
Housing First: Basic Tenets of the Definition Across Cultures

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Introduction

Pleace’s thoughtful analysis of some of the issues related to the definition and implementation of Housing First (HF) in Europe opens the door to a conversation that may prove useful in clarifying some of the ambiguities emerging from the recent widespread adoption of HF programs. It also sheds light on the prevalent use of the term HF to refer to an array of programs, approaches, and policies without an adequate explanation of the differences. Pleace poses three questions to frame his discussion: What is HF? What are the potential limits of HF? And, what is the nature of homelessness and the operational assumptions of HF? These questions, certainly not exhaustive of the topic, provide a useful framework for addressing some key issues surrounding the classification, operation, effectiveness, and dissemination of HF.

Service Diversification

Given the emergence of programs that significantly deviate from the original HF model, Pleace rightfully expresses concern about model drift, and states “there is a need to understand properly what is being delivered by various HF services.” In order to understand the relevance of what services are being delivered by programs calling themselves HF, it is useful to have a common definition of the type of programs we call HF. Housing First is a complex clinical and housing intervention comprised of three major components, a) program philosophy and practice values (referred to as “shared ethos” by Pleace), b) permanent independent housing, and c) community-based, mobile support services. Each of these factors includes both structural and operational aspects. For example, the first component – program philosophy and values – includes principles of psychiatric rehabilitation, recovery, consumer choice, and the belief that housing is a basic human right, among others.

These values directly correspond to HF practices such as the extent to which programs offer immediate access to housing without requiring psychiatric treatment or sobriety as preconditions, provide services in the sequence and intensity desired by the client, and support clients economically and clinically to live in the housing and neighbourhood of their choice. The extent to which a program embraces the HF philosophy and operates in a manner that is consistent with these principles is in large part a measure of its' fidelity to the HF model.

For the second component – permanent independent housing – two clearly delineated approaches have emerged in HF, with some variation in between: scatter-site individual apartments and single-site, congregate buildings with individual units. The Pathways Housing First model is identified with scatter-site individual apartments. This model of permanent independent housing emerged as the dominant approach in direct response to the program's commitment to honour client choice; for the vast majority of clients, the most requested option is an independent apartment of their own (which includes a rent subsidy). However, this option is not always available in other programs. This may be because a program does not have the funds or means to obtain rent supplements or, as in the case of Finland, public policy dictates that only single site, congregate housing can be offered to people who are homeless. Similarly, in countries where there is a national housing policy committed to providing public housing for people who are poor or homeless, there is often reluctance to offer supplementary rent stipends, thus eliminating the option of scatter-site housing and using rental units in the private market. However, there are also exceptions to this rule across Canada and several EU countries (notably Portugal and France) where there are large-scale demonstration projects testing the effectiveness of the HF model in the context of public housing and the use of rent supplements. Finally, some programs philosophically and operationally prioritize the creation of intentional communities of persons with psychiatric disabilities.

While the scatter-site apartment approach tends to be the model of choice for persons exiting homelessness, years of experience have shown that it is useful to have at least both types of housing (scatter-site and single-site). A segment of the homeless population may prefer single-site housing and not everyone succeeds one hundred percent in either model. We know that the evidence base for retention in the scatter site model is approximately 85%. We do not yet have an evidence base for the single-site model. Anticipating that a small percentage of clients will be unable to maintain an independent apartment, or would prefer more congregate living, single site programs with on-site services offer a useful and effective alternative.

The third component is community-based support services, referred to as “floating support services” by Pleace. An understanding of the type of services delivered and the manner and frequency in which they are delivered requires an understanding of whom the program seeks to serve. One operating principle of HF is that services must be client-directed; another is that they must meet the needs of the client. Services must be understood in the context of the wants and needs of the population served. Thus, in HF, the services component should take different forms depending on the severity of needs of clients served. For clients with severe co-occurring diagnoses, an Assertive Community Treatment (ACT) team is well-suited; for those whose mental health and addiction problems are moderate but not severe, Intensive Case Management (ICM) is a fitting clinical intervention. For HF programs that serve families, support services teams are also staffed by a family system therapist and child development specialist.

When HF programs serve different segments of the homeless population, they do not constitute a different model; they are HF programs with support services tailored to best fit the needs of that particular population. The key to maintaining a high degree of program fidelity in the services domain is to ensure that the support services are client-directed, recovery-focused and that there is a good fit between client needs and services provided. That said, modifications to the original model certainly do not always occur for explicitly consumer-centric reasons and are not necessarily viewed as enhancements. When inadequate funding, competing philosophical views (often under the guise of traditional assumptions as to what will or will not work in a certain context or assumptions of what is or is not best for clients), desires to adopt an evidence-based label but not the practice, or lack of understanding of the model dictate modifications and a diversity of services may be instituted that results in unwelcome model drift. An understanding of the core HF fidelity service elements and the rationale behind their adoption or modification is central to evaluating dissemination and program effectiveness.

In summary, programs defined as HF vary in the degree to which they meet criteria of program philosophy, housing, and services, and this variation, ranging from high to low, determines a program’s fidelity to the HF model. Using a multi-dimensional fidelity framework avoids the narrow constraints of dichotomous appraisals (is it or isn’t it?) and can offer a guide regarding which program dimensions are consistent with the model and which need to be adjusted to achieve higher fidelity. This type of approach to dissemination and fidelity has been used with several other complex evidence-based interventions such as ACT and Supported Employment has proven useful and effective in assessing the implementation, operation, and management of these programs to achieve the best possible outcomes for the clients they serve.

Potential Limits of Housing First

Approximately 15% of clients served in HF programs providing independent scatter-site apartments do not manage well. Pleace correctly identifies that this is typically a group with severe alcohol and drug addiction. Since the vast majority of clients served by HF programs are admitted with drug and alcohol problems, and there is no reliable way to predict who will and will not do well, it is not a viable option to screen out clients who will not succeed at intake. It takes months and sometimes years to sort out who among this high risk group will have numerous evictions and ultimately need more structure and services. The one consolation is that many among this small subgroup are able to adjust to living in a more supervised, harm reduction, congregate setting.

Pleace refers to research suggesting that while drug or alcohol use for people in HF programs “falls off to some degree,” it “does not stop”. It is important here to revisit the mission of HF: it is to end homelessness for people with complex needs. Of course, the ideal outcome would be to end homelessness and solve all problems related to mental health, addiction, and social exclusion, but we are not there yet. As Pleace points out, beyond a program intervention, larger shifts in social contexts and policies are needed to achieve greater success in alleviating poverty, facilitating recovery, and promoting social inclusion. Further, with respect to substance use, a philosophical issue often undergirds objections to harm reduction wherein sobriety is set as the standard for success – but we must ask, by whom? If sobriety is a client’s choice, then the program works with the client to achieve that goal. If a client chooses to drink in a mild or moderate way, perhaps no more or less than his or her neighbours, is that a problem? Sobriety is not a program mandate, but it is certainly supported if that is the person’s goal. The price of social assistance all too often comes in the form of sacrifices to self-determination and perhaps it is time to ask whether self-determination has greater psychological benefits than abstinence or sobriety. Further, the effectiveness of harm reduction must be evaluated in highly individualized ways across multiple domain of quality of life and this has made it an extremely difficult intervention to research and with which to make generalizations about success. Promising research is emerging, however, and we hope that future studies will continue to achieve higher levels of sophistication with respect to evaluating harm reduction techniques.

Also included in this question are concerns about cost. A proper analysis of HF program costs is best understood when we consider ‘floating support services’ as a fluid not a static entity. In fact, the question about how much support and what is considered optimal support is a more important question than the cost of the service. From a program perspective, the titration of services is related to the question of how best to support the client’s recovery. As clients improve, they can

be transferred from higher intensity services such as ACT to lower intensity support such as ICM, later to a light form of case management, and eventually, to no services at all. The reduction of services over time is not only a cost savings issue; it concerns the well-being and community integration of the client. Expectations for program interventions, such as HF, run high to produce drastic improvements in the outcomes mentioned by Pleace – improved mental health, reduced substance use, reduced social isolation, improved employment – yet simultaneously questions regarding the extent to which services can be lessened in the interests of cost savings are equally, and often more vociferously, posed. The question then becomes to what degree will we trade-off the potential for improved outcomes and personal recovery to achieve the maximum possible benefit to cost savings?

Conclusion: The Nature of Homelessness and Operational Assumptions

Pleace raises the concern that HF programs may draw too much attention to the most severely impaired and most vulnerable among the homeless at the expense of advocating for resources for people who are homeless solely because they are poor and need housing without services support. This issue is critically important when we consider how best to end homelessness for everyone who is homeless. HF has demonstrated that even the most vulnerable people need, first and foremost, a decent affordable place to live. They also need the support services to help maintain their housing and treat their problems. For the vast majority whose homelessness results from poverty without the complications of severe mental illness, decent affordable housing would be sufficient. Pleace warns that too much focus on the subgroup with clinical problems may distract us from addressing the larger social issues that contribute to homelessness: the role of labour markets, lack of affordable housing, inadequate welfare systems, and others. We couldn't agree more. But this need not be a zero-sum game.