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HOUSING FIRST, BUT WHAT COMES SECOND? A QUALITATIVE STUDY OF RESIDENT, STAFF AND MANAGEMENT PERSPECTIVES ON SINGLE-SITE HOUSING FIRST PROGRAM ENHANCEMENT

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Abstract

Single-site Housing First (HF) is associated with reduced publicly funded service utilization and costs and alcohol-related harm for chronically homeless individuals with severe alcohol problems. Many residents, however, continue to experience alcohol-related problems after their move into single-site HF. Thus, it is necessary to explore areas for program enhancement after individuals move into single-site HF. To this end, we collected qualitative data via 30 hours of naturalistic observation, staff focus groups ($n = 3$), and one-on-one interviews with single-site HF residents ($n = 44$), program staff ($n = 7$), and agency management ($n = 4$). Qualitative analyses were used to construct a conceptual or thematic description of residents', staff's, and management's suggestions for program enhancement, which comprised 3 areas: (a) enhancing training and support for staff, (b) increasing residents' access to meaningful activities, and (c) exploring alternate pathways to recovery. Development of programming addressing these areas may help residents continue to reduce alcohol-related harm and improve health and quality of life after their move into single-site HF.

Housing First (HF) is an approach to ending homelessness that focuses on providing immediate, permanent, low-barrier, nonabstinence-based supportive housing for individuals with the lived experience of homelessness (National Alliance to End Homelessness, 2015). Dubbed “harm reduction housing” (Tsemberis, Gulcur, & Nakae, 2004), HF strives to support housing retention, reduce substance-related harm, and improve various quality-of-life domains. HF has been implemented in two primary ways. In scattered site HF, people

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experiencing homelessness are offered affordable individual units scattered throughout a community and access to assertive community treatment. In single-site HF, individuals are offered apartment units or semiprivate cubicles within a single building and access to onsite case management and other supportive services (e.g., medical, psychiatric).

Although both models have shown positive outcomes, among chronically homeless adults with severe alcohol problems, single-site HF specifically has been associated with reduced publicly funded service utilization and associated costs (Larimer et al., 2009; Mackelprang, Collins, & Clifasefi, 2014; Clifasefi, Malone, & Collins, 2013) decreased alcohol use and problems (Collins, Malone, et al., 2012), and increased housing retention (Collins, Malone, & Clifasefi, 2013; Malone, 2009). Qualitative studies have indicated that moving into single-site HF improves residents' connection to service providers and increases their sense of stability and community (Collins, Clifasefi, Andrasik, et al., 2012; Collins, Clifasefi, Dana, et al., 2012).

Despite these promising outcomes, many single-site HF residents continue to experience alcohol-related problems, even after their move into single-site HF (Collins, Malone, et al., 2012). Recent studies have elucidated strengths and challenges of this approach and identified areas for potential program enhancement. One study indicated that homeless individuals' transitions into single-site HF are challenging for new residents and staff (Collins, Clifasefi, Andrasik, et al., 2012). For example, after moving into single-site HF, residents reported feeling relieved they had a place to live but disoriented about their new living situation (e.g., building rules, HF principles; Collins, Clifasefi, Andrasik, et al., 2012). Another study indicated that alcohol continues to play a central role in the lives of single-site HF residents (Collins, Clifasefi, Dana, et al., 2012). Findings also indicated that although staff supported the provision of nondrinking activities for residents, such activities were few and inconsistent because of frequent crisis management, low staff availability, and limited program resources (Collins, Clifasefi, Dana, et al., 2012). Thus, although the evidence points to HF as a successful approach to addressing homelessness, the question remains: Once an individual with the lived experience of homelessness has eliminated their fundamental need for housing, what comes next? The current study addresses this question.

Current Study Aims

Prior research has begun to document strengths and challenges of the single-site HF model and identified the need for HF program enhancement. No studies to date, however, have explored the perspectives of the single-site HF residents, staff, and management on how program enhancement could be achieved. Some studies have emphasized the importance of involving members of the homeless community more in developing the programming (Greysen, Allen, Lucas, Wang, & Rosenthal, 2012). Taking these points into account, we used a qualitative approach to elicit the perceptions of residents, staff, and management on the day-to-day living experiences in single-site HF, to identify preferred means of program enhancement and thereby inform community-based program development.

METHODS

Participants and Setting

The setting for this evaluation was a single-site HF program in Seattle, Washington. Participants included residents, staff, and management who lived or worked within the program. See Table 1 for a resident participant sample description.

Materials and Procedures

Sample description—Single-item sociodemographic questions assessed resident and staff participants' age, gender, race, and ethnicity.

Resident interviews—We conducted 44, 45- to 60-minute semistructured interviews with residents over a 7-month time period (between June and December 2013). Residents were informed about the purpose and procedures of the interviews and their rights and role as participants. Each participant provided written informed consent. Prompts were open-ended questions that explored residents' day-to-day experiences in single-site HF and elicited suggestions for program enhancement. Participants received \$20 for their time and were interviewed one time for the purposes of this study.

Staff participants ($N = 19$) had an average age of 41.4 years ($SD = 14.1$) and reported being predominantly of White/European American descent (17/19), with 2 individuals not reporting their racial/ethnic background. A slight majority of staff were female (10/19).

Staff and management focus groups and interviews—We conducted three staff focus groups, seven one-on-one staff interviews, and four one-on-one management interviews over a 6-month time period (between July and December 2013), involving a total of 15 staff and 4 management participants. Prompts during the 1.5-hour focus groups and 45- to 60-minute individual interviews queried the staff and management about their perceptions on the daily working experiences in single-site HF and elicited suggestions for program enhancement. Staff and management participants provided written informed consent and, in accordance with agency policy, were not compensated for their time beyond what had been allocated to the agency through subcontracted funds. Light refreshments, however, were provided at staff focus groups and interviews.

Data Management and Analysis Plan

The entire study took place over a 7-month time period (June to December 2013). Sessions were audio recorded and transcribed. Transcripts were stripped of personally identifiable information before qualitative data coding. Data analysis was conducted using a framework we piloted during prior program evaluation (Collins, Clifasefi, Andrasik, et al., 2012; Collins, Clifasefi, Dana, et al., 2012). The goal of the analysis was to construct a conceptual or thematic description (Sandelowski & Barroso, 2003) of key elements delineating residents', staff's, and management's experiences and perceptions of single-site HF and their suggestions for designing the programming to address its challenges and enhance its positive effects.

We (i.e., two psychologists, two postdoctoral fellows in health services research, and a doctoral-level psychology student) independently coded qualitative data, running Version 7 of ATLAS.ti (2012), using a constant comparative process consistent with grounded theory methodology (Glaser, 1992; Miles & Huberman, 1994). We conducted initial coding separately for each type of data (i.e., naturalistic observations, interviews, focus groups) using a line-by-line technique, whereby coders characterized the actions occurring in the observation, interview, or focus group exchanges (Charmaz, 2006).

Following initial and focused coding, which were conducted independently, we created a codebook in consensus meetings, pooling incident-by-incident codes and removing or collapsing idiosyncratic or redundant codes. In the next coding phase, we used the codebook to double code 10% of the sessions. Once adequate intercoder consistency (80%) was established (Miles & Huberman, 1994; Shek, Tang, & Han, 2005), a single coder independently coded the remaining sessions. Next, we pooled our memos and explored overarching themes (Dey, 1999). Residents, program staff, and agency management had various opportunities to review the findings. Their feedback served as a means of assessing usefulness, fit, and resonance of our interpretations and was integrated into this article.

RESULTS

Three components were cited as key to enhancing single-site HF programming: (a) increasing staff support and training, (b) providing consistent, meaningful activities for residents, and (c) exploring alternate pathways to recovery.

Increasing Staff Support and Training

Most residents reported feeling supported by staff. One resident explained: “If I don't communicate all day long [staff will] come up here, and they check on me. Its good people are always checking on me.” Some residents considered mutual respect to be fundamental to their positive relationships with staff: “I've always respected [lead staff member]. And he respects me because I always respect him. He's the man. He's the captain of this ship right here. And he's cool people, man.” Staff generally shared residents' positive sentiments. One staff member described working at the housing project as “a positive experience ... just the way that we are able to relate to the residents,” and stated that the staff “care tremendously for them.” Staff also felt they “got to learn a lot from a lot of residents.”

Many residents, however, acknowledged that there was tension in their relationships with staff. Some mentioned they had experienced conflict with staff—typically when intoxicated—and most regretted or felt remorseful about such incidents. One resident recounted: “I yelled at the staff ... there's times I've gone off. But that's not right, man. I try to pay attention.” Another mentioned she “went off on one of the sweetest people here at the front desk I just went off on her cussing and swearing at her. And I saw her the next day. I told her, ‘I am so sorry. I feel so bad.’ She said, ‘Don't worry about it’. I almost started crying.”

Staff corroborated reports of verbal abuse and the resulting stress: “Ok, yeah, you can yell and you can call me names ... that takes a lot out of you to have to sit there and let somebody berate you over and over.” Another staff member said: “Residents can be really

violent and really, you know, insulting to staff members. As much as I try not to take it personally, I consider myself to be a pretty sensitive person.” The relatively high staff turnover was attributed to stressful working conditions. One staff member disclosed:

You know, this is not a high-paying job. And, it's a very high stress job, and it's routinely a thankless job, if not outright being accused of holding people back or treating people wrong. Clients ... very frequently take their frustration out on the staff that work here. So with all that said, people don't stay very long sometimes.

Residents reflected on why situations can escalate. They reported struggling with the transition from homelessness to housing. Further, because of the newness of the housing model, none had lived in single-site HF before and did not fully understand how to function within it. Residents said the adjustment took time:

The first year I would crack a beer in my own house and look around for the cops. And, I thought the whole year there was going to be a snag, and I was going to get kicked out for sure. I just *knew* that so I didn't change my pattern at all. It was just like I was in the street.

Another resident said: “I finally realized that they wasn't going to take me out unless I really screwed up It took me a lot to realize that, and then when I finally did, I thought, ‘Hey man, I got a home now!’”

Residents and staff also discussed the need for more cultural awareness and diversity among staff, to reflect the range of values and cultures found among the residents. For instance, one resident noted: “There's a lot of Natives [American Indians and Alaskan Natives (AI/AN)] here, and Natives understand Natives.” Likewise, a staff member expressed concern that there was “nobody of color [on the staff]. We have nobody in the building right now that speaks Spanish on staff with the exception of our janitor. And we haven't cross-trained him to be working directly with staff That's a missed opportunity right there.”

Staff also indicated that although they theoretically understood and accepted the principles of harm reduction, the practical implementation of these principles is challenging. One member of management noted that the staff's value judgments can affect whether harm reduction was put into practice: “Conceptually it sounds great, but what it means on the ground ... are you really okay with that?” Even after having been employed for some time, several staff members—particularly those with less clinical training—were unsure how to embody harm reduction principles in their day-to-day role. Speaking to this point, one staff member noted: “You know ... I guess I don't ... I'm not involved as much in a lot of the different strategies”

Staff members experienced difficulty in navigating their roles and boundaries with residents in single-site HF, where residents have greater autonomy and more shared decision making than in other housing models. One staff member concluded: “Sometimes I think that they get a little too comfortable with you and think that you're their personal friend, and you have to start setting boundaries and then they get upset.” Residents reported experiencing boundary setting differently. Dual roles were often interpreted as staff exercising power over residents. One resident talked about how the role of case manager and payee sometimes overlapped,

with the same person serving that role: “There's not another landlord in the city that gets to be your [case manager] and you're landlord I think it's an obvious conflict of interest to me, but they sure don't see it as a conflict of interest. For them, this is normal operating procedures. And that makes me angry.”

Residents indicated that the staff needed more training to work effectively through underlying sources of tension. One resident asserted: “We lose from their lack of training, knowledge and information. Whatever they don't know, we suffered because we're the residents here. Y'all don't know how to handle all these different situations, all these different things, and it falls on us.” Another resident highlighted the importance of staff professionalism and self-care to maintain focus on residents' needs:

They're rude with us because they're just in that mood to be fucking rude to somebody, so they take it out on us. And that is not fucking right because this is our home. Don't come to work fucked up like that. Keep your shit at home with your shit, man. Or figure it out, man. Walk to work or do something, but don't take it out on us because that's not fucking right.

In fact, most staff members agreed they were not prepared to face the daily challenges of working in single-site HF when they were hired. One staff member said that the new staff “just have to jump in and experience it. You either make it or you don't.” Another staff member countered: “Why do we think that we can just hire bright, eager people and put them in a client interaction on their first day? I think that's damn near criminal.”

Consistent Meaningful Activities for Residents

Residents reported enjoying staff-organized activities, particularly art groups, games (e.g., bingo, dominos, cards), and outings (e.g., sporting events, zoo, aquarium, picnics, parks, museums, shopping). Staff members also frequently mentioned receiving positive responses to activities: “When we do have activities for residents, that's really fun for them. You know, things like bingo or movie night and stuff. They laugh and smile and everything and just are able to relax, which a lot of people don't do that here.”

However, residents and staff were aware that activities were inconsistently offered. Activities were based exclusively on staff availability and sometimes not offered as planned. Staff noted they often discontinued regularly scheduled programming to address emergent needs in the house. One staff member said that “good quality and reliable activities that really are satisfying and interesting” are lacking in the housing program due to “staff time” and “resources.” Lack of consistency is frustrating for many residents. One resident confirmed: “I like [activities], but they don't always happen on a regular schedule. And that gets on my nerves It's like what the hell?”

Some residents expressed interest in pursuing hobbies separately from other residents. This was often attributed to concerns about being in large groups of intoxicated individuals. One resident declared, “I just don't want to be around a bunch of drunks.” Another mused: “I don't know about [participating in activities]. There's always a couple yahoos in the crowd ... yelling at staff or yelling at some other resident, and they're just loud.” Others were interested in developing connections in the community outside the single-site HF program.

One resident stated, “I’d like to be around more normal people, you know? I’m trying with meet-up groups to meet people.”

Exploring Alternate Pathways to Recovery

Residents discussed their use of alcohol as self-medication or a means of coping with trauma (e.g., “I was in combat so I do have real bad PTSD sometimes ... and I keep it in check with the alcohol”), stress (e.g., “I learned from the first beer how well it cured anxiety”), and even alcohol-related consequences, such as withdrawal (e.g., “I don’t just have medical epilepsy. I have the alcohol seizures too, and they can both—they can kill me if I withdraw [from alcohol] too fast”).

Although they acknowledged these comorbid alcohol and psychiatric problems, residents also conveyed wariness of programs that carry an implicit or explicit requirement of sobriety. Some residents reported they “just burned out on [abstinence-based treatment]” after multiple unsuccessful attempts. Some residents espoused theories as to why abstinence-based treatment had not worked for them in the past. One indicated that hearing other’s stories triggered cravings,

I went to [Narcotics Anonymous] and this guy was talking about how his pockets were turned inside out looking for crack I had a using dream of crack after listening to his thing. So ... I just really didn’t want to go back.

Some residents felt they had lacked in motivation for treatment and asserted that “you have to want it. And most people, they go through multiple times with places before they finally get it. I mean, you have to want it. I didn’t want it.”

A few residents shared that—after many failed treatment episodes—they had achieved longer term sobriety only after their move into single-site HF. One resident disclosed: “I’ve never sobered up at a place where you’re supposed to sober up—so they never worked for me. I’ve been to many 3-month programs, and ... I would walk out of there and get a bottle. So those things never worked for me either. And I did sober up [at single-site HF], although I don’t think that’s their mission whatsoever.”

Residents proposed suggestions to change, enhance, and redefine pathways to recovery from psychiatric and alcohol problems. Namely, they expressed interest in participating in groups where they could learn to reduce their substance-related harm, without expectations of sobriety. One resident said:

I believe ... if they had something related towards, you know, drinking but not, you know, [Alcoholics Anonymous] meetings ... I don’t know what the name of it would be. But if the name of it was under the radar enough ... more of the guys would go. They don’t want to feel pounded over the head that they have to stop drinking.

Many AI/AN and non-AI/AN residents expressed interest in traditional indigenous healing practices such as talking circles or talking stick groups (i.e., gatherings where all members of a community have an opportunity to speak on matters of the heart). Conversely, other

residents stated a preference for one-on-one counseling over group treatment because they were concerned about other residents' outbursts.

Regardless of their preferred therapeutic format, most residents expressed interest in talking about “various life issues” without an exclusive focus on reduction or abstinence from alcohol. Residents felt recovery should focus on positive things people can do in the here and now and on “how things have changed and improved for the good” in their lives. Residents concluded that such conversations might be easier to have if you can “keep people's attention.” Along those lines, one resident suggested that recovery be woven into conversations “while you're doing art”:

Because some people don't want to talk about their problems because they don't want to be wrong. They don't want to admit, “Oh, I'm an alcoholic.” They don't want to talk about—people just don't want to think of all the bad things that come along with drugs and alcohol, and they know the effects. But they're just ... they're lost, and they don't know what heals you. And just somebody loving you heals you. Just somebody taking interest in what you're doing heals you. Just saying that person's name, taking your time out for them, it makes a person—it fills the soul, it fills the heart. The people here mainly need compassion.

DISCUSSION

The aim of this study was to develop a conceptual or thematic description of residents', staff's, and management's experiences and perceptions of single-site HF and their suggestions for program enhancement, to contribute to enhanced psychological well-being and improved quality of life after individuals move into housing. Participants' suggestions were represented in three primary categories: (a) increasing staff support and training, (b) providing consistent, meaningful activities for residents, and (c) exploring alternate pathways to recovery.

Increasing Staff Support and Training

HF is a relatively new model of supportive housing and—compared with traditional continuum of care, provider-driven, abstinence-based housing models—involves a low-barrier practice that prioritizes supporting residents' autonomy, housing retention, substance-related harm reduction, and quality-of-life improvement (Tsemberis et al., 2004). Both residents and staff described the challenges of adapting to living and working in a single-site HF program. Thus, the point in time at which individuals move into, or begin working at, single-site HF may be a critical one to focus on for program and/or intervention development. Specifically, single-site HF programs may benefit from including orientation programming co-designed with current residents and staff to help newcomers adjust more quickly to this housing model. Orientation could include information and interactive exercises to promote new residents' and staff's (a) practical understanding of the single-site HF approach; (b) understanding of roles, power dynamics, crisis de-escalation, and boundaries; (c) sense of cultural humility and respect for the diverse backgrounds; and (d) capacity for self-care.

Consistent Meaningful Activities for Residents

Residents and staff emphasized the importance of meaningful activities, specifically nondrinking pursuits, selected by residents, that are geared toward increasing autonomy, improving health and well-being, reconnection to self, and contributing to community (e.g., hobbies, work, volunteering, education, sports, cultural activities). Although residents appreciated currently offered services, programs, and activities, they were excited to brainstorm and share their own ideas. In line with prior research (Collins, Clifasefi, Dana, et al., 2012), residents also wanted more consistency within the program. Despite a desire for meaningful activities, many residents also had concerns about participating in programming with intoxicated residents, citing a low threshold for distress and the unpredictability of others' behavior. Thus, this type of programming must allow for group and individual participation and should incorporate distress tolerance and stress management components to equip residents with the necessary skills to cope with such challenges. Meaningful activities should also involve dedicated program staff who have appropriate training and who are committed to designing programming jointly with residents.

Exploring Alternate Pathways to Recovery

Although single-site HF residents show significant improvements on alcohol outcomes as a function of time spent in housing (Collins, Malone, et al., 2012), many continue to experience significant alcohol-related harm (Collins, Malone, et al., 2012). Prior studies with this population have indicated that most single-site HF residents have made multiple abstinence-based treatment attempts and are not ready, willing, and/or able to commit to abstinence-based goals (Larimer et al., 2009; Collins, Clifasefi, Dana, et al., 2012).

The current findings corresponded to the existing literature: Participants reported that abstinence-based treatment was neither efficacious nor desirable. Thus, to augment the positive effects of single-site HF, future efforts should focus on developing empirically supported alternate pathways to recovery: (a) increase access to recovery pathways in residents' own community (vs. formal treatment settings); (b) integrate approaches that are compatible with and complementary to the harm reduction and low-barrier single-site HF model; (c) expand the definition of recovery goals and pathways to better correspond to the range of residents' needs and interests (e.g., client-driven goal setting; Collins et al., 2014); and (d) weave recovery into daily activities.

Conclusions and Future Directions

In the present study, we created a conceptual or thematic description of residents', staff's, and management's suggestions for enhancing programming in one single-site HF program. Our findings indicated that residents, staff, and management were interested in increasing staff training and support, providing more consistent, meaningful activities for residents, and exploring alternate pathways to recovery. Although our findings are limited to one specific HF program, it is worth noting that this program has been cited as the flagship model, upon which many other single-site HF programs have been based. Thus, we are confident that the findings from this study would extend to other single-site HF programs serving similar populations. Next steps will include the collaborative development and evaluation of the

proposed programming to enhance the effects of single-site HF in reducing residents' alcohol-related harm, increasing housing retention, and improving resident quality of life.

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Table 1

Baseline Descriptive Data for the Residents (N = 44)

Variable	M (SD) / %
Age	53.2 (7.8)
Gender	
Female	18.2
Male	81.8
Race	
American Indian/Alaska Native/First Nation	20.4
Asian	0.0
Black/African American	11.4
Native Hawaiian/Pacific Islander	2.3
White/European American	43.2
“More than one race”	20.4
Other	2.3
Ethnicity	
Hispanic/Latino/a	9.1

Note. M = mean; SD = standard deviation. 100% of individuals who identified as “more than one race” considered themselves American Indian/Alaska Native/First Nation in addition to another race.