A Housing First Manual for Ireland

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A copy of this report can be downloaded free of charge from www.homelessdublin.ie

December 2020

Acknowledgements

Housing First in Ireland is built upon close collaboration between the Department of Health and Department of Housing. We wish to acknowledge the commitment of the Minister for Housing, Local Government and Heritage, Darragh O'Brien TD, and Minister of State for Public Health, Well Being and National Drugs Strategy, Frank Feighan TD, and senior officials within both departments, for continuously driving and supporting the rollout of the national Housing First programme.

Our deep appreciation and gratitude to Dr. Sam Tsemberis for taking the evidence-based Housing First model that he conceived in New York in the 1990s and translating it into a practical guide that is firmly grounded in the Irish context. Sam's commitment to the clients and staff of Housing First in this country has been unstinting since he first visited over a decade ago. Warm thanks also to Sara Sembroski for her editorial support from the United States.

Sincere thanks to the editorial group consisting of Professor Eoin O'Sullivan (Trinity College Dublin), David Silke (Housing Agency), Marieke Altena (HSE), John Healy (Genio), Tara Doheny (Genio) and Bob Jordan (Housing First National Director) for their expert insights, guidance and inputs on preparatory drafts of the manual. This manual is firmly based upon the experiences of Housing First practitioners in Ireland, including frontline staff working in NGOs, Local Authorities and HSE. We thank everyone who so generously participated at consultation workshops and those who made individual contributions.

National and regional specialists in mental health and addiction commented on many of the chapters. We are particularly grateful to Marieke Altena in the HSE National Inclusion Office for leading out on the health service aspects and for co-ordinating a wide range of inputs from across the HSE.

This manual was commissioned and funded by the Genio Trust. Special thanks to Tara Doheny from Genio who expertly project managed the production of this manual from inception to publication, and without whom it could not have been delivered so successfully.

- The Housing First National Implementation Committee

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Background and Context

Housing First is an internationally recognised, evidence-based solution for people who sleep rough and long-term users of emergency accommodation with complex needs. Housing First successfully engages with these individuals by offering and providing immediate access to a home of their own, as well as access to person-centred, community-based and recovery-oriented supports.

The Housing First model was developed by Dr. Sam Tsemberis at Pathways, a housing organisation in the USA.

In Ireland, a national implementation plan for Housing First was published in 2018. The plan commits Ireland to the rollout of Housing First in every county, and sets annual targets for each local authority.

The aim of this manual is to provide practical guidance on how Housing First can continue to be implemented successfully in Ireland. It covers issues such as prioritisation of clients, housing selection, the process for home visits, and how to ensure clients are at the centre of decision-making.

Housing First National Implementation Plan 2018 - 2021

The 'Housing First National Implementation Plan 2018-2021' was launched by the Minister for Housing, Planning and Local Government and the Minister for Health in September 2018. It describes how the Government's goal to extend Housing First to every county in Ireland is to be delivered and it specifies the number of Housing First tenancies for each local authority to achieve by the end of 2021. The post of National Director of Housing First was established in early 2018 to drive national implementation; and a Housing First National Implementation Committee oversees delivery nationwide.

Government policy since 2013 has supported a Housing First approach to ending rough sleeping and long-term homelessness. A Housing First pilot project ran in Dublin from 2011 to 2014. Based on its success, a regional Housing First service was contracted by the Dublin Region Homeless Executive in 2014. An initial target of 100 tenancies was increased to 300 as part of the actions included in the Government's housing and homelessness strategy, 'Rebuilding Ireland' (2016). The Dublin Housing First service, which was jointly delivered by Focus Ireland and the Peter McVerry Trust from 2014 to 2019, delivered over 300 tenancies and a housing sustainment rate of over 80%.

The 'Housing First National Implementation Plan' followed a review of 'Rebuilding Ireland' in 2017, which committed to expanding the Housing First programme nationwide. Prior to the implementation plan's publication, a survey of homeless services was conducted to assess how many homeless individuals could potentially benefit nationally. Based on this assessment, three-year targets were established for each of the 31 local authorities, totalling 663 tenancies by the end of 2021. This target is kept under review and the Dublin target was revised upwards when the service was re-tendered in 2019.

The implementation plan commits to maintaining fidelity to the evidence-based Housing First model. This includes the provision of permanent secure housing to people rough sleeping and in homeless accommodation, without any preconditions around sobriety or housing readiness. It also includes the delivery of time unlimited (i.e. for as long as the tenant needs) visiting housing and health supports. A joined-up approach between Government departments, local authorities, the Health Service Executive (HSE), service providers and voluntary housing bodies is recognised as critical to ensuring that all the housing and support and treatment services defined as practices of Housing First are present.

Criminal Justice Strand

As part of the rollout of Housing First to specific target groups, the Department of Justice, the Irish Prison Service and the Probation Service are contributing funding support towards the establishment of a Housing First Criminal Justice Strand for 75 individuals over the three-year period from 2020 to 2022. The Housing First Criminal Justice Strand will manage service-users (those leaving prison and / or subject to probation service supervision) presenting as homeless with a range of high and complex needs in the criminal justice sector. The Dublin Housing First team will be enhanced to comprise additional skillsets, including an in-depth knowledge of the criminal justice system and familiarity with court procedures, post-custody arrangements and obligations.

Service Reform Fund

A number of supports for the national programme are being resourced under the Service Reform Fund, a fund established by government to support the implementation of reforms in disability, mental health and homelessness services in Ireland. Under this fund, the University of Limerick has been commissioned to conduct the national evaluation of Housing First, focusing on the housing and health outcomes for participants. In addition, an Action Research programme, supervised by Genio and with ethical approval from Trinity College Dublin, supports nationwide implementation of Housing First by surfacing challenges and sharing good practice across the different sites. National training workshops, involving both local and international experts, are also being delivered.

Regional Governance of Housing First

Leadership responsibility for the delivery of Housing First services is shared across agencies, depending upon their statutory functions or contractual arrangements.

Overall, local authorities have a statutory responsibility to provide homeless accommodation and related services to homeless persons, while the HSE is responsible for the provision of health supports to people who are homeless. Local authorities are also responsible for the allocation of social housing to homeless persons – including Housing First clients. This may include social housing directly provided by the local authority, social

housing provided by an Approved Housing Body (AHB), or social housing supports delivered in the private rented sector, including through the Housing Assistance Payment (HAP) scheme.

The day-to-day management of regional Housing First services is provided by NGOs that are appointed as the 'NGO Housing First service provider'. In most regions, both housing and health supports are provided directly by a multidisciplinary team of Housing First staff, employed by the NGO. In some regions, health services are provided by HSE-employed staff who work in an integrated way with staff at the NGO.

Statutory Management Group

Under the Housing (Miscellaneous Provisions) Act 2009 , a structure called the Statutory Management Group (SMG) is in place to jointly address the provision of services to people who are homeless at a regional level; and each region has a lead local authority (e.g. Galway City Council in the West Region).

The SMG comprises constituent local authorities for the region, the HSE and other agencies including, for example: the Department of Justice, the Department of Social Protection, the Probation Service, the Irish Prison Service, and Tusla.

The NGO Housing First service provider (an induvial NGO or consortium of NGOs) is contracted by the SMG's lead local authority to deliver regional Housing First services. A Steering / Management Group comprised of local authorities, HSE services and homeless service providers is in place in most regions to coordinate and oversee Housing First service delivery.

This manual is intended as a practical resource for all those working to implement Housing First in Ireland, in particular frontline workers in local authorities, the HSE, and housing and homelessness organisations – but also, more widely, policymakers, researchers, students, and other community stakeholders. The manual will be reviewed and updated on an ongoing basis.

Foreword

Minister for Housing, Local Government and Heritage

Housing First is a critical component of the Government's strategy to reduce and eliminate long-term homelessness. It targets homeless individuals with a history of rough sleeping and long-term use of homeless accommodation who have complex needs around substance use disorders and mental health.

The Housing First model is an evidence-based approach that provides direct access to permanent housing, together with intensive housing and health supports delivered mainly to the person's home. It is a strong example of how inter-Departmental and inter-agency collaboration can deliver the range of supports that homeless people need to exit homelessness and to help them address the issues that may have contributed to making them homeless in the first place.

The 'Housing First National Implementation Plan 2018–2021', jointly launched by my Department and the Department of Health in September 2018, established a national target to create 663 additional Housing First tenancies by the end of 2021. Over 50% of these tenancies have already been delivered by nine regional Housing First services, spanning every local authority and HSE Community Health Organisation area in the country. The success rate of the programme through housing sustainment is over 85%, which compares very favourably with the best outcomes achieved by Housing First internationally. While I know we have a lot more to do to meet our target, my Department is fully committed to resourcing the provision of housing for the Housing First programme.

This 'Housing First Manual for Ireland' is another significant step forward for the rollout of the national Housing First programme. It provides practical guidance to frontline workers in local authorities, the HSE and NGOs on how Housing First is to be implemented, including the selection of housing, processes for home visits, integrating housing and health supports, and ensuring that the service user is at the centre of decision-making. The manual has been written by the international founder of Housing First, Dr. Sam Tsemberis, and uniquely adapted to the Irish context in close collaboration with an advisory group of experts in housing and health and with the practitioners of Housing First throughout the country.

A key driver of the Housing First programme is the provision of permanent one-bedroomed homes to homeless individuals, mainly through social housing provided by local authorities and Approved Housing Bodies. We know that, at present, approximately 74% of individuals experiencing homelessness are single adults. My Department is determined that an appropriate pipeline of one-bedroom properties is made available through the various social housing delivery programmes. We are also committed to ensuring that Housing First tenants get the visiting housing supports they need by way of Homeless Exchequer funding (as provided for under Section 10 of the Housing Act 1988) for local authorities, and we recognise the critical role played by the Department of Health and the HSE in ensuring that complementary health supports for Housing First are also in place.

In line with the Programme for Government commitment to further expand the Housing First programme, my Department has already tasked the Housing Agency with quantifying the potential level of additional need for Housing First tenancies, in close consultation with regional authorities. This manual will be a valuable resource to the State and voluntary agencies involved in growing the Housing First programme in the years ahead and in delivering on the Government's objective to resolve long-term homelessness in Ireland.

Darragh O'Brien TD
Minister for Housing, Local Government and Heritage

Foreword

Minister of State for Public Health, Wellbeing and the National Drugs Strategy

First, I would like to extend my sincere gratitude to Dr. Sam Tsemberis, the original founder of the Housing First Programme, for the care he has taken in crafting this manual for the Irish context. It provides a bespoke response to the challenges associated with long-term homelessness and rough sleeping. The manual will support the delivery of housing and health services for people who are homeless; and will help to improve their lives and fulfil their potential. I also acknowledge the contribution of the HSE, the Dublin Region Homeless Executive, homeless NGOs and Genio in developing the manual.

Housing First is internationally considered as best practice in addressing the needs of people who are long-term homeless and with complex needs. The success of Housing First is due to the bringing together of housing and health services (drug and alcohol, mental health, and primary care). It also highlights the critical role of housing as a social determinant of health.

Last July, the Minister for Health and I met with the Minister for Housing and agreed to work together to provide health supports for people who are homeless, especially those with mental health and addiction needs. We committed to provide additional resources to the HSE for the health needs of people who are homeless in Budget 2021. We have delivered on this commitment, with an investment of €15 million in the HSE Winter Plan and National Service Plan for 2021. This includes an allocation of €1.125 million to provide health supports for 218 new tenancies under Housing First.

People who are homeless can be at a far higher risk of problem drug use than people in secure housing, with particularly high levels of use and risk amongst rough sleepers and those using emergency accommodation. This underlines the importance of homelessness services and addiction services working together. We have seen the benefits of this collaborative approach in protecting people who are homeless and use drugs during the Covid-19 pandemic.

Housing First aligns with national policies on mental health and drugs, as set out in ‘Sharing the Vision’ (Department of Health, 2020) and ‘Reducing Harm, Supporting Recovery’ (2017). These policies are focused on recovery and harm reduction and recognise the strong inter-relationship between mental health, drug addiction and homelessness. Housing First also supports the emphasis in Sláintecare on providing healthcare in the community.

For Housing First to be successful, adherence to the principles and practices of the original programme is required. This manual will assist housing and healthcare practitioners in implementing the model in Ireland. It provides guidance on how people can be supported to access and maintain tenancies; and how support staff, including addiction and mental health staff, can play critical roles in this process. The manual outlines how staff should provide recovery-focused mental health and addiction supports, using a harm-reduction approach in tandem with tenancy supports. As such, the manual provides a blueprint for wrap-around services for a programme that has demonstrated the importance of inter-agency and inter-departmental working. There is also invaluable information on home visits, employing peer specialists and adjusting Housing First to rural areas.

Frank Feighan TD
Minister of State for Public Health, Wellbeing and the National Drugs Strategy

“Housing First is the only service that has treated me like a human being and I feel listened to. They provided me with a house that I turned into a home for me and my son. I can finally put the years of sleeping rough in tents behind me and move on with my life.”

- Housing First Tenant

Chapter 1

Introduction to Housing First

This chapter presents an overview of the values and principles of the Housing First programme, and a description of the core practices and skills that are an integral part of Housing First case management, treatment, and housing services.

Introduction

Housing First provides a comprehensive and holistic approach to addressing homelessness for people experiencing mental health, physical health, substance misuse, social, behavioural, and other challenges. The programme consists of three major components:

- Permanent, affordable housing;
- Mobile case management and treatment services (mental health, health, and addiction services); and
- A programme philosophy based on client choice and recovery.

Ireland's national Housing First programme is based on the Pathways Housing First programme, which is the model that has produced the research evidence for the effectiveness of Housing First[1].

Housing First programme philosophy is based on psychiatric rehabilitation, and support services emphasise client choice and recovery. Housing is provided in accordance with client preference, which almost always means an independent home in the community.

Much of the publicity about Housing First emphasises its effectiveness in ending homelessness. In the Pathways model, ending homelessness is simply step one in the journey towards recovery and community integration. While some variations exist, well-run Housing First programmes in North America, the EU or New Zealand all look more similar than different[2].

The Irish 'Housing First National Implementation Plan 2018-2021' is closely aligned with the principles and practices of other international implementation programmes, including those in Canada and France[3].

In Ireland's Housing First programme, the required housing stock comes from social housing (i.e. publicly-funded housing managed by local authorities and AHBs), as well as housing that is rented from private landlords with the aid of a subsidy. The case management support service is provided by NGOs (which are contracted to provide this service) and treatment is provided by the HSE, General Practitioners (GPs), and other social service providers. The programme philosophy of Housing First should inform the practice of staff across all agencies participating in the initiative, including external agency partners.

The aim of this manual is to define, and support implementation of, a core set of principles and practices to create well-organised, multi-agency Housing First team structures that collaborate to provide housing and support services which aid recovery and community integration for the programme's participants. The expectation is that Housing First services across Ireland will adhere to the principles and practices of Housing First internationally – to provide a uniform quality of supports across all regions.

Experience from the national implementation of Housing First in other countries has shown that, when Housing First programmes adhere to these principles and practices and operate programmes with a high degree of fidelity[4], participants achieve higher rates of housing stability and significantly greater improvements in quality of life[5].

Why Housing First?

Housing First provides communities with an effective approach to housing a chronically homeless segment of the population, and to keeping them housed. Those who are chronically homeless tend to go through cycles of living on and off the streets (rough sleepers) or are frequent users of shelters, emergency rooms, detox facilities and hospitals.

Housing First provides an effective solution for individuals who have repeatedly tried and failed to exit homelessness, who have given up on the treatment-then-housing 'staircase' approach, or who have been given up on by systems that regard them as 'treatment resistant', 'hard to reach', 'not housing ready', or 'homeless / rough sleeping by choice'. Housing First successfully engages these individuals by offering and providing immediate access to an apartment of their own, as well as access to person-centred, community-based, recovery-oriented visiting supports.

The proper implementation of Housing First can serve to:

- Expand the current practice of housing providers and clinicians;
- Embolden policymakers;
- Expand existing Housing First programmes;
- Introduce new policies and funding to bring Housing First to scale; and
- Introduce a shift to effective consumer-driven, person-centred supports and treatment for people experiencing homelessness and diagnosed with mental illness and substance use disorders.

By providing a person with a home, Housing First offers dignity and ignites hope in individuals who have often been treated in an undignified manner, who have remained homeless and who have felt hopeless for years. The transformation of moving out of homelessness into a home of one's own begins a process of physical and psychological healing and instantly changes that person's social status from an outcast on the streets to a member of a community.

Housing First's proven success factors include the following:

- Housing First consistently shows significantly better outcomes than standard care in reducing homelessness, increasing housing stability, and improving quality of life[6].
- The Housing First client-directed approach empowers clients to make their own choices, direct their own course of action, and experience a sense of mastery that serves as a pillar in their recovery process.
- Housing First can be implemented quickly because engagement with clients is accelerated by the offer of immediate access to housing. Housing First does not require years to build. The programme secures housing from the existing vacancies in social housing or by renting units from private landlords. On average, clients move from homelessness into their own apartment in a period of four to six weeks.
- Housing First case management and treatment services take a holistic, recovery-oriented approach that supports community integration and social inclusion.

Who is Prioritised for Housing First?

Individuals prioritised by Housing First are people who experience rough sleeping and those who have long stays in emergency accommodation, with accompanying high support needs around mental health and substance use disorders.

Rough sleepers are the most visible group amongst people experiencing homelessness and, in the public mind, they often represent the totality of homelessness. For this reason, they also draw the attention of policymakers.

From a management of health services perspective, rough sleepers attract attention because, even though they comprise only a minority of those experiencing homelessness at any point in time, based on international evidence, they utilise about 50% of all available homeless services. This is a consequence of having multiple untreated problems, including physical and mental health problems, substance use disorders, nutritional deficiencies and trauma, all of which are exacerbated by homelessness, and result in this group's frequent use of emergency rooms, inpatient services, admissions for stabilisation or detoxification, police transports, prison time, shelter bed-use, and other acute care services. This pattern of high service utilisation is very costly, ultimately resulting in a cyclical pattern of acute care service use with poor outcomes for both the system and the individual.

Why Housing First Works

Most clients who have been homeless for years have experienced failure (either voluntarily or involuntarily), and sometimes on several occasions, to engage in 'treatment first' programmes. For this group, using housing as leverage or coercion for treatment participation has not proven effective.

Before there was a Housing First programme, the 'treatment-then-housing' or 'staircase' model was all that was available for people experiencing homelessness. The 'treatment-first' model was likely developed from the outdated traditional medical model and the clinician's perspective, rather than the perspective of the service users. The move to more holistic practice plus incorporation of new research findings on treatment effectiveness have been adopted in the field of addiction treatment, but they are not as widely in use in the homeless service sector.

Now, Opioid Substitute Treatment (OST) is offered to clients to support them in recovering from opioid dependence, with clients being fully involved in the development of their care plans. In addition, the harm-reduction approach has been a key component of addiction services for several years.

The 'treatment-first' model was based on several erroneous assumptions about the needs and competencies of people experiencing long-term homelessness, struggling with substance use disorders, or diagnosed with psychiatric disabilities. Some of these assumptions are manifest as programme requirements in traditional homeless service programmes, including the beliefs and practices that:

- Clients must first demonstrate they can live successfully in transitional housing before they can manage independent housing such as a place of their own.

- Clients with addiction problems must first be sober before they can be housed.
- Clients with psychiatric problems must first be treated or free of symptoms before they can be housed.
- Clients will value housing more if they must earn it (i.e. housing as a reward) by demonstrating compliance with treatment, sobriety, and following programme rules.
- Clinicians must set goals for clients because they are incapable of making choices or settings goals for themselves.
- Clients with psychiatric disabilities need to live in group homes with on-site staff because they require round-the-clock supervision.

These beliefs persist even in the face of empirical evidence from numerous quantitative and qualitative studies showing that, in Housing First programmes, clients diagnosed with psychiatric disabilities can set their own goals and, when provided with the right support, can live independently in the community attaining sobriety or completing a series of transitional or preparatory programmes[7]. The evidence from studies of Housing First also indicates that clients are more likely to remain housed when programmes allow them greater choice. These findings are consistent with research on psychiatric rehabilitation, which indicates that the most effective way for a person to learn the skills necessary for living independently in the community is not in a group home or a shelter, but in an independent housing unit where support can be provided for these skills to be developed and put to use[8].

Housing First is a Values-Based Programme

Housing First is strongly values-based. The programme interventions are built upon a core set of values about human rights, dignity and empowerment. The many interventions that comprise the Housing First programme are better understood and easier to grasp if programme staff and the agencies involved endorse these beliefs and values.

The core values of Housing First are:

- **All people have a right to housing; housing is a basic human right.**
- **People with psychiatric disabilities and substance use disorders should not have to prove they are 'housing ready' or have to 'earn the right to housing' by first complying with psychiatric treatment or attaining sobriety.**
- **The programme is strengths-based. Strengths are recognised and appreciated, and each person's potential for creativity, growth, and recovery is acknowledged, honoured, and encouraged.**
- **Respect, hope, and creating possibilities are the foundations of helping.**
- **People have the power of choice and their life choices are honoured and upheld.**

These values are consistent with behavioural science research that has found that people are more likely to make positive changes under the following conditions[9]:

- In the context of a positive relationship.
- When they set their own goals.
- When they are taught skills.
- When they can modify the environment.
- When they receive support.
- When plans and supports are based on the here and now.
- When they have positive expectations or hope for the future.
- When they believe in their self-efficacy.

The Housing First approach does not view the root causes of homelessness (e.g. mental illness or substance use disorders) as evidence of individual failings. Rather, homelessness is understood in the context of national policies that result in income disparity, poverty and lack of affordable housing. Government policies and funding that have addressed homelessness by investing in shelters and emergency accommodation have not been as successful in reducing homelessness as those that have addressed the structural problems that prevent people from securing and retaining housing. This includes housing strategies that commit to the large-scale provision of social housing and other forms of affordable housing.

Housing First is designed to create small, community-level clusters of collaborative programmes that will work together to effectively remedy the problems created by existing system-wide practices that are siloed and can impede access to and coordination of housing and services for those who have remained homeless.

Housing First is designed in equal measure to address existing system problems and to support participants in their own design of a system that meets their needs.

Housing First seeks to support client choice and client voice, not to change people to fit into existing programmes. It is designed to empower people to express their preferences, develop self-efficacy, and to challenge existing programmes to modify their practices to effectively engage and serve the needs of all members of their community, including those struggling with mental health problems and substance use disorders.

When communities introduce Housing First programmes, the so-called ‘hard-to-house’, ‘homeless by choice’ or ‘treatment-resistant’ clients generally show a dramatically different and very positive response, and engage with the Housing First programme. Clients quickly grasp that this programme respects that they have wishes and plans of their own, and it is not designed to demand that they must change. Rather, it is there to actually listen to them and support them in meeting their own, self-defined needs.

Programme Culture

Internationally, the Housing First model is underpinned by the following ethos:

- Housing as a basic human right.
- Warmth, respect, and compassion for all clients.
- A welcoming and trauma-informed programme culture.
- Recovery-focused services
- Active engagement and relationship-building.

- Social inclusion using a 'scattered-site' housing model.
- Separating housing from treatment.
- Harm reduction.
- Social prescribing.

The Housing First programme is both an intervention and a culture. The programme conveys a welcoming and inclusive approach, voice, tone and manner (e.g. 'Hello! It is nice to see you again!'). Housing First office spaces have messages of welcome, inclusion and commitment to client-directed service.

Housing as a Basic Human Right

"Everyone has the right to a standard of living adequate for the health and wellbeing of him- [or her-]self and… family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [or her] control."

—Article 25(1), United Nations Declaration of Human Rights, 1948.

In the Housing First programme, housing is not offered as an enticement to get an individual into treatment or as coercion to get an individual to sober up. It is instead offered as a matter of right.

The Pathways Housing First programme has an 85% success rate for housing – and for keeping housed – people who have been homeless for years. This rate has been verified by numerous scientific and empirically sound studies[10].

However, even after years of operation, and after thousands of people have been housed, it is not possible to predict which tenant will succeed in housing and which one will fall into the 15% for whom the programme does not work well. Therefore, every person who meets the admission requirements of Housing First is provided housing and a chance (multiple chances, if required) to succeed in living in a home of their own.

Warmth, Respect and Compassion

Warmth, respect and compassion lie at the heart of all communication between Housing First staff and clients. Although these qualities are seldom documented in chart notes, they are the heart and soul of the Housing First programme.

These are the elements that create a healthy, positive, forward-looking, hopeful programme culture that benefits staff and clients alike. A warm, barrier-free welcome is essential. When a client enters the programme, the first message he or she should receive – both verbally and non-verbally (including through programme signage) – is: "Hello! We are glad you are here".

While these qualities may seem self-evident to some, it is important to understand that the client experience is not only what is being done for them but also how the service is provided. What is the staff's attitude or tone? For example, during an intake meeting that involves a staff member sitting with a client and obtaining information regarding demographics and psycho-social history, there is information being collected verbally but there is also non-verbal

communication. Is this passive data collection, or is the staff member engaged, interested and demonstrating empathy to the client's answers?

It is important that Housing First staff members are mindful and intentional about the non-verbal messages they convey because some of the most important messages – respect, hope and validation – can be conveyed through these channels.

What follows is a description of Housing First's principles and practices[11].

FIVE PROGRAMME PRINCIPLES AND PRACTICES

I. Principle 1: Consumer Choice

Making choices about one's life, and experiencing the consequences of those choices, is fundamental to the process of learning and growth. Client choice – which translates into the experience of self-efficacy and self-determination – is a core principle of Housing First because it helps clients to develop a sense of mastery and wellbeing.

Most traditional housing programmes are highly structured and allow only a narrow range of options to clients. Housing First programmes, on the other hand, are driven by client choice – free from a predetermined sequence of services and with the freedom to develop a life plan based on each client's dreams and aspirations. Clients determine the sequence of service(s) they receive.

When offered such choice, most people experiencing homelessness request a place to live as the first step. The Housing First programme begins by honouring that request and taking all the steps necessary to help the client fulfil that goal.

Ideally, clients can actively participate in the selection of location, housing unit, furniture and household items, and decor. However, given the limited supply of social housing units, especially one-bedroom properties, there may be restrictions to housing choice (but no more so than for any other person requiring social housing). The important dimension here is providing the programmatic conditions where the client has at least the same experience as everyone else in the community – without encountering additional barriers to housing because they were homeless or diagnosed with mental illness or a substance use disorder.

Once housed, clients continue to choose the type, sequence and intensity of services and supports. The Housing First team use a 'Stages of Change' approach[12] when supporting changes in other life domains beyond housing, including but not limited to family reconnection, employment or health. Staff actively encourage client participation in conversations about health, mental health and social connectedness; and offer suggestions for reducing risks and harmful behaviours associated with substance abuse. Clients have a choice to accept or reject any suggested services; however, **they must meet with their case manager in their apartment at least once a week or more often if needed.**

Home Visits

Clients are required to meet with Housing First programme staff for regularly scheduled home visits, typically four times per month, or in times of crisis as often as needed[13].

Home visits and honouring the client's choices are especially important in times of crisis, such as when a client runs out of money, is under threat of eviction, or when they have relapsed. Staff should restrain urges to take control or try to fix a chaotic situation but, instead, support and actively explore options, allowing the client to make their own decisions. For example, if a client is facing eviction due to having too many people staying in their home, staff can support the client to determine their best course of action: "What shall we do here? The landlord is pushing for eviction. Do you want to try to negotiate with the landlord? Ask your friends to leave? Leave this apartment and start over in a different one?" And, after the crisis is settled: "Let us figure out how you lost control of this apartment

and see what you can do to prevent that from happening again…"

Housing First staff must learn to balance the principle of consumer choice with assertive engagement. Practising consumer choice is not a passive approach. Staff must find ways to remain actively engaged with their clients through good and bad times.

By supporting clients to make their own decisions, especially under difficult circumstances, clients benefit from their experience and learn to make better decisions on their own the next time. This learning process is one of the cornerstones of developing mastery and self-determination.

Harm Reduction - A Client-Directed Practice

Because drug and alcohol use often co-occur with histories of trauma and abuse, all Housing First staff should be trained in trauma-informed care[14]. This includes administrative and maintenance staff, accountants, drivers, and any staff members who have direct contact with clients. The goal is to expand trauma-informed care from an individual intervention to an agency and team culture.

Trauma and addiction are intimately related[15]. Housing First works within a harm reduction approach by providing access to housing for people who are actively using. Short-term abstinence is not a requirement for Housing First clients. Rather, the programme acknowledges that alcohol and drug use are a normal part of human experience; and the goal is to help clients to reduce use, and to reduce destructive behaviours related to use, by immediately removing them from the high-risk environment of homelessness. Harm reduction aims to offer the client a different way of thinking about and addressing their problems[16].

The Housing First philosophy is reflected in the commitment to harm reduction that has been adopted by mainstream addiction services in Ireland for over two decades. Components of the harm reduction approach include:

- Healthcare screening and intervention;
- Needle exchange;
- Education and counselling;
- Opioid Substitute Treatment (OST); and
- Naloxone treatment.

For many, exiting homelessness removes a major reason for abusing alcohol or drugs. Once safety and security are assured, which the housing provides, attention often shifts to thinking about what is needed to hold onto housing. Behaviours around drug and alcohol begin to change after the person is housed – not because it is required by the programme but because it matters to the person.

Housing First staff refrain from manipulating or coercing participants into making choices to adhere to a programme regime. Change is more likely to be lasting and meaningful when it is consistent with the client's values and preferences and arises from within the participant, borne from their insight about how drug and / or alcohol use interferes with or creates serious problems in their life.

It is important to note that a harm reduction approach is not averse to a 12-step or abstinence model of treatment. If participants choose a 12-step, detox,

or rehab programme, staff are most encouraging. By the same token, harm reduction is not a practice leading to abstinence or sobriety. Harm reduction is simply a set of 'here and now' practical strategies to help people minimise adverse effects and reduce the negative consequences of drug and alcohol use.

In addition to substance misuse, the harm reduction approach is used to address problems in other life areas – such as exploitative relationships, poor health, trouble with managing money, unemployment, depression, anxiety, and more.

Techniques[17] available in harm reduction and motivational interviewing – such as decisional balance – encourage participants to explore the pros and cons of making changes in any area of life. The main goal is to establish and maintain ongoing open and honest communication, where participants feel safe, understood and supported to explore why they are having problems: "Why do you use? When do you use? What does it do for you? How well does it help you manage your stress? What's your go-to drug in difficult situations? Why? Are there any downsides of using? Have you considered other options? Where do you see your life going a year from now? How does that line up with where you are today? What's the next step for you?".

It is an important distinction that, while Housing First workers take a non-judgmental, harm-reduction approach to working with clients in active drug use, workers may understand but do not condone or encourage the continued use of illegal or harmful substances. All interventions related to alcohol and substance use are intended to maintain open and honest communication, and to support the client in protecting or improving their own safety and health, and that of others.

The ongoing communication between staff and client is best thought of as a journey. There are many decisions, high points, and low points along the way. Progress is not linear; there are steps forward – and then things go sideways and relapse is an expected part of the journey. Staff try to maintain a steady course as empathetic and accepting guides with the goal of understanding and analysing the choices made by clients, which result in negative consequences – so that the reasons for those choices (trauma and substance misuse) can be fully explored and healed.

Housing First programmes consistently report that providing decent housing, privacy and security helps people to cut back on their drug and alcohol use. It seems that providing housing first – rather than using it as incentive after a client has abstained – creates a powerful incentive to hold onto housing and generally improves quality of life.

II. Principle 2: Separation of Housing and Services

Housing First in Ireland uses a 'scattered-site' housing model, with clients being allocated permanent, secure social housing in properties provided by local authorities or AHBs, or in the private rented sector, sourced and secured from landlords by the Housing First service provider.

The 'scattered-site' housing model is consistent with research findings on clients' housing preferences – a home of their own is the top choice of most clients. This maximises the potential for tailored approaches to treatment: each person is in their own unit and, unlike in congregated housing settings, an individual behaviour does not affect the group. The independent unit also means clients have optimum ability to proceed with treatment plans at an individualised pace.

In Housing First, the principle of separating housing from treatment is evident at programme admission. Clients are not required to participate in psychiatric treatment or attain a period of abstinence to be housed. Treatment for mental health and substance misuse is a separate conversation to the discussion about selecting a home, moving in, and the responsibilities of tenancy.

The 'harm reduction' approach – described earlier in this chapter – creates an atmosphere of mutual respect, where clients can begin to trust staff and have an open and honest exchange about drug or alcohol use because they understand that talking about their problems with substance use is not linked to admission or eviction from housing.

Using a scattered-site, independent housing model (compared to housing clients in a single large building or group home) ensures the integration of people with histories of long-term homelessness into local communities. The Housing First programme does not rent more than 20% of the units in any one housing development. Thus, neighbours of Housing First tenants are people of all ages and from all walks of life – and Housing First tenants have the same rights and responsibilities as all their neighbours.

In Housing First programmes, loss of housing only occurs for lease violations, not for treatment non-compliance or hospitalisation. Some Housing First tenants may place themselves at risk of losing their home because they relapse, stop paying rent, have too many guests or are disruptive and are threatened with eviction by the landlord. Every effort must be made to relocate a client before an eviction (see Chapter 6). At such times, Housing First staff continue to work with the client to address the issues putting them at risk of losing their home – and to help them secure alternative housing before eviction occurs, if possible. Because the team is community-based, they can flexibly provide continuity of support when a Housing First tenant must move from one apartment to another or moves from the hospital or prison back to their home.

By separating a client's treatment status from the criteria for getting and keeping housing (yet maintaining a close ongoing relationship between these two components), the Housing First programme helps prevent recurrence of homelessness if clients relapse into substance abuse or experience a psychiatric crisis. When

necessary, team members can provide intensive treatment by facilitating admission to a stabilisation or detoxification service, to rehabilitation programmes, or to hospital to address a clinical crisis. Once treatment is completed, the client is helped to return home. Thus, there is continuity of support and treatment – even though there has been a disruption in housing status.

Most Housing First services are provided in the client's natural environment (i.e. their home or local community). The service is time-unlimited in that it is offered for as long as a client needs that level of support. The pace of the programme and the experience of each client is individualised because clients can choose the type, frequency and intensity of services. Progress and graduation from the programme occur at different times for each client

When the client is self-sufficient, there can be a complete separation of housing and services. Graduation typically means that the person no longer requires the support of case management services. However, to graduate, clients do not need to move out of their homes. Graduation simply means that services are discontinued. The client continues to live in their home with no need for further home visits. The client may either no longer need any services or may begin to receive services through their community clinics or local GPs.

III. Principle 3: Matching Services to Client Needs

No Wrong Door and Active Engagement

To provide the services needed by each client, either directly or through a network of referrals, Housing First staff operate with a 'no wrong door' (NWD) approach[18]. This is an approach that commits to seamless delivery of services for each client.

In an NWD approach, a client can seek any of several services: health services, assistance with benefits, dentistry, clothing, addiction treatment, or any other service. Even if the Housing First programme does not directly provide the service requested, staff will take the necessary steps to ensure the client is linked to the service that can assist them, thus ensuring connection to appropriate care regardless of the point of entry.

For service delivery to be successful, it is essential for all staff members (frontline and support staff) to establish a positive therapeutic alliance with every Housing First client. This must be guided by the Housing First ethos that staff genuinely care about the clients. Clients are not referred to by their diagnosis or by any other label or category. The programme rejects an atmosphere in which there are two classes of people: providers and recipients. Instead, programme staff strive to create a culture in which decisions are shared and everyone works together.

It is highly recommended to include people with lived experience ('peer specialists') as members of the staff of the Housing First

team. People with lived experience are a key support for creating and maintaining a programme culture that embodies and supports equality and recovery[19].

Most clients served by Housing First programmes have long histories of receiving services from many different community providers. They may have had experiences which raised expectations and dashed hopes, or they may have had experiences where their strengths and potential went unnoticed and unexplored, and where expectations of them were detrimentally low.

Housing First programme staff use an active engagement and recovery-focused approach to consistently show their concern and authentic interest, and to demonstrate to each client that this programme is different. Staff may have to approach a client many times as they strive to develop a positive relationship and rekindle their sense of optimism about the future. Staff don't give up, even if the client repeatedly expresses that they have no interest in the help being offered. Workers are trained to assume a practical, helpful, encouraging, but generally humble stance: they don't take the refusal of services personally. They continue to help and offer services – but they do not impose them. This practice is particularly important during times of crisis, when the client may be extremely stressed, hospitalised, imprisoned, or, in some rare cases, returns to homelessness.

Social prescribing (SP) can play a useful role in adhering to the Housing First principle of matching services to client needs. SP is an approach for connecting people to non-medical sources of support, or to resources in the community, to help them address the health and other challenges they are experiencing. The principles of SP are consistent with the client-directed, choice-driven philosophy of Housing First and, similarly, the prescribed social services are community-based. SP may include a range of community-based activities, such as arts and cultural activities, gardening, debt advice or budgeting, physical activity and leisure, library membership, and more. It can also include learning or educational activities, volunteering, housing maintenance, tenancy support services, benefits and entitlements, family and relationship support, employment, legal advice, and other resources or services[20].

IV. Principle 4: Recovery-Focused Services

The recovery movement in mental health broadly recognises the ability of people with severe mental illness to participate in mainstream society. While the term 'recovery' has been used in the field of addiction for decades, its usage and application in mental health services is relatively recent. Integrating recovery-focused services into Housing First programmes provides a set of values and practices that can be of benefit for the entire mental health system.

Two major influences have led to the widespread adoption and application of recovery in mental health. The first is the data from longitudinal studies of individuals with severe mental illness that report between 47% and 67% of individuals recover from (schizophrenia) severe mental illness[21]. In these studies, recovery is defined much like it is for health problems: there are no longer signs or symptoms of mental illness and the person is typically living in the community among their neighbours.

The second definition of recovery has been introduced by the mental health consumer / survivor movement, which is comprised mostly of people with the lived experience of mental illness, as well as advocates for the rights of the mentally ill. This definition of 'recovery' describes an approach or a process. It does not entail a full remission of symptoms or a full return to normal functioning. Recovery in this sense refers to the process of coping with or overcoming the illness and the effects of the illness. For the population served by Housing First, this means sufficiently overcoming poverty, homelessness, unemployment, isolation, trauma, the negative consequences of involuntary treatments, and the loss of social roles to retain some degree of control over one's own life.

The two definitions of 'recovery' are often used interchangeably, which has resulted in some confusion about the concept of recovery. Some authors use 'recovery' as the clinical definition of living without signs and symptoms and apply the term 'recovering' to describe living with the illness but not having the illness define the whole person. Thus, 'recovering' is defined as an active process that includes managing symptoms, reducing the destructive impact of traumatic or negative events and, simultaneously, actively working to address issues in other life domains. It is not a 'static, product or result' but rather 'a lifelong process that involves an indefinite number of incremental steps in various life domains'[22].

According to Anthony, recovery 'is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles'[23]. The goal is to incorporate and manage the illness as only one part of a newly expanded self, one that includes the skills and strengths to minimise the intrusion of the illness while still striving to achieve other life goals so that one's life is no longer defined by his or her illness[24].

This vision of how to work with individuals with severe mental illness is a departure from traditional psychiatric treatment, which focused on eliminating symptoms. If we take the analogy of a physical illness, like diabetes, it is easier to see how the traditional goals fall well short of what the person with diabetes expects from life. For example, we do not demand that

adolescents be cured of their diabetes before they can learn to drive or that adults with diabetes must no longer take insulin before they can pursue their employment or educational goals. When applied to mental illness, this approach states that people with psychiatric disabilities do not need to delay resuming a full life while waiting for their symptoms to disappear or to be cured[25].

The Housing First programme takes this recovery-focused, holistic approach by offering a decent and affordable place to live and then providing support services that aim not only to ameliorate symptoms but also to reduce the negative impact of the illness, and assist clients achieve the maximum degree of recovery possible.

V. Principle 5: Social Inclusion and Scattered-Site Housing

The 'housing' of Housing First is usually a decent, affordable home integrated in the local community. This housing model – called "scattered-site independent housing" – is consistent with clients' preferences, allows for separation of housing and services, and facilitates easy relocation without disruption of services.

Housing First recommends that no more than 20% of the units in any one development are occupied by Housing First tenants. The scattered-site model helps to ensure that people with experience of long-term homelessness, who may also have psychiatric disabilities and other complex challenges, live in integrated buildings and communities. It is not a housing 'programme'; it is their own home. Clients recognise and appreciate the enormous difference between the two and they become invested in keeping their homes.

If clients have a difficult adjustment in their first Housing First home, they can be relocated to another one, maintaining continuity of staff support throughout the transition. The difficulties experienced in the initial tenancy can become valuable learning opportunities for both the client and the Housing First team, helping them to develop insights into what went wrong and what skills will need to be developed to prevent future tenancy breakdown.

Most new tenants become invested in their own success, which includes being a good neighbour. In the scattered-site model, Housing First clients move into their home alongside other people from the community – their new neighbours – rather than being

placed in a programme with other clients and support staff on site. As such, with the scattered-site approach, integration into the community begins the day the person moves in.

Conclusion

This introductory chapter has described the Housing First programme and provided evidence for its effectiveness. The rationale is provided for selecting Housing First as an intervention to address chronic homelessness in Ireland.

The programme's values, principles and practices are described to prepare the reader for what is expected in terms of how services should be provided under Housing First. It is important to operate Housing First correctly and to use these guidelines because high adherence to Housing First programme fidelity delivers better outcomes for clients. The following chapters describe who is served by Housing First, how housing is procured, and what services are provided.

[1] Aubry, 2015; Stergiopoulos, 2015; Tinland, 2020; Tsemberis, 2004

[2] Padgett, 2016

[3] Resources that complement this Irish manual include: the 'Canadian Housing First Toolkit' and the 'Housing First Guide Europe'.

[4] See Chapter 10 for more on the concept of programme "fidelity".

[5] Goering et al., 2015

[6] Goering, 2014

[7] Aubry et al., 2015; Padgett et al., 2015; Stefancic, 2007; Stergiopoulos et al., 2015; Tinland et al., 2020

[8] Greenwood et al., 2005

[9] Anthony, 1993; Anthony, et al., 2002

[10] Peng et al., 2020

[11] See also: Housing First Guide EU, 2016; Tsemberis, 2015

[12] See Resource 1 (Section 4) for a full explanation of the 'Stages of Change' approach.

[13] See Chapter 5 for a detailed description of home visits.

[14] See Resource 1, Section 1 for further information on Trauma-Informed Care

[15] Mate, 2011

[16] See Resource 1, Section 3 for further information on Harm Reduction

[17] See Resource 1 for further details.

[18] No Wrong Door, 2016

[19] For more on peer specialists, see Chapter 8.

[20] A more detailed description of Social Prescribing is included in Resource 1, Section 8, 'Community Integration and Social Inclusion'

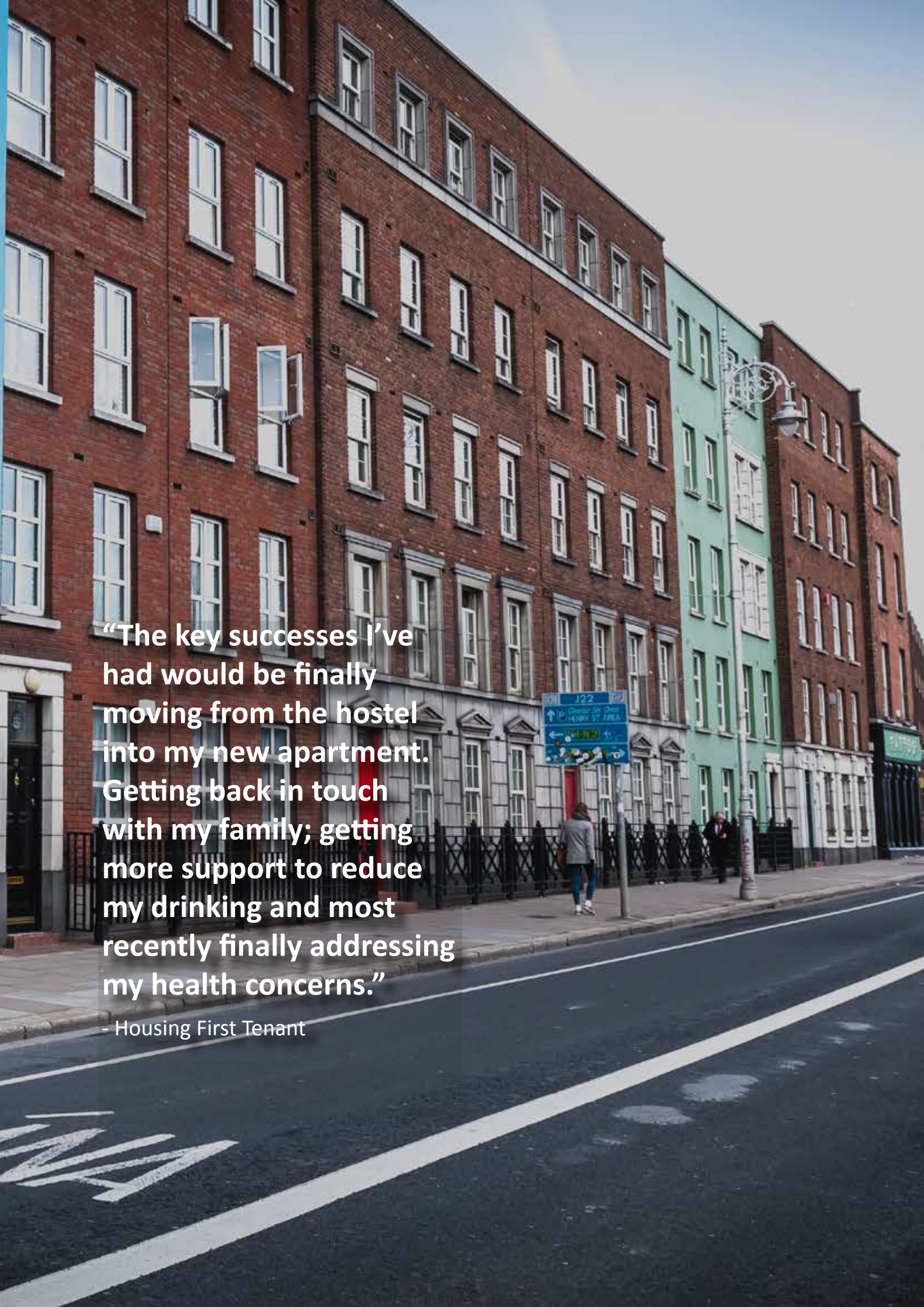
[21] Harding et al., 1987

[22] Deegan, 1988

[23] Anthony, 1993

[24] Hunter, 1994

[25] Davidson et al., 2005

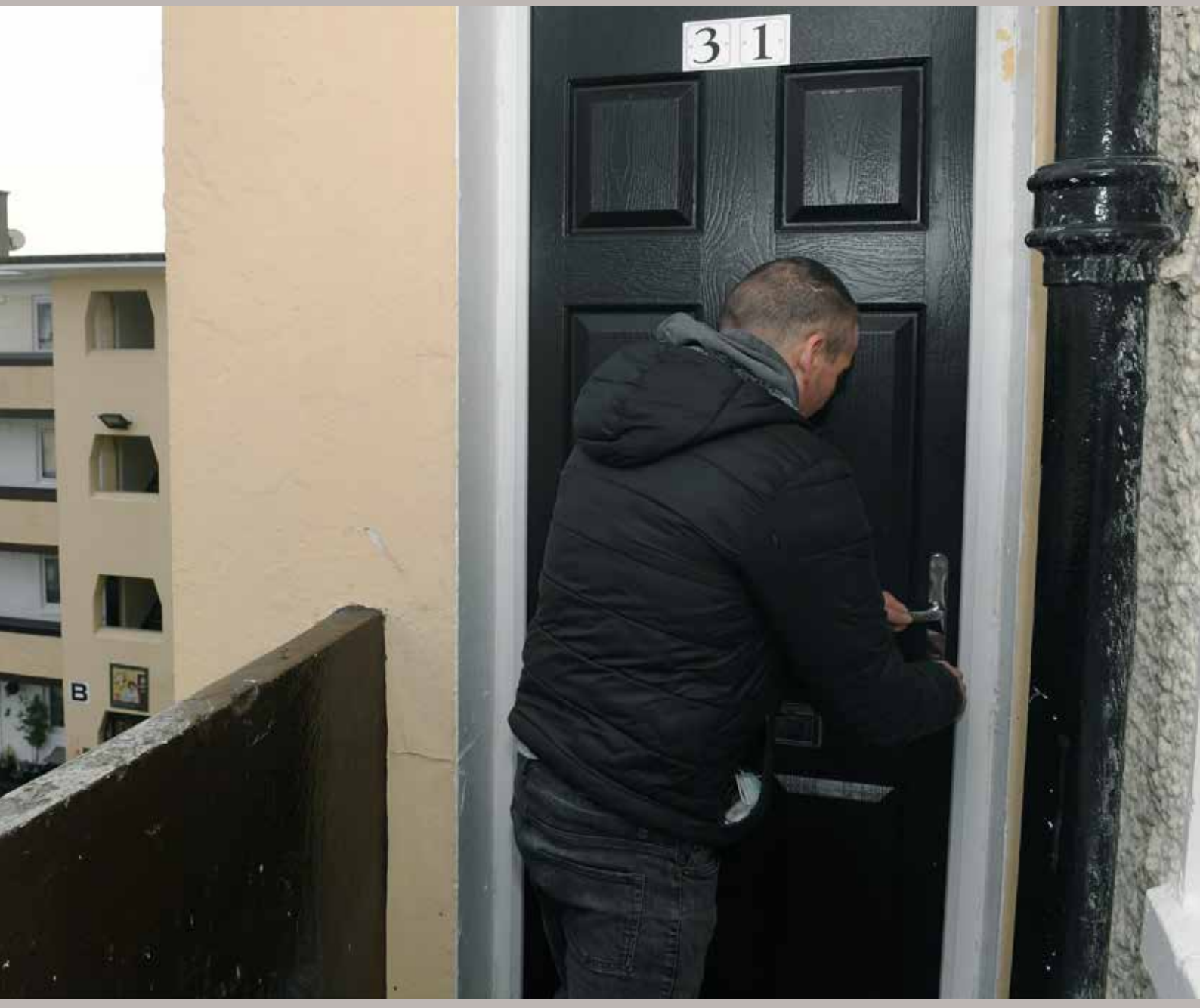


“The key successes I’ve had would be finally moving from the hostel into my new apartment. Getting back in touch with my family; getting more support to reduce my drinking and most recently finally addressing my health concerns.”

- Housing First Tenant

Chapter 2

Prioritisation



This chapter describes how local services select and prioritise clients for Housing First.

How Do We Prioritise for Housing First?

The goal of the Housing First programme is to prioritise and engage those who have remained outside the existing service system by providing a different type of programme. It is anticipated that some individuals will not fit the traditional clinical criteria for admission to mental health, addiction or other services. There may be others who are reluctant to engage in treatment and require outreach and home visits to build trust ahead of providing treatment.

If Housing First programmes discover that they are encountering a host of problems in engaging the clients they have enrolled, this should serve as a validity check that the programme has indeed enrolled precisely the right group of clients. The expectation is that the Housing First programme will be inclusive and flexible and will strive to deliver services on clients' own terms. With Housing First, success is defined by the programme's ability to change to successfully meet the needs of the client. This is a radical shift from expecting clients to conform to programme rules to succeed.

In implementing Housing First in Ireland, each local authority, in coordination with the HSE and the partner NGOs responsible for service delivery at local level, may determine the referral, admission and prioritisation process for the service, provided this process is consistent with the aims and definitions included in the 'Housing First National Implementation Plan'. Specifically, the ways in which the qualifying criteria are defined, and the ways in which people are prioritised among those who fit the qualifying criteria, will need to be tailored to the practical realities of each local context.

The National Implementation Plan states that: 'the priority target group for a Housing First response are people with a history of sleeping rough and long-term users of emergency homeless accommodation with high and complex mental health and addiction needs'[27].

The targets for each region of the country set out in the National Implementation Plan are determined by local authorities by quantifying the number of people in their areas who meet the criteria of long-term homeless (LT), rough sleeping (RS), and / or with high support needs (HSN).

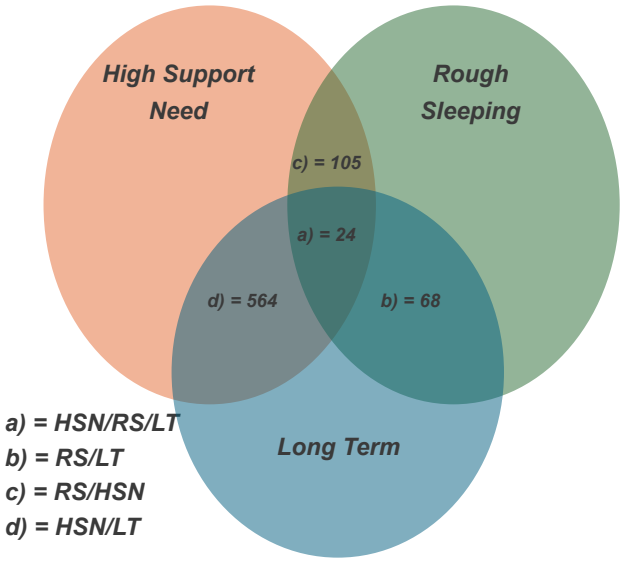


Figure 1: National Housing First Programme Selection Criteria

Partners in Housing First delivery in each region will need to consider questions such as the following:

- 'Long term homelessness' is clearly defined in Irish policy as six months or more, consecutively or cumulatively, in emergency accommodation or sleeping rough[28]. Do all people in the area who meet this definition equally meet the 'long term homeless' criteria for prioritisation, or should priority correlate directly with each person's length of time homeless?
- Are one of the three qualifying criteria to be weighted more than the others? For example, do we want to address the needs of rough sleepers first, regardless of their level of support need or length of time homeless? Or prioritise those who are homeless the longest, regardless of whether they are in emergency shelter or sleeping rough?
- How do we determine what constitutes 'high support need'? Do we prioritise physical health needs over mental health needs? This prioritisation process should be considered in the context of the participating agencies in each Housing First programme and, if possible, based on clinical data about prospective programme participants.
- How can we balance criteria based on objective data (e.g. length of homelessness as recorded on PASS[29]; level of support need as reflected in diagnoses or hospital presentations and admissions; number of nights sleeping rough rather than in an emergency bed) with common-sense approaches that make use of existing on-the-ground knowledge of the homeless population among outreach workers and shelter and healthcare providers? Service providers in most areas will be able to point to those who are considered the most vulnerable, the most excluded, or in the most immediate need of the life-saving intervention of Housing First, yet – depending on the extent to which those individuals engage with services – they may not be prioritised using objective data alone.

The prioritisation process in use in the Cork Region Housing First services provides an example of how prioritisation is implemented in practice.

A key to the sustainability of Housing First, as an alternative to traditional 'staircase' models of homeless service provision, is its ability to free up resources from the over-use of emergency accommodation by prioritising the small percentage of people in homelessness who use a disproportionately high percentage of resources in that area. Each local authority will have priorities determined by the number of people sleeping rough and the pressure on emergency accommodation systems, and intake criteria for Housing First will be determined with reference to these concerns and priorities.

Prioritisation will vary in the local context across Ireland's nine regions. Housing-focused groups overlap in membership; and local services providers will have direct knowledge of individuals who will benefit from Housing First. This may include individuals who may not clearly fit the selection criteria, but who have a long history of not engaging effectively with existing providers. Decisions about prioritisation should be made in consultation with the local authority, the HSE and the designated NGO service-provider; and should also include other key stakeholders.

The Cork Region Housing First services uses a Venn diagram based upon the one included in the National Implementation Plan, with three overlapping data sets. The data sets include both objective criteria – i.e. PASS data on long term homelessness and rough sleeping, and HSE data on frequency of presentations at Emergency Departments – and information gathered through consultation with outreach workers, emergency shelter workers, and the HSE Adult Homeless Integrated Team based in homeless services.

While people included in any of these data sets are considered eligible for Housing First, priority is given to those who are included in all three data sets, followed by those who are included in two. Using this approach, a person who is long-term homeless as recorded on PASS, and also among those most frequently requiring ambulance call-outs, or presenting for urgent care, would be in the priority group, as would a person who is identified by both outreach workers and health clinicians in homeless services as being highly vulnerable.

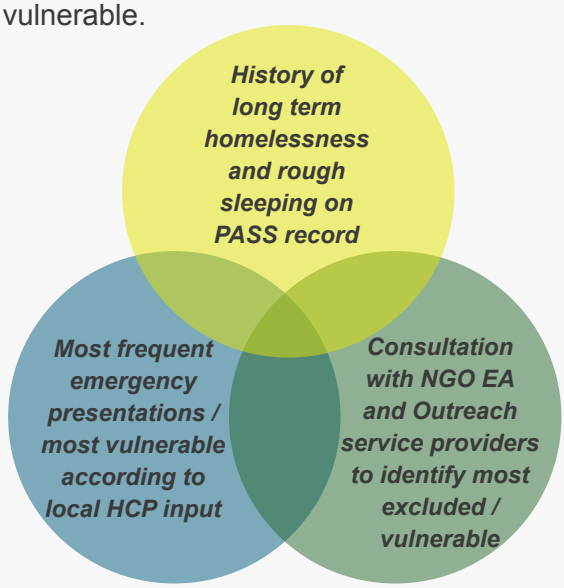


Figure 2: Admissions and prioritisation tool for Cork Region Housing First

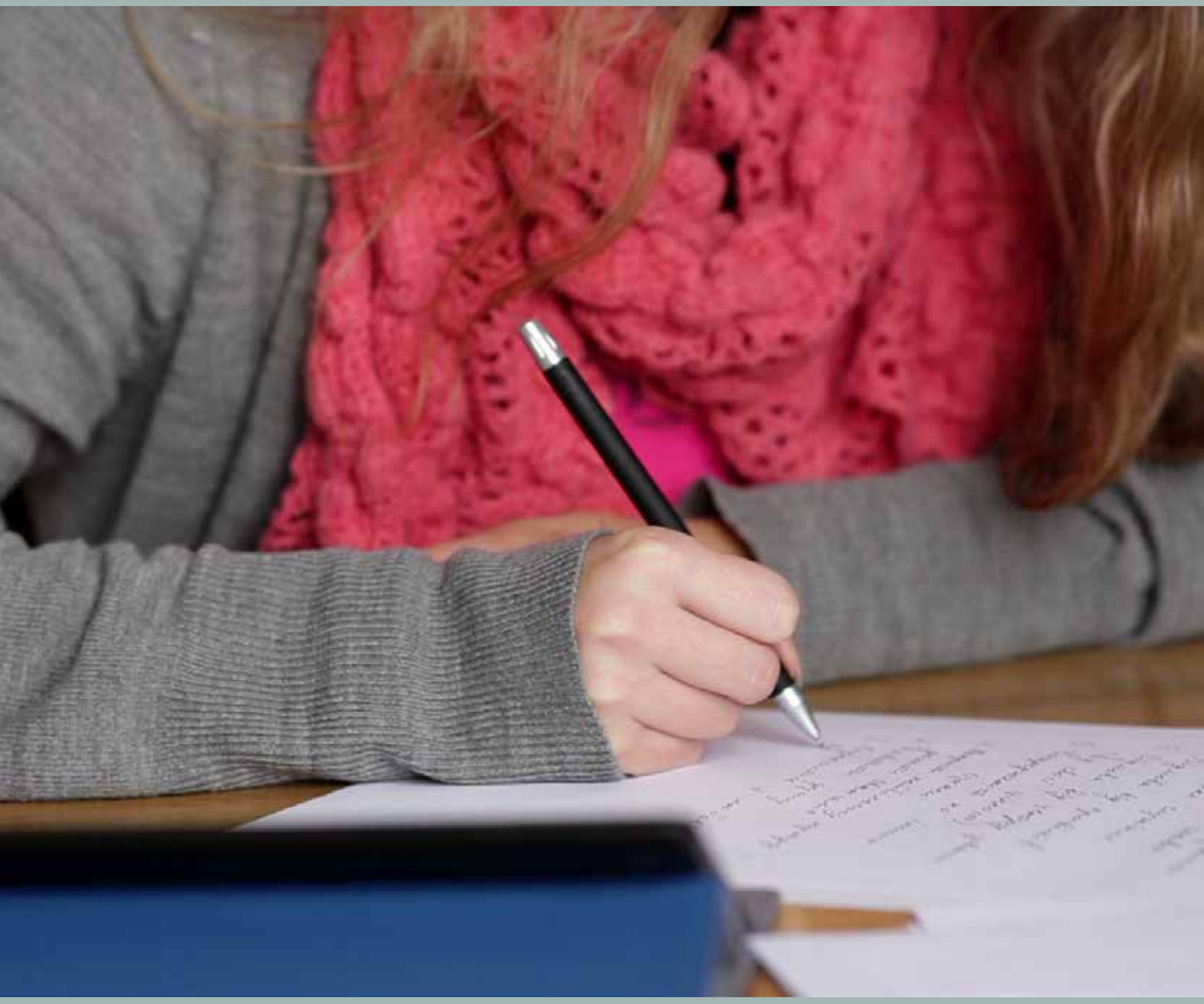
[27] https://www.housing.gov.ie/sites/default/files/publications/files/housing_first_implementation_plan_2018.pdf

[28] Department of Environment, Heritage and Local Government, 2008.

[29] The Pathway Accommodation and Support System (PASS) is an online shared system used by every homeless service provider and all local authorities in Ireland. The system provides real-time information in terms of homeless presentation and bed occupancy.

Chapter 3

Health and Support Services



This chapter describes the community-based, mobile support and treatment services provided by Housing First. Because the services teams are often interdisciplinary and comprised of staff from different agencies, there is also a discussion of team governance and service coordination.

Housing First services in Ireland are offered in a manner that is consistent with Pathways' founding principles for Housing First:

- Consumer choice;
- Separation of housing and services;
- Matching services to client needs;
- Recovery-focused services; and
- Social inclusion and scattered-site housing.

The Pathways Housing First programme is best-known for providing immediate access to housing, as a matter of right, and not requiring treatment or abstinence as a precondition. However, Housing First is about much more than the question of 'What should we address first?'. The reason housing is offered first is because the programme is driven by the principle of client choice, and housing is almost always the first choice of people experiencing homelessness.

The same guiding principle of client choice is the foundation for the approach taken by treatment and support services in Housing First programmes: choice, self-determination and humanism underpin all aspects of the approach. The transformative aspect of Housing First is not based on a specific sequence of housing and service-related tasks, but on personal agency and the redistribution of decision-making power from clinician to client.

Ireland's National Housing First programme provides an opportunity for local authorities, AHBs, the HSE and NGOs in the homeless sector to take a new approach to both housing and treatment / support services. The Housing First model has proven effective in engaging and successfully treating a previously poorly served and highly vulnerable segment of the homeless population, but it requires buy-in, flexibility and creativity for Housing First to be implemented successfully.

Community-Based Care

The Housing First model requires that community-based care be the main plank of health service delivery. In Ireland, changes from a largely inpatient-based model of mental health service delivery to a community-based approach commenced in the mid-1980s, when a new model of mental health care was proposed[30]. It was to be comprehensive, with a multi-disciplinary, community-oriented approach, ensuring that care should be provided in an individual's home, with a variety of community-based services.

Currently, most of the activity of mental health services is carried out in the community, in publicly-funded mental health services, and patients with mental health problems are seen in outpatient settings, day hospitals, day centres, and at home[31]. Further improvements – and the resources to fund them – are required, but mental health and addiction services configuration is already closely aligned with the community-based approach advocated by Housing First. Hence, health care and treatment professionals – particularly within the fields of mental health and substance use disorders – already work in collaboration with clients to support them to take their next steps. Overall, the Housing First model is complementary to healthcare service configuration that has been in place in Ireland for several years.

‘No Discharge’ Policy

Housing First challenges housing authorities to proactively prevent evictions and calls on healthcare and case management services to operate with a ‘no discharge’ policy[32]. This requires housing and support services alike to work with creativity and innovation to find new ways to effectively address their clients’ needs.

One of the more challenging aspects of the Housing First programme is helping clients achieve goals beyond housing stability. When a person is housed, there is a period of positive change and stability. However, international programmes have found that clients do not report the same magnitude of change in other domains.

One of the explanations for the modest outcomes in other life domains is that many agencies have implemented Housing First with only case management support. In Ireland’s Housing First implementation, an inter-disciplinary team – with robust clinical support from the HSE – will hopefully deliver better health and recovery outcomes.

The way to ensure we get better outcomes is to refuse to become complacent with housing stability and continue to help our clients to strive for recovery.

Providing Support and Treatment Services

Clinical and social support services, in addition to case management and housing supports, are essential services to assist in clients’ transition from homelessness to being housed and then to keeping their housing.

An array of services is provided either directly by the Housing First programme or through coordination with other community agencies. As part of the Housing First programme, HSE clinical staff typically provide services in clients’ homes and community settings, rather than office or clinic-based settings.

Over time, clients may choose to receive treatment at community clinics, but this choice is made by the client rather than required by the Housing First programme. The services offered by the programme are aimed at assisting clients to fully integrate into their communities and provide a range of treatment and supports that encompass everything from healthcare and counselling to practical help with shopping and paying bills.

The overarching aims of treatment and support services are to have clients engaged in the Housing First programme in a manner that feels comfortable and helpful to them; and to foster trust that the programme is there to help them realise their goals. Therefore, it is important for all staff, regardless of discipline or specialty, to commit to a ‘whatever it takes’ approach to providing services. At times, this commitment may translate to first assisting clients with an everyday task before

addressing their treatment needs. This requires staff to take a flexible and holistic approach to treatment and services, one that easily and cheerfully accommodates requests that are not strictly within one's area of expertise – but are important to the client. The requests for assistance are as varied and individualised as the clients themselves.

All staff supporting the client should be fully integrated into the Housing First programme and work as a cohesive team to support each client in the way that is most helpful to him or her. As is outlined later in this manual, the core full-time Housing First team membership will vary, but all teams should be able to source the appropriate skill-set to support their clients. Across housing and health, Housing First staff work as one team; therefore, clinical staff need to be flexible to do tasks that are outside their area of expertise but are nonetheless important to the client at a particular point in time. That said, while flexibility is crucial for all staff, as with any multi-disciplinary team, role clarity remains important.

The Housing First programme will also assume responsibility for linking clients to other formal supports and services, including health clinics, GPs, mental health services and addiction services; and to informal community resources, such as self-help groups and other community supports, as and when desired by the client. Some of the core services that are directly delivered across all Housing First teams are tenancy support, mental health and addiction supports. The specific specialist positions will vary depending on population, existing service, and level of need across the nine regions of the Housing First programme nationally. The staff working in Housing First programmes need to have (or quickly develop) a working knowledge of several evidence-based clinical practices. The first is to ensure that each staff member receives training on the Housing First approach described in this manual. In addition to the information about how the model works, staff should receive ongoing implementation support through participation in regularly-scheduled community of practice meetings to discuss clinical cases and apply Housing First principles to work in the field.

Furthermore, each Housing First team should have (or soon develop) a core set of clinical competencies and training in relevant evidence-based approaches that includes, but is not limited to:

- Integrated and person-centred assessment, care planning and case management.
- Motivational Interviewing.
- Stages of Change.
- Recovery-focused care.
- Trauma-informed Care.
- Intercultural awareness.
- Dual diagnosis i.e. Integrated Dual Diagnosis Treatment (IDDT).
- Suicide/mental health risk assessment.
- Advanced directives or relapse prevention planning i.e. Wellness Recovery Action Plan (WRAP).
- Brief Intervention, i.e. SAOR screening.
- Naloxone training.
- CPR/First Aid[33].

Housing First Programme Staff Composition

In some cases, the Housing First team will directly deliver most services the clients receive. This is referred to as the 'standalone' model. In other regions, the team will broker access to mainstream healthcare services, including addiction and mental health supports. This is referred to as the 'shared care' model[34]. Regardless of whether the services are provided directly by the Housing First team or by a mixture of direct and mainstream supports, the Housing First programme philosophy and programme practice should look the same across all regions.

Staff roles in Housing First programmes perform generally the same functions as in other services except that the programme philosophy is client-driven and the provision of services is (or can be) provided in the client's home or in the community. At the core of this team practice philosophy is the client.

The client's expressed preferences should guide the service or treatment plan. The capacity of the client to direct the services they receive should be assumed in line with the Assisted Decision Making (Capacity) Act 2015. Agreeing the supports which the client receives involves listening carefully to the client, making observations and offering options for services or treatment, and being guided as much as possible by the choices the client makes. In teams using the 'shared care' model, the Housing First staff play the central role in ensuring that all of the service providers are fully integrated, and that the client successfully receives the appropriate supports and treatment they need.

Housing First programme staff consist of case managers and housing workers employed by the local NGO service-provider. Some of the larger programmes may include additional clinical supports. The NGO staff vary in number depending on the number of clients to be served and are typically trained in social work, social care or addiction treatment. The staffing patterns are not fixed across areas. Each area will, however, have a Homeless Action Team (HAT) or other multi-disciplinary team to assist the Housing First programme with health and social needs.

Housing First teams may look slightly different depending on regional priorities and what resources are provided to teams locally. The intensity of support that clients may want and need, and the size and spread of the location in which the service is to be delivered (e.g. rural areas) are significant factors. When funding was allocated for Housing First programmes, regions identified gaps in existing HSE staffing to enhance multi-disciplinary supports. Most of the regions have added mental health and addiction-focused staff positions; and some Housing First programmes have dedicated health staff that may include a part-time psychiatrist, public health nurse, occupational therapist or psychologist. Mental health social workers and their attendance at HAT meetings increase access to mental health supports for Housing First clients.

In summary, the team is comprised of all the staff members of the local NGO service-provider, the HSE and includes all the clients served by that team.

Regardless of whether a Housing First region is structured with a stand-alone team, is led by an NGO with a multi-disciplinary team, or adopts more of a brokering model, the following are some of the positions that will be needed to support Housing First clients:

- Team leadership.
- Psychiatrist.
- Mental health nurse.
- Addiction counsellor.
- Peer specialist.
- Occupational therapist.
- Case manager.
- Housing worker.
- Psychologist / trauma specialist.
- Education, training, and employment coordinator (or Supported Employment specialist).

Specialist Supports Provided as Part of Housing First

Peer Specialist

A key component of Housing First programmes is the inclusion of people with lived experience as members of the staff team. The peer specialist serves an essential role in the team's success because he or she provides valuable advice from the perspective of someone who has 'been there and done that'. The presence of a peer specialist working as an active member of the team demonstrates to the other team-members and to the programme's clients that recovery is indeed possible. The fact that a person diagnosed with a severe mental illness, substance misuse disorder, and/or who has experienced homelessness —just like the Housing First clients —is now an active and productive member of the team, provides a powerful, positive and inspiring example. The peer specialist proves that recovery is not just a philosophy or a theory; it is a lived experience.

Peer specialists have experienced both the service-provider role and the programme recipient role so they are in a good position to help ensure that the team is operating from a client-centred, recovery-focused approach. In addition, peer specialists can empathetically articulate how clients may view or experience the team's intervention, which provides invaluable insights. A full exploration of the role of peer specialists is included in Chapter 8 of this manual.

Supported Employment Specialist

While Housing First clients typically identify housing as their top priority, finding a job is often the second priority they identify.

Supported Employment (SE) - also known as Individual Placement and Support (IPS) – offers an effective way to help clients get and keep a job. This practice is highly compatible with Housing First's values, mission and operation.

SE operates on the principle that every individual, regardless of abilities, has the right to learn, work and contribute to his or her community. Similarly, every individual has the right to seek an education and to find meaningful employment that will improve their quality of life.

The SE process has no lengthy assessments, and no transitional employment or training period. The only question needed to begin the process is: "Do you want a job?". If the answer is affirmative, the client and the SE specialist begin to plan the steps needed to achieve this goal.

The SE specialist teaches, guides, and coaches clients as they write CVs, search for jobs, prepare for interviews, find transportation to and from work, undergo training, adjust to a work schedule, and accept new responsibilities. The SE specialist can help the client identify career paths, meaningful jobs, negotiate accommodations with employers, and serve as a liaison or support between the clients and their employers.

The most effective teams do not rely on one SE specialist to accomplish all that must be done for clients to choose, get, and keep employment. The entire Housing First team must be involved and committed to helping clients find employment. “Work is everybody’s business” is a Housing First slogan that captures the need for every team-member to make employment a high priority—when it is a high priority for clients.

Some clients fear that they may not succeed in the jobs market. For staff working with such clients, Motivational Interviewing and a Stages of Change approach can be very useful[35]. These approaches will help the client identify their anxieties about work and help the team understand what the logical next step for a client might be.

Employment is about developing financial independence and social inclusion. It also has enormous psychological meaning. The self-definition of a client changes from a person who is a client in a programme to a person with a job. The new social role defined by employment opens entirely new possibilities for socialisation and social inclusion and allows for the opportunity to utilise and acquire new skills.

Clinical Governance

Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver. It is an integral component of governance arrangements and helps to improve patient experiences and achieve better health outcomes in terms of quality and safety.

In the context of Housing First, clinical governance is necessary to ensure quality, safety and satisfaction with the health services provided to clients; and the process should be clearly specified.

Clinical governance is either directly provided by HSE line management or senior clinical staff (e.g. consultant psychiatrist), or approval is sought by the Housing First NGO service-provider from the HSE. It is the responsibility of the relevant Community Healthcare Organisation (i.e. the regional structures of the HSE) to arrange the most suitable clinical governance arrangements for the health supports provided to Housing First clients.

Roles and responsibilities for the Housing First operational team should be clearly defined via a Standard Operating Procedure (SOP). In practice, challenges with gaining informed consent and capacity are sometimes overcome by an agreement to separate housing and health in terms of intake. The NGO service-provider, with the approval of the relevant local authority, can agree to take sole responsibility for housing decisions, meaning that the HSE is not involved with housing decisions. Once the Housing First clients are identified as being on the Housing First caseload and are housed in tenancies, the clinical supports can then happen at that point, post-tenancy.

Integration of Service, Treatment and Supports

Implementation of Housing First requires the integration of services, treatment, and supports across the health and housing systems. This presents a challenge given that these two systems have different structures and ways of working and, similarly, within the health system, services are structured and provided in different ways.

As has been outlined earlier in this chapter, for Housing First to work successfully, it is essential that services coordinate closely to deliver on the choices of the client as best they can.

The ways to facilitate service integration in the delivery of Housing First include:

- Memorandums of Understanding (MoUs) with services;
- Integrated care pathways;
- Documented and agreed processes and procedures;
- Shared IT systems/tools;
- Shared care meetings;
- Co-location; and
- Shared learning (education and training).

Integration of health supports is key in the standalone model of Housing First[36].

Clinical Care Coordination

Clinical care coordination involves deliberately organising clients' care activities and sharing information between all the professionals concerned with a client's care to achieve safer and more effective outcomes. The clinical coordinator establishes the individual's biological, psychological and social determinants of health through collating health records from the multiple services involved in the individual's care. They have responsibility for coordinating, facilitating and integrating the health care for the individual.

The coordination role requires working closely with the client and all of the healthcare services involved in the client's care (including homeless services, GPs, Public Health Nurses, Emergency Departments, acute hospitals, and community mental health teams) with the goal of improving their health and quality of life. The role also involves evaluating care through service-user feedback and measuring health and social care service use.

Clinical coordination also involves linking with other health services – GPs, pharmacies, consultants, Clinical Nurse Specialists, etc. Typical tasks can include:

- Making sure people are aware of appointments and facilitating them to attend them;
- Linking with relevant services when needed, e.g. need for a review or advice;
- Arranging referral of the client to other health agencies / professionals; and
- Ensuring all agencies involved in the client's healthcare are kept up-to-date with what is going on for the client. This includes, in particular, ensuring the local Emergency Departments (EDs) are up-to-date with the client's current health status, should they present to the ED, and that relevant personnel in the EDs are aware that the person is a Housing First client.

Mandatory ‘shared care’ protocols across a wide range of stakeholders facilitate health integration for Housing First clients via the Homeless Action Team (HAT) structure. Where access to a service is challenging, the local service-provider NGO will report back to the HSE lead for support. The process thereafter is to facilitate a shared care meeting between relevant stakeholders to remove blockages to support for the client.

[30] Planning for the Future, 1984

[31] Vision for Change, 2006

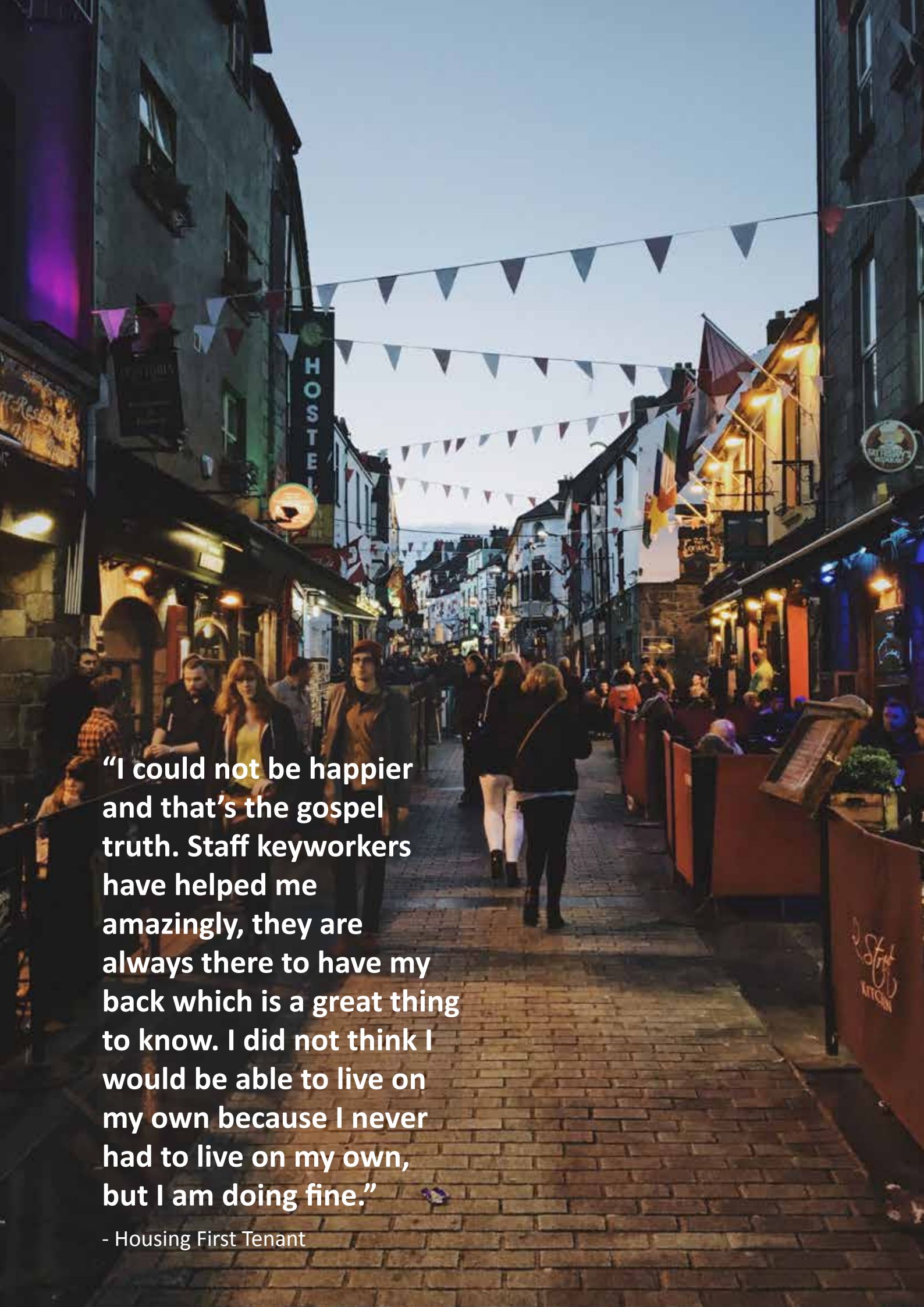
[32] Essentially, this means making a commitment to work through any challenges that arise with each client for as long as it takes.

[33] For further details on the evidence-based approaches that support Housing First, see Resource 1.

[34] See Appendix 1 for more information on the ‘standalone’ and ‘shared care’ models of Housing First.

[35] More details on Supported Employment, Motivational Interviewing and Stages of Change are included in Resource 1.

[36] See Appendix 1



“I could not be happier and that’s the gospel truth. Staff keyworkers have helped me amazingly, they are always there to have my back which is a great thing to know. I did not think I would be able to live on my own because I never had to live on my own, but I am doing fine.”

- Housing First Tenant

Chapter 4

How the Housing First Team Works

This chapter looks at the day-to-day work of Housing First teams, covering team culture, communication, meetings and staff wellbeing. It also looks at how teams approach service delivery – including through recovery-focused services; the 'no discharge' approach; matching levels of service to clients' needs; and integrated care planning. The chapter concludes with a note on the 'limits of choice'.

Working as One Team

Housing First services consist of multi-disciplinary teams and staff from at least three different agencies (the local service-provider NGO, the HSE, and the relevant local authority) – each of which have different cultures for programme practices. Successful Housing First services develop a practice that is seamless between staff-members and across agencies. This requires all staff working in the Housing First service to embrace the principles and practices of Housing First to ensure that every staff-member is using the same approach and is aligned with the mission and practices of the programme.

This is not to say, however, that there is no room for differences of opinion on Housing First teams. In fact, open dialogue and debate about clinical and case management issues are encouraged. Such dialogue must be conducted in a respectful manner that best represents the interests of the client. The most effective way to ensure that the wishes of the client are respected is to include them as part of the Housing First team meeting any time there is a decision to be made that will impact their life.

Close collaboration among all team-members is essential because Housing First clients will have contact with the housing worker, case manager and health staff from the HSE. Using a team approach is the most effective way to coordinate the work of individual staff efforts for the same client.

Team Culture

The culture of the Housing First team is defined by the values of the Housing First programme, as well as the team's operational guidelines. These values shape the way team-members address programme clients and each other, and serve as guidelines for the team's practices and day-to-day operation.

A respectful, warm, and affirming disposition when relating to clients and/or other staff constitutes an essential dimension of recovery. The team that operates in this way is essentially modelling recovery for their clients and themselves. Effective teams are characterised by :

- Team members having a shared vision and goals for their clients and for the team;
- Agreement about practice protocols;
- Members who feel free to introduce or explore new ideas; and
- Members who have a sense of psychological safety while working as a team.

Developing the right team culture requires selecting the right staff. One of the keys to an effective team is selecting staff-members who share the humanitarian and social justice values upon which the Housing First programme is based.

The language used by Housing First staff to speak about clients among themselves or in a meeting should be that used as if the client is present. Staff must view people in the programme without prejudice and not judge people based on their life circumstances, life choices or history. Staff should treat each person with dignity and warmth. Humour is common in the programme, but never at the expense of the client. All people in the programme, staff and clients included, are recognised as having their own personality quirks and needs and as complex individuals.

Communication

Qualitative dimensions of interactions between the service-provider(s) and client are essential to good practice. This refers to non-verbal communication by staff, such as body language, voice tone and eye contact – and the degree to which the interaction demonstrates authenticity, empathy, respect, and hope. Are the interactions conducted in an egalitarian, shared-decision manner? Are staff always punctual for appointments and do they deliver on their promises? These qualities are the building blocks for developing what is referred to as the 'therapeutic alliance'[38].

In implementing Housing First, the use of language is carefully monitored to ensure that the way staff communicate about the people they serve emphasises their treatment as unique individuals rather than a 'priority population', such as 'chronically homeless' or 'mentally ill'. Programme participants are never defined by their diagnosis, perceived needs or level-of-care determination (e.g. people are never described as 'treatment resistant' or 'low functioning').

It is in the context of a positive therapeutic relationship that clients can begin to feel supported, safe, and accepted. The relationship is the vehicle through which all service delivery takes place, and the quality of that relationship affects the extent to which clients will actively participate or refuse to engage in services. Therefore, developing a positive and trusting helping relationship or 'therapeutic alliance' is an essential precondition for effective service delivery.

Operating a successful team approach also requires frequent communication among team members. Many Housing First teams use group text and a shared drive to keep each other informed about the wellbeing of their clients, changes in clients' plans, changes in appointments, or other time-sensitive information.

It may be common for the interpersonal intensity of Housing First service delivery to take its toll on Housing First staff when clients face challenges. Staff may try to assist clients who are participating in unhealthy behaviour and are unwilling or unable to change. They may need support to buffer the intensity and stress of this work and, often, the best source of support can be obtained from their colleagues. This requires that teams work to develop and maintain a healthy and nurturing culture focused on recovery for all, including for Housing First programme staff.

Monthly Review Meetings

It is recommended that Housing First teams schedule at least one meeting every month to discuss team process and reflect on their own goals. The team can review its efficiencies and inefficiencies, examine incidents that were managed well and others where there was room for improvement, and develop or update team goals – much like the team does for clients.

Daily Team Meetings

It is useful for the entire Housing First team to have a brief daily team meeting to discuss the clients to be seen that day, the services that will be provided, and the whereabouts of team members. Another function of the meeting is to ensure that each team member has the most current information about clients' needs and goals. This is crucial because there are no individualised

caseloads: all team members are expected to provide services to any client served by their team.

On teams where core staff have drawn in supports from the wider health system or other social services, core Housing First staff should ensure they are familiar with the outcomes of these consultations with the client. This may involve inviting other services to participate in team case reviews or meetings, as relevant.

In the daily meetings, it is helpful to name every single client and very briefly discuss their current needs, including any updates in service provision. These client reviews should remain brief because the team meeting also serves many other functions, including preparing for upcoming appointments and home visits with clients. Home visits are relatively brief events and staff would benefit from preparing for these ahead of each visit by having input from other team members working with the client.

The daily meeting is a highly focused and efficient event. It has been likened to the atmosphere in an operating room or control tower. The language used is brief, precise and goal-directed. Phones are off (except for emergency phones) and everyone is actively listening and looking for ways to be helpful. If an issue arises that is too complicated to resolve during the brief rollcall of the daily meeting, it is tabled until after the meeting.

Logistical planning can also be effectively addressed during the daily meeting. It is often the case that more than one client needs to be seen at a clinic, has appointments with the local authority, or needs a lift to the supermarket. Working as a team, the Housing First staff members can be more efficient because a single member can accommodate the needs of several clients at once.

Similarly, home visits can be conducted more efficiently by assigning one staff-member to see all the clients living in a particular area, rather than seeing only "their" client and driving long distances to do so (as can occur in programmes using an individual 'case load' approach).

The daily meeting also ensures that each team member knows something about each of the clients served by the team, assuring continuity of care when team members go on holiday, sick leave, or staff turnover occurs.

Staff Wellbeing

Organisations (whether statutory or NGO) which undertake to deliver authentic Housing First services must be prepared to invest in the wellness of staff members who may, through their work, be exposed to trauma, volatile situations, personal risk and grief. In addition to regular supervision, appropriate training and a supportive culture among the team, further supports that take account of the particularly challenging nature of the work should be considered. These might include:

- Access to counselling;
- External supervision;
- Formal therapeutic debriefing following a client death or a critical incident; and
- Team retreats or 'away days', which provide an opportunity to reflect on one's own work and the work of the team, to relax and enjoy each other's company, and to replenish and recharge for the work ahead.

Recovery-Focused Services

The journey of recovery is an individual journey, and it is a journey of awakenings. Each client awakens and realises his or her own dreams. Many clients have had their hopes and dreams dashed by years of homelessness and negative, stigmatising myths about mental illness and substance use disorders. Team members can play an essential role in this process of awakening by tracking and pointing out even the most incremental positive changes and celebrating milestones and the reaching of goals through an active treatment planning process.

It can be a positive experience of relationship-building and positive reinforcement for team members and clients to agree in advance on how certain milestones will be celebrated: the team may send along a small housewarming present with the team member carrying out a home visit to mark one month from moving in (e.g. a plant or a special mug for tea). A particularly difficult step for a client to make (whether a phone call to family, a long-put-off medical exam, or meeting with probation services) might be discussed and planned for, and it might be agreed that the client and a staff member will go out for coffee and cake to celebrate after that step is taken.

The reasons for celebration and the appropriate ways to celebrate will be as individual as the clients themselves, but Housing First teams should be creative and proactive in ensuring that clients' achievements are acknowledged and that the positive regard of the team is explicit. It is a long journey, and it is important to celebrate each step along the way.

The 'No Discharge' Approach

Within Housing First programmes, continuity of care is assured because the same staff can conduct outreach, engage clients when they are homeless, assist them in finding and moving into suitable housing, and then continue to provide treatment and support until the client graduates from the programme. This kind of continuity of care is very well suited for clients with long histories of frequent and fragmented interactions with social, mental health, addiction and criminal justice systems.

Each Housing First team is accountable for their clients' outcomes. Teams must make every effort to operate with what is essentially a 'no discharge' policy by making a commitment to work all challenges with each client for as long as it takes to achieve success.

In cases where the behaviour of a client (or that of guests or associates) poses a significant risk to the safety of staff, 'no discharge' should not be interpreted to mean 'engage / visit at all costs'. In such cases, it may be necessary for Housing First staff to remove themselves from unsafe situations, and their safety should always be their primary concern when assessing risk and making decisions about engaging. However, rather than discharging the client from the programme when this occurs, the Housing First team should take a creative problem-solving approach to the challenge of how best to minimise and mitigate risk so that some level of engagement can remain in place. For example, it may be agreed that home visits are to be suspended and support meetings are to take place only in public places for a period of time; or that

lone working does not take place with a particular client or in a particular location, and team members must visit in pairs; or that technology-based means of support are employed.

Sometimes, risk may be elevated due to issues related to medication (or non-medication), the use of particular substances, or other concerns which – if addressed appropriately by the client with the support of the Housing First team – can be managed back to a lower risk level. The team should be honest with the client about the reasons why risk to staff safety, or to the safety of the client or other clients, is a concern and – if feasible – the client should be invited to contribute to the resolution of the problem.

If, despite every effort of the team, it is determined that continued engagement with a client represents an unacceptable level of risk to members of the Housing First team, it may be necessary to suspend in-person supports for a period. This is different to 'discharge', however, in that the door should always be left open to re-engagement when this is assessed as safe, following a change on the part of the client or a change in circumstances. If the client consents, the team should continue to advocate with other services for the needs of the client, to facilitate a change that may make the resumption of personal supports possible.

Matching Levels of Service to Clients' Needs

The services clients need vary from person to person and from one domain to another in the same person. Many services needed by clients cannot be provided directly by the Housing First programme. These services may be provided by other statutory agencies, NGOs, religious groups, community-based support groups and more.

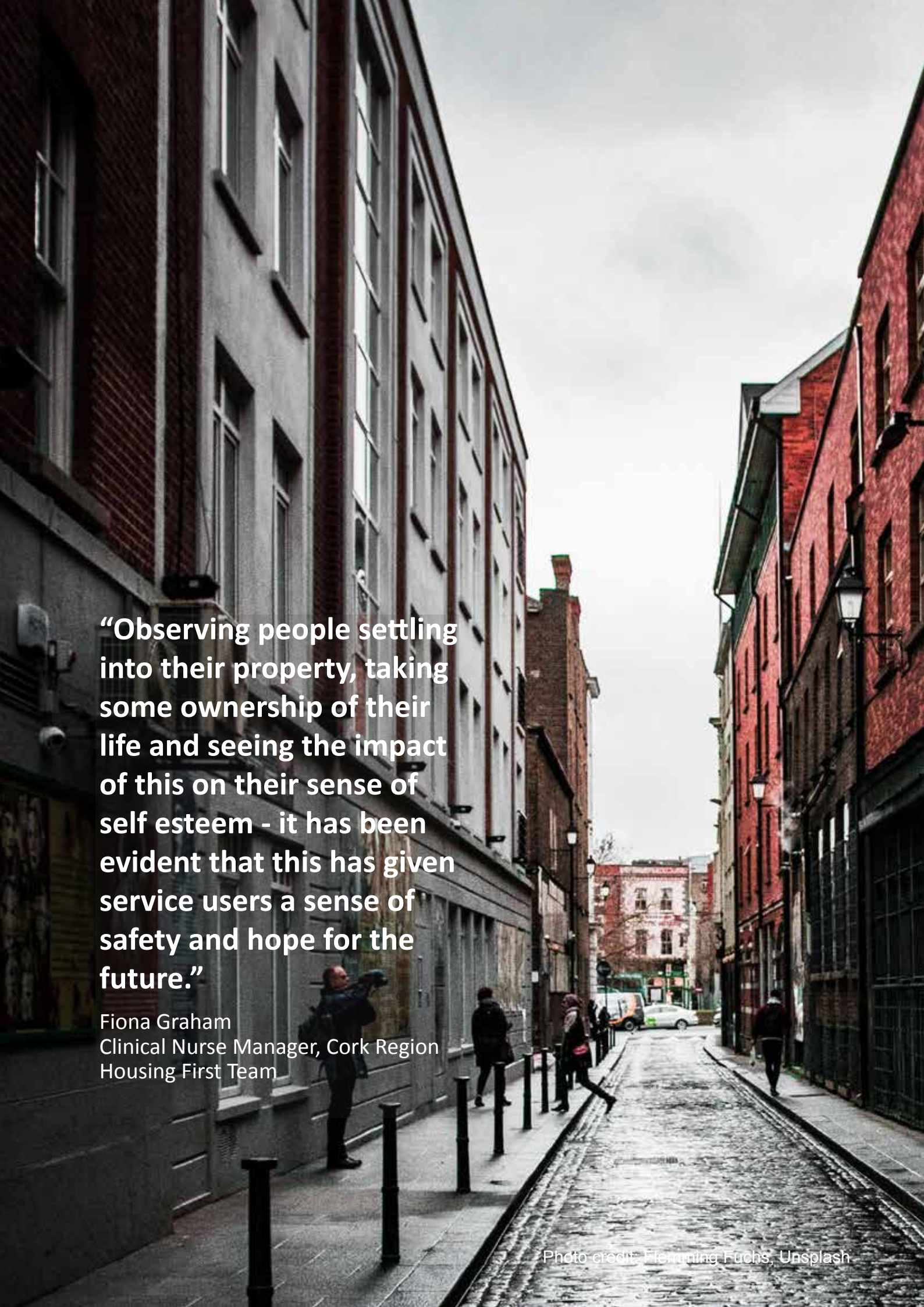
It is important to emphasise that the Housing First programme is responsible for assisting clients to secure these services. This requires the Housing First team to identify and take the steps necessary to ensure that the client receives the level of support needed to successfully obtain these other services.

Examples of service-related domains or goals include assistance with managing guests, housekeeping, stopping smoking, relationships, etc. A useful framework for conceptualising how to proceed in assisting clients is to use a 'Stages of Change' framework[39]. The 'Stages of Change' approach refers to five steps for clients towards making positive changes in their lives. The five specific stages are:

- Pre-contemplation;
- Contemplation;
- Preparation;
- Action; and
- Maintenance.

This 'Stages of Change' approach can be used to identify a person's readiness to change in relation to their alcohol or drug use, but it works just as well in other life domains, such as fitness, diet, sleep, etc.

Stages of Change is not a person-specific framework but, rather, an issue-specific framework. That means that the same person may be in the 'pre-contemplation' stage of addressing their issues with uninvited guests, while simultaneously in the 'action' phase of addressing their diabetes. Careful treatment planning must take differences in stages into account.



“Observing people settling into their property, taking some ownership of their life and seeing the impact of this on their sense of self esteem - it has been evident that this has given service users a sense of safety and hope for the future.”

Fiona Graham
Clinical Nurse Manager, Cork Region
Housing First Team

Photo credit: Flemming Fuchs, Unsplash

Integrated Care Planning

Care or treatment plans are like the maps that guide the journey clients take, supported by Housing First staff. Housing First team members can make suggestions to help clients identify some areas in which they want to enact change in their lives, but the client ultimately determines what, when, and how they change.

Once a goal is identified, it is broken down into several action steps – with a timeline for completion that is also determined by the client. This timeline provides the client and the team with an agenda that describes a course of action to realise each goal.

The care / treatment plan focuses as much on all the things a client can do to achieve their goal themselves as on the areas where the client needs assistance. Every plan should be developed using a strengths-based approach[40].

The following structure offers a framework for identifying and structuring clients' goals:

- Client's goal:
- Client's role or steps to be taken:
- Team's role:
- Timeframe or frequency of action:

For example, a client might explain that they heard meditation might be helpful and express the goal to 'learn how to meditate to relieve my stress'. To achieve this goal, the client's role will be to:

- Practise meditation at the local community centre twice a week; and
- Practise meditative breathing techniques for five minutes three times a week

The immediate next steps for the Housing First team, meanwhile, will be to:

- Ensure that whatever needs to be in place for the client to access the community centre class (e.g. registration, admission fee, equipment such as a yoga mat, etc.) is in place;
- Plan a time to take the client on a tour of the community centre to learn about using the facility; and
- Have the nurse review the breathing exercises with the client this week.

Integrated care planning allows for all of a client's health needs to be met in one setting. It can occur in multiple ways, depending on who is providing the care, what type of care is being provided, where the care is taking place, and how services are being coordinated.

Examples of integrated care models may include:

- 'Coordinated care', which concentrates on communication with care providers and the client themselves;
- 'Co-located care', which involves service providers being physically located in the same facility; and
- 'Integrated care', which emphasises practice change whereby all providers practice in a high-functioning team and client needs are addressed as they occur.

A shared knowledge base across providers is a feature of integrated care and is achieved through shared care planning and shared medical record access, where appropriate consent is given This provides an opportunity for the extended team to truly treat the whole person and their identified needs as they arise[41].

Initial Care Plan

During the initial assessment and care-planning interview, invariably, almost all clients state that housing and housing-related concerns are of primary importance. Housing First programmes are ideally suited to provide clients with the assistance and resources to have them realise their most important goal: to obtain housing. This establishes an excellent precedent for a working alliance. Concerns such as rent,

furniture, building management, neighbours, and other matters related to renting and maintaining a home are always a part of the housing-related goals conversation between the Housing First team and the client.

With their housing goals relatively quickly achieved, it becomes possible for clients to begin to focus on other goals, most of which are broader and cover various aspects of the client's life. For example, clients have often lost contact with family members, but may be able to renew past relationships since they are now a part of the Housing First programme.

Clients' goals are as numerous and diverse as the clients themselves. Goals may include obtaining a valid ID, eating healthy food, getting a job, assessment of need for medication and commencement of medication if required, reducing drug use, writing poetry, staying out of the hospital, meeting a girlfriend/boyfriend, getting a library card, getting new eyeglasses, or getting clean and sober.

One of the demonstrated Housing First outcomes is that many clients list mental health treatment and substance abuse treatment as important goals after they are housed. Therefore, current mental health and addiction services aim to assist clients not only by having community-based services and a harm reduction approach, but also by assisting with other needs, including accommodation and social welfare. In short, moving into a new home creates a fundamental change in the client's mind-set and ability to focus on next steps rather than all energy being focused on immediate survival. It provides the client with something of value; they become invested in holding onto it; and realise that their level of addiction may jeopardise this precious asset. So, rather than the Housing First programme pushing the client to change, the client is taking the initiative towards their own recovery.

For clients who still find it difficult to relax their vigilance or get a good night's sleep after being housed, the next step might be assessment by a psychiatrist or other mental health professional to fully explore the factors related to poor sleep and relaxation and to formulate an appropriate care plan with the client. Medication may be required for treatment of the symptoms of any mental health disorder uncovered, but only as part of a tailored programme of care incorporating other evidence-based psychotherapeutic interventions.

Other frequently-reported goals include finding a relationship or a job. Addressing health concerns is also near the top of many clients' lists.

One of the most valuable lessons learned from the Housing First programme is that clients who are seemingly incapacitated in the face of multiple challenges are, in fact, capable of setting and meeting their own goals for housing and treatment if they are provided with the right resources and support.

Care planning is an active and dynamic process. As one goal is reached, another new goal emerges: one, perhaps, that could not have previously been imagined. For example, Joe's initial goal was to stop drinking to keep his apartment. At that starting point, going at it one day at a time, he could not imagine that – two years after attending his first AA meeting – he would be invited to be a keynote speaker for an AA public information event. The successful realisation of one goal creates opportunities to develop and achieve higher ones –goals that may have once seemed unthinkable to the client.

The Limits of Choice

The client-directed nature of the Housing First programme is similar to the person-centred, evidence-based model of care practised within mental health and addiction services, embracing components such as community-based care and harm reduction. This more holistic approach long ago replaced the traditional restrictive, paternalistic medical model, helping to end the stigma associated with having a mental health disorder and mitigating the sense of being failed that clients had previously encountered. While further improvement in the delivery of person-centred approaches is required, their adoption by mental health and addiction services facilitates the collaborative working of Housing First and health services for the wellbeing of clients.

Housing First offers clients choice in the type, sequence and intensity of services. However, what happens after a client is housed and they say they do not want any treatment or services? Is that a legitimate choice? The answer here is both yes and no. The client can refuse treatment, but they have already agreed to the two conditions of the Housing First programme: 1) the home visit and 2) the terms of the standard lease. So, the Housing First team can accept 'no treatment' as a legitimate choice but 'no home visit' is not an option. The quality of the relationship with the client is the key variable that determines if an impasse will develop and how it will be resolved.

Assertive engagement refers to active outreach to clients to ensure that they are managing well in their homes and that their immediate needs are met. At various times during the long course of this programme, clients may require an increase or a decrease in the level of services they need. The period after move-in is a time of frequent visits and the same is true when a client is in crisis. The increase in service intensity during a crisis is particularly important even as the client may be refusing visits.

[37] Wholey 2012

[38] Ardito, 2011

[39] Prochaska, 1992. See Resource 1 (Section 4) for full details of the 'Stages of Change' approach.

[40] Rapp, 2004. For more on the Strengths-Based Approach, see Resource 1 (Section 6).

[41] Heath, 2013

Chapter 5

The Home Visit

Home visits are among the most crucial interventions of Housing First. The client's home is the stage where many of the team services are provided. In this chapter, we describe how to conduct successful home visits.

The Art and Science of the Home Visit

The home visit serves many purposes. It is both casual and focused. On any given day, Housing First team members make many home visits, so they need to be efficient, prepared, and organised. The visit not simply a social call. While it is social in nature, it is also a targeted intervention. The home visit is not formally a treatment visit, but since it is a professional who is visiting the home of a client, there is treatment going on. The team member is not providing a prescribed treatment – rather, it can be considered a visit to invite the client to participate in treatment or develop a plan for productive, meaningful activity.

The emotional tone of a Housing First home visit is much like that of a visit with a relative. It begins the same way: “How are you?”, “Good to see you”, and so on.

The conversation begins with the issues currently being addressed by the client and the team, and it may evolve into developing new plans or activities. The visiting staff-member is warm, caring and casual – but the visit is also a mandatory, targeted intervention.

Balancing all the different and somewhat contradictory components of a home visit requires an intuitive and thoughtful approach, which is why we refer to this event as the ‘art and science’ of the home visit.

Arranging Home Visits

For best results in ensuring the client is home when the Housing First team visits, the visit must be arranged in advance. It is useful to arrange all home visits for the month at the beginning of each month and at a time that is convenient for the client. In this way, the client can anticipate and prepare for the visit.

Team members prepare for the home visit by reading the client’s most recent progress notes and reviewing the client’s goals, so there can be effective follow-up during the visit. The team must be punctual and reliable.

Locations

Sometimes, a visit starts in the home and ends up in the community. Team members often meet clients at their home and help transport them to a clinic or other appointment. At other times, the team can meet a client at home and then go shopping with them or take a walk together around the local area. These outings are important because they also provide the team member with an opportunity to observe how clients interact with others in their own communities.

Purpose of the Home Visit[42]

The primary purposes of the home visit are to ensure the client’s wellbeing and mark progress on their treatment plan goals. The team should observe the client’s mood and general physical condition. The visit also serves as a social connection because, for some clients, this may be their only contact of the week.

The second most important reason for the home visit is to ensure that clients are managing well as tenants and that their apartments are being well maintained. In partnership with the client, the Housing First programme is motivated to have the client succeed in their tenancy. The team can observe the condition of the unit and help the client report problems to the landlord. If the client asks for help, the team member can call the landlord and advocate on the client’s behalf.

Much can be observed during a home visit. Team members can learn about clients' habits by carefully observing their living space. The team member may observe new family photos on the wall, unpacked bags, a particularly tidy apartment, dirty dishes or empty wine bottles on the counter, for example. If it is appropriate, these observations may be addressed at the time or they may be filed away as points that can be returned to during a future visit. Those residing in Housing First programmes are typically there over significant periods of time; and engagement, trust and disclosure can occur on a long-term trajectory.

Staff Roles and Responsibilities

A major part of the home visit is providing services such as medication delivery, follow-up care and goal planning. Home services have a repetitive nature that provides an opportunity to connect and develop a deeper and more authentic relationship with the client. Building a relationship takes time – especially when some clients are suspicious of the mental health system or any government system because they have a history of not being treated well. During the early phases of the programme, clients may not acknowledge problems or share troubling issues they face. Team members must be patient, and convey acceptance and concern – but never judgment.

One of the interesting things about a home visit is that it creates a shift in power dynamics between client and staff. The home visit, after all, occurs on the client's own turf. This – coupled with the Housing First programme philosophy that housing is a basic human right and not dependent on a client's participation in treatment – poses interesting challenges for the team member.

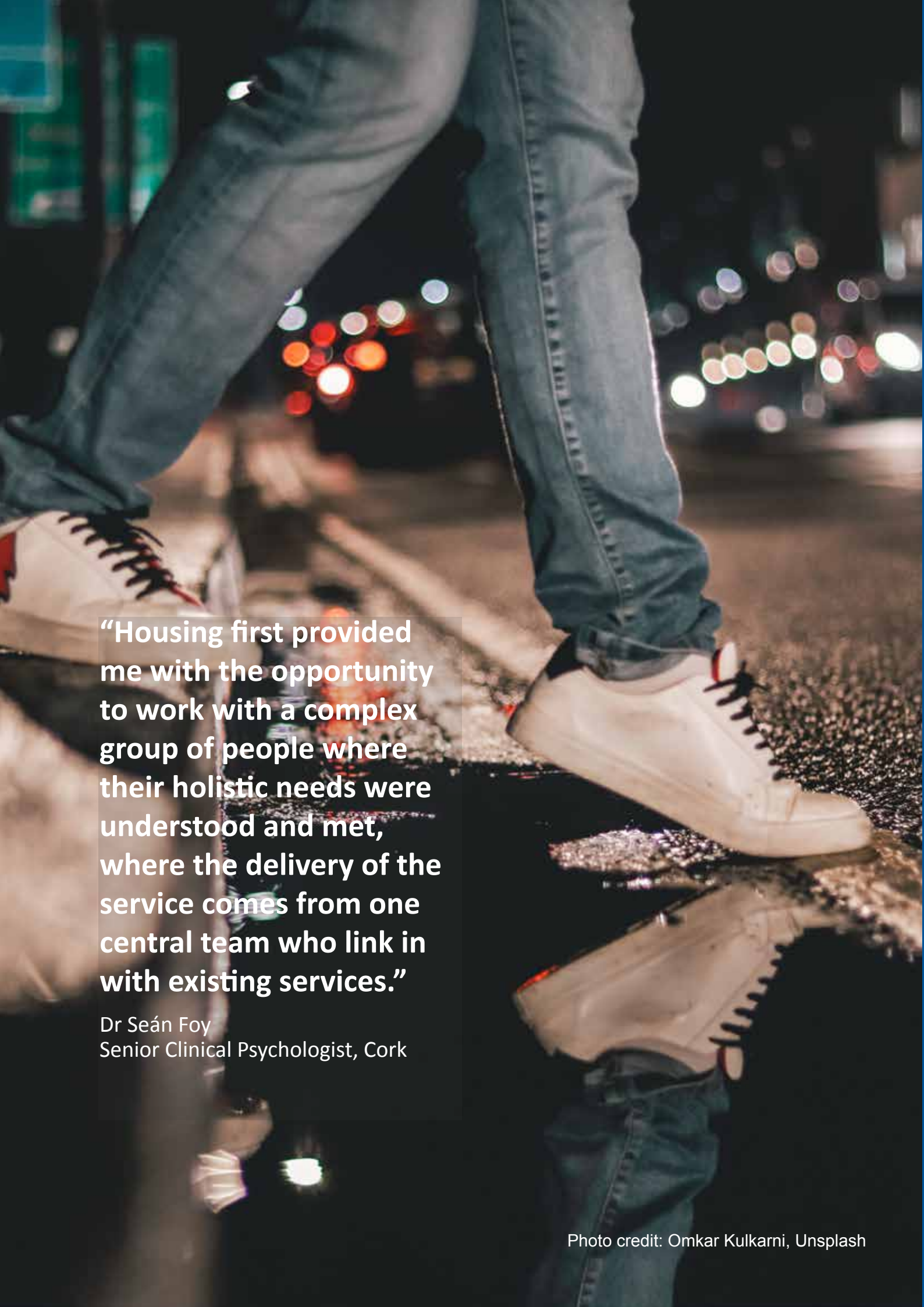
The challenge is for the staff to engage the client into treatment, especially when the treatment is not mandatory. Short, hurried visits, or an absent client when the team comes to call, can be indications that the team is not engaging well with a client. The client's degree of engagement may be an indicator of the staff's clinical skills. Another measure of the team's success is the extent to which they are warmly welcomed into their clients' apartments.

Surprise home visits should occur only if there are concerns that a client is in danger or hurt and only after all other ways to contact the client have been exhausted. It is in rare instances and after several tries that the Housing First team must use their duplicate keys to enter a client's home.

The home visit, both in its form and content, provides a wealth of information about the client, the staff, the client's living conditions, and the condition of the treatment relationship. It is a microcosm of the entire Housing First programme. Most of the work of the programme takes place during the home visit[43].

[42] See https://www.youtube.com/watch?v=JOb8tX1MFGk for a video in which Housing First service-providers discuss the purpose and importance of the home visit.

[43] Advice on conducting virtual home visits is included in Resource 2, 'A Guide to 'Home Visits' Delivered Remotely'.



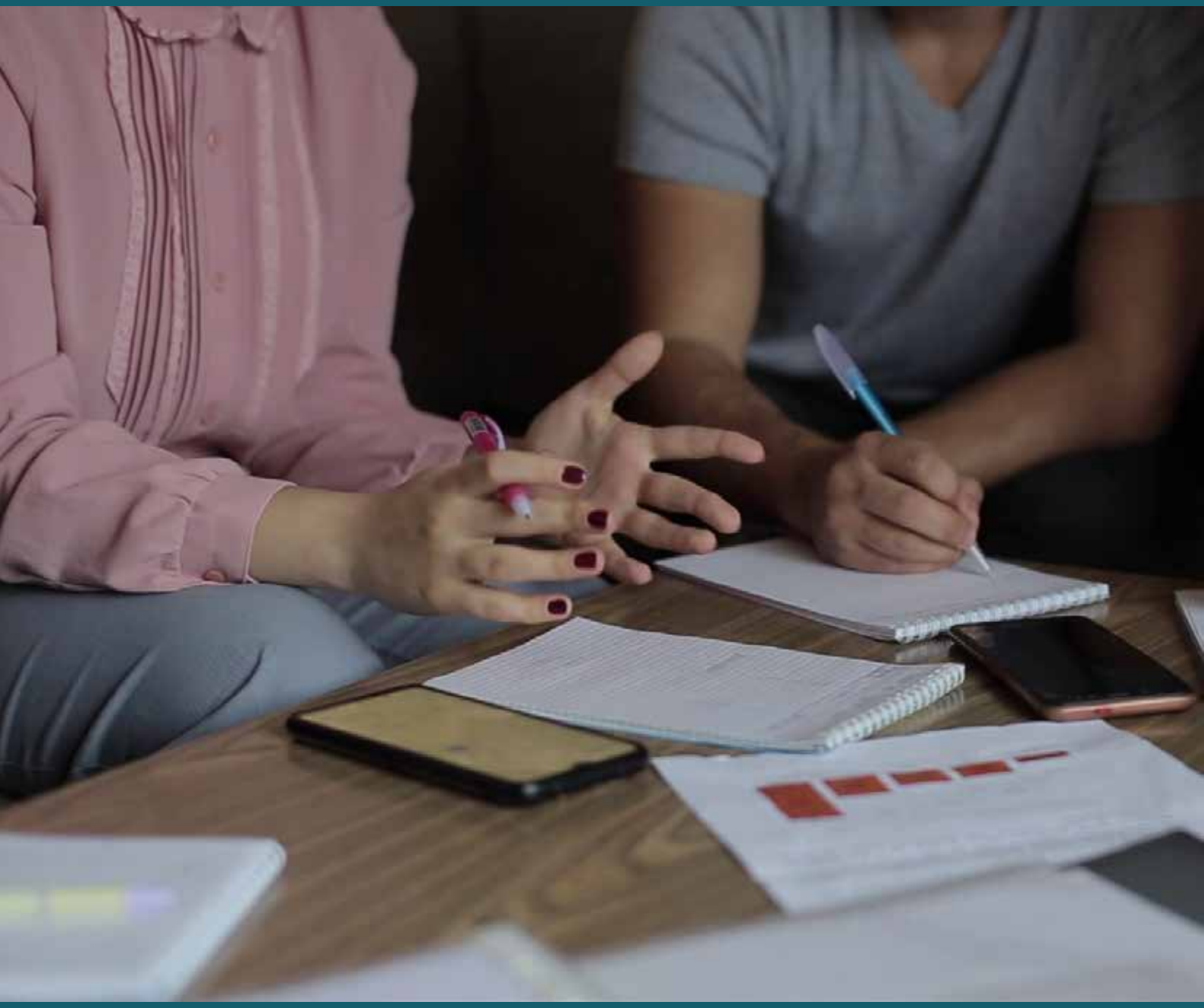
“Housing first provided me with the opportunity to work with a complex group of people where their holistic needs were understood and met, where the delivery of the service comes from one central team who link in with existing services.”

Dr Seán Foy
Senior Clinical Psychologist, Cork

Photo credit: Omkar Kulkarni, Unsplash

Chapter 6

Housing Support Services



This chapter describes the approach to housing and tenancy support in Housing First services. The functions of tenancy support include coordination of the acquisition of housing; assisting clients in setting up and settling into a new tenancy; the management of problems that arise in the tenancy; and the provision of ongoing support to clients, landlords and other Housing First team members.

The separation of housing and treatment is a core principle of Housing First, and refers primarily to the fact that an individual is not required to engage in treatment to access or remain in housing, nor does a tenancy breakdown affect the person's continued access to treatment and support from the Housing First team. Ideally, this separation is reflected in the configuration of the Housing First staff team, with one or more roles focused primarily on the acquisition of properties and the management of tenancies; and other roles focused specifically on providing holistic and specialist health, social and personal development supports. However, it is understood that some smaller Housing First teams will necessarily provide housing and tenancy support services as part of their general case management function.

While team configuration and job titles may vary, and the method used to provide these services may look different across regions, it is essential that all Housing First programmes provide housing and tenancy support services to clients, landlords and Housing First team members in a way that is consistent with the programme's principles and evidence-based practice. For the purposes of this chapter, the housing and tenancy support function will be described as if provided by a staff position called the 'housing worker'.

Home Visits with a Housing Focus

As detailed in Chapter 5, home visits are an essential feature of the Housing First programme. Approximately 70% to 80% of contact with clients happens in their home.

When home visits are conducted by support or treatment staff, the focus is on the treatment plan and other matters relevant to the client's health care and wellbeing. When the home visit is conducted by the housing worker, the focus is housing and tenancy related issues.

Role of the Key Worker or Housing Case Manager

It is essential to the success of Housing First that programme staff assume responsibility for:

- Assisting clients to manage their tenancy;
- Supporting landlords (the term "landlord" is used to represent staff of local housing authorities, AHBs and / or private landlords); and
- Working closely with their other Housing First team members to maintain the programme's good reputation as a supported housing service.

Communication is one of the keys to success. It is essential that there is clear and ongoing communication between housing workers, landlords, the client and support services staff. Immediately after the housing worker completes a home visit, notes must be entered into the client's record, reporting on the conditions in the housing unit; building, neighbour, or landlord issues; and any changes in the condition of the apartment or the habits of the tenant. In addition to notes, if an issue is urgent or developing, it must be immediately reported to the other members of the Housing First team.

The housing worker role can be uniquely challenging because, at times of conflict or disagreement, it is the housing worker that must mediate between the landlord and the tenant, or the landlord and the wider

Housing First team. The goal of the housing worker is to represent the interests of each party involved in the disagreement, while simultaneously functioning as an integral member of the Housing First team. There is built-in tension and stress inherent in the role of the housing worker – since the three parties they must support are not always in agreement.

The housing worker is the first point of contact for landlords and property managers and is the staff member who is likely to first receive complaints about a tenancy. The aim is to address issues immediately as they emerge and avoid threats, legal proceedings and evictions.

Working with Landlords

Housing First services must have a clear and consistent policy and practice regarding landlord support and landlord relations. Services must ensure that the Housing First team protocols become standard practice across all arms of the programme.

The first step in the development of landlord relationships is for the Housing First staff to have regularly-scheduled meetings with the region's lead local authority to ensure there is regular communication and feedback regarding properties and tenancies. Members of the Housing First team can explain the role of the housing worker and the wider team in supporting the tenant and the local authority to increase the likelihood of successful tenancies. The local authority should be informed that the Housing First team is there to address behavioural and other issues, and that landlords will receive prompt support from the Housing First team, should problems arise.

Communication with the local authority and other landlords is ongoing. The Housing First programme must ensure that the housing worker and other team members have the contact information for every landlord; and that all landlords are familiar with and have contact information for the primary contact person for the team (the housing worker or staff member with housing worker responsibilities). When landlords make contact to address a problem, it is essential to respond to their concern immediately and follow up to ensure the situation is being addressed, even if it cannot immediately be resolved. The responsiveness and ongoing communication of the Housing First team is what builds the landlord's trust and increases their willingness to collaborate with the programme.

It is important to check in with landlords on a regular basis – not only when there is a concern. Landlords must feel supported in participating in the Housing First programme and, in the case of some private landlords, in having accepted tenants that would have ordinarily been unable to access their units. Housing workers should make every effort to get to know each landlord, agent or property manager on a personal basis to create a positive relationship that is not crisis-focused. Each prospective tenant should be brought by the housing worker or other Housing First team member to meet their landlord; and the Housing First team should ensure that the client is aware of the rules and expectations surrounding tenancy. In most instances, tenants will work directly with landlords and property managers to address housing issues. However, each party knows that the housing worker's support is readily available, should they need it.

Housing Retention and Eviction Prevention

Building a positive relationship helps landlords to have a better understanding of the Housing First programme and the challenges that clients experience; and may provide some leniency when clients face potential termination of a tenancy.

Prevention of eviction is critical to maintaining a successful Housing First programme and the most effective means to prevent eviction is to focus on practices that ensure housing retention.

The termination of a tenancy should be the practice of last resort and the Housing First staff should develop actions that enable the client to take pride in their home and to acquire the skills necessary to take care of it, like independent living skills (e.g. cooking, cleaning), social skills and being a considerate neighbour.

However, the practices and focus of prevention and housing retention should be uniquely tailored to individual tenant need. Secure housing is essential to assist clients with goals of becoming self-sufficient, and housing retention provides that foundation.

Protocol for Home Visits

As outlined in Chapter 5, although Housing First staff conducting home visits must behave as guests invited into a person's home, the home visit is also a programme requirement that must be met. This 'balance of power' approach is consistent with Housing First's client-driven philosophy; and places the onus on staff to develop and maintain positive relationships with clients, so that there is increased likelihood of clients opening their doors when staff knock.

The protocol for conducting home visits begins with respecting the client's right to privacy and the acknowledgement that staff need permission to enter a client's home. Visits are scheduled at times convenient to both clients and staff. Only in crisis or emergency situations are staff permitted to enter a client's home without their permission, and usually in this event they will be accompanied by the landlord or An Garda Síochána.

Conducting a 'Housing' Home Visit

In every visit, the primary focus is the client. However, for all Housing First staff, part of the visit should include questions about the condition of the housing unit: "Is everything in working order?", for example.

When housing workers conduct home visits, the visit includes a formal assessment of household conditions such as plumbing, electrics, window and door locks, and other structural issues. A general evaluation of cleanliness, clutter, guests and other indicators of good apartment upkeep should also occur.

Some clients may require assistance in making requests for repairs or services from the landlord; and housing workers (and/or other Housing First staff) may be asked to provide support in this regard. It is a useful practice to take photographs of the condition of the apartment when the client moves in and when the client moves out.

Property Management Challenges

The wear and tear of daily use means that an apartment or house will have occasional maintenance issues. The best remedy for such issues is early intervention. The Housing First team needs to orient the newly-housed client to life in their apartment or house and simultaneously gain some understanding about areas of growth in which the client may need support. Upon moving in, there should be an orientation and checklist that examines the condition of the property: for example, are the doors and windows secure and locking? Is there a working heating system, washing machine, refrigerator, cooker and washing/ sanitary facilities, amongst other requirements?[44]

Health and Safety Issues

Housing First staff may find it necessary to educate some clients about maintaining a clean and healthy environment, covering issues such as rubbish disposal, laundry, expired foods, and regular apartment cleaning. The best teaching method is the one that the client can understand. In many cases, it is best to perform or demonstrate how a task is done, rather than offering a verbal explanation alone. For example, a staff member could go shopping with the client, purchase the correct size rubbish bags for the kitchen and bathroom, and then, together, place the bags into the bins. For disposal of rubbish, it can be helpful to create a calendar. Every Housing First household would do well to have a large calendar where home visit dates are written as well as all other important dates to remember. Very concrete and practical help is often needed. If some issues persist, the team will need to adjust their level of support until the client masters the relevant skill. Creativity is often required.

Clutter can become a significant challenge when it impinges on the health and safety of the client and / or other tenants in the building. It is best to deal with this issue right away. In extreme cases, if the clutter reaches unacceptable levels or constitutes a health hazard, the Housing First team may have to take action – such as cleaning and removing clutter against the tenant's wishes, for the sake of the client and other tenants in the building. Such action may ultimately prevent the termination of the tenancy.

Being able to assist a client with these kinds of challenges depends on the strength of the relationship the Housing First team have established with the client.

Social Relations and Guest Management

Loneliness

Clients can feel very lonely when living in their own dwelling after years of shelters, institutions, or in the company of others on the streets. Loneliness, when coupled with substance abuse, can quickly become problematic.

The most frequent reason for housing loss in the Housing First programme – accounting for 70% to 80% of evictions – is not drug and alcohol use alone. It is excessive drug and alcohol use plus having frequent visitors who are disruptive to other tenants and neighbours.

Staff must take an active role in helping clients develop ways to cope with loneliness in positive ways. One proactive way to help address social isolation and loneliness is for Housing First staff to visit frequently during the early adjustment phase. Different team members can visit at different times during the day and week and, if possible, even during the weekend. Loneliness can also be tempered by having the client work closely with the team's peer specialist or with other mutual support programmes in their community. Peer specialists are often able to connect with clients in a way that is comfortable and non-threatening, as well as having knowledge of positive community groups or activities[45]. The peer specialist can also model how to connect with others informally; and show the client how to engage and develop new friendships.

Personal Relationships: Invited Guests

Once housed, many clients begin to think about relationships: reconnecting with family, having a romantic relationship, reconnecting with friends, or other social ties. Some clients may be eager to establish new ties, while others may initially rely primarily on the Housing First team for their social support. For some clients, relationships develop spontaneously while, for others, socialising may be difficult and require more intention.

For those that struggle with solitude, an independent property can present some significant challenges. The Housing First team can support clients by understanding their socialisation goals and then working together to develop a plan to realise them. Some clients, for example, find social role-play exercises useful for anticipating what to say when greeting neighbours or beginning a conversation with someone who is attending the same programme. The Housing First team tailors the support to the self-defined goals of the client.

A common problem for Housing First tenants concerns guests. Some newly-housed clients have difficulty balancing the guest policy in their tenancy agreement with requests for a place to stay from desperate and vulnerable friends or relatives, who may still be living on the streets. Others may invite company from their homeless days to cope with loneliness.

Clients have a right to have guests. Problems develop, however, when one guest invites other guests or when a guest who was invited to stay overnight is very reluctant to leave.

What if the client is not willing or able to ask guests to leave? In these complicated situations, the client's behaviour may result in a breach of their tenancy agreement, which may put them at risk of the tenancy being terminated. Many difficult decisions – which involve the tenant, the guest, the Housing First team, and the landlord – must be made quickly and often under pressure. The regularly-occurring home visit provides an effective way to observe and address these situations as they emerge; and to intervene before problems escalate into a crisis that puts the tenancy at risk.

There are times when a client may become involved in a relationship with someone who is a threat to his or her wellbeing, recovery, and/or housing. Ultimately, the client will decide on a course of action. Regardless

of the outcome of the client's decisions – even those resulting in arrest or the tenancy being terminated – the responsibility of the Housing First team is to be responsive, offer support, and to help the client identify how the particular relationship is affecting his or her life.

When a destructive relationship develops, the Housing First team needs to make every effort to work closely with the client to help determine whether the client is freely choosing this relationship or is participating in the relationship under threat or duress. If the client chooses not to be in this relationship and is looking for assistance, the team has several options to explore with the client. For example, the Housing First team can increase the number of home visits —and show up in pairs —to create an atmosphere that becomes uncomfortable for unwanted visitors, especially if they are engaging in illegal activities. It can also be useful to explain to the unwanted visitors that they are not named on the tenancy agreement and must leave, or else legal action may be necessary. Invoking legal action can be useful to motivate the departure of unwanted guests. However, in the event of this approach, the Housing First team must be prepared to follow through with legal action if the guest does not comply. The team may also need to work with the client and assist them with calling the Gardaí or accompany them to the station to make a complaint.

In rare instances, it may be necessary to work with the client and the landlord to have the client moved to another unit. As ever, the short-term goal is to address and solve the problem, but the larger goal is to help clients learn from their experiences so they can develop the skills and self-confidence to better maintain their homes and their lives.

When is Relocation Necessary?

Housing First programmes have tremendous housing retention rates of between 75% and 95%, depending on the degree of adherence to programme fidelity[46]. That means, however, that between 5% and 25% of the clients in any programme may not be able to successfully maintain their tenancy. Housing First team members must realise that, regardless of whether a client accepts support services, there is a possibility they might not adhere to the rules and responsibilities specified in the tenancy agreement, and they may require relocation. It is also realistic to expect that, on occasion, some clients will develop illnesses that may require long-term hospitalisation, or engage in actions that could result in imprisonment or the tenancy being terminated. Team members understand that relapses are an integral part of recovery from mental illness and substance use disorders. The journey to recovery is often long and each relapse must be dealt with one event at a time, with a quiet hope that it will be the last.

The Housing First model also anticipates that, as with anyone else's life, unforeseen circumstances often necessitate a move to a new location. This can be for positive reasons, such as reunification with children or starting a new family, as well as for negative reasons. Therefore, moving from one unit to another is a rather routine procedure in a Housing First programme and it is useful to have an agreed procedure for facilitating such moves among the NGO / AHB and local authority partners. Issues such as who holds the nomination rights to the proposed new property, which local authority area the person's housing application is valid in, and whether the tenant is on a housing transfer list, can all

create ‘red tape’ barriers to the team’s ability to creatively problem-solve tenancy issues.

Potential barriers to the facilitation of tenant relocation should be identified early in the establishment of the Housing First service, and protocols agreed in advance of issues arising, in order to manage these events as rapidly and efficiently as possible. Tenants should also be advised of their tenancy rights (and obligations) and signposted to organisations (e.g. Threshold and FLAC) that can provide independent advice and representation.

Relocation as Prevention

If there are problems with tenancy breaches, the decision to terminate the tenancy or relocate the client is not solely under the control of the Housing First team. This is especially the case where there is ongoing anti-social behaviour that is affecting neighbours and the wider community.

In such cases, the landlord (usually the local authority or an AHB), the Housing First team, and the client may all have some influence on how resolutions are made. Once clients are housed and settled into their new homes, it is important to have conversations about how they managed in their previous housing environments. Creating a new lifestyle away from homelessness often requires clients to fill their days with new activities – the many hours spent seeking out food, shelter and safety are now empty and available and must be filled with positive activities centring on what motivates the client most (e.g. relationships, work or other positive activities). Giving time and attention to addressing the challenges of this lifestyle transformation can help nip potential problems in the bud, and perhaps prevent tenancy breaches.

In most cases where the tenant has breached their agreement, an eviction may be avoided by transferring the client to another housing unit. Relocations must be an acceptable solution to all parties involved. It is important to note that a social housing property is the tenant’s permanent home and they must therefore agree to a voluntary transfer to another property. The relocation rate (i.e. the proportion of clients moving out of their first apartment into a second) for Housing First teams can be as high as 20% to 30%, especially when a high percentage of clients have severe substance use disorders. The rate of relocation from the second apartment to the third is typically about half the rate of the first relocation, indicating that clients learn a valuable lesson from losing their first home – and change their behaviour to secure the second one.

Relocation and Staff Attitudes

The examples above describe some of the more difficult aspects of operating Housing First programmes. The most important thing to remember during a relapse or the chaos of relocations is to be compassionate. It is easy to lose perspective as the housing provider, the landlord and the team are frustrated and disappointed when the client relapses and/or damages an apartment. But any expression of exasperation is misplaced. In these situations, we need to remember that it is the client who is really suffering the most; it is the client who has suffered the worst and most painful consequences of their relapse; and it is the client who often suffers from the shame, self-hatred, guilt and humiliation of another failure. There are plenty of natural consequences suffered by the client and there is absolutely no need for providers to react to the ‘failure’ by passing judgement or berating the client from a moral high

ground. The correct and most helpful clinical response to the client experiencing the trauma of another relapse is: “I am really sorry you are going through this. What is the best way to help you now?”.

Eviction Prevention and Dispute Resolution

Any action to address tenancy breaches that the landlord takes with the support of the Housing First team must be consistent with the rights and responsibilities outlined in the Residential Tenancies Act 2004 and the processes overseen by the Residential Tenancies Board in the case of AHB and private rented tenancies. In all cases of serious or consistent breach of tenancy (e.g. serious antisocial behaviour, which can result in a seven-day notice being issued by the landlord) and circumstances in which there is an immediate health and safety risk, a tenant must be issued a formal warning and given a reasonable opportunity to rectify tenancy issues before being issued with notice of termination.

The issuing of warning notices (templates for which are available on the rtb.ie website) offers an opportunity to work with a tenant to put a plan in place to resolve issues while maintaining their tenancy. Both the housing worker and the wider Housing First support team should be involved in the process of supporting the tenant to resolve any tenancy issues that arise and retain the tenancy wherever possible. Active and assertive engagement and intervention by the Housing First housing worker and team should effectively mitigate against evictions. Negotiated relocations are an option. The Housing First programme can have access to short-term rent subsidies to avert termination proceedings or to facilitate relocations. Terminations are damaging to the tenant’s record and damaging to the programme’s reputation and must be vigorously avoided.

Where the breakdown of the tenancy is unavoidable, Housing First teams must follow the notification processes and notice periods set out by the Residential Tenancies Act. A tenant has the right to appeal a termination through the Residential Tenancies Board, and it is conceivable that a circumstance may arise where a Housing First support worker is supporting a client through this process, and the respondent is the housing provider within the same Housing First service. This must be handled sensitively and with respect for the roles of all concerned and the rights of the tenant to put his or her case forward.

The Residential Tenancies Board (RTB) dispute resolution service may be engaged to resolve disputes between tenants and landlords related to rent increases, the condition of the property or a tenant’s refusal to leave following appropriate notice of termination. Third parties, typically neighbours, may also engage the RTB dispute resolution service to take a case against a landlord who they perceive to have failed in his or her obligation to resolve issues related to the external condition of the property or alleged anti-social behaviour on the part of the tenant.

Housing First service providers should familiarise themselves with the processes of the RTB and be prepared to engage with the dispute resolution service, if the need arises. However, it is far preferable to resolve any disputes informally between the parties

involved. Early, frequent and positive engagement between landlords and tenants, as and when tenancy issues arise, as well as a responsive and responsible approach to neighbour complaints and concerns, should enable most disputes to be resolved informally without the involvement of the RTB.

Alternative Residential Options

Some Housing First tenancies end prematurely for a range of reasons, the most frequent of which relate to a variety of problems, including problems associated with invited or uninvited guests, as discussed earlier in this chapter. However, a housing crisis, request for transfer or the surrender of a tenancy may also be due to abandonment of the unit, imprisonment, a mental health crisis, hospitalisation, domestic violence, a relationship ending or the death of a partner.

In the overwhelming majority of cases, relocation – i.e. the offer of an alternative Housing First property – is the appropriate response. However, there are some situations when Housing First may not be working for the individual; and alternative residential arrangements may be needed. This conclusion can only be drawn, in agreement with the tenant, after all available rehousing placements and support packages have been explored, and home visits have been escalated to the greatest possible extent (i.e. multiple visits per day). The reasons may be related to the impact of physical health, mental health or addiction treatment, which exceeds Housing First programme capacity, or a terminal or progressive illness requiring full-time care. In these circumstances, the Housing First team may discuss options with the client and select an alternative placement.

Long Term Supported Accommodation (LTA) is a type of low-threshold housing for individuals with high support needs who do not have the capacity to live in the community. Residents have their own room within a congregated housing complex under a long-term tenancy or licence agreement. Support and medical staff are onsite, either on a 24-hour basis or during daytime hours, depending on the level of needs of the residents. Meals, laundry facilities, communal rooms and recreational facilities are also provided. Every resident has a key worker and a personal support plan, and independent living skills are fostered. Vacancies for LTA places are filled by the relevant local authority by seeking referrals from homeless services, including Housing First providers.

Other residential options for homeless individuals with high support needs include a nursing home or hospice, which – unlike LTAs – are mainstream services that are not specifically targeted at people with a history of homelessness.

Housing Retention and Limits on Client Choice

Client choice is a central guiding principle of Housing First, but it is also the concept most frequently misunderstood. In Housing First programmes ‘choice’ does not mean ‘absolute choice’. Choice of homes is tempered by the availability of one-bedroom social housing units and, in the case of private landlords, choice is limited by affordability, location and other determinants

of the rental market. There is no choice about signing a lease, paying the rent, being a good tenant, or having a home visit. There is no choice about terminations for tenancy breaches or arrests for illegal activities. In some ways, 'choice' in the Housing First context can be understood as offering individuals experiencing homelessness, extreme poverty and complex clinical problems the same choices as everyone else.

The principles of harm reduction and client choice do not provide immunity from the consequences of one's actions. Clients in Housing First programmes have responsibilities and face the same consequences as every other person in the community. The main difference is that Housing First clients have a case manager and a team who supports them and advocates on their behalf. If a client violates the lease and is about to be evicted, the Housing First team will advocate on their behalf with the landlord to try and prevent the eviction. If the client is evicted, the Housing First programme will try and provide emergency accommodation until another tenancy becomes available. The team works with the client to understand the circumstances that led to the eviction as a way of preventing their reoccurrence.

In order to reduce risk to the client and to other tenants, the client choice in re-housing options may be restricted, particularly if the nature of the violation that led to eviction included threatening or disruptive behaviour. Every client gets a second chance and a third chance, but how many more chances should the Housing First programme offer? It is natural to have doubts about the possibility of housing the client successfully. The client may also begin to doubt. The client and the Housing First team may have to convince the local authority to give the client another chance.

There will be a few clients (usually less than 10%) who cannot manage the freedom of living independently. This is discovered after several apartments are 'lost' and after several unsuccessful relocations. For these clients, a different type of housing arrangement may be needed. The Housing First team can continue, if appropriate and if the new setting permits, to provide support and treatment in the client's new setting.

Housing and Community Integration

Housing First aims to support clients to integrate into their community and the scattered-site housing component (i.e. units integrated into housing developments with non-Housing First tenants) plays an important role in achieving this goal. As explained in Chapter 1, the Housing First programme typically does not rent more than 20% of the total units in any housing development. For example, in a 20-unit building, no more than four will be Housing First units.

In communities where housing developments are small, or in rural areas where housing stock is mostly single family housing, this percentage does not apply. What is important here is not the absolute number of units, but the programme's commitment to the principle of providing socially-integrated housing.

The scattered-site model allows clients to live in normal community settings. The

likelihood of stigma associated with being a member of a Housing First programme is thus reduced because the programme is not visible and clients live in the same settings as any other resident in the community. Clients interact with their neighbours, shop at the local supermarket, and go to the cinema, coffee shop, or park – just like everyone else. The socialisation pattern of their neighbours sets the local standard for social integration. Clients soon discover that being a lease-holding home-dweller and living life on their own schedule is an enormous boost to their autonomy, self-determination and dignity.

[44] See the 'Minimum Standards Checklist' in Resource 3. While this list is by no means exhaustive, it is offered as a heads-up to help Housing First teams plan and anticipate potential issues.

[45] See Chapter 8 for more detail on the role of peer specialists.

[46] For further information on programme fidelity, see Chapter 10.

Chapter 7

Housing Procurement

This chapter describes how housing units are made available to Housing First programmes, how units are secured for clients, the unit selection process, the use of emergency accommodation, housing quality standards, and how units are prepared for occupancy. It also describes some operational and managerial issues related to property management.

Housing First Properties

The vast majority of properties for Housing First programmes are social housing units provided by either local authorities or AHBs, with some regions also securing a number of units from landlords in the private rented sector. In practice, approximately 50% of the required number of properties to meet Housing First targets are provided by local authorities, mainly from their own stock.

Most of the units provided under Housing First nationally will be one-bedroom properties.

Allocation of Housing Resources

Local authorities and AHBs are the primary providers of housing units for Housing First. However, in some regions, units will also be rented from private landlords, through direct tenancy agreements between the landlord and tenant, or through leasing agreements with the local authority or AHB as intermediary landlord.

In the overwhelming majority of cases, the local authority nominates Housing First tenants to both social housing units from its own stock as well as the units managed by AHBs. In order to meet Housing First fidelity standards[47], decisions regarding tenant placement must take into account the client's expressed choices and preferences. In most cases, it will be the Housing First service provider(s) who will have carried out accommodation preference assessment work with clients, and who will be in a position to carry out viewings and receive feedback on properties directly from clients. Therefore, decisions regarding tenant placement should involve collaboration between the local service-provider NGO and the local authority.

In many cases, the NGO delivering the Housing First service at local level will also be the AHB responsible for delivery of a proportion of the housing target. In instances where housing is provided by a different AHB, the local authority and the NGO providing Housing First service delivery will coordinate decisions on which Housing First client(s) to put forward for the AHB housing, and the independent AHB will then make the decision as to whether or not to accept the referral.

Admission to Housing First and discharge from Housing First is made on a collaborative basis. These decisions must be made jointly between the relevant partner agencies, with adherence to the priorities defined in the 'Housing First National Implementation Plan'[48], and fidelity to Housing First principles, which preclude sobriety requirements or 'housing readiness' assessment as a prerequisite to housing. Furthermore, once a client is admitted into Housing First, all partner agencies – including the local authority, the local NGO service-provider's delivery team, and the HSE health service providers, as well as any other AHB or support agency involved in the support plan – must commit to and practise a 'no discharge' and 'commitment to rehouse' policy.

Immediate Access to Housing

Housing First's mission is to provide "immediate access to a place of your own". Because the process of connecting a client with housing requires assembling

necessary client documents, completing the housing application, approval of the application, identifying and furnishing an available unit, and coordinating the move-in, the period from approval to the allocation of a social housing tenancy can be variable. A social housing support in the private rented sector with a Housing Assistance Payment (HAP) may be faster, but depends – in this case – on the availability of a suitable property in the market and the willingness of the landlord to accept the HAP.

The National Housing First Plan sets an ambitious target of four weeks from date of admission to date of move-in as a Key Performance Indicator, which helps to create a sense of urgency in relation to housing clients. In practice, it may take longer for some clients than for others and the majority move into their new home between four and 12 weeks after their admission date.

Initial programme activities, while rapport and trust with clients is built, must always focus on what is most urgently needed from the client's perspective. The Housing First team is correct to anticipate that, 90% of the time, this most urgent need will be described by the client as "I just need a place to live". Programmes should review their intake and admission processes on a regular basis to ensure they are operating as efficiently as possible; and should continually aim to reduce time from admission to move-in. The goal of reducing the time from admission to move-in must be a goal that is shared by all agencies including the local authority, the local NGO service-provider, and any other organisations participating in delivery of the Housing First service.

Housing First staff demonstrating that they understand their clients' sense of urgency about getting their own place to live as quickly as possible is an excellent way to build trust. It shows programme staff keep their word and is the basis of establishing a positive foundation for eliciting a welcoming response when the staff begin to conduct home visits.

Standard Tenancy Agreements: Rights and Responsibilities

Signing a Standard Tenancy Agreement and agreeing to its terms and conditions is a Housing First programme requirement. It is also a requirement of local authority and AHB tenancies.

Tenants of Housing First programmes must abide by the formal contractual terms of the tenancy agreement. It should be anticipated that some clients may need intensive or ongoing support in meeting these obligations (e.g. in developing budgeting skills to ensure rent payment; independent living skills to ensure adequate upkeep of the living space; becoming familiar with the norms and expectations of neighbours and housing providers with regard to noise and visitors; etc.).

The primary aim of all stakeholders in Housing First delivery should be the sustainment of the tenancy, where possible, and this should be the context in which breaches of tenancy should be addressed. For example, growing rent arrears should trigger not only a warning related to the breach of tenancy, but proactive engagement from the support team to determine why the rent is not being paid, how the tenant understands and feels about the potential consequences of not paying the rent, what support the tenant may welcome in organising timely rent payment

and, potentially, negotiation with the housing provider around gradual repayment of arrears to avoid tenancy breakdown.

A housing provider engaged in Housing First delivery, whether a local Authority or AHB, should be open to this approach and to working with the tenant and their support team to avoid tenancy breakdown where breaches of tenancy occur.

The Residential Tenancies Act (RTA)

The legislation that sets out the rights and responsibilities of landlords and tenants in Ireland is the Residential Tenancies Act 2004. The Act applies to all private rented dwellings and to dwellings let by AHBs. The Act does not apply to local authority tenancies. However, where a local authority leases properties to an AHB for sub-letting to tenants, the tenancy agreement between the AHB and tenant is subject to the terms of the Residential Tenancies Act.

All Housing First housing providers that are subject to the Residential Tenancies Act (i.e. AHBs or NGOs leasing properties from local authorities) should ensure familiarity and compliance with the requirements around registration of tenancies, notice requirements for termination of tenancies and rent arrears, limits on rent increases and rent reviews, and their responsibilities around dealing with anti-social behaviour by the tenant.

For tenancies to be successful, Housing First tenants must follow the normal rules for their building and community. Property Management Companies are in place in many private apartment developments and they will enforce these rules (e.g. rules around rubbish disposal, door security, car parking, etc.). The main difference between Housing First tenants and other tenants in the same building or housing estate is that Housing First tenants have a case manager that visits them regularly in their homes.

Rental Costs

Housing First tenants in either local authority or AHB properties will pay a differential (i.e. means-tested) rent calculated by the local authority. Differential rent calculation formulas vary between local authorities but, in general, tenants will pay approximately 15% to 20% of their assessable income toward their rent. For many Housing First tenants, this will amount to a 15% to 20% portion of their weekly payment from the Department of Social Protection (DSP).

Housing First tenants in the private rented sector receive the Housing Assistance Payment (HAP), which is a form of social housing support provided by all local authorities to private landlords, with the tenant paying a rent contribution to the local authority based on its differential rent scheme.

If a person has been identified as a priority for housing under Housing First, according to the criteria set out in the 'Housing First National Implementation Plan', but they do not have any entitlements or other income at the time of admission, the Housing First programme should still endeavour to provide housing while working with the tenant towards obtaining entitlements. If a Housing First tenant's income changes during the course of their tenancy (e.g. if they transition from a DSP payment to income from employment), the differential

rent calculation used in the local authority area will be used to re-assess the amount of their contribution.

Housing Options

Depending on the housing resources available in each region, there may be several sources for obtaining housing. It is advisable not to admit clients into the Housing First programme if a housing unit is not currently or imminently available. The pace of admission for clients in the programme should not be determined by the case management capacity but, instead, driven by the availability of housing units.

Clients should be presented with all the available options in available units before making a choice. This may require the partner agencies to agree which client will be approached first, second, or third with the housing offer, as the scope for choice between multiple units will reduce as each available unit is chosen. While there is no set formula for determining which prospective Housing First tenant should be prioritised for choosing between multiple units, considerations might include the immediate vulnerability of each person in their current circumstance (e.g. sleeping rough vs. in temporary accommodation); the potential to build trust and support agency in a person who might be more challenging to engage; or the opportunity to set a different tone and sense of ownership with a person who has had previous tenancy breakdowns where they may not have felt at home or invested in the property they were allocated.

In rare instances, an independent property may not be the client's first choice. They may decide that a more supervised setting – such as a group home where there are more people around and services are on-site – is preferable; or they may want to attend a drug rehabilitation programme before committing to take care of their own place. In either of these examples, the Housing First team should honour and support the client's choice and assist them in reaching their goal.

Housing Choice

Clients' preferences are weighed against the allocation of social housing units or availability of private rented properties, neighbourhood preferences, and the client's patience or impatience with the search. Most clients are likely to accept the first property they are shown. The experience of the Housing First programme to date shows there is a greater likelihood of housing success when clients are actively involved in selecting their own housing. Naturally, choice is guided by the realities of the availability of units, as it is for any other renter.

Ideally, as a Housing First service plans for intake of a new client, there should be a vacant social housing unit available for immediate occupancy, or capacity within the service to begin to search for a suitable apartment in the private market. The goal is to have clients move into a place between four and 12 weeks after the initial intake. Some clients may require longer periods of engagement to build trust.

Emergency Homeless Accommodation

Having access to emergency accommodation is an essential component of Housing First programmes. It is highly recommended, but not listed as a

programme fidelity component because not every Housing First service has the capacity to provide a place to stay until a property is secured. Access to emergency accommodation (i.e. low-cost hotels, B&Bs or Supported Temporary Accommodation) is especially useful when working with clients who are rough sleeping on the streets, in parks or in other public places.

Ideally, immediately after the client meets the eligibility criteria and is admitted into the Housing First service, the Housing First team should be prepared to assist the client in progressing their exit from homelessness that same day. If the person is sleeping rough, immediate access to safe emergency accommodation should be offered. The Housing First team should determine what type of emergency accommodation the person would be willing and able to take up and, with the person's consent, work closely with the local authority's Assessment and Placement Service to secure a suitable placement. In general, Supported Temporary Accommodation (with placements of up to six months and a suite of support services onsite) can be arranged for clients that are willing to accept the offer of accommodation.

In the Housing First programme, a key component of emergency placement while awaiting housing allocation is that the providers operate with a harm reduction approach.

The use of interim or respite accommodation has several advantages:

- It immediately establishes a positive interaction; a sense that this programme delivers on its word.
- The client can rest, get nourishment, and immediately begin to feel better.
- Housing First team members are viewed as trustworthy and caring.
- Clients have a place to stay, day and night, and where they can keep their things.
- The client begins to believe that things might really change.
- Team members can locate the client the next day for follow-up, thus expediting the admission to move-in process.

Client Access to Facilities and Other Amenities

During this interim period, the Housing First team meets frequently with clients to ensure day-to-day needs are met; and the team continues to progress the admission and housing process. They can also begin to address issues such as health, social welfare benefits, identification, legal issues, and any other matters that need immediate attention. While in temporary homeless accommodation, Housing First clients participate in the search for units, view available units, and develop plans for their impending move.

Clients may move directly to a Housing First property following release from hospital, prison or another setting in such a way that their discharge date is coordinated with their Housing First move-in date. In these cases, clients with a history of homelessness that meet the Housing First criteria are admitted to the programme before discharge; and the team begins the search for an appropriate apartment. In some institutional settings, the client may obtain leave and accompany the Housing First team to see and choose a home, and then return

and stay in the institution while the unit is prepared. A lead-in time of three to six months from referral to discharge is usually required to enable all the preparatory work to be carried out (i.e. housing application, welfare payments, medical supports, estate management, mobility adaptations, etc.). A shorter lead time may mean that the person will be discharged to Supported Temporary Accommodation while a long-term property is being put in place.

Housing Quality Standards

All properties provided to the Housing First client or programme must be in good physical condition. The RTB has a useful infographic for AHBs on minimum standards[49].

Minimum standards for rented accommodation are set out in law in the Housing (Standards for Rented Houses) Regulations 2019. Where rental arrangements in privately-owned properties are being subsidised by the local authority via the Rental Accommodation Scheme (RAS) or the Housing Assistance Payment (HAP), local authority staff in RAS and HAP units are responsible for organising inspections of the accommodation to ensure compliance with minimum standards, as part of the process of transferring tenants into these schemes.

AHBs are required to ensure that their rented properties are safe and comply with the minimum standards. The AHB sector is regulated, on behalf of the Department of Housing, Local Government and Heritage, by the Housing Agency, a government body tasked with the development of housing policy and the implementation of housing programmes.

Units used for Housing First tenancies must meet the minimum standards for rented accommodation, regardless of who the housing provider is. Before the move-in, the Housing First programme staff conduct an inspection to ensure that the unit is compliant. Using the Rented Housing Standards Checklist, staff examine doors, windows, locks, paint, floors, walls, electrical wiring and outlets, lights and light switches, plumbing, sinks and toilet, and heating; and verify that there is a working refrigerator and oven. Staff members review these items and inform the housing management agency about any needed improvements which, optimally, are completed before move-in. If the repairs can only be made after move-in, Housing First staff schedule the repair to ensure completion. In most cases, clients move in only after the unit has satisfactorily passed the programme's inspection[50].

Making a Home: Physical and Emotional Comfort

Once the property is secured, there is a flurry of activity that includes shopping for furniture and household items, learning about the housing estate or the apartment block, and exploring the local neighbourhood (supermarket, pharmacy, bus/tram stops, library, places of worship, and other amenities). This is a bit like the honeymoon period of the programme, filled with a mixture of relief and joy as clients are living in a place that they can call home. This is also a time of enormous adjustment and it is not unusual for the Housing First team to see the client every day or even several times a day at the outset.

It is essential that units are furnished before clients move in. Properties provided by

the local authority may require appliances and flooring, as well as furniture. Where a property is acquired by the programme unfurnished, ideally, the furniture and fittings should be purchased new, and selected by the client.

The Housing First team can support the client in making an application to the DSP for an Exceptional Needs Payment to cover the set-up costs of their new tenancy, including flooring, appliances, furniture, bedding and utensils. Exceptional Needs Payment applications are assessed and administered by the Community Welfare Officer (CWO), and typically require submission of a Supplementary Welfare Allowance (SWA-1) form, proof of tenancy, proof of income, and a list of the items required and their cost. The application process may also require a visit to the property by the CWO.

If the Exceptional Needs Payment is granted by the DSP, and used for the purchase of furniture, appliances, and fittings for the Housing First property, those items purchased with the grant are the property of the tenant to whom the grant was awarded.

Housing First programmes must budget for the expectation that, in some cases, particularly on a second or third rehousing following tenancy breakdown, the Exceptional Needs Payment application may be unsuccessful, and the programme will need to cover the costs of furniture and fittings directly.

Once an apartment is selected, clients are in a position to select furniture. It is useful if the Housing First programme negotiates an arrangement with a local furniture store to receive a significant discount, given the volume of business the programme will provide. Furniture that is reasonably priced, durable, comfortable, and can be delivered and installed on short notice, is preferable. One convenient way to manage the process is to have a limited catalogue of available furniture that can be shown in print or online to the client. This saves trips to shops but, again, shopping is fun and taking a trip to the furniture shop may be well worth the time. These decisions, and other decisions – large and small – should always be left for the client to make.

The typical start-up furniture package includes:

- Bed
- Bureau or dresser
- Sofa
- Coffee table
- Television
- Kitchen table and chairs

Where properties are sourced from the private rented market or where an existing Housing First property has been vacated by a prior tenant, the furniture and appliances may already be in place and, if in good condition, will remain for the incoming tenant. If this is the case, there are still ample opportunities to support the tenant in making the home their own through the selection of household supplies, paint colours and decorative touches.

Shopping for Household Supplies

Usually on moving day, Housing First staff go shopping with the client to purchase some essential household and personal items, such as a kettle, dishes, pots and pans, bedding, towels, utensils, cleaning and laundry supplies, and more[51]. The Housing First programme also provides at least one week's worth of groceries upon move-in. It is critical that all clients have a phone – the client must be able to reach the team at any time (24/7 on-call service is an essential part of the Housing First programme) and the Housing First staff must be able to reach the client.

Clients are encouraged to participate in as many of the moving-in activities as they wish.
In every aspect of this process – from the initial discussion about housing preferences to moving day, and from shopping for furniture and household supplies to deciding which clinic to use – Housing First staff encourage clients to take ownership of the decision. Actively including clients in decision-making should not be confused with the idea that the programme is expected to or can deliver on every item the client chooses. The choices clients are faced with are often limited and difficult to make (e.g. accept a property that is immediately available in a neighbourhood that is unfamiliar or wait longer for a property in a more desired location). Actively engaging with clients means they are participating in making decisions that affect their lives because it is, after all, the clients that live with the consequences of their decisions.

Safety and Security Issues: The Basics

Housing First staff instruct all tenants in the use of the emergency on-call system, as well as how to reach the ambulance, fire brigade, Gardaí or out-of-hours GP. Tenants will also be provided with emergency contact numbers for gas, electricity and plumbing problems. Some tenants may need instruction on the use of appliances, telephone, keys or codes for locking systems, and how to exit the apartment and who to call in case of fire or carbon monoxide alarm activation.

In Housing First, staff hours are, at a minimum, Monday to Friday, from 9am to 5pm, but Housing First programmes are usually contracted to provide cover outside normal working hours and at weekends, with at least one team member available on call by mobile phone 24/7 to provide assistance, manage a crisis, help resolve a conflict, or just provide some light conversation during a stressful or lonely time. Staff members should rotate on-call duties regularly to prevent staff burnout.

Keys

There should be three sets of keys for each apartment: one for the client, one for the support services team, and one for the landlord. There are many instances when a spare set of keys may be needed. Clients may lose their keys and the team can open the unit and avoid the high cost of a locksmith. Access may be necessary if a client is hospitalised or arrested and needs items from the apartment, or if the Housing First staff needs to look after the client's pets

or plants and so on. There may also be the need to enter when the client is in crisis or having an emergency.

Staff should make it clear to clients that the duplicate keys in the staff's possession exist only to assist the client. In accordance with tenancy rights legislation, Housing First programme staff are not permitted to enter the client's home without permission – unless there is an emergency.

[47] ***For more on Housing First fidelity, see Chapter 10.***

[48] ***"The priority target group for a Housing First response are people with a history of sleeping rough and long-term users of emergency homeless accommodation with high and complex mental health and addiction needs" (Government of Ireland, 2018, p.11).***

[49] ***https://www.rtb.ie/images/uploads/general/AHB_Minimumstandards.pdf***

[50] ***See Resource 3 for a Guide on Minimum Standards for Rented Accommodation***

[51] ***For a complete list, see Resource 5.***

Chapter 8

Peer Specialists and Housing First

This chapter provides information about the role of the peer specialist on Housing First teams. It is organised to answer the following questions:

1) What qualifies one as a peer specialist?
2) What is the role of peer specialists on Housing First teams?
3) What kind of training and supervision do peers require?
4) How do peers complement the knowledge and services of Housing First teams?
5) What is the role of peers in supporting community integration?

As briefly described in Chapter 3 of this manual, 'peer specialists' are staff employed by the Housing First programme whose job descriptions recognise that their personal experiences can be beneficial to understanding, engaging and motivating clients.

Housing First was developed in partnership with people with lived experience. People with lived experience are people who have been through homelessness, mental illness, or substance use disorders; and who can draw upon their own experiences to support others. Their inclusion in the ongoing delivery of the Housing First programme ensures the voices of clients are present and heard.

The Housing First programme has its origins in a profound commitment to peer support. The programme was developed out of a client-directed drop-in centre where half the staff was comprised of peer support[52]. There were several reasons for hiring people with lived experience: the programme valued direct input from programme participants, peers fostered strong engagement and empathy skills, and it ensured the ongoing inclusion of the client perspective in programme design, operation and governance. Hiring peer support staff was also intended to reduce the boundaries between professional staff and programme participants. Finally, hiring peer specialists created a third voice in the service sector community: a body of participants with a perspective and a unique voice. Peer support staff could interpret the participants' experiences for the professional staff and explain the intentions of professional staff to the participants, simultaneously serving as role models for both groups[53].

Profile of Peer Specialists

Peer specialists or peer support staff are individuals who, at one point, overcame personal challenges in which they needed to obtain assistance and treatment in order to engage in personal recovery or to integrate into normative social roles. Examples of the challenges faced by individuals with lived experience include; mental health problems; problematic substance use; a history of prison custody, homelessness, domestic violence, physical or sexual abuse; and other challenges. This is not an exhaustive list, as there are other traumatic events that may also be included. These are some of the conditions and challenges of what can be considered as part of one's recovery or reintegration story.
Housing First programmes should have a peer specialist as one of the staff members of the support services team. The peer specialist or peer support worker should have personal experience in having sought assistance in overcoming their obstacles and should be currently in recovery from substance use, mental health problems, homelessness, or have overcome other obstacles for a period of at least one year.

It is recommended that peer support workers employed as paid staff should have completed at least one year 'in recovery' and that they have access to supervision and support. The nature of the peer's support work with Housing First clients places them very close to the self-same situations they have been addressing in their own lives. It therefore requires them to have a strong grounding in the skills, coping mechanisms, information or treatments used in their own recovery.

The Role of the Peer Specialist on a Housing First Team

Peers can play a crucial role in helping Housing First teams to provide treatment and support services in a manner that is grounded in recovery principles. When working with individuals who have experienced long periods of homelessness (chronically homeless), it is often the peer support worker who can best relate to the client's experience and, by demonstrating this understanding to the client, is best-placed to earn the client's trust to a profound degree.

Peer support staff understand how clients feel after they are housed and what it is like adjusting to a new home and a new community. Peers can offer practical help with basic needs and everyday living, such as finding the right supermarket or clothes shop. Providing meaningful and practical assistance with day-to-day struggles and offering effective and sustained support is the basis of developing a caring and trusting relationship, and hopefully serves the client as a model for developing other relationships.

From the perspective of the client, the services offered by the traditional staff may be perceived as 'the employee is doing their job'. Clients understand that this is an employee of an agency who is paid to provide a service. Employees operate in a formal and professional manner; and they are bound by agency rules of conduct, agency policies and procedures, and professional standards of ethics and conduct that determine what they say to the client and how they may intervene. These professional and agency norms can create a certain 'professional distance' and may be subtle barriers to connecting with individuals who have shunned or are mistrustful of 'the system'. The peer specialist can help to reduce this distance as they have walked in the client's shoes and have 'been there, done that'.

Peer support specialists can provide other Housing First team members with insights from the client's perspective and thereby improve the quality of care provided by the team. The peer can provide team members with insight into the experience of being homeless, being evicted, feeling suicidal, and managing day-to-day life while in the throes of all that turmoil. Peers can also assist the team in overcoming obstacles to engage clients, especially those that distance themselves from traditional treatment providers.

Properly integrated peer support can assist the team by providing a client lens in a trauma-informed approach[54]. During team meetings and case conferencing, peer specialists can help raise awareness by pointing out how stigma, fear and professional bias may interfere with seeing the client clearly. There may be socioeconomic, educational and ethno-racial differences between team members and the clients served; and the peer may be able to offer some awareness in noting these differences. Additionally, the peer's presence and participation in the ordinary day-to-day operation of the team serves every day as a powerful reminder to both team members and clients that recovery is possible.

Training and Supervision for Peer specialists

Peer support specialists should be trained and certified (if possible) in their specialty. They should receive core Housing First training and any other training available to the rest of the team. Training must also focus on issues of maintaining boundaries in the contexts of engagement, and building authentic and trusting relationships with clients.

Special attention should be given to when and how peers can disclose that they have direct lived experience, as well as experience as a recipient of services. Peer support specialists should be trained to develop and learn how to use their own 'recovery story'. No two recovery stories are the same, despite many similarities that have a connective and relatable quality that makes its use effective.

The recovery story begins with a peer's difficult times, including the moment they felt most hopeless. In peer training programmes, supervisors teach the peer specialist that the 'hopeless place' is not somewhere to spend a lot of time, but a limited amount of sharing is required to demonstrate their common experience with the client. Most of the recovery story should be spent discussing how the peer overcame their issues; how they tapped into their own strengths; about the skills they had to develop; how they used treatment, support and community resources, etc. The information provided by the peer should not be presented as advice. Rather, it is rooted in modelling and relatability.

Agency and Team Support Needed when Hiring Peers

Organisations that have not employed peer support workers in the past need to put in place appropriate policies and supervision processes when hiring peers. Peer support is an entirely different discipline that requires different knowledge and skills. The goal is to develop and expand the skills-set of the Housing First team through the addition of a peer worker. It is not to train peer workers to become like all the other staff. Traditional social service providers must recognise peer support as a discipline requiring special supervision and support.

An experienced peer support supervisor will avoid the common pitfall of allowing clinical staff to use the peer specialist as assistants to the case managers. This is when peers are delegated the bulk of the team's practical jobs – such as transporting clients, searching for apartments to rent, assisting with moving in or moving out, and other similar tasks. Peers who are employed in this way may be vulnerable to adopting a more subservient, less effective role within the team. A negative 'them and us' culture can also create conflict within the team.

Supervising peer support workers requires an approach that is grounded in positive reinforcement and accountability. Supervisors need to be available to provide informal feedback and support outside structured supervision times. Feedback should be more personal and address the barriers and challenges faced by the peer in the workplace. It is useful to focus on what the peer specialist sees as barriers.

When discussing challenges in supervision with peers, it is very common to hear that their role is commonly misunderstood and that pieces of what they do are considered 'boundary violations'. This is largely because most peers are supervised by staff who use the same guidelines with both traditional clinical services staff and peer support specialists – this is an often-occurring mistake.

A well-supervised team meeting can also reinforce the unique role of each team member, including the peer specialist. Team meetings are excellent opportunities for each team member to articulate their point of view about each client. The team meeting is also an excellent forum for the team and the peer to educate each other about their unique perspectives on their clients' issues.

Finally, with peer specialists, there is a need for ongoing training, refreshers and supervision on issues of boundaries, confidentiality, and self-care.

Community Integration and Social Inclusion

Peers are excellent at community integration work. They know first-hand the significance and experience of the transition from streets to housing or from substance abuse to treatment. Peers can help clients manage expectations about how life changes after becoming housed and develop the life skills needed to maintain a successful tenancy. Peers can address needs for socialisation and support during that critical period of six to 12 months after a person is housed.

Peers do not make assumptions about things that most people take for granted (e.g. ordering a meal in a café, getting a library card, doing an internet search) – because they have faced these challenges themselves. They can be more attuned and know where to take the conversation around exploring new social activities, hobbies, and opportunities that provide a sense of purpose and belonging to one's community.

Peers should be looking to identify a client's strengths, needs, abilities and preferences for how the team assists the person. In the same way that other disciplines on the team focus on medical interventions or housing support, the peer support worker can be the team's consultant on homeless culture, addiction culture, and coping with mental illness. To keep the team rooted in empathy and focused on recovery, they can provide an ongoing understanding of what it is like to overcome these challenges.

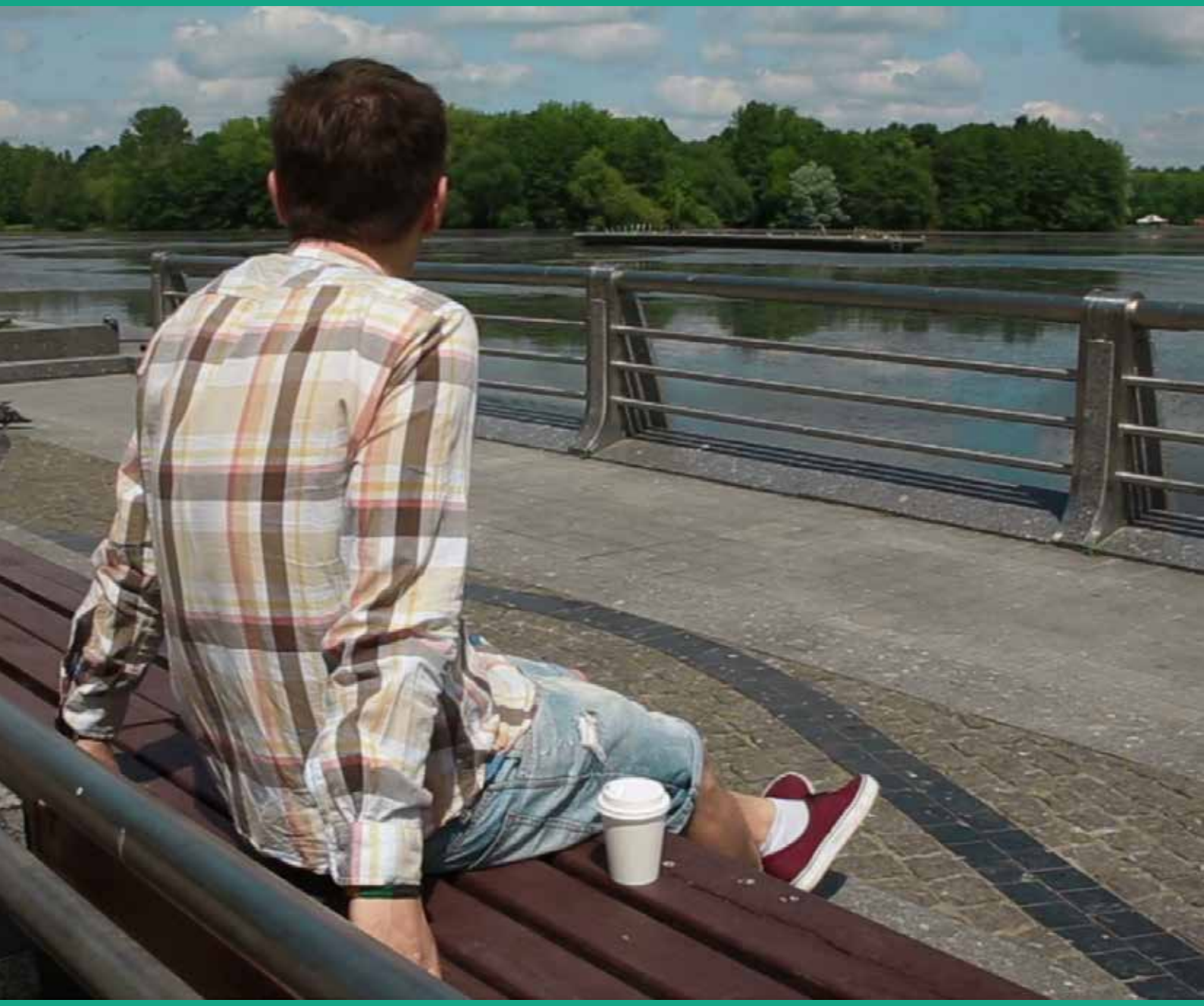
[52] ***Tsemberis, 2005, Davidson et al., 2018***

[53] ***Tsemberis, 2010***

[54] ***See Resource 1 (Section 1) for more on trauma-informed care.***

Chapter 9

Rural Housing First



This chapter provides suggestions about how to modify the Housing First programme to operate effectively in rural or more remote areas, including suburban communities, small towns and villages.

Operating Housing First in Rural Areas

The absolute numbers of people who are homeless in rural areas is small relative to the numbers in large urban centres. Thus, with a well-organised effort, it is possible for rural areas to end homelessness for people prioritised by the Housing First programme. It is an achievable goal, and the Housing First programme is well suited to help communities reach it.

The important tasks facing communities implementing Housing First in rural areas are to:

- Develop a common definition of the priority group;
- Agree on the area of the community to be served; and
- Identify the wider resources that participants may need over and above those provided by the NGOs, local authorities and HSE delivering the Housing First programme.

Rural Health

Rural health or rural medicine is the interdisciplinary study of healthcare delivery in rural environments. The healthcare needs of individuals living in rural areas may be the same as those living in urban areas, but rural areas can lack access to healthcare and other clinical and social services, compared to their urban counterparts. Typically, unlike their urban counterparts, rural areas have a great deal of connectedness and continuity; members of the community are acquainted with each other and have a history of cooperation and collaboration.

Identifying Who Is Homeless and Who Housing First Will Serve

One of the most frequently-made observations about rural communities is that 'everyone knows everyone else'. This cultural norm will be helpful in identifying the people in the community experiencing homelessness and especially those who should be prioritised for Housing First.

Community Stakeholders

Building on the strength of community ties, convening a meeting of the community stakeholders that have contact with people experiencing homelessness is an excellent way to identify the people to be served by the Housing First programme. The community stakeholders may include representatives from shelters, social service agencies, clinics, hospitals, post offices, churches, social protection offices, An Garda Síochána, the business community, charities, and any other members of the community, including people experiencing homelessness.

The goal of such a community stakeholder meeting is to identify those among the homeless who have health, mental health, addiction, or other needs – in addition to their housing need. Ideally, the Housing First service can be scaled to serve the entire group of individuals identified by this stakeholder group. The formal definition of prioritisation used in the Housing First implementation plan describes rough sleepers and frequent users of emergency services. Homelessness can be experienced differently in rural areas; and this should be taken into account, especially where there are little or no State-funded homeless services available within the community.

Eligibility for Housing First must also be determined by the person's vulnerability. Does the person suffer from severe health or mental health problems? Has the person ever managed a home or lived on their own? Has the person ever been hospitalised, treated in a detox facility or arrested? Does the person have emotional or behavioural problems that interfere with their ability to get along with others or to take care of themself? Does the person have a severe problem with substance use? Does the person have a source of income or manage their own money? Does the person have severe medical problems (e.g. diabetes) that require regular treatment? And for how long has the person been homeless?

Answers to these questions – in addition to other first-hand knowledge from the stakeholders – can help to determine who is admitted to Housing First and, to some extent, it will also help to anticipate the level of service support that will be needed.

Using health, mental health, and substance use indicators as one component of eligibility – and the time spent homeless as another – communities can create a prioritisation list for who is admitted to the Housing First programme. The community should establish a process by which relevant local community stakeholders set the criteria and determines eligibility; and there should be a sense of ownership and active participation in the selection process and in the Housing First programme in general.

Providing Support and Treatment Services

The distance workers must travel to reach clients and vice versa can be a challenge in rural areas. It can take an hour or more to reach the place where one tenant lives, and then another hour or more to reach the next person.

Programmes must anticipate and plan for additional costs related to transportation, paying staff to use their own cars, paying for services to bring clients to programme activities and buses (where available) – and they must support all other creative ways to help increase the contact between workers and clients, clients and family, and clients and community.

A key aspect of Housing First delivery in Ireland has been the identification of centrally situated satellite towns (e.g. Sligo and Letterkenny in the Northwest region), where there are clusters of homeless individuals and where there is also the possibility of identifying housing and health supports for Housing First. In effect, these towns are 'local bases' for dispersed Housing First teams, who can then work outwards to cover catchment areas that encompass the entire region.

Telehealth and Technology

The home visit is the venue where most services are provided in the Housing First programme. To maximise staff time and efficiency, and visit as many clients as possible as frequently as needed, teams will have to made creative use of available technology.

A smartphone or iPad can deliver many remote services. A mobile phone, and ideally a smartphone, is an essential tool for all Housing First participants in rural areas. People typically live alone in their own apartment in the Housing First scattered-site independent housing model. Contact and other supports are essential to wellbeing. Once people have a smartphone or computer, they can go online, visit websites of interest, communicate via text or email,

and generally feel more connected, just like the rest of us. Since Housing First clients live under the poverty line, they face formidable financial challenges in securing the right technology but one that is well worth making the effort to meet. However, even with a smartphone or computer, signal quality and the cost of broadband services may have to be addressed.

Providing health and mental health services in rural areas can be especially challenging and – given the shortage of providers and the time needed for travel – health services staff time would be much more efficiently and effectively used if clients are assisted to come to the office or clinic as much as possible.

Telehealth – implemented with the proper equipment and support – can successfully be used in combination with more traditional face-to-face services. Using telehealth can extend the reach of the staff to an entire region.

As an example of adaptation of Housing First to rural areas, Pathways to Housing, Vermont operates a highly effective rural Housing First programme[55]. About 20% of the clients have been taught to use computers and now have them in their homes. The team members use Skype, Google Hangout, or other programmes to make virtual home visits, thus increasing the frequency of contact.

The Pathways Vermont Housing First service also uses video conferencing to conduct team meetings. This allows the programme to maintain small teams spread across large geographic areas, as well as to sustain connections with dispersed clients.

Telehealth/Technology for the Housing First Team

Holding regular team meetings and many informal smaller meetings is essential to the coordination of client services in Housing First. In rural areas, it may be more efficient for team members to remain in different locations and attend meetings or receive supervision remotely. Technology allows for more time to be available to visit clients, rather than driving long distances each way simply to attend a staff meeting.

Challenges for the Team Model in Rural Communities

The challenge for the Housing First team in rural communities is that, typically, there is either a shortage of specialty services or the distances to reach these services is challenging. Therefore, team members are always exploring communities for resources of interest and support to their client.

Auxiliary supports in rural areas can be provided by family members and other community members, including church members, social clubs, retailers and mutual support groups. Mutual health and other support groups can also be attended virtually.

Housing First programmes can also modify their practice to accommodate the need for additional face-to-face contacts by meeting in the community, e.g.in restaurants or cafés. Other providers in the community (e.g. pharmacies and supermarkets) may have useful delivery services.

Community Asset Mapping

Asset mapping looks at the skills, capacities and resources within a given community. This approach assumes the resources needed to solve a problem probably already exist within the community. Therefore, asset mapping can be viewed as creating an inventory of resources.
Identifying resources is particularly important in rural areas, where people must rely on their neighbours, families, and other community-based supports, such as volunteers or the faith community.

There are different levels of asset mapping for rural communities. Asset mapping is conducted by the Housing First service, in collaboration with the client. The mapping can be done using a spreadsheet, database, or an actual physical map. Assets can be people, physical structures or places, organisations, community services, post offices, pharmacies, libraries, shops, other businesses or agencies… The list can go on and on, and depends on the needs and preferences of the client.

Individual-level asset maps are person-centred. While the assets defined at the community level can and should be brought to bear on individual needs, the asset map built with and for a Housing First participant is client-specific. It might include concrete assets or resources (such as specific family members, a church, the location of a friend's house), as well as intangible assets, such as ways to build self-determination, exercise or meditate. Transportation or travel routes can also be included[56].

Individual asset mapping also includes human resources, e.g. healthcare providers, case managers, housing coordinators, and local authority representatives. Other valuable resources include the housing maintenance worker or agency, An Garda Síochána, the County Council offices, religious organisations, and mutual support groups. The local librarian is also often a valuable resource.

There are many others who might be able to help make the transition into housing easier for Housing First clients. Who else can help the client transition into their communities? Rural communities are tightly woven systems. Every connection made on behalf of Housing First clients and the Housing First programme can lead to additional connections.

Summary

In conclusion, taking some steps to modify and adapt the Housing First programme for rural areas can achieve the same positive results in ending homelessness for individuals with complex needs. By adjusting the operations and modifying the definitions of some programme components, and adding technology enhancements, Housing First can expand its ability to provide reliable and responsive supports, as well as comprehensive, multidisciplinary services that are consistent with high programme fidelity. The use of technology and telehealth in supportive housing is novel and may also be applied in urban settings with clients who need a high volume of contacts, or when housing units are highly dispersed and transportation is a challenge. Technology has also proved to be a very useful resource during the 2020 Covid-19 pandemic.

[55] Stefancic, 2013; http://PathwaysVermont.org

[56] See Community Asset Mapping Guide, Resource 6

Chapter 10

Programme Fidelity and Programme Outcomes

In this chapter, we explain the concept of 'programme fidelity' for the Housing First model and introduce the Pathways Housing First Fidelity Scale.

What is Programme Fidelity and Why Do We Need It?

The Housing First services of Ireland's National Housing First Programme are required to operate in a manner consistent with the Housing First programme description in this manual. However, different services nationwide are in large, medium and small towns and cities, in rural settings, with different numbers of staff and clients to be served, and with different resources and collaborating partner agencies in their networks. How can we ensure that all these services – that may look different – are, in fact, providing Housing First in the same way?

'Fidelity' is defined in the dictionary as the degree to which something matches something else; being faithful, loyal to something; accuracy in details. Here, 'fidelity' refers to the degree to which individual, local Housing First services effectively adhere to the programme practices described in this manual. Programme fidelity includes an assessment of programme content – staff composition, staff practices, services provided, and programme dosage – the duration, intensity, and frequency of services.

Housing First is an evidence-based practice, which means there is research evidence from multiple studies of programme replication that have identified the characteristics of Housing First that are essential components for achieving optimal client outcomes. These characteristics have been consolidated as the Pathways Housing First Fidelity Scale[57]. The scale is comprised of 41 items to assess the degree of adherence of a local service to the standards consistent with highly effective Housing First programmes. The items are organised under the operating principles of Housing First: consumer choice, matching services to client needs, separation of housing and services, and recovery-focused services, and social inclusion and scattered-site housing, as well as an additional domain that examines programme operations.

Using the Housing First fidelity assessment scale to ensure optimal client outcomes is like conducting other quality assurance protocols. The assessment can detect areas of programme practice that are inconsistent with high fidelity practice and alert the team to adjustments that may be required. It can serve as a review to help staff consider how they are applying the Housing First programme principles across the many complex client situations they encounter. In this way, it also fosters team cohesion and a uniform practice across team members.

An optimal use of fidelity assessment is to incorporate it as part of the service's ongoing quality assurance protocol and administer it every six to 12 months.

The Pathways Housing First Fidelity Scale

What follows are brief descriptions of each domain in the fidelity scale, a sampling of items under each domain, and some examples from qualitative research on high and low scoring practices.

1. Consumer Choice

This domain is fundamental to many areas of operation, including service choice, self-determination and recovery. In the choice domain, services typically score above the mean for overall practice, but there is

variation on individual items. For example, in a meeting hosted by a low fidelity service, there would be little discussion of client choice. There may be caring and competent staff discussing clients and making reasonable decisions about the services they believe the client needs, but the staff do not use a framework of choice for deliberation of service options or they actively subvert client choice, believing they are able to make the best decision for the client. This type of team meeting may be standard practice for a hospital inpatient service, but it would score low on consumer choice on the Housing First scale.

Housing First teams that score at the mid-range of the scale would acknowledge choice, but primarily as 'negative choice' (i.e. clients have the choice to not participate in services or behaviour change, but it is not a full collaborative process that supports autonomy, self-determination, and client decision-making).

High fidelity programmes embrace a positive view of client choice, actively engage clients, invite their input, and collaborate to create opportunities.

1a. Consumer Choice in Housing (Sample Items)

- The service does not require clients to demonstrate housing readiness to gain access to housing.
- The degree to which the service enrols clients that meet the Initiative's prioritisation criteria.
- The extent to which clients live in scattered-site housing that is also available to people without psychiatric or other disabilities.

1b. Consumer Choice in Services (Sample Items)

- Extent to which programme clients choose the type, sequence, and intensity of services on an ongoing basis.
- Extent to which the programme provides [or has strong linkages to] psychiatric services.
- Extent to which programme provides, or has strong linkages to, nursing/medical services.

2. Separation of Housing and Services

This dimension examines the extent to which programmes have requirements for treatment or sobriety as a prerequisite for either obtaining housing or remaining in housing. Also assessed is continuity of services in the event of disruptions in housing, such as relocation, hospitalisation or incarceration.

Separation of Housing and Services (Sample Items)

- Extent to which clients with substance abuse disorders are not required to participate in treatment.
- Extent to which social and clinical services are mobile and can deliver services at locations of participant's choosing.

3. Recovery-Oriented Practice

Recovery orientation examines the extent to which the programme encourages self-determination, allowing clients to learn from their mistakes. It actively maintains a practice culture that is respectful, inspires hope, and creates possibilities. Even if the system is focused on lowering costly

utilisation of services, recovery-oriented programmes manage to keep the focus on the individual client, their goals, and quality of life.

Recovery Oriented Practice (Sample Items)

- Programme conducts person-cantered planning.
- Extent to which staff use motivational interviewing[58] in all aspects of their interaction with clients.
- Extent to which programme uses an array of creative techniques to engage clients who are difficult to engage.

4. Programme Operations

This dimension examines the day-to-day operation, organisation and discipline of the Housing First service. This includes assessing the appropriateness of frequency of contacts, how crisis is managed, quality of staff supervision, and client representation in the programme's decision-making process.

Programme Operations (Sample Items)

- Extent to which the service consistently maintains low client/staff ratio.
- Extent to which staff function as a multidisciplinary team /case managers and clinical staff know and work with all programme clients.
- Extent to which staff meet frequently to plan and review services for each client.

Programme Self-Assessment

The Pathways Housing First Fidelity Scale can be administered to programme staff, but it is recommended that the staff members completing the survey have at least six months' experience. Each staff member completes the survey independently without conferring with their colleagues. Subsequently, the staff members who completed the survey meet and discuss their scores. In instances where team members have scored items differently, there is a discussion about the items until a team consensus is reached. The consensus score on each item is taken as the final fidelity rating for that item. The final consensus ratings are then summed and totals for each domain are obtained and the total score for the scale is calculated for the service.

From a quality improvement perspective, these initial scores can serve as a baseline if there are areas identified that need improvement, and a team-based improvement plan can be formulated. The baseline scores can then be as a comparison of team progress when the next annual assessment is conducted.

In cases where team scores are high to begin with, the repeat assessment assures the team that programme fidelity is being successfully maintained.

The fidelity assessment process can provide an opportunity: for team self-reflection, to explore staff feelings and beliefs, and to examine how each team members' values may impact on team operation.

Programme Fidelity in Context

Programme fidelity assumes that the Housing First team being assessed is one small operation in a much larger context. Housing First does not control the local housing supply, other social services providers, healthcare, mental health care, addiction treatment, justice, or government benefits. And yet these larger systems have a direct impact on the Housing First service's ability to achieve its goals. This indicates that Housing First services must serve as local advocates for their clients within these larger systems and, ultimately, help other systems adopt a more effective, user-friendly, client-driven approach.

Similarly, the organisations that host and operate the Housing First case management services have a culture and values of their own. In some instances, the Housing First programme is a natural extension of the service-provider NGO's mission and values; however, in other cases, the Housing First programme is a departure from business as usual and adjustments need to be made. Thus, the larger system context and the host organisation for the Housing First service are considered when assessing the level of fidelity to the Housing First model.

Evaluation of the National Housing First Programme

In addition to fidelity assessments for local services, there is an evaluation planned for the National Housing First Programme. Dr. Ronni Greenwood from the University of Limerick will direct the evaluation in partnership with the National Housing First Implementation Committee, and she describes the planned evaluation as follows: "The purpose of this research is to evaluate the National Housing First implementation from a process and outcome perspective across the nine sites across Ireland. The primary aims are to: 1) monitor and assess systems implementation, 2) evaluate and monitor the target population access to housing and supports, 3) monitor and assess each programme's fidelity to the Pathways Housing First model, and 4) monitor and assess service users' outcomes".

The potential benefits of this study are to gain insight into novel ways that Housing First can be implemented via an integrated services approach among the different statutory and voluntary bodies in Ireland. The research will highlight barriers to and facilitators of programme fidelity in the Irish context. It will also monitor the outcomes of Housing First for individuals with long histories of homelessness who have long been excluded from the housing and services they needed. These findings will be important to the expansion of existing programmes and the implementation of new Housing First services across Ireland.

Action Research on Housing First Initiative

In addition to the national evaluation, the Housing First programme is participating in an 'action research' project on an ongoing basis. Through this action research project, data are obtained from participant interviews are analysed to generate actionable knowledge and to yield information about the progress of Housing First on a regular basis.

This ongoing process enables programme planners to learn from implementation and adjust operations as the programme is developing. The action research will inform the programme planners throughout the various stages of the implementation process and contribute both nationally and locally to Housing First knowledge transfer.

[57] ***Stefancic 2010, see Appendix 2.***

[58] ***For more on Motivational Interviewing, see Resource 1 (Section 5).***

USEFUL RESOURCES FOR HOUSING FIRST FRONTLINE STAFF

Resource 1: Evidence-Based Practices for Housing First

The practices described here require many hours and days of training and supervision support to be delivered correctly. These descriptions are intended to provide an overview and spark interest in pursuing further training. It would be very useful if Housing First team members were formally trained in some or all of these practices. For example, one team member may be trained as the Integrated Dual Disorder Treatment (IDDT) substance abuse specialist; another as the trauma-informed care specialist; and a third as the Supported Employment specialist. In this way, team members develop specific skills, and their expertise can be shared with their wider team, thus improving their overall clinical competence.

The following practices are recommended for Housing First programmes:

- Trauma-informed care.
- Integrated Dual Diagnosis Treatment, with the core elements of harm reduction, Stages of Change, and Motivational Interviewing.
- Strengths-based approach and person-centred planning.
- Wellness Recovery Action Plan (WRAP)[59].
- Supported Employment.
- Community integration and social inclusion – including through the use of social prescribing.
- Incorporating Peer Specialists (as covered in Chapter 8 of this manual).

These practices are based on the client-driven and humanistic values and principles that are integral to Housing First. In the Housing First programme, the support and treatment teams' focus on recovery means they can easily incorporate these practices into their day-to-day work.

Generally, it is best to introduce new practices into a Housing First programme one at a time – after the team has been in operation for a few months and has learned to coordinate the day-to-day activities of obtaining housing and providing clients with support services. All the practices described here are well documented in the field of mental health; and practitioners have written books and developed toolkits and videos for most of them. Again, no single team member is expected to master all these practices, but the team's collective expertise should include some knowledge of all of them.

[59] https://copelandcenter.com/wellness-recovery-action-plan-wrap

1. Trauma-Informed Care

Trauma and its Psychological Impacts

Many of the clients served by Housing First have experienced the devastating effects of violence and abuse, which proceed to shape every aspect of a person's life, even years after the traumatic experiences. To cope with the enduring impact of trauma, an individual may construct a sense of self, a sense of others, and a belief system about the world that is based on the experience of very painful events. The effects of traumatic experiences are especially acute when trauma begins in childhood, is perpetuated by someone the person loves and should be able to trust, and the abuse is ongoing.

Survival from trauma often means the individual severs connections with their family, their community, and ultimately with themself. Even many years after the abuse, survivors often feel powerless and unable to advocate for themselves. Post-traumatic stress-disorder (PTSD), the after-effects of trauma and the coping strategies of people who have experienced trauma can be difficult for others to understand. The defences that people develop after being repeatedly hurt can make the task of connecting with them extremely difficult.

Perhaps the biggest misunderstanding about trauma is the emphasis on the direct harm or injury caused by traumatic events (e.g., abuse, violence and neglect). What is not understood is the devastating impact on psychological development. A significant harm of ongoing abuse is the failure to fully develop one's self-capacities.

The Trauma-Informed System

Enduring and meaningful healing occurs when the people providing support share a philosophy about trauma, services, the helping relationship, and the impact of trauma on the lives of their clients. How we understand trauma will determine the overall approach to the supports and services we deliver.

In a trauma-informed programme, trauma is not viewed as a single discrete event but, rather, as a defining and organising experience that forms the core of an individual's identity. The focus is on understanding the whole individual and appreciating the context in which that person is living their life. Rather than asking: "How do I understand this problem or this symptom?", we ask instead: "How do I understand this person?" This shifts the focus onto the individual and away from some limited aspect of his/her behaviour. It gives the message that their life is understandable, and their behaviours make sense when understood as part of a whole picture.

Trauma and Triggering Events

Present-day events that serve as reminders of past dangerous experiences are called 'triggers'. Triggers activate a person's alarm system. When someone is triggered, they may feel and act as though they are back in the time of danger, even though they are not.

Those who have been traumatised may live with implicit memories of terror, anger, and sadness generated by the trauma, but with few or no explicit memories to explain the feelings. Most traumatised people develop extreme coping strategies to manage the effects of overwhelming traumatic stress. Because bodies automatically, as a matter of survival, express what has not been verbalised, traumatic memories can be transformed into physical outcomes, including chronic pain (especially pelvic), gastrointestinal problems, asthma, heart palpitations, headaches, chronic fatigue, and other illnesses. Further, survivors of severe abuse may present with a bewildering array of symptoms, including insomnia, sexual dysfunction, dissociation, anger, suicidality, self-harm, drug addiction and alcoholism[60]. Trauma from prolonged abuse can also lead to disruptions in emotion, attention, memory, sense of self, attachment to others, and relationships. Some specific behavioural adaptations utilised by individuals experiencing homelessness may include layering of clothes, hypervigilance, seeking anonymity in large shelters, fear of shelters, not bathing, or being unwilling to seek dental or medical care.

Current problematic behaviours and symptoms may have originated as legitimate and even courageous attempts to cope with or defend against trauma. A trauma-informed framework views 'symptoms' as adaptations. Adaptations are an attempt to solve a problem and symptoms occur in response to something, not randomly. There is a function and a purpose to the responses, usually an attempt to solve a problem. Every adaptation supports a survivor's reaction in both the past and present. Coping strategies used by survivors may have helped them endure abuse while it was occurring but can be limiting for them as adults, as they attempt to move past such experiences. Such coping strategies may present barriers to treatment and recovery and be perceived as pathological conditions in services or treatments that are not trauma-informed.

Why an Integrated, Trauma-Informed Approach is Necessary

Many service-providers do not recognise or understand these multiple, varied and complex effects of abuse-related trauma. These effects are also often misunderstood because they are masked by seemingly unrelated behaviour. It is well documented that many traumatised people seeking help are not only misunderstood and not given the help they need, but are also re-traumatised. This is not only a setback to their recovery, but often results in them refusing care or not trying again to get the help they need.

[60] Herman, 1992

Individuals with a history of trauma experience severe and persistent mental health and/or substance abuse problems; and are frequently the highest users of inpatient, crisis and residential services. They are also likely to have increased encounters with the police. People living with a combination of mental health issues, substance abuse and trauma histories are likely to have more severe difficulties and to use services more often than someone with any one of these problems alone.

Mental health best practice recommends that substance use problems and PTSD should be treated concurrently within the context of an integrated approach to assessment, treatment planning and intervention. But, still, most people with trauma and substance abuse do not received trauma-focused treatment.

Trauma-Informed Versus Trauma-Specific Models

The primary task of the trauma-specific model is to address the impact of trauma and to facilitate trauma recovery. This includes individual and group interventions designed to treat post-traumatic stress disorder. These services are designed to treat the actual effects of sexual or physical abuse trauma. The services would include techniques to help clients manage dissociate symptoms, desensitisation therapies, and skill-based therapies for the modulation of overwhelming emotional responses.

The trauma-informed care model involves understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been victimised may have in a particular setting or service. At a minimum, trauma-informed services should endeavour to do no harm —to avoid retraumatising survivors or blaming them for their efforts to manage their traumatic reactions. For example, an unaddressed trauma history can result in a woman resorting to drug use to manage her anxiety and flashbacks. The use then results in angry and impulsive behaviour, related to the effects of the drugs. If this is understood only as a relapse and/or a lack of commitment to sobriety, and to aggressive or inappropriate behaviour, neither staff nor the woman will make the connections necessary to assist her to substitute other means of coping, reducing these symptoms, or understanding the connection between the trauma, drug use and behaviour.

Trauma-Informed Care and Housing First

Trauma-informed services integrate an understanding of trauma – including the effects and the conditions that enhance healing – into all aspects of service delivery. Housing First services must provide the training and ongoing supervision to operate as a trauma-informed service. These services are not specifically designed to treat symptoms or problems pertaining to abuse-related trauma, but are informed about and sensitive to trauma-related issues present in survivors. This requires that all components and all

collaborating agencies in Housing First are trained to provide services that have a basic understanding of the role that trauma plays in the lives of people seeking housing, mental health and addiction services.

Trauma-informed services need to accommodate the vulnerabilities of trauma survivors and:

- Facilitate clients' participation in treatment.
- Use language that communicates the values of empowerment and recovery.
- Eliminate the use of punitive approaches, shaming techniques and intrusive monitoring.
- Ensure all staff adopt the 'do no harm' credo to avoid damaging interactions.
- Deal with conflict through negotiation.

Becoming trauma-informed also requires close collaboration with other support systems serving these clients and the local network of private practitioners in the treatment of abuse-related trauma. This means moving trauma from the periphery to the centre of our understanding.

Without a shift to trauma-informed services, there will continue to be a failure to meet the needs of traumatised individuals. Trauma survivors often live lives of great pain and confusion and may not initially recognise trauma as the source of many of their struggles. Trauma-informed services need to be knowledgeable so they can assist people in making the link between their current difficulties and their past abuse.

What do you Need to Know to be Trauma-Informed?

Trauma-informed service provision requires a conceptual framework to understand clients and their symptoms in the contexts of their life experiences, culture and society. This framework includes:

- Collaboration between provider and client;
- An understanding of symptoms as attempts to cope; and
- An understanding of the effects of abuse and the differences between simple and complex trauma.

Furthermore, in order to have a meaningful dialogue with clients concerning their traumatic experiences, we much have a clear conceptual framework to understand what the client is experiencing, as well as an understanding of why they are having those experiences. The starting point for all of us is knowledge of violence, substance abuse and mental health problems and their interaction.

Guiding Assumptions in Case Management

The most helpful, respectful and empowering model for helping abuse survivors involves working from a trauma framework and understanding clients and their symptoms in the context of their life experiences, their cultures and their society. Trauma theory emphasises what 'has happened' to a person rather than 'what is wrong' with the person. It takes a view of trauma as a defining and organising experience that forms the core of an individual's ongoing responses to stressful events rather than a single discrete event. An adaptation model:

- Seeks to emphasise resiliency in human responses to stress;
- Helps survivors recognise their strengths and inner resources, instead of defining themselves by weakness and failure;
- Reduces shame;
- Engenders hope; and
- Helps reinforce a framework that views everything a part of a larger whole.

A trauma-informed framework sees the helper (i.e. service-provider) as an essential part of the healing process. Forming a respectful relationship with survivor client is the first and most important step. Using this relationship, we can help clients develop skills to manage feelings and memories. When clients are better able to manage feelings and traumatic memories, their symptoms and crises will lessen. It is important for the helper/provider to be self-aware, as this work will change the therapist. It is not possible to do this work and not be affected.

A critical point here is that service-providers are to work from the client's frame of reference, "a radical acceptance of the client's point of view"[61]. This includes learning from them what adaptations they were required to make to deal with their abusive experiences. Here, collaboration, empowerment and validation are crucial. Interventions used with trauma survivors must promote agency, choice, and voice in our clients. Clients benefit most when they participate actively in setting their own goals and have control over decisions that affect them. The expectation that clients be 'cooperative' and 'compliant' with authorities resonates with being controlled and abused.

The core of the trauma-informed framework is the application of problem-solving strategies, balanced by validation strategies. From the client's perspective, maladaptions (i.e. traits that are – or have become – more harmful than helpful) are the solutions to problems they want solved, whereas many case managers think that the maladaptions are themselves the problems to be solved. The case manager must first validate the client by finding the wisdom or value in the client's emotional, cognitive and behavioural responses.

[61] Linehan, 1993

A second type of validation is the case manager's belief in the client's inherent ability to heal from abuse and build a life worth living. The case manager identifies and reinforces the client's strengths, not their fragility. A strengths-based perspective demands a different way of seeing clients, their environments, and their current situations. We must be genuinely interested in and respectful of our clients' stories, narratives, and accounts, as well as the interpretive angles they take on their experiences.

In a strength-based approach, rather than diagnosing deficits and prescribing treatment to address them, we help clients identify and build on their capacities. This supports clients in understanding that they have skills, experiential knowledge, hopes and interests, and that they can do some things masterfully.

Identifying strengths means recognising the survivor's skills, talents, and abilities, as well as the resources they possess, including both resiliency and achievements. Recognising and naming client strengths requires the ability to have perspective and see alternative viewpoints, have empathy for self and others, set appropriate boundaries in relationships, have willpower and initiative, and awareness of own psychological needs.

2. Integrated Dual Diagnosis Treatment

The importance of focusing on dual disorders emerged from the findings that substance-use disorders are common in people with severe mental health disorders – and mental health disorders are common among people with substance use disorders. Unless treated in an integrated manner, these so-called 'dual disorders' have poor prognosis and treatment outcomes. Those with dual disorders tend to have high rates of hospitalisation, financial problems, family problems, interpersonal conflicts, high rates of incarceration, high morbidity rates for medical problems (including HIV and hepatitis), and early mortality. Traditional treatment treats each condition separately, either sequentially or in parallel. Although not definitive, the available evidence suggests that integrated care models for dual diagnosis disorders are the most effective models for patient care[62].

Integrated Dual Diagnosis Treatment – IDDT – can help clients identify the magnitude of their substance misuse and make necessary connections to the psychological reasons driving their use, so they can begin to see how their abuse of alcohol and other drugs is ineffective in addressing their mental health problems and interferes with their life goals.

IDDT calls for a harm reduction approach when working with clients and provides a framework to match treatment interventions to a client's openness to progressive change. To successfully implement IDDT, the substance abuse specialist and the entire Housing First team must understand the interaction between mental illness and substance use disorders. IDDT incorporates several other evidence-based practices, including Motivational Interviewing and Cognitive Behavioural Therapy.

Housing First clients are often actively using alcohol or other drugs when they enter the Housing First service, and may be uninterested or ambivalent about stopping Their use most often occurs in a social context, so their challenge to give up drugs or alcohol also involves giving up friends and acquaintances and feeling isolated. And isolation can feel stressful – which can lead to use.

These are not simple or quick problems to solve. Our clients are coping with multiple concurrent stressors that include the negative press of drug-using friends or relatives, social isolation, the physiological reactions related to substance abuse, the crushing effects of poverty, anxiety related to securing drugs, and the challenges of mental illness. Addressing these issues requires service-providers to coordinate a significant number of service and treatment supports; and require clients to make difficult life-changing decisions, for which they will need substantial support. These issues are interrelated and must be addressed holistically: IDDT is but one component and the seamless coordination of mental health and addiction services is essential if the client is to make meaningful progress.

[62] Hakobyan et al., 2020

Motivational Interviewing can help service providers effectively discuss clients' ambivalence about such large-scale personal change. It is also very helpful to learn about the Stages of Change, a framework for understanding clients' relationships to their substance use disorder[63].

There is evidence that Brief Interventions (BI) for individuals in the early stages of substance use result in a sustained reduction in substance use[64]. The HSE national model for training in Screening and Brief Intervention for Alcohol and Substance Use is the SAOR© (Support, Ask and Assess, Offer Assistance and Referral) model[65]. SAOR offers a step-by-step guide for practice, to guide workers in using a person-centred approach throughout their conversation, encounter or engagement with a service-user. The programme supports workers from their first point of contact with a service-user to enable them to deliver brief interventions and to facilitate those presenting with more complex needs with entry into treatment programmes as per the National Drugs Rehabilitation Framework's National Protocols and Common Assessment Guidelines (2011). Since 2012, the HSE's Screening and Brief Intervention (SBI) project has coordinated the national rollout of a one-day SAOR© screening and brief intervention training programme for alcohol and substance use in partnership with the National Addiction Training Programme.

Cognitive Behavioural therapy (CBT) has also been found to be effective in helping clients develop ways to identify people or situations that are likely to trigger their alcohol and other drug use, and it teaches clients strategies for coping with triggering situations, people, and their cravings. CBT can also be used to teach a variety of social skills, such as effective ways to refuse alcohol and other drugs in social situations when clients experience a great deal of peer pressure to use. Clients are also taught to manage the stress that results from these situations.

The Housing First approach has several elements in common with IDDT. Services are longitudinal and client-centred, clients are not required to attain abstinence, and both approaches emphasise building trust and nurturing relationships with clients. Another shared assumption is that conditions are often long-standing; both approaches accept the reality that change takes time. Some research studies suggest that 60% of the clients who receive IDDT will be in remission within four years – if the treatment provider maintains a high degree of fidelity to the IDDT model. The Housing First and IDDT approaches share a philosophy of working collaboratively with each client and recognising that progress is not linear. The clinical skills embedded in IDDT help the Housing First teams work with clients in a manner that is consistent with clients' own needs and goals.

[63] Both Motivational Interviewing and Stages of Change are described in further detail later in this section.
[64] Darker et al., 2016
[65] O'Shea and Goff, 2009

Implementation Principles of IDDT

When IDDT is effective, it leads not only to reduction or abstinence in substance use, but also to improvements in other areas of clients' lives, including reduced hospitalisations; symptom reduction; reduced violence; reduced victimisation and involvement with criminal justice; better physical health; and gains in productive functioning, including employment and improved relationships and family life.

As practised in the Housing First model, the basic implementation principles of IDDT include:

- Integrated treatment: Mental health and substance abuse are both viewed as primary diagnoses and are targeted for concurrent treatment.
- Assertive engagement: Staff make every effort to actively engage reluctant clients and to reach out and provide services in the client's natural living environment. They also provide all manner of assistance (both clinical and practical) to develop trust and a working alliance.
- Motivation-based treatment: Interventions must be adapted to meet a client's motivation for change, or 'stage of change'. The programme's 'stages of treatment' approach provides a framework for assessing the client's motivational state and setting goals, which helps teams and clients select interventions that are appropriate to achieving those goals.
- Harm reduction approach: The programme focus is to reduce negative consequences of mental illness and substance abuse. The goal here is to try to protect the client from the dire consequences of substance abuse, including a return to homelessness, infectious disease or incarceration. Developing a good working alliance is key; this includes establishing the ground rules that allow for an open and honest discussion about the client's drug use without the client fearing negative consequences from that honest discussion.
- Time unlimited services: IDDT programmes do not produce dramatic results over short periods of time. Severe psychiatric disability and substance misuse are seldom a quick fix. Clients improve gradually, and the programme recognises that individuals recover at their own pace and need to be given enough time and support to achieve this goal.
- Multiple psychotherapeutic modalities: Individual modalities include Motivational Interviewing and Cognitive Behavioural Therapy; group modalities include Stages of Change groups, harm reduction groups, and self-help groups such as Alcoholics Anonymous. When possible, a family systems therapy may also be used

3. Harm Reduction

Harm Reduction is a foundational component of Housing First programmes because clients are not required to take medication or attain sobriety as a precondition for housing. Harm reduction is a compassionate and pragmatic alternative to traditional 12-step treatment for people who are unwilling or unable to work with the abstinence-based approach and have continued to remain homeless. The goal in harm reduction is to help the client live a better life.

Harm reduction is solution-focused, compassionate, and pragmatic. This approach simply accepts that some clients will use drugs and refuse medication. It accepts the clients' position on these matters and works with them from where they are to reduce the risks associated with these choices. For example, a Housing First team may work with a client who refuses to take medication because voices they hear tell them it "kills their soul". Team members might help the client learn ways to lower their own voice when responding to the voices they hear, to avoid disturbing neighbours who in turn might call the landlord or the police.

Harm reduction is about observing and celebrating small positive steps. This approach acknowledges any steps in the direction of healthy behaviours or reducing risk. Celebration is called for when a client proudly announces to the staff member, "Last week I went from drinking 12 pints a day to 8!". When a client who has remained sober for five weeks tells the harm reduction group on Monday morning that he relapsed over the weekend, harm reduction group members will congratulate him for being right back in the group and for having fallen off the wagon for only two days.

Harm reduction requires an individualised approach. A flexible approach must be taken with each client because clients vary widely with regard to the severity of their substance misuse or symptoms; their willingness to try different interventions (such as moderation, safer use or trial abstinence); their psychiatric status; and their personal beliefs, values, strengths and weaknesses.

Housing First programmes practise the following principles of harm reduction, which are based on the work of Andrew Tatarsky and G. Alan Marlatt:

- Substance abuse and psychiatric symptoms are best understood and addressed in the context of the whole person in their social and cultural environment.
- The relationship between helper and client is one of respect rather than authoritarian. This is a collaborative relationship where goals and strategies are discussed and planned jointly.
- The emphasis is on personal choice and responsibility for deciding future behaviour.
- Goals are client-directed. The client's motivation, goals and strengths determine the course of treatment. The treatment begins with where the client is – psychologically, socially, spiritually, culturally and even geographically (e.g. home visits). Abstinence

(or any other preconceived goal) is not held out as a starting point in treatment. Harm reduction is not incompatible with the abstinence-based approach, but the goal of harm reduction is client safety and wellness – not sobriety.

- Alcohol and other drug use are viewed on a wide continuum of risk from not very risky to life-threatening, and the treatment approach matches the severity.
- Engagement in treatment is the primary goal. However, staff do not insist on change and do not challenge a client's point of view; they must communicate with empathy and consider that the client has valid reasons to use alcohol or other drugs or to refuse to take medication. The client's ambivalence about sobriety is honoured and made a conscious part of the conversation. Teams use 'decisional balance', where clients are urged to consider the pros and cons of using and not using and to explore reasons to change and reasons not to change.

In the Housing First context, providing clients who are homeless and dually diagnosed with a safe and secure place to live, regardless of their substance use or psychiatric symptoms, goes a long way toward reducing the harm and risk associated with street life and street drugs. Harm reduction is a very effective Housing First engagement tool and a way to quickly gain the client's trust.

To reduce harmful behaviours, Housing First teams must get to know their clients and familiarise themselves with their clients' patterns of use. Does the client use marijuana, methamphetamine, heroin and alcohol? Does the client use more when they are with former friends from the streets? Is the client able to moderate their use if alone in their apartment? Could the client make use of a needle exchange programme? Could they try to reduce alcohol use, for example, drinking three days a week instead of five? Is the client willing to try 'trial abstinence' or take a break from alcohol or drug use? Does the client need help from the team to manage money for groceries and other basic needs?

Many harm reduction strategies are possible, and the appropriate one will depend on factors including the client's goals, strengths, and stage of change.

4. Stages of Change

The Stages of Change model, developed by James Prochaska and Carlo DiClemente, is based on the theory that people alter their behaviours in progressive steps, at their own pace. The model identified five Stages of Change. Relapse – a common occurrence for many clients who struggle with substance use disorders – is included in the maintenance stage. As mentioned in the IDDT description earlier, treatment is usually more effective when it mirrors the client's stage of change.

Stage One: Pre-Contemplation

At this stage, clients do not believe their substance abuse or behaviour is a problem, and they are unable to acknowledge any negative effects from such behaviour. Essentially, the client is in denial. Common traits of Stage One are defensiveness, resistance to suggestions about substance use, and the feeling of being coerced or being controlled.

Stage Two: Contemplation

At this stage, clients are somewhat aware that their behaviour can result (or has resulted) in harmful consequences. During periods when the client is not using, they begin to consider the possibility of a different way to manage their substance use disorder. Clients in Stage Two may voice awareness of the problem, yet still believe its significance is low, or that they can manage it. Common traits of Stage Two are distress, seeking to evaluate, and a desire for control or mastery.

Stage Three: Preparation

At this point, clients are aware that their substance abuse has negative consequences for their lives. In many cases, clients have learned from successful past attempts to change, and they are starting to figure out how to put those lessons in place. Common traits of Stage Three are intent to change, readiness to change based on action and attitude, and engagement in change process.

Stage Four: Action

At this stage, clients are actively modifying their behaviour or their environment. Clients have a plan and programme in place, designed to help them better control their substance use disorder or negative behaviours. Common traits of Stage Four are verbalising a desire to make a change, taking suggestions that help move away from people who are using, and developing new friendships with people who are more supportive of managing drug and alcohol use — and some may be in, or at least support, recovery. Common traits at this stage include: clients asking for help when they feel like using; coping by calling on friends, a team member, a peer, or a sponsor; and asking for assistance.

Stage Five: Maintenance

At this point, clients are sustaining and further incorporating the changes they have already made. They are also actively avoiding relapse. Common traits are discussing what they are doing to maintain these changes, describing situations that are difficult for them (and stating how they cope with them), and talking about how they can avoid relapse.

In the stages of change and harm reduction approach, when relapse happens, it does not mean that all that has been gained is now lost. The key to handling relapse is to intervene immediately and learn from what happened. Relapse is not a result of a character flaw or loss of morality; it is often simply a part of the recovery process. Some signs of impending relapse may include arguing, forgetfulness, stress symptoms, lack of self-care or moodiness.

5. Motivational Interviewing

A core clinical skill, Motivational Interviewing (MI) should be part of the basic training curriculum for all staff working in Housing First services – or in any programme with a client-driven approach to services. This skill is used in the practices of IDDT, harm reduction, and when attempting to change any negative behaviour.

MI is a client-directed counselling approach, developed by clinical psychologists William R. Miller, Ph.D. and Stephen Rollnick, Ph.D. Its overarching concept is that change is possible, and that the desire for change must come from the individual. The client is ultimately responsible for and in control of making the change.

The five principles of Motivational Interviewing, as described by Miller and Rollnick, are listed here:

1. Avoid argumentation and direct confrontation: Arguing with and confronting clients can cause them to feel attacked and coerced, which adversely affects their desire to fully participate in treatment. One tenet of MI is that the counsellor or team member is present as a facilitator of change, but the client must ultimately drive the change.
2. Express accurate and genuine empathy: This involves understanding the client and being able to imagine what it must be like to experience what the client is experiencing. MI uses much of Carl Rogers' work to inform its practice. Rogers used the term 'unconditional positive regard' to describe what a client needs to experience to feel comfortable trusting and examining the toll that some behaviours are taking on their life.
3. Support self-efficacy and optimism: The team members and the client must believe that change is possible. A group setting in which others have had success can be an extremely powerful tool. Building on a client's past success is also a good way to prove that change is possible and that it can be done.
4. Roll with resistance: A team member runs the risk of increasing resistance by pushing back and getting into a power struggle with a client. Instead, the team member needs to be flexible and use the client's 'momentum' to further explore his or her views.
5. Heighten discrepancy (use decisional balance): The team member needs to become adept at helping the client see how their behaviour (e.g. substance misuse) is helpful in some ways and negative in other ways and that, when looked at all together, on balance, the behaviour is leading their either toward or away from current goals.

Numerous techniques have been derived from MI principles and applied to the various Stages of Change (remember, Housing First teams must match the stage of treatment with the stage of change). The following table illustrates some of these linkages and techniques.

Stage of Change	MI Principle	Clinical Technique
Pre-contemplation	Empathy -Heighten discrepancy (decisional balance) -Roll with resistance -Avoid argumentation	-Develop rapport -Do not confront -Do elicit discrepancy (client describes how choices either support or undermine goals) -Explore pros and cons of substance abuse -Raise doubts, reframe the issue, take a questioning stance
Contemplation	-Enhance client's self-efficacy -Examine client's value in relation to change -Empathy	-Elicit positive statements for change: tip the balance toward change -Examine pros and cons of not changing; emphasise the pros -Support positive change, listen to the 'talk' the client uses -Reframing and shift of focus, take a questioning stance, offer information
Preparation	-Support self-efficacy -Empathy	-Help client clarify goals, lower barriers to change, explore expectations of change -Assist with learning decisional balance tools, help client elicit social support, ask open-ended questions, listen reflectively -Affirm, educate, offer options of tapering down, consider a trial of moderation
Action	-Empathy -Avoid doing for; do with -Support self-efficacy	-Affirm and help develop plans for realistic change -Educate, help create and strengthen a support network, improve problem-solving skills, anticipate problems, tolerate the fear of ambivalence -Strengthen and support the client's commitment for change
Maintenance	-Self-efficacy -Empathy	-Broaden community support -Affirm the client, review long-term goals and relapse prevention plans

Table 1: Linkages between Stages of Change, Motivational Interviewing and Clinical Techniques

When a client relapses, the Housing First team needs to maintain empathy and help the client examine what happened to learn from the experience and build that learning. The team must work with the client and encourage the client to see this as an opportunity to learn in order to avoid future relapses.

6. Strengths-Based Approach

The strengths-based approach (SBA) underlines the service philosophy of Housing First and it includes both philosophical and practical dimensions. SBA is effective and evidence based and has shown positive outcomes in numerous research studies[66]. The strengths-based approach views the person as a great resource, not as a problem.

Recovery is the main objective of SBA. A strengths-based approach is designed to have clients who are working towards their recovery 'own' their recovery process. This is facilitated by providing services that support client's ownership of their success by supporting:

- Hope for the future.
- A more positive sense of self.
- Positive social roles.
- A sense of place and belonging within the community.
- Personal meaning and a sense of purpose.
- The sense that what they decide and do matters.

These goals are communicated through an ongoing relationship with Housing First staff, while also remaining focused on improving mental health, potentially reducing or eliminating substance use, and increasing the ability to function well and succeed in the housing of their choice.

Six Core Principles of the SBA

There is enormous compatibility between the principles of Housing First and SBA. SBA principles include:

1. People with psychiatric disabilities have a continuing capacity to learn, grow and change.
2. The focus is on the individual's strengths, rather than on their psychopathology.
3. The client directs the helping process.
4. The helping relationship is primary and essential.
5. Assertive outreach is the preferred way of serving people.
6. The community is rich with resources; naturally-occurring community resources are preferable to formal programme resources.

How Strengths-Based Differs from Traditional Services

Primarily, the SBA approach provides increased client choice in decision-making regarding the large and small goals. Equally important is that, instead of focusing primarily on problems as assessed by mental health professionals (such as the need to reduce symptoms, end substance use or build readiness prior to entering housing), SBA focuses primarily on supplying crucial recovery supports that people say they want and need (e.g. housing first).

[66] Rapp, 2004

The role of the service provider fundamentally shifts from deciding what a person needs and/or from acting in what is perceived by staff as being in the person's 'best interest'. SBA acknowledges and supports the person's right to make life choices, thereby developing a sense of self-agency in the person and providing them with the dignity of risk. SBA helps people make choices, thus supporting them as they move from being passive recipients of services to becoming active consumers, who are the drivers of their own recovery journey.

From What's Wrong to What's Strong

Rather than focusing primarily on what is 'wrong' with the person (symptoms, substance use concerns, self-defeating behaviours, lack of skill, resource deficits), SBA focuses foremost on what is 'right' with people (i.e. their goals and desires, capabilities, survival skills, creativity, what they really want, their resources and supports, motivation, and what they can already do well or well enough). Rather than categorising people by diagnosis, level of functioning, degree of vulnerability, or stage of change – and providing a standardised service package for a category of people – SBA tailors services and supports to the individual to build personal pathways to recovery.

SBA Uses a Holistic Approach

SBA engages people and relates to them as unique individuals, who have many strengths and unlimited potential for learning, growth and change. Here are the words of one client describing the process of recovery when participating in an SBA-informed programme:

"When we begin to be more confident in ourselves, we begin to acknowledge positive aspects of ourselves that are also a part of our reality. People are not just an addict or a collection of psychiatric symptoms. We also have many talents, strengths and inner wisdom… As we gradually begin to identify with positive aspects within ourselves and our surroundings, we come to realise we can call upon our inner and outer resources and strengths to move us forward in our recovery. The addiction and mental illness gradually become a less dominating and all-encompassing part of our lives…"

- Jay Walker, Housing First Client, LA

Avoid Labels and Other Categories

People are much more than their labels or diagnoses. Individuals are seen holistically, as a unique whole person in a particular life context; accept their quirkiness, in their full humanity – not merely as 'chronically homeless' or an 'addict' or 'service recipient', but as a unique individual contending with challenging conditions who wants to move forward and rebuild a life.

To facilitate this view, SBA uses person first language (e.g. instead of 'homeless person', try 'person that experiences homelessness'. Instead of 'he's an addict', use 'he is struggling with a substance use disorder').

Engagement and Relationship-Building

Strong and positive helping/peer relationships are the basis of SB work and are the main foundation of recovery. The work is a partnership between the team and the client. Team members consistently demonstrate genuine caring. The staff is warm, concerned, empathetic, active, interested, curious, informal, friendly rather than formal, business-like or detached. The relationship is purposeful versus reactive: SBA assists the person to recover and rebuild the life they want, rather than just reacting to unmet needs or crises. The relationship is empowering and recognises that both the worker and the participant are whole people. Mutual trust and caring are stressed above professional distancing, neutrality or enforcement of stiff artificial boundaries.

Housing First staff actively or assertively engages the client, but the process is unhurried. It takes time to build a trusting and healthy relationship. People may not trust or open up right away, it is highly likely they have experienced trauma and have been violated in various ways and may actively fear formal helpers. Housing First staff are not invasive or overly intrusive – they allow people to maintain their space and to set the pace for engagement. They respect people's privacy and boundaries, offer practical assistance in a matter-of-fact manner, and are impeccable and reliable as proven via follow-through on all commitments. Staff communicate in a manner that is genuine and non-judgmental and they continue to connect and offer assistance repeatedly, over time. Housing First staff do not give up on the person even if the person is reluctant to engage and even when the client makes decisions that don't pan out, get them into trouble or cause them to lose their home. Staff persist in their efforts to engage and stick with the person through hard times, setbacks and relapses.

SBA is a Hope-Instilling Practice

Hope is expressed through behaviour and attitude. Staff express and model respect, treat the client with dignity, focus on their positive potential, and try to help people make the best of their situations. Staff will offer to teach the skills the person says they want to learn and assist them to expand the resources base by describing possibilities and exposing people to opportunities and recovery role models. The person is supported as they move forward and the focus is on the potential for a 'real life' in the community, rather than the continual need for formal services and a life bounded by the formal service system.

Assessing for Strengths

In SBA, major emphasis is placed upon assisting the person to identify their strengths and supporting them to express their strengths in their home and community. A clear understanding of each person's strengths is needed to set goals and create strength-based personal plans. A strength assessment is both an event and a process. Strengths assessment is not done like conducting a questionnaire but, rather questions

are asked in natural conversation as part of getting to know and serve the person. We can also assess strengths by noting things the person says, does, or has in his or her environment, and checking our observations out with the person.

The initial assessment is best accomplished by meeting with the client in an informal setting, either during an apartment visit or while having a coffee. The assessment is conducted in a conversational manner by asking open-ended questions and follow-ups to understand how the person views him or herself across the various life domains—family, work, friends, health, etc. The staff listens carefully and explores the person's strengths from different angles encouraging the person, notice and appreciate their strengths in each area. Staff can invite the person to consider using their strengths in different areas.
A frequently used (but inconclusive) list of life domains includes: Living situation, Financial, Vocational, Educational, Social supports, intimate relationships, Leisure/ recreation, Health and wellness, and spirituality.

Inner and outer strengths

Inner strengths are those that are the qualities or traits of the person: their skills, what they know how to do well and enjoy doing, their special talents or gifts, knowledge and wisdom, their interests and what they are curious about, their aspirations and hopes for the future, and includes what they are already doing that helps them manage their life today. Outer strengths come through the person's surroundings, social and family supports, or cultural background and community ties.

Goal-Setting Using SBA

The process of strengths assessment and goal-setting takes several meetings. The process seeks to develop a holistic understanding of the person and his or her life situation and to identify important life projects. It is best to begin with areas where potential exists, where change and/or growth are desired, or where strengths exist but are not fully expressed.

Goal-setting involves the following actions:

1. Working with the person to create a clear vision of what longer term success in that area might look like/mean for them;
2. Figuring out and supporting the development of concrete targets that can be achieved in the next 2-3 months that will move the person toward where they want to be in the longer run; and
3. Assisting the person to develop goals for any domain that is currently important to them.

The goal-setting process is continuous—it is not a one-time effort. As the person explores life and recovers, their goals will change. New goals may emerge serendipitously. Over the course of the relationship, these emerging goals may prove to be of higher priority than the current goals. The process is flexible and adaptive.

While most people enjoy goal-setting, some people are not interested. If they do not want to work on a given domain, staff understand and accept that. This is not a mandatory exercise. Some the language of goal-setting may be disliked. Try and use other words such as: "Where would you like to be in a few months in terms of…?" or "Are there ways you hope I could help you with…?".

Goal-setting is unlikely if the person feels hopeless or in crisis. Work on hope-building and wait until the crisis subsides. Goal-setting should be a calm, thoughtful and deliberate process. Consider introducing the client to peer role models. Some people can lack exposure to or awareness of possibilities and need some guidance in exploring new possibilities.

The SBA Personal Goal Plan

The Personal Plan is thorough, detailed and highly specific. Each goal has action steps and these steps should be:

- Achievable--doable with a high likelihood of success.
- Small and discrete, practical very small steps.
- Stated in positive terms.
- Understandable and meaningful to the person.
- Concrete – success can be seen in the mind's eye and stated in behavioural terms.
- Measurable--the actions can be measured in some way, such as how many times, at what point in time, how often, or how much.

For each step include space for comments about what happened, what was learned, what new actions remain to be taken.

Failed Attempts, Revisions and Corrections

There are several reasons why people fail at achieving their goals. Here is a list of seven common reasons why people do not meet their goals and a suggested remedy for each problem:

- They were not really the person's goal – revisit and ensure motivation is there.
- There were not enough resources or supports – re-write the plan with added supports.
- The person lacks skills – teach the skills the person lacks.

- Rear or failure or lack of self-confidence or fear of success – remember to build hope.
- No reward or incentive — build in celebrations and make sure rewards are intrinsic.
- Too abstract/vague or unclear or written in professional language – rewrite goals in the person's language.
- Poor pacing – remember the client sets the pace for change, do not rush them, or try to slow them down.

The Skill of Celebration

When setting goals and targets, reinforcement and encouragement plays an important role. It is essential to find ways and reasons to celebrate and recognise progress towards the goal throughout the entire process (assessment, planning and intervention). Notice, honour and celebrate the many small steps that move the person forward on their recovery journey.

Celebration encourages the person to recognise their movement and provide an incentive to keep moving forward. It is useful to develop rituals that acknowledge progress and keep supporting the process of change. Find ways to tell recovery stories. This should be done between the client and the staff member, the staff member and their team, and the team and their organisation. This is what is meant by developing an organisational culture to support recovery.

Celebrations can be very small, free or inexpensive—such as encouraging words, treats, tweets, small prizes, desired experiences (a cup of coffee, a note written on a free downloaded greeting card, a kind word, a walk, etc.). The most important dimension of any celebration is authenticity. This is not a hollow or false endorsement, nor is it a stale routine –keep it fresh! Help the person learn to celebrate and note their own progress on the journey ("What would you like to do to celebrate or mark that you accomplished X step on your personal plan?").

Summary

SBA aligns the work of the client, the worker, the team, the programme, the agency and the social service system to promote outcomes that most clients desire. SBA encourages self-determination, choice and self-efficacy; includes on-going monitoring of progress toward recovery goals; and supports community integration. SBA builds on personal, interpersonal, social, community and cultural strengths; and helps people reclaim a full and valued life beyond, or in spite of, their vulnerabilities and disabilities.

7. Supported Employment

"Nothing that I have studied has the same kind of impact on people that employment does."
— Dr. Robert Drake and Debbie Becker, Dartmouth Psychiatric Research Centre

Housing First services should have one or more of team member trained in supported employment (SE). If clients express an interest in working, the SE approach assists them in seeking, gaining and keeping employment as soon as possible. SE explores the client's career or vocational interests and helps the client find the position best suited to their preferences.

Though the SE specialist is the point person for employment, it must be a team effort. Work is not just the specialist's business; work is everybody's business. This adage is particularly relevant to employment because the team needs every member's support to develop a network of potential job opportunities. Personal and professional connections are very important ways to build these networks.

Once a client is employed, staff must provide both the practical and emotional support needed for the client to succeed. Support may be offered at the job site or off-site. Among the techniques and skills required for effective employment placements are job coaching, teaching the necessary job skills, and providing counselling and other ongoing supports targeted toward workplace success.

The entire Housing First programme follows these principles of Supported Employment:

- Zero exclusion: No client who expresses an interest in working should be dismissed.
- Benefits counselling: Provide clients with clear, accurate, and easy-to-understand information about the impact of employment on entitlements.
- Rapid job search: Start the process immediately and try to secure employment for a client in about six months.
- Competitive employment is the goal: The goal is to find clients paying jobs in the marketplace. Education and volunteer work are not as highly regarded by SE theory but, in Housing First programmes, if engaging in education or volunteering is the client's first choice, client choice trumps theory.
- Client preference: The client directs the job search.
- Follow-along supports can be indefinite: The team will provide support to the client for as long as the client wants it.
- Coordinated efforts: Employment efforts and clinical efforts are closely coordinated.

It is important that the Housing First team has frequent discussions about the value of work, and that all team members believe that work is a realistic goal for clients.

For clients who are working, it is not out of the ordinary for employment-related issues to arise. Like most people, clients who are working, taking classes, attending treatment groups, and looking after family commitments can be overwhelmed. Because Housing First uses a team approach, all team members share information and ideas and work together with clients on employment issues—not just the SE trained staff. The team leader, substance abuse specialist, and any other team members can all help the client think about a job, search for a job, and help the client manage the application process.

Housing First teams should set goals for the number of clients employed. If, for example, the team has 10% of its clients working (even for a couple of hours a week), they can set a new goal to increase it to 30% the following year.

8. Community Integration and Social Inclusion

Groups and Events

It is helpful to clients' well-being for Housing First to offer a range of possible engaging meetings and events. Groups can be formed around common interests, for example: a cooking group can offer a way for clients to gather for an instructive and enjoyable experience, and it can be another avenue for client engagement. Diet is an important part of a client's health and wellbeing. Learning useful shopping or cooking tips, recipes and nutritional information contributes to health awareness, connection and self-responsibility. In cooking group, clients participate in preparing a meal under the supervision of a team member, beginning with shopping for the ingredients, cooking together, and sharing the meal together.

Various specialty groups can be initiated by the Housing First service, such as arts or photography workshops, engagement in the creative process, attending cultural events, and walks to appreciate the landscape around them.
Other group-focused suggestions include: computer classes, a science club, a harm reduction group, a men's group, a women's group or a monthly tenants' meeting.
Staff members encourage clients to seek out relevant groups and supports in their communities.

In recent years, the mental health system has seen a dramatic shift going from providing services and interventions that inadvertently fostered dependency on the provider to a recovery model that emphasises empowerment, self-determination, and system-independence for clients. One way to achieve change is to help clients develop natural supports in the community. These support networks can include family and friends, peers, community members, and mutual support groups.
There are several ways to facilitate the growth of these natural supports:

1. Community Resources: After discussing clients' interests, the Housing First team helps clients learn about the resources in their communities. Team members also assess any barriers that may prevent clients from following through in obtaining community support, and they try to develop strategies for clients to use when entering new situations.
2. 'Circles of support': In this client group activity, each client takes a turn at the centre of a circle of other clients. Each client lists the diverse supports that radiate in and out of the centre. From these group meetings, clients may recognise that it is time to reconnect with relatives—their immediate family, siblings, children, grandchildren or other family members.
3. Peer support groups: There may be peer support groups in the community, including 12-Step groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and other recovery and support programmes. The Housing First service can also initiate a mutual support group by providing the resources and space for a movie night, for example, or a current events group.

4. Activities: Natural supports can also mean participation in social, recreational, political and spiritual activities. Clients may meet new people if they get a job, take a class, return to education, attend religious services, or join a community group. Attending social, cultural and sporting events, taking walks in the park, or volunteering with a local charity are all social activities that provide opportunities to increase community integration for clients.

Social prescribing is a practice that takes a holistic approach to services and treatment and seeks to provide client-directed support to people living in poverty and experiencing health and mental health problems. The principles of social prescribing are consistent with the client-directed, choice-driven philosophy of Housing First and, similarly, the prescribed social services are community-based. Thus, social prescribing may prove to be a useful complement to – and expansion of – practices, supports and treatments in Housing First services.

In essence, social prescribing is about connecting people to non-medical sources of support or resources in their community – to help them address the health and other problems they are experiencing. This holistic and client-directed approach and resources include a range of community-based activities, such as arts and cultural activities, green space or gardening, debt advice or budgeting, physical activity and leisure, library membership, and more. It can also include learning or educational activities, volunteering, housing maintenance, tenancy support services, benefits and entitlements, family and relationship activities, employment, legal advice, and other resources or services. Communities will vary in the availability of resources available, but this is not a fixed list. Housing First staff and clients are encouraged to develop as many opportunities for community engagement and personal fulfilment as possible.

The term 'social prescribing' is used interchangeably with other terms, such as 'community referral', 'linking schemes', or 'case management'. Some people prefer not to use the term 'prescribing' as it can be seen to place the client in the role of patient or passive recipient and underplay the importance of self-management, choice and control. On the other hand, 'prescribing' may be appealing to stakeholders in the medical profession and help them take social interventions more seriously. The key point here is that social prescribing is person-centred and tailored to the individual needs of each client.

Social prescribing can serve to expand the definition of support services by using a peer-based, values-driven approach that is best implemented by 'local clusters' of collaborating providers or organisations in each community. It is a complement, not an alternative, to medical or mental health care; and has been found to be useful when working with individuals with multiple diagnoses.

Social prescribing can serve to support and augment the practice and skills of GPs and primary care teams to improve mental health, addiction, and primary care outcomes by helping people to take more control over their health and well-being[67].

[67] NHS Health Scotland, 2016

Resource 2: A Guide to 'Home Visits' Delivered Remotely

This guide[68] is intended to give useful advice in relation to using telephone support instead of 'home visits' during times (e.g. the Covid-19 pandemic) when in-person visits may not be feasible. In such instances, the telephone call becomes the 'visit'.

The Call is the 'Visit'

The quality of the relationship between the client and case manager is key to the success of Housing First. The 'visit' is an opportunity to build and maintain that relationship.

If replacing a home visit with a telephone call, explain the new context to your client, and discuss how you are both going to deal with it.

- Share and explain relevant Public Health advice and updates.
- Communicate information about availability of other services which may be needed, e.g. delivery, opening hours, etc.
- Explain the arrangements that will be put in place if you yourself become ill, and that support will be continued by another member of the Housing First team.
- Explore what things the person has learned about themself during this period of isolation.

Find the Best Communication Channel for Each Customer

Given the financial difficulties faced by most Housing First clients, they are likely to have limited access to diverse communication channels.

Find out and agree on each client's preferred or best communication channel.

Mobile phone may be the most familiar channel, but find out if they prefer (and have) WhatsApp, Zoom, Facetime or other channels. There are people who prefer texts, WhatsApp messages, or even written letters.

Explore your Client's Needs

When you meet face-to-face, you take in a lot of information visually – you will have to be more active on calls.

Have conversations about food, medication or hygiene products.

If the call is taking place during a period of 'lockdown', how is the client doing with the isolation?

[68] This document draws on a document prepared by our Spanish colleagues in the European Housing First Hub, Hogar Sí, (formerly RAIS), and work by Sam Tsemberis and Hilary Melton. This document incorporates additional material and experience from Irish services, including material prepared by Focus Ireland for the Irish Housing First programme.

Suggested topics to discuss and note include the following:

- Schedules (sleeping time, food intake...).
- Activities (TV, cleaning, walking, cooked meals...).
- Social relationships (calls made or received; other interactions).
- Mood (speech speed, tone, content).
- Drug / alcohol consumption pattern.
- Amount of food and medication intake.
- State of comfort, state of the home, interactions with neighbours...?
- Benefits and entitlement payments.
- How does your client manage their budget now?

Ask open questions where clients can explain what they are they doing; talk about their fears; tell anecdotes; and discuss TV programmes and movies they have watched, books they are reading, information / news they received. With skill and investment of time, a phone / Zoom dialogue can become as effective as a regular home visit.

Establish a Routine

Plan telephone interactions with your clients in advance, and use them to discuss the client's own routine-planning. The very substantial changes caused by something such as the Covid-19 pandemic can make people feel they are losing control. Planning and routine may offer consistency and relieve anxiety.

- Encourage your client to think about setting up a planned daily routine, structuring the day with different activities.
- Encourage your client to lead a healthy lifestyle. Suggest some exercise; regulation in the use of drugs (which may be increased by boredom); healthy food; taking the time to clean, tidy up and redecorate their home.
- Always end your call by scheduling the next call and always call at the agreed time.

Create a Sense of Proximity

In addition to having a set routine, it can be a good idea to send your clients texts or WhatsApp messages at unusual times (early in the morning, evening...), asking how they feel, wishing them good morning or a nice day, reminding them of some aspect of the day's plan that you discussed, sharing quotes or a song that you like... It is all about being present and increasing your presence in the lives of clients to combat social isolation.

Support Social Connections

The shift to telephone contact decreases the amount of time the support worker spends travelling around, and so can increase the amount of time they have for each client. This new context can be used to introduce new activities to engage in with your clients.

This can be a good opportunity to invite clients to intensify or initiate different forms of communication with people in their network - friends, family members. Isolation accentuates the need for connection and contact.

Protecting Your Client's Confidentiality and Private Information

Using web-based communication platforms raises a few important issues related to protecting your client's confidential and private information. These considerations need to be seen in the context of compliance with GDPR and privacy / data protection legislation.

- Where the client is receiving a call in their home, you need to ensure that this is in a private space when they will not be overheard.
- If you are using a digital platform such as Zoom, use an official organisational subscription to the service, rather than a personal account.
- You should note that Skype is a non-encrypted service and therefore is less secure than services such as Zoom or Microsoft Teams.

Individual and Collective Messages

While sending collective texts or message to all your clients has certain advantages, if you want to do this, you must do so in a way that does not reveal the contact details of your clients to each other, as this would be a breach of their privacy under GDPR.

If you have established a system for collective messages you can use it, for example, to:

- Send messages to provide Covid-19 updates, share inspiring texts, songs or films shown on TV or YouTube.
- Launch activities each morning at a certain time to generate dialogues.

Connection with Oneself

During periods of 'lockdown' or restricted movements / social interactions, invite your clients to look for spaces where they can engage with themselves in activities in which their minds can flow.

- Sensitively promote an attitude of acceptance of the situation and of engagement with the present, accepting any feeling without fighting it, returning with kindness to be in the moment. This sums up the attitude of mindfulness therapies.
- If appropriate, you could discuss with your clients their feelings about what they are experiencing and how there may be long-term lessons from even such an unwanted time. Transform negative into positive opportunity.
- Writing can be beneficial for some people, as well as exercising emotional regulation and relaxation. You could suggest that your client starts a journal, and then they can read it if they want to when you call.
- You can suggest soft physical exercises or yoga stretches (or other exercises your client or you may know).

Help the client deal with the current crisis by using:

- Identification of strengths.
- Active listening.
- Wellness recovery action plan (WRAP)[69].
- Connection with mental health services and other emergency resources.

Either through phone-calls or from your knowledge of clients, you can possibly identify a number of clients who are clearly going to find a 'stay at home' phase or more complete isolation particularly challenging. Some indicators to look out for are:

- People without a phone and / or with greater social isolation.
- People with peaks in consumption of substances to which they are addicted.
- People with suicidal ideation and natural depressive states.
- People with unstabilised mental illness.
- Women who suffered or suffer gender violence; women living in shared housing.
- People suffering from serious medical illnesses.

It will be necessary for you to explore with such client in greater detail and depth how they feel, and the support they receive may have to be closer and more intense. In addition, you will need more personalised support for clients, for example, ensuring that the health of people with pre-existing illnesses does not deteriorate.

Check the availability of ongoing medications and medical appointments. This will help you to focus the time and resources you spend with these clients, as well as to plan follow-up meetings and to develop specific strategies with the service coordinator for those clients.

[69] https://copelandcenter.com/wellness-recovery-action-plan-wrap

Resource 3: RTB Guide for Approved Housing Bodies on Minimum Standards for Rented Residential Accommodation

Guide for Approved Housing Bodies on Minimum Standards for Rented Residential Accommodation

By law, Approved Housing Bodies must ensure that their rented properties provide tenants with a safe and healthy environment to live in and comply with the Minimum Standards. Local Authorities are responsible for the enforcement of the regulations. If your property does not comply to these Minimum Standards, as a landlord, you could be prosecuted. New standards came into effect on 1st July 2017 and the information below summarises the Minimum Standards and highlights the new obligations for landlords. For further details contact your local authority.

1

The building must be free from damp and in good structural repair **(internally and externally).**

2

There must be hot and cold water available to the tenant(s).

- **Sanitary facilities must be in a safe condition and in good working order.**

3

The building must have adequate ventilation and heating, which tenant(s) can control.

4

Facilities for the installation of cooking equipment, cooker hood or extractor fan and suitable and adequate number of kitchen presses for food storage shall be provided.

5

Electrical wiring, gas and water pipes should be in good repair.

- **Properties should, where necessary, have a carbon monoxide alarm. These should be in suitable locations and in good working order.**

6

In houses there must be access to a fire blanket and fire detection and alarm system.

- **In multi-unit buildings, there must be a fire detection and alarm system, an emergency evacuation plan and emergency lighting in common areas. It is important that fire safety equipment is maintained.**

7

There must be suitable safety restrictors attached to a window which has an opening through which a person may fall and the bottom of the opening is more than 1400mm above the external ground level. Suitable safety restrictors must secure the window sufficiently to prevent such falls. Lockable restrictors that can only be released by removable keys or other tools should not be fitted to window opening sections.

8

Each bathroom or shower room should contain a **permanently fixed heater that is properly maintained.** The room should be properly ventilated.

9

Information must be provided to tenants on the property, building services, appliances and their maintenance requirements.

10

There must be access to refuse storage facilities.

11

Efforts must be made to prevent infestation of pests and vermin.

Source: SI No 17 of 2017 Housing (Standards for Rented Houses) Regulations 2017

RTB Bord um Thionóntachtaí Cónaithe Residential Tenancies Board

Údaráis Áitiúla Éireann Local Authorities Ireland

An Roinn Tithíochta, Pleanála, Pobail agus Rialtais Áitiúil Department of Housing, Planning, Community and Local Government

Resource 4: RTB Safety Information Guide for Approved Housing Bodies

Safety Information Guide for Approved Housing Bodies

It is very important that AHB landlords are aware of their responsibilities for safety, in particular on fire safety. The guide below describes the safety requirements from the Housing (Standards for Rented Houses) Regulations 2017. AHB landlords must also comply with the Fire Service Acts (1981 and 2003) and should refer to the guidance document 'Guide to Fire Safety in Flats, Bedsitters and Apartments'.

Fire Safety

In houses, there must be a suitable, self contained fire detection and alarm system and a suitably located fire blanket. It is recommended that smoke alarms are either mains-wired with battery back up or are 10 year self contained battery operated.

Safety in Multi-Unit Buildings

- A suitable fire detection and alarm system must be provided in **common areas** in a multi unit building.
- It is important that all fire safety equipment and lighting is maintained.
- Each unit must have a suitably located mains wired smoke alarm.

Ventilation

Rooms should contain suitable and adequate facilities for the safe removal of fumes and other products of combustion to the external air in situations where a heat producing appliance is used.

Ventilation

All habitable rooms should have adequate ventilation.

Gas and Electricity Safety

Installations for supply of gas, oil and electricity including pipework, storage facilities and electrical distribution boxes should be maintained in good repair and safe working order.

Emergency lighting

Emergency lighting must be provided in all **common areas** in a multi unit building.

Carbon Monoxide Safety

Each house shall contain, where necessary, suitably located devices for the detection and alarm of carbon monoxide.

CO

Windows

There must be suitable safety restrictors attached to a window which has an opening through which a person may fall and the bottom of the opening is more than 1400mm above the external ground level. Suitable safety restrictors must secure the window sufficiently to prevent such falls. Lockable restrictors that can only be released by removable keys or other tools **should not be fitted** to window opening sections.

Fire Safety

Each self contained unit in a multi unit building* must have a suitable fire detection and alarm system, fire blanket and an emergency evacuation point.

* A multi unit building means a building that contains two or more dwellings that share a common access.

RTB Bord um Thionóntachtaí Cónaithe
Residential Tenancies Board

Údaráis Áitiúla Éireann
Local Authorities Ireland

An Roinn Tithíochta, Pleanála, Pobail agus Rialtais Áitiúil
Department of Housing, Planning, Community and Local Government

Resource 5: Move-In Household Items Checklist

These items are usually purchased for participants in Housing First programmes when they are moving into their new home:

Bedroom Items:

- Duvet set with sheets.
- Two pillows and pillowcases.

Kitchen Items:

- Dishes, cups, glasses, and cutlery (four-person set).
- 18-piece non-stick cookware set.
- Stainless steel kitchen utensil set.
- Kitchen gadgets: strainer, ladle, spatula, etc.
- Kitchen towel, oven mitt and pot-holder kitchen set.

Bathroom Items:

- Six-piece towel set (two bath towels, two hand towels and two face-cloths).
- Bathmat, shower curtain and rings.

Other Household Items:

- Multi-surface angle broom with dustpan.
- Twist mop and mop bucket.
- Paper towels, toilet paper, napkins.
- Cleaning supplies and a bag full of groceries.

Ideally, the client and Housing First staff shop together to purchase these items. Clients can add additional items if they cover the cost.

Resource 6: A Guide to Mapping Community Assets

Community asset mapping is most useful when it is person-specific and location-specific.

The resources listed on a community assets map provide information about resources that clients have an interest in, and that they can access for support or services in their local community.

Asset Mapping Process

1. Begin to identify resources:
   Identify anything or anyone that can be used to smooth the transition into the community.

2. Conduct appreciative enquiries:
   Ask questions to identify community resources.

3. Mapping:
   Build relationships with people within the relevant resources, beyond the basic online data sources.

Begin with resources you already connect with and expand from there. Include:

- Agencies
- Contact names, phone numbers, emails
- Addresses
- Scope of services offered
- Hours of operation
- Eligibility criteria / process for accessing resources

Resources can also include:

- Contact information for the Housing First case manager and wider team
- Healthcare providers (GP, dentist, clinics, Hospital Departments, etc.)
- Groups with common purpose
- Local pharmacies (number, opening hours, and contact person)
- Supermarkets and other food shops
- Repairs and other services
- Community centres
- The local library
- Places of worship
- Family, friends, other social support.

APPENDICES

Appendix 1: Models of Housing First Teams in Ireland

Broadly speaking, there are two ways in which Housing First is staffed in Ireland. The first involves a separate team that houses most of the relevant expertise across tenancy support and health. The second involves a 'shared care' or brokering model, where a smaller core team supports clients directly – but also draws in additional expertise from mainstream housing and health services.

The following diagrams illustrate the different approaches to organising the tenancy and health supports in Ireland currently. The first diagram illustrates a stand-alone team, where many of the health and tenancy supports are drawn from a dedicated team which works exclusively on Housing First in the region. The team does draw on specialist and hospital-based supports – but most of the day-to-day support is delivered by the team directly.

Figure 3: Standalone Team Model for Housing First

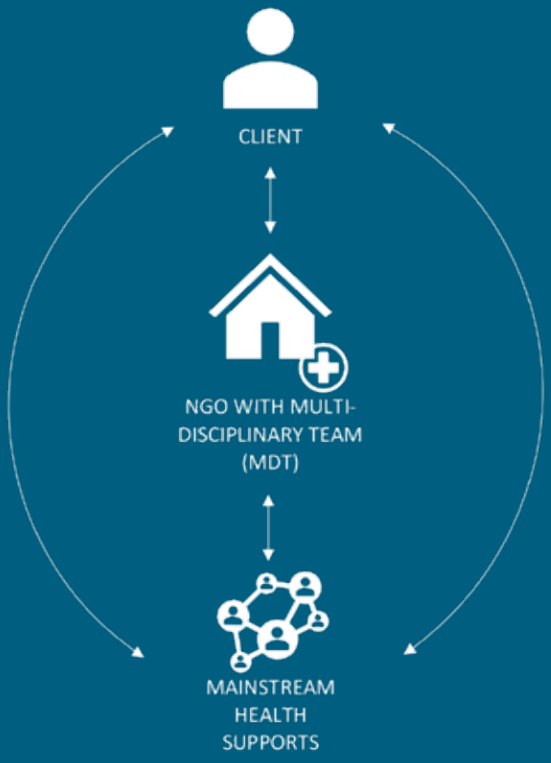


Figure 4: Shared Care Model for Housing First (1)

This second diagram illustrates the case when a service-provider NGO has a broad range of in-house tenancy and health support staff, albeit not dedicated exclusively to Housing First clients. In this 'shared care' model, the clients are supported by a multi-disciplinary team employed by the NGO – and the NGO also draws heavily on mainstream health supports.

Our third diagram illustrates a 'shared care' model where a smaller Housing First team of NGO and health workers provide tenancy and health supports directly to Housing First clients – but also broker much of the supports which the clients receive from the wider homeless and health systems. In this approach, it is essential that the core Housing First team supports the clients proactively to ensure they are receiving the intensive, integrated supports for which they are referred.

Figure 5: Shared Care Model for Housing First (2)

Appendix 2: Pathways Housing First Programme Fidelity Scale

Domain 1: Housing to Match Client Needs					
	CRITERION	**1**	**2**	**3**	**4**
1	**Immediate Access to Housing Without Readiness Preconditions:** Extent to which clients are not required to demonstrate housing readiness to gain access to housing units.	Clients have access to housing only if they have enough income, and/or have successfully completed a period in transitional housing or outpatient/ inpatient/ residential treatment.	Clients have access to housing only if they meet many readiness requirements such as sobriety, income, abstinence from drugs, medication compliance, symptom stability, or no history of violent behaviour or involvement in the criminal justice system.	Clients have access to housing with minimal readiness requirements, such as willingness to comply with program rules or a treatment plan that addresses sobriety, income, abstinence, and/ or medication compliance.	Clients have access to housing with no requirements to demonstrate readiness.
2	Priority Enrolment for Individuals with Obstacles to Housing Stability: Extent to which service prioritises enrolment for individuals who experience multiple obstacles to housing stability.	Service has many rigid client exclusion criteria such as substance use, symptomatology, criminal justice involvement and behavioural difficulties, and there are no exceptions made.	Service has many client exclusion criteria such as substance use, symptomatology, criminal justice involvement and behavioural difficulties, but exceptions are possible.	Service selects clients with multiple disabling conditions, but has some minimal exclusion criteria.	Service selects clients who fulfil criteria of multiple disabling conditions including 1) homelessness, 2) severe mental illness and 3) substance use.
3	Housing Availability (Intake to move-in). Extent to which service helps clients move quickly into permanent housing units of their choosing.	Less than 55% of clients move into a unit of their choosing within 6 weeks of entering the service.	55-69% of clients move into a unit of their choosing within 6 weeks of entering the service.	70-84% of clients move into a unit of their choosing within 6 weeks of entering the service.	85% of clients move into a unit of their choosing within 6 weeks of entering the service.
4	Housing Choice: Clients choose the location and other features of their housing.	Clients have no choice in the location, decorating, furnishing, or other features of their housing and are assigned a unit.	Clients have little choice in location, decorating, and furnishing, and other features of their housing.	Clients have some choice in location, decorating, furnishing, and other features of their housing.	Clients have a wide range of choices in location, decorating, furnishing, and other features of their housing, given local area housing affordability.

5a	Integrated Housing: Extent to which clients live in scattered-site private market housing which is otherwise available to people without psychiatric or other disabilities.	Clients do not live in private market housing, access is determined by disability and 100% of the units in a building are leased by supportive housing programmes.	Clients live in private market housing which may or may not be determined by disability, and more than 40% of the units are leased by supportive housing programmes.	Clients live in private market housing where access is not determined by disability and 21- 40% of the units are leased by supportive housing programmes.	Clients live in private market housing where access is not determined by disability and less than 20% of the units are leased by supportive housing programmes.
5b	Integrated Housing (Rural Services): Extent to which clients live in scattered-site private market housing which is otherwise available to people without psychiatric or other disabilities.	<60% of clients live in buildings. that satisfy the following criteria: 1-3 unit building = 1 tenant 4-6 unit building =2 tenants 7-12 unit building =3 tenants	60-69% of clients live in buildings that satisfy the following criteria: 1-3 unit building =1 tenant 4-6 unit building =2 tenants 7-12 unit building =3 tenants	70-79% of clients live in buildings that satisfy the following criteria: 1-3 unit buildings = 1 tenants 4-6 unit buildings = 2 tenants 7-12 unit bld g= 3 tenants	80% of clients live in buildings that satisfy the following criteria: 1-3 unit buildings =1 tenants 4-6 unit buildings =2 tenants 7-12 unit buildings =3 tenants
6	Standard Tenant Agreement: Extent to which clients have legal rights to the unit with no special provisions added to the lease or occupancy agreement.	Clients have no written agreement specifying the rights and responsibilities of tenancy and have no legal recourse if asked to leave their housing.	Clients have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to clinical provisions (e.g. medication compliance, sobriety, treatment plan).	Clients have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to programme rules (e.g. requirements for being in housing at certain times, no overnight visitors).	Clients have a written agreement (such as a lease or occupancy agreement) that specifies the rights and responsibilities of typical tenants in the community and contains no special provisions (programme requirements for minimum contact frequency may be included).

7	Permanent Housing Subsidies and Tenure: Extent to which housing subsidies and tenure are assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy agreement.	There are rigid time limits on the length of housing subsidies and tenure in housing such that clients are expected to move by a certain date or the housing is considered emergency, short-term or transitional.	There are standardised time limits on housing subsidies and tenure, such that clients are expected to move when standardised criteria are met.	There are individualised time limits on housing subsidies and tenure, such that clients can stay as long as necessary, but are expected to move when certain criteria are met.	There are no expected time limits on housing subsidies and tenure, although the lease agreement may need to be renewed periodically.
8	Affordable Housing: Extent to which clients pay a reasonable amount of their income for housing costs.	Clients pay 61% or more of their income for housing costs.	Clients pay 46 - 60% or less of their income for housing costs.	Clients pay 31-45% or less of their income for housing costs.	Clients pay 30% or less of their income for housing costs.
9	Privacy: Extent to which clients are expected to share living spaces, such as bathroom, kitchen or dining room with other tenants.	Clients are expected to share all living areas with other tenants, including a bedroom	Clients have their own bedroom, but are expected to share living areas such as bathroom, kitchen, dining room and living room with other tenants.	Clients have their own bedroom and bathroom, but are expected to share living areas such as a kitchen, dining room and living room with other tenants.	Clients are not expected to share any living areas with other tenants.
Domain 2: Services to Match Client Needs					
10	Interventions Target a Broad Range of Life Goals: Extent to which the service systematically delivers specific interventions to address a range of life areas (e.g. physical health, employment, education, housing satisfaction, social support, spirituality, recreation & leisure, etc.)	Interventions do not target a range of life areas.	Service is not systematic in delivering interventions that target a range of life areas.	Service delivers interventions that target a range of life areas but in a less systematic manner (range exists across the service but less diversity of areas among clients).	Service systematically delivers interventions that target a range of life areas (range exists across the service and among clients)
11	Service Choice: Extent to which clients choose the type, sequence, and intensity of services on an ongoing basis.	Services are chosen by the service-provider with no input from the client.	Clients have little say in choosing, modifying or refusing services.	Clients have some say in choosing, modifying or refusing services and supports, but staff determinations usually prevail.	Clients have the right to choose, modify or refuse services and supports at any time, except the minimum programme contact requirement.

12	Peer Support Services: Extent to which peer specialists (1) self-identify as an individual with a serious mental illness who is currently or formerly a recipient of mental health services (or substance abuse for services with SA as explicit primary focus); (2) Have a status considered equivalent to other staff specialties (e.g., full professional status on team); (3) Provide direct services to clients; (4) Provide consultation to other staff from their perspective to inform overall programme practice.	Peer specialist fulfils only ONE criteria or service does not have a peer specialist.	Service fully meets TWO criteria, or partially meets THREE.	Service FULLY meets THREE criteria, one of which must be criterion (1), or PARTIALLY meets four criteria.	Service FULLY meets ALL 4 criteria. ICM: Not required, but can receive extra points.
13	Tenancy Support Services: Extent to which service offers services to help clients maintain housing, such as help with landlord relations, property management services, and co-signing/subletting of leases.	Service does not offer any housing support.	Service offers some housing support during move-in but no follow- up or ongoing services are available.	Service offers some ongoing housing support services but does not offer help with landlord relations, property management services, or co-signing/subletting of leases.	Service offers ongoing housing support services, including help with landlord relations, property management services, utility set-up, or co-signing/sub-letting of leases.

14	Psychiatric Services. Extent to which the service has strong linkages, provides active referrals and conducts follow-up for the provision of psychiatric services. Specifically, the service: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/ providing consultation with other providers regarding services on a regular basis and coordinating care.	Service FULLY meets less than 2 criteria.	Service FULLY meets 2 criteria or PARTIALLY meets 3.	Service FULLY meets 3 criteria or PARTIALLY meets all 4.	Service FULLY meets ALL 4 criteria for brokering psychiatric services.
15	Substance Use Treatment. Extent to which the service has strong linkages, provides active referrals and conducts follow-up for the provision of substance abuse services. Specifically, the service: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/ providing consultation with other providers regarding services on a regular basis and coordinating care.	Service FULLY meets less than 2 criteria.	Service FULLY meets 2 criteria or PARTIALLY meets 3.	Service FULLY meets 3 criteria or PARTIALLY meets all 4.	Service FULLY meets ALL 4 criteria for brokering substance use treatment services.

16	Employment & Educational Services. Extent to which the service has strong linkages, provides active referrals and conducts follow-up for the provision of employment & educational services. Specifically, the service: 1) has established formal & informal links with several providers2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/ providing consultation with other providers regarding services on a regular basis and coordinating care.	Service FULLY meets less than 2 criteria.	Service FULLY meets 2 criteria or PARTIALLY meets 3.	Service FULLY meets 3 criteria or PARTIALLY meets all 4.	Service FULLY meets ALL 4 criteria for brokering employment & educational services.
17	Nursing/Medical Services. Extent to which the service has strong linkages, provides active referrals and conducts follow-up for the provision of nursing/medical services. Specifically, the service: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, & directly introducing participants to providers, & 4) conducts follow-up including communicating/ providing consultation with other providers regarding services on a regular basis & coordinating care.	Service FULLY meets less than 2 criteria.	Service FULLY meets 2 criteria or PARTIALLY meets 3.	Service FULLY meets 3 criteria or PARTIALLY meets all 4.	Service FULLY meets ALL 4 criteria for brokering nursing/medical services.

18	Social & Community Integration Services. Extent to which services supporting social integration are provided directly by the Housing First service. 1) Initial neighbourhood orientation, 2) facilitating access to and helping clients develop valued social roles and networks within & outside the service, 3) helping clients develop social competencies to successfully negotiate social relationships, 4) enhancing active citizenship and participation in social & political venues.	Service provides one service or does not provide any social integration services.	Service FULLY provides 2 services or PARTIALLY provides 3.	Service FULLY provides 3 services, or PARTIALLY provides 4.	Service FULLY provides all 4 services.
19	Financial Services: Extent to which services supporting financial stability are provided directly by the Housing First service. Includes assistance with: 1) obtaining or maintaining benefits, 2) budgeting, 3) rent payment, and 4) representative payeeship.	Service provides one service or does not provide any financial support services.	Service FULLY provides 2 services or PARTIALLY provides 3.	Service FULLY provides 3 services, or PARTIALLY provides all 4.	Service FULLY provides all 4 services.
Domain 3: Separation of Housing And Services					
20	Absence of Coercion: Extent to which the service does not engage in coercive activities towards clients.	Service routinely uses coercive activities with clients, such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance of clients.	Service sometimes uses coercive activities with clients and there is no acknowledgment that these practices conflict with client autonomy and principles of recovery.	Service sometimes uses coercive activities with clients, but staff acknowledge that these practices may conflict with client autonomy and principles of recovery.	Service does not use coercive activities such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance with clients.

21	Only Contingencies of Tenancy are Lease Adherence and Programme's Minimum Contact Requirements: Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment or service provisions.	Clients can keep housing only by meeting many requirements for continued tenancy, such as sobriety, abstinence from drugs, medication compliance, symptom stability, or no involvement in the criminal justice system.	Clients can keep housing with some requirements for continued tenancy, such as participation in formal services or treatment activities (attending groups, seeing a psychiatrist).	Clients can keep housing with minimal requirements for continued tenancy such as compliance with their treatment plan and meeting individual clinical or behavioural standards.	Clients can keep their housing with no requirements for continued tenancy, other than adhering to a standard lease and meeting minimal contact requirements with programme staff.
22	Substance Use Treatment Not Required: Extent to which clients with substance use disorders are not required to participate in treatment.	All clients with histories of alcohol/substance use, regardless of current use or abstinence, are required to participate in substance use treatment (e.g., inpatient treatment, attend groups or counselling with a substance use specialist).	Clients with past alcohol/drug use who have not achieved a specified period of abstinence must participate in substance use treatment, even if they are not currently using.	Clients with current alcohol/ drug use whose use has surpassed a threshold of severity must participate in substance use treatment.	Clients with current or past alcohol/drug use are not required to participate in substance use treatment.
23	Psychiatric Treatment Not Required: Extent to which clients with psychiatric disabilities are not required to take medication or participate in psychiatric treatment.	All clients with psychiatric disabilities are required to take medication and participate in psychiatric treatment.	Clients with psychiatric disabilities are required to participate in mental health treatment, such as attending groups or seeing a psychiatrist, and are required to take medication but exceptions are made.	Clients with psychiatric disabilities who have not achieved a specified period of symptom stability are required to participate in mental health treatment, such as attending groups or seeing a psychiatrist.	Clients with psychiatric disabilities are not required to take medication or participate in formal treatment activities.
24a	Off-site Services. Extent to which social and clinical service providers are not located at participant's residences.	Social and clinical service providers are based on-site 24/7.	Social and clinical service providers are based on-site during the day.	Social and clinical service providers are based off-site, but maintain an office on-site.	Social and clinical service providers are based off-site and do not maintain any offices on-site.
24b	Mobile services. Extent to which social and clinical service providers are mobile and can deliver services to locations of participants' choosing.	The service has no mobility to deliver services at locations of participants' choosing.	The service has limited mobility to deliver services at locations of participants' choosing.	The service is generally capable of providing mobile services to locations of participants' choosing.	The service is extremely mobile and fully capable of providing services to locations of participants' choosing.

25	Services Continue Through Housing Loss or Institutional Stay: Extent to which clients continue receiving services even if they lose housing.	Clients are discharged from services if they lose housing for any reason. (Services are contingent on staying in housing.)	Clients are discharged from services if they lose housing, but there are explicit criteria specifying options for re-enrolment, such as completing a period of time in inpatient treatment.	Clients continue to receive services if they lose housing, but for less than 90 days, or they are discharged if they do not meet "housing readiness" criteria (see item 1a)	Clients continue to receive services for at least 90 days, even if they lose housing due to eviction or short-term institutional stay, although contact frequency may be reduced.
26	Care Coordination During Stays in Institutions. Extent to which the Housing First service coordinates admission, treatment and discharge with other service providers when the client experiences an institutional stay (e.g. hospital, jail): 1) service consults with external providers regarding admissions, 2) service consults with external providers regarding client's treatment, and 3) service consults with external providers regarding discharge planning.	Service provides ONE or none of the services.	Service FULLY provides 2 services.	Service PARTIALLY provides ALL 3.	Service FULLY provides ALL 3 listed services
27	Commitment to Re-House: Extent to which the service offers clients who have lost their housing through eviction or institutionalisation access to a new housing unit.	Service does not offer clients who have lost their housing a new housing unit nor assist with finding housing outside the Housing First programme.	Service does not offer clients who have lost housing a new unit, but assists them to find housing outside the programme.	Service offers clients who have lost their housing a new unit, but only if they meet readiness requirements, complete a period of time in more supervised housing, or the service has set limits on the number of relocations before consideration of referral to alternative housing.	Service offers Clients who have lost their housing a new unit. Decisions to re-house Clients are 1) individualised, 2) client-driven, 3) minimise conditions that clients need to fulfil prior to receiving a new unit, 4) safeguard client wellbeing, and 5) there are no universal limits on the number of possible relocations before consideration of referral to alternative housing.

Domain 4: Recovery-Oriented Approach					
28	Person-Centred Planning: Service conducts person-centred planning, including: 1) development of formative treatment plan ideas based on discussions driven by the client's goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment.	Service does not conduct person-centred planning.	Treatment/service planning FULLY meets 1 criterion or PARTIALLY meets 2.	Treatment/service planning FULLY meets 2 criteria or PARTIALLY meets all 3.	Treatment/ service planning FULLY meets ALL 3 criteria.
29	Client Self-Determination: Extent to which the Housing First service increases clients' self-determination and autonomy by offering and honouring day-to-day choices as much as possible, with services adjusted to the varying needs and functioning levels of clients, but with the goal of enhancing self- determination.	Service directs clients' decisions and manages day-to- day activities to a great extent that clearly undermines client self-determination and autonomy OR service's approach does not actively identify and acknowledge client values, strengths, and perspectives; offer options and provide support that allows clients to make informed decisions; and respect and honour client choices and decisions.	Service provides a high level of supervision and clients' day-to-day choices are constrained.	Service's approach partially supports client autonomy, self-efficacy and competence by often identifying and acknowledging client values, strengths and perspectives; offering options and providing support that allows clients to make informed decisions; and respecting and honouring client choices and decisions.	Service's approach fully maximises client autonomy, self-efficacy and competence by consistently identifying and acknowledging client values, strengths, and perspectives; offering options and providing support that allows clients to make informed decisions; and respecting and honouring client choices and decisions.
30	Harm Reduction: Extent to which the service use a harm reduction approach to substance use.	Clients are required to abstain from alcohol and/ or drugs at all times and lose rights, privileges, or services if abstinence is not maintained.	Clients are required to abstain from alcohol and/ or drugs while they are on-site in their residence or clients lose rights, privileges, or other services if abstinence is not maintained.	Clients are not required to abstain from alcohol and/ or drugs, but staff work with clients to achieve abstinence not recognising other alternatives that reduce harm OR staff do not consistently work to reduce the negative consequences of use.	Clients are not required to abstain from alcohol and/ or drugs and staff work with clients to reduce the negative consequences of use according to the principles of harm reduction.

31	Ongoing client education: Clients receive regular education in Housing First and harm reduction principles.	Clients are not provided with any education in Housing First or harm reduction principles.	Clients receive education in both Housing First and harm reduction principles at service entry.	Clients receive education in Housing First OR harm reduction principles through a formal process at entry and at least annually thereafter.	Clients receive education in both Housing First AND harm reduction principles through a formal process at entry and at least annually thereafter.
32	Motivational Interviewing: Extent to which staff use motivational interviewing in all aspects of interaction with clients.	Staff are not at all familiar with motivational interviewing.	Staff are somewhat familiar with principles of motivational interviewing.	Staff are very familiar with principles of motivational interviewing, but it is not used consistently in daily practice.	Staff are very familiar with principles of motivational interviewing and it is used consistently in daily practice.
33	Assertive Engagement: Extent to which the service uses an array of creative techniques to engage clients who are difficult to engage, including (1) strategies that are individualised and varied, (2) interventions that are motivational and collaborative, and (3) positive incentives to promote recovery.	Service provides ONE or none of the techniques.	Service FULLY provides TWO techniques.	Service PARTIALLY provides all THREE techniques.	Service FULLY provides all THREE techniques.
Domain 5: Programme Operations					
34	24-hour Coverage: Extent to which the service responds to psychiatric or other crises 24-hours a day.	Service has no responsibility for handling crises after hours and offers no linkages to emergency services.	Service does not respond during off-hours by phone, but links clients to emergency services for coverage.	Service responds during off-hours by phone, but less than 24 hours a day, and links clients to emergency services as necessary.	Service responds 24hours a day by phone directly, and links clients to emergency services as necessary.

35	Contact with Clients: Extent to which service has a minimal threshold of non-treatment related contact with clients.	Service meets with less than 70% of clients 4 times a month face-to-face. ICM: 3 times	Service meets with 70 - 79% of clients 4 times a month face-to-face. ICM: 3 times	Service meets with 80 - 89% of clients at least 4 times a month face-to-face. ICM: 3 times…	Service meets with 90% of clients at least 4 times a month face-to-face. For participants not meeting this threshold, factor in: 1) if the service has formal assessment process for routinely determining contact frequency based on client need, and 2) whether this is explicitly documented for clients with reduced contact.
36	Low Client/ Staff Ratio: Extent to which the service consistently maintains a low client/ staff ratio, excluding the psychiatrist & administrative support.	36 or more clients per 1 FTE staff. ICM: 50 or more...	21-35 clients per 1 FTE staff. ICM: 36-49	11-20 clients per 1 FTE staff. ICM: 21-35	10 or fewer clients per 1 FTE staff. ICM: 20-or less…
37	Team Approach: Extent to which staff function as a multidisciplinary team; clinicians know and work with all clients.	Fewer than 20% of clients have face-to-face contacts with at least 3 staff members in 4 weeks. ICM: N/A	20 - 49% of clients have face-to-face contacts with at least 3 staff members in 4 weeks. ICM: N/A	50 - 79% of clients have face-to-face contacts with at least 3 staff members in 4 weeks. ICM: N/A	80% or more of clients have face-to-face contacts with at least 3 staff members in 4 weeks. ICM: N/A
38	Frequent Team Meetings: Extent to which staff meet frequently to plan and review services for each client.	ICM: Service team meets at least once every two weeks but does not review each client each time, or meets less than once a week.	ICM: Team meets at least once every two weeks and reviews each client each time, and conducts case conferences.	ICM: Team meets at least once a week, but does not review each client each time, and conducts case conferences monthly.	ICM: Team meets at least once a week and reviews each client each time, even if only briefly, and conducts case conferences monthly.

39	Meeting (Quality): The service uses its weekly organisational programme meeting to: 1) Conduct a brief but clinically relevant review of at least ½ caseload; 2) Discuss participants with high priority emerging issues in depth to collectively identify potentially effective strategies and approaches; 3) Identify new resources within & outside the service for staff or participants; 4) Discuss programme-related issues such as scheduling, policies, procedures, etc.	Meeting fully serves 3 of the functions.	Meeting FULLY serves 4 of the functions, or PARTIALLY 5.	Meeting FULLY serves 5 of the functions or PARTIALLY all 6.	Daily team meeting FULLY serves ALL 6 functions.
40	Staff Supervision: Direct service staff receive regular, formal supervision.	Staff do not receive any supervision.	Staff receive regular supervision from someone without extensive experience and training in Housing First.	Staff receive regular (less than weekly) supervision from someone with extensive experience and training in Housing First.	Staff receive weekly supervision from someone with extensive experience and training in Housing First.
41	Client Representation: Extent to which clients are represented in the service's operations and have input into policy.	Service does not offer any opportunities for client input into the service (0 modalities).	Service offers few opportunities for client input into the service (1 modality for input).	Service offers some opportunities for client input into the service (2 modalities for input).	Service offers opportunities for client input, including on committees, as peer advocates, and on governing bodies (3 modalities).

Appendices

GLOSSARY

AA: Alcoholics Anonymous

AHB: Approved Housing Body

An Garda Síochána: Ireland's national police service

BI: Brief Interventions

CBT: Cognitive Behavioural Therapy

CPR: Cardio-Pulmonary Resuscitation

CV: Curriculum Vitae

CWO: Community Welfare Officer

DSP: Department of Social Protection

ED: Emergency Department

EU: European Union

FLAC: Free Legal Advice Centres

GDPR: General Data Protection Regulation

GP: General Practitioner

HAP: Housing Assistance Payment

HAT: Homeless Action Team

HSE: Health Service Executive

HSN: High Support Needs

ID: Identification

IDDT: Integrated Dual Diagnosis Treatment

LT: Long-Term homeless

LTA: Long-Term supported Accommodation

MI: Motivational Interviewing

MoU: Memorandum of Understanding

NA: Narcotics Anonymous

NGO: Non-Governmental Organisation

NWD: 'No Wrong Door'

OST: Opioid Substitute Treatment

PASS: Pathway Accommodation and Support System

PTSD: Post-Traumatic Stress Disorder

RAS: Rental Accommodation Scheme

RS: Rough Sleeping

RTA: Residential Tenancies Act

RTB: Residential Tenancies Board

SAOR: Support, Ask and Assess, Offer Assistance, and Referral

SBA: Strengths-Based Approach

SBI project: Screening and Brief Intervention project, a HSE project that coordinates the national rollout of a one-day SAOR screening and brief intervention training programme for alcohol and substance use

SE: Supported Employment

SMG: Statutory Management Group

SOP: Standard Operating Procedure

SP: Social Prescribing

SWA: Supplementary Welfare Allowance

Tusla: the Child and Family Agency, the dedicated State Agency responsible for improving well-being and outcomes for children

WRAP: Wellness Recovery Action Plan

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