
Considering Alternatives to the Housing First Model

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Introduction

The ‘Housing First’ model of permanent supported housing developed at Pathways to Housing in New York (Tsemberis, 1999; Tsemberis *et al.*, 2004) is being implemented by many service providers in the United States and is quickly becoming a key model for homeless services in many countries in Europe. However, as discussed by Pleace (2011) in *The Ambiguities, Limits and Risks of Housing First from a European Perspective*, the scope and applicability of the Housing First model, particularly in European countries, should be considered further before widespread implementation and endorsement of the model. Pleace (2011) outlines three central questions about the Housing First model, which can be summarized as: 1) What is Housing First? ; 2) Does Housing First adequately address the needs of homeless people? ; and 3) What is the role of Housing First and who does it serve? In this commentary, we contribute to the discussion in these three areas by drawing upon our experience, along with the work of others, to expand our critical understanding of this high-profile topic, and add our thoughts to ongoing policy discussions in Europe regarding Housing First.

Defining the Housing First Model: What is Housing First?

The first point made by Pleace (2011) is that the Housing First model is imprecisely defined and there is wide variability in the services provided by programmes claiming to be Housing First programmes. Pleace astutely differentiates between the Pathways to Housing First (PHF) model and a vaguely defined set of services called the Housing First model. Although a manual, along with a checklist (not a fidelity scale), of the PHF model has been published (Tsemberis, 2010), there are no studies showing that greater adherence to checklist items results in greater effectiveness as has been found in other evidence-based practices whose implementation is guided and can be evaluated with fidelity scales (Teague *et al.*, 1998;

Bond, 2004). This means that the necessary and sufficient elements of the Housing First model for client success have not been determined, and it is unknown whether it is important for programmes to adhere strictly to the PHF model. Our previous review suggested that the central active ingredient in such models is the ready availability of housing subsidies, and that evidence that assertive community treatment is essential for the effectiveness of these programmes is weak, at best (Rosenheck, 2010).

A meta-analysis of 44 unique community housing models, including Housing First, found that all housing models achieved significantly greater housing stability than 'non-model housing' (i.e., treatment with no specified housing component), but no housing model was found to be more successful than all other models (Leff *et al.*, 2009). Therefore, having a model may be better than having none, but there has not been adequate research to herald one model over the others. It is notable that published randomized controlled trials of PHF have often used unspecified usual care programmes as the comparison group (Gulcur *et al.*, 2003; Tsemberis and Eisenberg, 2000; Tsemberis *et al.*, 2004) instead of programmes with a particular housing model. Importantly, there have been no randomized controlled trials – that we know of – of Housing First specifically in Europe to provide confidence that the results found in the U.S. are generalizable to the European context, in which subsidized housing for disabled people may be more generally available. Some European researchers have argued that the Housing First model will not be applicable in some contexts and that the model will need to be tailored to meet local needs, although the ways in which it should be modified are not entirely clear and have not been studied empirically (Atherton and Nicholls, 2008).

In defining what Housing First is and how effective it is, it may be important to point out that although Housing First claims not to require clients to comply with psychiatric treatment, they are actively connected to an assertive community treatment team and subject to assertive engagement strategies, which may be the functional equivalent of 'required treatment' and thereby stigmatizing (Strickler, 2011). In essence, the term 'Housing First' may be misleading, in that it is really 'Housing and Case Management First'. Also, as mentioned by others familiar with the PHF model (Kertesz *et al.*, 2009), clients are required to participate in a money management programme to pay 30% of their income in rent and to have bi-monthly contact with staff. These additional requirements seem inconsistent with the claims that client choice is the predominant value, and they muddy the waters for those planning to implement Housing First.

The Needs of Homeless Adults

The second question posed by Pleace (2011) is whether provision of Housing First meets the needs of homeless adults, and what potential limitations of the model need to be considered. Housing First, along with less clearly defined permanent supported housing programmes, have primarily shown success in housing outcomes, with minor or no improvements observed in clinical, social, and quality of life outcomes (Rosenheck *et al.*, 2003; Tsemberis *et al.*, 2004; Leff *et al.*, 2009; Tsai and Rosenheck (forthcoming)). As discussed by Pleace (2011), unemployment and social isolation are problems for homeless adults even after they have obtained housing. In fact, subsidized housing may create disincentives for employment (Tsai *et al.*, 2011) and for independent housing (Messenger, 1992), much in the way that disability benefits and public income support have been found to be associated with less employment (Drew *et al.*, 2001; Resnick *et al.*, 2003). Thus, the field may need to move beyond providing Housing First to consider how to improve life after supported housing is obtained, i.e., what is Second?

Several studies have begun to address social isolation in supported housing through alternative treatment models. One programme, called the Peer Housing Location Assistance Groups (PHLAG) (Lucksted *et al.*, 2008), offers homeless veterans peer support groups to help them find and obtain housing in the open housing market. The PHLAG programme has shown some success in helping clients obtain independent housing and has demonstrated the potential of peer support.

Another programme is the group-intensive peer support (GIPS) (Tsai *et al.*, 2011) model that was developed for the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) programme, a national supported housing programme for homeless veterans. Clients in GIPS are expected to attend weekly group meetings as their default psychosocial intervention, to learn from their peers how to obtain a housing voucher, search for housing, sustain housing, and integrate into the community. Group meetings are led by case managers, but clients act as active peers providing content and feedback to each other. Individual assertive community treatment is provided to clients only on an as-needed basis, instead of serving as the default mode of support. At the study site that implemented GIPS, clients not only reported acquiring housing vouchers faster, but reported greater social integration as compared to those at comparison sites (Tsai and Rosenheck, under review). This may reflect the fact that clients were attending groups and interacting with peers in the community instead of waiting for case managers to meet them in their homes. In theory, such a model should be less costly and thus more cost-effective than conventional assertive community treatment-based models, but randomized trials have yet to be published.

Apart from programmes linked with supported housing, there have also been 'citizenship' interventions developed to encourage homeless adults with mental illness to take more active, civic roles in their communities (Rowe *et al.*, 2001) and 'supported socialization' programmes to encourage interpersonal development (Fisk and Frey, 2002). How these interventions, along with established evidence-based practices like supported employment (Becker and Drake, 2003), might fit into permanent supported housing models has not been explored and may be neglected when there is a narrow focus on Housing First.

Costs and Clientele of Housing First

The final question of Pleace (2011) may be the most important, and that is: who should Housing First be for? Asked another way, are Housing First services more intensive than needed for some homeless adults? And are they cost-effective for some groups but not others? The Housing First model is expensive to implement and incurs large programme and capital costs that have not always been included in analyses of Housing First cost-effectiveness (Kertesz *et al.*, 2009; Kertesz and Weiner, 2009). Consideration of whether Housing First is needed for all homeless clients is an important question, the answer to which is likely to be 'no' in some cases. It may be necessary to differentiate between chronically homeless or dually diagnosed adults and other homeless populations. Chronically homeless adults constitute a minority of the total homeless population (U.S. Department of Housing and Urban Development, 2011).

The cost-effectiveness of Housing First has not been demonstrated in a cost-effectiveness analysis, and the only cost study of PHF published thus far did not include the costs of the intervention, which have not been assessed. In addition, some cost reductions have only been shown for chronically homeless adults with severe mental illness who are heavily dependent on public assistance and have shown repeated failures to stay housed through other services (Kertesz *et al.*, 2009; Kertesz and Weiner, 2009), and 25% of participants in the seminal trial in this area were hospitalized at the time of programme entry (Tsemberis *et al.*, 2004). There has been much less research showing the clinical and cost-effectiveness of Housing First with homeless adults who are not chronically homeless or who have, primarily, substance abuse problems. In a randomized controlled trial of supported housing, homeless adults who were not assigned to receive subsidized housing were still able to obtain independent housing through employment and living with others (Tsai *et al.*, 2011). Some have argued that shared housing or 'doubling up' is more economical and does not have adverse health effects (Ahrentzen, 2003; Yinghua *et al.*, 2010).

Housing First is not only expensive because of the use of housing subsidies and associated capital costs, but because assertive community treatment is provided as part of the model. Assertive community treatment is a costly, staff-intensive model of treatment and its costs likely to be offset only if treatment is designed for the most severely mentally ill clients with high cost hospitalizations (Stein and Test, 1980; Latimer, 1999). However, studies have shown that some clients can be graduated from assertive community treatment to lower-intensity, presumably less expensive, services without any adverse clinical outcomes (Salyers *et al.*, 1998; Rosenheck and Dennis, 2001), and that such time-limited treatment can reduce post-treatment costs (Jones *et al.*, 2003).

Time-limited intensive case management for homeless clients has also been found to be useful for some homeless populations (Susser *et al.*, 1997; Kaspro and Rosenheck, 2007). Group-based models like GIPS (Tsai *et al.*, 2011) and PHLAG (Lucksted *et al.*, 2008) could potentially be more cost-effective, as staff may be able to be more efficient with their time and carry larger client caseloads. Additional research is needed on alternative supported housing models as they are being developed. Further investigation is also needed on how to improve the outcomes of supported housing clients in domains other than housing and on how to move clients to greater independence over time.

Conclusion

In conclusion, we are in accord with Pleace (2011) that there many important questions that remain about Housing First, in general, and particularly in regards to implementing it in European countries. Clearer definitions of what Housing First is, what types of clients the model serves, and how limitations of the model might be addressed would be important for both future research and implementation of the model. We suggest that research on Housing First is in its early stages and that the model may not warrant widespread adoption without exploration of diverse models. Viable alternative service models need to be considered and empirically evaluated so that European countries can make informed policy decisions regarding Housing First.

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