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The Role of Housing: A Comparison of Front-Line Provider Views in Housing First and Traditional Programs

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Abstract

Purpose—Within the mental health system, there are two distinct service models for adults who have severe mental illness and are homeless: one prioritizes treatment before accessing permanent housing (Treatment First) while the other provides permanent housing upfront followed by clinical support (Housing First). Investigating front-line providers working within these two models affords an opportunity to learn more about their implementation from an insider perspective, thus shedding light on whether actual practice is consistent with or contrary to these program models' contrasting philosophical values.

Methods—Forty-one providers were recruited from four agencies as part of a NIMH funded qualitative study. Multiple, in-depth interviews lasting 30–45 min were conducted with providers that explored working within these agencies. Thematic analysis was utilized to compare the views of 20 providers working in Housing First versus the 21 providers working in Treatment First programs.

Results—Providers viewed housing as a priority but differences emerged between Treatment First and Housing First providers along three major themes: the centrality of housing, engaging consumers through housing, and (limits to…) a right to housing.

Conclusion—Ironically, this study revealed that providers working within Treatment First programs were consumed with the pursuit of housing, whereas Housing First providers focused more on clinical concerns since consumers already had housing. Clearly, how programs position permanent housing has very different implications for how providers understand their work, the pressures they encounter, and how they prioritize client goals.

Keywords

Front-line providers; Homelessness; Qualitative research

Introduction

Within the mental health system there are two distinct service models for adults who have severe mental illness and are homeless: the residential continuum model and the Housing First model. The predominant approach to date that characterizes the majority of services is the residential continuum approach (Leff et al. 2009; Locke et al. 2007), which positions permanent, independent housing as the end point of the continuum and is only for those who are successful in transitional and congregate settings. Success is defined by treatment

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compliance, psychiatric stability, and abstinence from substance abuse, and is attributed to effective treatment. By contrast, the a Housing First model utilizes a supported housing approach (Ridgway and Zipple 1990; Rog 2004) in which consumers start with permanent, independent apartments and providers work with consumers regardless of their symptoms, substance abuse, or whether they participate in formal treatment (Tsemberis et al. 2004). This paper will refer to these two models as “Housing First” and “Treatment First” since the traditional residential continuum positions treatment as the primary intervention that can lead to stable, permanent housing while Housing First, as the name implies, regards access to permanent housing as the primary intervention to end homelessness (Padgett et al. 2006).

The role of front-line providers in both Housing First and Treatment First programs has received relatively little attention compared to studies evaluating consumer outcomes. Yet, the varying arrangement of housing and services results in very different job descriptions and expectations for providers working in these two models. Treatment First providers typically work within an individual case management model (O’Hara 2007) and are expected to uphold program rules in order to facilitate the consumer’s transition to the next level of housing. Housing First providers, on the other hand, typically work within assertive community treatment (ACT) teams, which is an evidence-based practice (Bond et al. 2001; Matejkowski and Draine 2009), and are expected to work with consumers as they navigate living in the community. While comparing provider approaches and their relative effectiveness is challenging given this variation in service models, investigating front-line providers affords an opportunity to learn more about the implementation of Treatment First and Housing First programs from an insider perspective, thus shedding light on whether actual practice is consistent with or contrary to these program models’ contrasting philosophical values.

Background

As mental health care shifted from state psychiatric hospitals to the community, the mental health system became inevitably involved in housing as it strove to meet the broader psychosocial needs of consumers (O’Hara 2007). Simultaneously, as many consumers found themselves unable to find stable living in the community and struggling with addictions, they became a significant subgroup within a larger homeless population (Drake et al. 1991), which has received increasing policy attention over the past three decades (Hopper et al. 1997; SAMHSA 2003). In the United States, this has resulted in multiple service systems—mental health, addictions and homeless services—addressing the needs of this hard-to-reach population while having different funding streams and priorities regarding the primary problem needing assistance as well as the most appropriate interventions and outcomes. Housing programs for homeless persons with severe mental illness have been shaped by parallel but interrelated agendas, one devoted to improving mental health and another focused on providing shelter from life on the streets (Hopper and Barrow 2003). This has resulted in housing itself being regarded simultaneously as an input or an intervention (i.e. appropriate housing leads to better clinical outcomes) and an output or an outcome (i.e. adequate supports and treatment will lead to housing stability) (Newman 2001).

Although Treatment First positions permanent housing as an output or outcome, such programs consistently combine housing and treatment services under a single roof with service providers, usually in the form of case management services, located on-site. Consumers must then ‘graduate’ through a series of placements typically starting with drop-in centers or shelters, through transitional housing, and finally into permanent housing (Kertesz et al. 2009; Wong and Stanhope 2009). For successful consumers, permanent housing can be independent apartments or apartments in a building inhabited by people with psychiatric disabilities. If a consumer relapses, becomes unstable, or chooses not to follow

rules necessary for congregate living, in most cases he or she cannot remain in the program, which by default entails sacrificing one's current housing.

In contrast, the Housing First model positions permanent housing as an input or intervention, and essentially "unbundles" housing and services. Support services, usually in the form of ACT teams, are located off-site, but are available on-call 24 h a day, 7 days a week and most services are provided in the consumer's natural environment (e.g. apartment, workplace, and neighborhood). The service is time-unlimited in that it is offered as long as a consumer needs that level of support. Access to housing is not contingent on sobriety or participation in psychiatric treatment, although limited program requirements include that consumers pay 30% of any income toward their rent and meet with team members on a regular basis. Achieving housing stability is accepted as an ongoing task for many clients and they can risk losing housing due to lease violations. Accordingly, Housing First providers are still very much focused on the housing process, either working with clients to prevent housing loss or in the event a client loses their housing, there is a strong commitment to rapid rehousing.

For those providing and receiving services, the relationship between housing and support services is interrelated and highly complex, making the distinction between housing as an input or an output less clear. For example, although the clinical justification for the continuum approach has been described as consumers needing to acquire the requisite skills for independent living (Sylvestre et al. 2007), it can be argued that the approach is also shaped by the belief that consumers "earn" housing by demonstrating their moral worthiness (Dordick 2002; Kertesz et al. 2009). This belief that public benefits should in some way be earned by those deemed worthy is deeply embedded within US social welfare policies (Trattner 1998). It is unclear, however, to what extent Treatment First providers hold this belief and how they may perceive their role as 'gate keepers' to permanent housing.

The Housing First model, on the other hand, is based on a principle of consumer choice, (Tsemberis et al. 2004; Tsemberis et al. 2003). In this model, housing is considered a "right" from a value perspective as well as a prerequisite to achieving mental health stability from a clinical perspective. Support services have also been described as striving to respect consumer choice in terms of organizing services around consumer driven goals (Salyers and Tsemberis 2007). Although the Housing First model was not developed explicitly as a recovery-oriented practice, its approach is consistent with recovery principles that are currently informing mental health reform in the United States (New Freedom Commission on Mental Health 2003), namely: (1) consumer choice and self-direction, (2) person-centered care, (3) empowerment, and (4) personal responsibility (Onken et al. 2007; SAMHSA 2006). The extent to which Housing First providers endorse a consumer-driven approach, however, has not been empirically investigated, even if immediate access to permanent housing was initially a consumer-driven design.

In addition to investigating how front-line providers might differently implement their program models, the issue of whether coercion is a part of either model is also an important consideration given the mandate for a more recovery oriented system (New Freedom Commission on Mental Health 2003). Treatment First, for example, has been characterized as "leveraging" an offer of temporary housing and the promise of future permanent housing in exchange for medication adherence, abstinence, and observation of rules (Allen 2003; Robbins et al. 2006). This inherent power dynamic could lead to coercive practice that is inconsistent with a recovery orientation. Despite program values mitigating against coercion in Housing First, specifically a separation of housing and treatment, little is known about how providers actually carry out their responsibilities in such programs. It is important to consider, therefore, the degree to which providers in either program use housing as a tool for treatment compliance especially within an era of recovery.

Drawing upon in-depth interviews with front-line providers working in both Housing First and Treatment First programs, and using the program type as the point of comparison, this study investigates provider perspectives on the provision of services within both a Housing First and Treatment First approach. Specifically, this study will address the following questions: what do providers see as the role of permanent housing in the delivery of services? How does the process of accessing permanent housing affect providers' relationships with clients? How do front-line providers articulate and translate their programs' values and philosophy pertaining to permanent housing?

Methods

Sampling

The 41 front-line providers included in this study were part of the New York Services Study, a longitudinal qualitative study of new consumer enrollees of programs serving homeless adults with co-occurring psychiatric and substance use disorders. Twenty providers were from a program that used the Housing First model and 21 providers came from three other programs that were part of the residential continuum "Treatment First" model. Providers were recruited through their client's participation in the study. 83 clients were initially recruited by inviting all new enrollees to these programs to participate in the study during a 1 year recruitment period (individuals without DSM Axis I diagnoses and a history of substance abuse were excluded). One client declined enrollment due to privacy concerns. All other participants gave informed consent to be interviewed and to have their provider at the program be interviewed—all of whom consented. Both client and provider participants were paid $30 per interview and all study protocols were approved by the authors' university institutional review board.

Data Collection Procedures

Study protocols included multiple in-depth interviews with providers: baseline interviews within a month of their client's enrollment in the study and follow-up interviews either six-months later or when their client left the program, whichever came first. Although 83 clients initially enrolled in the NYSS, only 57 clients required follow-up provider interviews since many clients, all of whom were from TF programs, had already left their program at the time of the baseline provider interview. In total, the 41 providers participated in 129 interviews (79 baseline and 50 follow-up). Of the 57 clients who stayed in programs long enough to require a follow-up provider interviews, staff turnover resulted in only 37 clients having the same provider complete both baseline and follow-up interviews, with turnover equally affecting Housing First and Treatment First programs (65 vs. 66%, respectively). Even with a small provider sample, significant group differences found HF providers to be predominantly white compared to higher percentages of African-Americans and Latinos providers in TF. Although not significant, there were also higher percentages of graduate level providers within the HF program (see Table 1).

Semi-structured interviews were conducted by four trained interviewers familiar with the mental health service system usually in a private office at the provider's agency. The interviews lasted approximately 30–45 min, with interviewers asking providers both general questions about their work experience, as well as client-specific questions, including a detailed description of their most recent interactions with their client. Interviewers were trained to ask additional probing questions based on providers' answers. Some of the questions included: what is working here like for you? What's your approach to working with clients who have serious mental illness along with substance use disorders? How would you describe your relationship with (specific client enrolled in the study)? What are your

expectations for (client x) and do you think he or she will meet them? All interviews were transcribed verbatim and entered into ATLAS/ti software.

Data Analysis

Thematic analysis (Boyatzis 1998) was utilized to compare the views of providers working in Housing First versus Treatment First programs. Following Boyatzis, this process included: (1) generating codes to be attached to similar quotes or topics across transcripts for data reduction; (2) revising these codes to become themes that fit with the nature of the data through identifying and comparing similar ideas across transcripts; and (3) determining the reliability of the codes and themes by identifying both positive and negative examples or qualifications to the themes.

For this study, the analyses, including the development of a code book, centered on key issues related to housing (acquisition and/or retention), program philosophy, and coercion or consumer choice. Initially, the first two authors independently coded close to half of the transcripts ($n = 59$) and then compared results in order to reach a consensus about the appropriateness of assigning a particular code to a given passage or quote and on the nature of the themes emerging from the data. Ongoing memo-writing was used in the development of these themes that allowed for the exploration of ideas and the documentation of analytic decision. The resulting themes were then tested against the remaining 70 transcripts in order to further refine and/or revise them by identifying supporting and negative cases found in the raw data of the transcripts, making sure that multiple transcripts from the same provider were not exclusively used in the testing of themes to avoid relying on a single provider's experience. ATLAS.ti software was used in this process to help separate and sort coded material based on program type and the nature of each theme. Several strategies for rigor were employed including prolonged engagement with study participants, peer-debriefing within the data collection and analytic processes, independent and co-coding of transcripts, refinement of themes through negative case examples, and the use of memo-writing to aid in the development of ideas as well providing a decisional audit trail (Padgett 2008).

Results

The following three themes related to housing emerged from provider interviews. These themes both reflect and articulate differences between Housing First and Treatment First program models.

The Centrality of Housing

Housing First (HF) providers viewed housing as a necessary but not sufficient step toward independent living. As one explained,

> It's a hierarchy of needs. You have to house people before you expect them to work on life-changing things, like becoming sober or getting back together in a relationship or going to see a doctor regularly. And you can't really ask people who are living on the street or in shelters to do that. It's just too chaotic.

Another provider echoed these sentiments, stating,

> The primary need that needs to be addressed is housing, and that those other needs are also secondary to the very basic and essential need for shelter. And I think that it's…the more they do this, the more I can 100% see the logic of that.

Providers' endorsement of this approach was often based on the changes they witnessed after the consumer moved into their own apartment, "*We've had actually in the last month or so three people who were doing much better with their substance use. One client in*

particular has gotten out of detox…kind of straightened himself out." Overall, as one HF provider explained, "*Getting the housing support as a first kind of platform in their recovery is really a unique thing as far as my experience in doing this type of social service work*."

Even though Treatment First (TF) programs are based upon a premise that treatment is the primary intervention, front-line provider efforts were mostly focused on accessing housing placements that would move consumers to the next level of the continuum. TF providers invested significant time coaching consumers through the housing placement and referral process. One provider describes the process,

> We hold groups, we do role-play for [housing] interviewing…'this is what you can expect, this is what they're looking for.' I teach them things like body language, eye contact, how to be honest without being too honest. How not to lie but minimize. For instance, we have some clients here that don't really believe they're mentally ill, and they're housing ready. I tell them that it's ok to say that you don't think you have a mental illness. However, [I tell them] you have to add to that, 'but my psychiatrist says I have this.' And they'll ask you how you feel on your medication, and as long as you say it helps you and makes you concentrate better.

Some TF providers did endorse the importance of developing independent living skills as "*giving people life tools, which will keep them in housing*", but clearly prioritized housing placements, "*we are here to place you in housing so you can be stable, and end this history of homelessness*", defining their work almost entirely in terms of "*having housing; that's the goal of the program*."

The emphasis on housing placement within TF programs often overshadowed clinical concerns. One provider focused on housing spoke about his client's mental health status, "*He didn't appear to be a threat to himself or others (laughs). That's all I can say about that*." At times, suspicions of substance use were downplayed for fear that it might jeopardize a consumer's housing application. As one provider explained," *So we really didn't know that she–you know, we suspected it* [*drug use*] *but I don't think we really pursued it because we didn't want to lessen her chance of getting housing*. Other aspects of consumer's lives also presented obstacles to housing placements. As one provider explained, *"It's really their backgrounds that make it the hardest. If there's any arson, forget it. If there's a murder, and it's documented, I'd say almost no chance. If it had happened and it's not documented, I won't say anything."* Another summed it up this way,

> if you really look at this whole thing, the client is a commodity. And you are here to sell that client. That's the big picture…So, I'm a salesman, and that's the product, and that's the way I see it. I have to do whatever I can to sell the product.

Whether or not they went as far to "commodify" their clients, TF providers' success was ultimately defined by gaining access to the next step in the housing continuum.

Engaging Consumers Through Housing

Within HF programs, immediate access to housing with few strings attached was viewed as a potentially useful way to engage consumers. One provider explained that HF,

> creates a much more firm foundation for creating a clinical relationship with someone and establishing trust with someone because it is all about the trust, when you immediately get the person housing. Because automatically, you have something that you're offering them, and doing that, especially in doing that in a way that says, also no strings attached.

It was also viewed as enhancing trust and candor:

> It completely changes the nature of the relationship to the person, and people will open up to you in ways that they wouldn't otherwise. Because insofar as you have to hide your drug use, you might be inclined to hide this aspect of your life and that aspect of your life, and once people feel as though they have to hide certain things, it turns into a slippery slope.

One HF provider mentioned that the separation of housing and services "*definitely appeals to me because it seems a much more realistic approach to getting people to join in on their treatment plan and cutting away the hierarchy of patient versus clinician*." Others talked about the clinical utility of working with consumers once they have independent housing, "*It makes it a lot easier for the participants, and more exciting for us because we get to see people in their own environment, which is a lot easier clinically to assess people when they're in their own surroundings*."

HF case managers were still concerned about consumer perceptions that there were strings attached to their housing despite efforts to reassure them otherwise. As one CM explained,

> He might feel that we will shut down his apartment if he's not doing well, which I think we try our hardest to tell people that that's not really the case, that apartments only get shut down due to behavioral things that threaten the apartment, not necessarily just because of drug use or just because of something like not taking medication or something like that. Um, but I think people just in general, people feel that that's a real threat.

Even the offer of immediate access to permanent housing itself was sometimes met with skepticism that had to be overcome,

> He was excited about the prospect of moving into his own apartment. Most people's reactions are like his, which was he didn't believe that we were offering him an apartment. He was excited to get back on his feet …but there just seemed to be a wall, and I didn't know what that was or if it was just 'Here comes another social worker with another promise.'

Nevertheless, most agreed that "*housing first is really essential to the relationships that we're able to develop with our participants*."

The fact that TF providers served the role of both facilitator and gatekeeper often led to engaging consumers through the promise of housing. One provider explained of his consumer, *"Yeah, he's not going to volunteer [to comply with program expectations] if we don't have any leverage, except with the housing."* TF providers were more likely than HF providers to discuss discretionary power as part of their job. One TF provider admitted, *"I said fine, I can't force you into this housing program, but I'm taking you off my priority list as far as getting you housing."* Using housing as leverage within these TF programs was viewed as part of the larger continuum that providers were working within. In discussing what happens when consumers choose not to take medication,

> Then, I would basically tell them something like, if that's the case, you need to decide where you're gonna live. Because I'm not gonna be able to get you housed unless you're psychiatrically stable. And if I'm not gonna be able to get you housed, you're not gonna stay here very long because I only have [a certain amount of] beds…And I tell all the clients if they're not serious, don't waste my time.

The receipt of housing, therefore, played a role in how both HF and TF providers engaged with and related to their consumers but for the former it was a way to build trust and for the latter a way to leverage engagement in treatment.

(Limits to…) A Right to Housing

Within TF programs housing was regarded as something consumers must earn by demonstrating themselves to be "housing ready." As one provider explained,

> He proves himself by being in this program for many days, participating, actively participating, providing clean urines, and showing that we can give him the housing. … So he needs to show that he can be trusted in an apartment by himself.

For TF providers, earning housing was understood as demonstrating the ability to be sober, engaged in treatment, and successfully adapt to congregate settings. As one TF provider explained, *"Once he's there, he's living with other people, and that's helping him work on his social skills…how to live with others and getting along with others. And if he does well with that, he will move on."* The process of earning housing takes time, as another provider stated, *"We make it very clear that you can't just come in and next month, you're gonna have housing."* Another provider tried to sum it up *"I know it is not easy but sobriety and patience are the two key ingredients for finding housing."*

On occasion, positioning access to housing as something to be earned or a privilege caused some providers to question the wisdom of the overall approach, with one stating, *"I think that the whole system is inherently flawed because if it wasn't the people wouldn't need to go to treatment so many times."* Another opined, *"I think that these kinds of places are inherently revolving doors…I don't know if there needs to be a total revamping of the rules or if there needs to just not be any or change some of the rules that they have…"* Overall, however, TF providers valued their work and the system because some clients did find stable housing, *"it's not a revolving door for everyone."*

When HF providers were asked if consumers are housing ready when they come to the program, a more typical response included, *"Well, 'housing ready' just means we have an apartment ready for you here. It's the Housing First model."* HF providers articulated a view of housing as a basic right, not something to be earned. One provider stated,

> The reason why I'm here [at the agency] is because we have a very strong Housing First mission where we believe that everyone has the right to have their own apartment and live independently whether or not they're taking meds or sober or what have you.

Several HF providers explained how the model changed their thinking regarding the issue of access to housing. As one provider explained

> Coming to [HF agency] changed my perspective on everything because I worked at a drug TC [therapeutic community] program before, where abstinence is definitely a must before they even try to get you housing…

Another HF provider stated,

> You know when I'm doing outreach and I'm showing apartments, I'm not showing them the apartments thinking, "Oh, shit, in two weeks they're gonna relapse and I'm gonna have to take them out." I don't ever have to think that way, never, never, never, never. …and I would never work on an ACT team where there wasn't housing included. I just wouldn't.

While HF providers predominantly supported the idea that consumers have a right to housing, there were a few instances when someone questioned whether independent housing should be an absolute right,

> the most tragic ones are when you move someone into an apartment, and it becomes a drug den. So you have to figure out a way to help that person to maintain that apartment, and if they can't…

Determining when this point came was difficult, but for some of the HF providers there were clear cases where the model did not work,

> I don't see the value in somebody having six apartments [moving due to tenancy problems] unless it warrants that. But I don't see the value in people who are using drugs to the point where their neighbors are afraid to walk up the stairs, and people are busting into other apartments.

Overall, however, HF providers agreed, "*I really align with the agency's mission*", while another provider pointed out, "*from a philosophical standpoint, I definitely can endorse the model in terms of the practical day to day…and I personally enjoy it.*"

Discussion

Despite working in programs operating from very different philosophical premises, both Treatment First and Housing First providers gave top priority to housing as the key component of their role. However, due to the differing program structures, this priority had very different implications for front-line practice. Ironically, while the Treatment First program model positions clinical deficits as the primary target of intervention and Housing First's primary target as homelessness, the inverse was true when one examined front-line provider practice. Treatment First providers were consumed with the pursuit of housing, whereas Housing First providers were able to focus more on clinical concerns since consumers have already obtained permanent housing. For Treatment First providers, the pressures of having consumers comply with the conditions necessary to secure housing placements led case managers to focus more on ways to maneuver through the system rather than addressing consumers' specific clinical needs. The pressure of the continuum model even encouraged some Treatment First providers to overlook or not address mental or substance use problems since making them explicit could jeopardize a consumer's chances of moving on into more permanent housing placements. The model, in effect, created disincentives for providers to concentrate on clinical concerns that may impede a consumer's longer term recovery. In fact, most providers expected that while these programs would be effective for some consumers, many would fail and cycle in and out of services.

In contrast, Housing First providers, viewed immediate access to permanent apartment living as an effective means to engage consumers and establish a trusting relationship. Despite the fact that sobriety and treatment were not required by the program, Housing First providers appeared more likely or open to working on these goals both because accessing permanent housing was not a preoccupation and because consumers could be more open with providers without risking the loss of housing. Maintaining housing stability was still a priority for Housing First providers, and the few consumers who could not do that (usually attributed to severe substance abuse) caused some to question the effectiveness of this model for all consumers.

A key difference between programs was that Treatment First providers had to juggle the role of gatekeeper and advocate for their clients. This tension was apparent since success was ultimately defined by housing placements yet from a values perspective providers endorsed the idea that consumers must 'earn' housing through good behavior. This value orientation, which reflects the dominant social discourse surrounding 'worthiness' and not 'getting something for nothing', contradicted Treatment First providers' efforts to 'work' the system in order to increase consumers chances to access housing. Rather than fostering collaboration with consumers, however, providers' efforts often resulted in the increased use of discretionary power as they attempted to motivate consumers to act in a manner that made attaining housing more likely. This influenced the clinical relationship between providers

and consumers by bringing in the potential for coercion, which was often perceived as the only way to coax consumers through the system.

The room for discretionary power in Housing First was lesser due to consumer choice being an integral part of the program structure, but still providers were cognizant of the consumer perception that housing could be used as leverage for treatment compliance. Interestingly, they expressed the need to assure consumers that they were not subject to the rules they had experienced in other programs. In fact, Housing First providers had experienced working within both systems and came to explicitly endorse the Housing First approach both in terms of values and effectiveness, whereas Treatment First providers did not comment on the Housing First approach making it unclear whether they were aware of an alternative model. Overall, Housing First and Treatment First providers had outlooks that were largely consistent with their respective program philosophies, raising the importance of organizational context in shaping providers' approach to working with consumers, while also bringing up the question as to whether providers self-select an agency whose values are consistent with their own.

Limitations

The purpose of this study was to examine the views of two groups of providers who work within very different service models that combine housing and services for people experiencing homelessness and severe mental illnesses. The use of qualitative inquiry and thematic analysis allowed for insight into providers' perspectives, attitudes, and orientations that is not intended to be generalizable to all service settings. Nevertheless, relying exclusively on what providers say rather than observing what they do leaves a potential 'gap.' In addition, given the scope of the study to compare provider perspectives within different organizational models, the issue of how variations in provider or client characteristics affected provider perspectives was not addressed, and would have been limited by a small provider sample. With that caveat, it is important to recognize that some of the variation in themes may reflect differences in the type of service structure (ACT vs. individual case management) along with other group differences that may have affected provider perspectives and attitudes about the role of housing. Housing First providers who were part of an Assertive Community Treatment team were more likely to be white and have a Masters level degree that is often required for ACT licensing. Treatment First providers working with individual caseloads in case management services were more likely to be either African-American or Latino and have a Bachelors or Associate level degree. While noting that previous research has shown consumers and providers often have discrepant preferences about appropriate housing arrangements (Piat et al. 2008), the specific scope of this study did not incorporate consumer perspectives from within these two program models.

Implications

In both Housing First and Treatment First programs, housing and services are brought together in order to improve client outcomes. Clearly, positioning permanent housing as a service input or as a service outcome has very different implications for how providers understand their work, the pressures they encounter, and how they prioritize client goals. Providers within Housing First appear less constrained by system demands and are able to demonstrate many of the elements of a recovery orientation, notably consumer choice, minimizing coercion, and individualized services (New Freedom Commission on Mental Health 2003). This recovery orientation and Housing First's growing evidence base has led to the program's increasing adoption throughout the United States and internationally.

However, there are many unanswered questions about the implementation of Housing First in diverse geographic areas and service systems. Also, as Treatment First continues to be the

dominant service paradigm (Leff et al. 2009; Locke et al. 2007), there remain questions about what aspects of the traditional model should be preserved or modified to make services more effective, with the most significant issue being how to permit providers to actually focus on consumers clinical problems through effective treatments. In this vein, focusing on how these models are implemented within the context of front-line practice can provide valuable answers (Stanhope et al. 2009). This study revealed the way in which program structure can translate in unexpected ways in front-line practice as providers attempt to be effective within the constraints of the system. Also, the successful uptake of new or revised models depends on the receptivity of providers to these approaches. The likelihood of adopting new practices, especially evidence-based practices, is significantly higher when an intervention model is compatible with adopters' current values and when 'users' (front-line staff) are considered as well as 'choosers' (policymakers or administrators) (Dearing 2008). Successful dissemination of evidence based and recovery-oriented practices will require careful attention to the core tasks of front-line service provision and how these providers enact program philosophies and structure.

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References

Allen M. Waking Rip van Winkle: Why developments in the last 20 years should teach the mental health system not to use housing as a tool of coercion. Behav Sci Law. 2003; 21(4):503–521. [PubMed: 12898505]

Bond G, Drake RE, Mueser K, Latimer E. Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. Review article. Disease Management and Health Outcomes. 2001; 9:141–159.

Boyatzis, RE. Transforming qualitative information: Thematic analysis and code development. Thousand Oaks: SAGE; 1998.

Dearing JW. Evolution of diffusion and dissemination theory. Journal of Public Health Management and Practice. 2008; 14(2):99–108. [PubMed: 18287914]

Dordick GA. Recovering from homelessness: Determining the "quality of sobriety" in a transitional housing program. Qualitative Sociology. 2002; 25(1):7–33.

Drake RE, Osher FC, Wallach MA. Homelessness and dual diagnosis. American Psychologist. 1991; 36:1149–1158. [PubMed: 1772152]

Hopper K, Barrow SM. Two genealogies of supported housing and their implications for outcome assessment. Psychiatric Services. 2003; 54(1):50–54. [PubMed: 12509666]

Hopper K, Jost J, Hay H, Welber S, Haugland G. Homelessness, severe mental illness, and the institutional circuit. Psychiatric Services. 1997; 48:659–665. [PubMed: 9144820]

Kertesz SG, Crouch K, Milby J, Cusimano RA, Schumacher J. Housing First for homeless persons with active addiction: Are we overreaching? The Milbank Quarterly. 2009; 87(2):1–52.

Leff HS, Chow CM, Pepin R, Conley J, Allen IE, Seaman CA. Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. Psychiatric Services. 2009; 60(4):473–482. [PubMed: 19339322]

Locke, G.; Khadduri, J.; O'Hara, A. Dennis, D.; Locke, G.; Khadduri, J., editors. Housing models. National Symposium on Homelessness Research. 2007. Retrieved July 20, 2008, from http://aspe.hhs.gov/hsp/homelessness/symposium07/locke/index.htm

Matejkowski J, Draine J. Investigating the impact of housing first on ACT fidelity. Community Mental Health Journal. 2009; 45(1):6–11. [PubMed: 18563563]

New Freedom Commission on Mental Health. DHHS Pub. No. SMA-03-3832. 2003. Achieving the Promise: Transforming Mental Health Care in America. Final Report.

Newman SJ. Housing attributes and serious mental illness: Implications for research and practice. Psychiatric Services. 2001; 52(10):1309–1317. [PubMed: 11585940]

O'Hara A. Housing for people with mental illness: Update of a report to the President's New Freedom Commission. Psychiatric Services. 2007; 58:907–913. [PubMed: 17602005]

Onken SJ, Craig CM, Ridgway P, Ralph RO, Cook JA. An analysis of the definitions and elements of recovery: A review of the literature. Psychiatr Rehabil J. 2007; 31(1):9–22. [PubMed: 17694711]

Padgett, DK. Qualitative methods in social work research. 2. Los Angeles: SAGE; 2008.

Padgett DK, Gulcur L, Tsemberis S. Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse. Research on Social Work Practice. 2006; 16(1):74–83.

Piat M, Lesage A, Boyer R, Dorvil H, Couture A, Grenier G, et al. Housing for persons with serious mental illness: Consumer and provider preferences. Psychiatric Services. 2008; 59(9):1011–1017. [PubMed: 18757594]

Ridgway P, Zipple AM. The paradigm shift in residential services: From the linear continuum to supported housing approaches. Psychosocial Rehabilitation Journal. 1990; 13(4):11–31.

Robbins PC, Petrila J, Le Melle S, Monahan J. The use of housing as leverage to increase adherence to psychiatric treatment in the community. Administration and Policy in Mental Health and Mental Health Services Research. 2006; 33(2):226–236. [PubMed: 16520904]

Rog DJ. The evidence on supported housing. Psychiatr Rehabil J. 2004; 27(4):334–344. [PubMed: 15222146]

Salyers MP, Tsemberis S. ACT and recovery: Integrating evidence-based practice and recovery orientation on assertive community treatment teams. Community Mental Health Journal. 2007; 43(6):619–641. [PubMed: 17514503]

SAMHSA. National Consensus Statement on Mental Health Recovery [Brochure]. 2006. Retrieved May 2, 2010 from http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

Stanhope V, Henwood BF, Padgett DK. Understanding service disengagement from the perspective of case managers. Psychiatric Services. 2009; 60(4):459–464. [PubMed: 19339320]

Substance Abuse and Mental Health Services Administration (SAM-HSA). DHHS Pub. No. SMA-04-3870. Rockville, MD: 2003. Blueprint for change: Ending Chronic Homelessness for persons with serious mental illnesses and co- occurring substance use disorders.

Sylvestre J, Nelson G, Sabloff A, Peddle S. Housing for people with serious mental illness: A comparison of values and research. American Journal of Community Psychology. 2007; 40(1–2): 125–137. [PubMed: 17587174]

Trattner, WI. From poor law to welfare state: A history of social welfare in America. 6. New York: Free Press; 1998.

Tsemberis SJ, Moran L, Shinn M, Asmussen SM, Shern DL. Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. American Journal of Community Psychology. 2003; 32(3–4):305–317. [PubMed: 14703266]

Tsemberis S, Gulcur L, Nakae M. Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health. 2004; 94(4):651–656. [PubMed: 15054020]

Wong YLI, Stanhope V. Conceptualizing community: A comparison of neighborhood characteristics of supportive housing for persons with psychiatric and developmental disabilities. Social Science and Medicine. 2009; 68(8):1376–1387. [PubMed: 19251346]

Table 1

Demographic characteristics of provider sample

	Housing First, *n* = 20	Treatment First, *n* = 21	Total *n* = 41
Gender			
Male	9 (45%)	7 (33%)	16 (39%)
Female	11 (55%)	14 (67%)	25 (61%)
Race/ethnicity			
White	12 (60%)	6 (29%)	18 (44%)
African-American	5 (25%)	9 (43%)	14 (34%)
Latina/o	1 (5%)	6 (29%)	7 (17%)
Other	2 (10%)	0	2 (5%)
Length of employment			
< 1 year	6 (30%)	9 (43%)	15 (37%)
1–3 years	6 (30%)	7 (33%)	13 (32%)
> 3 years	8 (40%)	5 (24%)	13 (32%)
Highest educational degree			
Graduate	13 (65%)	7 (33%)	20 (49%)
Bachelor	4 (20%)	9 (43%)	13 (32%)
Associate	2 (10%)	5 (24%)	7 (17%)
High school	1 (5%)	0	1 (2%)
Previous experience with similar client population			
Yes	16 (80%)	16 (76%)	32 (78%)
No	4 (20%)	5 (24%)	9 (22%)