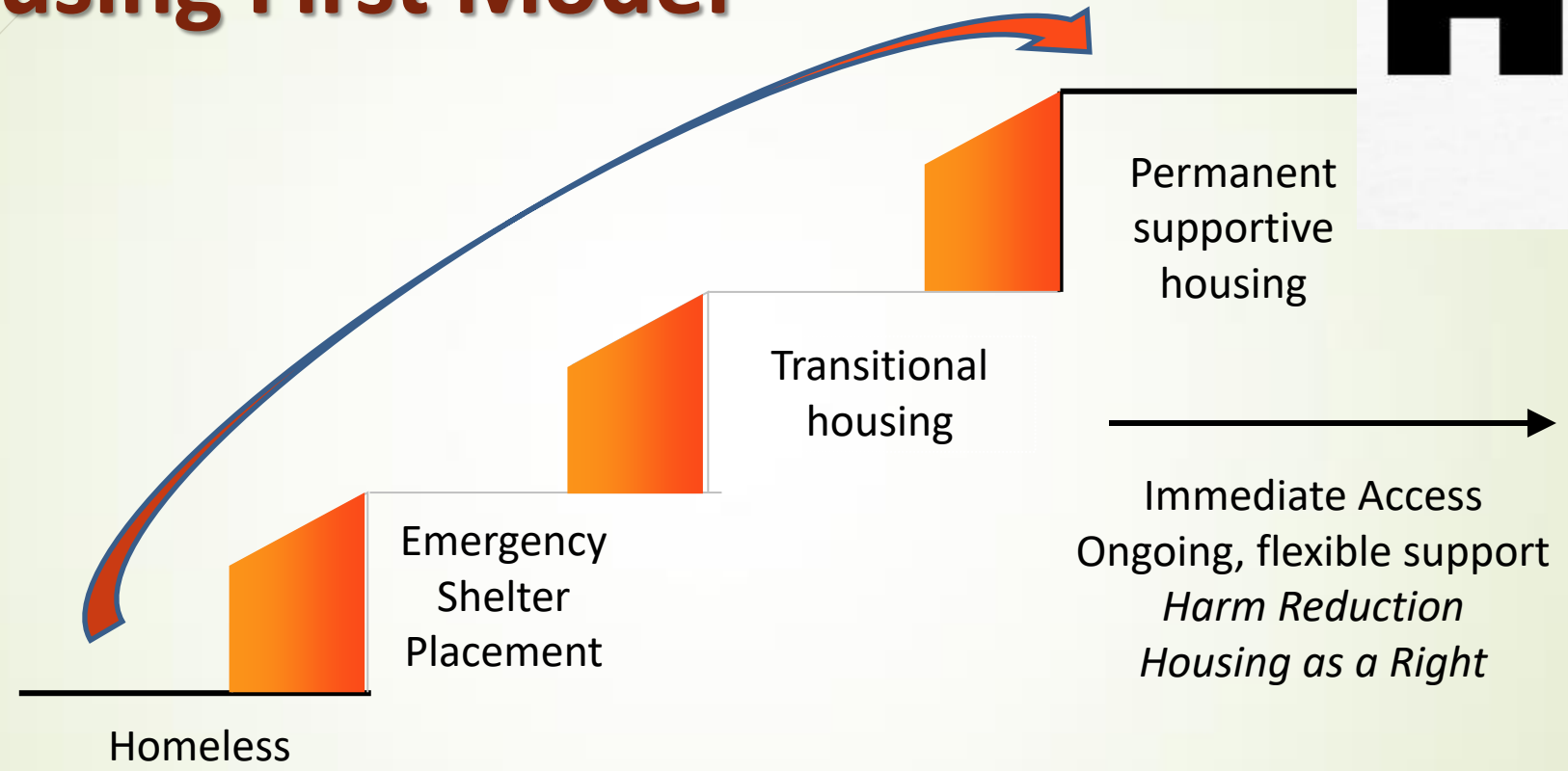
- **PATHWAYS SCATTER SITE MODEL**
- Roots in psych rehab
- Consumer movement
- Social justice
- Services separate philosophically and physically
- Tenant based rents
- Location choices
- Point od Entry is case management

IN COMMON

Immediate access
Harm reduction
House most vulnerable
Separation H&S

- **SINGLE SITE MODELS**
- Roots in housing development
- Advocacy for ending homelessness
- Services on site but separate domains
- Project based rents
- Point of Entry is housing

Pathways' Housing First Model



There's no place like home.

*Immediate Access to A Place of Your Own
Support and treatment follows

Goals and Practices of Pathways Housing First Program

1

Client preferences direct services: the sequence, type and intensity of service

2

Provide immediate access to permanent housing ***and*** the supports needed to address complex problems

3

Improve quality of life; client-directed treatment and support; goal is community integration

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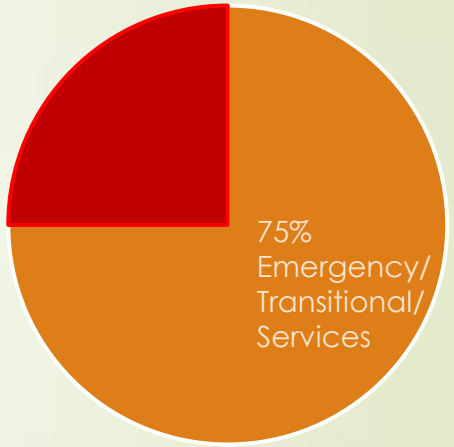
II. HOMELESS SERVICES Founded on an Emergency Response Model (e.g., Red Cross/Health Care for the Homeless → Why Not FEMA?

- Emergency outreach
- Emergency shelter
- Safe Haven
- Food programs
- Clothing programs
- Faith based programs

Homeless services Staircase (Treatment First) approach

Policy/Funding/Investment



Homeless Services System is Built Upon :
1) assumptions about mental illness, addiction and functional ability, and
2) Social prejudice and bias concerning the motivation of the poor ("economic hazard ratios" and "brought it upon themselves")

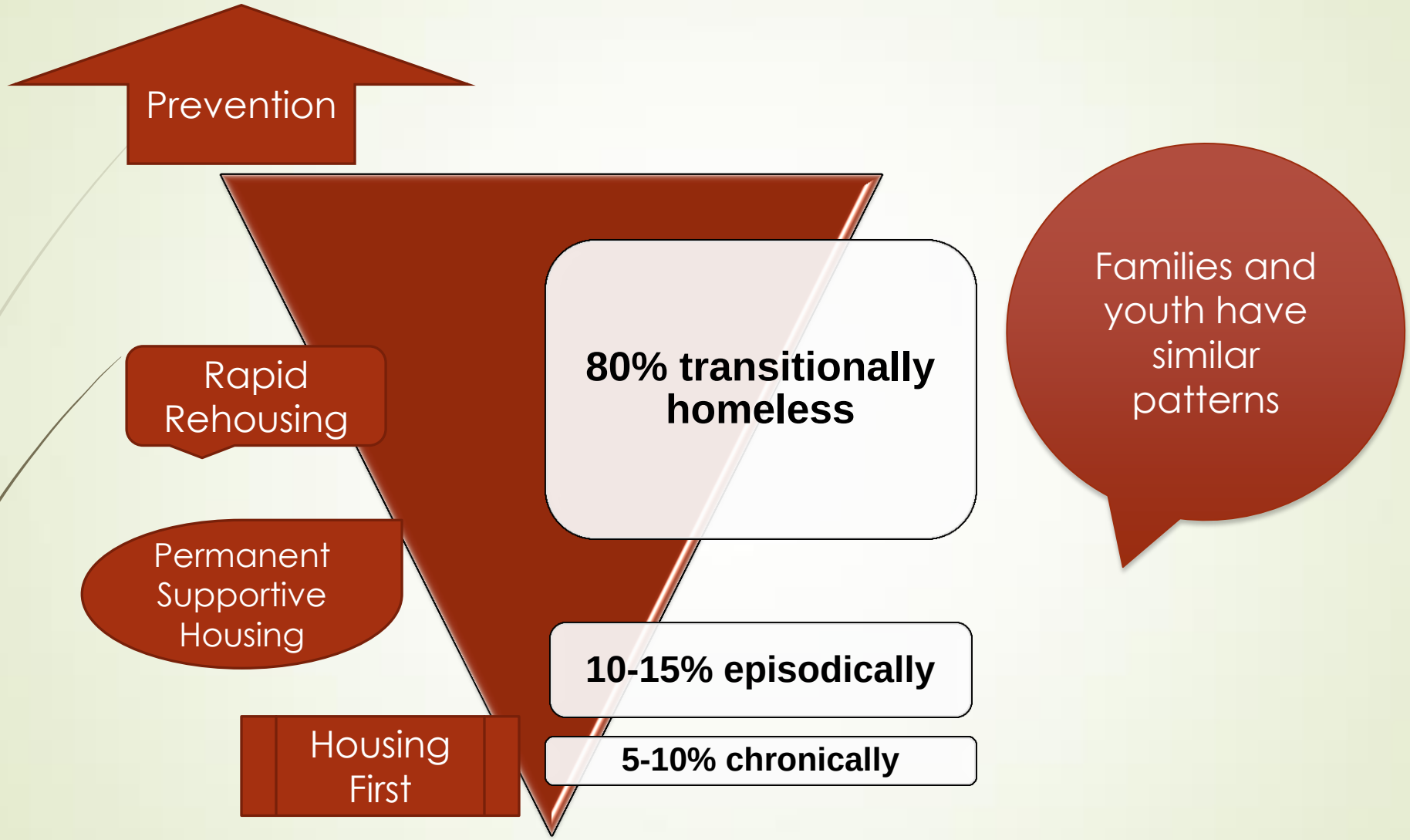
Clinical Assumptions About the Staircase Model

- Individuals need to be stable and sober before they can manage supported housing
- Assessments of ability to function and need for services are accurate and have predictive validity
- Referrals between agencies work

Commonly held biases and prejudices about the poor

- Prejudice and bias concerning the character and motivation of the poor
- A) “they brought it upon themselves”
- B)“they must earn it to value it anything else is enabling”
- C) A)“don’t make it too easy or economic hazard ratios”

What Approach Works for WHO?



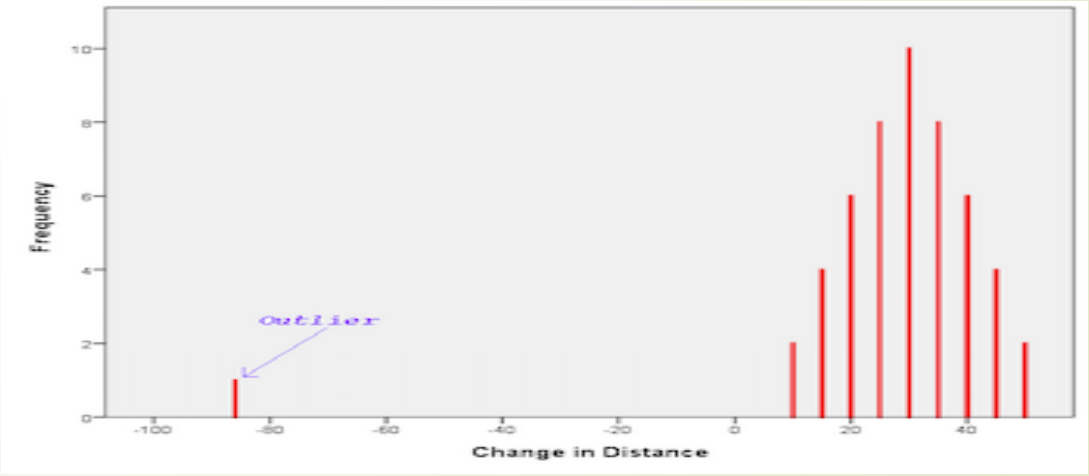
Who does Housing First Serve?

Public perception of homelessness

A word about that 10%
What Outliers Teach Us

"Normals"
teach us rules;

"Outliers"
teach us laws



Laws of Medicine by
Siddhartha Mukherjee

What Works and What Needs to Change

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III. What attitudes or practices need to change to operate Housing First programs ?

Factors of Paradigm Shift

- View of people served

  (capabilities or strengths based)
- Program philosophy (recovery, ti, etc.)
- Power relationships
- Commitment to ongoing support w/o discharge
- Treatment practices (e.g., home visits,

  "whatever it takes"


CHANGE YOUR POINT OF VIEW
FIRSTCOVERS.COM

Jeopardy question 1

- He escaped from the inpatient service of the NY State's Creedmore Psychiatric Center and went to Oakland California where he founded a consumer-run drop in center known as "The Oakland Independence Support Center"

Who is Howie The Harp? 1955-1997

- From NY Times Obit: He is widely credited with being a pioneer in advocacy for mental patients founding or co-founding many organizations that are now part of national or international movements.

HF Programs Have a Welcoming Culture

- Trauma informed care approach more engaging and less stigmatizing
- Shifts responsibility for engagement and continuity of care to provider
- Demonstrated as verbal, non-verbal and atmosphere

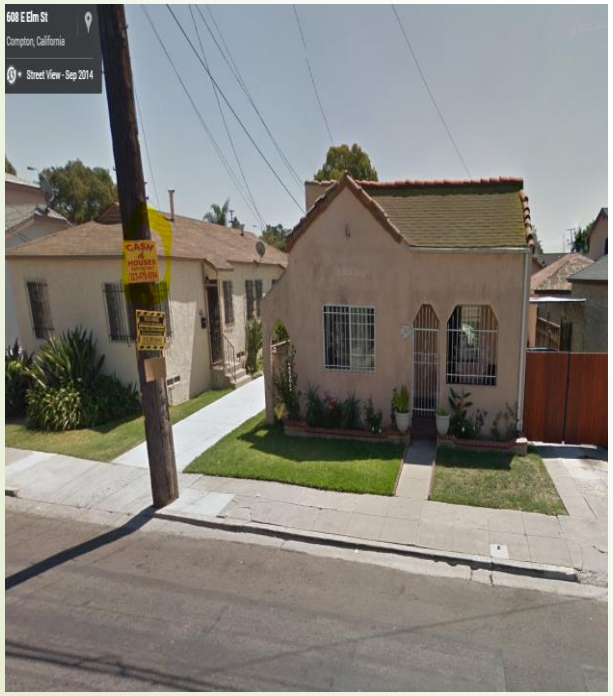
III. PRINCIPLES AND MAJOR COMPONENTS

FIVE PROGRAM PRINCIPLES:

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

P 1. CHOICE IN HOUSING:

Typically scatter site independent apartments rented from community landlords



- Most frequent choice
- Integrated into the community (reduces stigma)
- Individualized planning and progress
- Rapid start up
- Relocation without service disruption
- Puts rental market within reach

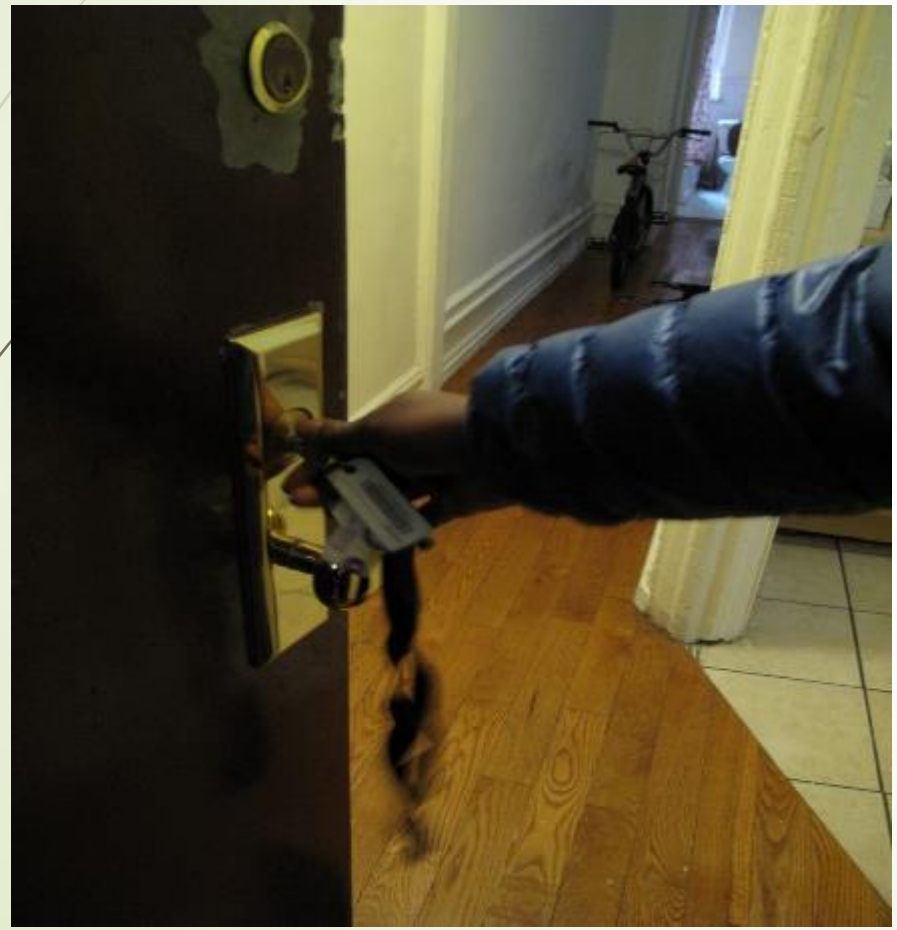
Making a home

- Rent subsidy
- Utilities
- Lease signing
- Furniture
- Mapping neighborhood
- Emergency numbers
- Team numbers
- ++ frequency of visits
- Positive stress

Working with Community Landlords

1) Common Goal: Landlord, participant, and program all want decent, well-managed, affordable housing
2) Benefits for landlords: guaranteed rent, no rent loss for vacancies
3) Support staff responsive to landlords
4) Master leasing allows sharing liability and creative solutions to housing barriers

2 Program Requirements



<u>Program Requirements</u>:

1) **Meet the terms and conditions of a standard lease (pay 30% of income)**
2) **Agree to a weekly home visit**

   (weekly or as needed)

P 1: Service Choice: *Client directed;*

"No wrong door" "whatever it takes"

May not be what Medicaid pays for…

Understanding the client's point of view

P 2: Housing and Services are Separate Domains

- Use different criteria for success in housing and success in treatment services.
- Different criteria for success in tenancy and clinical outcomes
- Applies at admission and throughout housing tenure
- Provides continuity of clinical care during housing crisis, AND continuity of housing stability during clinical crisis.

P 2: Separation of Housing and Services

- Also refers to continuity and coordination of support through disruptions in housing

LEAP
PROPERTY MANAGEMENT

P 3. MATCHING SERVICE NEEDS

Community based, responsive, and flexible

High Need

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

HYBRID TEAMS

Moderate Need

ICM - case management team provides support and brokers services

Case loads of 1 to 15/20

Blended team models

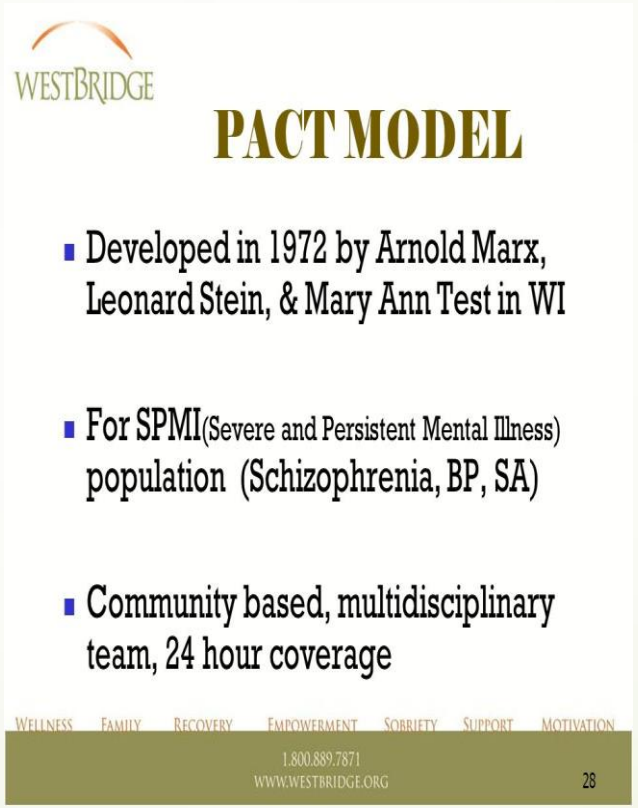
All teams use a recovery orientation

Jeopardy question 2

- A psychiatrist and a psychologist who were part of the first Programs for Assertive Community Treatment in 1972 in Madison Wisconsin and known as the originators of the ACT model.

Who is Len Stein and Mary Ann Test?

- Leonard Stein MD



- Mary Ann Test

Home Visits:
70%-80% services provide by home visits


Chronicle / Mike Kepka

Lindsay Casale
Program Director
Pathways to Housing Vermont

Having Difficult conversations

Meet John

Age: 69

Homeless: 35 years


64
C
John’s Apartment
Old North End

John Kane
1943 - 2015

Having Difficult Conversations

Pathways Vermont

Learning Objectives

- To understand and practice a core component of our work
- Identify our discomfort in conversations
- Become more comfortable with tools for having difficult conversations

What is our job?

- ~~To be someone's friend~~
- ~~To be someone's family~~
- ~~To make people feel better~~
- ~~To find solutions to people's problems~~
- ~~To be a witness to someone's struggles~~
- ~~To console someone~~
- ~~To advocate on behalf of someone~~
- **To have difficult conversations**

What is a difficult conversation?

- An authentic dialogue that explores a topic that is challenging to discuss
- A framework to explore deeper struggles than what is immediately obvious
- A mutual conversation that may include vulnerabilities, pain, differing worldviews, assumptions, etc.
- An opportunity for change, hope, growth, transformation, possibilities…

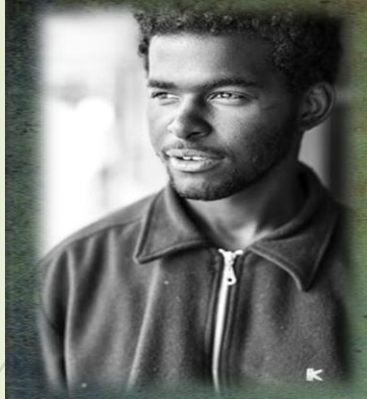
It's hard for me to talk about....

- Self-harm
- Sexual behaviors
- Harm to others
- Cutting
- Body-odor
- Family relationships
- Wanting to die
- Criminal record
- Domestic violence

Write a list of at least 3 topics that are difficult for you to discuss (especially with people you are supporting through your role)

Signs you may be avoiding a difficult conversation

- You walk into situations with a sure notion of the outcome
- You can't get past the "surface" (talking about the weather, etc.)
- You're looking to "debrief" interactions with someone else
- It's been awhile since you've learned something new



P 4: RECOVERY FOCUSED PRACTICE

Harm Reduction

"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*

Harm Reduction

A perspective on treatment that includes a set of **practical** strategies to **reduce the negative consequences** of drug use (food, relationships, finances), that incorporates a spectrum of strategies from safer use to abstinence.

-The Harm Reduction Coalition

Principles of Harm Reduction - Intervention

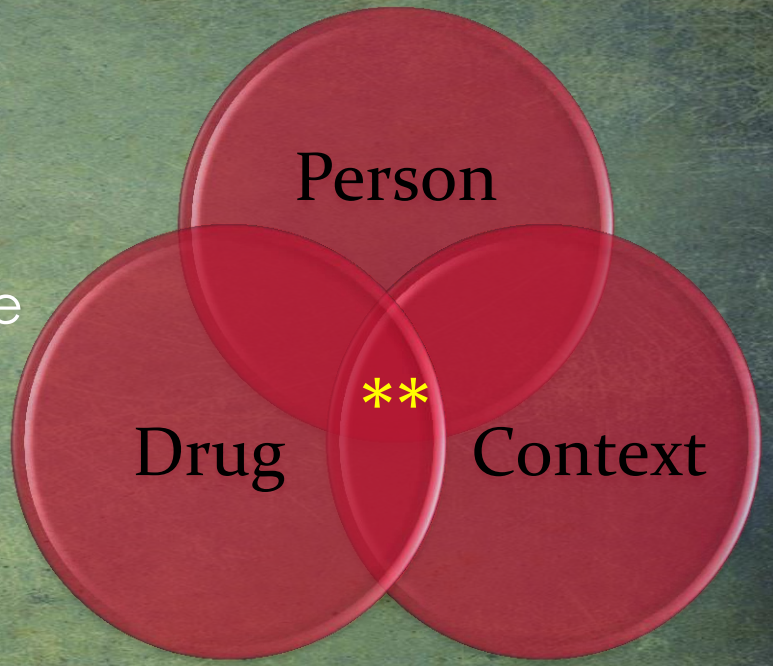
Meet people where they are

Understanding 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

Managing Housing and Relapse in A Harm Reduction Context

- Consequence of traditional abstinence based approach: Eviction, Discharge, toll on self esteem)

- Harm reduction: Relapse is an expected part of recovery: managing housing loss (role clarity), preventing eviction, providing strengths based support, e.g., noting the time spent sober (half empty to half full).

Why do people use?
How is it addressed?
Having an open and honest conversation

- To fit in
- Social pressure
- Take the edge off
- Less nervous
- Change mood
- Liquid courage
- Easier to flirt

What are the costs and benefits of changing vs. not changing behavior?

Decisional Balance: Having open and honest conversation

Option	Benefits	Costs
Making Change (reducing alcohol)	Family would trust me again More money Better health	Won't have a way to relax Lose my friends Life will be boring
Not Changing	Helps me relax I Feel like I fit in Love the buzz I get	Less money Cannot see my kids Legal problems

Housing First and Harm Reduction

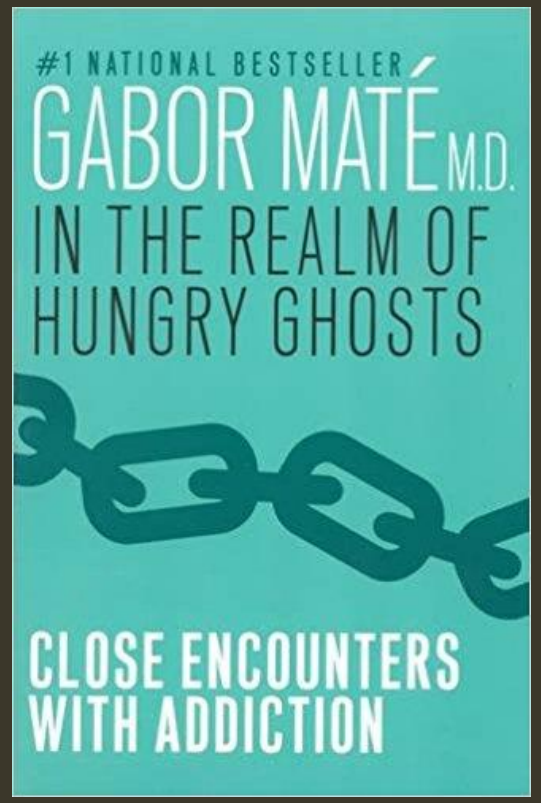
Meet people where they are…

but don't leave them there.

Jeopardy question 3

- He is a physician who works with people who are homeless and has written a book about his work called “In the Realm of Hungry Ghosts”

Who is Gabor Mate?



PATHWAYS HOUSING FIRST PRACTICES

Trauma Informed Care

Trauma-Informed System of Care

- ***trauma is viewed not as a single discrete event but rather as a defining and organizing experience that forms the core of an individual's identity.***

The after effects of abuse and violence. . .

- on people's "victim" behaviour and coping strategies can be difficult to understand.
- The defenses that many people develop after being repeatedly hurt in relationships, can make the task of connecting with them extremely difficult.

Trauma-Informed System of Care

- Enduring and meaningful change occurs when the people who make up the system share a philosophy about trauma, services, the helping relationship, and trauma clients.

- How we understand trauma will determine to how we envision the overall approach to the work we do.

- In a trauma-informed approach the focus is on understanding the whole individual and appreciating the context in which that person is living their life.

- Rather than asking: “How do I understand this problem or this symptom?”

- We ask instead: “How do I understand this person?”

PATHWAYS HOUSING FIRST PRACTICES

Recovery Oriented Services

- Recovery is more than
- +reduction of psychiatric symptoms.
- +reducing drug alcohol use.
- +participation in services or reduction in use of acute care services.
- It is about quality of life
- and the pursuit of everyday happiness
- that is meaningful to the consumer.

Social Inclusion/ Integration into Community

- Building community supports in integrated neighborhoods (self help, spiritual, cultural, personal skills and interests)
- Services assist participants with community integration activities—orientation to building
- GRADUATION!

P 5: Team Operations

- Frequency of team meeting depends on service intensity (needs of clients)
- Formal and informal communication among team members
- Cross coverage: geographical areas; staff leave, continuity of care over time
- Individual case management models and team models
- Going from “caseload” to “workload”
- Providing other needed services and effectiveness of referrals

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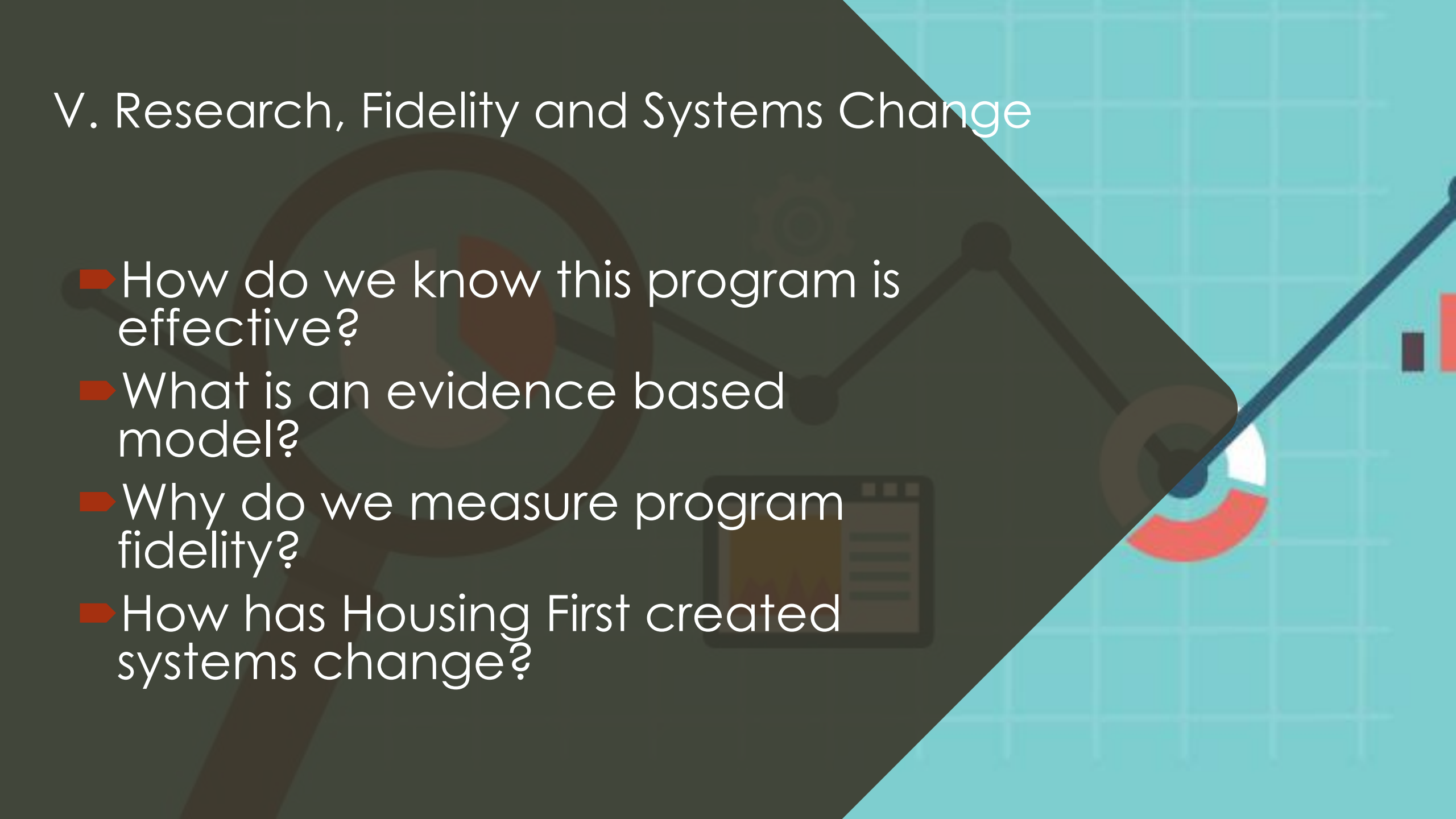
- IV) **Lived experience**
- V) Research, Program Fidelity, and Systems Change

Matt Kaegel
Pathways to Housing Vermont

- Lived experience

V. Research, Fidelity and Systems Change

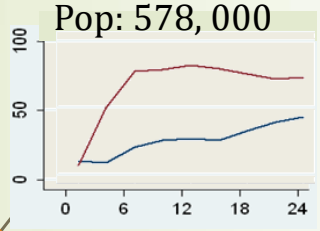
- How do we know this program is effective?
- What is an evidence based model?
- Why do we measure program fidelity?
- How has Housing First created systems change?



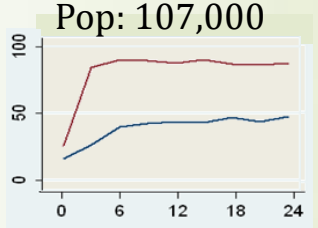
Housing First in 5 Cities (N=2,215)
Different sizes and populations

Mental Health Commission of Canada | Commission de la santé mentale du Canada

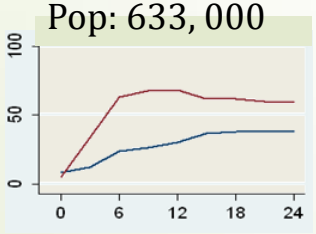
Vancouver
Pop: 578, 000



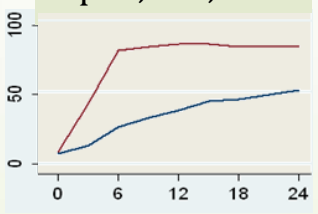
Moncton
Pop: 107,000



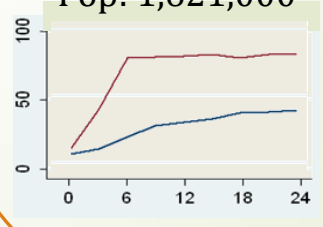
Winnipeg
Pop: 633, 000



Toronto
Pop: 2,503,000

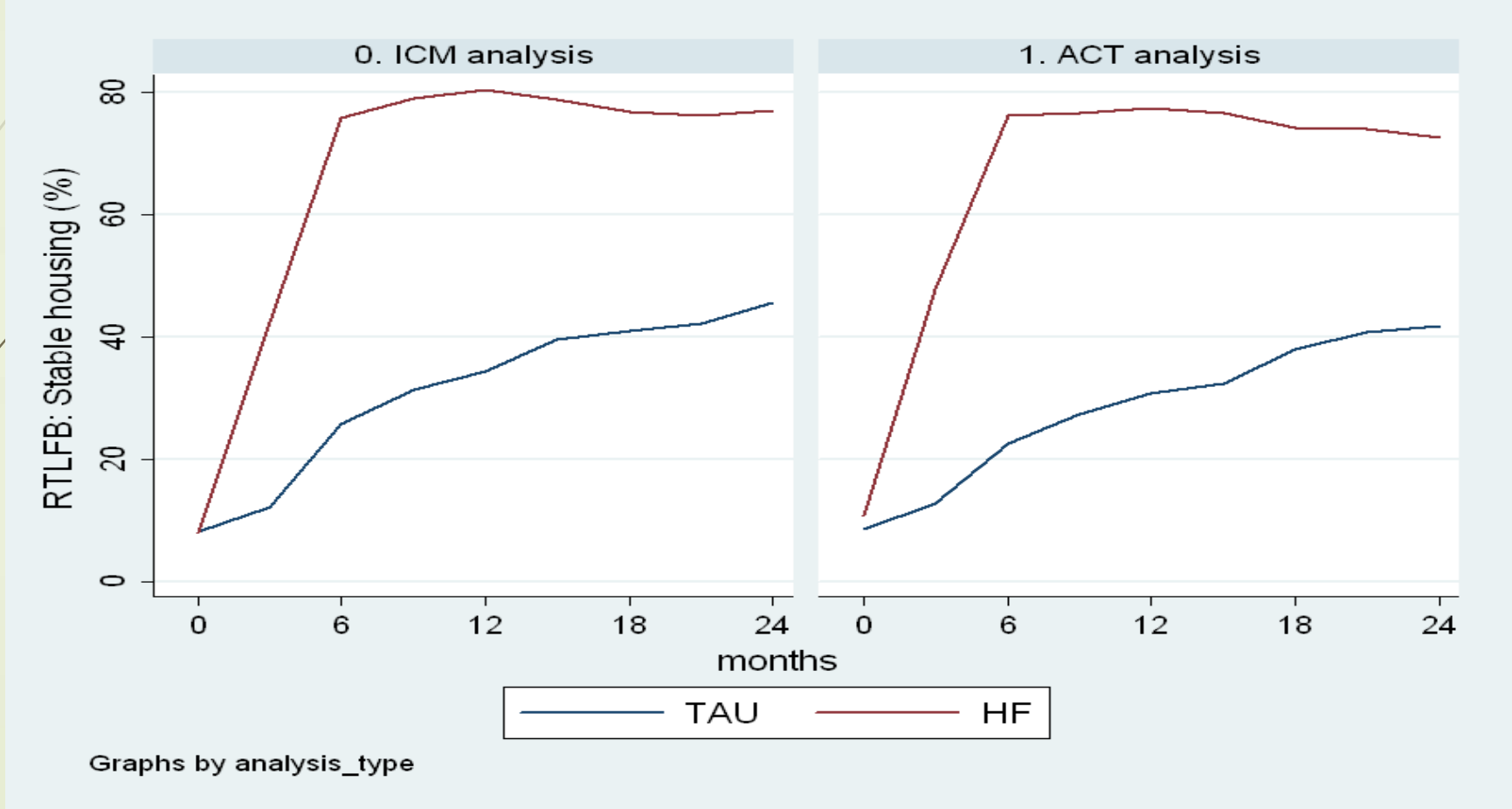


Montreal
Pop: 1,621,000



HF outcomes for moderate and high need participants

Percentage of time housed



Cost offsets vary depending on need level

Cost Analysis: HF high need with ACT

- Housing First costs $22K per person per year
- Average net cost offset of $21.4K CAD (96%) per person.
- $10 CAD invested in HF with ACT saved $9.60 CAD

Cost Analysis: HF moderate need with ICM

- Housing First costs $14K CAD per person per year
- Average net cost offset of $4.8K CAD (34%) per person.
- $10 CAD invested in HF with ICM saved $3.42 CAD

Research evidence

- See www.payhwayshousingfirst.org
- 1999 psych services concurrent longitudinal 5 year outcomes (Tsemberis)
- 2004 RCT N=225 in NYC (Tsemberis)
- 2006 long stay shelter users (Stefancic)
- 2006 HUD Study (5 cities) (Pearson)
- Denver Cost Study (Parvensky)
- 2008 Mixed methods RCT (Padgett)
- 2012 Chronic Inebriates (HUD) DESC, Pathways DC, UW cost study
- 2014 Canadian RCT (over 100 papers)
- EU Studies (Portugal, France RCT*)

Jeopardy 4

- This is title of the first peer reviewed paper about what came to be called “Housing First”

What is?

Tsemberis, S. (1999). **From streets to homes**:

An innovative approach to supported housing for homeless individuals with psychiatric disabilities. Journal of Community Psychology, 27, 225-241.

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

Program Fidelity

- The degree to which something matches something else
- Being faithful, loyal to something
- Accuracy in details

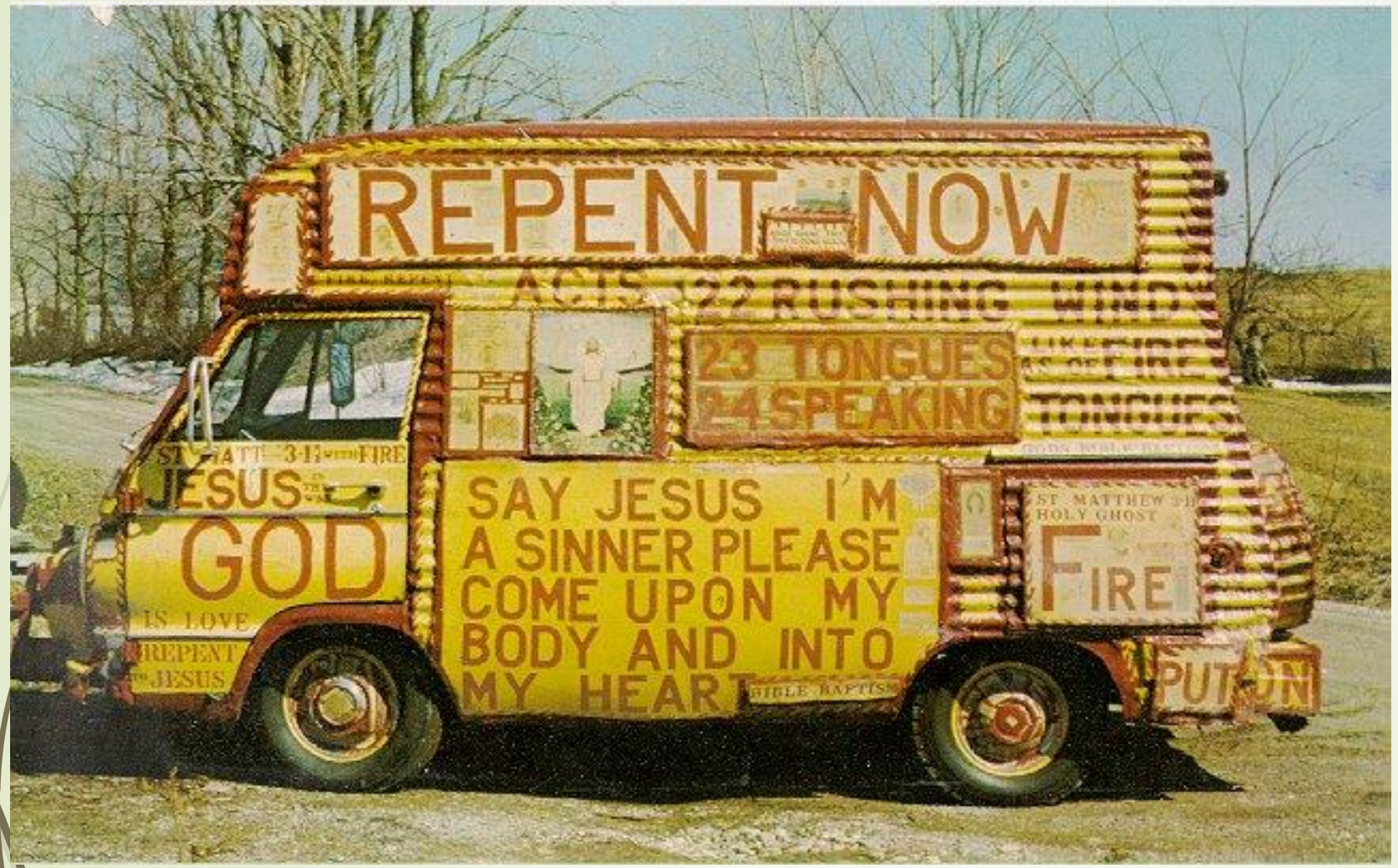
Is it Housing First?

- Analogy: Is it a car?
- A passenger vehicle designed for operation on ordinary roads and typically having four wheels and a gasoline or diesel internal combustion engine. See also hybrid.

Is this a car?

Admission:
Immediacy
Burdened by
Assessments
Housing
choice
Accessibility

Is this a car?



Compatible Ideology;
Support needed
Versus
Support provided

Is this a car?

Housing:
Affordable
Safe
Decent
Private
Services:
Reliable
24/7

Is this a car?

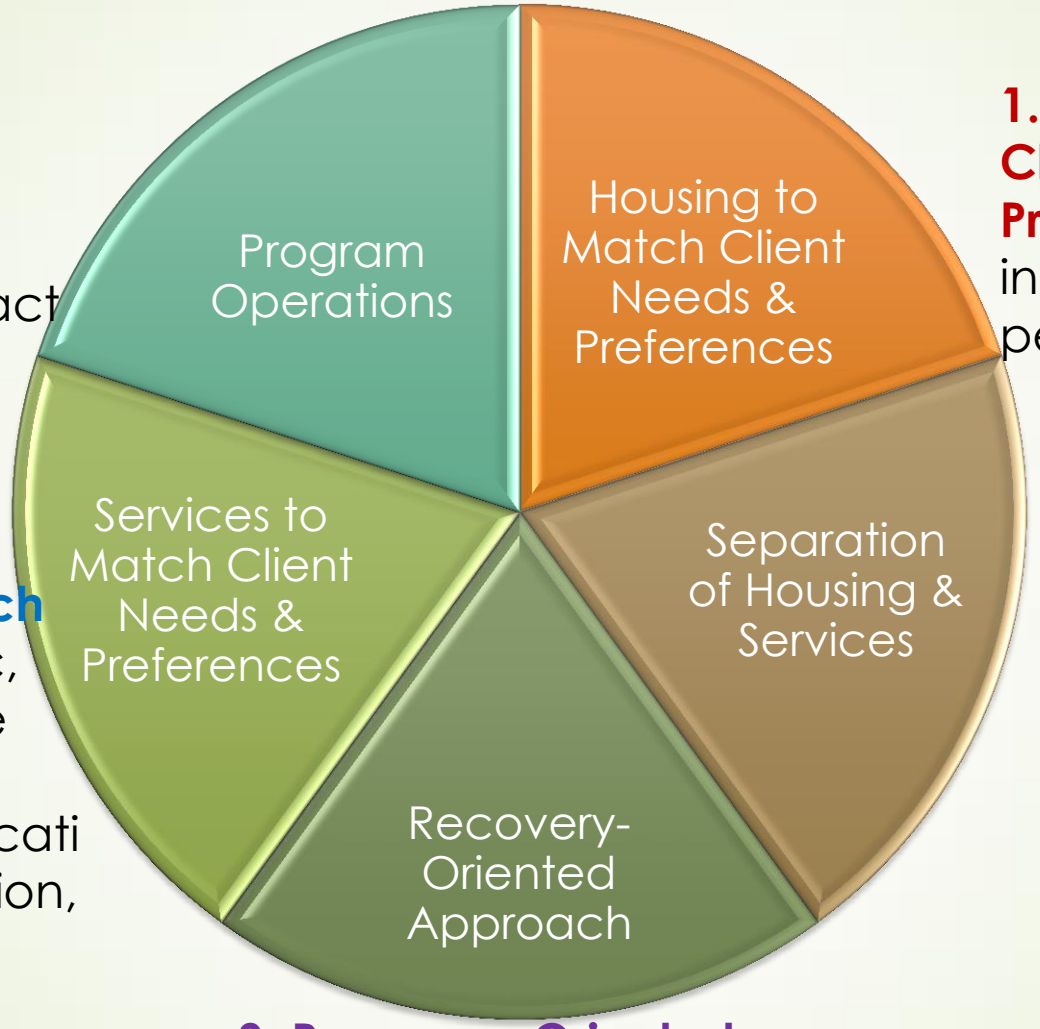
Services:
Harm reduction
Trauma Informed
Motivational/
Inspirational
Consumer directed

Why Fidelity?

- Understand current practice & make improvements
  - How are services being delivered?
  - How are staff roles understood and enacted?
- Goal is to maximize outcomes
- Learn about effective ways to apply values & principles

Housing First Fidelity: 5 Domains

5. Program Operations: team structure, staff communication & organization, contact with participants



1. Housing to Match Clients Needs & Preferences: choice, integrated, affordable, permanent

4. Services to Match Needs: psychiatric, nursing, substance use, employment/education, social integration, etc.

2. Separation of Housing & Services: no housing readiness, standard rights & rules of tenancy

3. Recovery-Oriented Approach: choice, harm reduction, self-determination, recovery

2 Ways of Conducting Fidelity Assessments

External review by HF Experts

- Team of experts visits your program
- Conducts interviews reviews practices
- Provides feedback in an interactive process

Internal review or Self-Assessment

- Each team members rates HF practice
- Dialogue with entire team to develop a team consensus

Self-Assesment of Program Fidelity

- Use of self-assesment measure
  - Developed by Stefanic et al (2013) & Gilmer et al. (2013)
  - Further validated by Goering et al. (2016)

1. Completion of measure by program staff
2. Group conciliation session to produce consensus ratings

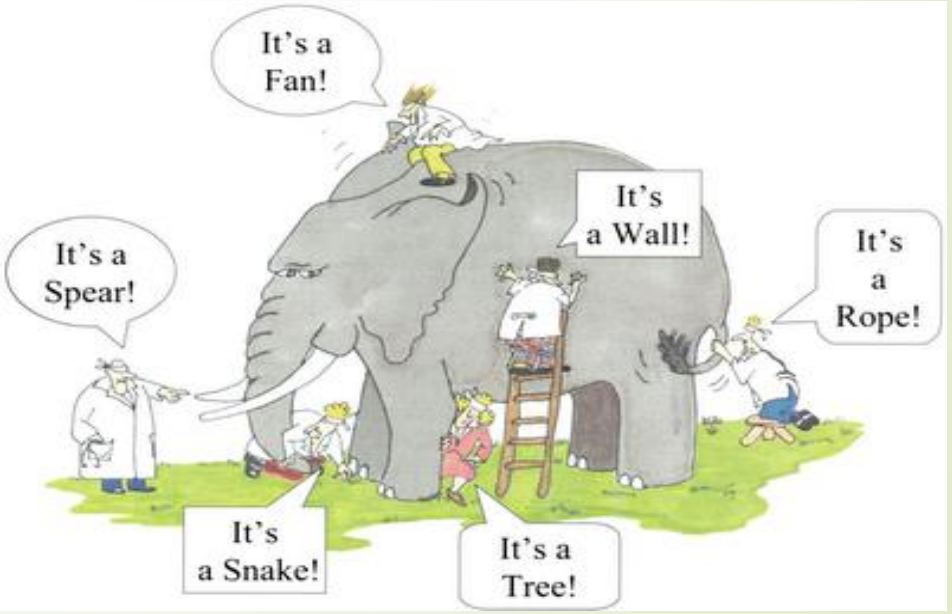
Fidelity Site Visit

- **1) Before visit: collect basic info**
  - What types of housing do participants live in; how long did it take to get into housing; staffing pattern; % participants relocated; % discharged.

DAY OF VISIT

- **2) Team meeting observation**
- **3) Individual interviews with staff**
  - All frontline providers; Each discipline
  - Team Leader
  - Program Director, Administrators
- **4) Focus group with program participants**
- **5) Chart review (random selection)**
- ***Optional: home visits***
- **6) Fidelity Team Exit Summary/Debrief**

Multiple sources of data



Pathways Housing First Fidelity Assessment Tool

HOUSING FIRST FIDELITY SELF-ASSESSMENT

Please select the answer choice that best describes the **housing process and structure** that this program offers its participants (Questions 1-7).

1. How does the program determine the type of housing in which a participant will live?

Program assigns participant to the first available housing unit	Program conducts a clinical assessment and determines the most appropriate housing based on participant's clinical need / functioning	Program assigns housing based on a clinical assessment, but with input from the participant regarding their preference	Participant chooses the type of housing they want to live in OR All participants have the option of a scatter-site apartment
1	2	3	4

2. How does the program determine the neighborhood in which a participant will live?

Program automatically assigns participant to the neighborhood with	Program conducts a clinical assessment and determines the most appropriate	Program assigns housing based on a clinical assessment, but with input from	Participant chooses the neighborhood they want to live in, given

4. To what extent does this program have ready access to affordable housing through the use of housing subsidies?

Program does not have access to housing subsidies or subsidized housing units, and does not provide support for participants to obtain them	Program does not have access to housing subsidies or subsidized housing units, but provides advocacy and support for participants to obtain housing subsidies or subsidized housing units	Program has direct access to housing subsidies and/or subsidized housing units, but there is a waiting period for participants	Program has ready direct access to housing subsidies and/or provides subsidized housing units for all participants
1	2	3	4

5. What percent of participants pay 30% or less of their income towards their rent (excluding costs for other services such as food, housekeeping, and nursing) in permanent supported housing?

0-14%	15-29%	31-45%	46-60%	60-84%	85-100%
1	1	1	2	3	4

6. On average, how long does it take participants to move from enrollment into permanent housing?

Within 6 months	Within 6 months	Within 3 months	Within 2 months	Within 1 month	Within 2 weeks
1	2	3	4	4	4

percent of participants live in the following housing types? **(Fill in % for each)**

ergency/short-term, or transitional housing	**b.** Hotel	**c.** Congregate housing/ Group Home	**d.** Social Housing; no support services	**e.** Social housing; with support services on-site	**f.** Social housing; with support services off-site	**g.** Supportive housing (specialized housing for persons with psychiatric disabilities with support on-site)	**h.** Independent apartments rented from community landlords	**i.** Other housing type fill in: _____ _____
____%	____%	____%	____%	____%	____%	____%	____%	____%

Key Point

Fidelity is fundamental.

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

Fidelity & Outcomes

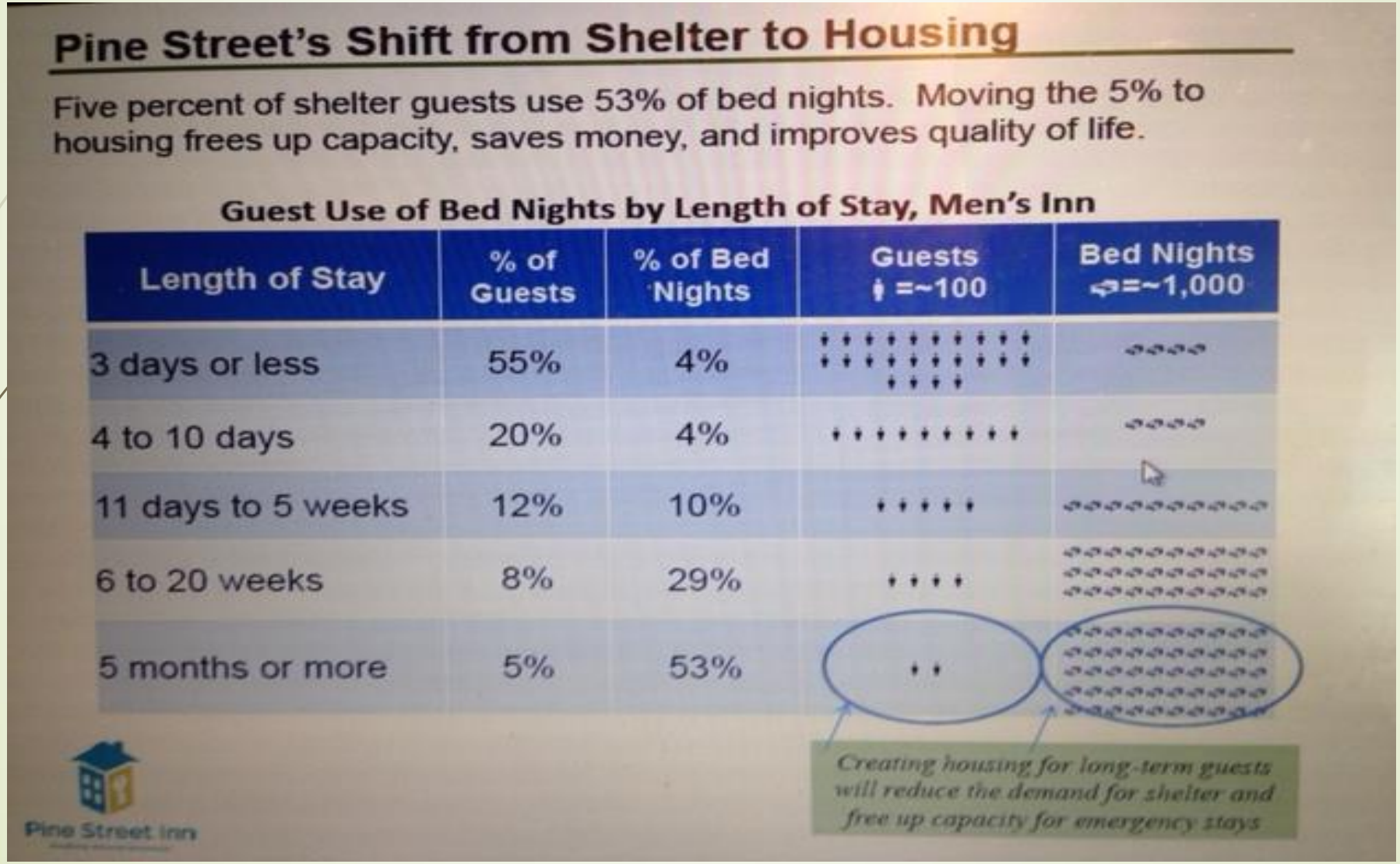
Higher program fidelity is associated with:

- Increased housing stability
- Increased quality of life
- Decreased drug/alcohol use
- Reduced use of acute care or emergency services (*Goering et. al in Psych Services, 2015*)

5. Using HF Principles to Create System Change

- InTarget Population: **Community** sets priority among homeless population
- **Collaboration**: **Partnership** among agencies (identification, data sharing, resource sharing, etc.). Lead Roles, 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**)
- Leadership/Collaboration model

V. USING HOUSING FIRST PRINCIPLES TO DRIVE SYSTEM CHANGE



Shelter utilization and capacity in a housing first approach

- CAPACITY Shelter of 30 beds = 30 x 365 = 10,950 bed nights
- **Average stay per guest**:
- 10 people staying 10 nights = 100 bed nights
- 10 people staying 180 nights = 1,800 bed nights

Annual Shelter Capacity	**# Guests**
10 nights per guest =	1,095
180 nights per guest=	61

Redesigning the System: System Transformation

Permanent housing (scatter-site, off site services)

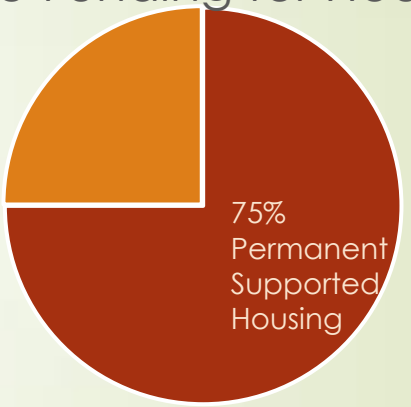
Permanent Single Site (on-site services)

Shelter
Transitional Housing

Outreach
Emergency response

>Less restrictive to more restrictive >

Prioritize Funding for Housing



HF Europe

Western and Northern Europe:

- Netherlands
- Portugal
- France
- Ireland
- Sweden
- Denmark
- Norway
- Finland
- Germany
- Belgium
- Italy
- Spain
- Czech Republic
- Scotland
- England

10-year outcomes for Ireland and Finland 2008-2018

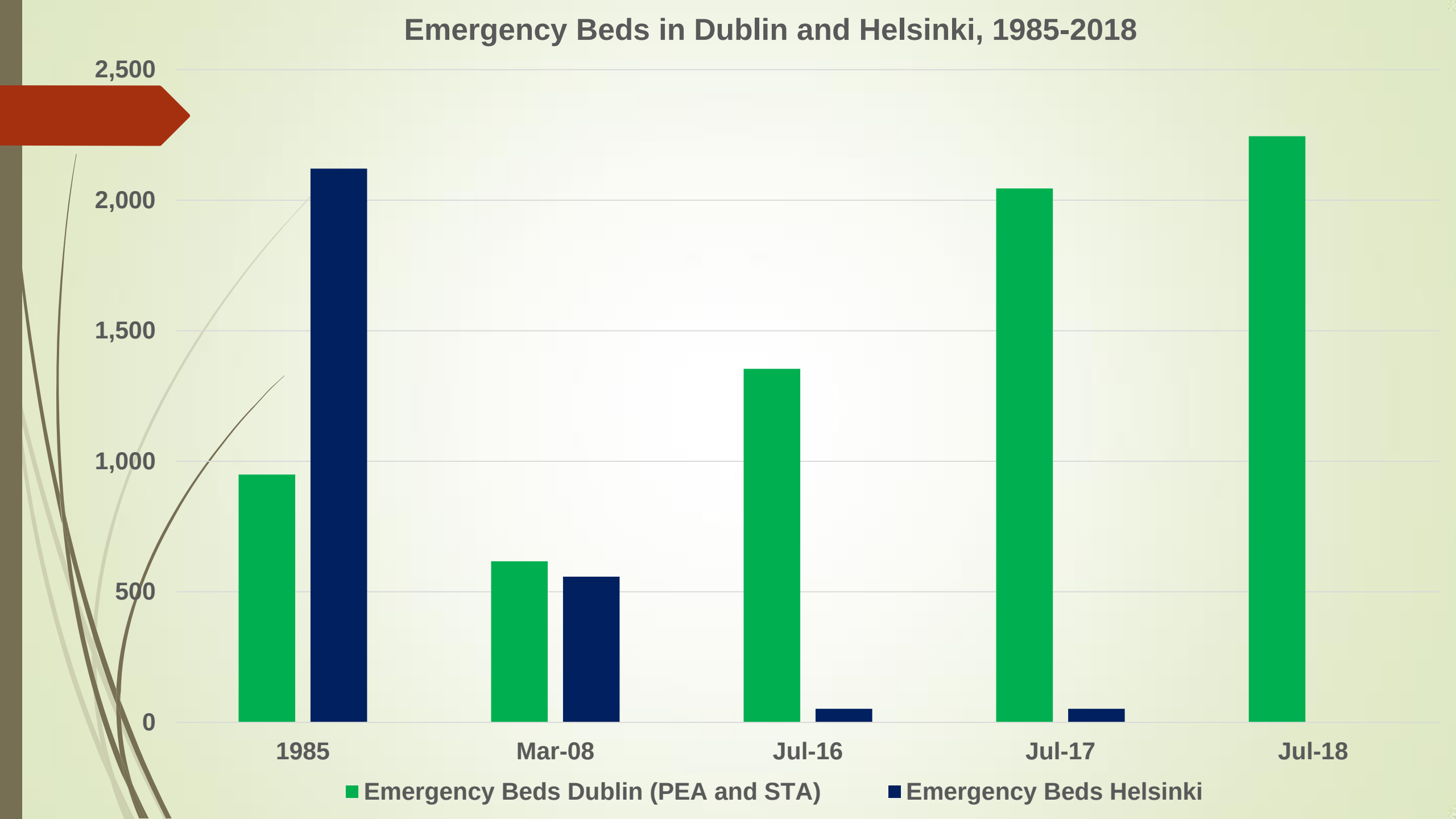
FINLAND

- Adopted HF as National policy
- Converted shelters to permanent housing (national lottery)
- Invested in developing affordable housing (17,000 units)
- Rent subsidies for elderly, disabilities, single parents, students, widowed, etc.
- Shelter beds from 2100 to 50
- HOMELESS (RS)COUNT FROM 3100 TO ZERO
- Ref: **Y-Foundation**

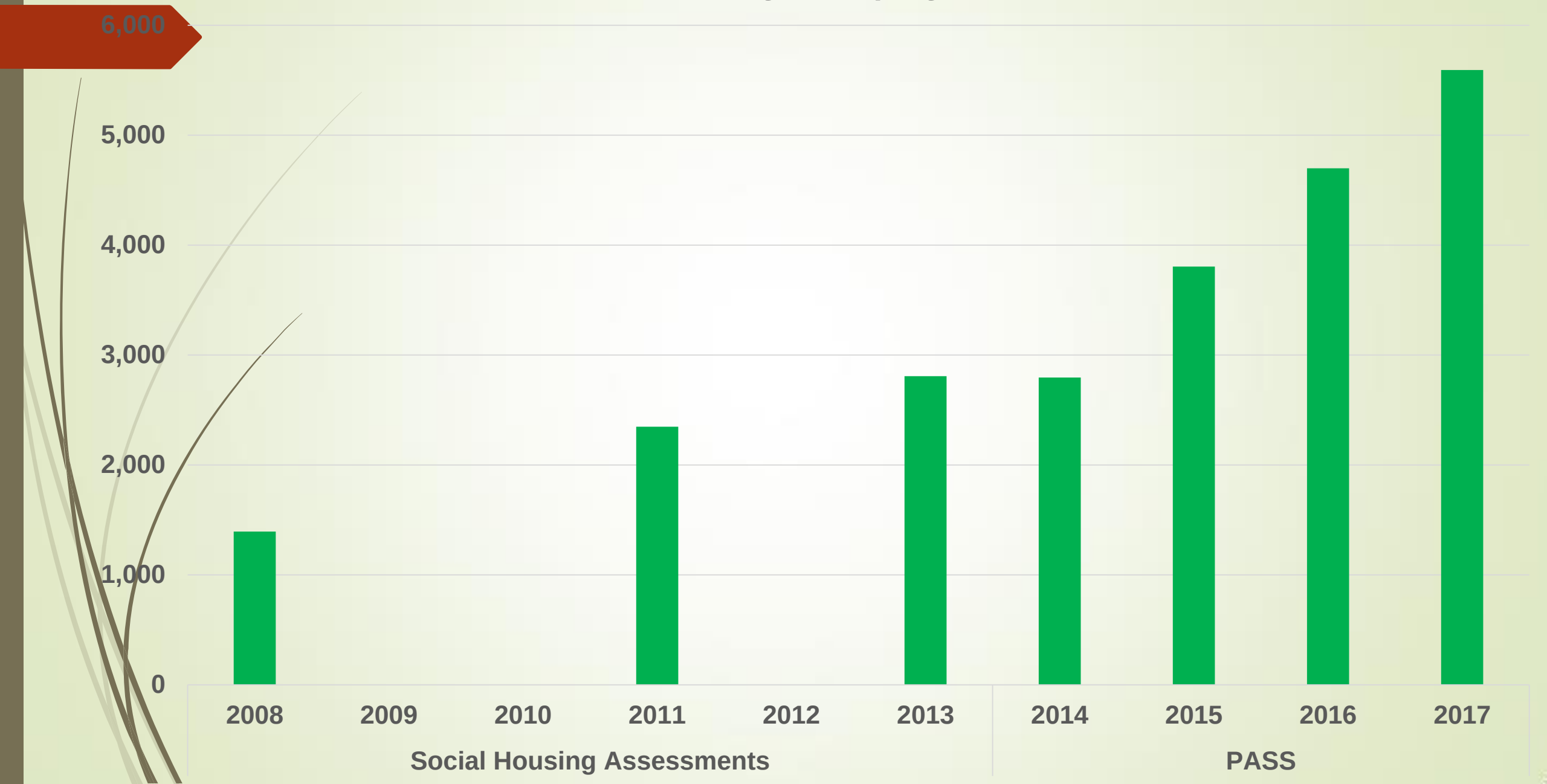
IRELAND

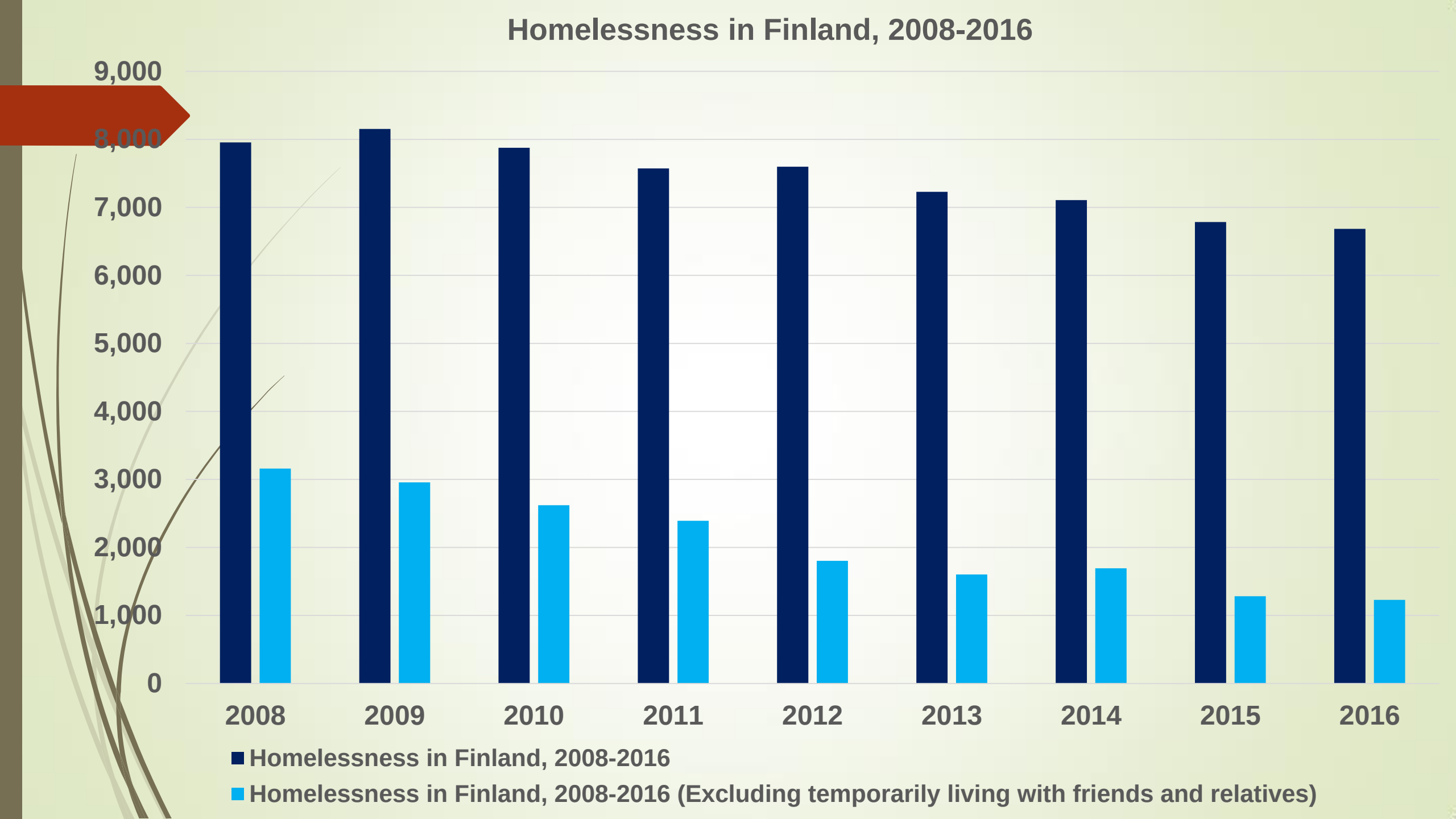
- Addresses homelessness as an emergency or emergency accommodation
- Increased the investment in shelters and emergency accommodation
- Promised development of social housing
- Went from a low of 600 shelter beds to 2100
- HOMELESS (RS) COUNT FROM 1200 T0 5400


Bered dig att möta din Gud.


Emergency Beds in Dublin and Helsinki, 1985-2018
2,500
2,000
1,500
1,000
500
0
1985
Mar-08
Jul-16
Jul-17
Jul-18
Emergency Beds Dublin (PEA and STA)
Emergency Beds Helsinki

Homelessness in Ireland (2008-2017) - Emergency Accommodation and Rough Sleeping




Homelessness in Finland, 2008-2016
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
2008
2009
2010
2011
2012
2013
2014
2015
2016
Homelessness in Finland, 2008-2016
Homelessness in Finland, 2008-2016 (Excluding temporarily living with friends and relatives)

Lessons Learned from Finland

- National Housing First policy with sufficient funding
- Began to eliminate investment in transitional and shelter programs
- Converted existing building to PSH
- Acquired, built and rented a total of 17,000 mixed income units
- A financially sustainable non-profit landlord
- Services provided by referral agencies
- Rent supplements as prevention to 7 high risk groups currently housed
- Unified social and economic policy vision, social values of inclusion and assistance for those less fortunate

We know how to end homelessness
Why haven't we done it?

We need
To find the
political will
To make
change!

HOUSING FIRST PROGRAM FIDELITY

Questions About Program Operation

Sam Tsemberis, Ph.D.,
Founder and CEO
Pathways Housing First

Question #1

True or False?

Housing First means that the first thing you do is place the client into an apartment of their own *right away*.

Question #2

YES or NO?

Incorporating peer specialists, is helpful and recommended…

but should peer specialists be accompanied by a regular staff member when conducting a home visit?

Question #3

What is more HF?
A or B?

How do we respond?

You are enrolling a client into your HF program and he tells you he has a family emergency and needs a bus ticket to go see his relative in Colorado Springs…

DO YOU

A. Buy him the bus ticket OR
B. Listen and try to calm him down to finish the application so he can get housing?

Question #4

True or False?

If you or your team members feel threatened by a particular client, the team still has to conduct the visit.

Question #5

True or False?

If your program does not have the rent funds to begin looking for housing right after admission it is not housing first.

Question #6

True or False

‘Immediate access to housing' requires that the program find an apartment in about 4 to 6 weeks after admission.

Question #7

Multiple Choice

If one of your participants has lost two apartments and is not doing well in the third, do you?

A) Have a sit down and discuss where they would like to be referred

B) It's Housing First so you let the client decide

C) Ask the client to explain how the next one will be different before you proceed?

Question #8

Multiple Choice

- **In the Pathways Housing First program, the type of housing a consumers receives is:**
- A) An apartment in project based/single site building with onsite harm reduction services
- B) A market rate, scattered site apartment in the community with off site services
- C) The housing of their choice
- D) Dependent on what the program actually has available

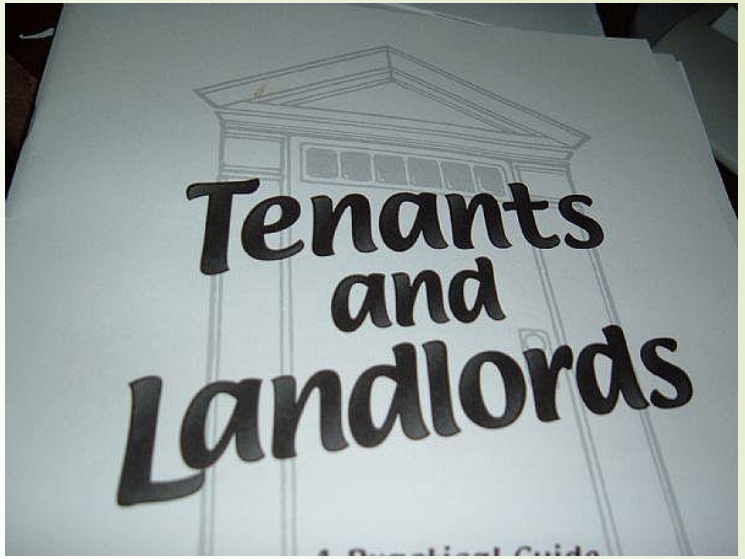
Question #9

True or False?

Harm reduction is only practiced in the treatment of substance and alcohol use

Question #10

Multiple Choice



HF programs separate housing from services so the responsibility for maintaining decent, quality, affordable apartments is:

a) The client's

b) The service team

c) The landlord's

d) All of the above

References

- Goering, P., et. al, (2014). Further Validation of the Pathways Housing First Fidelity Scale. Psychiatric Services, Psychiatric Services, 09/2015.

- Stefancic, A., Tsemberis, S., Messeri, P., Drake, R., and Goering, P. (2013). The pathways housing first fidelity scale for programs serving individuals with psychiatric disabilities. *American Journal of Psychiatric Rehabilitation, 16, 240-261*.

- Tsemberis, S. (2015). *Housing First: The pathways model to end homelessness for people with mental illness and addiction*. Minneapolis, MN: Hazelden.

Thank You!
Questions?
Comments?