Housing First

A Review of the Literature

September, 2010

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Permanent supported housing was intended to provide services and housing to those individuals with functional disabilities who needed continued support to stay housed (Y.-L. I. Wong, Park, & Nemon, 2006). It was intended to serve previously homeless persons with serious mental illness, substance abuse, and physical disabilities (Y.-L. I. Wong, et al., 2006). For these individuals, services may be provided within the residence or out in established community agencies (Y.-L. I. Wong, et al., 2006).

Some models of permanent supported housing are based on the Housing First model while others use more of a transitional housing approach (Casey, 2007). As a treatment and housing program, housing first is meant to facilitate independent living by incorporating financial aid, mental health services, case management, and ACT teams (Wright & Kloos, 2007).

Throughout the literature, housing first is seen as being permanent scatter-site independent housing (Casey, 2007; Culhane, Metraux, & Hadley, 2002). It uses community based service supports (Culhane, et al., 2002). However, it also may require services to be offered on-site but not by live-in staff (Culhane, et al., 2002). Housing first emphasizes normal housing and clients’ choice (Carling, 1990; Culhane, et al., 2002; Livingston, Srebnik, King, & Gordon, 1992). Single apartments within a community that are linked with services and case management are seen to have a higher cost than emergency shelters, transitional housing, and other permanent housing models which are run and operated by mental health programs (Culhane, et al., 2002). However, they are shown to work better at improving the clients’ conditions than case management alone (Rosenheck, Kasprow, Frisman, & Liu-Mares, 2003). The National Institute of Mental Health defines supported housing as a housing approach that focuses on clients’ goals.
and preferences, uses an individualized and flexible rehabilitation process, and has strong emphasis on normal housing, work, and social networks (Ogilvie, 1997). Permanent supported housing was created to address integrating housing services, psychiatric services, substance abuse, income support, social support, and vocational/educational services (Cheng, Lin, Kasprow, & Rosenheck, 2007).

As mentioned earlier, housing first is a model of permanent supported housing. It was developed primarily for persons with long standing homelessness and mental illness (Casey, 2007; Pearson, Locke, Montgomery, & Buron, 2007). Housing first was developed to accommodate the hardest to house populations. The Interagency Council on the Homeless define chronically homeless persons as those disabled and continuously homeless for a year or longer, or having had at least 4 episodes of homelessness during the last 3 years (Livingston, et al., 1992; Nelson, Wiltshire, Hall, Peirson, & Walsh-Bowers, 1995; Pearson, et al., 2007). The first priority is to get the person off the street and into services. However, sometimes housing availability is limited. Whenever possible programs following a Housing First model will try to skip transitional housing and place the individual directly or nearly directly into permanent housing (Pearson, et al., 2007).

Housing first follows a low demand approach (Pearson, et al., 2007). Supportive services are offered but not required to remain in housing (Pearson, et al., 2007). Assertive outreach is often part of the program model (Pearson, et al., 2007). Whether the individual accepts services or continues to use drugs and alcohol, every effort is made to continue to offer case management and to hold housing for clients who experience brief absences from housing no matter the reason (Pearson, et al., 2007). One program to use the Housing First model was the Pathways to Housing program with New York State and
New York City in 1992. This was the original model of a Housing First program. The NYC Pathways program showed that a low demand model of housing coupled with permanent housing and services yielded high retention rates, even after 6 months (Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003).

Domains

According to conversations with Sam Tsemberis, the Housing First model can be broken down into major domains. These domains allow researchers and providers alike to determine what elements are parts of the model. The domains include housing choice and structure, separation of housing and services, service array, and program structure. The domain of housing choice and structure includes all aspects of the greater community in which the housing is located. It also includes elements meant to measure the amount of independence, privacy, and control that each client has over their own housing and services. The service array domain includes measures and criteria for services that are available either through the housing or in the community and the location in which they are provided. The separation of housing and services domain shows paths by which clients enter the housing first system along with the criteria to remain in the housing program. Lastly, the program structure domain deals primarily with the administrative and staff side of housing first. This domain includes concepts that deal with who is being served along with support, program orientation, and peer culture. Each domain addresses the major themes found within the housing first model.

Housing Choice & Structure
One of the primary focuses of housing first is on housing stability (Carling, 1990; Ridgway & Zipple, 1990). Within the model, stable housing is built on the idea that housing should be permanent in nature (Ridgway & Zipple, 1990; Tsemberis, 1999). Under this model housing should also be safe, secure, and decent to live in (Brown & Wheeler, 1990; Livingston, et al., 1992; Y.-L. Wong, Filoromo, & Tennille, 2007). The Housing First model suggests that housing be provided using scattered sights (Casey, 2007; Ridgway & Zipple, 1990; Y.-L. Wong, et al., 2007). Scatter sight housing had been seen to be more desired and beneficial to residents. In one study, residents in cluster-site housing dropped out at a higher rate than scattered-site housing (Y.-L. I. Wong, Poulin, Lee, Davis, & Hadley, 2008). Cluster site housing may have created more stress for the residents because of more disruptions from other residents (Y.-L. I. Wong, et al., 2008). In most studies, scatter site housing is defined as having no more than 10% of the total units in any one building (NYC) (Newman, Reschovsky, Kaneda, & Hendrick, 1994; Tsemberis, 1999).

Client choice is emphasized as an essential part of housing selection (Ridgway & Zipple, 1990; Rog & Randolph, 2002; Tsemberis & Asmussen, 1999). The program aims at protecting each resident’s autonomy and privacy (Y.-L. Wong, et al., 2007; Yeich, Mowbray, ByBee, & Cohen, 1994). Residences are seen as normal independent housing, integrated into the existing community, where the environment can be a tool used towards rehabilitation (Johnson & Rogers, 2009; Parkinson & Nelson, 2003; Y.-L. Wong, et al., 2007). To be consistent with the housing first model, there would be a de-emphasis on professional services and increased emphasis on natural supports that already exist within the community.
Also, in order for people to gain access to housing and to remain housed, the housing must be affordable. In some previous research, more affordable housing was correlated with fewer days admitted to hospitals per month (Brown, Ridgway, Anthony, & Rogers, 1991; Brown & Wheeler, 1990; Keck, 1990; Newman, et al., 1994). To determine affordability, most previous research has deferred to the HUD standard of 30% or less of the income of the tenant (Hatfield, 1992; Johnson & Rogers, 2009; Keck, 1990; Newman, et al., 1994). Housing must also include any additional special features that make it accommodating towards people with psychiatric disabilities (Parkinson & Nelson, 2003).

Elements of housing choice & structure have been tested in previous studies on housing first and supported housing. In the 5-year evaluation of the NYC pathways program, there was an 88% retention rate of persons placed in supported housing using the housing first model (Tsemberis & Eisenberg, 2000; Y.-L. I. Wong, et al., 2008).

In a study by (Hatfield, 1992), the availability and quality of housing accommodations had a direct impact on the ability of mental health clients to leave their family’s home. The better the quality and availability, the easier it was for them to move on their own and remain housed. This shows that tenure could be a factor of housing conditions as well as program characteristics.

Measures of access to housing first are missing from current literature. There is a need for recognized standards with which we can measure the ability to get into a housing first program and remain in a housing program. Each program may have different requirements for admissions criteria, treatment responsibilities, or levels of choice for the resident. However, in one article by (Tsemberis & Asmussen, 1999),
housing programs were deemed successful if participants were placed in housing as soon as it became available, no more than 15 days.

Separation of Housing & Services

Under the housing first model, services can be offered within the home or out in the community (Keck, 1990; Ridgway & Zipple, 1990; Rog & Randolph, 2002; Tsemberis & Asmussen, 1999; Y.-L. Wong, et al., 2007). However, they should be integrated into the community and not be an in-patient setting. Whatever the type of services provided, the model states that services are kept separate from housing where housing is not contingent on utilizing services or the resident’s progress (Livingston, et al., 1992; Pearson, et al., 2007; Siegel, et al., 2006; Witheridge, 1990). To remain consistent with the housing first model, the housing agency cannot also be the agency giving the services to the residents. Housing is owned, managed, and maintained by regular landlords out in the community. Services can be given by the program staff or other community organizations.

The entry requirements needed in order for homeless veterans to get housed are very important to their ability to be successful and remain housed. The housing first model calls for low demand housing with no dismissal policies (Carling, 1990; Hopper & Barrow, 2003; Siegel, et al., 2006; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000). Housing first is meant to be used with the hardest to house population of homeless persons with mental health and substance abuse problems. The housing needs to be reflective of the understanding that the residents might come up against hurdles in their recovery and need the stability of permanent housing. Residents might
not seek the services they need or may not disclose relapse issues if they feel their housing is in jeopardy.

The domain of separation of housing and services can be measured in various ways. Some tests look at how the residents are housed. Others look at the obstacles that keep the homeless from housing or make it difficult to stay housed once in a program. Still other research has looked at how the residents of homeless programs feel about their housing or the process by which they received housing.

The path by which residents enter housing programs may affect their housing outcomes. It has previously been seen that residents who entered housing from the streets were more likely to leave housing within 12 months of entry and more likely to have temporary absences from the housing first program (Pearson, et al., 2007). On the other hand, residents who entered housing first programs from shelters, jail, crisis houses, living with friends or psychiatric hospitals had higher housing stability over 12 months of residency (Pearson, et al., 2007).

Previous research has examined housing tenure for homeless persons diagnosed with mental health or substance abuse disorders. (Tsemberis, 1999) found in their study, that after 3 years, 84.2% of housing first participants remained housed. The comparison group without supports had 59.6% remaining housed after 2 years (Tsemberis, 1999). Supported housing led to much higher housing retention over a longer period of time than the group without supports. Similarly, (Tsemberis & Eisenberg, 2000) found that after 5 years, 88% of supported housing participants in NYC remained housed. Only 47% of the participants in the city’s residential treatment system remained housed during the same time period (Tsemberis & Eisenberg, 2000). In this project they found that housing
program characteristics were better predictors of housing retention than most other personal or clinical variables examined (Tsemberis & Eisenberg, 2000).

**Service Philosophy**

Housing first calls for services to be broad and flexible supports, individually tailored, responsive to clients’ needs, and time-unlimited (Fakhoury, Murray, Shepherd, & Priebe, 2002; Pearson, et al., 2007; Rog & Randolph, 2002; Siegel, et al., 2006). The housing first model suggests that services offer continued support for clients in formulating housing and support goals (Carling, 1990; Fakhoury, et al., 2002; Ridgway & Zipple, 1990). There services are chosen by clients in duration, intensity and are voluntary (Ridgway & Zipple, 1990; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000). All programs identified under the housing first model are called to focus all services on harm reduction (Pearson, et al., 2007; Ridgway & Zipple, 1990; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000; Y.-L. Wong, et al., 2007). Under the housing first model, clients are seen as normal people empowered by the program to regain control over their housing and services (Carling, 1990; Nelson, Hall, & Walsh-Bowers, 1997; Parkinson & Nelson, 2003; Tsemberis & Asmussen, 1999).

Only a few elements of the service philosophy domain have been tested in previous housing research. The elements of personal choice and control have seen the most testing in terms of outcomes and satisfaction. In an article by (Ogilvie, 1997) clients’ ratings on happiness and life satisfaction were positively correlated with greater choice and less influence by others. Such elements as satisfaction and level of choice can be measured using the Overall Choice and Empowerment scale (Siegel, et al., 2006).
Service Array

Some of the services included in housing first can be 24-7 crisis support, psychosocial services, employment/vocational skills, building social skills/social networks, money management, medication management and independent living skills (Kasprow, Rosenheck, Frisman, & DiLella, 2000; Keck, 1990; Rimmerman, Finn, Schnee, & Klein, 1992; Siegel, et al., 2006; Tsemberis & Asmussen, 1999; Yeich, et al., 1994). In order to help the residents become independent, service providers should be able to aid and enable clients to build and maintain support networks with family, friends, and community members (Hatfield, 1992; Y.-L. Wong, et al., 2007).

The domain of service array has been tested in various ways in previous research. Some research examined types of services, others tested delivery and gaps between services. Still, so much more is needed in order to determine what services are in demand and how to maximize the experience and benefits for the client. Research has shown that an overwhelming number of homeless people suffer from substance abuse problems and mental health issues. In previous studies, substance abuse was positively correlated with homelessness and housing instability (Dickey, et al., 1996; Goldfinger, et al., 1999; Hurlburt, Wood, & Hough, 1996; Tsemberis & Eisenberg, 2000).

Various types of services exist within housing first programs. They can be aimed at therapy, training/education, social networking, or even life skills. Services may impact clients in different ways. In a study by (Rimmerman, et al., 1992) psychosocial rehabilitation services were positively related to the outcome of symptomology, therapeutic goals, and social integration. In another study, social supports were seen to
have a direct buffering effect on the health and well-being of the client (Ogilvie, 1997). Increases in the number of social supports led to decreases in symptoms, and shortened illnesses as reported by clients (Ogilvie, 1997).

How clients feel about the services they are being offered or obtaining is also important to the success of their housing stability. In some studies, clients reported that the areas in which they wanted the most help were in dealing with emotional upsets, financial matters, and making friends (Keck, 1990; Livingston, et al., 1992; Yeich, et al., 1994). In a study covering the topic of service and evaluation, a modified version of the Working Alliance Inventory was used to evaluate services/service providers (Rosenheck, et al., 2003).

Community characteristics can have an influence over the number and types of services offered as well as the client’s ability to access existing services. In a study published by (Davies, Bromet, Schulz, Dunn, & Morgenstern, 1989), they found that residents had reductions in symptomology when they were associated with homes that were centrally located within their service region and when the services fostered respect for residents, avoided overprotecting, and integrated community resources for social and recreational activities (Davies, et al., 1989). Residents located in housing that is centrally located may have easier access to services and transportation within the community.

HUD previously performed an evaluation of a program using a Housing First model. They reported that within the Housing First program housing, clients experienced month to month changes in levels of impairment but over 12 months no clear trends developed in terms of changes in psychiatric systems or drug and alcohol use (Pearson, et al., 2007). They also found improvements in financial situations of the residents (Pearson,
et al., 2007). It was noted that income was increased and residents managed their money more successfully, however, this was due to increases in entitlements and not employment (Pearson, et al., 2007). Housing stability was the only real outcome the Housing First model shown in this report (Pearson, et al., 2007).

**Program Structure**

Within the housing first model, program structure can be measured in a variety of ways. Some measures explore the frequency of services; others address the variety of services or client satisfaction. One study determined that clients should meet twice a month with their case manager for involvement with the money management program (Tsemberis & Asmussen, 1999). Additionally, satisfaction of clients with services was measured using questions aimed at determining the frequency of contact, if the coordinator was helpful (case manager helpfulness), the relationship between client and staff, and overall satisfaction with the housing program (Tsemberis, 1999).

The organization of a housing program and its staff can influence a client’s experiences and maybe even their success in remaining housed. Although the resident may never be fully aware of how their program is organized, the influence of program factors on staff and their ability to do their jobs can be beneficial or detrimental to the client. A housing first program should operate with the notion of developing the most facilitative environment rather than a least restrictive environment (McCarthy & Nelson, 1991; Ridgway & Zipple, 1990; Shepherd, 1995). All services should emphasize a practical orientation (Ridgway & Zipple, 1990). They should also adhere to a harm reduction model.
Interactions between housing first staff and clients are very important. These interactions have been shown to influence the interpersonal environment of the resident which in turn affects the symptoms and behaviors of the residents (Snyder, Wallace, Moe, & Liberman, 1994). Previous studies have measured the staff/resident interactions using the Quality of Interactions Schedule (QUIS) (Dean, Proundfoot, & Lindesay, 1993) or the Hospital-Hostel Practices Profile (HHPP).

In order to allow housing first staff to be as effective as possible, it has been suggested that a case manager to client ratio of 1:25 is ideal (Rosenheck, et al., 2003). However, other researchers argue for even smaller caseloads where case managers would have case loads of 6-7 clients at a time (Brown & Wheeler, 1990). Depending on the program and treatments used, some clients may need more attention and assistance than others. Most researchers argue in support of allowing case managers enough time to meet the needs of their clients no matter the level of intensity needed. Therefore, small caseloads and flexible staff schedules might be very beneficial to the clients and the overall program success (Brown & Wheeler, 1990). Along the same lines program capacity is a much debated topic with no real consensus (Y.-L. I. Wong, et al., 2006).

Still others argue the importance of who is allowed to staff housing programs. The concept of peer support is highly advertized. Some research has set a standard of maintaining that 50% of staff should be people in recovery from homelessness, substance abuse, or psychiatric disability (Tsemberis & Asmussen, 1999). Having staff that lived through similar experiences will help develop a peer culture with the residents, staff and providers. Shared personal experiences can be an asset in terms of the peer support staff’s
ability to relate to the veterans and be seen as a friend and not a treatment provider (Brown & Wheeler, 1990; Carling, 1990; Tsemberis & Asmussen, 1999).

Implications

Throughout the last few years, many research projects have begun to look at the implications and future direction of supported housing and the housing first model. Some projects have even begun to look at the overall effects of supported housing on other services and programs in the community. The results have been mixed but encouraging. Previous research has shown that supported housing programs using a housing first model have led to a reduction in inappropriate use of medical and psychiatric inpatient care by homeless veterans (Culhane, et al., 2002; Parkinson & Nelson, 2003). These types of programs have also been shown to influence a reduction in overall cost of services to the community (Culhane, et al., 2002). With less time in hospitals and in-patient facilities, there is a lower cost to the community. Since clients are getting continuous care and engagement, they may be able to avoid severe symptoms and breakdowns that otherwise may have eventually led to costly commitments and stays in hospitals. Some research even found that the provision of rental assistance alone was as effective at keeping people from becoming homeless as rental assistance and case management (Culhane, et al., 2002; Wood, Hurlburt, Hough, & Hofstetter, 1998). However, rental assistance alone could reach 16 times as many households with the same amount of money, thus further showing the cost effectiveness of housing first (Culhane, et al., 2002; Wood, et al., 1998).
Additionally, there have been many researchers who argue that housing itself is enough of a benefit to the homeless to justify the housing first program and any cost. Although, some research has shown that tenure in housing did not differ by housing type when comparing community residences and supported housing programs (Siegel, et al., 2006). (Siegel, et al., 2006) found that at 18 months 31% of supported housing residents had left their program where as 63% of those staying in community residences had left their housing. Residents in supported housing programs reported higher satisfaction with their housing on measures of autonomy and economic viability, but also reported stronger feelings of isolation (Siegel, et al., 2006). Although it is important to note that those residents in supported housing programs had significantly less use of crisis services than the ones in community residences (Siegel, et al., 2006).

Housing First and Homeless Veterans

As discussed throughout this paper, supported housing interventions have been shown to be effective among homeless Veterans. A recent study by O’Connell, Kasprow, & Rosenheck (2009) provides excellent support for the use of direct placement supported housing as opposed to multistage models of supported housing to improve clinical outcomes and reduce health service utilization and costs among homeless Veterans. This study used observational data to compare homeless Veterans who were placed directly into supported housing \((n = 139)\) versus those who received services in residential treatment prior to housing \((n = 183)\) as part of the HUD-VASH program (Rosenheck, Kasprow, Frisman, Liu-Mares, Dilella, Dausey, et al.2002; Rosenheck et al., 2003). After controlling for potentially confounding baseline differences (e.g., level of substance use), results from this study indicated that while Veterans in both conditions experienced
similar overall levels of housing, quality of life, and clinical outcomes, Veterans in the multistage model of supported housing had health care costs that averaged more than three times those of direct placement participants during the initial period of residential care. Further, the health care costs for Veterans in the multistage model of supported housing were $9,000 dollars more on average for the two years after baseline when compared to Veterans placed directly into supported housing.

Other research on homeless veterans has shown that women veterans were more likely than men veterans to be housed at a 1 year follow-up (Kasprow, et al., 2000). Also, participation in the Section 8 program correlated with better quality of housing, more affordable housing, reduction in number of days hospitalized and improved residential stability (Kasprow, et al., 2000).

Limitations

Within housing first research, as within all homeless research, there are some limitations to the studies, data, and interpretations. The most glaring limitation in housing first literature is in the use of the term “housing first” without adhering to any clear guidelines or model fidelity. Programs may label themselves as housing first but may not share the same objectives as other programs. Some programs may want to end homelessness rather than provide choice and optimization of services and supports to enable community integration and enhance self-efficacy.

Other limitations in housing first success can come from the housing itself. Placing residents in housing where they can be fully integrated into the community usually means low income housing which may be unsafe, un-kept, or put them at risk of victimization from neighbors. Even scatter-site dwellings have been shown to still end
up in low-income neighborhoods (Tsemberis & Eisenberg, 2000). Residents may be able to blend in better in these areas but also may be exposed to more risk. Other limitations may come in the form of the availability of affordable housing (Ogilvie, 1997; Ridgway & Zipple, 1990) or landlords wanting to rent to normal people instead of those in special housing programs (Ogilvie, 1997).

Some main barriers to housing first programs come in the form of financing and budgets. Housing first programs can carry a heavy cost and not all locations are prepared or willing to cover the costs. Some housing programs may need to change the parameters of their program in a particular area in order to get funding or have housing available to residents.

A final limitation to housing first programs is in identifying those persons who need it. Restrictive admissions policies at emergency shelters and other temporary and permanent supported housing programs don’t allow persons with mental illness, co-occurring disorders, or those who may be harmful to themselves or others to get off of the streets. Housing first programs aim at helping the chronically homeless and those who have previously been unable to be housed. However, if clients are unable to link with services or programs then it may be impossible for any outreach efforts to identify them. If they can’t be recognized as a vulnerable population, then they can’t be linked with housing (Y.-L. I. Wong, et al., 2006).
References


