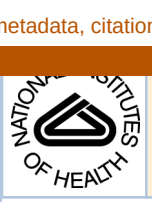

Published in final edited form as:
J Behav Health Serv Res. 2013 April ; 40(2): 169–179. doi:10.1007/s11414-012-9312-0.

Understanding the Critical Ingredients for Facilitating Consumer Change in Housing First Programming: A Case Study Approach

Dennis P. Watson, PhD,
Department of Public Health, IUPUI, 714 N. Senate Ave., Indianapolis, IN 46202

Dana E. Wagner, MA, and
Center for Urban Research and Learning, Loyola University Chicago, 1032 W. Sheridan Rd., Chicago, IL 60660, (312)915-7760, dwagne2@luc.edu

Michael Rivers, MA
Center for Urban Research and Learning, Loyola University Chicago, 1032 W. Sheridan Rd., Chicago, IL 60660, (312)915-7760, Rivers747@hotmail.com

Abstract

Housing First is a form of permanent supportive housing for chronically homeless consumers with mental health and substance abuse issues. In light of the model's growing popularity and wide diffusion, researchers and policy makers have identified a need to better understand its critical ingredients and the processes through which they affect consumer outcomes. Researchers used a bottom-up approach to understand the critical ingredients of Housing First within community-based programs. Interviews and focus groups were conducted with 60 informants (staff and consumers) across 4 "successful" Housing First programs. Qualitative analysis demonstrated six program ingredients to be essential: (1) a low-threshold admissions policy, (2) harm reduction, (3) eviction prevention, (4) reduced service requirements, (5) separation of housing and services, and (6) consumer education.

Keywords

dual diagnosis; housing; homelessness; implementation; supportive services; qualitative

The Housing First model (HFM) was developed as a form of permanent supportive housing for individuals who are chronically homeless and who have been dually diagnosed with a serious mental illness (SMI) and substance use disorder. This approach to housing is unique because it does not demand abstinence/sobriety, medication compliance, or a significant level of engagement in services. This is in contrast to the "Treatment First" approach followed by the majority of housing programs.[1] The HFM has been demonstrated to lead to a number of positive outcomes for consumers, including high housing retention rates,[2,3] fewer hospitalizations,[4] higher perceived choice in services,[5,6] reduced substance use and abuse,[7] and reduced involvement in criminal activity.[8]

Promising results from initial research on the HFM have placed it at the center of federal and local policies aimed at complete elimination of chronic homelessness.[9,10] An eleven percent drop in chronic homelessness between 2007 and 2010 has been largely explained by

Please address all correspondence to Dennis P. Watson. (317)274-3245, dpwatson@iupui.edu.

Conflicts of Interest
The authors have no conflicts of interest to declare.

the national diffusion of the HFM.[11] However, the lack of clear guidelines for replication of the model has led to significant departures in its implementation.[12-14] This paper describes the critical ingredients of the HFM as identified through a qualitative comparison of four Housing First programs. A better understanding of the critical ingredients of the HFM is an important next step in the development of instruments that can accurately measure the fidelity of HFM implementation.

Housing First versus Traditional Treatment First Approaches

The HFM was first developed in the early 1990s by Pathways to Housing Inc. (hereafter known as Pathways) in New York City as a response to recognized inadequacies in the Treatment First approach.[1] Rather than referring to a specific type of housing, "Treatment First" is a general name for housing programs with policies and practices guided by the biomedical model. As such, Treatment First programs follow a linear/continuum approach in which consumers must earn access to the program by first obtaining sobriety and medication compliance and then agreeing to participate in therapeutic services. Once admitted, consumers are in constant threat of losing housing if/when they have a substance use relapse or refuse to participate in services. If consumers who are experiencing chronic homelessness are able to access Treatment First programming, they often experience difficulty maintaining housing due to mental health symptoms and behaviors that make adjustment to living in highly structured environments difficult.[1,13,15]

The HFM refers to a specific type of housing based on the Pathway's design. In contrast to Treatment First programs, the HFM places low demands on consumers and has been recognized for the relative flexibility of its service structure.[5,16] This is because the HFM is guided by a human rights approach as opposed to a biomedical one. As such, housing access and stability are the primary goals of the HFM, rather than treatment or recovery. Indeed, the two most common features associated with the HFM are immediate access to housing and high levels of consumer choice with minimal or no demands being placed on the consumer in terms of service participation or abstinence.[1,14]

Diffusion of the Housing First Model

Adaptations to program models are often made during the implementation process.[17] Previous studies of programs developed to address chronic homelessness have demonstrated that staff frequently possess an incomplete understanding of the practice models being implemented.[18] Both of these issues are problematic considering that modifications to program models, whether at the organizational- or staff-level, make it difficult to (a) assess the degree to which program outcomes are related to the model in question and (b) hold organizations accountable for the programming it claims to have implemented.[19]

Recognizing the need to better understand the HFM in light of its diffusion and adaptation, the United States Department of Housing and Urban Development (HUD) commissioned Pearson, Locke, and McDonald to conduct a study to identify common features of the HFM through a comparison of Pathways and two similar programs.[14] This research pointed to five general features of Housing First programming that distinguished it from Treatment First housing (Pearson et al. discuss four features in their report however, the authors argue that one of these items represents two distinct features.): (1) the direct or nearly direct placement of consumers in housing; (2) not requiring consumers to participate in supportive services; (3) the use of assertive community outreach to engage potential consumers; (4) the use of a harm reduction approach to substance use; and (5) continuing to provide housing and services if consumers leave for short periods of time (typically for hospitalization or incarceration).

Pearson and colleagues' findings are important but limited for two reasons. First, their selection of programs based on their similarities to Pathways creates a top-down understanding of the HFM, consequently limiting the theoretical generalizability of their findings to programs that have consciously implemented the HFM developed by Pathways. Second, their findings leave much to question in the way of process (i.e., understanding how these critical ingredients work), as the researchers focused their data collection and analysis on relatively easily observable policies and practices and their associated outcomes. Indeed, Pearson et al. discuss the need for additional research aimed at better understanding the ingredients of Housing First programming critical to its success.

The aim of the current study was to identify the critical ingredients of the HFM in order to inform research seeking to understand how variations in adaptation might affect consumers.

Methods

Researchers employed an integrated study design that combined elements of both case study and grounded theory to compare four Housing First programs located in the same large Midwestern city.[20,21] The case study method is useful for setting the boundaries of a study (unit of analysis, number of cases), while grounded theory provides a step-by-step process for building emergent theory. The research team collected and compared data from multiple levels within the programs, including administrative interviews and administrative documents, as well as focus groups and individual interviews with staff and consumers. Triangulation of findings from each level within the programs strengthens validity.[22] The primary research questions guiding the study were: (a) What are the critical ingredients of Housing First programming? and (b) How do these ingredients affect consumer outcomes?

This study design addresses the limitations of Pearson et al.'s[14] study previously discussed by not restricting the selection of programs to those strictly following the Pathway's model. Therefore, researchers conducted a bottom-up investigation of the critical ingredients of the HFM, an approach which allows for findings that have greater theoretically generalizability. It also provides a better understanding of program processes through the collection and analysis of rich qualitative data that is collected from multiple levels of the programs (rather than just the administrative level).

Sampling

Programs/Cases—The research team developed a list of seven Housing First programs for sampling with assistance from local experts (i.e., individuals working closely with the city to provide training and technical assistance to Housing First programs). To be included in this list programs had to: (a) self-designate as Housing First; (b) be considered a strong example of Housing First programming by local experts; and (c) possess four out of the five features of Housing First programming found by Pearson et al.[14]

Researchers selected four programs/cases from this list based on the significant degree of differences they had from each other in terms of (a) consumer capacity (program size), (b) population served, (c) years providing Housing First programming, and (d) housing type (single-site or multiple-site). Four cases is the minimum number recommended when using the case study method, and selection based on degree of difference helps to assure that the results will demonstrate the differing extents to which cases reflect the subject of study when the number of cases is small.[23,24] Table 1 demonstrates the differences that existed between each of the programs.

Informants—The researchers requested management from each of the programs to invite potential informants to focus groups based on their ability to speak knowledgeably about

organizational policies and practices, and in the case of consumers, their ability to interact in a group setting with minimal difficulty. For interview recruitment, management provided a list of all consumers with a dual diagnosis and a list of all staff that had regular consumer contact as part of their job duties. Informants who participated in focus groups were not excluded from interview selection. Researchers randomly selected informants when there were more than five on a list. At one program the researchers were asked to make an announcement so consumers and staff could choose to be part of the selection process; therefore, research participants were not selected from the entire population at this program. This was not problematic since the primary level of interest was the program, rather than individual staff or consumers.

There were a total of 60 informants. Of these, 19 participated in both a focus group and an interview. There were 4 consumer focus groups (24 total informants), 3 staff focus groups (18 total informants), 21 consumer interviews, and 16 staff interviews. Consumer informants were housed at their current programs for a range of 9 months to 10 years, with an average of 17 months. The time staff informants had worked in their programs ranged from 1 to 20 years with an average of 5 years. Consumers were provided with a $30 grocery store gift certificate for their time, while staff were provided with a $5 coffee shop gift card (staff were provided less incentive because they were working at the time of their interviews, and were thus compensated by their employers). All procedures were approved by the university's Institutional Review Board.

Data collection procedures

Structured interviews with administrative staff (i.e., upper-level management) were conducted to gain basic information regarding program history, mission, population served, staff composition, and initial implementation of the HFM. Focus groups and individual interviews were semi-structured. The primary purpose of focus groups was to understand program policies, procedures, and practices related to the HFM. Examples of questions include: "What Policies and procedures are essential to Housing First practices within the program?"; "How does your program define consumer success as it relates to Housing First?"; and "What supportive services are offered for consumers?". The purpose of the interviews was to understand informants' perceptions of and experiences with the HFM. Examples of questions include: "How do your experiences (as staff or consumer) with your current program compare to your experiences with other programs?"; "What are the most important pieces of the HFM?"; and "How has living/working in the model affected you/ your consumers?".

Data analysis

Data collection and analysis were overlapping, a process referred to as flexible data collection in qualitative research,[21] so incremental learning could guide collection efforts at subsequent levels. The first author conducted all data collection and carried out first and second level analysis with the assistance of NVIVO 8, a qualitative data analysis tool. First, labels were assigned to sections of data in order to break them down into pieces.[24] Themes were then identified both within and across cases as they related to the research questions.[23] Emerging themes were reviewed by and discussed with administration at each agency, local housing experts, and the secondary authors. Sharing developing themes with key stakeholders and colleagues is a method for ensuring rigor and validity in qualitative research.[22] Once an ingredient was identified, it was considered to be critical if it was either (a) present in all four of the sample programs or (b) themes in the data demonstrated that alterations in the ingredient between programs led to significant differences in informants' experiences and perceptions.

Results

The research team determined that the following six ingredients were critical to the HFM.

Low-threshold admission policy (LTAP)

Each of the programs had a low-threshold admission policy (LTAP), designed to place as few entry requirements as possible on consumers. Staff discussed the LTAP as the primary feature of their program that made it, and other Housing First programs, unique from the Treatment First programs. Staff discussed how the LTAP eliminated traditional barriers to housing access for chronically homeless consumers and how it was an important starting point for developing strong consumer-staff relationships:

> …it's the entry point for the supportive housing program and [it] sets the *foundation for the relationship* that the potential resident would have with us. And so having as *few barriers as possible* is that very important starting point. (staff informant)

While consumers were generally unfamiliar with the exact details of the LTAP, it created what they described as a relatively simple admissions process compared to what they had experienced in Treatment First programs. The general narrative of consumer admissions stories was that someone in the community (e.g., friend, government worker, social worker, clergy member) connected them to the program. Shortly thereafter a staff member came out to meet them and/or they submitted an application with a social service worker in the community or by going to the program office:

> When I lost everything I called the nun [whom] I used to volunteer for [and she said], "I need you to go in the shelter for a couple months"…then about two months span time they [staff from the program] called me and told me my apartment was available…I was just thankful that I was able to get in here *that soon.* (consumer informant)

Consumer stories demonstrated that it took anywhere from one day to one year to be placed in permanent housing. Even consumers who did not access housing for up to one year discussed the admissions process as relatively fast and simple, which speaks to the system barriers to housing that LTAPs aim to address.

Harm reduction

A harm reduction approach to substance use was followed by all programs. Each program worked with consumers to reduce negative consequences associated with drug use rather than requiring complete abstinence (as would be found in a Treatment First program). While staff considered the LTAP to be the mechanism that helped consumers gain access to housing, harm reduction was considered the practice or "tool" used to keep consumers housed:

> At one point I think maybe one [Housing First or harm reduction] becomes dominant…[P]articularly in, when you're doing case management, I think harm reduction is in the forefront because *that's the practical application*…but Housing First is the philosophy we're working from, which encompasses harm reduction. (staff informant)

The "philosophy" referred to by this staff member is the idea that consumers have a right to housing regardless of the behaviors in which they choose to engage (i.e., the human rights approach that underpins the HFM). In this light, harm reduction stood out as the most essential ingredient for running a successful Housing First program: "[A]ll the time harm reduction [and] Housing First are *working hand-and-hand [sic]*, you *can't have one without*

the other at [this program], you just can't" (staff informant). In fact, while all of the programs considered themselves to operate under the Housing First umbrella, most staff and consumers were more familiar and comfortable using the term "Harm Reduction Housing".

Consumers regularly described harm reduction as reducing the stress and/or fear related to the possibility of losing their housing due to substance use and "taking the judgment out" of their housing situation. As one consumer explained:

> Because I mean that's scary when your housing is tied to your ability to remain abstinent. I mean you live kind of in a constant fear…It's not conducive to remaining sober with that kind of pressure, and it's not conducive to remaining housed…it's a huge relief when you realize your housing is not tied to your ability to remain abstinent. (consumer informant)

Both staff and consumers felt that the reduction in fear related to harm reduction led to improved staff and consumer relationships because consumers could be open with case managers about their problems without fear of being judged: "I finally found some people I could trust…Cause I always *thought I was gonna be judged*, whatever I did, *and they [the staff] didn't judge me*" (consumer informant). This was a very important ingredient of the HFM for all informants since honesty about substance use often led to consumer eviction in the Treatment First programs with which they were familiar.

Eviction prevention

Eviction prevention, a form of case management intervention aimed at preventing consumer housing loss due to lease violations, has significant overlap with harm reduction in that it helps assure consumers will remain safely and securely housed. The following selection from a staff member demonstrates the importance of eviction prevention to the HFM:

> …the *ultimate failure* to me as far as [the program's] mission *is [a consumer's] eviction to homelessness*…if we used the [H]ousing [First] model but then we said abstinence [only after consumer admission] or we said pay rent or things like that, its failure because ultimately they would end up evicted, back to homelessness you know, and that's what [this program] was created to try to avoid…. (staff informant)

Because eviction of a consumer was an example of a programmatic failure in all the programs, eviction prevention was necessary to assure program success.

Eviction prevention largely consisted of either the program developing a plan *with* the consumer to address their behaviors and/or the case manager advocating to the landlord/property manager on behalf of the consumer. Discussions with consumers reinforced the importance of eviction prevention, as they told stories of themselves and of others who were able to remain housed thanks to eviction prevention interventions:

> …they [the property manager for the building] was talkin about puttin me out… Well the property management talked to them [the case management staff], and I guess they gave me a good report, so *the property management let me stay*. (consumer informant)

Negative behavioral symptoms related to mental health and/or substance abuse diagnoses were addressed as a matter for eviction prevention when they became excessive and could include anything from consumers having illegal substances in their unit, to causing disruptions in common areas, to not paying rent on time. While all of these behaviors were usually related to substance use of some kind, the behavior, not the substance use itself, was always the focus of the intervention. For instance, non-payment of rent (consumers were

allowed to manage their own money in all of the programs) related to substance use was the most frequent issue brought up when consumers and staff discussed eviction prevention:

> …probably six or seven months after I moved in, I relapsed. So, I went through a period of drug addictions…They [the staff] actually helped me out. I had fallen behind on rent for a few months, so they gave me the opportunity to make up the rent that I hadn't paid…. (consumer informant)

In this and other examples, informants discussed developing realistic approaches (e.g., budgeting so there was money left to pay rent) to dealing with inevitable behaviors related to substance use for consumers who were not ready for and/or accepting of abstinence as a service goal.

Reduced service requirements

Each of the programs had significantly reduced service requirements for consumers when compared with traditional Treatment First housing. Informants discussed how allowing consumers to have choice over service participation was a powerful tool for facilitating positive change. Staff largely discussed how giving consumers the choice to participate in services helped facilitate the learning process because it made consumers responsible for their own decisions:

> It [giving consumers the choice to participate in services] actually also puts a lot of responsibility on the consumer…And it actually *gives the consumer a lot more responsibility* because they're making choices, and if they make bad choices they live with the consequences of those choices. And that's a lesson that a lot of people just have to learn. (staff informant)

Like staff, consumers also discussed how having choice in services led to learning. However, consumers' discussions focused on how choice increased the meaningfulness of services by allowing them to engage in activities they felt were important and to avoid activities they perceived to be irrelevant. This is demonstrated in the following focus group selection:

> …you *shouldn't be forced* to do something you don't want to. [A]nd then there's certain groups that they've had in the past you know that I didn't like and it *didn't have nothing to do with me or my situation*, so I wouldn't go, *why waste my time*? (consumer informant)

Consumer beliefs around this issue were frequently rooted in their experiences living in other programs that required them to participate in services: "…they're taking *different approaches*…they're kind of like *more open* to our experience and try to walk with us and kind of *give us a voice*…." (consumer informant)

Separation between housing and case management roles and responsibilities

The degree of separation between providers of housing (i.e., property management) and providers of case management services was demonstrated to be important because of its effect on the consumer-staff relationship. While all of the programs had some separation between these two types of providers, it became increasingly difficult for consumers to develop trusting relationships with case managers as the lines between case management and property management roles blurred.

Staff as rule enforcers—This blurring was more prevalent in the two single-site programs where case managers often had to act as enforcers of housing rules (i.e., monitoring consumer behavior, making consumers aware of lease violations, and assisting in the eviction process). While there were many examples of positive relationships described

by consumers at these two programs, there were more examples of indifference and/or negativity in consumer descriptions of their relationships with case mangers than in the multiple-site programs: "My case worker, me and him always going at it cause this dude, it be like he be *singling me out* for some reason…." (consumer informant). Other consumers in single-site programs also described feeling as if their personal boundaries were violated by case managers who were enforcing program rules.

Enforcement of program rules was a significant source of role conflict for case managers in the single-site programs:

> [Y]ou know, that is something that *I've struggled with*…let's say they're not paying their program fees, so where does that enforcement come from? Does that come from me, you know reminding them?…I'm trying to work with them to maintain their housing, and then, but I'm also the one reminding them, well they're violating [their lease]…if I worked at [multiple]-site, if there was an issue it would be the landlord going to the participant, going to the participant and or the caseworker, saying this is the problem that I'm having and it's up to us to advocate for them, instead of [me] *work[ing] both roles*. (staff informant)

This staff member's frustration is related to her inability to act solely as an advocate for the consumers with whom she works. However, this staff member also explained that she did not see this strictly as a problem of single-site housing, but as a problem that occurs when case management works on the site where consumer housing is located. When discussing this issue with staff at the two single-site programs, the first author learned that case management offices were formerly located off-site at both before cuts in funding forced relocation to the same site as housing. Staff in both programs described how role conflict was not a problem for case management until their offices were moved.

Staff as advocates—Neither of the multiple-site programs had offices located in any buildings where consumers were housed. The data demonstrate that the roles of case managers and property management were more clearly defined in these two programs. Consumers in these programs rarely discussed being upset over case managers' enforcement of rules and case managers did not discuss any conflict in their job duties. This suggests that case managers in multiple-site programs were better able to act as advocates for consumers:

> I got in a lot of trouble when I first got into [this program] cause I went off the wall…[I] just was getting high and just didn't care. I mean things were really out of control. But they really advocated for me. I mean building management was ready to get rid of me and break the lease and get rid of me. But [the staff] really went to bat you know, and then helped me turn things around. So I mean, yeah, they were *real dedicated to Housing First.* (consumer informant)

Advocacy demonstrated "dedication" to the HFM for this consumer, which points to the importance of clearly defined roles for case mangers and property managers in Housing First programs.

Strategies to inform and educate consumers

Consumers' understandings of housing services were largely based on their histories with Treatment First programs; as one staff member stated: "[Consumers] *come to understand* that they're gonna be accepted into a housing program and *[they have] to be clean* [abstain from substance use]" (staff informant). Consequently, it was very important that programs educated consumers about HFM policies and practices, primarily harm reduction. Data from consumers repeatedly demonstrated that education about the HFM was the mechanism that helped them attach meaning to the choices provided through the ingredients of harm

reduction and reduced service requirements. Attaching meaning to choices helped consumers feel good about their personal achievements:

> After that talk we had [in an educational meeting about harm reduction]…That's what woke me up, and I still, I wanted to change. *I could do it on my own* where I don't have to be forced into and I don't have to report to them about it. (consumer informant)

At the program where consumers received the least education (Program 3 in Table 1), only two of the consumers who participated in individual interviews had ever heard the terms "Housing First" or "harm reduction" before their interview: "I heard it here [for the first time], this is what this interview was about, harm reduction" (consumer informant). This was a major difference from the other programs where the majority of consumers could provide at least a basic definition of one or the other. Staff at this program discussed how they were frustrated over their consumers' lack of understanding of the HFM and harm reduction:

> …she [a consumer who was intoxicated and directed to her room] needed to be educated [about harm reduction]…To be honest, we have offered harm reduction, but it goes in one ear and out the other. It it's kind of like I feel they *need to be mandated* to attend these classes. (staff informant)

Consumers at this program were not educated about the HFM because it was the only program that did not require consumers to engage in any services. While this staff member's statement about mandatory services might seem in conflict with the HFM, it is important to note that most HFM programs do require some level of service engagement,[12,14] though the expectations of consumers are typically much lower than Treatment First programs. Indeed, all of the other programs required consumers to engage in case management services. These services were the primary mechanism through which consumers developed understanding of the model:

> [I]t was shortly after that in one of our one-on-one sessions where [my case manager] said…"You realize your housing is not contingent on you being abstinent?". And I hadn't realized that at that point…*[T]hen things started to change.* I started working real close with them, being honest with them. (consumer informant)

Therefore, the data suggest that consumer education strengthens the impact of harm reduction policies and practices and reduced service requirements on consumer outcomes.

Discussion

The findings demonstrate that the first five ingredients discussed—low-threshold admissions policies (LTAP), harm reduction, eviction prevention, reduced service requirements, and separation of housing and services—create a service structure that is considerably more flexible than that of Treatment First housing. Regarding consumer outcomes such as mental health symptoms and substance use, the data suggest that this flexible structure positively affects consumers by reducing the amount of stress they face regarding housing access and permanence. This is supported by previous research that has identified the benefits of secure housing for consumers living with mental health and substance abuse issues.[25-27] It does this in the following ways: simplifying the housing access process; reducing the number of rules for which consumers can be evicted; and strengthening the consumer relationships with staff —an important source of support that has been demonstrated to positively affect mental health outcomes.[28] However, due to consumers' experiences with Treatment First programs, consumer education regarding the HFM and its associated practices is an essential component for assuring the benefits of a flexible service structure are fully realized. Without

this education, it is highly likely that consumers will continue to understand and/or act as if they are in a Treatment First program, believing their housing is tenuous and avoiding interaction with staff.

The LTAP, harm reduction, reduced service requirements, and the separation between housing and services have all been discussed to some extent in the HFM research literature and are all cornerstones of the original Pathways model.[1,14] While the first three of these ingredients were part of the program selection criteria for this study, they were not probed for in interviews with staff and consumers, and the themes related to them emerged directly from the data. Additionally, the findings above add an extra layer to the existing literature in that they unpack many of the processes put into action by these ingredients and begin to illuminate how they affect consumer change.

The fact that harm reduction was identified by informants as the most essential ingredient is significant considering that previous research has demonstrated that this is the most common ingredient to be left out when programs make adaptations to the HFM.[12] This is likely due to the strength of abstinence-based approaches to substance abuse guided by the biomedical model and moral views of addiction.[29] Views stemming from these approaches have made it difficult for harm reduction to gain traction in the United States, despite its overwhelming popularity as a public health intervention throughout the rest of the world.[29]

The current literature does not discuss the importance of eviction prevention or strategies to inform and educate consumers about the HFM. The absence of explicit discussions of eviction prevention as an ingredient of the HFM is surprising considering that: it has been demonstrated to be a key component of permanent supportive housing services in general;[30] the primary goals of the HFM is housing stability for consumers; and the population the model serves is known to engage in behaviors leading to housing instability.[1] It is also surprising that the importance of strategies to inform and educate consumers has not been discussed in the previous literature since consumer expectations of programming are likely to be framed by previous experiences with Treatment First programming. This is not to say that consumers cannot come to understand the HFM without explicit education. It is more likely that it will simply take them longer to make the realization, which has the potential to negatively impact individual-level outcomes.

Finally, much of the literature written about the HFM has focused on assertive outreach as one of the main pathways through which programs overcome consumer's unwillingness to engage with Housing First programs based on their experiences with Treatment First programs.[1,14] However, assertive outreach was only implemented by one program within the current sample (Program 1 in Table 1). It is possible that the lack of assertive outreach in the programs created a selection process whereby consumers who had less distrust of social services were admitted to programming. However, even staff and consumers at this program did not discuss outreach as important. Future research should look more critically at outreach as an "essential" ingredient of the HFM.

Limitations

The primary limitations of this study are related to the methodology employed. First, qualitative methods make it difficult to establish causality between program ingredients and outcome measures (e.g., housing retention, service engagement, substance use, mental health symptoms). However, the current research does begin to illuminate the processes through which causality can be tested. Second, although the findings are not statistically generalizable, there have already been a number of quantitative studies establishing the link between the HFM and consumer outcomes.[4,31] Additionally, the bottom-up approach and use of programmatic differences as selection criteria strengthen the theoretical

generalizability of the findings by helping to assure that the findings are relevant to issues related to diffusion of the model and any similarities between the programs were related to the HFM and not any other factors the programs might have shared.[21]

Implications for Behavioral Health

Without a thorough understanding of what the components of the HFM are and how they work to affect outcomes, it is likely that programs will continue to make modifications to the HFM. It is also likely that these same programs will attribute outcomes, positive or negative, to a HFM that has not been appropriately implemented. This study adds a unique perspective to the literature on the Housing First model due to the bottom-up approach to understanding its critical ingredients and the processes through which they lead to improved outcomes for consumers. This is an important building block for future research which should be aimed at testing these findings by quantitatively investigating the connections between ingredients of the model and specific consumer outcomes. This will help identify which ingredients are absolutely essential to the model, and thus contribute to the development of fidelity measures that can effectively guide HFM implementation and evaluation.

Acknowledgments

Research funding provided by the National Institute on Drug Abuse (R36 DA027770)

References

1. Tsemberis S, Asmussen S. From streets to homes -- the Pathways to Housing Consumer Preference Supported Housing Model. Alcoholism Treatment Quarterly. 1999; 17(1):113–131.
2. Mares AS, Rosenheck RA. Evaluation of the Collaborative Initiative to Help End Chronic Homelessness. 2007 http://www.hudhre.info/documents/CICH_SystemIntegrationAndClientOutcomes.pdf.
3. Perlman, J.; Parvensky, J. Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report. Colorado Coalition for the Homeless; Denver, CO: 2006. http://www.shnny.org/documents/FinalDHFCCostStudy.pdf
4. Sadowski LS, Kee RA, VanderWeele TJ, et al. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. Journal of the American Medical Association. 2009; 301(17):1771–1778. [PubMed: 19417194]
5. Greenwood RM, Schaefer-McDaniel NJ, Winkel G, et al. Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. American Journal of Community Psychology. 2005; 36(3-4):223–238. [PubMed: 16389497]
6. Tsemberis S, Gulcur L, Nakae M. Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health. 2004; 94(4):651–656. [PubMed: 15054020]
7. Padgett DK, Stanhope V, Henwood BF, et al. Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with Treatment First programs. Community Mental Health Journal. 2010; 47:227–232. [PubMed: 20063061]
8. DeSilva MB, Manworren J, Targonski P. Impact of a Housing First program on health utilization outcomes among chronically homeless persons. Journal of Primary Care & Community Health. 2011; 2(1):16–20.
9. National Alliance to End Homelessness. A Plan, Not a Dream: How to End Homelessness in Ten Years. National Alliance to End Homelessness; Washington DC: 2000.
10. United States Interagency Council on Homelessness. Opening Doors: Federal Strategic Plan to Prevent and End Homelessness: 2010 Fact Sheet. 2010 http://www.ich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf.

11. United States Department of Housing and Urban Development. The 2010 Annual Homeless Assessment Report to Congress. Office of Community Planning and Development, HUD; Washington, D.C.: 2011.
12. George C, Chernega JN, Stawiski S, et al. Connecting fractured lives to a fragmented system: Chicago Housing for Health Partnership. Equal Opportunities International. 2008; 27(2):161–180.
13. Henwood BF, Stanhope V, Padgett DK. The Role of housing: A comparison of front-line provider views in Housing First and traditional programs. Administration and Policy in Mental Health and Mental Health Services Research. 2010; 38(2):77–85. [PubMed: 20521164]
14. Pearson, CL.; Locke, G.; McDonald, WR. The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness. U.S. Department of Housing and Urban Development Office of Policy Development and Research; Washington, D.C.: 2007. http://www.huduser.org/publications/homeless/hsgfirst.html
15. Padgett DK, Gulcur L, Tsemberis S. Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. Research on Social Work Practice. 2006; 16(1):74–83.
16. First Author. forthcoming.
17. Durlak JA. Why program implementation is important. Journal of Prevention & Intervention in the Community. 1998; 17(2):5–18.
18. McGraw SA, Larson MJ, Foster SE, et al. Adopting best practices: Lessons learned in the Collaborative Initiative to Help End Chronic Homelessness (CICH). The Journal of Behavioral Health Services & Research. 2009; 37:197–212.
19. Smith E, Caldwell L. Adapting evidence-based programs to new contexts: What needs to be changed? Journal of Rural Health. 2007; 23(Suppl):37–41. [PubMed: 18237323]
20. Corbin, JM.; Strauss, AL. Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. Sage Publications; 2008.
21. Eisenhardt KM, Graebner ME. Theory building from cases: Opportunities and challenges. Academy of Management Journal. 2007; 50(1):25–32.
22. Patton MQ. Enhancing the quality and credibility of qualitative analysis. Health Services Research. 1999; 34(5):1189–1208. [PubMed: 10591279]
23. Eisenhardt KM. Building theories from case study research. The Academy of Management Review. 1989; 14(4):532–550.
24. Glaser, BG.; Strauss, A. The Discovery of Grounded Theory: Strategies for Qualitative Research. Aldine Transaction; New York: 1967.
25. Foster S, LeFauve C, Kresky-Wolff M, et al. Services and supports for individuals with co-occurring disorders and long-term homelessness. The Journal of Behavioral Health Services and Research. 2010; 37(2):239–251.
26. McNaughton, CC. Transitions Through Homelessness: Lives on the Edge. Palgrave Macmillan; 2008.
27. Padgett DK. There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. Social Science & Medicine. 2007; 64(9):1925–1936. [PubMed: 17355900]
28. Turner, RJ.; Brown, RJ. Social support and mental health. In: Scheid, TL., editor. A handbook for the study of mental health: Social contexts, theories, and systems. 2nd ed.. Cambridge University Press; New York: 2009.
29. Marlatt GA, Witkiewitz K. Update on harm-reduction policy and intervention research. Annual Review of Clinical Psychology. 2010; 6(1):591–606.
30. Backer TE, Howard EA, Moran GE. The role of effective discharge planning in preventing homelessness. The Journal of Primary Prevention. 2007; 28(3-4):229–243. [PubMed: 17557206]
31. Larimer ME, Malone DK, Garner MD, et al. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. Journal of the American Medical Association. 2009; 301(13):1349–1357. [PubMed: 19336710]

Table 1

Characteristics of the Programs Based on Key Differences used as Sample Selection Criteria

Consumer		Years providing Housing	
capacity	Population served	First programming	Housing type
54	Chronic homeless with dual diagnosis	11	Single-site
93	Homeless women	8	Single-site
38	Homeless men with dual diagnosis	7	Multiple-site
10	Homeless with HIV/AIDS	7	Multiple-site