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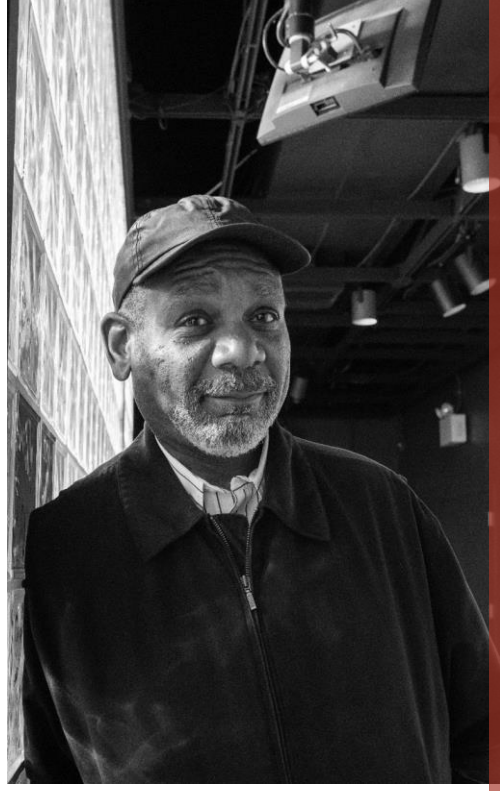
Housing First: How & Why It Works



Andrew Spiers, LSW & Khalil Martin, LSW

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Housekeeping

- We invite you to be present with us!
  - Stay for the duration of the training
  - Participate in discussion
- Questions and comments welcome throughout
- Sign-in and sign-out
- QR codes
- Course evaluation is required to receive a certificate
- Certificates will be distributed via email next week

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Today's Agenda

- ✓ Housing First vs. housing first
- ✓ 5 key principles vs. fidelity measures
- ✓ *Housing Choice and Structure*
- ✓ *Separation of Housing and Services*
- ✓ *Service Philosophy*
- ✓ *Service Array*
- ✓ *Program Structure*
- ✓ Q&A

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Learning Objectives

- Differentiate between a high fidelity Housing First model and a low-barrier approach to housing.
- Assess your agency's current fidelity to the Housing First model.
- Identify three ways to move your current service provision closer to a high fidelity Housing First model.

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Checking In…

By show of hands, tell us how you're feeling after yesterday…

- I learned a lot and I'm excited to dive back in today!
- That was a lot of info and I'm still wrestling with some ideas.
- I feel overwhelmed! I'm not sure I can keep up with all of this!

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Fidelity vs. Approach

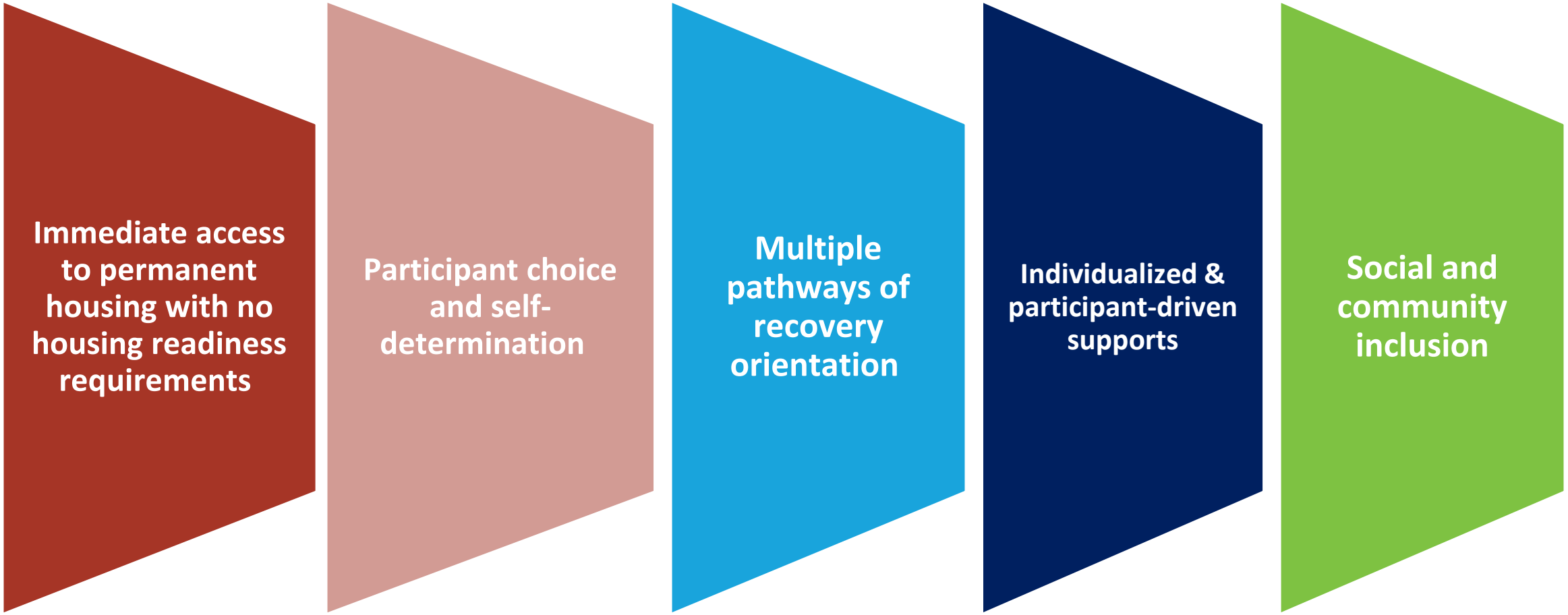
- A low-barrier housing approach.
- Relies on the 5 key principles.
- Seeks to meet someone's basic needs first, then provide wrap-around support services.

housing first

- An evidence-based program model.
- 38 distinct fidelity measures.
- Utilizes ACT/ICM teams.
- Permanent supportive housing.

Housing First

Key Principles of Housing First



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Fidelity Measures

- Without the five key principles, it's **not** Housing First

- High fidelity Housing First actually requires adherence to **38** individual principles in **5** categories
  - *Housing Choice and Structure*
  - *Separation of Housing and Services*
  - *Service Philosophy*
  - *Service Array*
  - *Program Structure*

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Housing Choice and Structure

1.1. Program participants have much choice in the location and other features of their housing.

- Apartment viewing
  - Typically 3 apartments
  - Where?
  - Close to/far away from
- Furniture shopping
  - Furniture is a **necessity**
  - Philadelphia Furniture Bank
- Other housewares

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1.2. Program helps participants move into the units of their choosing. (under 6 weeks upon securing a housing subsidy)

- Be up-front and realistic about move-in timeline
- Master-leasing hugely helpful for this
  - If not, maintaining strong relationships with landlords who have units and will rent to your population is **vital**
- Maintain vacancy rate of 8%
  - Also beneficial for emergency relocations
- Access to emergency shelter in interim

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1.3. Housing tenure is assumed to be permanent, with no actual or expected time limits, other than those defined under a standard lease or occupancy agreement.

- *Not* rapid re-housing
  - Putting individuals with PSH-level needs in RRH rarely works
- Housing and supportive services are available for as long as the individual needs
  - Sometimes this means through end-of-life
- Leases between Pathways and landlord are renewed yearly, as are “Use & Occupancy Agreements” with participants

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1.4. Program participants pay a reasonable amount of their income (less than 30%) for housing costs.

- Participants asked for 30% program contribution
  - Increases investment in maintaining the unit
  - No contribution if no income
- Utility allotment for each month
  - Ex. $65/mth for electric, $30/mth for gas
  - Participants cover the cost of overages
  - Requires some life skills coaching!

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1.5. Program participants live in scattered-site private market housing which is otherwise available to people without psychiatric or other disabilities.

- Centers choice
- Prevents NIMBYism
- No more than 20% of units
- Rapid start up & ease of relocation
- Normative context for neighborly behavior

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1.6. Program participants are not expected to share any living areas with other tenants

- No shared housing or roommates
  - Acuity of mental illness and substance use makes this challenging
- Single adults
  - Piloting work with some couples on our SUD-focused teams
- Work to reunite parents with children, if desired
  - Housing First and harm reduction work very challenging with kids

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Low Barrier-Approach

Common variations from high fidelity model—

- *Often single site/congregate setting*
- *May include shared housing*
- *May contract out property management*
- *Move-in timeline not as quick*
- *Case managers tasked with finding units*
- *Case managers liaise with landlords*
- *No budget for furniture or housewares*

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Reassess!

- Did you change any of your scores?
- Are you closer or farther from fidelity?
- Why?
- What changes could you make to your program or service provision to get you closer to fidelity?

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Separation of Housing and Services

2.7. Program Participants are not required to demonstrate housing readiness to gain access to housing units.

- Everyone is housing ready!
- No sobriety mandates
- No requirements for engaging in mental health treatment
- Be aware of what tasks participants are asked to complete independently, this can enforce housing “readiness” inadvertently

Immediate access to permanent housing with no housing readiness requirements

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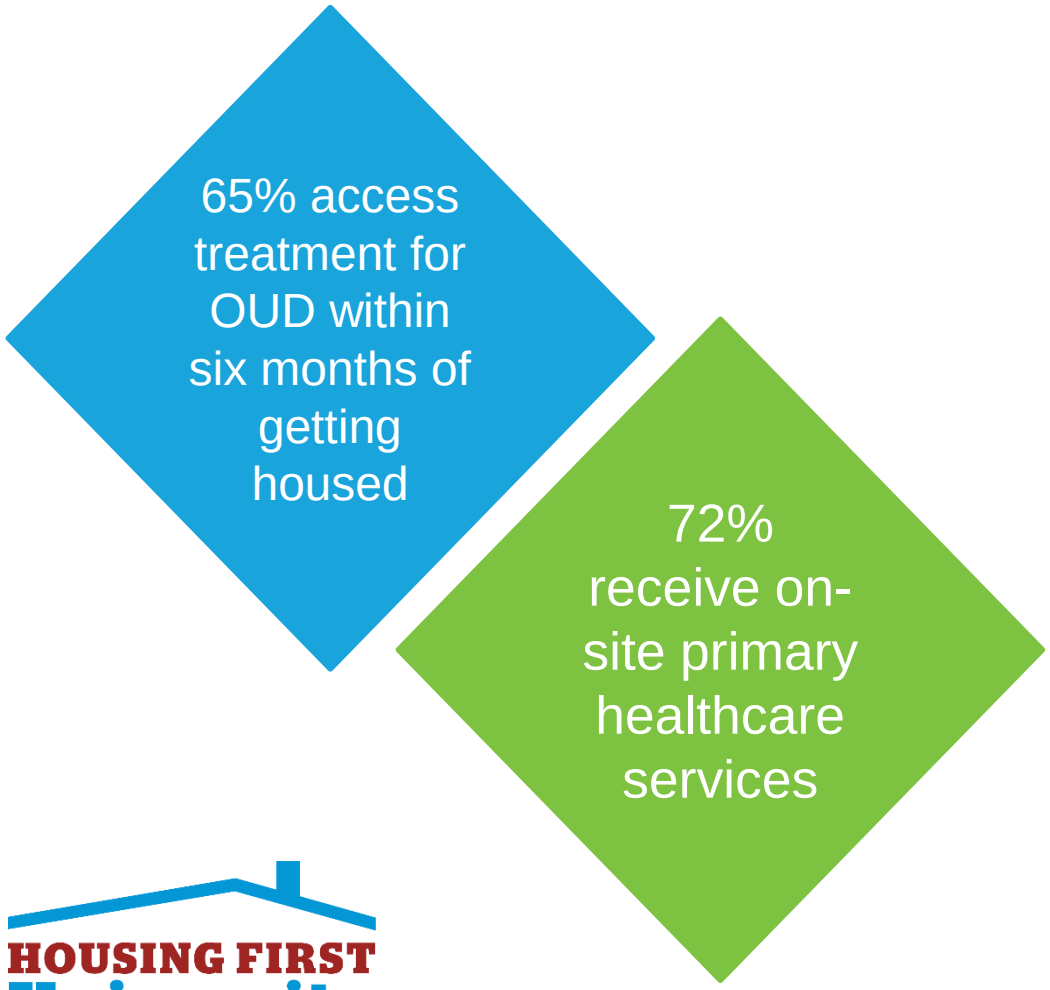
2.8. Continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.



- Our primary goal is to keep the participant housed
- We must visit participants in the home, everything else is optional
- Redefining “success”
- No *requirements* to engage in medical or behavioral health care, community inclusion, supportive employment, etc.

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The Role of Harm Reduction

- Housing *is* harm reduction
- Focus on the reduction of specific behaviors or patterns
- Set up systems to reduce risk
- Provide supportive monitoring for safety maintenance
- Do not expect overnight miracles
- Meet them where they're at but don't leave them there
- Functional, not beautiful
- Highly individualized

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Accountability without Termination

Lease violations— *too much noise, too many visitors, non-payment of rent, illegal activity, etc.*

- May be relocated
- Ongoing clinical conversations to prevent recurrence
- If evicted, short term housing provided until rehousing is possible and another unit is identified
- Staff help with relocation

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2.9. Program participants have legal rights to the unit, with no special provisions added to the lease or occupancy agreement.

- In a Master-leasing situation, program may be the “lease-holder,” but unit belongs to the participant
- “Use and Occupancy” agreement mirrors a standard lease

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2.10. Program offers participants who have lost their housing, access to a new housing unit with no standardized limits on the number of relocations.

- Relocation considered routine with 20-30% losing first unit
  - Relocation to a 3rd apartment is roughly 10-15%
- Program assists with relocation
- No "Larry rule" policies
- Program does not perform lock-outs
- This doesn't mean "anything goes"

Our work is often **habilitative,** rather than *rehabilitative.* If participants have never lived independently before, the learning curve for being a good tenant is **significant!**

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2.11. Program participants continue receiving program services even if they lose housing.

- "Service only"
  - Can be temporary or permanent based on circumstances
- Assist participants with identifying alternative housing
  - Safe haven, shelter, SRO, sober living, etc.
- Participants continue to receive services while incarcerated, receiving inpatient medical or behavioral health services, etc.
  - Exception for nursing home facilities

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2.12. Program staff are not located at participants' residences and are mobile, with the ability to deliver services in locations of participants' choosing.

- Housing First is a *community* mental health program
- All services are mobile (case mgmt, nursing, primary care, psychiatry, etc.)
- This centers client choice and builds comfort and rapport

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Low Barrier-Approach

Common variations from high fidelity model—

- *May prioritize folks who demonstrate greater housing "readiness"*
- *Expect participants to be moving towards sobriety eventually*
- *Define "success" narrowly, based on provider goals (not participant goals)*
- *See eviction as a failure and may be hesitant to rehouse*
- *Discharge folks in need of "higher level of care"*
- *Office-based services, not mobile*

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Service Philosophy

3.13. Program participants choose the type, sequence, and intensity of services on an ongoing basis.

- Radical acceptance of the participant's point of view
- Participants are allowed to change their minds
- We prioritize the participant's goals and timeline
- Eventually, participants will usually make their way around to addressing the tasks we would've hoped for
- Sometimes housing isn't goal #1

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3.14. Program participants with psychiatric disabilities are not required to take medication or participate in formal treatment activities.

- Participants need to undergo a psychiatric evaluation in order to be “authorized” for treatment
- This can be as simple as an informal conversation with one of our psychiatrists on a street corner
- Further services are offered (consistently), but not required

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3.15. Program participants with substance use disorders are not required to participate in formal treatment activities.

- Treatment is always an option, never a requirement
- We don’t view harm reduction as a gentle on-ramp to abstinence

3.16. Program utilizes a harm-reduction approach to substance use (it does not require abstinence and works to reduce the negative consequences of use).

- Narcan/overdose response training for all staff, participants, community partners
- Education on safer use practices

3.17. Staff consistently utilize principles of motivational interviewing in daily practice.

- Learning about our participants *from* our participants
- Delivering interventions appropriate to one's stage of change

3.18. Program uses an array of techniques to engage participants who are difficult to engage.

- If they don't want what you're offering, offer what they want
- Get creative!

3.19. Program does not engage in coercive activities to promote engagement or treatment adherence among participants.

- We only offer services participants request
- Non-punitive communication about potential consequences of actions
- Housing status is not threatened during challenging times
- Participants become better at decision-making by getting to practice making decisions
- *Coercing* someone into change doesn't lead to lasting results

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3.20. Program conducts person-centered treatment planning.

- Our assessments and treatment plans are designed to be completed by the participant with the assistance of staff
- Personal Goal Plan
- Overdose Prevention Plan
- Personal Safety Plan
- Strengths & Needs Assessment
- Environmental Matrix Assessment

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Treatment Planning

- All assessment paperwork completed by the client with *assistance* from staff
  - Learn about your participants *from* your participants
  - Promotes buy in
  - Clearly outlines the role of the individual, staff, and community
- Participants don't want to be "saved" by us

We don't do things *for* people.
We do things *with* them,
so that eventually they can
do them independently.

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3.21. Program systematically deliver specific interventions to address a broad range of life areas.

- Permanent supportive housing
- Specialty case management via ACT/ICM
- Integrated care
- Community inclusion
- Supported employment
- Health services navigation
- Alumni group

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3.22. Program increases, and is a strong advocate for, participants' self-determination and independence in day-to-day activities.

- We don't do things for people. We do things with them, so that eventually they can do them independently.
  - Cooking
  - Cleaning
  - Grocery shopping
  - Transportation
  - Financial management

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Low Barrier-Approach

Common variations from high fidelity model—

- *"But they don't want housing"*
- *Adherence to "rules" > meeting client needs*
- *Believe treatment for mental health or SUD is needed for all*
- *Program rules and regulations promote abstinence*
- *Expect linear, regular "progress"*
- *Do not address social or recreational needs*

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Service Array

4.23. Program offers services to help participants maintain housing, including assistance with subsidies, utility setup, neighborhood orientation, landlord relations, property management, budgeting, and shopping.

- Program manages subsidies
- Master-leasing handles apartment leasing, utilities, landlord relationships, & property management
- Peer specialists and other team members assist with identifying community resources, shopping, and budgeting
- Representative payeeship offered

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4.24. Psychiatric services are provided directly by the program.

- Two staff psychiatrists
- One works with MH-focused teams
  One works with SUD-focused teams

4.27. Nursing services are provided directly by the program.

- Registered nurse on each clinical team
- *Staffing shortages*
  Use of LPNs
  Technology

4.25. Integrated, stage-wise substance use treatment is provided directly by the program.

- Collaboration with Project HOME & Prevention Point
- Center of Opioid Excellence (COE) designation
- Low-threshold, onsite MOUD treatment
  - Same Day Entry
  - Home Induction
  - Harm Reduction Approach
  - Non-Traditional Settings
  - Flexible Programming
  - Inclusive of peer supports

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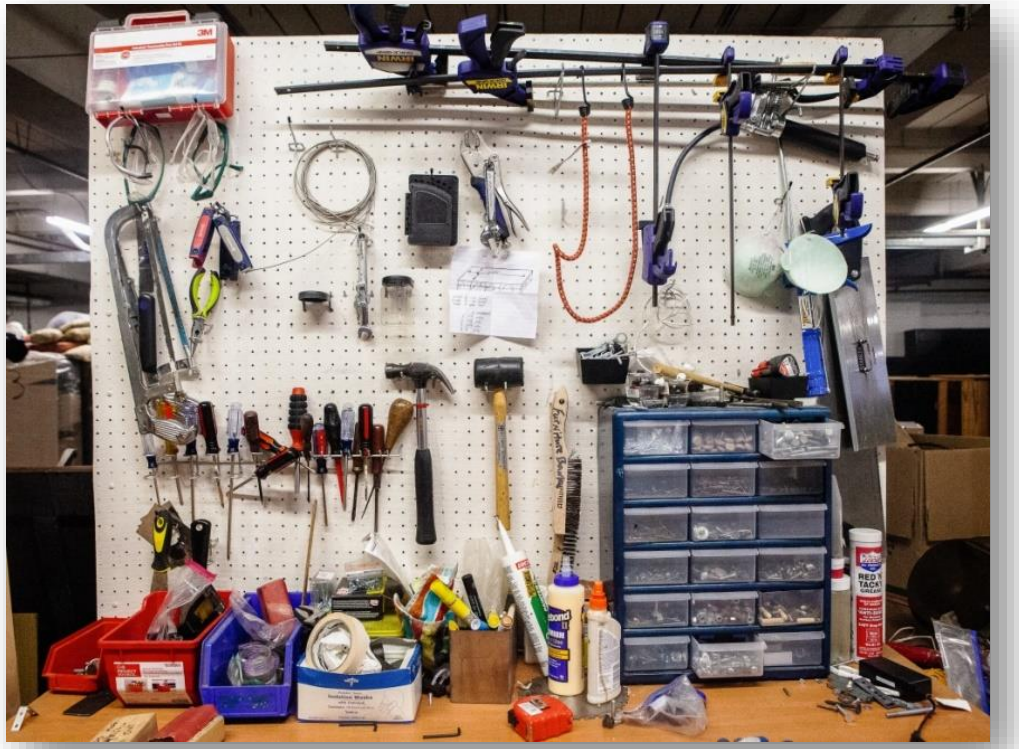
4.26. Supported employment services are provided directly by the program.



- Assistance with seeking, gaining, and keeping employment
- Employment Liaison on each team
- Vocational Specialist
- Monthly employment workshops
- Work First initiatives

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4.28. Services supporting social integration are provided directly by the program.

- Restaurant club
- YMCA
- 12-step/mutual aid groups
- Gardening club
- Hiking club
- Events calendar
- Baseball games
- Flea market trips

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4.29. Program responds to psychiatric or other crises twenty-four hours a day by phone and links participants to emergency services as necessary.

- Clinical team members rotate on-call support
- Staff respond to after-hours emergencies within 15 minutes via telephone or 2 hours if needed in person

4.30. Program is involved in inpatient treatment admissions and works with inpatient staff to ensure proper discharge.

- Support with accessing crisis or inpatient/outpatient MH support as needed
- Substance Use Specialists facilitate admissions to D&A treatment

Low Barrier-Approach

Common variations from high fidelity model—

- *Rely on community partners for everything outside of case management*
- *No in-house nursing services*
- *No in-house substance use treatment services*
- *Psychiatrists not harm-reduction oriented*
- *External supported employment services*
- *Little to no community inclusion efforts*
- *No emergency on-call supports*

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Program Structure

5.31. Program gives priority enrollment to individuals with multiple obstacles to housing stability.

- 111 status
  SPMI
  SUD
- Screen people “in,” not screen people “out”

5.33. Program has a minimum threshold of contact with participants to ensure safety and well-being.

- 1x/week per model
- 1x/month per funder

5.32. Program consistently maintains a low participant staff ratio (10:1) excluding the psychiatrist and administrative support.

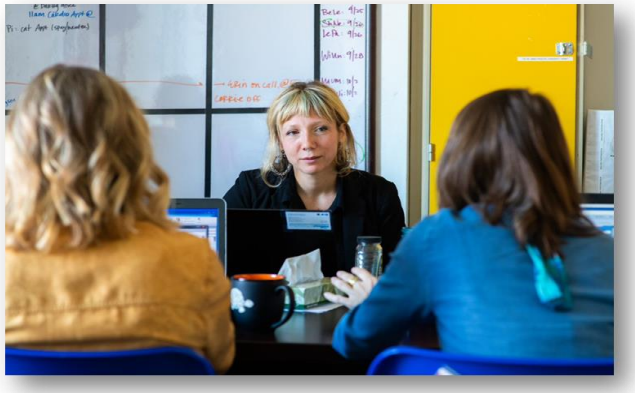
5.34. Program staff function as a multidisciplinary team; clinicians know and work with all program participants.

5.37. Program has a staff member with professional status on team who meets local standards for certification as a peer specialist or meets specified qualifications.

5.35. Program staff meet frequently to plan and review services for each program participant.

Master-list meeting,
Integrated care meeting,
Relocation meeting

Clinical team meeting,
Case consultations



5.36. Program uses a daily organizational meeting to conduct a brief, clinically relevant review of all participants and contacts in past twenty-four hours, and to develop a daily staff schedule.

Morning rounds

M-F

9-10 am

5.38. Program offers participants opportunities for representation and input in program operations and policies.

- Tenant's meeting
- Annual participant satisfaction surveys
- MOUD program design
- Participant advocate program
  - Philadelphia City Council
  - SAMHSA HHS Region 3 Opioid TaskForce Town Hall
  - National conferences

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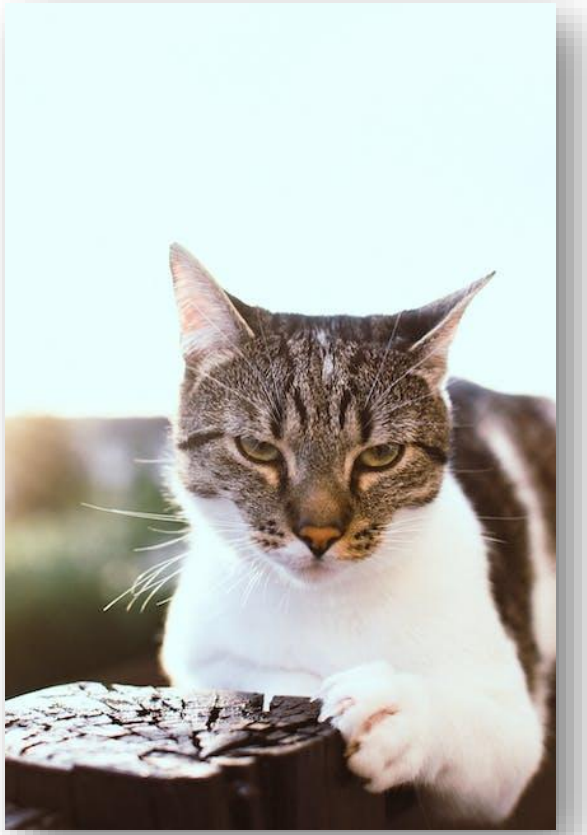
Low Barrier-Approach

Common variations from high fidelity model—

- *Screening people out of services*
- *High levels of need but low levels of contact*
- *No shared caseloads*
- *No interdisciplinary team members*
- *Significantly higher staff to client ratio*
- *Infrequent communication regarding caseload*
- *Little to no client input in program design or review*



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Moving On

Discharge

- Success looks different for every participant
- Based on their goals, not ours
- Services are time-unlimited
- Step-down team
- Graduation is possible!

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Alumni Association

- Level even lower than Team 6 BCM (Discharge from services)
- Option for participants to graduate if they choose
- Network of graduates to facilitate transition and maintain connection
- Opens flow serves more people in need

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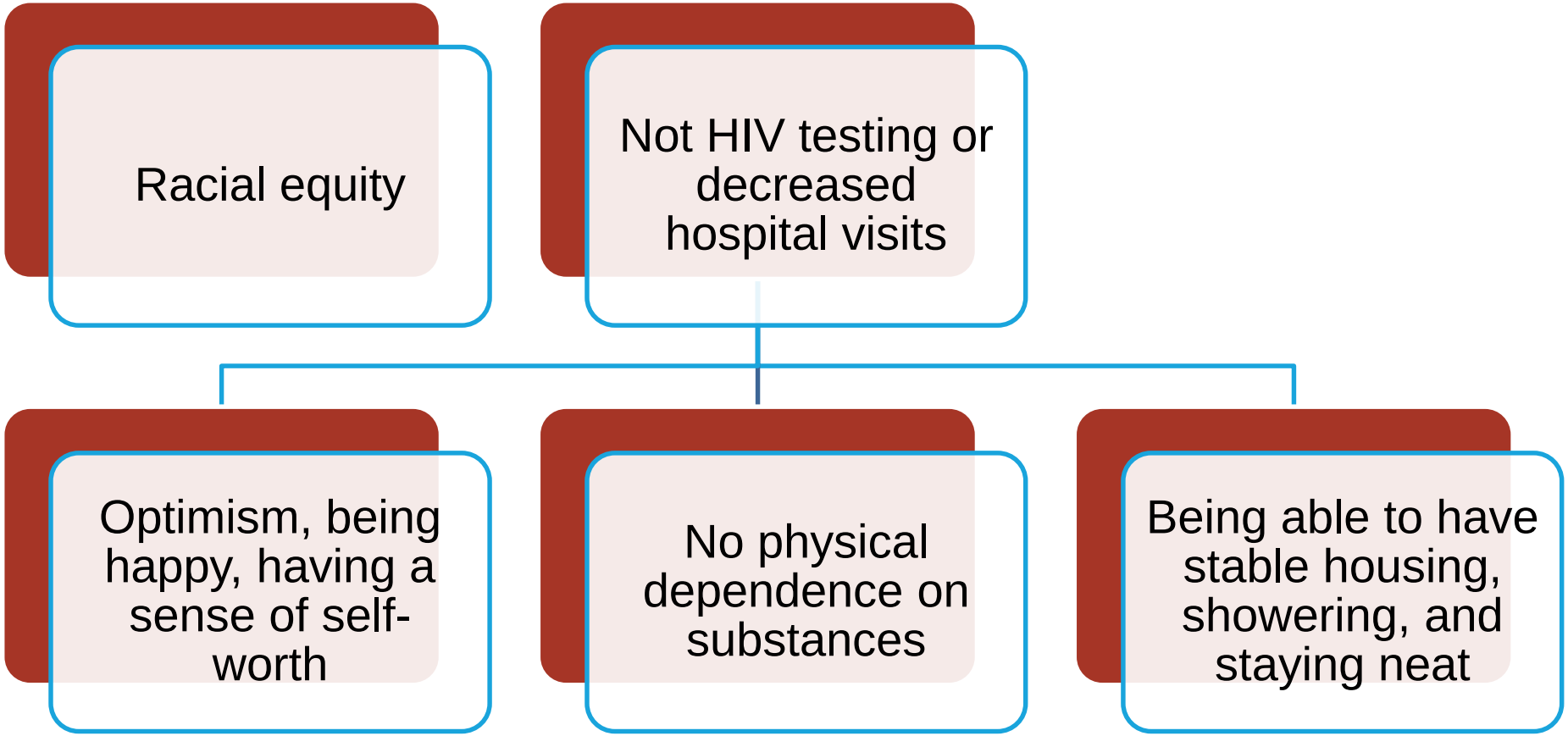
Measuring Success



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