

Healing Hands



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**From Homelessness to Housing:
Challenges and Opportunities of Housing
Transitions**

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I. Introduction

People experiencing homelessness are often living with both chronic and acute physical and mental health conditions. Henwood, Byrne & Scriber observed in 2015 that “Adults who experience prolonged homelessness have mortality rates 3 to 4 times that of the general population.” Their research found that people experiencing homelessness were significantly more likely to die from an accident, hypothermia, cancer, and infectious diseases; by contrast, the majority of people who had been housed in a Housing First program that they examined were most likely to die of “natural causes.”¹ These findings reflect both the increased health risks and dangers of prolonged homelessness and the difficulty in accessing consistent health care while experiencing homelessness.

One of the most important forms of health care is access to housing, which protects people from the elements and from many other dangers and health risks associated with living on the streets. Given resource challenges, and social and political barriers, achieving housing for people experiencing homelessness can be a lengthy and difficult process. Yet achieving housing is one of the most important things that can be done to support the health and well-being of people experiencing homelessness. Research has shown that housing has a positive effect on both chronic and acute medical conditions, patients’ ability to manage treatment and medications, access to mental health services and substance use treatment, and general quality of life.²

Although housing is an extremely important piece of the health care puzzle for people experiencing homelessness, it is also not a one-stop solution. Once housing has been established, difficulties do not magically end—and in fact, the transition into housing after a period of prolonged homelessness can present entirely new difficulties for people who have been living on the streets or in shelters. This issue of *Healing Hands* will present some of the key challenges faced by newly housed individuals and their care providers, and will consider a variety of principles, concepts, and approaches that can be useful in mitigating and transforming these challenges, in support of the best possible outcomes for a client’s health and well-being.

Housing 101: Key Approaches

While some housing programs still emphasize **housing readiness**—a linear approach to care that requires clients to achieve behavioral stability and/or sobriety before entering housing—evidence increasingly supports the use of more low-barrier approaches to housing, such as:

Housing First: This philosophy posits that housing should be the first step in addressing homelessness. In many cases, there are no requirements around treatment, recovery, or behavioral stability prior to placement in housing; rather the housing placement is viewed as the first intervention. Additional health and social services are provided to clients after they have been placed in permanent housing situations.

Permanent Supportive Housing (PSH): PSH emphasizes a combination of permanent and affordable housing with the ongoing provision of services, which may be provided on-site or off-site, depending on the specific housing model being utilized. Ideally, interdisciplinary care teams can promote ongoing stability, mental and physical health, and recovery services for newly housed individuals.

Housing delivery models can include **single-site housing**, **scattered-site housing**, **mixed population solutions**, and more. To learn more about these philosophies and models, check out NHCHC's spring 2018 Healing Hands publication, [*Housing Solutions for People Experiencing Homelessness*](#).

II. Challenges of Transitioning into Housing

A 2011 [NHCHC publication](#) reported the findings of a survey of clinicians and clients in PSH programs.³ This report includes key themes and difficulties faced by clinicians as they support clients through housing transitions, and explains some of the difficulties experienced by clients after being housed. The report notes that becoming housed “includes changing one’s entire culture of living” from street survival mode to living stably in housing. “Street survival mode generally operates on a day-to-day manner where future planning is of limited use because so much is out of one’s control, and the level of sensory stimulation is quite high.” By contrast, “Stable housing introduces the need for individual decisions not normally feasible when living on the street.” This cultural transition can introduce a variety of stresses stemming from the necessity of immediate behavior change.

This cultural transition requires that people quickly learn new behaviors and skill sets, so that they can pay rent, keep the house clean, grocery shop, get along with neighbors, and

II. Challenges of Transitioning into Housing

(cont.)

perform a wide variety of household tasks. Common reasons for evictions of recently housed people include lease violations (such as inviting other people to stay in the home who are not on the lease or the presence of illegal substances) and the cleanliness and upkeep of apartments and properties. These reasons for eviction are often a combination of environmental and personal factors—for example, if a person engages in hoarding behaviors in an apartment that was not particularly well-maintained by landlords or property managers to begin with, it can lead to infestations or other health challenges.

Importantly, the NHCHC research says that clients report:

Feeling lonely and isolated. Street life tends to be very social, with people often living in groups for safety, and the loss of a social network and transition into living alone can be challenging.

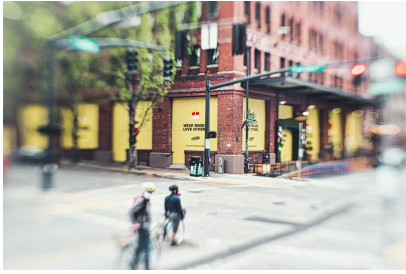
Experiencing “housing guilt.” This feeling can arise when a person feels guilty to be housed while their friends are still on the streets, and can sometimes lead to difficult conflicts of interest when helping friends becomes a risk to housing status—for instance, if a person lets friends who are not on the lease live with them, or opens their home to friends who use substances while they are trying to maintain sobriety.

Relapsing and failing. Clients are sometimes surprised at the difficulty of adapting to housing and may be dealing with fear, self-doubt, and a sense of failure when difficulties arise. These feelings may translate into a sense of “undeserving” that chips away at their motivation to take the steps necessary to maintain housing. ³

There are many other issues that arise in conjunction with these challenges. People with substance use issues are at risk of relapse after moving into housing—and particularly for people who use opioids and may have had their tolerance decreased after being away from substances, there is an increased risk of overdose and death related to overdose. The sudden isolation can have repercussions for both substance use disorder and mental health. In some cases, phobias may arise, or individuals may have difficulties staying inside when they are used to sleeping outdoors. In addition, the large change in environment and daily routine can cause trauma histories to manifest in new ways.

This wide range of post-housing challenges is, of course, highly individualized—and an effective care plan must account for the individuality of a client’s needs.

III. Individual Needs, Risks, and Traumas



“

Just like the individual challenges that every person navigates, the transition out of the trauma of homelessness and into a place of safety and security and stability looks so different for everyone.”

*- Brittney Dunham,
Preble Street,
Portland, ME*

Brittney Dunham is Senior Director of Residential Services at Preble Street in Portland, Maine. Preble Street is a nonprofit human service agency that provides low-barrier services for people experiencing homelessness, hunger, and poverty throughout the state of Maine. This includes street outreach, teen services, emergency food programs, anti-trafficking services, a temporary quarantine shelter, and three Housing First apartment buildings, which are overseen by Ms. Dunham. The three apartment buildings focus on wraparound services and are staffed 24 hours a day. The staff works to mitigate eviction risks and provide security in the building. Residents are provided with continuous case management that connects them to medical services as well as mental health and substance use providers, all of which are provided in-house to decrease the need for transportation.

Ms. Dunham notes that the biggest challenge faced by the programs she works with is that housing is really not a one-size-fits-all approach for anybody. Just like the individual challenges that every person navigates, the transition out of the trauma of homelessness and into a place of safety and security and stability looks so different for everyone. Overall, there is a gap in the type of services that are provided for people who are experiencing homelessness. There is a thought that people should transition into whatever they are provided, with no consideration for what someone has experienced or might experience later, and this sets people up for failure. Societally, people ask: What could go wrong when we stick people in an apartment? Isn't this what they wanted? But the reality is that it takes more than just four walls for someone to feel safe and secure in their housing situation.

“In the provider community, people sometimes think that this is the thing we've been working toward, finding someone a place to live, and forget to talk about the ways that people still need to be supported—in some cases, even more—once they move into housing,” says Ms. Dunham. “We don't talk enough about the transition, the loneliness, the isolation once the chaos of their lives sort of falls to the side. Housing doesn't mean that everything is

III. Individual Needs, Risks, and Traumas *(cont.)*

solved. From a health care perspective, I also think that sometimes care providers have the idea that once people don't have to worry about finding a place to sleep and getting their needs met, everything else will fall into place and people will want to work on other issues (like medical issues, substance use, mental health, etc.). But that is also a whole process that requires wraparound supports. We need to continue to have grace and understanding with people."

In the development of wraparound supports, Preble Street incorporates a highly individualized approach that accounts for the different histories and needs of different clients. Case workers "meet people where they are at." A big piece of the approach is focused on activities of daily living, or "helping people acclimate to living in an apartment for sometimes the first time in their lives, and minimizing the possibility of eviction," explains Ms. Dunham. She notes that a large number of clients struggle with hoarding, "coming from years of having nothing to collecting everything they



Photo provided by Pathways to Housing PA

can once they have an apartment. Other folks have only lived communally and don't know how to cook or clean or upkeep the apartment. And the largest component that is a key motivator in this work is making sure that people feel really connected to community. When you are in homelessness, you have a built-in community of other people with you—soup kitchens, shelters, camps; you're always surrounded by people, and whether or not they are your friends, there are people around. Moving into an apartment can be incredibly lonely, so implementing harm reduction activities into the daily lives of everyone in these buildings is a key component. Some people come in and need help accessing services (like food stamps, Social Security, disability benefits, etc.); for others, what's needed is vocational work, reacclimatizing to working or volunteering, or relearning how to integrate back into society. We want people to have time to think about and learn about what they want for themselves, and how they can begin to dream about their lives again."

“**...the largest component that is a key motivator in this work is making sure that people feel really connected to community.**”

IV. Developing Supportive Wraparound Services



“

There isn't really a way to predict who it will be that struggles, or what their specific issues will be... which is why it is so important to build a trusting relationship so that folks know they can come to you without fear of losing their housing.”

*- Caitlin Synovec,
National Institute for
Medical Respite Care*

Caitlin Synovec is Program Manager at the National Institute for Medical Respite Care (NIMRC), an initiative of NHCHC. Before joining NIMRC, Ms. Synovec worked in direct services as an occupational therapist (OT) in Baltimore. In that capacity, she assisted clients with the many skills that need to be developed or re-established for people who have been recently housed or who have experienced a setback (e.g., a health event like a fall or a stroke) after a period of being housed. This skill set included health management skills, organizing a home, cleaning, getting to know a neighborhood, accessing transportation, cooking, and developing other skills necessary for daily life.

Ms. Synovec notes that one important lesson she learned is that “it’s hard to predict what will make a person successful and what their barriers will be. As a provider, you have to recognize that... some people may get into housing and thrive and not need you (which is wonderful), while in other cases the transition may be really difficult for people. Some people may not do as well as you expected, so...you have to be flexible and ready to address new things that come up. There isn’t really a way to predict who it will be that struggles, or what their specific issues will be...which is why it is so important to build a trusting relationship so that folks know they can come to you without fear of losing their housing.”

In terms of practical suggestions, Ms. Synovec recommends spending time with people in their homes, if they are comfortable with that. This allows care providers to work on skills and services in the daily geography of clients' lives, using specific applications and examples that clients can try out right away. It also “shifts the power dynamic a bit,” notes Ms. Synovec, “because you are in their space... doing the work right where they are living.”

She also emphasizes the importance of collaborating with a case management team to address both mental and physical health needs of a person, based on their priorities. It is important for teams to be constantly communicating about the client’s needs and progress from the perspective of team members with expertise in medical care, mental health, substance use treatment,

IV. Developing Supportive Wraparound Services *(cont.)*

community resource supports, etc. Of course, different organizations have different levels of resources available to support clients, but some case management teams may also include additional health care professionals. For example, it would be extremely helpful to include occupational therapists to help with skill development on home visits, physical therapists to assist with chronic pain and mobility limitations, or home health care and personal care attendant services. (It is important to note that due to the stresses of homelessness and untreated chronic health conditions, patients who are housed at 50 may have the health needs of 75-year-olds in some cases, so they may need additional medical help and lifestyle supports in order to live independently.)

In addition to providing recently housed individuals with access to a case management team and the support of experts, education is a key piece in promoting the development of personal skill sets and increased self-reliance. People who have been living in shelters or outdoors, in some cases for many years, often need specific instructions on how to take care of themselves in a housed setting.



Photo provided by Pathways to Housing PA

IV. Developing Supportive Wraparound Services *(cont.)*

For example, Boston Health Care for the Homeless Program (BHCHP) uses a Housing Guide to educate clients moving into housing on the skill set that is needed to maintain housing.⁴ This Housing Guide was developed by **Joanne Guarino**, BHCHP Consumer Advisory Board and Board of Directors member, and illustrates the importance of peer support during housing transitions. The Guide includes space for new tenants to record important contact information, and contains a list of resources that may be helpful as they settle in. It also has step-by-step instructions on things like:

- **How to stay safe and create a safety plan**
- **How to keep rooms clean (a room-by-room guide)**
- **How to buy groceries**
- **How to do laundry**
- **Weekly meal planner template**
- **How to keep track of appointments and bills**
- **How to keep a weekly schedule**
- **How to create a budget**
- **How to open a bank account and write a check**
- **How to stay connected to family and friends**
- **How to get a photo ID**
- **How to get a library card**
- **How to use the internet**
- **How to set up an e-mail account**
- **How to be informed about your record**

Written resources like this one, particularly when used in conjunction with home visits by supportive members of a care team, can help newly housed individuals transition into a new way of thinking about being in their new home.

V. Key Principles and Best Practices



“

We immediately offer rental subsidies and housing with no barriers to those who need it. There is no predetermined end point.”

- Andrew Spiers,
Pathways to Housing PA

Understanding the numerous challenges associated with transitioning from homelessness to housing will lead care providers to clearly see the importance of wraparound supports and education at every stage of the process. This process of offering both material and educational resources is enhanced by the integration of important principles of trauma-informed care. This section will offer a more in-depth look at some concepts and principles that will enhance relationship building and collaboration at every stage of the housing process, with the goal of increasing housing retention in the interest of the health and well-being of clients.

VI. A Deeper Look at Housing First

Andrew Spiers is Director of Training and Technical Assistance at Housing First University,⁵ a program of Pathways to Housing PA located in Philadelphia, Pennsylvania. This program



operates seven clinical teams serving 550 formerly homeless adults, all of whom have a history of chronic homelessness and diagnosis of a persistent mental illness and/or substance use disorder. Most of these clients would not be considered ready to live independently by other programs and services. Pathways to PA is a high-fidelity Housing First program, adhering as closely as possible to the Housing First model, and has an 85 percent housing rate after five years—which is consistent, says Mr. Spiers, with other high-fidelity Housing First programs. Housing First has been around since 1992, and Mr. Spiers says that Pathways to Housing PA incorporates 30 years of data to support their low-barrier housing programs: “We immediately offer rental subsidies and housing with no barriers to those who need it. There is no predetermined end point. Once folks get into housing, we provide comprehensive wraparound supports in the community to assist them with maintaining that housing.”

VI. A Deeper Look at Housing First *(cont.)*

The Housing First model has five key principles, explained here by Mr. Spiers in conjunction with how these principles are put into practice at Pathways to Housing:

1

Immediate access to housing with no housing readiness requirements. “We are not asking folks to abstain from substance use or take medications if they were not already doing so—just removing all possible barriers for folks to get connected to housing.”

2

Participant choice and self-determination. “This means making sure that our services are responsive to participants’ wants and needs. Our participants have the choice whether or not to engage in any treatment. There are really only two requirements for housing: that you’ll sign and adhere to the tenets of the lease, and that you’ll allow us to visit in home at least every two weeks.”

3

Multiple pathways of recovery orientation. “We recognize that folks may or may not want to pursue recovery, and that recovery looks different for everyone. We don’t preach abstinence-only, we utilize harm reduction, and we recognize that recovery is not linear and folks have different goals even as we offer support and resources.”

4

Individualized and participant-driven supports. “We don’t have a lot of set rules and policies because we want our programs to be responsive rather than prescriptive, and to account for the personal experiences of the folks we are working with. Activities and service offerings have been expressly requested by participants and we are responding to them rather than inventing offerings. We offer activities and connect people to resources so that eventually they can continue to pursue those things on their own. We are doing things with people, not for people.”

5

Social and community inclusion. “Our motto is: ‘Providing homes, restoring health, and reclaiming lives.’ We are getting people into housing and connecting people with health care to address underlying health conditions, but we are also helping folks rekindle relationships with friends and family or connect with faith-based groups or pursue volunteer opportunities or employment. We are addressing all the domains of community inclusion so that our participants feel like fully invested community members who can pursue their goals and dreams.”

VI. A Deeper Look at Housing First *(cont.)*

Mr. Spiers sees these core principles as speaking directly to the difficulties that people encounter upon being housed. “The sense of isolation can be really challenging for folks. We see individuals who have been unsheltered for 30 years live in a unit and not spend much time there, or sleep on the floor for months, or maybe it takes a year before they move into their bedrooms. We can normalize that and support people through it. We all know that change causes stress—and not just bad changes. Positive changes are also stressful as you learn new things. So we provide extra support around those transition times. When we move someone into their first unit, we might go see them every day for a while, to make sure they are adjusting and that there are no concerns. (A small concern can turn into a large problem in a couple of weeks.)”

Mr. Spiers emphasizes that presence and follow-ups are a part of trauma-informed care. He notes that the experience of homelessness itself is “actively traumatizing,” so care provision has to be considered. Becoming housed may be difficult because of trauma histories, and may even bring up traumatic events. “The self-regulation skills we teach folks in therapy may not be possible for people actively experiencing the traumas of homelessness. We can’t teach folks not to be hyper-vigilant when they need to be hyper-vigilant to survive. We have to make sure that our interventions make sense based on circumstances,” and that people are given time, support and de-stigmatizing care as they process their trauma histories in a new environment.



VII. Principles of Care



“

A crisis is an opportunity for growth and new learning that can inform future iterations of the safety plan, as we find out what else is needed or wanted for support.”

*- Jay Levy,
Eliot Community Human
Services*

Jay Levy is the Regional Manager at Eliot Community Human Services in Lexington, Massachusetts. Eliot CHS has outreach teams that do a mix of clinical work, case work, and peer work, and works with a Housing First program—transitioning people into housing then working with housing stabilization issues. Housing stabilization efforts follow the REACH model: “While we’re still doing outreach,” explains Mr. Levy, “we pair a housing stabilization worker that also engages with the clients, working as a team to bridge the engagement and trust...by developing a common language and learning to represent the goals, objectives, and values of the client. Outreach workers and housing stabilization workers participate together in the transition into housing, then the housing stabilization worker stays on the case.”

Mr. Levy explains further: “One thing we do in preparing people to transition to housing is talk about the universal challenges that we all face when trying to maintain housing. Our four mantras are: Pay rent, get along with neighbors, take care of property, and stay safe. We are here to assist with those universal challenges and journey with the client... and if there’s an issue in any of those areas, figure out together how we can make it go more smoothly.”

“When someone is housed, we do a great welcoming and celebration involving outreach and housing stabilization workers. We provide housewarming gifts, have something celebratory like a cake or cookies, and talk with the client about their journey and how they were able to get to this point—both what has and hasn’t worked. We praise their successes. Then we jump off into discussing challenges with maintaining the place. At the end of the celebration, we talk about the idea of safety planning. We communicate about a safety plan [in case] there is a crisis with any of the four key concerns, or a mental or physical health crisis, or an addiction crisis... A crisis is an opportunity for growth and new learning that can inform future iterations of the safety plan, as we find out what else is needed or wanted for support. This often leads into working with people on their pathways to recovery. Our Housing First model does not require sobriety or recovery or meds compliance, but as we journey with a person who is hitting barriers, and can see together, jointly with the client, whether any

VII. Principles of Care *(cont.)*

of these challenges connect to perhaps other issues with addiction or health or the need for more supports in their lives. And ultimately, we are trying to connect people to a meaningful structure in their lives.

"The Housing First research has shown that one of the things involved in successful housing is [community integration]; even if people maintain housing [after homelessness], they often have a profound sense of isolation. So we look at how to connect people to meaningful structures and broaden their natural supports with community and friends and neighbors. This could be a gym, or anything else that is meaningful for them. It's not about our agenda or what we think it should be, but about what resonates with the client."

According to Mr. Levy, the work at Eliot CHS Western MA Homeless Services follows a Pretreatment model to Homeless Outreach and Housing First. This model is based on five principles of care, which Mr. Levy describes like this:



1. Relationship Building

"In terms of stages of engagement, we are always assessing where we are in our engagement," Mr. Levy says. This involves the initial development of communication with the purpose of establishing trust and safety in the relationship, and involves communicating with clarity, from the outset, about the client's wants and needs as well as the organization's roles and offerings. Ongoing communication, based on this atmosphere of trust and safety, may involve making goals with the patient and developing guidance for ongoing work together based on the client's needs and values.

2. Common Language Development

It is crucial to relationship building that time is taken to develop a common language. This involves understanding the client's history, goals, and personal narrative, and paying attention to the words and phrases that they use to describe themselves. By listening for the ideas that the client likes to discuss, their approach to life, and their hopes, it is possible to develop a shared language where both people understand each other clearly and can discuss goals and aspirations.

3. Supporting Transitions: Interpreting and Bridge-Building

Beginning with understanding the inner and outer world of the client, the next step involves making a bridge between the client and available services. This may involve accompanying the client to

VII. Principles of Care *(cont.)*

appointments, or helping them access things like Social Security or disability benefits, and it may involve a linguistic component. There can be a language and cultural gap between the client and the resources and services that exist to assist them, and part of supporting the client's transition into housing involves interpreting these worlds. For example, it can be helpful to prepare a client for the language they will experience at a different resource (like a mental health clinic or a government office) to increase the client's sense of comfort at entering into a new environment. It is important, emphasizes Mr. Levy, "to keep in mind that clients are often traumatized and triggered by language about treatments and services and resources... so [building this bridge] can help avoid the client being triggered or shutting down."

Motivational Interviewing and Stages of Change

- * **Pre-Contemplation:** "Not even ready to think about making a change"
- * **Contemplation:** "Beginning to consider making a change, but not yet ready to make a commitment"
- * **Preparation:** "Preparing for action to change in the foreseeable future"
- * **Action:** "Actively implementing a plan for change"
- * **Maintenance:** "Maintaining, integrating, and developing the changes that have been made"

-- From Massachusetts Behavioral Health Partnership, found at <https://www.masspartnership.com/pdf/MotivationalInterviewingStagesofChange.pdf>

4. Facilitating Change

Mr. Levy uses the stages of change model (see text box) and motivational interviewing to assess where people are in the change process, specifically referencing their positionality in regard to:

- Substance use
- Mental health
- Medical concerns
- Income generation
- Housing

VII. Principles of Care *(cont.)*

Motivational interviewing can be used to understand which stage of change a person is experiencing in each of these areas. As Mr. Levy explains: “Perhaps they are in the action phase of wanting to get housed and have begun filling out applications and retrieving documentation...or perhaps they are pre-contemplative and haven’t expressed much interest yet. We work differently with them depending on which stage they are in, and we also identify and work with discrepancies—for instance, how addiction may not match up with a professed value and desire to change. We discuss discrepancies with clients in order to generate awareness, [but only when] they already like us and trust us and see that we are respecting their autonomy and pointing things out in a way that can be helpful for them in their goals.”

5. Promoting Safety

Safety promotion must be prioritized in terms of crisis intervention; for example, when people are in need of active crisis intervention or crisis-based services such as emergency medical services, detox, respite, or urgent mental health care—as well as in terms of harm reduction. Mr. Levy notes that “harm reduction comes together with facilitating change and helping people move into contemplative stages and action stages of change. For example, if someone is living outside and doesn’t want to go to a shelter, we might set them up with a tent and sleeping bag as harm reduction, but we are also using those items as a way of encouraging engagement and opening discussions about the housing search; we may be coming to understand why the person feels unsafe in shelters, and talking about whether there is a reasonable accommodation that can be made.” Measures designed to protect the safety of individuals and communities via harm reduction are measures that can open up lines of communication, care, and conversation—and potentially access, support, and change.

“

It’s all relationship-based work. We’re looking to take part in a productive dialogue that helps us cross cultural divides. Part of my advice is to be very aware of cultural divides as we connect with people in the field; there are many of them, all around us, if we tune in.”

- Jay Levy

Mr. Levy offers the following advice about bringing these five principles of care together to support clients on their journeys: “It’s all relationship-based work. We’re looking to take part in a productive dialogue that helps us cross cultural divides. Part of my advice is to be very aware of cultural

VII. Principles of Care *(cont.)*

divides as we connect with people in the field; there are many of them, all around us, if we tune in. Relationship building and common language development are essential to getting us to communication across cultural divides of age (young or elder), race (POC or white), class (middle-class and housed or unhoused and impoverished). It may also be that [a care provider] hasn't personally experienced a culture of addiction or recovery, such as AA or the 12 Steps. All of these can be divides. So it's important to learn the language that the other person speaks, as the onus is on us to do the crossing of the divide—which means tuning in and learning to listen well, and to respond in a way where we are upholding what is being said to us. And all the work flows from there, if we are able to get goal-focused while still cultivating accepting, open presence.”⁶

“

...we really need to remember to honor the voices of the people we're working with and really listen to what they are saying and what they feel they need and want.”

- Brittney Dunham

Brittney Dunham echoes the importance of developing trusting relationships where clients have autonomy to express themselves and formulate their own goals: “We come into this work for all the right reasons, with all the best intentions, and are working toward a common goal of helping people move toward a place of stability, recovery, and housing. But we really need to remember to honor the voices of the people we're working with and really listen to what they are saying and what they feel they need and want. In our work in Portland, that comes into play when we are discussing the best placement sites for people, because we want to make sure that we are getting everyone housed. But if we don't consider individuals and listen to what people need or want, we can do harm despite having the best intentions. If a person is really resistant to housing or rejecting apartments, there is probably a good reason for that, which might be based in fear or past experiences. Pushing things on people and not allowing people to be autonomous in this work is really harmful and will also affect their future relationships with the provider community.”

VIII. Conclusion

Housing is healthcare, but housing does not make problems magically disappear for people who have been experiencing homelessness. A high level of understanding and consciousness among care providers, plus a robust network of wraparound supports, is necessary to support people through the many challenges that arise when transitioning into housing. At the core of all of these supports should be an acknowledgment of the autonomy of the client, and a trauma-informed commitment to supporting them, as they are ready to take steps to change their lives, improve their health, and return to planning and dreaming about their futures. At the core of these supports should be the focus that the transition into housing can be a difficult one, and that this new chapter should be client-centered as well as client-led. The role of support staff is to provide trauma-informed accompaniment along the client's journey.

“In the 1980s,” says Jay Levy, “I was doing outreach work in New York City at the time of the HIV/AIDS epidemic, and for the first time, people were coming in who had been newly diagnosed with this terrible disease and were being rejected by peers and family. In that moment, I really discovered the power of meeting people where they were and connecting with them. There was little to do medically at that point, but just being with someone and not being fearful of them broke down barriers and helped cross divides. The power of acceptance is key: not being judgmental, really listening, saying you are there to work with them on what they want to do, and respecting their autonomy. And that's held up when we discuss goals and aspirations, particularly if those goals and aspirations also connect to the meaning in that person's world. It's important that we tune into people's stories—more than just the phrasing or words, but their stories and journeys and sense of meaning—then working with it rather than against it.”

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References

¹ Henwood, Byrne & Scriber. (2015). Examining mortality among formerly homeless adults enrolled in Housing First/ An observational study

² CSH. (2019). Health Outcomes & Data Measures: A Quick Guide for Health Center & Housing Partnerships

³ To read the report and supplementary case studies (NHCHC, 2011), visit: Policy and Practice Brief: Case Studies Illustrating Clinical Challenges in PSH and Clinical Challenges in Permanent Supportive Housing.

⁴ Guarino, Joanne. (n.d.) Housing Guide: Tips and Tools for a Successful Housing Experience.

⁵ For more information about the training opportunities, technical assistance, and consultation services offered by Housing First University, visit their website at HousingFirstUniversity.org

⁶ For more information on Jay Levy's new book and other publications and resources on homeless outreach and Housing First, visit his website at www.jayslevy.com

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