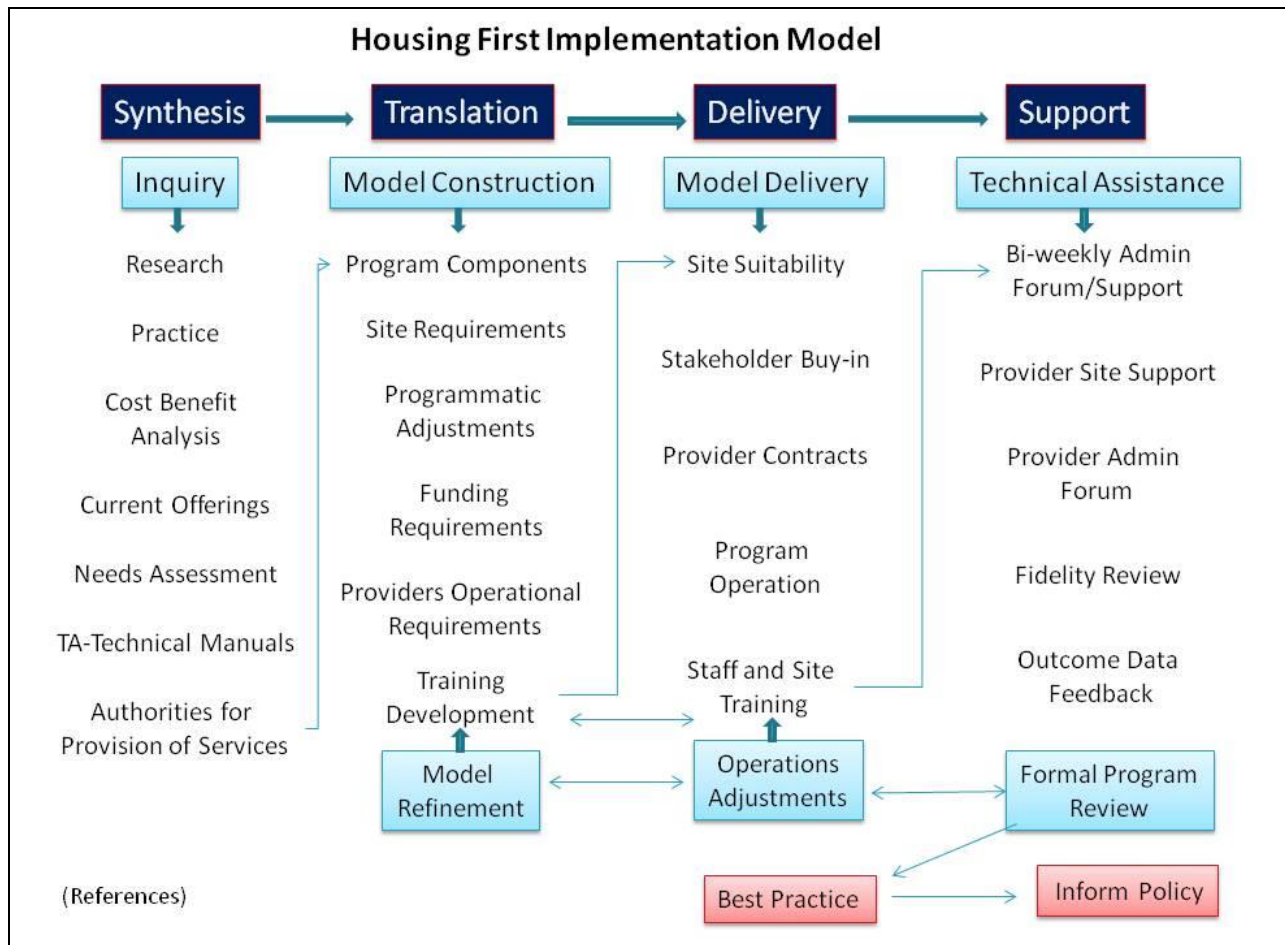


HOUSING FIRST MODEL: AN IMPLEMENTATION FRAMEWORK

The Secretary of the U.S. Department of Veterans Affairs, Eric Shinseki, has determined that the Housing First approach be VA policy and the model of care for chronically homeless Veterans in the U.S. Department of Housing and Urban Development VA Supportive Housing (HUD-VASH) program. HUD-VASH is a joint effort between HUD and VA to move Veterans and their families out of homelessness and into permanent supportive housing. In this program, HUD provides housing assistance through its Housing Choice Voucher Program (Section 8), enabling Veterans who are experiencing homelessness to rent privately-owned housing. VA offers eligible Veterans case management and supportive services through its healthcare system across the 50 states, the District of Columbia, Puerto Rico, and Guam.



Below are definitions of the framework terms; click on the link for relevant Housing First Program specific criteria and processes.

Model Framework - Defined

Synthesis

Inquiry

(click on link for program specific criteria and process)

Research: evidence in peer reviewed or other professional journals or publications that directly references the program model, or components of the model, and discusses process, outcome, utilization, effect, etc.

Practice: discussion, presentation in publications or on the web that cites the model or components of the model, practice evidence, or model design.

Cost-benefit Analysis: review of literature or existing program evaluation studies that demonstrate costs associated with program outcomes; and/or those costs associated with similar programs, costs associated with the lack of or ineffective programs, or use of alternative services.

Current Offerings: list, description, or discussion of sites or agencies using the model or components of the model and, if available, presentation of effect or impact.

Needs Assessment: formal or non-structured assessment through VA or other agency, or combination, providing evidence of value of implementing model.

Technical Manuals: presentation of the model or components of the model in publication or on the web, as implemented under other funding authorities or agencies presenting description of operational specifics for program managers.

Authorities for Services Provision: public law, directives, manuals, circulars, or other documents to authorize services, including EDMs and other internal documents.

TRANSLATION

Model Construction

(click on link for program specific criteria and process)

Program Components: key program operational principles and components, including intent, population served, course of treatment, outcomes and expected utilization and work load.

Site Requirements: necessary elements to implement at sites, general and not specific to individual sites, includes requirement specifics but general enough to list for all sites.

Pragmatic Adjustments: modifications of model, moving from 'perfect' model, based on research and practice, to a model that retains core components but satisfies unique aspects of VA or site.

Training Development: based on an assessment of design newness and current knowledge of site management and core staff, the necessary elements in educational curriculum development.

Funding Requirements: developed based on constructed model, needs assessment, funding availability, and developing site priority – the estimated total for each site and estimated total for all sites, considering start up costs, prorated for implementation date, and possible readjustment of funds once sites are operational.

Operational Requirements for Providers: recognizes the VA requirements and, if providers are a component of the model, the provider requirements such as education, facility structure, contractual agreements, etc.

DELIVERY

Model Delivery

(click on link for program specific criteria and process)

Site Suitability: the necessary infrastructure and support, including ability to obtain facility, contract (if necessary), access, feasibility of location within community.

Site Buy In: stakeholder commitment, including VA upper, mid, line level staff support as well as community support including political, community provider, continuum, coalition leaders and staff.

Provider Contracts: (if necessary) the contractual arrangements that providers may have existing or in the past and developing those contracts through processes necessary.

Staff and Site Training: initial educational scheme, including curriculum and method of delivery, to inform stakeholders through overview, and line level VA and community staff.

Program Operation: initial operational challenges and participant impact.

SUPPORT

Technical Assistance

(click on link for program specific criteria and process)

Core Group Forum Tele-Com: weekly or bi-weekly calls for management and line staff, VA.

Individual Tele-Com Site: calls with individual sites to address unique challenges.

Core Group Admin Tele-Com: calls with core administration and program leads.

Fidelity Review: on-site or tele-com reviews of model design through methods developed to determine model adoption and adherence.

Outcome Data: reviews of participant outcomes – meeting, achieving model intent, and effect.

Formal Program Review: on-site reviews by team staff, to review fidelity, outcomes, community integration, participant process and outcome measures.

REFERENCES

Housing First Implementation Criteria and Processes

Research

Prior to implementing Housing First, a systematic review of the literature was conducted. The findings are summarized below.

- **The problem and the need.** The majority of services and accompanying costs for persons experiencing chronic homelessness are incurred by a small minority of persons utilizing preventable and expensive acute healthcare services (Culhane & Bryne, 2010), and coming into contact with the criminal justice system (Poulin, Maguire, Metraux & Culhane, 2010). While existing services and interagency collaborations to prevent initial and repeat episodes of homelessness are vital in the fight to address homelessness, they are generally not sufficient in the absence of housing support (Gerber, Haradon, & Phinney, 2008), particularly for those who experience severe mental illness in addition to chronic homelessness (Newman, & Goldman, 2008). For those experiencing chronic homelessness, permanent supportive housing interventions such as Housing First are needed to provide residential stability and access to supportive services to prevent expensive acute health care use (Culhane, & Bryne, 2010), with accompanying personal and societal costs.
- **Outcomes for supportive housing.** Supportive housing interventions have been shown to improve housing outcomes and stability as well as reduce acute healthcare use and criminal justice involvement for persons experiencing chronic homelessness with severe mental illness (Culhane, Metraux, & Hadley, 2002; Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010). These reductions in acute healthcare use and criminal justice involvement resulted in significant cost savings when compared to those not receiving supportive housing services (Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010), with one study finding these savings offset 95% of the costs of providing supportive housing (Culhane, Metraux, & Hadley, 2002). Reductions in acute healthcare use is consistent with other studies on supportive housing for persons experiencing chronic homelessness documenting improved access to routine outpatient care for both physical and behavioral health needs (Mares & Rosenheck, 2011). Given this evidence, the provision of supportive housing services, such as Housing First, represents a strong investment in taxpayer dollars (Culhane, Metraux, & Hadley, 2002).
- **Outcomes for Housing First.** Multiple randomized studies document the ability of Housing First interventions to provide better residential stability and housing outcomes (Padgett, Gulcur, & Tsemberis, 2006; Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004) when compared to linear residential treatment approaches or treatment-as-usual conditions for persons experiencing chronic homelessness with severe mental illness. These beneficial residential stability and housing outcomes among Housing First participants did not come at the expense of increased levels of substance use compared to those in treatment-as-usual conditions (Padgett, Gulcur, & Tsemberis, 2006; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004), contrary to assumptions that the provision of housing without mandated sobriety would result in higher levels of participant substance abuse. Consistent with research on other, more general supportive housing interventions, Housing First participation has been shown to be associated with reduced costs and return in housing investment due to reduced use of acute healthcare services and criminal justice involvement by Housing First participants (DeSilva, Manworren, & Targonski, 2011; Larimer et al., 2009; Parker,

2010; Sadowski, Kee, VanderWeel, & Buchanan, 2009). In addition to these positive clinical and public health outcomes, qualitative interviews with Housing First participants supports the acceptability and positive perception of Housing First services among persons experiencing chronic homelessness with severe mental illness (Pearson, Montgomery & Locke, 2009).

- **Comparison of housing models - Housing First vs. treatment first.** Two studies that have systematically examined outcomes for persons experiencing chronic homelessness with severe mental illness document the superiority of housing plus supportive services housing models (Leff, Chow, Pepin, Conley, Allen, & Seamna, 2009; Nelson, Aubry, & Lafrance, 2007). Results from one study examining the long-term outcomes of persons who were chronically homeless with severe mental illness participating in a national multi-site housing project found that persons who received Housing First (vs. treatment first) had better housing outcomes and fewer days incarcerated, but with no observed differences in clinical outcomes (Tsai, Mares, & Rosenheck, 2010), consistent with prior studies of Housing First and other supportive housing interventions.
- **Veteran-specific outcomes.** Veterans experiencing homelessness are more likely than housed veterans to have higher rates of acute healthcare use and associated costs (Buchholz et al., 2010), suggesting the need for supportive housing services, especially among veterans experiencing chronic homelessness with severe mental illness (Schutt, Weinstein, & Penk, 2005). Among veterans receiving supportive housing services, no differences in supportive housing tenure has been found between veterans who did and did not receive residential treatment prior to their involvement (Mares, Kaspro, & Rosenheck, 2004). Consistent with other studies in the general population, research supports the superiority of supportive housing approaches among veterans to improve residential stability and housing outcomes (Rosenheck, Kaspro, Frisman, & Liu-Mares, 2003)

Practice

- Community-based supportive housing providers throughout the country, such as Boley Centers in Florida, have provided permanent housing “straight from the streets” with supportive services for people who were chronically homeless with serious mental health and substance abuse issues for some time (Clark, Teague, Henry, 1999). The full development of this type of program, with 20 years of research and well developed program standards is Pathways to Housing which became the model labeled Housing First (Tsemberis & Eisenberg, 2000)
- An early precursor of the VA involvement in supportive housing with an emphasis on Housing First was the development of the [Collaborative Initiative to Help End Chronic Homelessness](#) (CICH), an innovative demonstration project coordinated by the U.S. Interagency Council on Homelessness (USICH), jointly funded by the Departments of Housing and Urban Development (HUD), Health and Human Services (HHS [SAMHSA and HRSA]), and Veterans Affairs (VA). Initiated in 2003, it focused on improving outcomes for individuals who were chronically homeless by making funding available to support 11 communities to integrate housing and treatment services for disabled individuals who have experienced long-term and/or repeated homelessness. The following six core services were provided for 3-5 years: permanent supportive housing, case management, mental health treatment, substance abuse treatment, primary health care, and veteran's health services.

Cost-Benefit Analysis

- Prior to VA’s implementation of Housing First a review of literature comparing various approaches was conducted to determine cost benefit analysis. A groundbreaking study released

in 2001 documented substantial cost savings from community-based care compared to shelters, jails, and hospital beds (Culhane et al., 2001). Annual per capita costs of the Pathways To Housing, a New York City based Housing First Program, are \$22,500 compared with \$40,000 to \$50,000 for treatment first congregate housing programs, \$85,000 for a jail bed, and \$175,000 for a state psychiatric hospital bed (Anderson, 2005). This research and success with non-VA supportive housing programs influenced VA's decision to establish Housing First pilots.

Current Offerings

- In preparation for implementation of the Housing First model, VA reviewed its current offerings of housing alternatives for homeless Veterans. This review was a necessary step in the model development process to determine the need for the new program, to determine “fit” with existing programs, and to avoid duplication of programs already offered.
- VA currently provides the following programs that offer permanent, transitional, or temporary residential treatment and respite for homeless Veterans:
- HUD-VASH: The HUD-VASH program offers permanent housing with case management/supportive services in a joint partnership with HUD. The program targets chronically homeless Veterans and families, and provides the Veterans with placement in permanent housing of the Veteran's choice thru a Housing Choice voucher.
- Grant and Per Diem: This grant program provides transitional housing and supportive services to homeless Veterans via grants and per diem payments to non-profit community providers.
- HCHV Contract Residential Treatment: This VA program provides contract time limited residential treatment services with community based providers for homeless Veterans. VA operates a Safe Haven model development program for chronically homeless Veterans under the authorities provided for this program.
- Domiciliary Care for Homeless Veteran Programs: This VA program offers time limited residential treatment services to homeless Veterans. The facilities are usually on the grounds of the VA Medical Centers and have capacity to provide care for Veterans with mental illness and substance abuse treatment issues.
- A review of the offerings determined that many of the programs did not offer a low demand approach, often required sobriety and compliance with mental health treatment as a condition of admission or continued stay, and could not house Veterans rapidly. These models implemented a linear or step by step, graduated, approach to providing the Veteran permanent housing as opposed to providing a “housing first” approach. In fact, a significant proportion of VA's homeless programs offerings are transitional or residential treatment by design. The review indicated that implementation of a Housing First model would provide chronically homeless Veterans with a desirable and needed alternative.

Needs Assessment

- The VA, with 20 years of experience, utilized the existing HUD-VASH permanent supportive housing program as a core model to implement Housing First due to the importance of having a housing voucher available for Veterans. The selection of the 14 VAMC Housing First pilot sites was based on the needs of Veterans in large urban areas and targeted communities. In an effort to end homelessness among Veterans, the VA and HUD collaborated on the site selection by first deciding that the target population must be those Veterans who met HUD's definition of “chronic homelessness” or long term homeless who were living on the streets or shelters. The

Housing First model was specifically designed to serve this target group of Veterans who were literally homeless, rather than coming from a setting such as the VA's Grant Per Diem Program, residential treatment or other HUD funded, non-VA, housing program.

- In addition, the VA and HUD reviewed the national homeless Continuum of Care data from Homeless Coalitions that conducted their annual "point in time" surveys to determine the highest numbers of Veteran who were homeless, and specifically those communities with high populations of chronically homeless. The following sites were selected to participate in the 14 site Housing First pilot, with dedicated HUD-VASH Permanent Supportive Housing vouchers and enriched HUD-VASH staffing for the VA: Greater Los Angeles; San Francisco; New York City (Bronx and NY Harbor),; Philadelphia; Washington, DC; Chicago; Detroit; Denver; Dallas; Boston (New Bedford VAMC); Portland, St. Petersburg (Bay Pines VAMC, Fl.); Syracuse and New Orleans.

Technical Manuals

- The National Center on Homelessness among Veterans selected a core team of technical assistance experts from the VA, University of South Florida and Pathways to Housing to provide on-site Housing First Model Development and technical assistance to all of the 14 Housing First sites. This TA was complemented with bi-weekly conference calls with all of the sites. Besides the VA's standard HUD-VASH Handbook for regular HUD-VASH, it was agreed that all sites would use the book Housing First – The Pathways Model to End Homelessness for People with Mental Illness and Addiction, (Tsemberis, 2010). Dr. Tsemberis is the Founder of Pathways to Housing (Housing First) and a member of the core consulting team. In addition, a special chapter "HUD-VASH and Housing First" was written by several contributing authors in the National Center's "HUD-VASH Resource Guide for Permanent Housing and Clinical Care (2011) for use by the HUD-VASH pilot sites.

Authorities for Provision of Services

- Besides the established HUD-VASH program, there is no specific legislative authority for the Housing First model to offer Veterans who are homeless, but HUD encourages the use of this model and provides technical assistance and information about the model on its web site. Specific authority for Section 8 housing that encompasses HUD's Housing Choice voucher program is provided by the Housing and Community Development Act of 1974. The 2008 Consolidated Appropriations Act (Public Law 110-161) enacted December 26, 2007, allocated \$75 million dollars funding the HUD-Veterans Affairs Supportive Housing (HUD-VASH) voucher program, authorized under section 8(o)(19) of the United States Housing Act of 1937. This new program combines HUD Housing Choice Voucher rental assistance for homeless veterans with case management and clinical service support which is provided by VA at its own medical centers and also in the community.

Program Components

- There are a number of key components of the Housing First approach that must be incorporated into a successful Housing first model development initiative:
- Housing First programs targets Veterans who are chronically homeless with severe mental illnesses and/or persistent substance use/abuse problems.
- Permanent housing is provided to the homeless Veteran as quickly as possible and then treatment and other support services are wrapped around the Veteran, mostly on-site, to help the Veteran obtain and maintain permanent housing.

- This is a departure from many traditional programs that require treatment before housing and may require residential treatment or transitional housing before placement in permanent housing.
- Treatment and supportive services for Veterans in Housing First is most effectively provided by implementation of an Assertive Community Treatment (ACT) Team
- ACT is a service-delivery model that provides comprehensive, community based treatment to individuals with serious and persistent mental illnesses who have experienced chronic homelessness.
- Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers, most frequently, in the Veteran's home.
- ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. A dedicated ACT team provides these necessary services 24 hours a day, seven days a week, and 365 days a year.
- A typical ACT Team is comprised of the following staff: Case managers (SW, Nursing or Psychologist), a Peer specialist, a Housing Specialist, a Nurse Practitioner, a Psychiatrist (.25FTE-.5FTE), and a Program Assistant.

Site Requirements

- VA sites implementing Housing First were required to meet the following basic requirements:
- To use up to 50 HUD-VASH vouchers to target Veterans who were chronically homeless requiring additional case management support.
- To hire and implement ACT Teams for ongoing support services of Veterans and their families placed in the Housing First Program
- To participate in the in technical assistance, fidelity reviews, and data management activities as a model development site of the VA National Center on Homelessness among Veterans.

Programmatic Adjustments

- Only minor program adjustments were needed to implement Housing First at the fourteen Housing First sites. Due to hiring and recruitment constraints being experienced by some of the selected sites, facilities were allowed to contract Housing First program and case management services with non-profit community-based providers with experience in delivering a Housing First model.

Funding Requirements

- The fourteen Housing First model development sites each received approximately \$325,000 for startup costs and for the hiring of ACT team staff. Total costs for the first year of operation of the fourteen sites were \$4.5 million.

Providers Operational Requirements

- Contracted providers were required to meet the same requirements, such as fidelity standards, target populations, performance measures, as VA facilities implementing the Housing First model.

Training Development

- Besides formal technical assistance, the VA hosted two formal trainings in New Orleans for the 14 Housing First sites in 2011 and 2012. Representatives from the VA Senior Management of Homeless Services, the National Center, University of South Florida and Pathways to Housing led the trainings. The training was structured as an opportunity for all 14 pilot sites to learn about the core principles and practices of Housing First; organizational culture shift from a linear model of transitional housing to housing first; target populations; panel discussions on strategic implementation issues; administrative problem solving and information shared among the pilot sites. The second training in 2012 was held in conjunction with the first National Conference on Housing First where VAMC personnel could interact and learn from other non-VA Housing First providers who in some cases have been implementing the Housing First model for 20 years.

Model Refinement

- Housing First in the VA can best be described as an evolutionary process; whereby the “fidelity” of the Housing First model is being held as the ‘gold standard” and modifications are being made by the VA based on VA HUD-VASH resources, needs of Veterans, staffing/personnel processes and available access to other VAMC services that may not be present in non-VA Housing First models. For example, in order to meet the needs of Veterans who have serious co-occurring mental health and substance use/abuse issues, the addition of substance abuse counselors on the Housing First team was a priority. The expansion of peer specialists (Veterans in recovery) on many of the pilot teams is a natural evolution of the model and best practices in Housing First. From a funding perspective, the initial HUD-VASH allocation did not include financial resources for start-up costs, such as fully furnished apartments, utensils, security deposits, and move-in expenses. Therefore, the VA needed to forge community-based partnerships, often with homeless coalitions, non-profit providers and businesses to build the program. Although the Housing First model and approach is primarily “on-site”; Veterans do have access to a variety of behavioral health and healthcare service on the campus on the VAMC’s. Also the development of the Homeless –Patient Aligned Care teams (H-PACT), VA Safe Havens and Community Referral and Resources Centers (CRRC’s) exist in several of the Housing First pilot sites (i.e., Bay Pines, Portland, New York, etc.) where a comprehensive and “integrated” opportunity for the VA is possible.

Site Suitability

- The necessary infrastructure and support, including ability to obtain facility, contract (if necessary), access, feasibility of location within community.

Site Buy-In

- Implementation of the Housing First model required a high degree of collaboration between VA Housing First staff and the local Public Housing Authority staff. To facilitate that collaboration, national training was conducted jointly with both groups. VA staff and PHA staff were encouraged to meet regularly to share problems with implementation of the model and to problem solve issues related to model implementation.

Provider Contracts

- Four sites (San Francisco, Philadelphia, Washington, DC, and New York City) chose to implement Housing First through service contracts. Sites utilizing contracts were required to develop statements of work that required the same components as VA managed programs. Contracting for services resulted in substantially longer implementation times.

Program Operation

- During the first months of operation in FY 2012, the fourteen sites placed 455 Veterans in permanent housing with an average placement time of 123 days. Ninety per cent of the Veterans placed qualified as chronically homeless. The HUD-VASH programs at the fourteen sites placed 2,182 Veterans with an average of 132 days to placement and 50% of the Veterans meeting the chronic homelessness criteria.
- It should be noted that these are early program implementation results with some programs not being fully operational and having a full complement of staff. Early results also indicate a high percentage of homeless Veterans remaining stably housed with high satisfaction with program participation.

Staff and Site Training

- Each model development site was encouraged to provide additional training to their facility staff and to make their facilities aware of their targeting requirements, ACT Team support provided to program participants, and the basic Housing First model components.

Operations Adjustments

- The ability to rapidly house Housing First clients for model implementation sites was significantly affected by two factors that required program adjustments and interventions:
- Housing stock availability: Having housing stock immediately available is critical to the Housing First model. Most sites experience delays in housing Veterans rapidly by the lack of “move -in ready” housing stock, delays in Section 8 housing inspections, and processing and orientation delays at local Public Housing Authorities (PHA). A number of programmatic adjustments have been made to address this problem including VA staff conducting housing inspections, having landlord open houses, working with PHAs to increase housing ready stock, and working with PHAs to streamline administrative procedures. Some problems remain in this area.
- Furniture, household goods and move in subsidies: The lack of ability for VA or PHAs to provide these items directly has been a significant impediment to rapid placement. Both VA and PHA staff have worked with non-profit, charitable, and private funders to ameliorate this problem, but it remains a significant barrier to rapid placement.

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