SUPPORTIVE HOUSING PROVIDERS ASSOCIATION

Working Together, We Can Accomplish Anything

Implementing Housing First

A Housing First & Integrated Co-occurring Treatment Overview

September 19th, 2023

Tom Kinley

Midwest Harm Reduction Institute

Illinois Co-occurring Center for Excellence

Heartland Center for Systems Change

Heartland Alliance Health


Do The Best You Can
Until You Know Better
Then When You Know Better
Do Better
- Maya Angelou -

Acknowledgement
&
Gratitude

this is uniquely difficult work – and must be

“This work hurts on a core fundamental level” Dr Joshua Bamberger

YOU are the Now & the Future

- ❖ Keep finding new ways
- ❖ Challenge convention

- ➢ So much to change, locally, systemically, nationally.

Value expressed as dollars allocated to healthcare & other needs
Intake & access
Work experience & culture
How we see participants, each other, & people marginalized

Some of supervision & team meetings given to this – ideas of improvements, new ways of doing things

THE FUTURE

INTEGRATED CARE

Behavioral Healthcare

Substance Use & Addictions Care

Primary Healthcare

&

HARM REDUCTION

How prepared are we & how are we preparing for this?

OBJECTIVES

- Describe **core values & principles** of Housing First
- Identify components of a **co-occurring / dual dx treatment** program
- Strengthen our person centered, trauma & resilience aware, harm reduction, motivational interviewing **integration** approach with HF as an EBP
- Have **outlines for strategic planning** – program development / enhancement
- Familiarity with **Housing First Fidelity Index (HFFI)**
- *Familiarity with* ***Dual Diagnosis Capability in Addiction or Mental Health Treatment (DDCAT/DDCMHT)***

HOUSING FIRST

What's been YOUR experience?

HOUSING FIRST

Operating or considering?
One location or scattered site?

Coordinated Entry System

Where Housing First is housed …

CONTEXT & ORIENTATION

a quick review

a brief look back

HOUSING FIRST PRE-REQUISITES

From the Heart of Our Work
Integrating Our 4 Core Competencies in Practice

- **PERSON CENTERED**
- **TRAUMA & RESILIENCE AWARENESS**
- **HARM REDUCTION**
- **MOTIVATIONAL INTERVIEWING**

Interrelated - intuitively flow from each other & are **integrated**

Pull on one & the rest follow

one thought system

Not limited to work – truly life skills and approaches

Housing First

Gives life & demonstration to

Person Centered - Person Honoring

Trauma & Resilience Aware Responsiveness

Harm Reduction Guided Self & Community Care

Motivational Interviewing Enhanced Conversations

Improves conditions for inner voice & power awareness

… begin healing

What else do we need to be successful?

Our Essential Abilities

- **Self awareness:** self-reflection & sensitivity to those around us
- **Empathy & Compassion:** being present, acting with care & admiration
- **Welcome feedback** & input on how we're doing; adjust

Within . . .

- **Work Culture:** **mutual** *respect*, **mutual** *trust*, **mutual** *ownership,* **mutual** *accountability*
- **Personal Qualities:** *personal integrity* - values driven person of one's word; act with *intelligence* - the ability to think through a process, connect dots with cause-effect understanding & present a pathway in a progressive positive way toward a desired outcome, and to make adjustments as new information is received, & be able to articulate these; participate with an *active level of energy* that responds to a necessary level of urgency; *high tolerance & appreciation for ambiguity* - feel comfortable here.

(psychological-emotional flexibility)

PERSON CENTERED is to hold the belief

- **Every one has within them an inner voice, an internal guide, their internal compass**
- That inner voice over the course of life becomes distorted, buried, forgotten, hidden, distanced from, replaced, *traumatized*
- Every **recovery & healing encounter** reflects ***"something within me came to life when I met this person"***

Person Centered Care *includes* …

- **Redefine, re-perceive, *see <u>all</u>* behavior** as **strategic** to survival. Survival *physically, emotionally, and of one's sense of self*. - **APPROACHES TO DAILY LIFE IMPORTANT TO THIS PERSON**

- **Admire & Respect** what's brought a person to today and how they manage their day **{<u>strengths based</u>}**

- **Honor their inner voice … one's *will* to be**

Any program,
service,
or evidence based practice
is only as beneficial & strong
as the staff bringing life & application to it.

Staff: YOU!

You are uniquely & profoundly **the vital tool** for doing this work.

*The importance of this, of **YOU** cannot be overstated.*

➢ **The purpose of us – our primary function:**

building a relationship

creating safe space

THE *KEY INGREDIENT is*

the quality of our relationships

The most valued ability & skill then is that of engaging, building, sustaining and nurturing relationships in which people thrive.

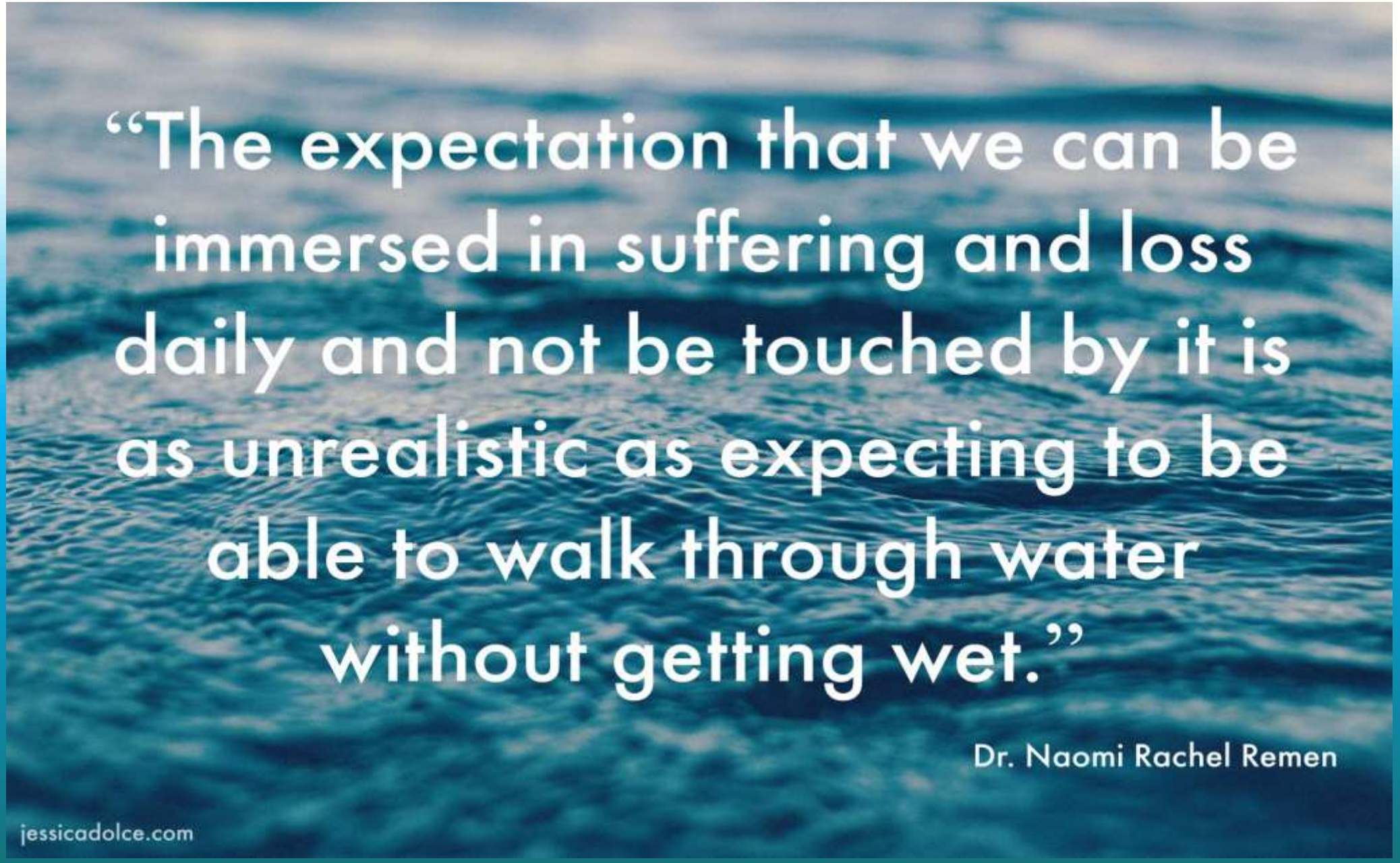
What do we want to accomplish with each other?

<u>This</u> determines that.

the quality of our relationships

Conversely, spirit breaking, dishonoring the will of another, and being oppositional & adversarial to them is to reinforce trauma, promote fear and defenses. Does harm, increases risk.

Rarely were any of us fully informed
or instructed on how
we are the fundamental tool to do this work
and what that translates to
in what we have to do with ourselves


"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."
Dr. Naomi Rachel Remen
jessicadolce.com

To know how to guide another

we first have to know and own that process within our selves for our selves.

Part of authenticity, credibility, knowledge. Walk the Talk.

Otherwise we get lost. Have little credibility. Why follow you?

A personal intimate deep challenge.

Why this special work is exceptionally difficult.

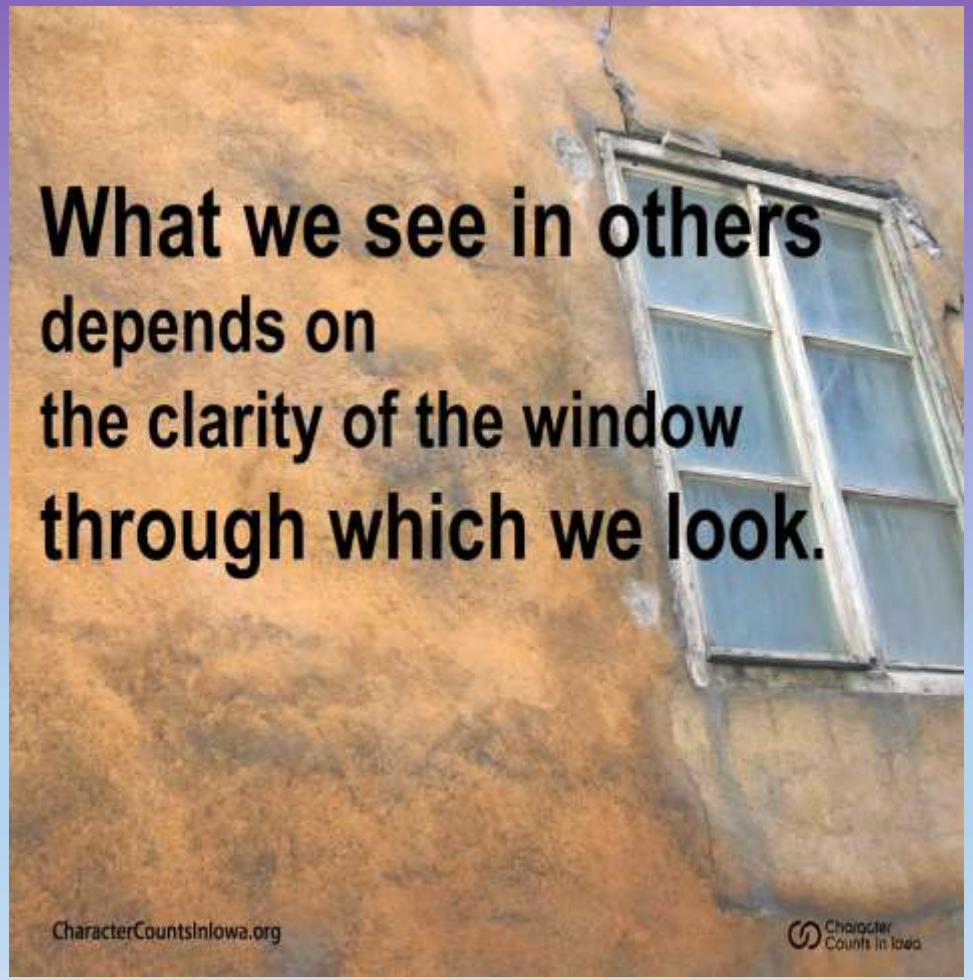
Recovering our own inner calm.

Healing our own trauma.

Doing our own harm reduction.

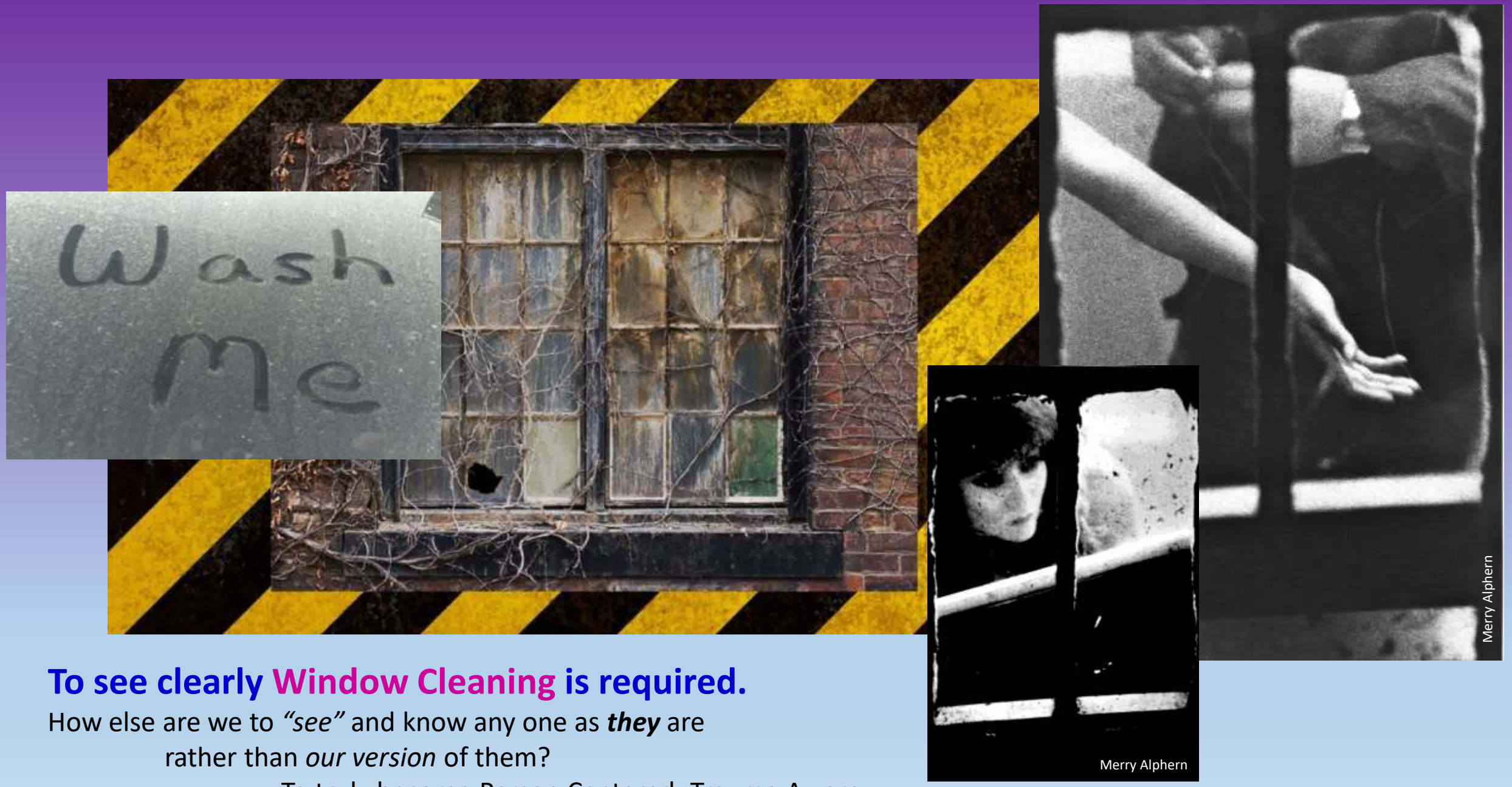
Preparation of our self as the most effective tool for this work.

HOW WE SEE OURSELVES, THE WORLD, & OTHERS



The Task of Self Awareness & Responding to Input

The ability to know our judgements & bias
The ability to respond to feedback
To recalibrate our response and change course



To see clearly Window Cleaning is required.

How else are we to *"see"* and know any one as ***they*** are
rather than *our version* of them?
To truly become Person Centered, Trauma Aware

And we need each other to facilitate our development.

This is relational work.

It's a partnership.

***Trauma is relational*.**

others are our mirror

Doing this work correctly, at our best, will have us experiencing trauma.

It's unavoidable & expected.

A word about being

non-judgmental
unconditional positive regard
unbiased

The near impossibility for 100% of this endeavor

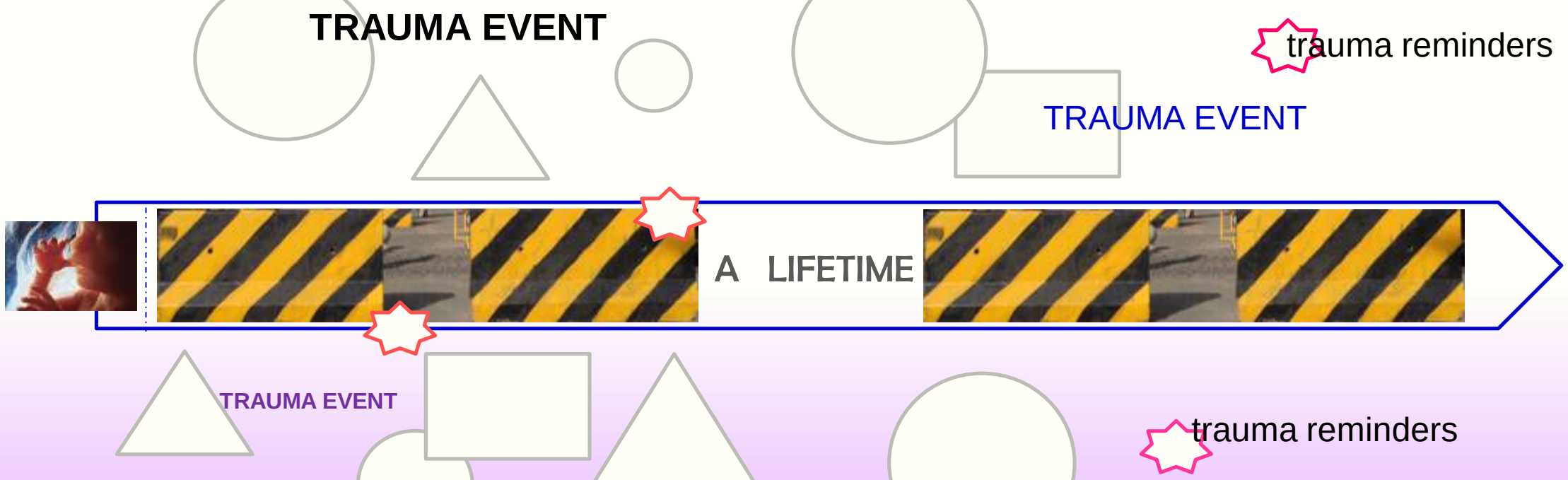
To instead be aware of and know one's judgements

And how to account for and offset them

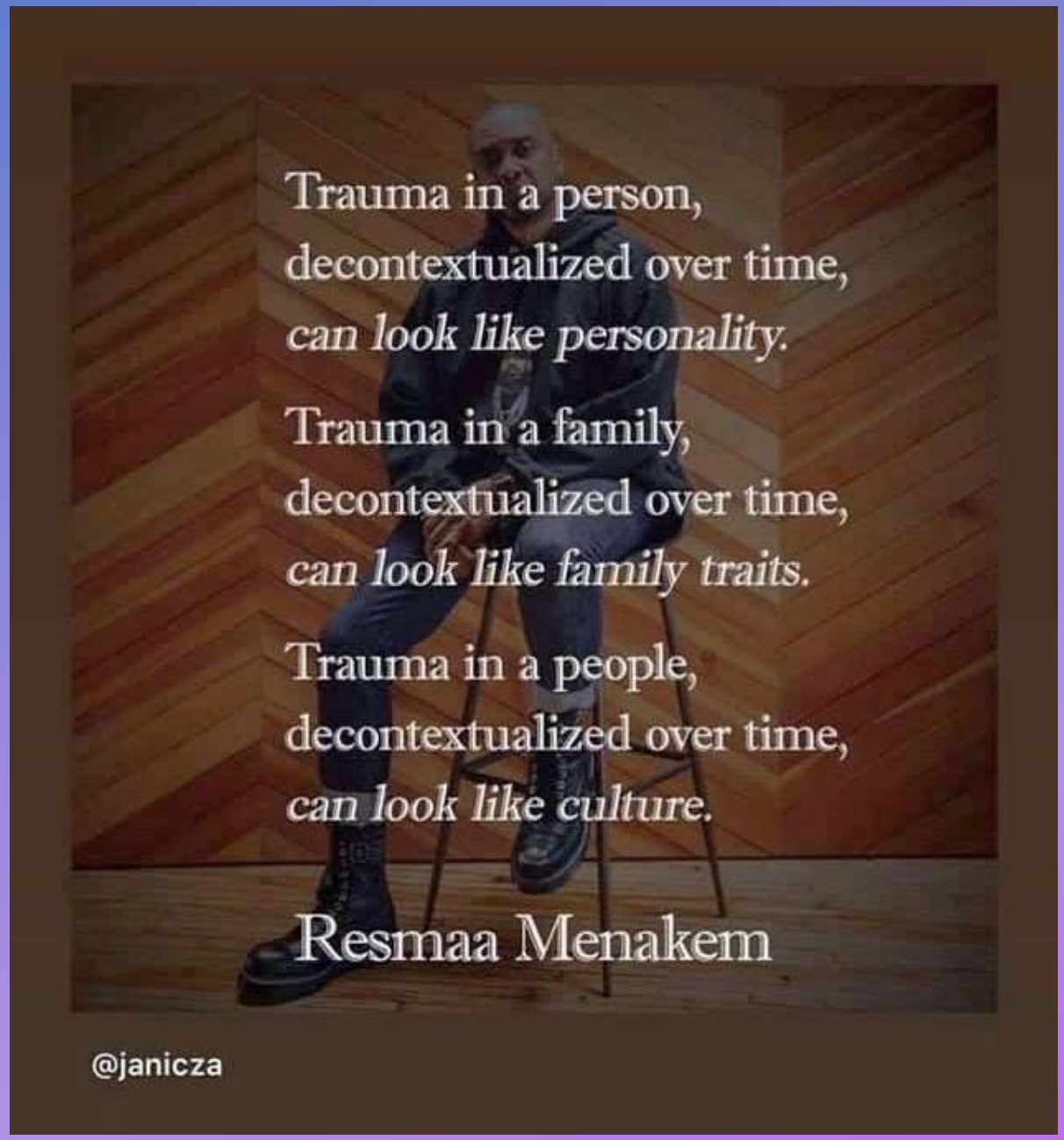
In trauma work in particular …

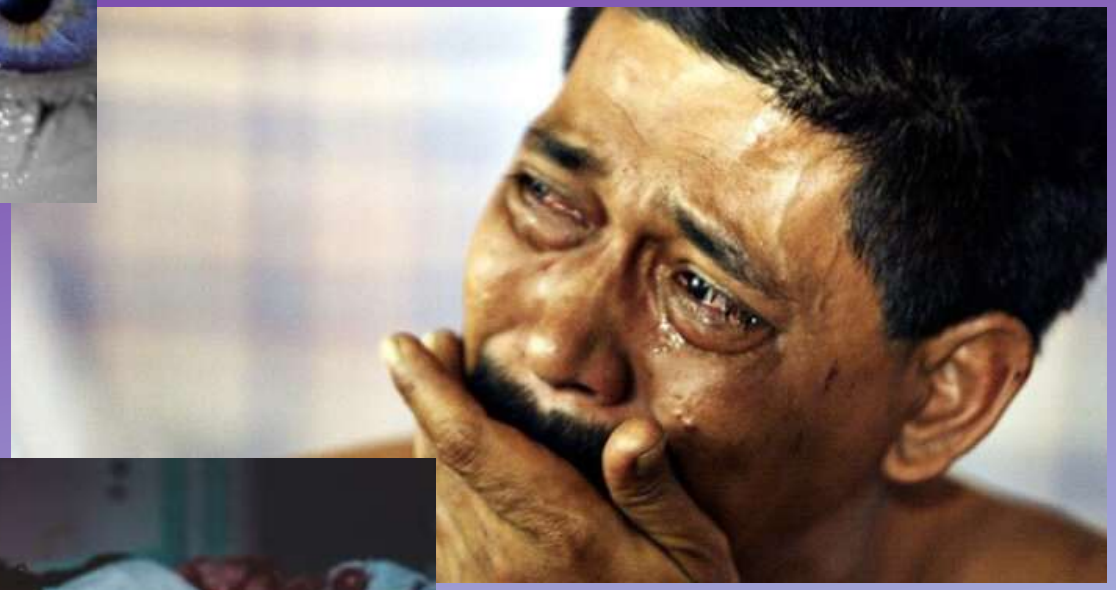
- **KNOW our judgements**
- What ***are*** my judgments? my biases & conditions? my reactions? My defensiveness vulnerabilities?
- Bringing unconscious to consciousness (our own inner voice work)
- **Internal guide** is often unconscious … remember **person centered** goal – support by doing one's own work

OUR TRAUMA



TRAUMA TEACHES US TO DEFEND & PROTECT OURSELVES
AND BE MISTRUSTFUL OF OTHERS & THE WORLD
Life as frequently or constantly threatening
Be on guard
Self-preservation (power, control, energy)


Trauma in a person,
decontextualized over time,
can look like personality.
Trauma in a family,
decontextualized over time,
can look like family traits.
Trauma in a people,
decontextualized over time,
can look like culture.
Resmaa Menakem
@janicza



Trauma isn't what happens to you. It's what happens inside of you as a result of what happens to you.

- Dr. Gabor Maté

Trauma is neurobiological. ***Inside us.***

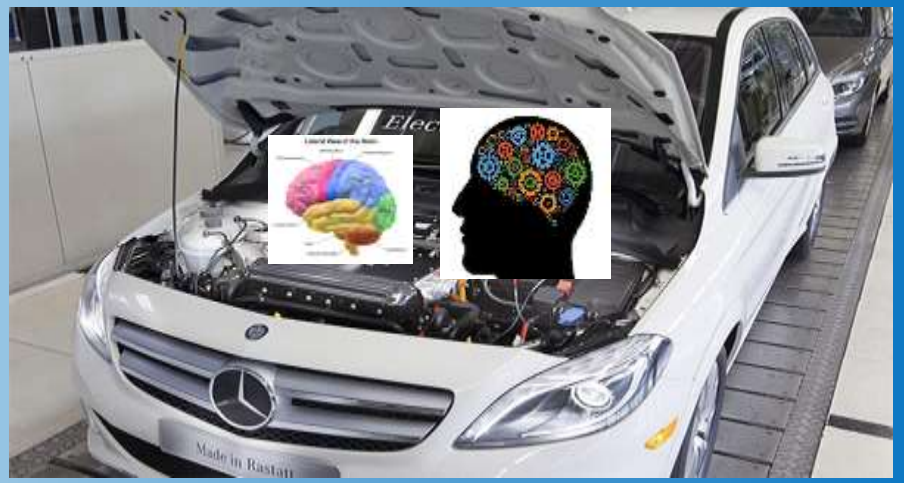
When you've a car and it drives fine, no problem.

If however it's not driving well, it's helpful to know what's under the hood.

Particularly if you're in the car repair business.

So it's helpful for us to know what makes us work, how we as people function.

… **WHAT'S UNDER OUR HOOD?**



Understanding & Appreciating

PEOPLE MAKING

To engage in person centered trauma aware care it's essential we understand

HOW WE BECOME THE PEOPLE WE ARE

Knowing this then guides what we can do.

For our self & for others.

Being human is largely a matter of our brain

How does the brain work?
How does it make us who we are?

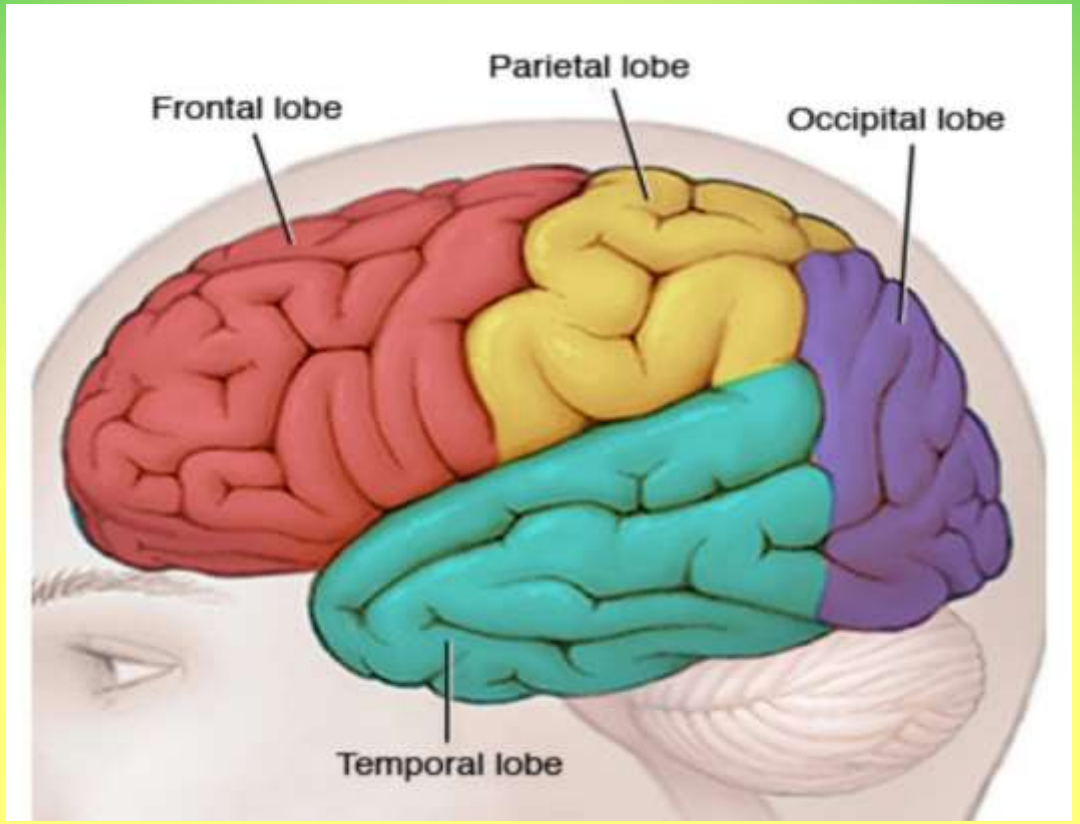
Programming the human computer
Our *original & permanent* operating system

Our Brain

a simple guide to

What makes us human

If I had your brain …



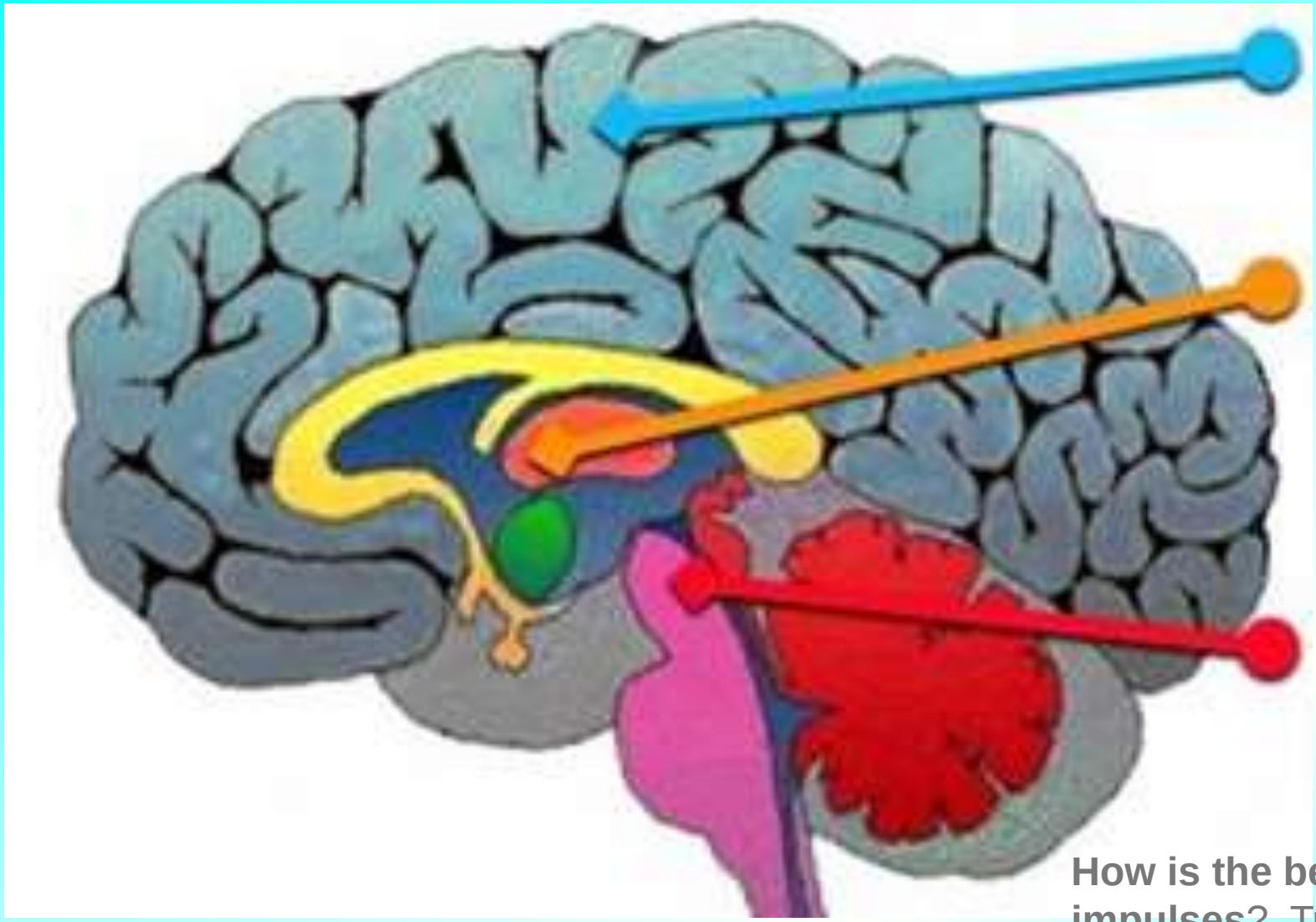
Neurodiversity

Occipital: vision
Temporal: hearing/auditory, memory, meaning, language, emotion, and learning
Parietal: sensory discrimination, sensory integration, goal-directed voluntary movement, some language functions
Frontal: logic, problem solving, judgment, creativity, reasoning, emotions, planning, part of speech, and personality

diencephalon: orientation in space/time
cerebellum & brain stem: fight/flight, feed/breed

OPERATING SYSTEM (OS1) & **NEURO PLASTICITY** - security patches/updates; rewiring, reprogramming

Activating The Trauma Parts



NEOCORTEX
reason

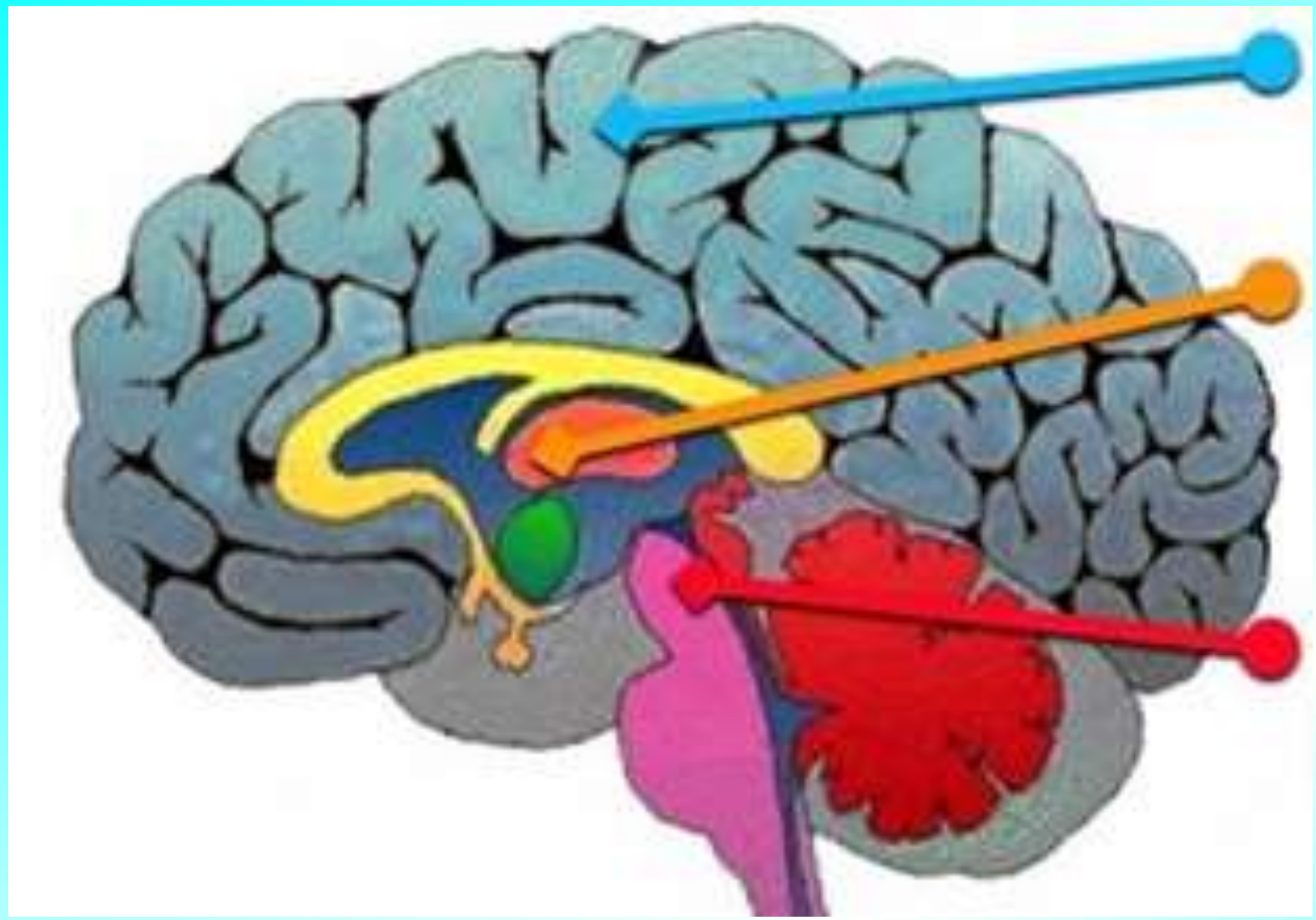
LIMBIC
emotion

PRIMITIVE
instinct, survival

- **Fight**
- **Flight**
- **Feed**
- **Breed**

How is the behavior we see linked to these impulses? Trauma taps into survival. Trauma impacts the ability of executive functions & the neocortex to balance & moderate instinct, emotion, & action.

Activating The Trauma Parts



NEOCORTEX
reason

to be programmed

LIMBIC
emotion

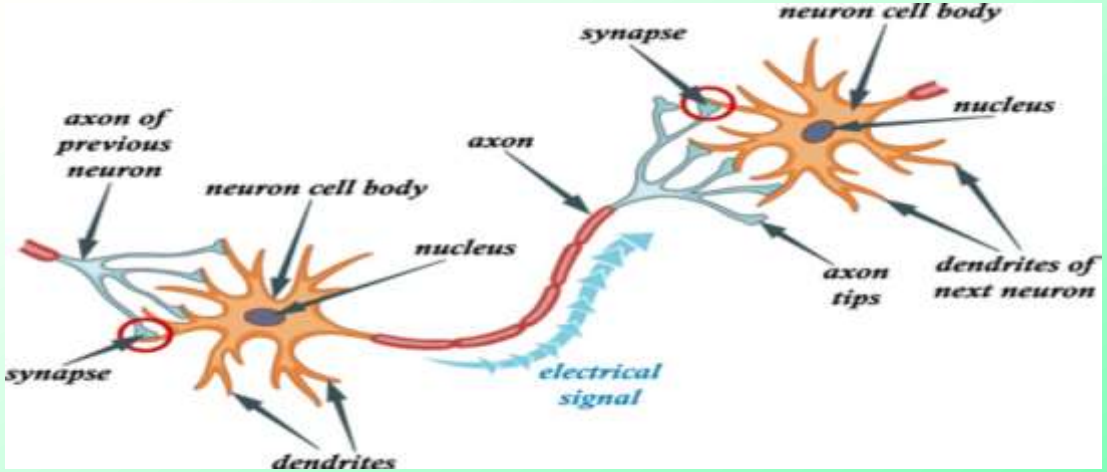
Connected to primitive
Potential to be moderated by neocortex

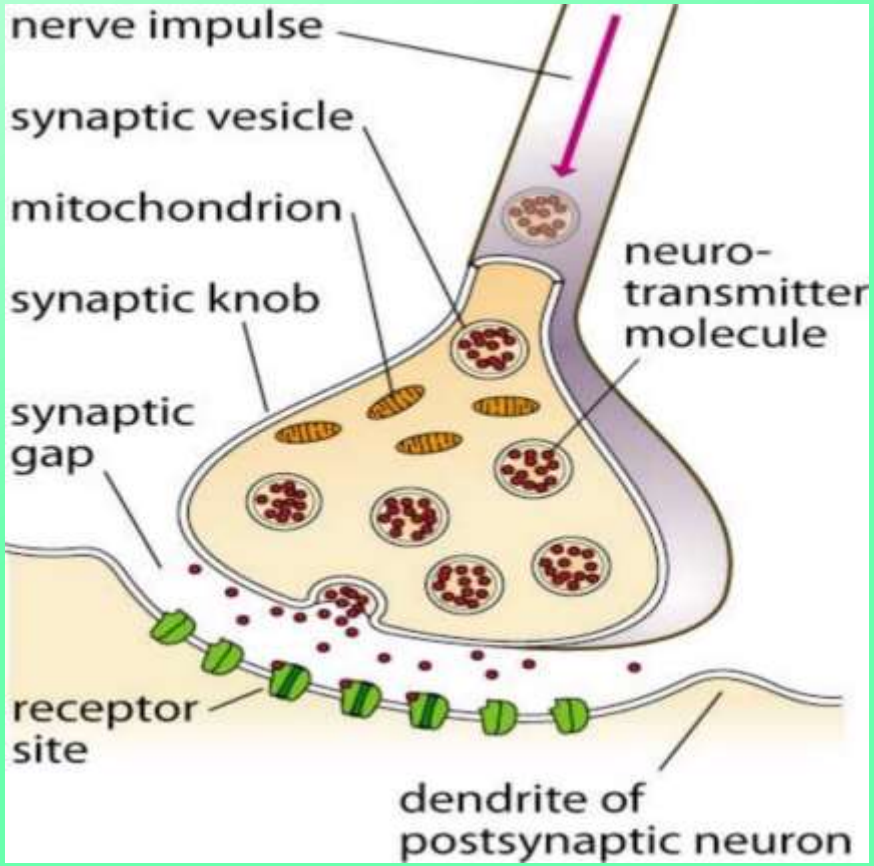
pre-wired

PRIMITIVE
instinct, survival

- **Fight**
- **Flight**
- **Feed**
- **Breed**

86 billion neurons (same) & their connections (different)

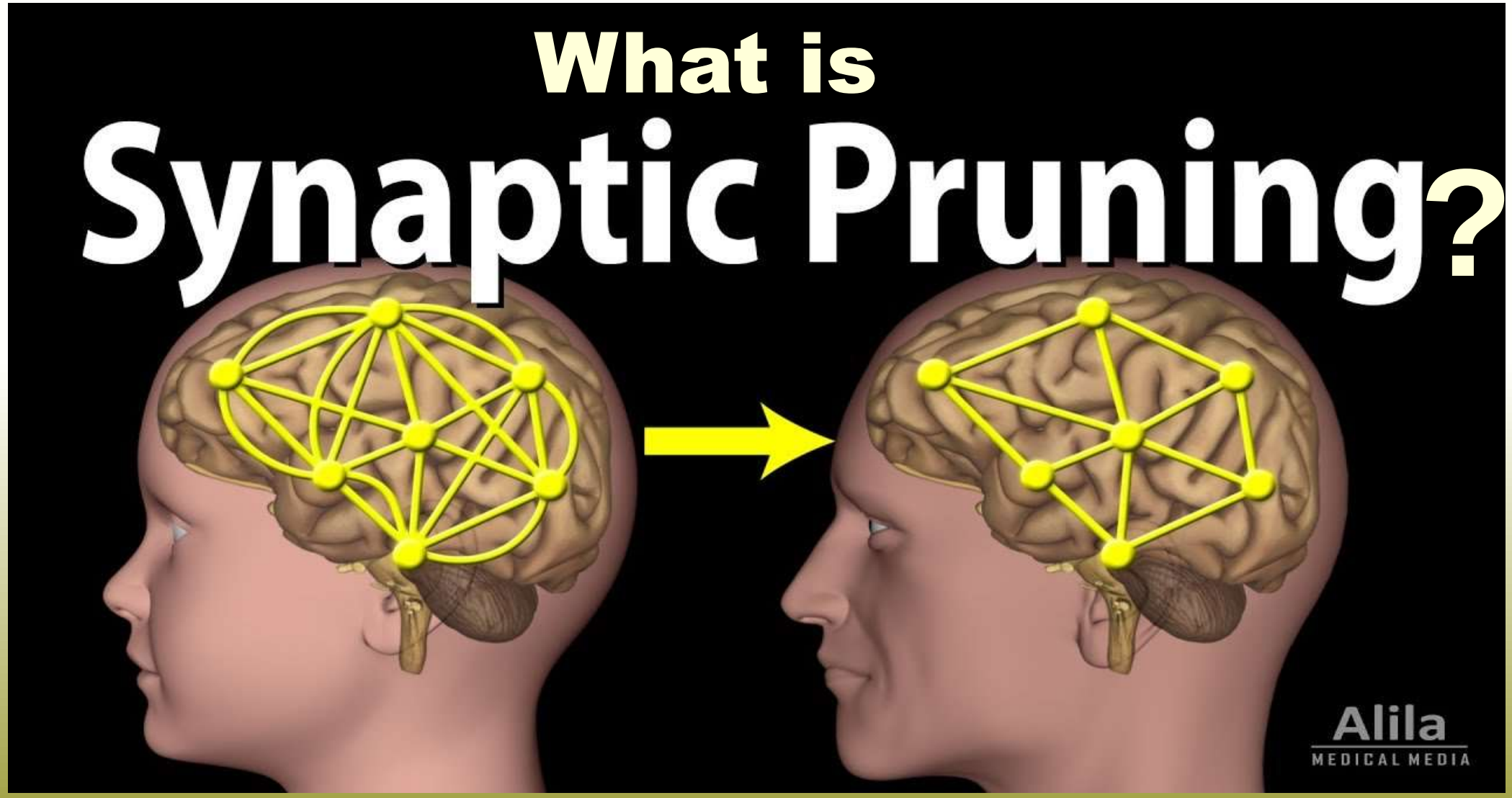




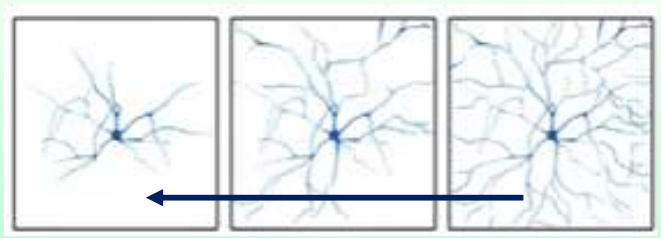
LIFE takes place here

- Mental illness takes place here
- Medications do their work here
- Substance use takes place here
- Joy, pleasure, pain and sorrow take place here
- Relationships take place here

NEURODIVERSITY - everyone's brain is similar & unique

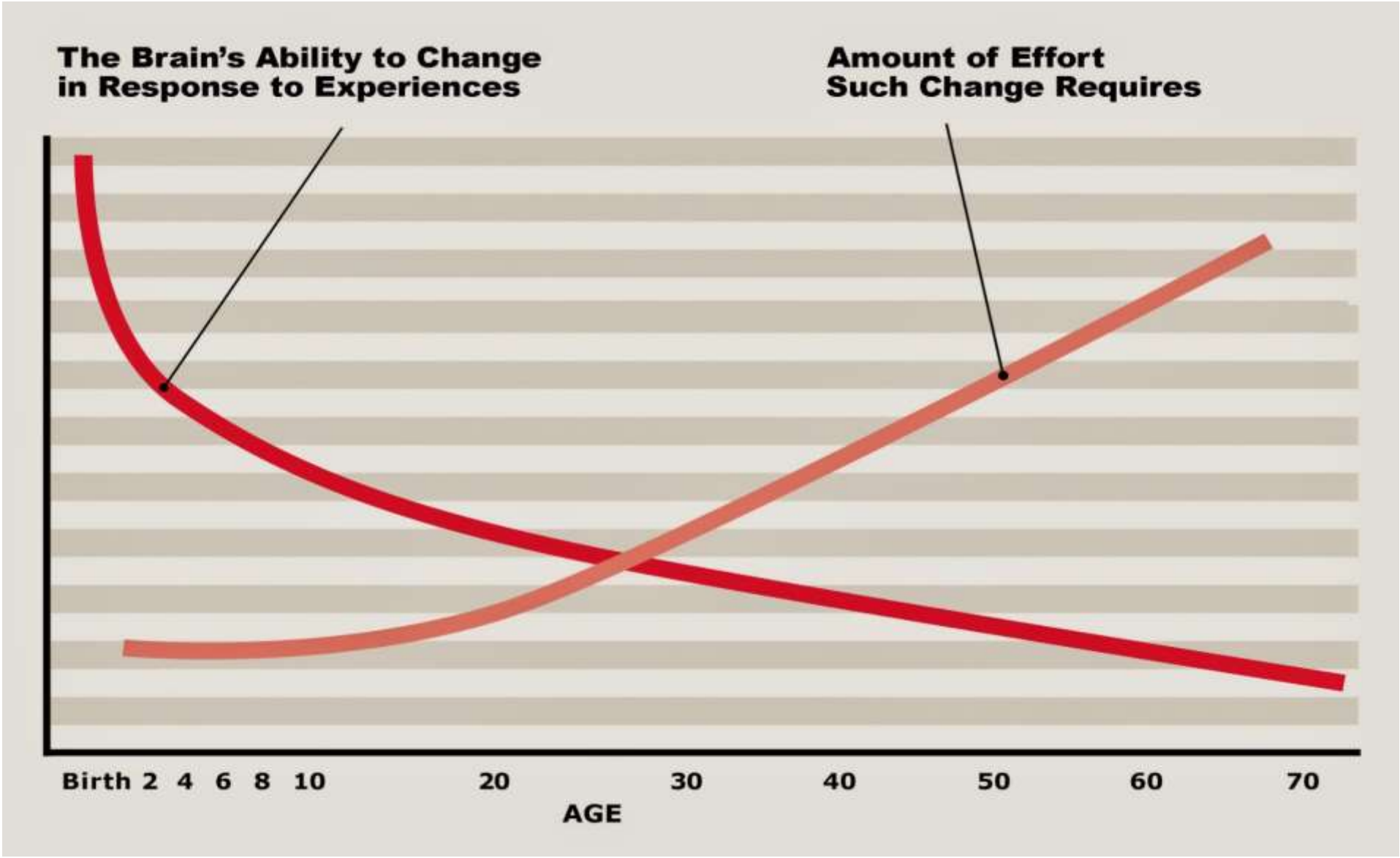

What is
Synaptic Pruning?
Alila
MEDICAL MEDIA

Synaptic pruning **decreases** # of connections between brain cells



Synaptic Pruning

- Occurs twice: 4-6 yrs & in later adolescence
- **What remains is what's used most**
  those life events – *trauma or security*
- **Sets the operating system for life**
- Around 30 yrs brain development plateaus



the Ounce

Start Early.org

neuroplasticity

our brain's ability to change in response to experiences

- **Kindness and acceptance literally rewire the brain**
- Over time, it takes the responses down different neural pathways than the usual automatic route and response
- Releases different neurotransmitters
- Conversely **being critical, shaming/blaming, disliking,** ***reinforces*** that perceived threat and ***strengthens*** the usual route and response

(a rabbit story)

TRAUMA AWARENESS & CARE: what happens inside of us

Between feeling a threat, rather than reactive defense response, **build in a pause**

For the prefrontal cortex thinking brain to begin moderating the primitive brain reactivity

❖ Bring the prefrontal cortex thinking "back online"

to here

Must feel safe, connected, valued, appreciated, hold significance

NEOCORTEX
reason

LIMBIC
emotion

from here

PRIMITIVE
instinct, survival

- ❖ **Fight**
- ❖ **Flight**
- ❖ **Feed**
- ❖ **Breed**

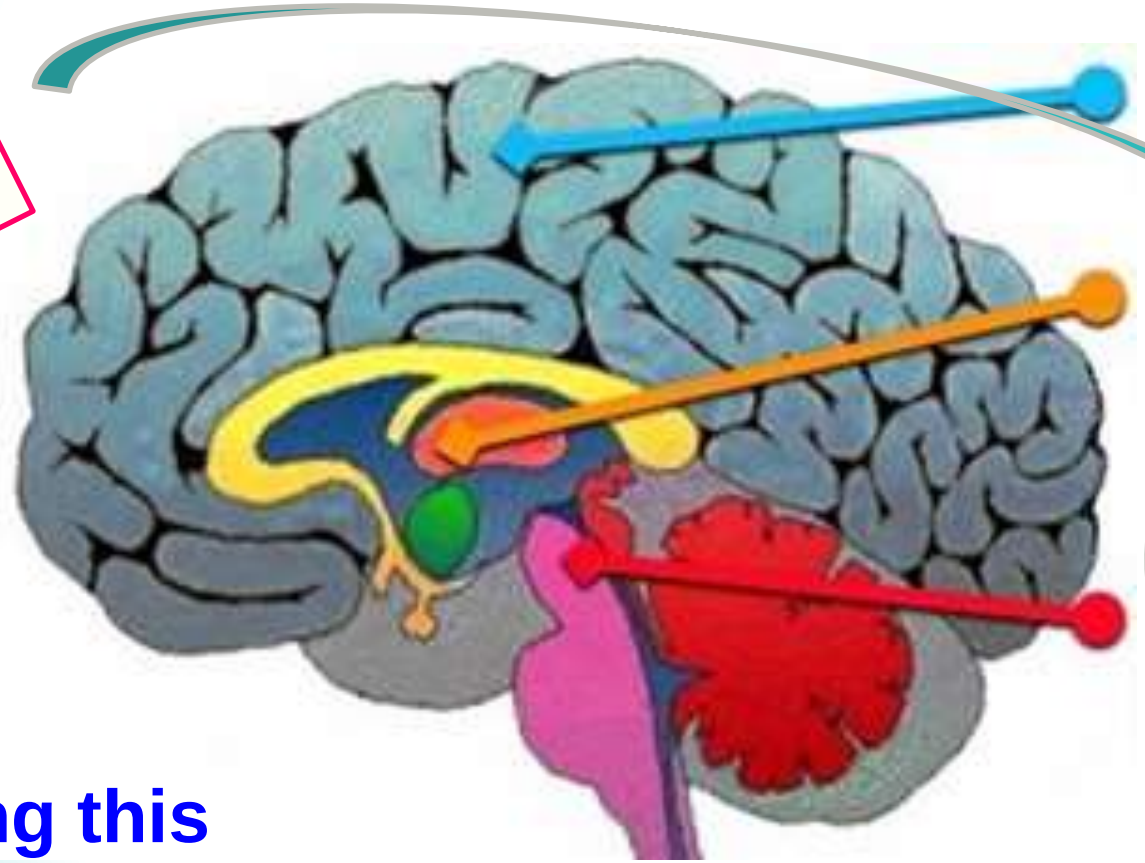
REMEMBER: none of us hears or thinks in the same way.
Synaptic Pruning's impact on cognitive dexterity.
And mental illness, substance use

MAP 1

EMOTIONAL REGULATION & INTELLIGENCE

Our OWN practice & version of getting to our thinking brain to manage our emotions & response over reactivity

to here



NEOCORTEX
reason

LIMBIC
emotion

from here

PRIMITIVE
instinct, survival

- **Fight**
- **Flight**
- **Feed**
- **Breed**

modeling this
guiding this

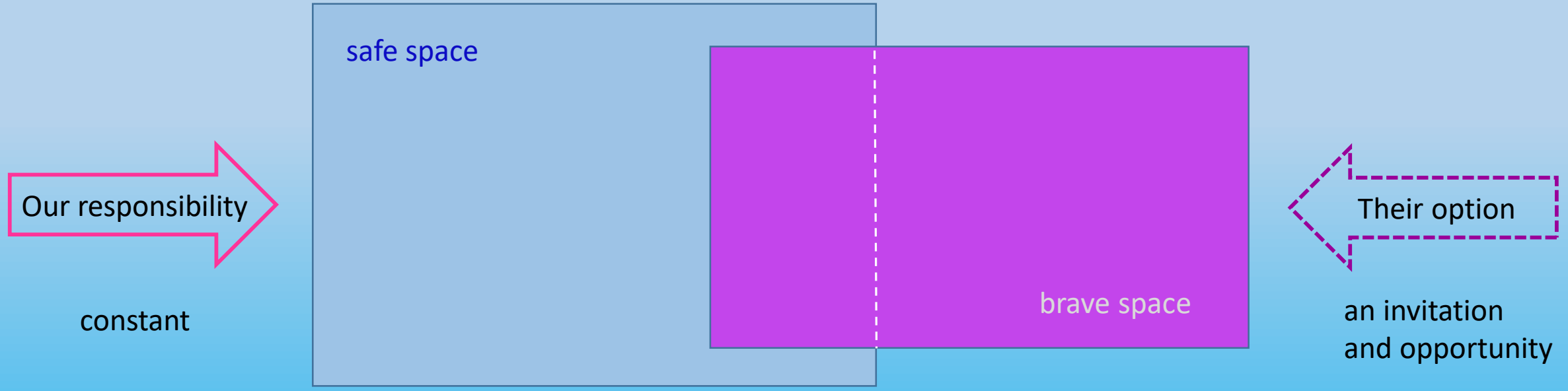
How do we become more comfortable & confident with this?

The power to choose exists *only*
when our automatic mental mechanisms
are subject to those brain systems
that are able to maintain conscious awareness.

- Dr. Gabor Mate, *In the Realm of Hungry Ghosts*

safe space brave space fluidity:
the growth zone

MAP 2



Safe space fosters & supports the courage to try brave new ways and appreciates fear & the need to be defensive

How does our relationship building reflect and uphold this?

What are the 4 Ingredients to our creating Safe Space?

Building Safe Space requires

Activates different neural pathways & NTs

Building safe space requires

SAFE SPACE also PROVIDES for …

- ❖ POWER DYNAMICS
- ❖ THE PROCESS OF HEALING
- ❖ TRAUMA ARMOR & DEFENSES

Establishing Safety

Trauma robs the victim of a sense of power and control; the guiding principle of recovery is to restore power and control to the survivor. The first task of recovery is to establish the survivor's **safety**.

- Judith Herman

Both physical and psychological / emotional safety.

Shared Power

Amplify the lesser power position's power

- **To place the decision/choice with the other person** (Person Centered)
  - my power in service to *your* power
    - Tell me about you
    - What do YOU want to accomplish?
    - What do YOU want to do?
    - How do I support YOU?
- **I follow the other person's lead**
- **I elevate their voice, support them in their choice**
- **As the relationship develops, collaboration** with the choice always the participants and without fear of my response (Motivational Interviewing use)
- **Disagreements, transparency, and safety**
  – and when limit setting *must* occur (incarceration example)

STAGES OF HEALING

- **Terror**
- **Rage**
- **Grief**
- **Vulnerability & the Unknown**

- The overwhelming consuming nature of each stage & the auto response to defend against experiencing
  - The need for ego strengths, insight, & support system to undertake this
    - Feels as if reliving, unprotected, relentless & never ending

TRAUMA PROTECTIVE GEAR & INTERACTIVE AWARENESS

1st: Recognize Trauma Armor & Defenses

and as a crucial means of self-preservation

2nd: Recognize *our* trauma response to *their* trauma response – our own protective gear reactions

and how this gets activated.

3rd: Provide a response back which reduces & minimizes being a trauma activator … is without threat.

Transform our experience of threat

How we feel threatened &
How we threaten (react)

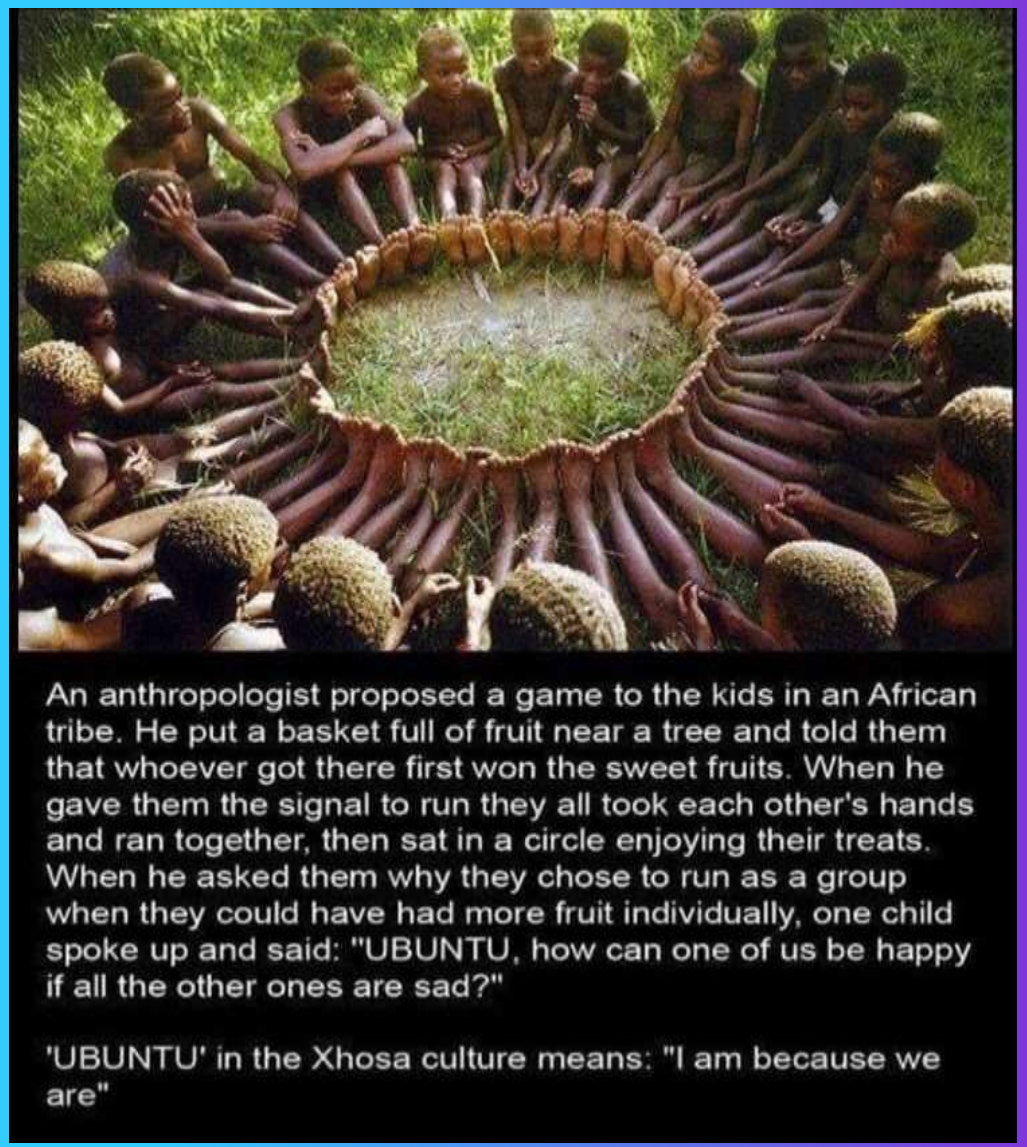
Our prior attention to & preparation for BEFORE an activation situation. And learning from.

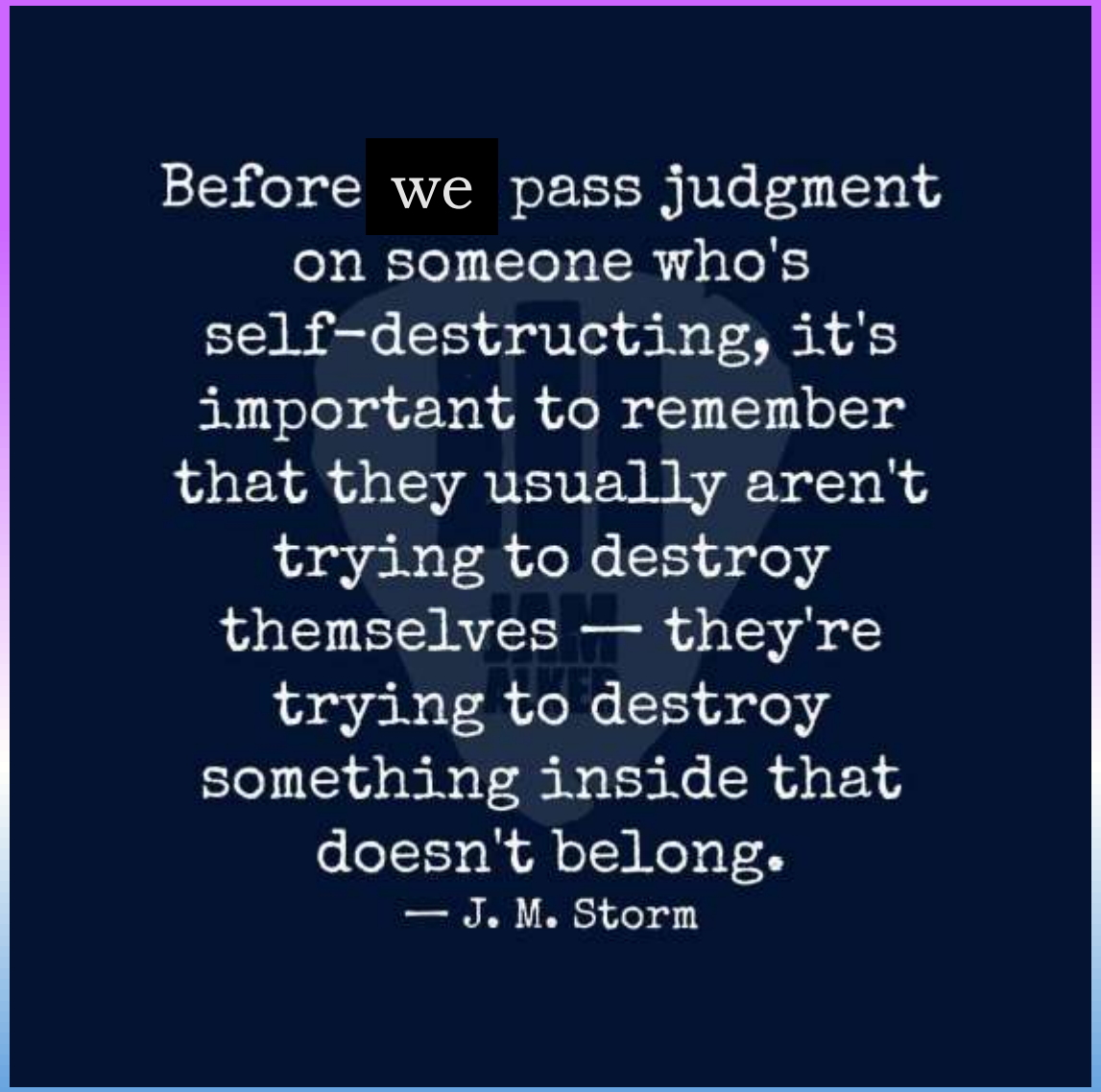
Trauma can be contagious
Resiliency can be contagious

- Use our *thinking* to manage our survival activation
- Prior preparation as much as possible – anticipate how we react

The absence of threat best neutralizes a trauma response.
Knowing too our position as staff is a pre-established trauma activator.
And we've the responsibility to keep everyone safe.

Community Care




Before we pass judgment
on someone who's
self-destructing, it's
important to remember
that they usually aren't
trying to destroy
themselves — they're
trying to destroy
something inside that
doesn't belong.
— J. M. Storm

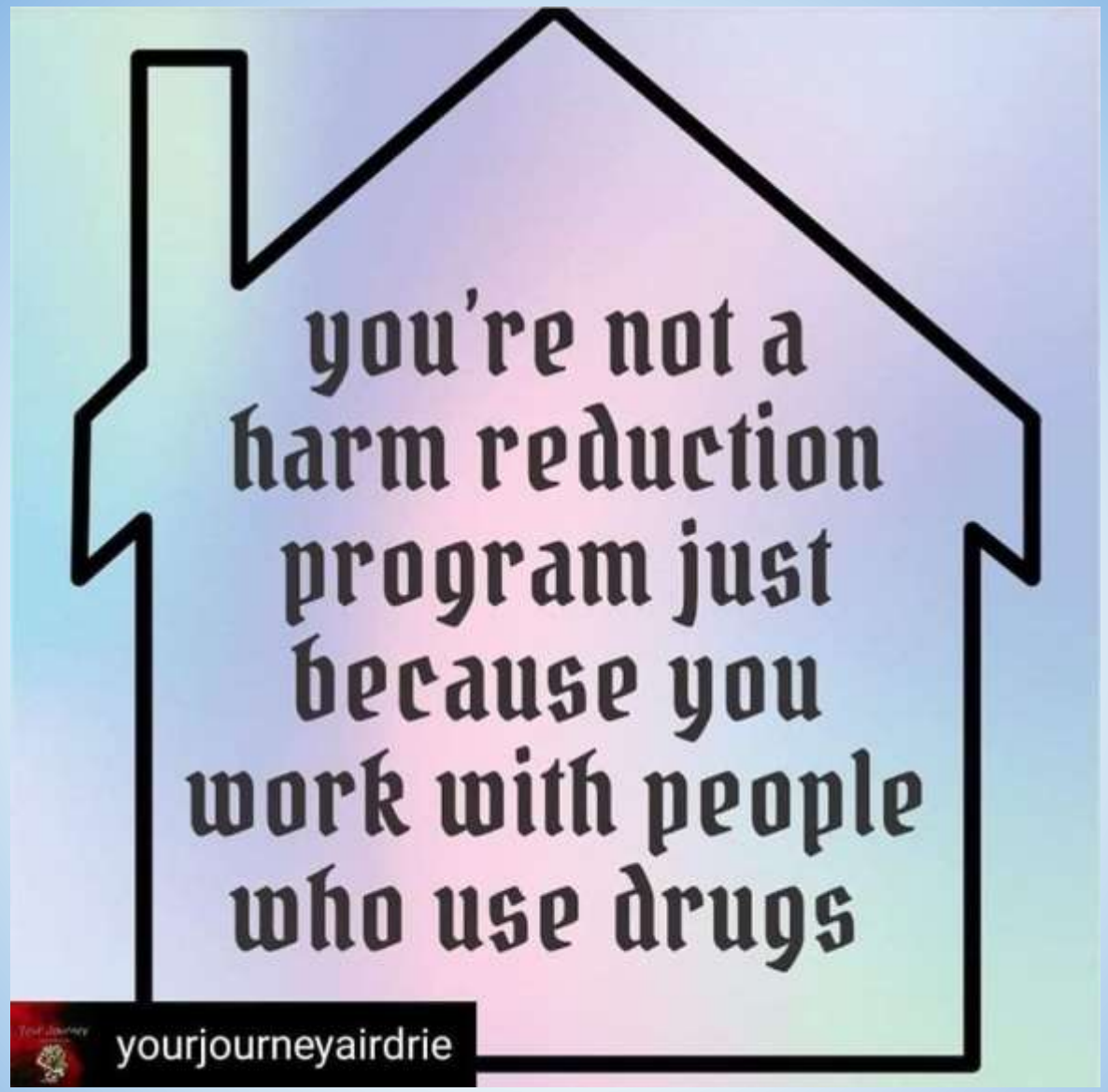
Co-Occurring Disorders and Trauma

SAMHSA TIP 2014

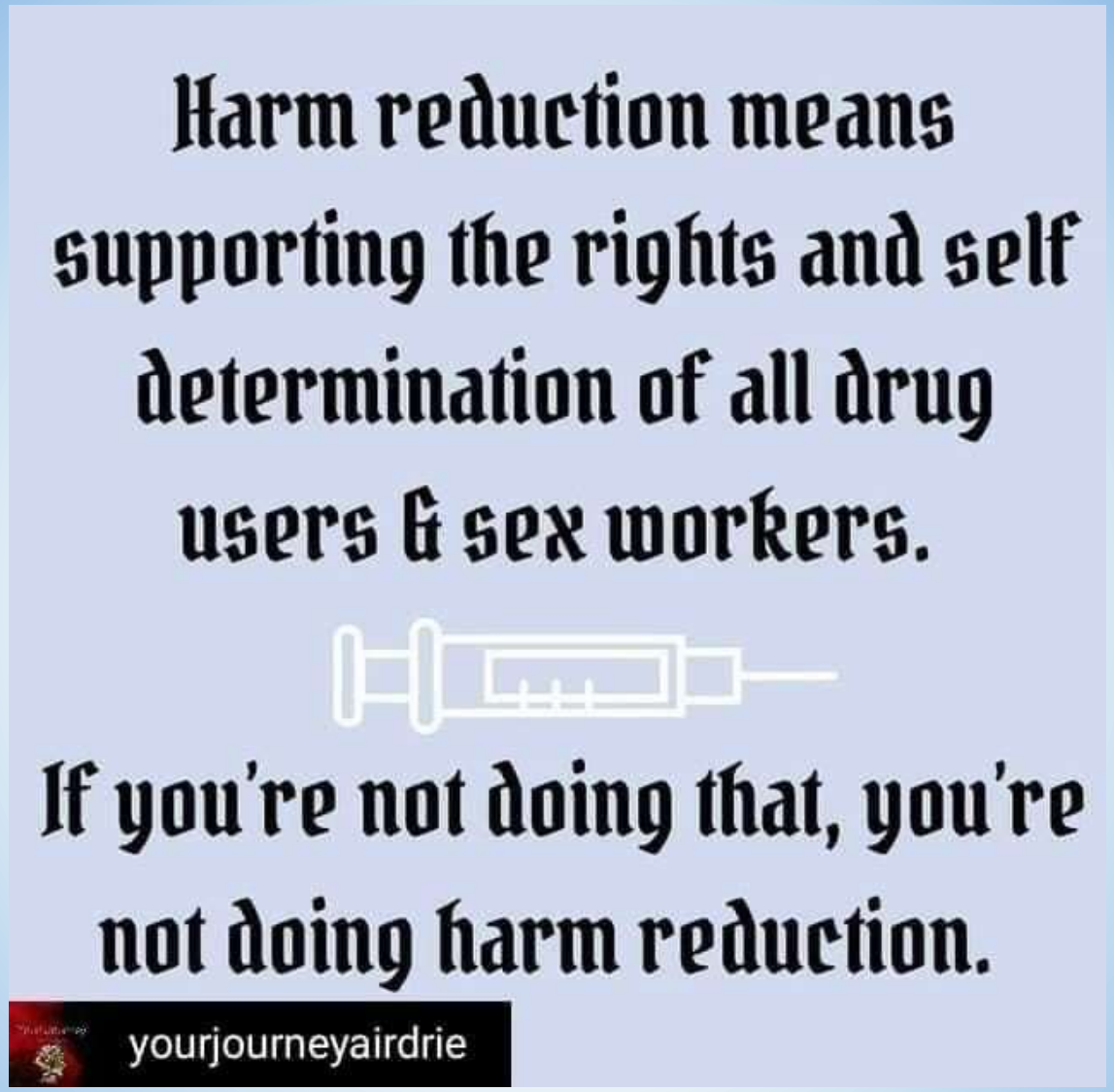
- **SU and other risky behaviors as attempts to take control of/reverse feelings of helplessness**
- BOTH abstinence and continued substance use may increase or decrease symptoms of PTSD
- **Compassion for substance use issues is increased when practitioners believe participants are self-medicating trauma**

Substance use is self-care & can be a trauma response


If harm reduction is paired with judgment, it is not harm reduction
@rachelharlich


you're not a
harm reduction
program just
because you
work with people
who use drugs
yourjourneyairdrie


Harm reduction is NOT...
a euphemism for things relating to drug use
reluctant acceptance of drug users with the goal of moving them towards abstinence
yourjourneyairdrie


Harm reduction means supporting the rights and self determination of all drug users & sex workers.
If you're not doing that, you're not doing harm reduction.
yourjourneyairdrie

… or with a behavior

Housing First example

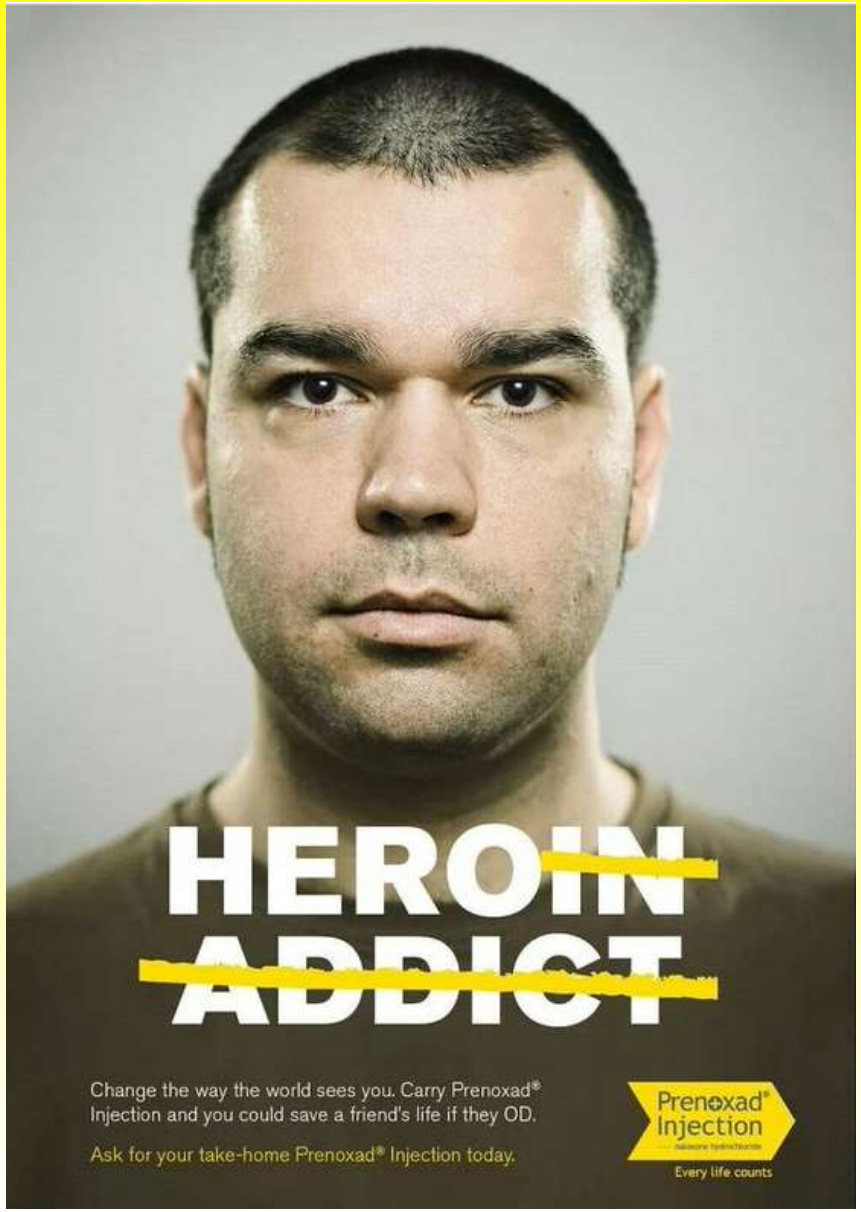
Endorsing Encouraging Promoting substance use???

- **Choice depends on conscious awareness**
- **Cultivating mindful awareness for intentionality**
- **Person centered - our belief in, valued, supported**

Cultures with a practice of martial arts – the awareness, understanding & appreciation of **energy**.

- Suppressing, denying energy, distorts it, builds it up.
- Instead, harness, guide and move in its flow

❖ **Harm Reduction in how our power is directed & used**



Midwest Harm Reduction Institute

Be curious, not judgmental

–Walt Whitman

Rethinking Addiction

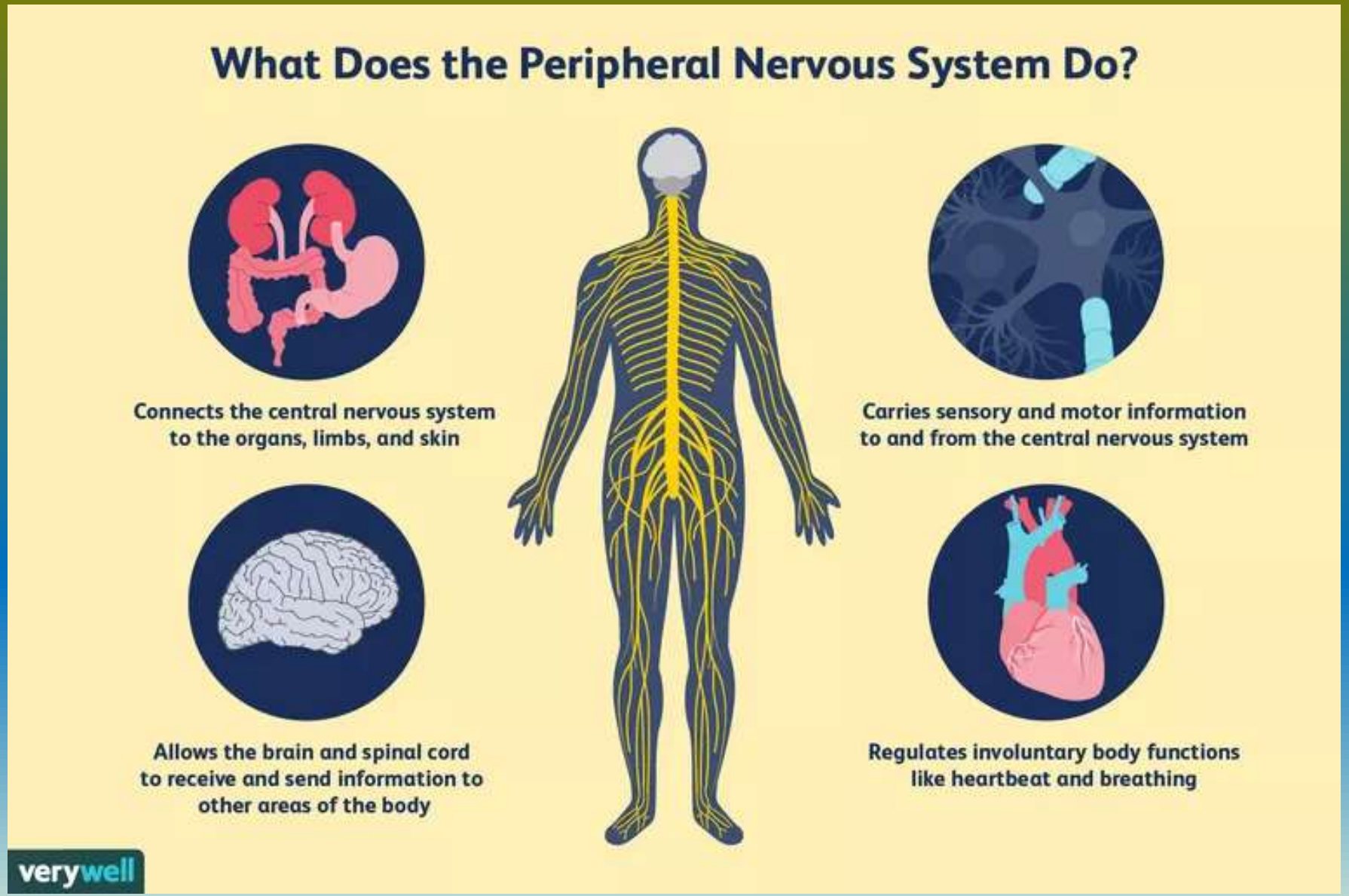
https://www.youtube.com/watch?v=C8AHODc6phg

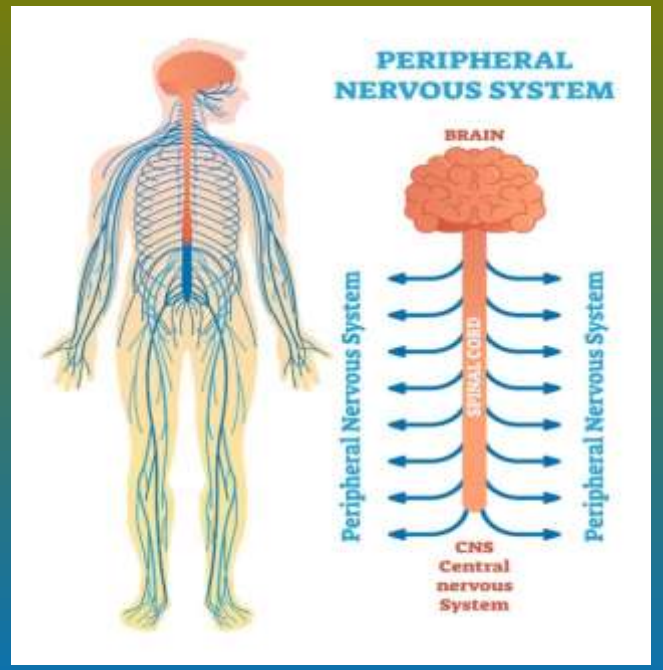
How Childhood Trauma Leads to Addiction

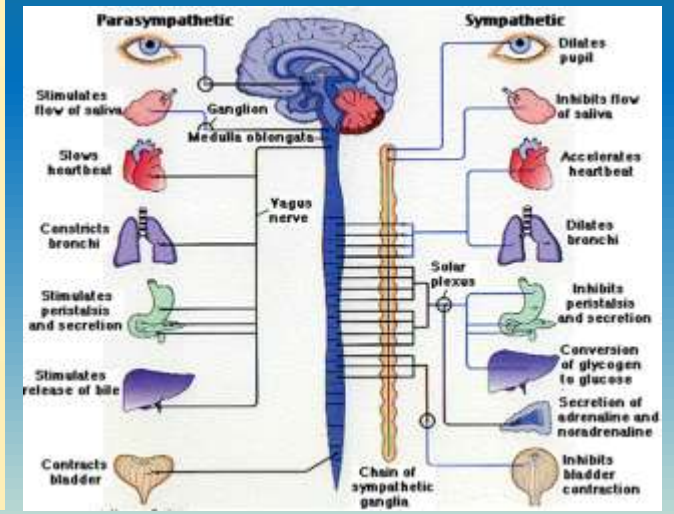
Gabor Maté

https://youtu.be/BVg2bfqblGI

Heartland Center for Systems Change





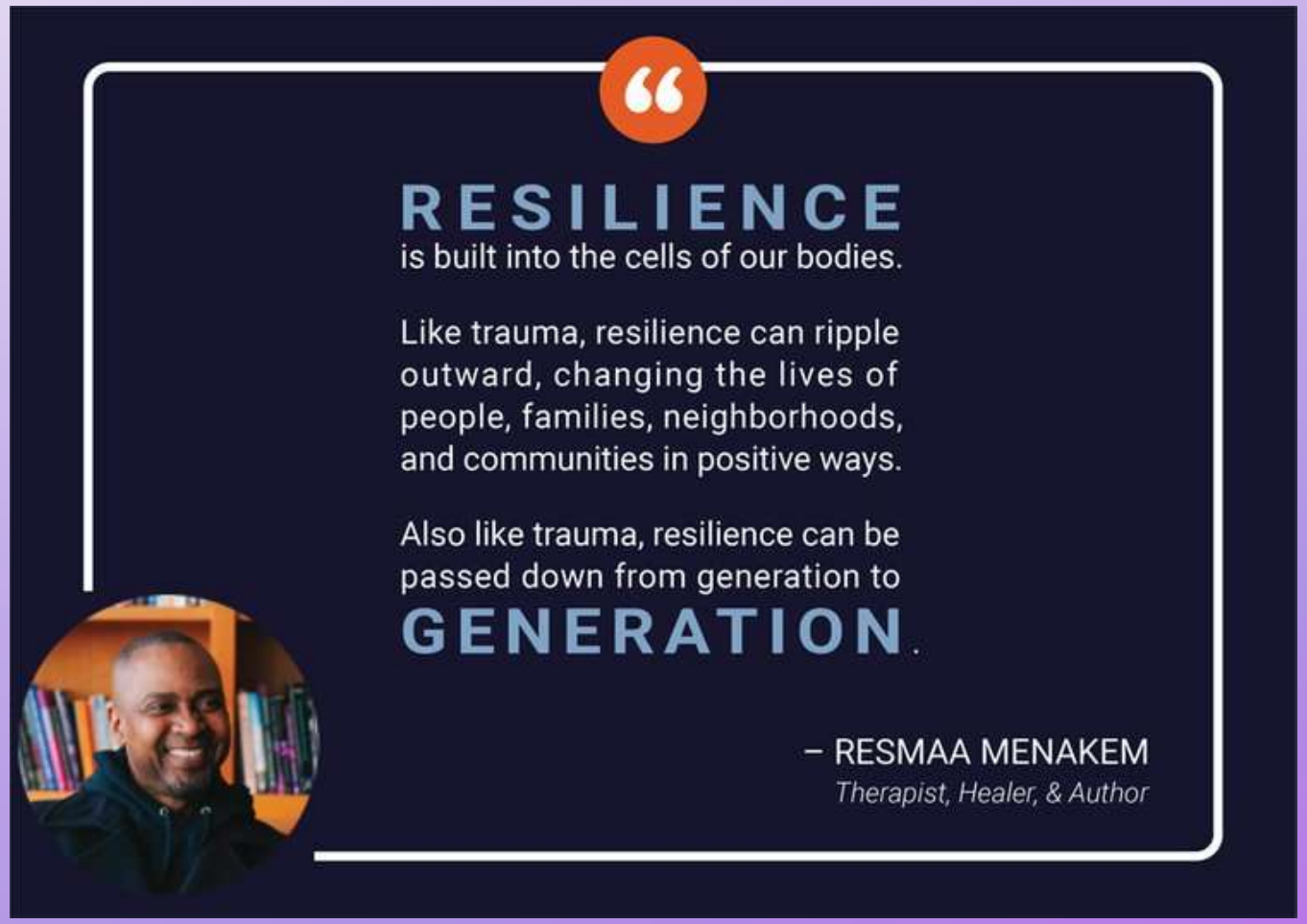


When we internalize trauma … **The health care costs of trauma and its physical toll on people**

“Working with people ‘where they are’ rather than ‘where they should be’”

I don’t need you to change to be a ‘better version’, more valued, more affirmed.
I admire & respect you as you are.
If there are quality & safety of life changes YOU want to make, you’ve my support.
I want you to be safe & prosper as fully as you want to and can.
Our world is better with you in it so please stay alive. How might I be of support with that too?

Inner Voice Presence & Connection



spectrum of trauma – spectrum of resiliency

If a person is alive …

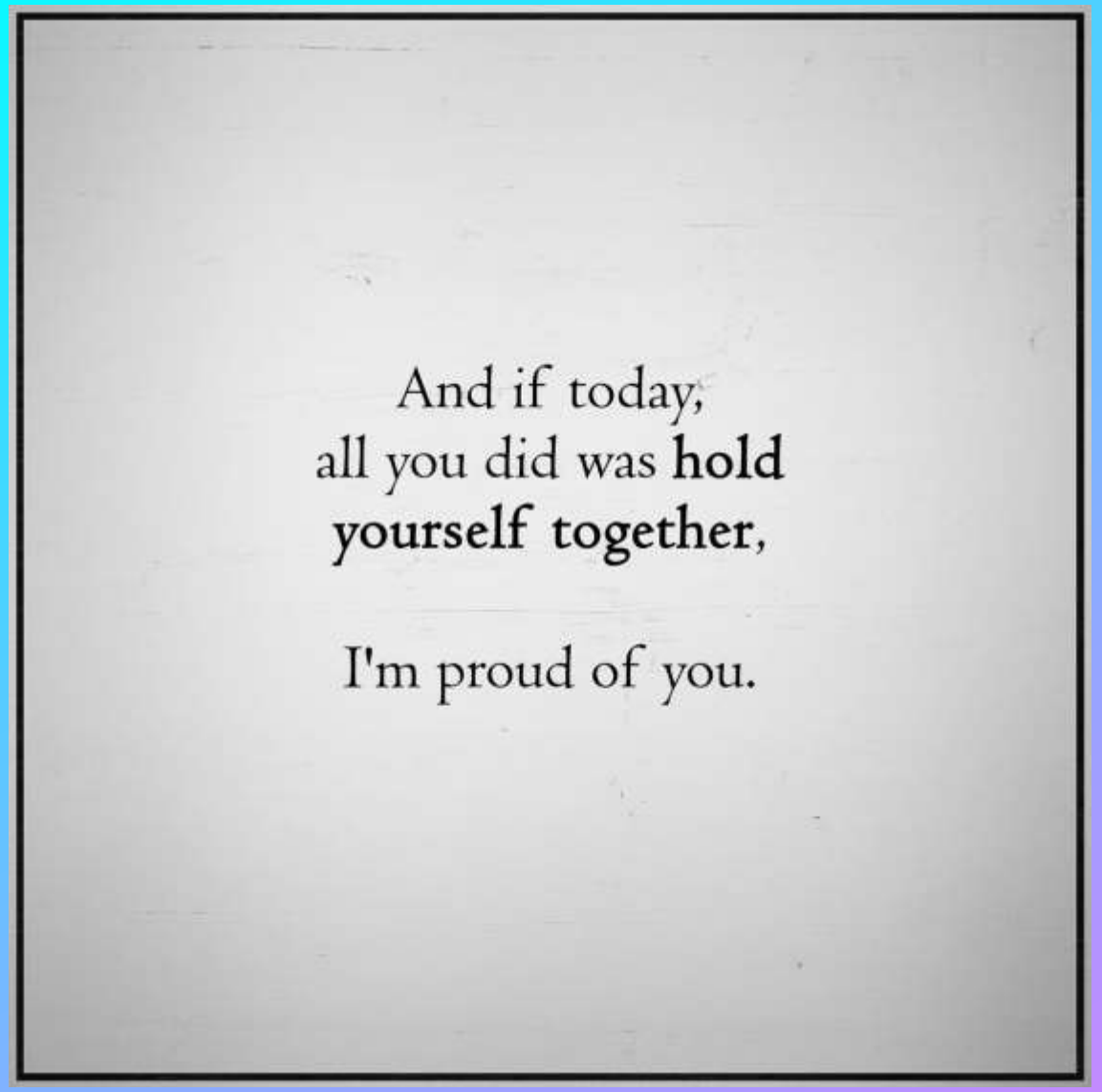
If a person is meeting with you

they're resilient.

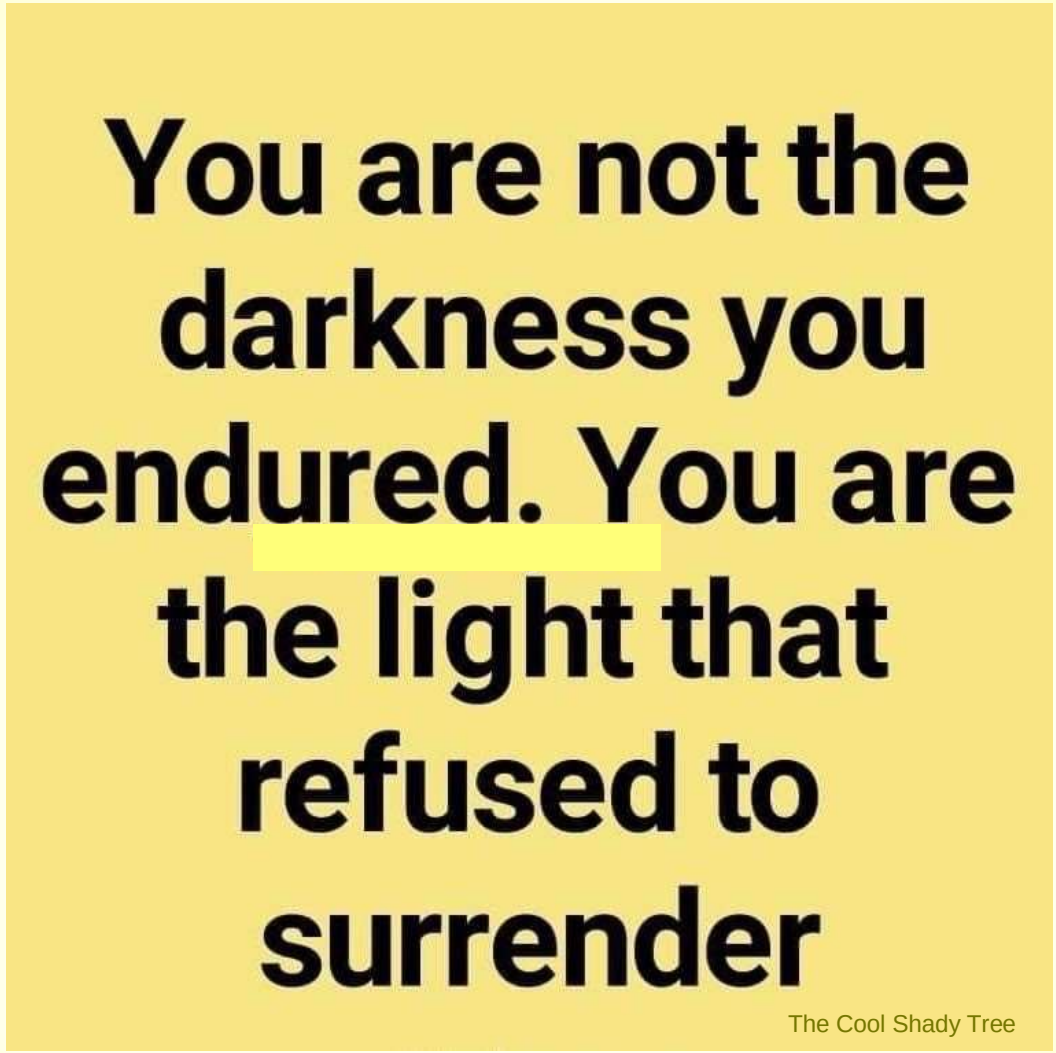
This is strengths based awareness & admiration *crucial* to healing & growth.

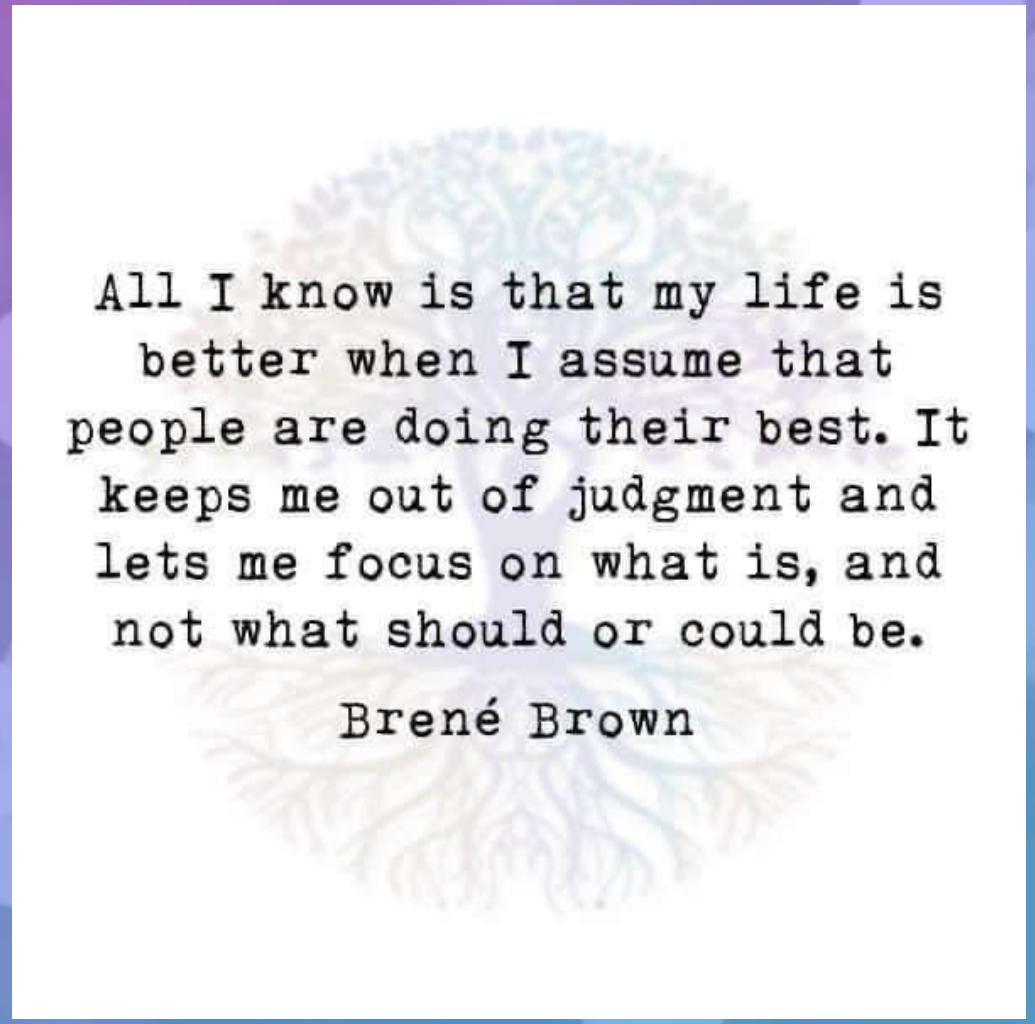
. . . as well as rage


www.kalendionpoetry.com
Someone begging
for their humanity to be acknowledged
can sound an awful lot
like rage.
www.kalendionpoetry.com
-Kalen Dion-


And if today,
all you did was **hold**
yourself together,
I'm proud of you.

strengths based awareness & celebration




All I know is that my life is better when I assume that people are doing their best. It keeps me out of judgment and lets me focus on what is, and not what should or could be.
Brené Brown

Belief in the Human Spirit *Strengths Based*

"I have consistently found if one dwells on the negative side of a patient's personality, one is unable to change behavior except for the worse. But if one looks for the **positive side** (*which is always there*), **contact is established**, and one can then motivate the patient to use their developing consciousness to solve their problems with the world."

Andrew Weil, *The Natural Mind*

Building and Keeping a Strengths Focus

when we talk about ourselves, clients, our team
an outlook & feedback balance

- 4 likes
- & 1 wish

BEGIN with ADMIRATION

for participants, for surviving
for staff, for taking on this work

Not doing so is our own trauma scarring

Affirm Everyone's Value, Worth & Contribution

To believe in and see the wholeness of the person at all time

person centered, inner guide always present

Very few of us were taught

healthy emotional regulation

if any at all.

And often what we witnessed was contradictory to what we were told.

So for **all** of us we have to learn that now

When our neuroplasticity & trauma reactions have largely already been set.

Our Own Fight/Flight Activation

- *Managing our adrenalin and cortisol build up; become toxins*
- It's there and reactive, intended to activate our attention
- Unreleased and built up over time affects health
  - sleep, headaches, stomach aches, vulnerable to illness, snap at people, inability to concentrate, fatigue, depression … what else?
- Mental health is body health
- **Breathe deep & exhale** – mindful complete whole breath cycle
- **Hydrate** – internal laundry
- **Body scan** – consciously relax each muscle, stretch
- Other approaches? To clear our head, body & spirit …

HARM REDUCTION

SAFE USE - RISK REDUCTION - SERVICES
THE MOVEMENT: PHILOSOPHY & POLITICAL
WORK EXPERIENCE
A WAY OF LIFE

the relationships we build & hold space for

de-escalation

HARM REDUCTION AS A RELATIONSHIP

control = power struggles

& messages of you’re incapable.

The Heart & Spirit of Harm Reduction

Am I experienced as safe or a threat, a harm?

Reduce the harm I introduce or pose

Motivational Interviewing

★ *Spirit of connecting & relating in safe space*

- **4 Languages**
  - Resistance/discord (staff responsibility)
  - Sustain Talk
  - Change Talk
  - Commitment
- **4 Processes**
  - Engagement
  - Focusing
  - Evocation
  - Planning
- **OARS**

From Motivational Interviewing …

A Fundamental Tool (OARS)

- Ask **O**pen-ended questions
- **A**ffirm
- Listen **R**eflectively
- **S**ummarize

When we understand & enact
Person Centered, Trauma Awareness …

Then Motivational Interviewing is about listening to the inner voice

And Harm Reduction is about directing power

And the challenge again is …

in our relationship building

Broadened here to also include neighbors & landlords

All good?
Got it?
Ready?


Permanent Housing
+
Supportive Services
=
Positive Outcomes!

Housing First: A Model to End Chronic Homelessness

What is Housing First?

- The Housing First model is **an approach to serving formerly chronically homeless individuals** (a group that makes up approximately 20 percent of the total homeless population) **regardless of their choice to use substances or engage in other risky behaviors.** Since 2000, the Housing First model has been widely accepted across the United States based on findings from multiple studies that demonstrated resident improvement in a number of areas.

- Pathways to Housing Inc., based in New York, is credited with developing the first Housing First program in the early 1990s. A key feature that distinguished the agency's Housing First program was that, unlike abstinence-based programs, it **did not require sobriety for individuals to be admitted to or to retain their housing.** This approach is based on **a harm reduction service philosophy** which seeks to reduce the negative consequences related to substance use (and other high-risk behaviors) rather than eliminating substance use altogether.

- The Housing First model has been endorsed by the U.S. Interagency Council on Homelessness, National Alliance to End Homelessness, and the U.S. Department of Housing and Urban Development (HUD).

Housing First

- Is based on the belief that **housing is a basic human right**
- The only prerequisite for access to housing is **homelessness**
- Addresses needs from the **participant's perspective** and **values participant's choice**
- Believes that **housing provides the necessary foundation** for the process of recovery
- Everyone who needs housing should immediately receive housing … and be supported in healing their trauma

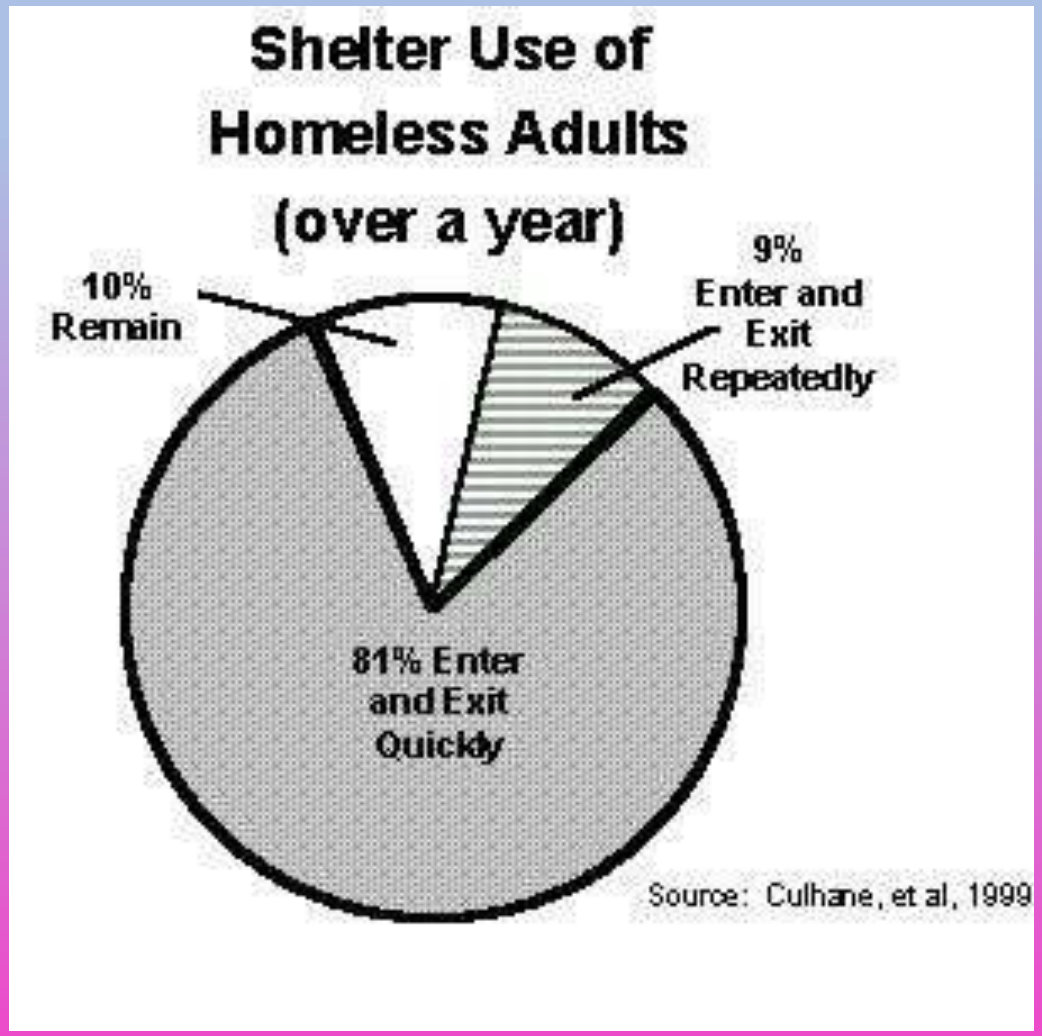
Housing First is characterized by:

- Direct placement into *permanent* housing
- Availability of supportive services *without* requirement to participate
- Use of assertive outreach to engage reluctant participants
  - What is assertive outreach?
- Approaches to ensure continued use (or return to use) does not result in eviction … also anger, symptoms of mental illness … other behaviors?
- Continuation of housing and care management services even while participants leave for shorter time periods

Outcomes of Housing First include:

- Reductions in problematic substance use
- Fewer emergency room visits and hospitalizations
- Higher perceived choice in services
- Reduced involvement in criminal activity
- Higher housing retention rates

Origins of Housing First



Denver's Housing First Collaborative

Emergency Room Services	↓ by 34%
Inpatient Hospitalization	↓ by 80%
Outpatient Care	↑ by 50%
Net result to health costs	↓ by 45 %

(Perlman & Parvensky, 2006)

Massachusetts
Home & Healthy for Good Project

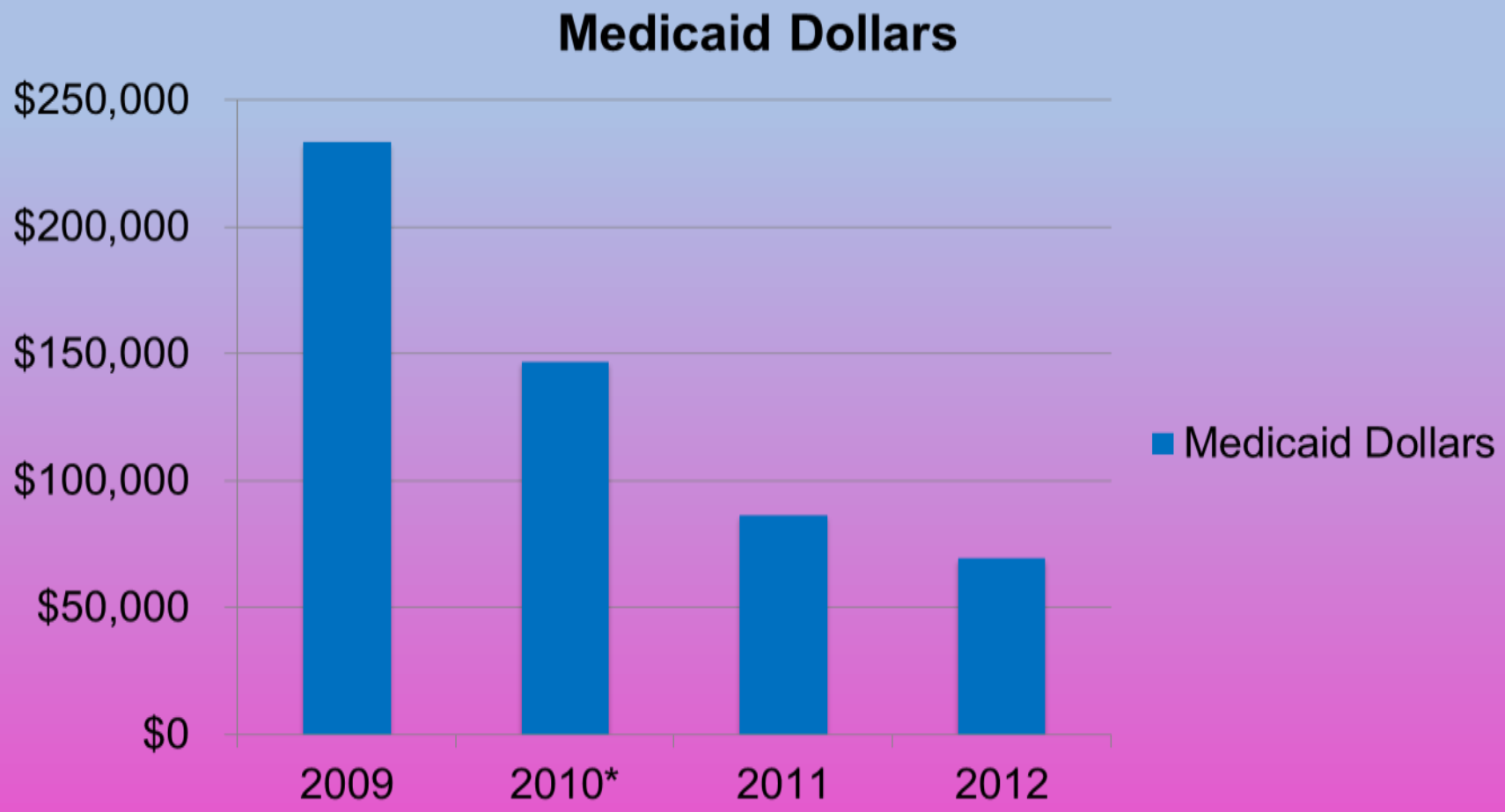
Source: http://www.mhsa.net/matriarch/MultiPiecePage.asp_Q_PageID_E_57

Chicago Housing for Health Partnership

- Reduced use of hospital system
  - Fewer hospitalizations and ER visits
- Better health outcomes
  - PLWHA were twice as likely to have undetectable levels of HIV in their blood
- Cost Savings
  - $1M saved for 100 chronically homeless housed

(Basu et al., 2011)

The Story of Carlos



*Carlos was housed in March 2010

Pathways to Housing

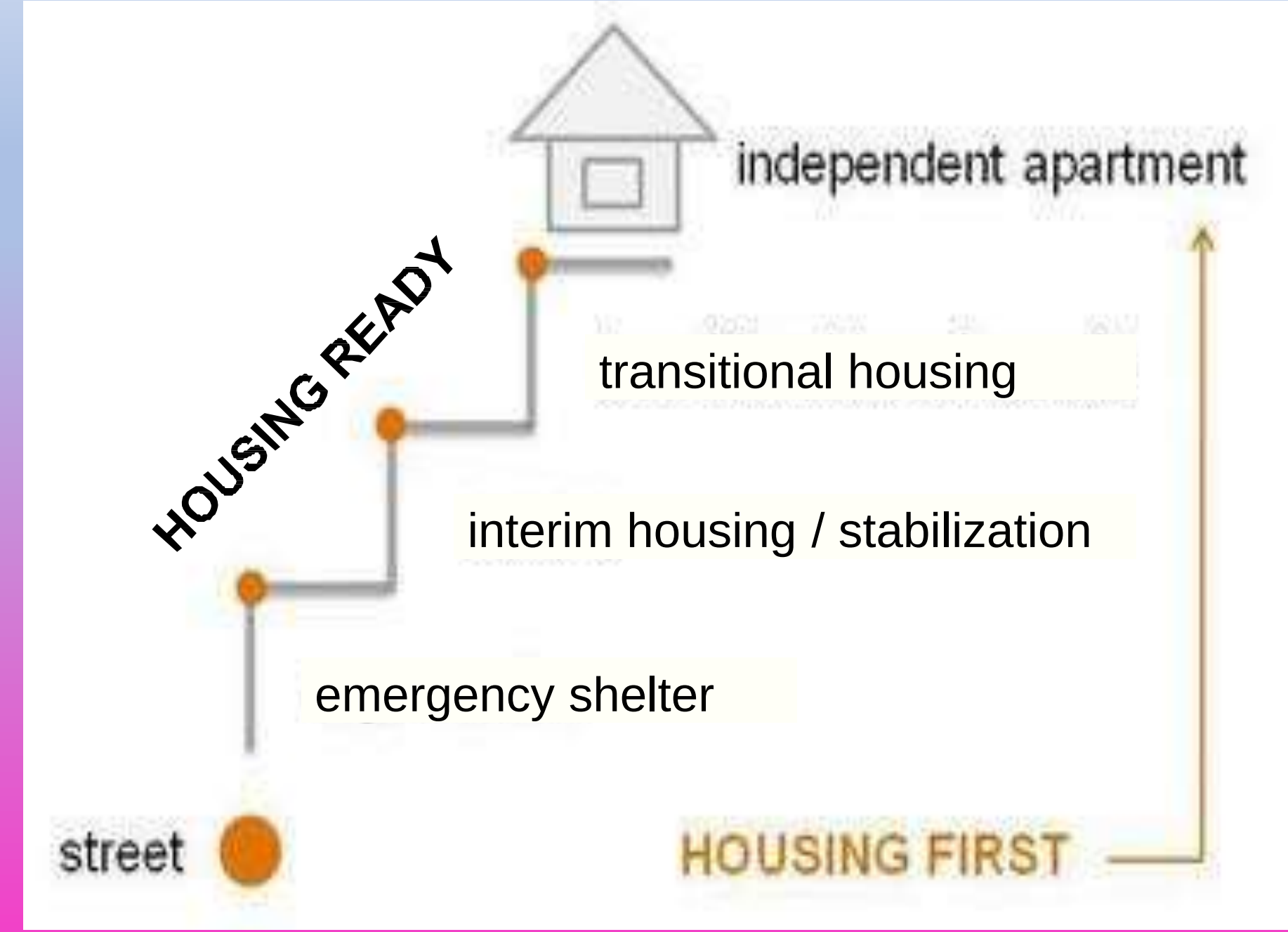
- Randomly assigned to either:
  - housing contingent on treatment participation (control)
  - housing without treatment prerequisites (experimental)
- Experimental group:
  - obtained housing earlier
  - remained stably housed at higher rates than control group
  - reported higher perceived self-determination
- Utilization of substance use treatment was significantly higher for the control group
- **BUT** no difference was found in substance use or psychiatric symptoms

(Tsemberis, 2004)

What do participants want?

- Given the choice, most participants prefer their own place in community settings
  - Creates a sense of home
  - Privacy, safety, security
  - Integrated housing
- Variety in housing and services

Adapted from webinar **Housing First:** Ending Homelessness for People with Mental Illness and Addiction www.monarchhousing.org


independent apartment
HOUSING READY
transitional housing
interim housing / stabilization
emergency shelter
street
HOUSING FIRST

Essential Program Elements of Housing First:

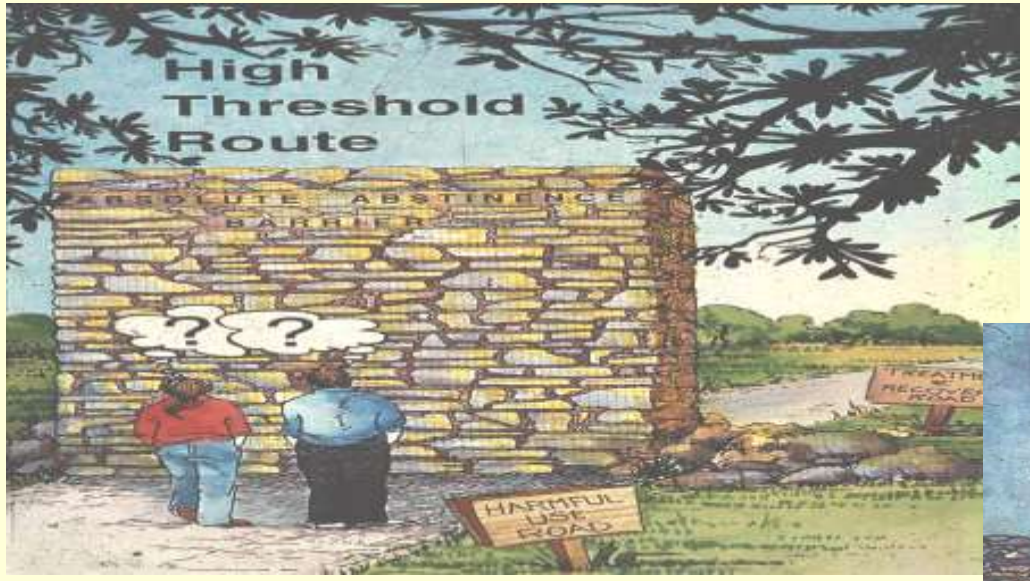
1. Low-threshold admissions policy:

- This describes a policy that places *as* ***few entry requirements*** *as possible* on participants, thus ***eliminating traditional barriers*** to accessing housing, such as *required abstinence from alcohol or other drugs or medication compliance*.
- Such a policy has been recognized as providing a basis for developing ***strong consumer-staff relationships*** necessary for housing stability and recovery.
- Such a policy complements assertive outreach which is often used by these programs to help reach and engage the participants who are the ***most vulnerable & the most alienated*** from services.

2. Harm reduction-based policies and practices:

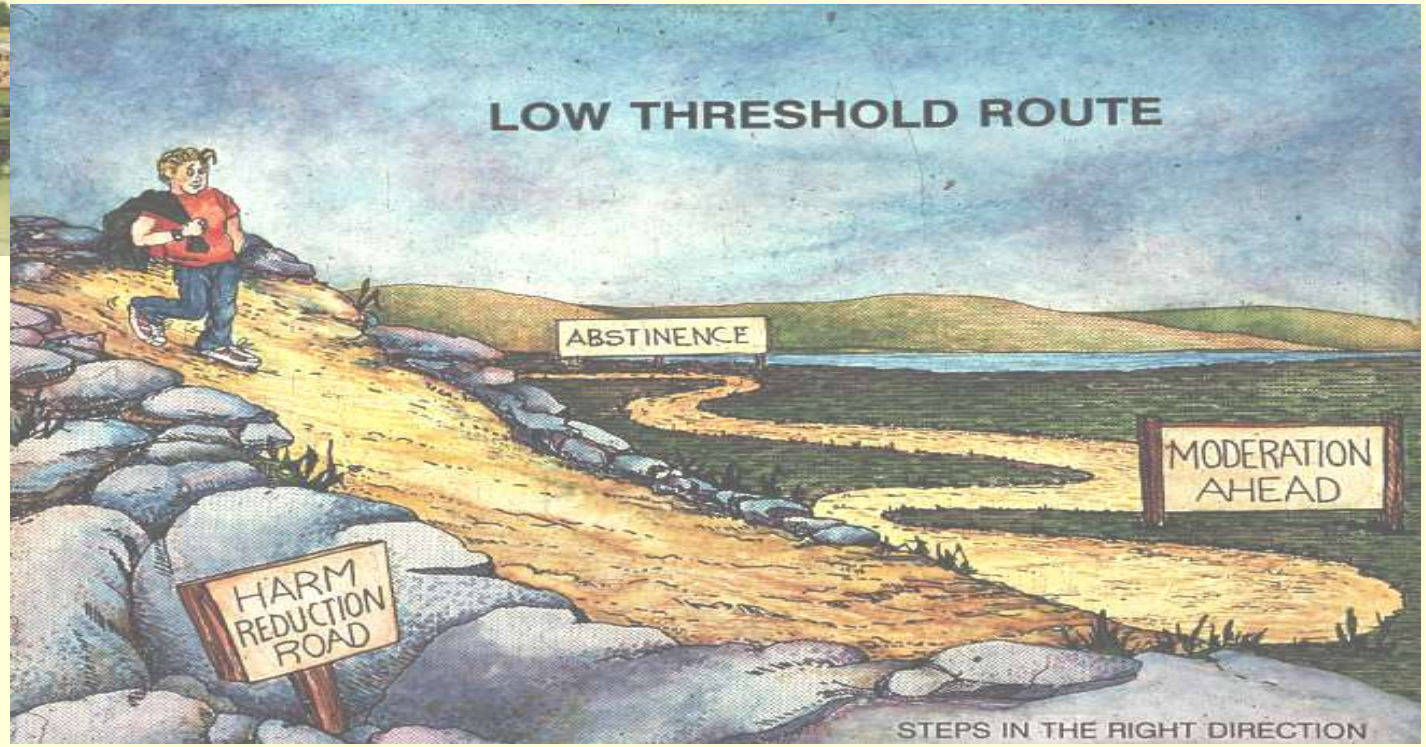
- While a low-threshold admissions policy is the mechanism that helps participants gain access to housing, **harm reduction** is considered the practice that is used to keep participants housed.
- Harm reduction focuses on reducing the negative consequences of high-risk behaviors, rather than eliminating them completely.
- When practiced correctly, harm reduction leads to ***stronger & more honest relationships*** *between participants and staff* and ***reduces the fear & stress*** related to losing one's housing due to substance use or other risky behaviors.

Perceived failure may intensify desire to use



Trauma & Power/Control

Success builds confidence, empowers, connects with inner voice



3. Separation of housing and services:

- Role definition between landlords/property management and case managers is *clearly defined & separated*, with case managers focusing on the role of ***advocate for the participant*** and landlords and property managers occupying the role of rule enforcer.
- Separation of these functions is essential for ***building & preserving the relationship*** *between case managers and participants, which serves as the basis for positive change*.

4. Reduced service requirements:

- This reflects a ***strengths-based*** service approach that acknowledges that ***participants know what they need*** and will take advantage of it if it is offered, rather than an approach that requires participation in services that may or may not be interesting or useful to participants.

inner voice, inner guide

5. Eviction prevention:

- This involves **developing a plan** to address behaviors that have led to lease violations and advocating with the landlord or property manager on behalf of the participant.
- Plans should **focus on the problematic behavior** itself (e.g. non-payment of rent, causing disruptions in common areas, etc.), especially for participants who are not interested in or ready for abstinence as a service goal.
- Plans should **not focus on substance use or mental illness** if those issues are the antecedents of the behavior.
- The plan should be based on **realistic ways** to eliminate or mitigate the problematic behavior (e.g., budgeting to ensure that rent gets paid, going directly to the apartment if intoxicated, or staying at a friend's house if intoxicated), and should be developed **in conjunction with the participant**.

6. Participant Education:

- Participant education about the **Housing First** program model and about **Harm Reduction** strengthens the impact of harm reduction policies and practices.
- It allows participants to attach meaning to the choices provided them and helps them to feel good about their choices and personal achievements.
- Without education, participants are likely to continue to understand the program in light of *previous experiences* with non-Housing First programs, believing that their housing is tenuous and so *avoid interactions with staff*.

inner voice, inner guide

Five Core Principles

- Immediate access to PH with no housing readiness requirements
- Participant choice & self-determination
- Recovery orientation
- Individualized & participant-driven supports
- Social & community integration

https://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first

Six Essential Elements

- Low threshold admissions policy
- Separation of housing and services
- Reduced service requirements
- Eviction prevention
- Consumer education
- Harm reduction-based policies & practices

(Watson & Shuman, 2013)

Low Threshold Admissions Policy

- Removes barriers to access housing
  - Ongoing substance use
  - Lack of engagement in health care or mental health treatment
  - Lack of income
  - Credit, rental history
  - Criminal background

"We should work to try and get people housing regardless of what they come to us with." –Housing First Staff

Separating Services and Eviction

Use different criteria for success in housing and in services

- Substance use and mental health symptoms are anticipated and not a housing problem
- Substance use or psychiatric symptoms ≠ eviction
- Eviction ≠ discharge from program

Our commitment is to the person

not the housing

Adapted from webinar **Housing First:** Ending Homelessness for People with Mental Illness and Addiction www.monarchhousing.org

Landlords as Partners

Landlord, program, and participants all have

a common goal:

All want **safe, decent, well managed** housing.

How can we work together to avoid eviction?

Adapted from webinar **Housing First:** Ending Homelessness for People with Mental Illness and Addiction www.monarchhousing.org

Consumer Education

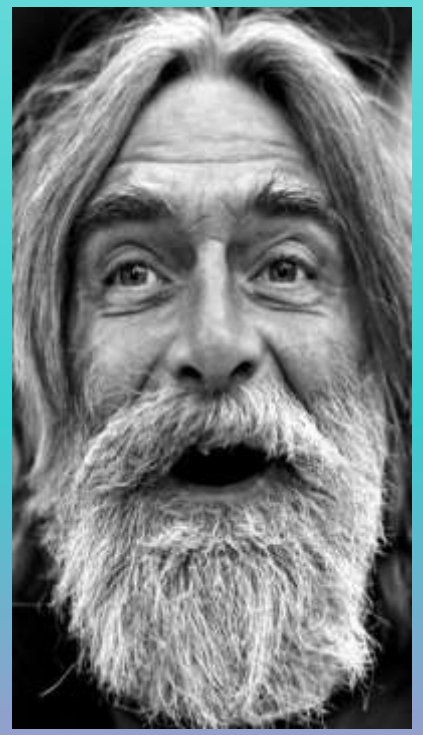
- Staff & participants need time to adjust to this new approach
- Everyone should have access to ongoing training and resources
- How do we explain HFM to participants?

Typology of Programs

	Consumer Education	
Program Flexibility	High	Low
High	*Empowerment*	*Enabling*
Low	*Treatment*	*Alienating*

(Watson, 2012)

Consumer Education



…[I]t was shortly after one of our one-on-one sessions where [my care manager] said…”You realize your housing is not contingent on you being abstinent?”. And I hadn’t realized that at that point … [T]hen things started to change. I started working real close with them, being honest with them.

– Housing First Consumer

Why Harm Reduction?

- If Housing First is to succeed, substance use can no longer be a barrier to accessing housing
- Homeless individuals with substance use problems must be offered the same options and rights as other people who are homeless
- **Homelessness is not a cure for addiction**
- **The opposite of addiction is connection.**

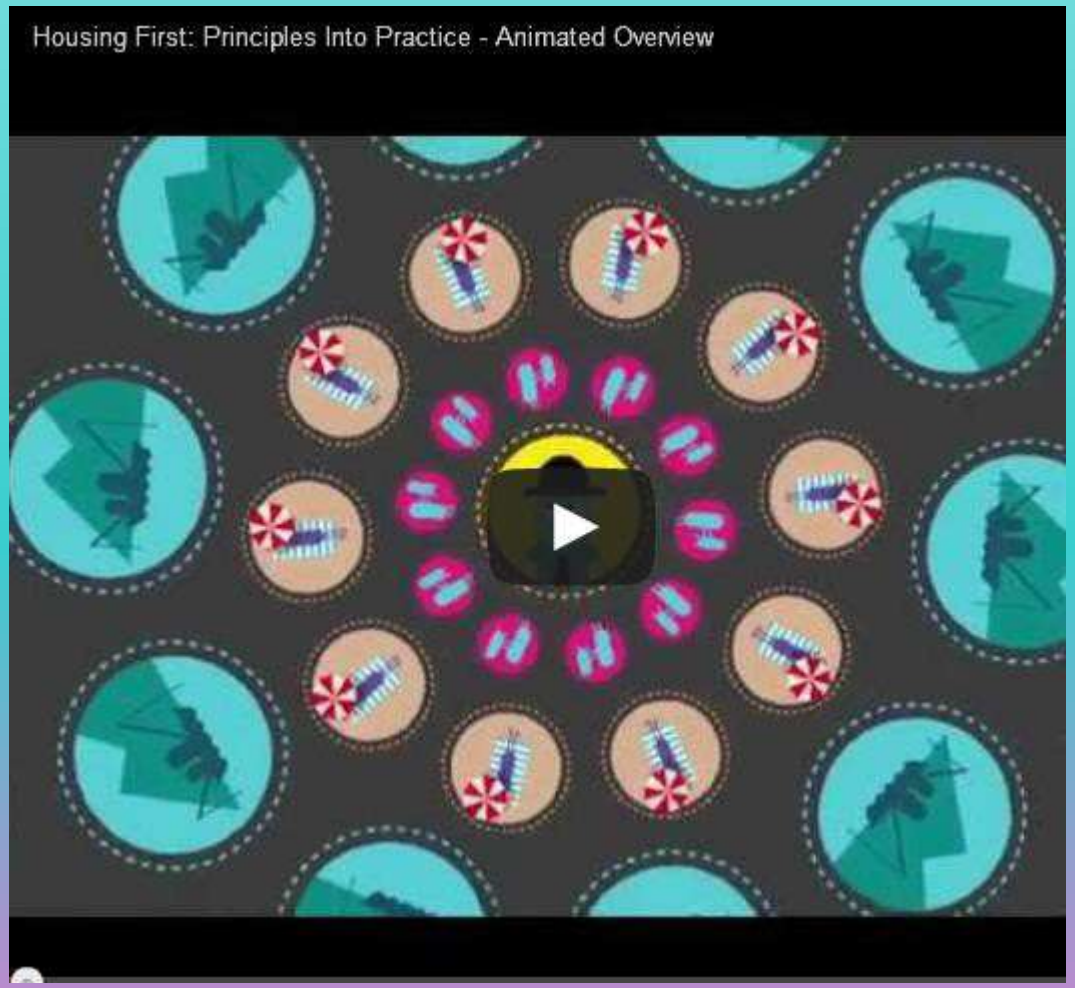
Housing First Checklist (USICH, 2016)

Core Elements of Housing First at the Program/Project Level

- ☐ Services are informed by a harm-reduction philosophy that recognizes that drug and alcohol use and addiction are a part of some tenants' lives. Tenants are engaged in non-judgmental communication regarding drug and alcohol use and are offered education regarding how to avoid risky behaviors and engage in safer practices.
- ☐ Substance use in and of itself, without other lease violations, is not considered a reason for eviction.

Full list available at …
https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf

Housing First Principles



https://www.youtube.com/playlist?list=PLn2dcn1mdW4oAhzNDrCrI0AGx11FJ_ukC

Common Challenges

- Excessive visitors, a lot of in and out traffic
- Noise complaints, knocking on doors
- Hygiene and cleanliness of unit, hoarding
- Non-payment of rent, budgeting
- Being taken advantage of (loaning money, non-participants taking over a unit)
- Intoxication
- Billing requirements

Other Considerations

- Fixed Site vs. Scattered Site
- Community relationships: police and other emergency services, local businesses
- Transitional options
- Access to neighborhoods that are safe and have access to transit, food resources, and other services
- Quality of life & meaningful activities
- Overdose prevention, naloxone access

Abstinent based Recovery Homes and **Harm Reduction based Housing First:**

- **a low barrier hybrid model**
- **assist recovery homes facilitate episodes of use**
- an array of housing that participants can fluidly move between based on their interests

Questions and Concerns

HOUSING FIRST FIDELITY INDEX (HFFI) MEASURES

Dennis Watson, Valery Shuman

HOUSING FIRST FIDELITY INDEX (HFFI) FIELDS

PROGRAM INFORMATION

HUMAN RESOURCES STRUCTURE and COMPOSITION
PROGRAM BOUNDARIES
FLEXIBLE PROGRAM POLICIES
NATURE OF SOCIAL SERVICES
NATURE OF HOUSING and HOUSING SERVICES

HOUSING TYPE

PROGRAM INFORMATION

- **Housing Retention data**
- **Program specific** only (not entire organization) and from **whose perspective** (Executive Leader, Program Director/Manager, Supervisor, Direct Service Clinical Staff)?
- **Staff** present as *client support staff** only OR staff who work on *client support* issues related to housing (eviction prevention, rent issues)?

  * *"case managers"*

  - Provided directly *OR* contracted out?
- **Funded units** of this program – on location or multiple locations?

HUMAN RESOURCES STRUCTURE & COMPOSITION

1. **Minimum Education Requirements** – at least 1 CM or direct supervisor with a MA or higher
2. **Crisis Intervention & Harm Reduction Knowledge** – requires ongoing training in HR and crisis intervention for staff
3. **Clinical Staffing** – have psychiatric staff and MHP on staff or contracted with

PROGRAM BOUNDARIES

1. **People Served** – solely individuals experiencing chronic homelessness and having a dual dx, and allows individuals currently using
2. **Outreach** – designated staff responsible for outreach
3. **Termination Guidelines** – only terminates residents who demonstrate violence, threats of violence, or excessive non-payment of rent

FLEXIBLE PROGRAM POLICIES

1. **Admissions Policy** – formal protocol for admitting individuals with the greatest need/vulnerability
   a. First come first served basis
   b. Assessed need vulnerability basis
   c. Combination of the two
   d. Within Coordinated Entry System
2. **Benefit/Income Policy** – possession of or eligibility for income benefits is not a prerequisite for housing
3. **Individual Choice in Housing Location** – program works with individuals to find desirable housing
   a. Initial, relocation, discharge planning
4. **Housing Relocation** – always attempts to relocate residents when they are dissatisfied with their current housing placement

FLEXIBLE PROGRAM POLICIES

5. **Unit Holding & Case Management Continuation** – holds housing for hospitalization and incarceration for more than 30 days and program continues to offer CM services while unit is unoccupied
6. **Missed Rent Payments** – flexible with missed rent payments, and holds resident accountable
   a. How many months missed payments/service fees before termination/discharge/eviction?
   b. Rep payeeship?
   c. Payment plan for back rent?
   d. Re-house after eviction if by landlord?

FLEXIBLE PROGRAM POLICIES

7. **Alcohol Use Policy** – allows alcohol use and housing allows alcohol units
8. **Drug Use Policy** – allows illicit drug use and housing allows illicit drug use in units
   - *Who holds lease? Master lease option?*
9. **Eviction Prevention** – formal policy and protocol to work with resident to prevent eviction, and has a staff member dedicated to eviction prevention
10. **Resident Input Into Program** – formal and informal mechanisms for receiving and implementing resident input
    - Formal program evaluation, quality assurance activities, concerns explicitly addressed, suggestions boxes, community meetings

NATURE OF SOCIAL SERVICES

1. **Service Approach** – residents are not requires to engage in any services except for CM to receive/continue receiving housing
2. **Harm Reduction Approach** to Service Provision – uses a HR approach and staff has a strong conceptual understanding
3. **Regular In-Person CM Meetings** – 2 to 3 per month, but more frequent meetings in first 1 to 6 months
4. **Small Staff-Resident Partnerships** – CM have 10 or fewer residents partnership
5. **Ongoing Resident Education** – ongoing resident education in Housing First and HR

NATURE OF HOUSING AND HOUSING SERVICES

1. **Structure of Housing and Services** – housing is scattered-site in building operated by private landlords
2. **Rapid Placement into Permanent Housing** – places individuals into housing in one week or less
3. **Temporary Housing Placement** – TH placement does not last more than a month

HOUSING TYPE

1. Would you identify this program as a HF program?
    a. If no, would you consider your program to run under the HF principles?
    b. For how many years?
2. How many years has the program operated under the principles of HF?
3. On a scale from 1 – not at all satisfied to 5 – very satisfied, how satisfied would you say you are with HF as an approach to housing?
4. Past year data includes numbers served, duration of those individuals in program, and numbers left program and reasons
5. Indications of higher level of functioning or resources (‘creaming’)?
6. HF principles but abstinence based approach to substance use?

DUAL DIAGNOSIS TREATMENT CAPABLE

SUBSTANCE USE + MENTAL HEALTH

CONSULTATION. COLLABORATION. INTEGRATION.

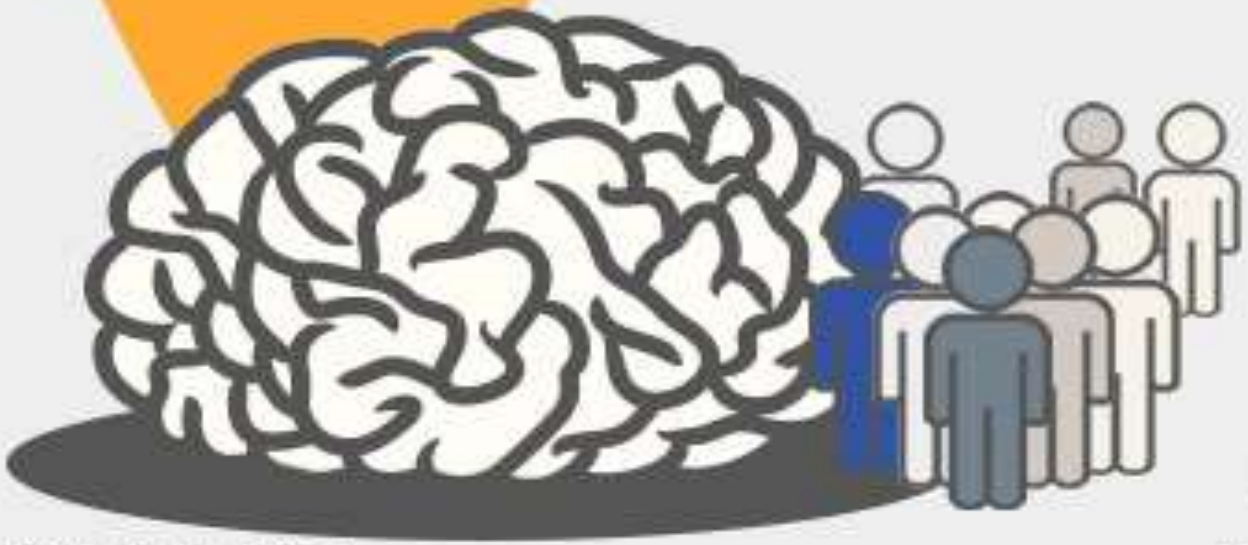
ILLINOIS CO-OCCURRING CENTER FOR EXCELLENCE

9.1 million in 2021

Co-Occurring Disorders

8.9

Million Americans
Living with a co-occurring disorder



SAMHSA

Only 7.5% enroll in
a treatment program

Substance Abuse Treatment
for Persons with Co-Occurring Disorders
A Treatment Improvement Protocol

TIP 42

SAMHSA

https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

- **POLICY**
  - Program Structure
  - Program Milieu
- **CLINICAL PRACTICE**
  - Assessment
  - Treatment
  - Continuity of Care
- **WORKFORCE**
  - Staffing
  - Trainings

POLICY Program Structure

- **Mission Statement** – primary focus on people with CODs
- **Certification & Licensure** – to provide both MH & SU tx
- **Coordination and collaboration** with MH or SU services – integrated with program structure
- **Financial incentives** – can bill for both

POLICY Program Milieu

- **Routine welcome and expectation for both** – regardless severity, all tx well documented
- **Display and distribution** of literature & participant educational materials – routinely, equivalently available for both, interrelated nature of COD

CLINICAL PRACTICE Assessment

- **Routine screening methods** – standardized, formal instruments with psychometric properties for both
- **Routine assessment if screened positive** – assessment formal, standardized and integrated for COD and well documented
- **MH & SU dx made and documented** – comprehensive dx services provided in timely manner and well documented
- **MH & SU hx reflected in EMR** – specific sections devoted to hx and chronology of both and interaction between is examined

CLINICAL PRACTICE Assessment

- **Program acceptance** – admits with moderate to high acuity including unstable in either
- **Program acceptance** – admits with moderate to high severity and persistence in either
- **Stage-wise assessment** – formal measure used for both, and well documented

CLINICAL PRACTICE Treatment

- **Tx Plans** – routinely address both equivalently, in specific detail; interventions, harm reduction, medications used
- **Assess and monitor interactive course** of COD – tx monitoring and documentation routinely reflects clear, detailed, systematic focus on change in both
- **Procedures for emergencies and crisis management** – routine capability with a process to ascertain risk of both; maintain in program unless alternate placement (hospital, detox) is necessary
- **Stage-wise treatment** – stage of change or motivation routinely incorporated into individualized plan; formally prescribed and delivered stage-wise tx for both

CLINICAL PRACTICE Treatment

- **Policies & procedures for medication** evaluation, management, monitoring, and adherence – clear standards and routine for med prescriber who is also a staff member; full access to prescriber and guidelines for prescribing in place; the prescriber is on the tx team and the entire team can assist with monitoring.
- **Specialized interventions** with content for both – routine sx management groups; individual focused therapies for both; systemic adaptation of an EBP (MI, HR, CBT, 12 Step …).
- **Education material** about both, tx and interaction of CODs – specific content for each routinely offered in individual and group formats

CLINICAL PRACTICE Treatment

- **Family education** – routine and systematic COD family group integrated into standard program format; accessed by families of the majority of participants with CODs.
- **Specialized interventions to facilitate use of peer support groups** in planning or during tx – routine facilitation targeting specific COD needs, intended to engage participant in MH, SU, or COD peer support groups.
- **Availability of peer recovery supports** for patients with COD – on site, facilitated and integrated into program; routinely utilized and documented with COD focus

CLINICAL PRACTICE Continuity of Care

- **COD addressed in discharge planning process** – both seen as primary, with confirmed plans for on-site follow-up or documented arrangements for off-site follow-up, no less than 80% of the time
- **Capacity to maintain tx continuity** – formal protocol to manage MH and SU needs indefinitely and consistent documentation this is routinely practiced typically within the same program/organization.
- **Focus on ongoing recovery issues for both** – routine focus on recovery and management with both seen as primary and ongoing.

CLINICAL PRACTICE Continuity of Care

- **Specialized interventions to facilitate use of community based peer support groups during d/c planning** – assertive linkage and interventions routinely made targeting specific COD needs to facilitate use of SU, or COD peer support groups.
- **Sufficient supply and adherence plan for medications** is documented – maintains med management in program with provider.

WORFORCE Staffing

- **Psychiatrist or other physician or prescriber** of psychotropic/MAT meds – staff member, present on site for clinical, supervision, tx team, and/or admin.
- **On-site clinical staff with licensure/certification**, graduate degree, or competency, substantive experience – 50% or more clinical staff have either license or substantial experience sufficient to establish competence in COD tx
- **Access to COD clinical supervision or consultation** – routinely provided on site by staff member and focuses on in-depth learning.

WORFORCE Staffing

- **Client review, staffing, or UR procedures** emphasize and support COD tx – documented, routine, and systematic coverage of COD
- **Peer/Alumni supports are available with COD** – available on-site with COD, either as paid staff, volunteers, or program alumni. Routine referral made.

WORFORCE Training

- **All staff have basic training** in attitudes, prevalence, common signs, and sx detection and triage for COD – most staff trained and periodically monitored by agency strategic plan (80% or more staff trained).
- **Clinical staff have advance specialized training** in integrated psychosocial or pharmacological tx of persons with COD – most staff trained and periodically monitored by agency strategic training plan (80%or more clinical staff trained).

DuDx CAPABLE TREATMENT EVIDENCED IN …

- Policy & Procedures
- Electronic Medical Record (EMR)
- Website
- Flyers, brochures, handbooks
- Curricula
- Interviews with program director, clinical staff, program participants
- Site tour

Prodromals &
H A L T

HUNGRY –DECREASED OR INCREASED APPETITE, SUDDEN WEIGHT LOSS OR GAIN

ANGRY – MOOD SWINGS, INTENSE EMOTIONS, IRRITABILITY, OR ANHEDONIA

LONELY – INTERPERSONAL DIFFICULTIES, SOCIAL WITHDRAWAL OR ISOLATION

TIRED – SLEEP DISTURBANCE, FATIGUE, LOW ENERGY, DECREASED MOTIVATION

NOTICING CHANGES

Questions and Concerns

Additional Resources:

- Housing First Practice Community
  http://housingfirstpracticecommunity.weebly.com/
- Pathways to Housing
  www.pathwaystohousing.org
- Downtown Emergency Service Center (DESC)
  www.desc.org
- National Alliance to End Homelessness
  http://www.endhomelessness.org/pages/housing_first
- USICH Housing First Checklist
  https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf
- Housing First in Permanent Supportive Housing Brief (HUD)
  https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf
- Canadian Housing First Toolkit
  http://www.housingfirsttoolkit.ca/
- https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/

References

Basu, A., Kee, R., Buchanan, D., and Sadowski, L. (2012). “Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care”. *Health Services Research*, 2012 Feb; 47(1 Pt 2): 523–543.

Denning, P. & Little, J. (2012) *Practicing Harm Reduction Psychotherapy, Second Edition*. New York: The Guilford Press.

Karus, D., Serge, L., & Goldberg, M. (2005). *Homelessness, housing, and harm reduction: Stable housing for homeless people with substance use issues*. Canadian Mortgage and Housing Corporation, available online at: ww.cmhc.ca.

Kraybill, K., Zerger, S. (2003). *Providing treatment for homeless people with substance use disorders, case studies of six programs.* National Healthcare for the Homeless Council, available online at: www.nhchc.org.

Perlman, J., & Parvensky, J. (2006). Denver Housing First Collaborative: Cost benefit analysis and program outcomes report. Denver, CO: Colorado Coalition for the Homeless.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). *Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis.* American Journal of Public Health, Vol. 94, No. 4, 651-656.

Tsemberis, S. (2010). *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction: Manual and DVD*. Hazelden.

United States Interagency Council on Homelessness (2016). “Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation.” Last Updated: September 2016. Full text available online at: https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf

Vakharia, S. & Little J. (2016). “Starting Where the Client Is: Harm Reduction Guidelines for Clinical Social Work Practice” *Clinical Social Work Journal*, April 2016, 1-12.

Watson, D. P. (2012). From Structural Chaos to a Model of Consumer Support: Understanding the Roles of Structure and Agency in Mental Health Recovery for the Formerly Homeless. *Journal of Forensic Psychology Practice*, *12*(4), 325–348.

Watson, D. P., Orwat, J., Wagner, D. E., Shuman, V., & Tolliver, R. (2013). The Housing First Model (HFM) Fidelity Index: Designing and testing a tool for measuring integrity of housing programs that serve active substance users. *Substance Abuse Treatment, Prevention, and Policy*, *8*(1), 16.

Watson, D. P., Wagner, D. E., & Rivers, M. M. (2013). Understanding the Critical Ingredients for Facilitating Consumer Change in Housing First Programming: A Case Study Approach. *The Journal of Behavioral Health Services & Research*, *40*(2), 169–179.

Additional Reading

Housing First Practice Community—Blog includes articles on harm reduction, website also has discussion forums and toolbox for Housing First providers
http://housingfirstpracticecommunity.weebly.com/blog

"Starting Where the Client Is: Harm Reduction Guidelines for Clinical Social Work Practice" by Sheila Vakharia and Jeannie Little
https://www.researchgate.net/publication/301343562_Starting_Where_the_Client_Is_Harm_Reduction_Guidelines_for_Clinical_Social_Work_Practice

"What's Under the Harm Reduction Umbrella?" by Jeannie Little
https://www.thefix.com/content/under-harm-reduction-therapy-umbrella-part-1

Web Resources

Reflection and Support for Staff

- T3 Changing the Conversation podcast:
  - http://us.thinkt3.com/podcast
- Coldspring Center Blog:
  - http://coldspringcenter.org/mattsmumblings/

Harm Reduction Advocacy

- Drug Policy Alliance
  www.drugpolicy.org
- Harm Reduction Coalition
  - www.harmreduction.org

Harm Reduction Therapy

- Center for Optimal Living
  - http://centerforoptimalliving.com/
- Harm Reduction Therapy Center
  - www.harmreductiontherapy.org

Harm Reduction Outreach and Resources

- Chicago Recovery Alliance
  - www.Anypositivechange.org
- Sex Workers Outreach Project
  - http://www.swopusa.org/

Peer Support Groups

- Harm Reduction, Abstinence, Moderation Support(HAMS)
  - www.hamsnetwork.org
- Moderation Management
  - www.moderation.org
- SMART Recovery
  - www.smartrecovery.org

Drug Education

- Erowid
  - www.erowid.org
- Blue Light Drug Forums
  - www.bluelight.org
- Guide to Drug Combinations
  - https://wiki.tripsit.me/wiki/Drug_combinations
- Worldwide Drug Survey
  - http://www.globaldrugsurvey.com/brand/the-highway-code/
- Drugs Meter: https://www.drugsmeter.com/
- Drinks Meter: http://www.drinksmeter.com/app/

Housing First Principles

https://www.youtube.com/playlist?list=PLn2dcn1mdW4oAhzNDrCrI0AGx11FJ_ukC


Thank you!
MBK Associates

for follow up & additional information …

Tom Kinley | Field Support & Systems Change Facilitation
Pronouns: he/him/his
Heartland Alliance Health | A Partner of Heartland Alliance
Midwest Harm Reduction Institute
Illinois Co-occurring Center for Excellence
Heartland Center for Systems Change
1207 W. Leland Ave. | Chicago, IL 60640
Mobile phone: 312-505-0132
tkinley@heartlandallliance.org