

Advantages of Housing First Rehousing Strategy for the Chronically Homeless

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Professor Brotzman

Jacqueline Carson

Abstract: Since the 1980s, chronic homelessness, a subset of homeless who have experienced long-term homelessness and suffer from a disability, has increased dramatically. The dominant methodology within the past few decades to house these individuals has been a treatment first Continuum of Care model. This model requires its clients to treat their health issues and become sober in order to obtain and maintain their housing. Another model, Housing First, has been increasing in popularity over the past few years. It prioritizes getting clients into housing before treatment, arguing that their health issues that plague them will become easier to treat after the stress of being homeless is eliminated. By examining the core methodologies and previous studies on the two methodologies, I argue that Housing First is superior to traditional Continuum of Care models because it has higher retention rates, is more cost effective, and is ethically superior.

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After food, the next necessities of life and labour are clothing, house-room and firing. When they are deficient, the mind becomes torpid, and ultimately the physical constitution is undermined.— Alfred Marshall

Introduction:

_____ With over 550,000 homeless individuals each night in the United States, homelessness has become a massive public health problem; individuals experiencing homelessness are subject to physical violence, mental health issues, increased incarceration, and sexual assaults. Since the 1980s, homelessness increased in numbers across the nation. It has left policy makers with the question of “how are we going to care for all of these individuals?” Over the past few decades, the treatment first Continuum of Care methodology of rehousing has been the predominant answer to this question. This methodology assumes that the cause of each individual’s homelessness is the health deficits that plague them. Thus, the health problems are addressed first, and must be consistently maintained in order to reach permanent housing. Another rehousing methodology, the Housing First model, operates under a different assumption. These programs presume that the state of homelessness itself exacerbates the health problems that each individual is experiencing. Thus, housing is targeted first. Housing First models simply give the homeless a home without conditions of treatment compliance or sobriety. The Housing First concept is simple but it works. Over the course of this paper, it is argued that the Housing First model is the better of the two methodologies for rehousing the homeless. This is because it effectively ends homelessness, is ethically superior, and is more cost efficient.

Definition of Homelessness in America:

University of California Berkeley Professor of Economics, Erin Mansur, described homelessness as “the most visible social problem in contemporary US metropolitan areas” (Mansur et al. 2001). While the problem is most striking in urban areas, homelessness is

everywhere. All races, genders, and ages can experience homelessness. While the homeless vary in characteristics, over 40% of the homeless suffer a disability (mental or physical) and abuse substances (Henry et al. 2015). Research from point-in-time estimates finds that 38 percent of homeless people were dependent on alcohol and 26 percent abused drugs, making substance abuse much more common among homeless people than the general population (National Coalition for the Homeless 2009). The homeless in America live an extremely stressful existence. They are exposed to the extremes of weather, are vulnerable to violence, placed in life threatening situations, are harassed, and have acute and premature mortality (Barrow et al. 1999)¹. The constant exposure to stressors leads to, as Hopper et al. 1997 claims, “adverse effects on physical, psychological, social, economics, legal, and spiritual well being; surviving day to day tasks become challenging.”

There is great variation in the incidence of homelessness but research suggests on any given night in the United States as of January 2015, there are 564,708 people experiencing homelessness. 69 percent of these people stay in a homeless residential program (emergency shelter, transitional housing, etc.) and 31 percent are in unsheltered locations . 206,268 are people in families with children - 36 percent of all homeless people. 23 percent of all homeless individuals are children under the age of 18. Nine percent are between the ages of 18 and 24 while 68 percent were 25 years or older. Approximately 8 percent of the homeless are veterans, 10% of which are women. 15% (83,170) experience chronic homelessness, defined as an individual who has a certifiable disease and has been continuously homeless over a period of two

¹ This study was first examined in Tsemberis, S.,(Ellen, I., O’Flaherty, B.) Chapter 3:Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010.

years. 12,105 of the chronically homeless are in families with children². A vast majority of the homeless grew up in poverty themselves; low-income households have limited resources and affordable housing is not abundant, making them more prone to homelessness. (National Coalition to End Homelessness, 2015, Burt & Cohen). 11.2 million extremely low-income households compete for 7.3 million units affordable to them. Further, only a quarter of eligible very low-income households received rental assistance (Charette et al. 2015). It is important to note that all of these statistics are probably underestimates. The population is hard to track and experiences a lot of turnover.

For the first time since the Great Depression, homelessness reappeared as a prominent issue in the 1980s. Pre-1980s, homelessness in America was so small that it was barely reported on. However, there were more than 2 million homeless annually by 1989 (Fennelly 2004). One study that examined the amount of shelter beds in 182 cities determined homelessness rates tripled between 1981 to 1989 (Burt 1997). Since then, homeless rates have continued to increase on average, moving up and down with differing economic trends (The State of Homelessness in America 2015). Increasing poverty and decreasing effectiveness of welfare programs strain low-income households and subsequently increase the probability of homelessness among the vulnerable (people with disabilities and substance use) and the extremely poor (Burt 1997).

There were many additional factors to the increases in homelessness beginning in the 1980s. First, wages went down after an apex in the 1970s. In 1973, the average private, non-supervisory, non agricultural wage peaked at \$9.72, but by 1983, the same worker was paid \$8.76. Housing prices remained steady causing housing to become less affordable as resources were stretched (Carlson, 2015 Homeless 101 ppt). Secondly, funding for federal programs that

² All of these statistics from this paragraph came from the HUD sponsored The 2015 Annual Homeless Assessment Report (AHAR) to Congress (Henry et al. 2015)

aided the poor decreased; between 1980 and 1983, \$140 billion in domestic spending was cut and welfare/support programs were hit very hard. The Department of Housing and Urban Development (HUD) alone went from over \$80 billion to under \$20 billion in a period of five years (Dolbeare and Crowley, 2002). Unemployment and disability benefits, food stamps, and family welfare programs all received budget cuts. (Open House). Funding for individual cities was curtailed, as well. In 1980, federal dollars accounted for 22 percent of large city budgets but by 1989, it was down to six percent. The cuts led to services closing such as urban schools, libraries, and hospitals (Dreier, 2004). All of these assistance programs were helpful at keeping low income individuals above water, keeping the poverty rate at 11.4% in 1978 (Persons Below Poverty Level in the U.S., 1975-2010). Once the programs were cut, housing and other expenses became increasingly difficult to maintain, leading to more homelessness and poverty (poverty rate was 15% by 1982)(Persons Below Poverty Level in the U.S., 1975-2010). As a result, the number of people living beneath the federal poverty line rose from 24.5 million in 1978 to 32.5 million in 1988 (Fennelly 2004). Thirdly, the job market began to shift. The strength of unions started to decline which led to decreased benefits for union workers and service sector workers. A greater share of income had to be spent on expenses that traditionally was covered by the union, such as healthcare (Kiley 2004). Additionally, from 1981 to 1986, “10.8 million (factory) workers lost their jobs due to plant closures, abolition of positions or shifts, or slack work” (Bureau of Labor Statistics,1990). These jobs, which were constant security for many low-income, low-skilled workers, disappeared, leading to increased unemployment for this population. Fourthly, though not causal, deinstitutionalization of the mentally in the 1950s and 1960s led to an increase of vulnerable persons with not enough affordable living arrangements,

adequate treatment and rehabilitative services. This lead to a lack of support and more mentally ill homeless persons (Lamb, 1984).

Homelessness is considered a major public health issue as it contributes to severe mental and physical illness, constant stress, victimization, sexual assault, homicide, poor sanitation, food insecurity and alcohol dependency (Homelessness & Health). Homelessness reduces national productivity and resources. However, most importantly, it hinders an individual's ability to live a dignified life.

The most visible definition of homelessness is a person living on the streets or in a shelter. Less apparent is someone who is staying with relatives or friends temporarily with no alternative. Additionally, a person could also be living out of their car, hotel, or crisis accommodation. These "types" are defined as primary, secondary, or tertiary homelessness by Johnson and Chamberlain (2008) and have been used in some recent literature studying homelessness.

For policy purposes, the Department of Housing and Urban Development (HUD) utilizes a much narrower definition of homeless individuals. HUD defines homeless individuals as "a person sleeping in a place not meant for human habitation (e.g. living on the streets) OR living in a homeless emergency shelter". There are many homeless individuals that are marginalized and excluded from services due to the definitions. HUD's definition means that an individual is not considered homeless if they are staying on a friend's or family member's couch and have no other alternative. A man may sleep at the friend's house once a week and outdoors for the rest of the week, yet if he is surveyed the night after he stayed at the friends house, he would not be considered homeless. This is just one example of how HUD's formal definition excludes many marginally, insecurely, and unstably housed individuals from accessing help and services.

Further, as defined by HUD, an individual experiencing chronic homelessness is defined as “either 1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR 2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years.³” The disabling condition must be verified by a professional before they are eligible for any services geared towards chronic homelessness. While other forms of homelessness exist, this paper will focus on the HUD definition of “chronic homeless.”

People experiencing chronic homelessness tend to be the most difficult to house due to their physical and mental disabilities, making them the most vulnerable individuals in the homeless population. We, as a society, have a duty to protect the vulnerable, as philosopher Robert Goodin argues in his book “Reasons for Welfare: The political theory of the welfare state.” He explains that the government has the political responsibility to prevent the exploitation of the vulnerable, of which the chronically homeless most formidably represent. The chronically homeless are constantly hindered by their own diseases; their life potential can hardly be reached. Research has found that chronically homeless individuals have a life expectancy of only 42-52 years, close to mortality rates of lowest developing countries (Opening Doors Update)⁴. With the increases in chronic homelessness over the past few decades, there has been a call to examine 1) the causes of chronic homelessness and 2) how to effectively care for the population to eliminate the problem. In particular, there has been a focus on rehousing projects which serves as the crux of this paper.

³ U.S. Department of Housing and Urban Development 2007

⁴ This information was first examined in n.d.n.a. “Housing First vs. Traditional Treatment Programs: Why It May Cost Less to End Homelessness than to Manage It” retrieved: <https://resources.oncourse.iu.edu/access/content/group/d7da3068-3d36-477e-8eb7-814d04a0e90f/Model%20Final%20Papers/Literature%20Review/lit%20review%20homeless.pdf>

Re-housing Programs

The dominant methodology for homeless re-housing programs over the past few decades has been the treatment first Continuum of Care model, which traditionally use linear residential treatment practices. Treatment first Continuum of Care agencies have been well developed and adopted in most American cities. They are supported and funded by HUD. The treatment first Continuum of Care model was developed after observing that all chronically homeless experience some sort of mental illness and substance abuse, as defined by HUD. The underlying assumption of the model is cause of homelessness is the personal health problems that plague the individuals, particularly their mental health and substance abuse. Thus, the health problems are addressed before housing is received. The homeless are targeted by outreach workers and transported to a service providing transitional housing unit. They individuals eventually move into Permanent Supportive Housing (permanent housing and continuous assistance from a social worker). In order to obtain Permanent Supportive Housing, each client must adhere to the mental health and substance abuse treatment programs. In other words, the Permanent Supportive Housing is not available to them until they demonstrate continued compliance with health services and achieve an extended period of sobriety. Most of the Permanent Supportive Housing consists of units that include the treatment and social services on site and all the clients reside in the same unit.⁵ If the clients do not maintain their sobriety or discontinue their psychiatric treatment, they are released from the program and lose their housing.

The second methodology is the emerging program, Housing First. Developed by Columbia University professor Dr. Sam Tsemberis in the early 1990s, Housing First takes a

⁵ Information in this paragraph summarized from Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010 pgs. 37-53.

harm-reduction approach. This approach has been gaining popularity over the last decade and has made its way into most American cities, though to a lesser extent than Continuum of Care programs. With Housing First, there are no treatment requirements to obtain or maintain housing. Homeless clients are placed into Permanent Supportive Housing immediately and paired with a social worker to aid their transition. The assumption with the model is that the stresses of not having housing exacerbate the personal health problems, so providing housing first will accelerate the recovery process. It upholds each client's autonomy by not forcing them to comply with a treatment that they do not desire. The only requirement is weekly meetings with their assigned social worker to check-in and evaluate their needs. Intensive case management and services are available in the form of an Assertive Community Treatment team, a group of medical professionals and social workers, who work with their clients to adjust to daily life once housed. All decisions for treatment, however, are client driven.

As opposed to Continuum of Care, all Housing First clients do not reside in one building. Generally, no more than twenty percent of the units in any one building are leased to Housing First clients in an effort to integrate the clients into the community. The only way the clients lose their housing is if they commit a lease violation. Lease violations vary, but commonly include allowing other homeless friends to live in the apartment without paying rent, an excessive number of complaints that lead to police visits, endangering the lives of other residents nearby, etc. A lease violation, however, does not mean that the client is evicted from the program. Instead the client will work with their case manager to identify the problem which caused the lease violation, address solutions to the issue, and are rehoused in a different unit ⁶.

⁶ Information in the above two paragraphs summarized from Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010 pgs.37-53.

It is important to note that treatment first Continuum of Care models of rehousing are not universal; it is simply a methodology. They do not follow a strict set of guidelines for their clients so there is some variability within programs. When treatment first Continuum of Care models are referred in this paper, they are being referenced with the basic methodology in mind. Housing First programs, however, exhibit much more uniformity; generally, all agencies using this methodology adhere to the same parameters.

The remainder of this paper is devoted to comparing the effectiveness of the two methodologies on a number of claims: effectiveness of solving homelessness and rates of retention, ethical philosophies, and cost effectiveness. After examining the programs holistically and reviewing previous studies, I argue that Housing First is more effective in caring for the chronically homeless than the Continuum of Care model.

Housing First directly solves homelessness and has higher retention rates

As Housing First founder Sam Tsemberis said, the Housing First approach “effectively ends chronic homelessness by using a consumer-directed service approach and immediately provides consumers with what they want most: an apartment of their own, free of treatment and sobriety conditions” (Tsemberis 2010). Because Housing First offers housing to its clients with no stipulations to maintaining it, the program maintains high rates of housing retention. It has led to large scale reductions in homelessness. Sermons and Henry (2009)⁷ found after the spread of Housing First programs, between 2005 to 2006, there was an 11.5 percent decrease in the number of chronically homeless. There was another 20.4 percent decrease from 2006 to 2007 in

⁷ This study was first examined in Tsemberis, S.,(Ellen, I., O’Flaherty, B.) Chapter 3:Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010.

major cities, totalling to almost a 30 percent decrease in chronic homelessness in those three years.

Not only are cities seeing decreases in the number of homeless, they are also seeing higher retention rates within the programs. Mares and Rosenheck (2007)⁸ examined seven out of eleven cities that used federally funded Housing First models and found they achieve 85 percent housing retention rates over the first twelve months. The high retention rates continue when studies examine longer time periods, as well. Tsemberis and Eisenberg (2000)⁹ found that over a five year period, 88 percent of Housing First clients remained housed as compared to 47% of clients in Continuum of Care programs. A few years later, studies still show similar retention results. Stefancic and Tsemberis (2007) found that 78% of Housing First clients that were previously chronically homeless in suburban areas remained housed over a four year period. A 2009 study found that 84% of Housing First participants across three different cities remained enrolled in the Housing First program one year after program entry (Pearson et al. 2009).

The time it takes to get clients off the streets or out of shelters and into housing appears to be shorter for Housing First. In a random control experiment comparing Housing First to a Continuum of Care program control group, Tsemberis et al. 2004 found that over six to twenty-four months, clients in the Housing First program spent 60-80 percent of the time in leased housing compared to the 12-30 percent for the control group. The researchers did not see any significant difference in psychiatric or substance abuse outcomes, however. Finally, a HUD sponsored study by O'Hara (2007)¹⁰ studied 28 Continuum of Care programs in the Philadelphia

⁸ This study was first examined in Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010.

⁹ This study was first examined in Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010.

¹⁰ This study was first examined in Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010.

metro area. They found 50 percent of formerly chronically homeless residents stayed in the program for three or more years. Out of those who left, one third went to live independently or went to other living situations, while two thirds returned to homelessness or unspecified locations. Those who returned to homelessness have more severe mental illness, greater incidence of substance abuse, and higher supportive needs (i.e. social services needs) than those who remained housed. In sum, Housing First offers higher retention rates and has led to declines in chronic homelessness since it took effect.

The chronically homeless who are part of Housing First programs have often previously tried and failed to get treatments for their substance abuse or mental health issues, such as intensive care programs at hospitals or substance abuse centers. For example, one treatment program, 1811 Eastlake, opened in 2005 in Seattle, Washington. They took in residents who had severe alcohol problems and had an average of 16 previous substance abuse treatment episodes (Spellman et al. nd.). This is not uncommon. These clients previously have not been successful in housing programs due to their addiction and health issues. They have a hard time maintaining their housing because their illnesses interfere with rational decision making (Tsemberis). Thus, because the treatment first Continuum of Care model is based on the assumption that its clients will make rational decisions, they lose their chance at housing under the program and they return to being homeless. Housing First realizes that clients with addiction problems and mental illnesses do not always make rational decision. By giving them Permanent Supportive Housing with no stipulations, the program is effectively ending the person's homelessness and it closes the gap left under a treatment first Continuum of Care model, where the homeless who fail to remain sober and seek mental health treatment are not able to obtain and maintain housing.

Further, because Continuum of Care programs house their clients in comprehensive housing and treatment units, the programs have far more limited capacity. One study by Lipton (2000)¹¹ examined treatment first Continuum of Care supportive housing programs in New York City. The researchers argue bundling housing and social services puts housing stability at risk. This is because when clients relapsed and were evicted, the program did not have the housing capacity to keep the client enrolled and the programs were unable provide the proper rehabilitary treatment necessary to ensure their client's future sobriety and mental health stability.

One ethical criticism of the Housing First methodology is that it neither properly rehabilitate the homeless nor does it adequately address the cause of their homelessness¹². It's argued that the cause of homelessness is the individual's health problems that plague them and should be addressed to prevent further homelessness. It's argued that Housing First does not accommodate these issues, and thus, is an ineffective means of combating chronic homelessness. To this, I would emphasize that the core word in "Housing First" is "First." The very name of the program denotes that there is more to come after housing. While rehabilitation is not at the initial forefront of the program as it is in Continuum of Care models, it does play a secondary role. Housing First takes a harm reduction approach because so many of the clients have undergone treatment in substance abuse and mental health institutions and failed before. Instead of quitting cold turkey, the program ensures their ultimate safety by providing housing first. Further, each client is required to meet with a staff member once a week to evaluate their needs and wellbeing. All clients have access to 24/7 treatment and support services that are usually provided by partner Assertive Community Treatment (ACT) programs. Moreover, the ordering of the rehabilitation care does not seem to make much a difference. Padgett et al. 2006 found Housing

¹¹ This study was first examined in Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010.

¹² Credit to Caroline Birdrow

First clients do not have any higher rates of alcohol or substance use compared to traditional Continuum of care programs. Thus, if you can not produce beneficial results in terms of rehabilitation, reducing harm becomes the next moral obligation, as is exemplified most by the Hippocratic Oath. When doctors take the Hippocratic Oath, they promise “I will, according to my ability and judgment, prescribe a regimen for the health of the sick; but I will utterly reject harm and mischief” (Paver n.d.). In other words, do no harm. By evicting clients from their programs, the treatment first methodology is not holding up to the standards that the Hippocratic Oath sets for care providers. Housing First, however, meets the Oath’s standards. Similarly, there is inconclusive evidence of the causality between substance abuse and homelessness, and vice versa, further invalidating this argument (McVicar et al. 2015).

Housing First is ethically superior

A key difference between the two methodologies is that Housing First allows its clients to have autonomy in their decision making while Continuum of Care presents limited choice sets with certain consequences to each choice made. Housing First leads to greater independence and choice. Multiple studies have found that the element of choice in housing and services are significant predictors of clients psychological well being (Greenwood et al. 2005, Gulcur et al. 2007)¹³. Housing First allows its clients to set their own goals which allows for greater support for recovery. Treatment first Continuum of Care models assume that their clients cannot make choices or set goals for themselves. Treatment first Continuum of Care programs use an element of coercion by offering housing as a reward. Most experts argue this does not lead to greater

¹³ These studies were first examined in Tsemberis, S.,(Ellen, I, O’Flaherty, B.) Chapter 3:Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010.

compliance (Monahan 2001, Tsemberis)¹⁴. Michael Allen (2003)¹⁵ argues that coercion violates therapeutic alliance and ethical principles of mental health practices.

Housing First offers a Kantian advantage over treatment first Continuum of Care models - it emphasizes autonomy instead of heteronomy. Heteronomous will is “one in obedience to rules of action that have been legislated externally to it. Such a will is always submitting itself to some other end, and the principles of its action will invariably be hypothetical imperatives urging that it act in such a way as to receive pleasure, appease the moral sense, or seek personal perfection” (Kant: Morality 2011). Autonomous will is “self-legislating.” Moral obligations here are imposed simply by oneself and not by external forces. Kant argues that heteronomy limits human freedom which is a basic tenant to morality. Housing First values the autonomy of their clients as exemplified most by not placing restrictions and limitations to obtaining and maintaining housing. Treatment first Continuum of Care models, on the other hand, seem to emphasize heteronomy by forcing their clients to comply with treatment and maintain their sobriety.

It is incredibly immoral to impose standards of proper rehabilitation, as Continuum of Care models do. Instead, Housing First programs allow for each client’s autonomy in their own recovery process. Its founder Sam Tsemberis, says that the program incorporates “a stages of change model and attempts to develop plans with consumers that are consistent with their stage of treatment readiness.” This goal setting allows them to “learn to make better decisions in the future. Experiential learning, in which consumers are supported in making and observing the consequences of their decisions, is one of the cornerstones of recovery” says Tsemberis.

¹⁴ This study was first examined in Tsemberis, S.,(Ellen, I., O’Flaherty, B.) Chapter 3:Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010.

¹⁵ This study was first examined in Tsemberis, S.,(Ellen, I., O’Flaherty, B.) Chapter 3:Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010.

Similarly, Housing First evades paternalism. Paternalism is defined as “the policy or practice on the part of people in positions of authority of restricting the freedom and responsibilities of those subordinate to them in the subordinates' supposed best interest.” Housing First actively avoids paternalism by allowing their clients to make their own choices. Allowing for an individual’s autonomy in their own choices allows them to choose their own best interest, a human right and one of Amartya Sen’s basic human capabilities necessary to live a dignified life. Continuum of Care models, conversely, are by their nature paternalistic. The methodology forces the clients to manage their issues causing their homelessness first before ending their homelessness, denoting that their homelessness is strictly a personal problem that they control. By conditioning the housing, they are inadvertently forcing choices on their clients, an action that is inherently paternalistic and hegemonic.

Housing First avoids social exclusion of their clients by housing them in apartments scattered throughout the city as opposed to the single-unit facilities that traditional Continuum of Care models does. By doing so, Housing First is avoiding the further marginalization of their clients in a society that already looks down upon them. Treatment first Continuum of Care models encourage social exclusion which is the “process in which individuals or entire communities of people are systematically blocked from (or denied full access to) various rights, opportunities and resources that are normally available to members of a different group, and which are fundamental to social integration within that particular group” (Adler School of Professional Psychology). Studies have found that living in single-site, as in traditional Continuum of Care models, housing units led to less social integration (Greenwood et al. 2005, Gulcur et al. 2007). Housing First encourages the opposite of social exclusion - social inclusion - which allows for community support and feelings of belonging. As Iris Marion Young argues,

equal treatment is a primary principle of justice. Assimilation requires that everyone is treated according to the same principles, rules, and standards. She claims, “equality involves full participation and inclusion of everyone in a society’s major institutions, and the socially supported substantive opportunity for all to develop and exercise their capacities and realize their own choices” (Young).

Studies have found that the clients also prefer integration into communities; it allows them to maintain a more dignified life. A study found that clients reported significantly higher housing satisfaction when living in independent scattered supported housing settings as Housing First provides instead of single site community residences (Padgett 2007)¹⁶. Yanos, Barrow, and Tsemberis (2004)¹⁷ found that Housing First clients reported feeling lonely but still preferred living in the scattered units as opposed to congregated single site residences. Further, when the individual leaves the program on his or her own accord (i.e. they are stable enough to live on their own), he or she can keep their apartment in their community and not be forced to find a new neighborhood to assimilate to. By encouraging community integration for their clients, Housing First allows for the eradication of marginalization, equality, and justice served for the homeless, characteristics that Continuum of Care fail to truly offer.

Some may argue that we should not impose basic standards of housing on the homeless.¹⁸ However, individuals participating in Housing First programs give their consent. They want the housing just as badly as the program staff want them to have it. When they consent to participate, there’s no loss in their autonomy. Secondly, the ethical loss of basic necessities autonomy here is outweighed by the program’s success in housing retention and the benefits associated with it.

¹⁶ This study was first examined in Tsemberis, S., (Ellen, I., O’Flaherty, B.) Chapter 3: Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010.

¹⁷ This study was first examined in Tsemberis, S., (Ellen, I., O’Flaherty, B.) Chapter 3: Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010.

¹⁸ Credit to Eric Charette for this counterargument and rebuttals

Further, not being housed leads to many negative outcomes. Being housed, even when not in treatment, leads to fewer vulnerabilities and negative outcomes than homelessness itself. Thus, the imposition of basic standards of housing is overcome by the many benefits that Housing First offers. Even if this was a valid argument, out of the two programs, Housing First does a far better job at maximizing the most amount of autonomy for each client than Continuum of Care programs. Again, Housing First avoids paternalism unlike treatment first Continuum of Care models. Instead, treatment first Continuum of Care models exemplify paternalism by forcing their clients to comply with treatment in the mental health and substance abuse deficiencies against their will. Thus, Housing First remains ethically superior to Continuum of Care models.

Overall, Housing First is morally and ethically stronger than Continuum of Care models because 1) it give its clients more autonomy in their choices, 2) it does not involve coercion, and 3) it preserves alliances between the client and the service providers and 4) promotes social inclusion, not exclusion.

Housing First is More Cost Effective

First and foremost, both Housing First and Continuum of Care programs are more cost effective than not housing the homelessness. In their study, Rosenheck et al. 2003¹⁹ randomly assigned homeless veterans with severe mental illness to one of three programs: supportive housing and case management, just intensive case management, and standard VA care (consisted of short-term broker case management as provided by Health Care for Homeless Veterans program outreach workers). They found that those placed in supportive housing had significantly

¹⁹ Information in this paragraph summarized from Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010 pgs. 37-53.

more days in stable housing than either of the other two groups. Due to cost offset from reduction in acute services used, the net cost was only \$2,000 per unit per month.

In another study, Culhane (2008) and Wong et al. (2005) examined the costs of the Permanent Supportive Housing program versus no intervention. They found the average cost of housing the chronically homeless in shelters is on average \$13,000 per person per year across eleven cities in the United States. Combining this with outpatient services for chronically homeless individuals with severe mental illness (such as hospitalization, criminal activity, crises services), the cost is upwards of \$40,500 per person per year. These costs do not include the non-monetary unmeasured costs to being homeless including feelings of dehumanization, social isolation, and violence susceptibility. The researchers found when the same group was provided Housing First, combined rent and services costs ranged from \$17,000 to \$24,000 per year (services were provided off-site, but clients had 24/7 access to them as is traditional of Housing First programs). Further, Larimer et al. 2009²⁰ studied the chronically homeless in Seattle over a two year period and found that in the year before entering Housing First program, the median costs for each individual were \$4,066 per month. In the six months after enrollment, costs were reduced to \$1,492 per month. After twelve months, the costs were \$958 per month. Cost reduction equaled \$42,964 per person per year and the net cost savings totaled to \$29,524 per person per year. Compared to the control group after six months, the benefits of the Housing First program offset the cost by a net \$2,449 per person per month(Larimer et al 2009).

Both Housing First and Continuum of Care models incur large costs just by the nature of the programs - they house and provide services to people who often don't have the means to pay. However, because Continuum of Care models often need single-site facilities with both housing

²⁰ This study was first examined in Tsemberis, S.,(Ellen, I., O'Flaherty, B.) Chapter 3:Housing First in "How to House the Homeless." Russell Sage Foundation. New York. 2010.

and treatments, they have much larger up front costs with construction (both the actual infrastructure costs and labor costs), permitting, and zoning, among other things. Implementing these programs takes an extended period of time because of this. As a result, Housing First can be operational much faster than Continuum of Care models (usually within three months of securing funding).

Many states and cities have witnessed the financial benefits of Housing First. A 2006-2007 study in Los Angeles County examine 10,193 homeless individuals and found that the 1,007 participants in the Housing First programs cost the public an average of \$1,707 each per month, as compared to \$2,897 per month for the individuals not in a Housing First (Flaming et al. 2014)²¹. Maine has also yielded positive cost results from the Housing First model. A statewide study examined permanent supportive housing in rural and urban Maine in 2007-2009 for homeless individuals with a serious disability (Mondello et al. 2014)²². The researchers found service costs were cut in half. After accounting for the cost of providing the supportive housing (\$13,358 annually), the average cost savings were \$135 per year per resident. In rural Maine, the service costs decreased by 38.3%. However, since the cost of providing supportive housing was cheaper (\$9,018 per year) in rural areas, the average cost savings were \$5,502 annually (Mondello et al. 2014). In Massachusetts, the Housing First agency Home and Healthy for Good (HHG) showed that clients' shelter use, health care, and jail time decreased dramatically over the first twelve months after they were put into Permanent Supportive Housing. These decreases reduced each individual's costs from an average of \$33,474 per year before housing to just

²¹ This study was first examined in n.d.n.a. "Housing First vs. Traditional Treatment Programs: Why It May Cost Less to End Homelessness than to Manage It" retrieved:

<https://resources.oncourse.iu.edu/access/content/group/d7da3068-3d36-477e-8eb7-814d04a0e90f/Model%20Final%20Papers/Literature%20Review/lit%20review%20homeless.pdf>

²² This study was first examined in n.d.n.a. "Housing First vs. Traditional Treatment Programs: Why It May Cost Less to End Homelessness than to Manage It" retrieved:

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\$8,634 per year after entering housing. With the costs of the program accounted for, the HHG model saved the public an annual average of \$9,372 per client (Massachusetts Housing and Shelter Alliance)²³. Compare these numbers to a New York City study of a traditional Continuum of Care program that followed 96 homeless men for 18 months. Individuals in the “critical time intervention” (community living and intensive case management for mentally ill homeless individuals) led to average cost of \$52,374 per participant over 9 months. Based on these numbers alone, it’s clear that Housing First is more cost effective (Susser et al 1997).

Moreover, there is evidence that Housing First programs reduce costs in other ways. Gulcur et al. 2003 studied housing programs in New York City. They found that Housing First clients used fewer social services and spent less time hospitalized than their counterparts in the control Continuum of Care group. This translated into higher costs for the Continuum of Care clients in terms of healthcare and decreased housing retention. The same study found that one third of clients in the Housing First trial entered the program while still in a psychiatric hospital which decreased healthcare costs. Overall, they found that Housing First has lower costs in institutional care than control Continuum of Care models during first 24 months of treatment. In a study of San Diego’s REACH Housing First program, researchers Gilmer, Manning, and Ettner 2009²⁴ compared 177 participants in Housing First program to 161 “propensity-score-matched control” clients that were in case-management/outpatient services. They tracked services for treatment and control groups over a two year period. The researchers found the “net cost of (REACH) services, \$417 over two years per person, was substantially lower than the total cost of

²³ This study was first examined in n.d.n.a. “Housing First vs. Traditional Treatment Programs: Why It May Cost Less to End Homelessness than to Manage It” retrieved: <https://resources.oncourse.iu.edu/access/content/group/d7da3068-3d36-477e-8eb7-814d04a0e90f/Model%20Final%20Papers/Literature%20Review/lit%20review%20homeless.pdf>

²⁴ Information in this paragraph summarized from Tsemberis, S.,(Ellen, I., O’Flaherty, B.) Chapter 3:Housing First in “How to House the Homeless.” Russell Sage Foundation. New York. 2010 pgs. 37-53.

the services.” Case management costs increased for REACH participants, but emergency and mental health services costs declined compared to the control groups. A Housing First initiative in Portland also showed important societal gains. Portland’s Community Engagement Program provides housing and intensive services to homeless individuals with mental illness and addictions. The program reduced the cost of healthcare and incarcerations from \$42,075 to \$17,199. The total cost of each person per year was \$9,870 which was a 35.7% annual cost saving in the first year of the program (National Alliance to End Homelessness).

Further, Housing First programs may work better in rural communities since they do not have to front the large costs of building single site housing and treatment facilities. Thus, in rural areas where the homelessness is often more spread out and less prominent in numbers, Housing First would arguably be a much more cost effective alternative than traditional Continuum of Care models would be.

Because of this cost effectiveness, it is clear that Housing First is also preferable on utilitarian grounds. Attributed to philosopher Jeremy Bentham, utilitarianism is defined as “a theory in normative ethics holding that the best moral action is the one that maximizes utility.” In other words, the most moral practice is the choice that does the most amount of good for the least amount of harm. Housing First arguably is far more utilitarian than Continuum of Care models. First, it is more cost effective, so more benefits and services can be distributed to more chronically homeless individuals on that basis alone. Secondly, by not having any restrictions on obtaining or maintaining housing, it reaches a wider spread of the chronically homeless population than Continuum of Care models do. Thus, Housing First is far more utilitarian than treatment first Continuum of Care models.

Some may argue that Housing First does not yield any different results than Continuum of Care models for reducing mental health and substance abuse outcomes, making its adoption ineffective and non-utilitarian. In response, I would argue that, while this is true, Continuum of Care models are not producing better results and they have not had the same success in ending chronic homelessness as Housing First programs. It is better to solve at least one of the homeless' main deficits than to solve none of them. This takes us back to the Hippocratic Oath, where if the problem cannot be fixed, it is better to reduce harm than to do nothing. Thus, Housing First is still more utilitarian than treatment first Continuum of Care models.

Case study: Pathways to Housing



To put the previous arguments into context, it is useful to examine a case study of a successful Housing First agency. Pathways to Housing began in 1992 in New York City and has served as the premier Housing First agency in the country. Dr. Sam Tsemberis created the agency and the model to address homelessness for those suffering from psychiatric disabilities and addiction disorders. Since its founding, housing retention rates have consistently been between 85-90 percent, and the program has housed over 2,000 people by 2011. They take on a “scattered site” housing model where housing is provided in apartments throughout the community. They aim to “foster a sense of home, self-determination, and...speed the reintegration of Pathways clients into the community. Pathways to Housing now has three partner agencies in Washington D.C., Pennsylvania, and Vermont. In 2009, Pathways to Housing partnered with the U.S. Department of Veteran Affairs to end veteran homelessness. Pathways to Housing has worked with 25 VA centers nationwide to expand Housing First and give thousands

of Veterans a home. Since their partnership, Veteran homelessness has decreased by over 23%(Pathways to Housing).

A personal anecdote from a Pathways to Housing client

To further humanize Housing First agencies, it is helpful to read the story of a true Housing First client.

Candice, a fifty-three-year-old native New Yorker, was homeless for more than fifteen years when she was referred to Pathways to Housing, a Housing First agency in New York City. She often stayed on the streets or in a tent near an Upper West Side park. Her blue tent drew immediate attention from citizens, outreach workers and the police which often led to her frequent and involuntary visits to psychiatric hospitals. After discharge, her cycle would repeat. Because of her obvious symptoms of psychosis, including paranoia and fear of government control, most outreach workers and aid workers encouraged her to seek treatment for her mental health. They knew that she would not be admitted to traditional continuum of care supportive housing programs without it. She repeatedly refused all psychiatric and medical treatment. When Pathways staff first met with Candice, they offered to help her with whatever she needed, including an apartment of her own. It took several visits to convince her that the offer was genuine, unconditional and free of government control. She eventually accepted the apartment under the agreement that her signature would not be required and she was allowed to pitch her tent in the apartment. After she moved in, the staff continued to work with her and try to better understand her. They learned that she was employed as a nurse at the time of her first psychotic episode over twenty years prior. As she grew more comfortable and felt safer in her apartment, she stopped using the tent and began to sleep on the couch, then eventually her own bed. She began to cook her own meals. Her relationship with her family was transformed from arguing to enjoyable visits. Her condition has continued to improve and she only had one hospitalization in the four years since receiving Pathways treatment.

- Summarized from Sam Tsemberis, Chapter 3, “How to House the Homeless” pg. 37-38

This case study exemplifies the benefits of Housing First. Firstly, it effectively ends chronic homelessness for those who are often excluded from traditional Continuum of Care models. Candice would not have been eligible for Permanent Supportive Housing under

treatment first Continuum of Care models due to her refusal of psychiatric treatment. With Housing First, however, her homelessness was eradicated and her condition was able to improve, subsequently. Secondly, Housing First was tailored to her individual needs. The staff recognized her need for her autonomy and respected her desires throughout the whole process. Their proven faith in her allowed Candice to build a trusting relationship which ultimately led to her housing and health success.

Conclusion

The Housing First model is far superior than traditional treatment-first Continuum of Care models for a variety of reasons. First, Housing First is effectively ending homelessness for the most vulnerable individuals. Many of Housing First clients have fallen through the gaps that traditional Continuum of Care models created by forcing sobriety and treatment compliance. There is no point where Housing First clients can be evicted from the program and become homeless again. Thus, Housing First works to care for individuals that have evaded the Continuum of Care programs and house the most vulnerable clients permanently. Secondly, Housing First is ethically superior. By emphasizing autonomy, it allows each client to set their own goals and make their own choices. Thus, Housing First has a Kantian advantage over treatment first Continuum of Care programs. Treatment first Continuum of Care programs exert a heteronomic power over their clients by holding housing over their clients heads to incentivize treatment. This is an injustice and not in line with current medical research on recovery. Further, the Housing First model promotes social inclusion, not exclusion, unlike most Continuum of Care models. Not only does the Housing First model have a Kantian advantage, it also is more utilitarian. More individuals can be housed for less cost. In a world of scarce resources, Housing First is the clear choice on a cost and ethical basis.

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