Housing First
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WORSHOP Q & A
PROGRAM PRINCIPLES (5)

1. Consumer choice
2. Separation of housing and services
3. Services array must match needs
4. Recovery focused practice
5. Community Integration/Social Inclusion
Service Choice?

"I'm sorry. What other options are there?"

Staff: “They don’t have to be here.”
It’s all about Housing & Choice”

Participants can choose the housing they want regardless of whether they are actively using.”

“Participants can choose to be clean and sober and they’ll get an apartment. Or they can choose to continue using and we’ll still give them housing in a room & board”
Who needs to look at it from whose perspective?

**Low choice**

"...what we're really saying is, 'How do I see something from [the client’s] perspective to get their buy-in and reframe it?' That's all it is - is reframing it in a way that's digestible and palatable for [the client]. And so, yeah it's manipulation, yes, but we believe that we're doing it with the best intentions."

**High choice**

"I spend a lot of time helping [staff] look at the perspective of the [client], and then helping [staff] move that way instead of what we think is the best thing for them..."
Choice in housing

Client participation;

Selection defined:

housing market

Availability

Benefits, etc.
Choice & Self-Determination

**Low:** Little talk about participant choice; do not use choice as a framework or actively subvert choice

**Medium:** Acknowledge choice, but primarily as “negative choice”
- Example: Clients have the choice to not participate in services or behavior change

**High:** Positive choice and creating opportunities
- “We wanted to give them choices about the areas that they live in. But we developed [another] apartment program because clients said, ‘OK, we want more choice, I want more choice. “
MATCHING SERVICE NEEDS
Community based, responsive, and flexible

**HIGH NEED**

**ACT (ACT-LIKE)**
Multidisciplinary team and provides direct support and treatment

Case load 1 to 10 or 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

**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
Matching Services to Client Needs

“Whatever it takes”

Most valuable service may not be what is defined by the Medical service codes
Important TO GO Beyond Services

What is important to a person includes those things in life which help us all to be satisfied, comforted, and content.

It includes:

- Being in a relationship
- Status and control (money and job)
- Things to do and places to go
- Rituals or routines/places of worship
- Comfortable pace of life
- Things to have
- People to see and places to go that give us joy
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

[reduce magnitude, impact, frequency, quantity, any small step is a step in the right direction]

Also includes substitution of positive behaviors or practices for negative ones
## Decisional Balance: Having open and honest conversation

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Benefits</th>
<th>Costs</th>
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</table>
| 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* |
Harm Reduction: Passive acceptance vs. Active Support

just try not to give up on them, and I show ’em that, you know, when they’re ready that, you know, we’re here to help you as much as we can.

• Waiting for readiness for abstinence; reliance on referrals to mainstream substance use treatment if client willing to accept

when I do a little digging, the [clients often] don’t actually have any kind of harm reduction tools or strategies. So, it’s really implementing what it means to implement harm reduction strategies to reduce the harm. And that’s where the rubber meets the road....for one person, he’s a poly-substance user. So he drinks and does [other illicit substances]. And it was really looking at what’s the most problematic for him. And the most problematic was the drinking. The drinking leads to a lot of frenzied encounters and a lot of hospitalizations. We’re going to talk about the other drugs, but that’s actually what we’re going to focus on is the drinking. What are the ways we can minimize the problems with the drinking?

• Supporting clients to identify problematic use and develop strategies to reduce harm
Balancing client initiative and provider responsibility

Restrictive / Overprotective

Laissez-Faire
Local Policies & Staff Values: Framing of Program Goal

**Low recovery orientation**
"Our main goal is really to keep them from going to jail and from getting back in the hospital."

**High recovery orientation**
“...people are people. We’re here to help them in their quality of life and to be what they want to be.”

- Even if the system is focused on lowering costly utilization of services, recovery-oriented programs manage to keep the focus on the individual client, their goals, and quality of life.
Team Approach

“everybody’s responsible for everybody”

• Shared sense of responsibility
• Shared sense of mutual support for each other
• Communication
• Team meetings
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
Multi-Level Influences on Programs

Environment / System
- Local Policies Regarding Funding For Services
- Local & National Qualifications for Housing Subsidies
- Local housing & availability
- Local culture
- Clients’ Access to Social Welfare and other benefits
- Availability of Other Community-Based Support

Organization
- Services
- Resources
- Training
- Values

Client Needs

HF Program
Fidelity Site Visit by External Team

1) Before visit: collect basic info
   ◦ Types of housing, how long to get into housing; staffing pattern;
   ◦ % participants relocated; % discharged.

DAY OF VISIT

2) Team meeting observation
3) Individual interviews with staff
4) Focus group with program participants
5) Chart review (random selection)
   Optional: home visits
6) Fidelity Team Exit Summary/Debrief

Multiple sources of data
Team Self-Assessment of Program Fidelity

Self-assessment measure

- Developed by St(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
Research on Fidelity

Higher program fidelity is associated with:

- Increased housing stability
- Increased quality of life
- Decreased drug/alcohol use
- Reduced use of acute care and emergency services

(Goering et. al in Psych Services, 2015); Gilmer et al. (2010) FSP program fidelity in Archives of General Psychiatry, 67, 645-652
Thank You!

Questions/Comments?

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