Introduction

In recent years, Housing First has emerged as a key response to homelessness in many parts of the world including the United States, Europe and across Canada. It is considered to be a highly significant policy and practice innovation that has had a dramatic impact on how homelessness is addressed. As the popularity of Housing First grows and takes deeper root across Canada, there is a growing interest in understanding how it works, and how it can be adapted to different community contexts.

As more and more communities move to embrace Housing First, there is a need to understand what works and for whom, and the contextual factors that shape success in facilitating community buy-in, and in the planning and implementation of the model. Housing First does not promise to be the only response to homelessness in a given community – ideally it plays an important role alongside other interventions, including prevention, emergency services, and other models of accommodation and support (including effective transitional and supportive housing models that lead to permanent and adequate housing). However, as a key strategy in reducing homelessness, the evidence for the effectiveness of Housing First cannot be disputed. Considerable research in Canada, the United States and other countries attests to the effectiveness of this model in providing permanent housing and supports to individuals and families we might otherwise deem 'hard to house', including the chronically homeless and those with complex mental health and addictions challenges.

The planning and implementation of Housing First is sometimes a challenge in communities where there is a lack of clarity about exactly what it means and how it works in different community contexts. There is often skepticism about whether local circumstances and conditions will allow for its effective application (Can it work in small towns or rural areas? What if there is very little affordable housing?). There is sometimes resistance from traditional service providers because the underlying philosophy of Housing First may clash with established values (the focus on Harm Reduction, for instance) or be seen as a threat to the status quo. Finally, there are questions about its effectiveness and applicability for specific sub-populations, be they youth, Aboriginal persons, or those with addictions or mental health challenges.

The framework presented here is intended to provide an overview of Housing First, its history and the core principles that underlie its application, drawing on the extensive research and evidence that now exists. The framework also outlines the 'philosophy' of Housing First, different program models and articulates some key issues that can have an impact on successful implementation. A common framework for Housing First provides researchers, planners and communities with clarity and guidance in developing effective strategies for implementation.

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What is Housing First?

Housing First is a recovery-oriented approach to homelessness that involves moving people who experience homelessness into independent and permanent housing as quickly as possible, with no preconditions, and then providing them with additional services and supports as needed. The underlying principle of Housing First is that people are more successful in moving forward with their lives if they are first housed. This is as true for homeless people and those with mental health and addiction issues as it is for anyone. Housing is not contingent upon readiness, or on 'compliance' (for instance, sobriety). Rather, it is a rights-based intervention rooted in the philosophy that all people deserve housing, and that adequate housing is a precondition for recovery. According to Pathways to Housing, an early adopter of Housing First programs in the U.S., "The Housing First model is simple: provide housing first, and then combine that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment." (Pathways to Housing website).

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Housing First is often held up as a way of doing things differently. As an approach, it can be contrasted with what has often been the standard approach to working with homeless people, where there is an expectation that individuals and families first ready themselves for housing by addressing their mental health or addictions problems, or minimally, that individuals and families move out of homelessness of their own 'free will', with little active intervention (Waegemakers-Schiff & Rook, 2012). This has been characterized as a 'treatment first' or 'treatment as usual' approach: people who are homeless are placed in emergency services and then other kinds of supported living environments (such as transitional housing) until they are deemed 'ready' for independent living (having received access to health care or treatment) or until housing is available. This service model is often highly regulated and involves expectations of compliance with treatment and abstinence from drugs and alcohol.

The Housing First approach differs substantially from the treatment first model, and is typically operationalized in the following way. First, through outreach or a targeted approach, people who are homeless are presented with the option of housing, without it being conditional on any lifestyle, behavioural or treatment expectations (such as abstinence). Second, people have some say in terms of the type and location of housing, taking into account the availability of affordable housing in a given community. There is an expectation that housing be of reasonable quality. Third, people are rehoused as rapidly as possible, minimizing time spent absolutely homeless or in emergency services. Finally, ongoing services and supports are offered and made available to those who want them and need them. These can include rent supplements, case management, help developing connections within the community, etc. For those with addiction issues, housing is not conditional on sobriety. Others may want abstinence-only housing. Matching supports to client needs and to the acuity of mental health and addictions issues is a challenge for effective programming. While providing shelter and supports is central to Housing First, the approach works best when it helps people nurture supportive relationships and become meaningfully engaged in their communities.

In most communities struggling to deal with homelessness, resources are generally scarce and priority is often given to high-needs clients who may have more trouble obtaining and maintaining housing on their own. This includes families, chronically homeless individuals and those with mental health and addiction challenges.

A History of Housing First

The roots of Housing First in Canada go back to the 1970s. At that time, Houselink, in Toronto, developed an approach to working with people with mental health and/or addictions issues where the provision of housing was considered a priority. The term 'Housing First' came into popular usage because of the development of programs in New York (Pathways to Housing) and Los Angeles (Beyond Shelter) (Waegemakers-Schiff & Rook, 2012). Though the name originated with the latter example, the concept was popularized by Sam Tsemberis through his work with Pathways to Housing (New York), which was established in 1992 (Padgett, 2007).

It is worth providing a short description of Pathways to Housing (Pathways), as this model has informed many future developments in Housing First. Pathways targets homeless people with more serious mental health and addictions issues (McCarroll, 2002). It began with a realization that for people struggling with these issues, prolonged experiences of homelessness often worsened their mental health or addictions issues.

According to the Pathways model, clients are identified through two intake streams; either through street outreach or discharge planning from hospitals. Once contact is made, clients discuss and choose the type of housing they want (and where) and the type of supports they will need. Working with private landlords and using a scattered site model, clients are offered accommodation. The definition and importance of scattered-site housing is emphasized in this quote by Sam Tsemberis:

> "It is not specialized housing, it is ordinary housing. What makes it different and what makes it effective is that people are also provided with lots of good services […] For people who have spent years excluded, in group homes, hospitals, jails, shelters, and other large public service settings, having a place of their own, their own home, has a huge appeal" (Tsemberis, as quoted in Evans, 2012).

Clients are provided with rental supplements, with the goal that they pay no more than 30% of their income on rent. Basic furnishing and supplies are provided, in order to help the person get set up in their new home. The only conditions of participating in the Pathways program are that people be willing to participate in a money management program whereby their rent is paid directly to a landlord (Greenwood et al., 2005), and that they agree to at least two staff visits per month.

Because a large number of clients have high needs, some will be provided with Intensive Case Management (ICM) to help them get established, while others with more acute needs may receive support from Assertive Community Treatment (ACT) teams on a weekly basis (Padgett, Gulcur & Tsemberis, 2006). The ACT team typically includes a nurse, psychiatrist, addictions specialist, employment counsellor and a peer.

> "Involvement of the ACT team, which is available 24/7, is meant to assure that tenants do not become completely isolated, decompensate (inability to maintain defense mechanisms in response to stressors) to the point of requiring hospitalization, become destructive to the point of jeopardizing the rental housing, and are not left without resource contacts for additional supports. The ACT team is also intended to provide quiet encouragement to those who wish to enter or maintain mental health and/or substance abuse treatment" (Waegemakers-Schiff & Rook, 2012:6).

The Pathways model emphasizes a recovery-oriented approach to services. This means that housing and clinical services are supplemented by regular counselling, life and social skills training, etc. and that all services are provided in a client-centred way. Support services are considered voluntary and housing is not conditional upon accepting treatment. People receive support based on their own choices and for as long as they feel it necessary. Once conditions improve, many people choose to end supports. "People are free to stop treatment when they decide they do not need them or are not benefiting from them. They are also free to return to services if they feel they need additional support. Our overall goal is recovery and full integration into the community" (Tsemberis, as quoted in Evans, 2012).

One of the strengths of the Pathways program is that it has been extensively evaluated, thus providing an evidentiary basis for the effectiveness of the intervention. Support for Housing First grew in the United States as the National Alliance to End Homelessness (NAEH) and the United States Interagency Council on Homelessness (USICH) both promoted the philosophy and program model as essential components of 10 Year Plans to End Homelessness.

The success of the Pathways model, and its adoption and active promotion by the NAEH, and by Philip Mangano of USICH, meant that people began to think more seriously about its applicability north of the border. The first large scale application of a program using a Housing First philosophy in Canada was the Streets to Homes program developed and implemented by the City of Toronto in 2005, after a pilot program that involved successful relocation of one hundred 'tent city' squatters (Falvo, 2008). Targeting rough sleepers, the Streets to Homes mandate is to "serve homeless people who live outdoors, which includes individuals living in parks, ravines, under bridges, on sidewalks, laneways, alleys, stairwells, building alcoves, squats and living in vehicles" (City of Toronto, 2007:61). Over 60% of Streets to Homes clients are housed in private rental units, about 20% in social housing, and an additional 18% in alternative/supportive housing units (Falvo, 2009).

Since that time, Housing First has been taken up and applied in many communities in Canada. In Vancouver, the prospect of hosting the Winter Olympics spurred the local community to implement a Housing First program. In 2008, all 'Seven Cities' in Alberta implemented Housing First as part of their adoption and adaptation of 10 Year Plans to End Homelessness. Around that time, Canada's Homelessness Partnering Strategy began advocating for Housing First as an underlying principle and practice that should be adopted by the 61 communities they fund.

The *At Home/Chez Soi* initiative, funded by the Mental Health Commission of Canada (MHCC) and which took place from 2009-2013, is one of the most important developments to solidify Housing First as a paradigm-shifting approach to homelessness in Canada. It is significant in several ways. First, the Government of Canada provided $110 million for the pilot project, which is a significant single investment that highlights the degree to which Housing First is emerging as a priority. Second, the projects in Moncton, Montréal, Toronto, Winnipeg and Vancouver were designed to enhance understanding of the opportunities and challenges to implementation when working with specific sub-populations, including Aboriginal people, newcomers, youth, etc. Finally, the funding prioritized research and evaluation, so that *At Home/Chez Soi* has emerged as the world's largest and most in-depth evidence-based exploration of the effectiveness of Housing First. The project has been reporting results that highlight program effectiveness and also shed light on effective strategies for planning and implementation. A final report is expected by the end of 2013.

The Core Principles of Housing First

The increasing popularity of Housing First and the variable ways in which the concept has been taken up and applied raises important implications about what Housing First is and what the underlying core principles are. On the one hand, the adaptability of the Housing First model means that communities can devise programs to meet their specific needs. Local and national contexts demand that the model be adapted. Such has been the case with the Pathways model as it has travelled around the globe. For example in many European countries and in Australia, the underlying and fundamental principles of Housing First have been applied in a variety of ways. The importance of taking into account cultural, policy and structural differences in social, health, welfare and housing supports suggests that strict adherence to the Pathways model may be neither practical nor desirable (Atherton & McNaughton Nichols 2008; Johnson et al. 2012; Pleace, 2010; Pleace & Bretherton, 2012; Johnsen & Texiera, 2010).

On the other hand, in Canada, there is growing interest in the model by policy makers, funders and providers. This suggests that fidelity to the core principles of Housing First is important in order to ensure that the program being undertaken is in fact a Housing First program. That fidelity to the core principles of Housing First may not be adhered to as it becomes more popular is not an idle concern[1]. In a review of Housing First practices in North America and Europe, Pleace and Bretherton argue that:

> "As 'Housing First' has permeated the thinking of policymakers and service providers across the US and the wider world, the core ideas of (Pathways to Housing) have been simplified, diluted and in many instances, subjected to change. The (Pathways to Housing) paradigm often only has a partial relationship with the wide range of new and remodelled homelessness services that have been given the 'Housing First' label (Kaakinen, 2012; Pearson et al, 2009; Pleace, 2012; Tsemberis, 2011, as quoted in Pleace & Bretherton, 2012:5).

As such, the case can be made that in the Canadian context, the philosophy and program model of Housing First must be guided by core principles. As new approaches to a complex issue become more popular, the concept can become a 'brand'– a name that can be applied to any program that provides accommodation and supports for people who experience homelessness. As such, it is important to define clear core principles to help articulate and clarify what is meant by Housing First, in order to guide planning and implementation. From a quality assurance perspective, such principles can become necessary to ensuring fidelity to the overarching goal of Housing First. While a number of programs and communities have attempted to articulate core principles (and these vary somewhat in emphasis[2]), the core principles presented here seek to identify what is common amongst these approaches.

THE CORE PRINCIPLES OF HOUSING FIRST INCLUDE:

1. IMMEDIATE ACCESS TO PERMANENT HOUSING WITH NO HOUSING READINESS REQUIREMENTS.
   Housing First involves providing clients with assistance in finding and obtaining safe, secure and permanent housing as quickly as possible. Key to the Housing First philosophy is that individuals and families are not required to first demonstrate that they are 'ready' for housing. Housing is not conditional on sobriety or abstinence. Program participation is also voluntary. This approach runs in contrast to what has been the orthodoxy of 'treatment first' approaches whereby people experiencing homeless are placed in emergency services and must address certain personal issues (addictions, mental health) prior to being deemed 'ready' for housing (having received access to health care or treatment).

1. The *At Home/Chez Soi* project is developing a fidelity scale that can be used by communities to assess the degree to which their program model matches core values and principles of Housing First.
2. The core principles espoused in this document are a slight variation of those cited on the Homeless Hub (Gaetz, 2012), which were adopted by the *At Home/Chez Soi* project. These principles were in turn shaped by those identified by Sam Tsemberis (Pathways), and by the Calgary Homeless Foundation (Appendix A).

2. CONSUMER CHOICE AND SELF-DETERMINATION. Housing First is a rights-based, client-centred approach that emphasizes client choice in terms of housing and supports.

   - Housing - Clients are able to exercise some choice regarding the location and type of housing they receive (e.g. neighbourhood, congregate setting, scattered site, etc.). Choice may be constrained by local availability and affordability.
   - Supports – Clients have choices in terms of what services they receive and when to start using services.

3. RECOVERY ORIENTATION. Housing First practice is not simply focused on meeting basic client needs, but on supporting recovery. A recovery orientation focuses on individual well-being. It ensures that clients have access to a range of supports that enable them to nurture and maintain social, recreational, educational, occupational and vocational activities.

   For those with addictions challenges, a recovery orientation also means access to a harm reduction environment. Harm reduction aims to reduce the risks and harmful effects associated with substance use and addictive behaviours for the individual, the community and society as a whole, without requiring abstinence. However, as part of the spectrum of choices that underlies both Housing First and harm reduction, people may desire and choose 'abstinence only' housing.

4. INDIVIDUALIZED AND CLIENT-DRIVEN SUPPORTS. A client-driven approach recognizes that individuals are unique; so are their needs. Once housed, some people will need minimum supports while other people will need supports for the rest of their lives (this could range from case management to assertive community treatment). Individuals should be provided with "a range of treatment and support services that are voluntary, individualized, culturally-appropriate, and portable (e.g. in mental health, substance use, physical health, employment, education)" (Goering et al., 2012:12). Supports may address housing stability, health and mental health needs, and life skills.

   Income supports and rent supplements are often an important part of providing client-driven supports. If clients do not have the necessary income to support their housing, their tenancy, health and well-being may be at risk. Rent supplements should ensure that individuals do not pay more than 30% of their income on rent.

   It is important to remember that a central philosophy of Housing First is that people have access to the supports they need, if they choose. Access to housing is not conditional upon accepting a particular kind of service.

5. SOCIAL AND COMMUNITY INTEGRATION. Part of the Housing First strategy is to help people integrate into their community and this requires socially supportive engagement and the opportunity to participate in meaningful activities. If people are housed and become or remain socially isolated, the stability of their housing may be compromised. Key features of social and community integration include:

   - Separation of housing and supports (except in the case of supportive housing).
   - Housing models that do not stigmatize or isolate clients. This is one reason why scattered site approaches are preferred.
   - Opportunities for social and cultural engagement are supported through employment, vocational and recreational activities.

While all Housing First programs ideally share these critical elements, there is considerable variation in how the model is applied, based on population served, resource availability and other factors related to the local context. There is no 'one size fits all' approach to Housing First.

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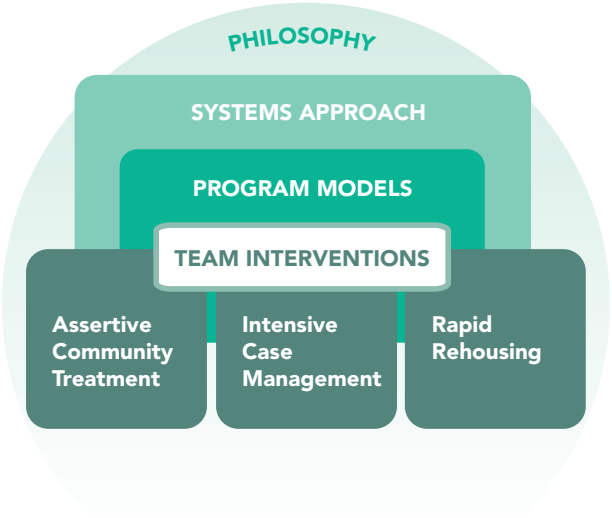
The Application of Housing First

In order to fully understand how Housing First is applied in different contexts, it is important to consider different models. While there are core principles that guide its application, it is worth distinguishing Housing First in terms of: a) a ***philosophy***, b) a ***systems approach***, c) ***program models***, and d) ***team interventions***.

FIGURE 1 **Application of Housing First**



PHILOSOPHY - As a *philosophy*, Housing First can be a guiding principle for an organization or community that prioritizes getting people into permanent housing with supports to follow. It is the belief that all people deserve housing, and that people who are homeless will do better and recover more effectively if they are first provided with housing. As a philosophy, it can underlie the work that an agency does, or that of a whole community. It can inform how outreach is conducted, or the mandate of an emergency shelter.

SYSTEMS APPROACH – Housing First can be considered embedded within a systems approach when the foundational philosophy and core principles of Housing First are applied across and infused throughout integrated systems models of service delivery. It is central to many coordinated approaches to ending homeless such as 10 Year Plans. Within a 'system of care' approach, all services and program elements within the homelessness sector – including many mainstream services - are guided by the principles of the model. As such, each program and service is expected to support and operationalize Housing First, each having a specific role to play in the larger system. While the service providers in the system are not Housing First programs on their own, they form different parts of a larger system that works towards achieving the goals of a Housing First program. For instance, many communities in Alberta have adopted the Housing First philosophy with the expectation that all programs – including emergency services – work towards this goal. The Calgary Homeless Foundation case study provides an illustration and explanation of how this works.

PROGRAM MODELS - Housing First can be considered more specifically as a program when it is operationalized as a service delivery model or set of activities provided by an agency or government body.

It is important to note that there is not a single program model for Housing First and that it can take many forms. As it grows in popularity it is applied in new ways and in different contexts, resulting in a broad range of program models. While some Housing First programs closely follow the Pathways model in that they are designed specifically to meet the needs of people with acute mental health or addictions problems, others focus more broadly on *anyone* who is homeless. The latter has been described by some as 'Housing First Light' because of the lower level of supports required, or in Europe, 'Housing Led' (Pleace & Bretherton, 2012:10). The Streets to Homes program in Toronto targets chronic rough sleepers, while other programs may focus on specific sub-populations such as Aboriginal people or youth, for instance. Different program models may offer different kinds of supports (for instance, not all programs provide rent supplements), and for different lengths of time.

The kind of housing offered may also differ substantially between programs. The Pathways to Housing model, for instance, rehouses people using a private-sector, scattered site model, which was also used by the *At Home/Chez Soi* team. This is in keeping with many studies of consumer preference regarding housing which reflect a desire to live independently in the community. In other national contexts, individuals are more likely to be provided with social housing units because there is a more robust supply; additionally, there is potentially less stigma attached to this option than might be the case in Canada (Johnson et al., 2012). Finally, in some communities individuals are housed in shared accommodation blocks, or congregate models of housing, as opposed to the scattered site approach.

TEAM INTERVENTION - Finally, one needs to consider Housing First *teams*. Teams are designed to meet the needs of specific target populations, defined in terms of either the characteristics of the sub-population (age, ethno-cultural status, for instance), or in terms of the acuity of physical, mental and social challenges that individuals face. Teams are constituted to include members with particular skills and knowledge, and with defined caseloads so that individual needs are best met. Caseloads can vary and are determined by the complexity of the client group. One of the key challenges of delivering Housing First programs is matching the team support to the needs of clients, and the different team models are often adapted to meet local needs or based on contextual factors (for instance, in smaller centres there may be limited access to health care professionals).

Housing First is implemented through the following kinds of teams:

- ASSERTIVE COMMUNITY TREATMENT (ACT) - ACT is an integrated team based approach designed to provide comprehensive community-based supports to help people remain stably housed. It is one of the most studied community programs in all of health care and has a very strong evidence base. Programs that follow the Pathways model typically offer intensive supports through ACT teams to address the needs of clients with mental health and addictions, and may support individuals in accessing psychiatric treatment and rehabilitation. These teams may consist of physicians and other health care providers, social workers and peer support workers. The latter are deemed to be key members of the team, for their experience of homelessness can become an essential resource for support and recovery. They help bridge the knowledge that other team members bring with knowledge of what it is to be homeless. ACT teams are designed for clients with the most acute needs and may provide support on an ongoing basis. In some cases, individuals will need to have access to supports 24 hours a day. The following are characteristics of ACT teams:
    - A multi-disciplinary team of professionals that provides wrap-around service directly to the client.
    - The team members are available 24/7 and provide real-time support.
    - The ACT team meets regularly with the client and with each other (could be daily).
    - The team is mobile, often meeting clients in their homes.
    - The staff to client ratio is generally 1 ACT team per 10 clients.
    - The program components are informed by client choice, peer support and a recovery-orientation.
    - Services are offered on a time-unlimited basis, with planned transfers to lower intensity services for stable clients.

Members of an ACT team include:

- Clinical/medical staff (psychiatrist, doctor, nurse, substance abuse specialists);
- Peer support workers; and
- Generalist case managers who may have varied professional/experiential qualifications and who broker access to housing and complementary supports.

ACT teams may also include:

- Housing support/tenancy expertise (landlord support, housing support per securing housing, move-in and maintenance of housing unit, rent subsidy/income support specialist);
- Basic skills training (cooking, cleaning, numeracy per paying rent); and/or
- Education/employment specialist (dedicated to broader goals of social integration and self-sufficiency).

(Adapted from the Mental Health Commission of Canada)

The ACT team model has been adapted in some contexts to address local challenges. Toronto, for instance, has established **Multi-Disciplinary Outreach Teams (M-DOT)**[3] made up of outreach workers, case managers, a registered nurse, a housing worker and part-time psychiatrist. M-DOT teams were developed with the goal of connecting with marginalized, hard to reach clients (living on the streets or in ravines, for instance) with significant illness or disability related to a health, mental health or substance use, and who may be completely disengaged (and alienated from) support services.

- INTENSIVE CASE MANAGEMENT – This can also be a team-based approach that supports individuals through a case management approach, the goal of which is to help clients maintain their housing and achieving an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. It has a moderately strong evidence base. It is designed for clients with lower acuity, but who are identified as needing intensive support for a shorter and time-delineated period. The *At Home/Chez Soi* project has identified that for many clients, the first three months can be most challenging, and providing appropriate levels of support may be crucial for recovery and retention of housing. The following are characteristics of ICM:

    - One-on-one case manager to client relationship using a recovery-oriented approach (the team of case managers may include Housing and Complementary Support Workers).
    - The case manager brokers access to mainstream services that the client identifies as needed to attain his or her goals.
    - The case manager often accompanies clients to meetings and appointments in support of their goals/needs.
    - Case managers are available on a regular schedule; caseloads are often shared to assure coverage of 7 days per week/12 hours a day.
    - The staff to client ratio is generally 1 case manager per 20 clients.
    - The duration of the service is determined by the needs of the client, with the goal of transitioning to mainstream services as soon as possible.

    (Adapted from the Mental Health Commission of Canada)

- RAPID REHOUSING – Often defined as distinct from Housing First, rapid rehousing operates on many of the same guiding principles. It is an approach that targets clients with lower acuity of mental health and addictions challenges. As such, the level of supports is much lower, and usually for a shorter period of time. Clients may be given short term rent supplements, and help in accessing services and supports.

  Rapid rehousing teams are included in this framework, because the boundaries between higher and lower needs clients can be quite fluid. In Edmonton, Homeward Trust has formed **LIFT teams** which are modified ICM teams that focus on rapid rehousing, and the provision of short-term, interim supports (three months), financial support and access to furniture, for instance.

3. MDOT is a multidisciplinary team approach that integrates housing and clinical supports. While it borrows from ACT it is time limited in duration. The objective was to transfer care to another ACT or ICM team (based on the level of need), once a client was successfully housed. This would allow access and flow in this highly specialized and well-resourced team. Some participants stayed with MDOT for 1 year or more, because this is how long it took to engage them and secure appropriate housing. That is, duration of treatment varied based on client needs.

Key Components: Housing and Supports

WHO IS HOUSING FIRST FOR?

Housing First is an approach that can potentially be applied to a broad sector of the homeless population to help them reduce or end their homelessness. However, many programs target those who experience chronic or episodic homelessness.

A common typology of homelessness categorizes people as temporary, episodic and chronic homeless in order to identify the duration of homelessness and the level of needs of services and supports4[4]. Individuals identified as temporarily homeless have a small number of episodes of homelessness that are usually of short duration. They typically manage to move out homelessness on their own, with little support from service providers. Individuals and families identified as episodically homeless have repeated episodes and for longer duration. Chronically homeless persons have fewer episodes, but for longer periods. A recent study of shelter users in Toronto, Ottawa and Guelph by Aubry, et al. (2013) found that approximately 88-94% of the homeless population can be considered transitionally homeless, 3-11% are episodically homeless, and the chronically homeless make up between 2-4%.

Episodically and chronically homeless persons are typically the target of Housing First strategies, because their life on the streets is more entrenched, their needs are more complex (mental health, health, addictions, disabilities), and the level of service use is much more intensive. Aubry et al. (2013:10) found, for instance that in spite of their small numbers, chronically homeless persons used over half of shelter bed stays in Toronto and Ottawa over a four year period. A convincing case can be made that targeting chronically and episodically homeless persons with Housing First cannot only improve the lives of impoverished people with high needs, but can also dramatically reduce the need for homelessness services over time.

Given the high needs of chronically or episodically homeless persons, the implementation of Housing First requires a consideration of the kind of housing that such individuals and families should be moved into, and the range of supports made available to them.

HOUSING

A key principle of Housing First is **Consumer Choice and Self-Determination**. In other words, people should have some kind of choice as to what kind of housing they receive, and where it is located. Understanding that housing availability is also an issue in many if not most communities, efforts should nevertheless be made to meet client needs, and ensure that the quality of housing they receive meets the Canada Mortgage and Housing Corporation (CMHC) standards of suitability. That is, housing should be adequate, affordable and suitable:

- **Adequate** housing is reported by residents as not requiring any major repairs. Housing that is inadequate may have excessive mold, inadequate heating or water supply, significant damage, etc.
- **Affordable** dwelling costs less than 30% of total before-tax household income. Those in extreme core housing need pay 50% or more of their income on housing. It should be noted that the lower the household income, the more onerous this expense becomes.
- **Suitable** housing has enough bedrooms for the size and composition of the resident household, according to National Occupancy Standard (NOS) requirements.

There are sometimes questions about the kind of housing that people should have access through Housing First. The Pathways model prioritizes the use of **scattered-site housing** which involves renting units in independent private rental markets. One benefit of this approach is that it gives clients more choice, and may be a less stigmatizing option (Barnes, 2012). It is in keeping with consumer preferences to live in integrated community settings. From a financial perspective, there is a benefit to having the capital costs of housing absorbed by the private sector. In other cases the use of **congregate models of housing**, where there are many units in a single building is seen as optimal although the effectiveness of

4. The typology of homelessness was first put forward in the United States by Kuhn and Culhane (1998). Later studies by Culhane (2007) and in Canada by Aubry et al. (2013) confirm the view that episodically and chronically homeless persons, while smaller in overall numbers, are major users of emergency and health services.

this model has not yet been proven. Benefits of this approach include supports that are more efficiently delivered, giving individuals a less isolated space where they can be directly encouraged to develop a sense of community. This is akin to the Common Ground approach pioneered in New York, and is also utilized as part of the Housing First approach in Vancouver. In some communities in Canada and more particularly in other national contexts (Australia, many European nations), social housing is more readily used to provide housing for individuals in Housing First programs. In such contexts, there is a more readily available supply of social housing, and living in buildings dedicated to low income tenants may not be viewed in a stigmatized way. In some communities such as Toronto, social housing includes both larger scale congregate settings, as well as scattered-site housing. Finally, for some Housing First clients whose health and mental health needs are acute and chronic, people may require **Permanent Supportive Housing** (PSH), a more integrated model of housing and services for individuals with complex and co-occurring issues where the clinical services and landlord role are performed by the same organization. Those who may benefit from tightly linked and supportive social, health and housing supports as a means of maintaining their housing stability may be best served by this model.

SUPPORTS

Housing First is much more than the provision of housing. It typically involves three kinds of supports[5]:

1. Housing supports: The initial intervention of Housing First is to help people obtain housing, in a way that takes into account client preferences and needs, and addresses housing suitability. This work may be done by independent housing teams, or special outreach teams tasked with making connections with people who are not accessing services through existing agencies. Key housing supports include:

- Helping the client search for and identify appropriate housing;
- Building and maintaining relationships with landlords;
- Negotiating with the landlord or access to social housing or permanent supportive housing.;
- Applying for and managing rent subsidies;
- Provide assistance in setting up apartments, including acquiring furniture and supplies;
- Landlord mediation, conflict resolution, crisis intervention;
- Develop skills for independent living.

2. Clinical supports: This includes a range of supports designed to enhance the health, mental health and social care of the client. Housing First teams often speak of a recovery-oriented approach to clinical supports designed to enhance well-being, mitigate the effects of mental health and addictions challenges, improve quality of life and foster self-sufficiency. As suggested above, the range of supports is necessarily client driven, and through a comprehensive assessment of client goals, interests and needs, appropriate services can be brought to bear. Some of these supports can be provided by the Housing First team itself (the ACT or ICM teams), and in other cases the teams will facilitate access to mainstream services.

A key challenge in providing clinical supports is matching the right supports to client interest and need. One of the things that has been learned by those who have been implementing Housing First is the need to have effective assessment measures to determine acuity. Flexibility is also important. In some cases a client may be matched with an ACT team, when it is later learned that an ICM team would be more appropriate (and vice versa). Susan McGee of Homeward Trust has remarked that it can take "several months to get the right match between client needs and appropriate supports" (McGee, Personal Communication, 2013).

3. Complementary supports: Housing stabilization usually requires a broader range of supports beyond housing and clinical supports. Such supports are intended to help individuals and families improve their quality of life, integrate into the community and potentially achieve self-sufficiency. Complementary supports may include:

- Life skills – skills for maintaining housing, establishing and maintaining relationships (including conflict resolution), engagement in meaningful activities.
- Income supports for those entitled to them.
- Assistance with finding employment, enrolling in education, volunteer work and accessing training.
- Community engagement.

5. These are adapted from the *At Home/Chez Soi* project.

The Evidence: Does Housing First work?

There is a substantial body of research that convincingly demonstrates Housing First's general effectiveness, when compared to 'treatment first' approaches, including research from Canada (Falvo, 2009; 2010; Goering et al., 2012; Waegemakers-Schiff & Rook, 2012; City of Toronto, 2007; 2009). In a recent review of the literature, Waegemakers-Schiff and Rook identified the major themes from 66 academic articles, including: "housing stability, satisfaction, choice versus coercion, changes in mental and physical health, issues of sobriety, reduced substance use and harm reduction, cost effectiveness, and quality of life" (Wagemakers-Schiff & Rook, 2012: 9). They note ironically that despite Housing First's emphasis on housing before treatment, virtually all of the articles focused on treatment and housing outcomes, such as decreased mental health symptoms and substance use. They also point out that virtually all of the studies focus on single adults, and the majority on people with serious mental illness and/or addictions challenges (ibid.: 11). This is not surprising given the degree to which Pathways and similar programs have been the primary focus of evaluation.

The *At Home/Chez Soi* Toronto research team also conducted a review of the literature and found the following evidence of the model's effectiveness:

HOUSING FIRST HAS A POSITIVE IMPACT ON HOUSING STABILITY (Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004; Culhane et al., 2002; Rosenheck et al., 2003; Mares & Rosenheck, 2007; Metraux et al., 2003; O'Connell et al., 2008; Pearson et al., 2007; Shern et al., 1997; City of Toronto, 2009). That is, people who participate in Housing First programs, even those with high needs and/or who are chronically homeless, generally tend to remain housed after a year (though they may move from one house to another). Tsemberis and Eisenberg (2000) demonstrated that 90% of the people involved in the Pathways program remained housed after five years. Gulcur et al. (2003) likewise demonstrated high levels of housing stability. In Toronto, a review of Streets to Homes showed that 87% of program participants remained housed (City of Toronto, 2009) after one year.

HOUSING FIRST REDUCES UNNECESSARY EMERGENCY VISITS AND HOSPITALIZATIONS (City of Toronto, 2007; Culhane et al., 2002; Gilmer et al., 2010; Larimer et al., 2009; Gulcur et al., 2003). Keeping people in a state of homelessness not only produces a range of worsening health outcomes (Frankish et al., 2005; 2008; Hwang, 2000), it also leads to lengthy and costly increases in hospitalization and in particular, emergency room visits (Hwang, 2010). As Goering et al. (2012:14) argue, "[t]his decrease in use of emergency and inpatient services is accompanied by increases in the use of community outpatient services that are better able to meet client needs and prevent unnecessary or lengthy hospitalizations. It also frees up necessary health care resources for others who need them".

HOUSING FIRST CAN LEAD TO IMPROVED HEALTH AND MENTAL HEALTH OUTCOMES, AND THE STABILIZATION OR REDUCTION OF ADDICTIONS SYMPTOMS (City of Toronto, 2007; Mares & Rosenheck, 2010; Perlman & Parvensky, 2007; Larimer et al., 2009; Greenwood et al., 2005). While it

is established that there are higher prevalence rates for mental illness and addictions, it is also understood that the experience of homelessness can exacerbate these conditions. Providing people with housing and supports reduces the risk of assault and trauma, and can help stabilize individuals with such problems. Housing stability reduces the need to access services in an emergency, and enhances the possibility of more effective health care case management and continuity of care.

HOUSING FIRST REDUCES CLIENT INVOLVEMENT WITH POLICE AND THE CRIMINAL JUSTICE SYSTEM (City of Toronto, 2007; Culhane et al., 2002; Gilmer et al., 2010; Perlman & Parvensky, 2007). Canadian research identifies the relationship between homelessness, involvement with the police, and prison (O'Grady et al., 2011; Gaetz & O'Grady, 2006; 2009; Novac et al., 2006; 2007; Kellen et al., 2010). Housing stability may decrease criminal involvement, and most certainly reduces the likelihood of street-based interactions between people who are homeless and the police.

HOUSING FIRST IMPROVES QUALITY OF LIFE (City of Toronto, 2007; Gilmer et al., 2010; Mares & Rosenheck, 2010; Perlman & Parvensky, 2007). In addition to desired improvements in health outcomes (including enhanced food security) a key goal of Housing First is to enhance social and community engagement. The research demonstrates improvements in community integration for most individuals, though for "a meaningful minority, the adaptation to housing may also be associated with challenges that can complicate the integration process" (Yanos et al., 2004:133).

The preliminary results of the *At Home/Chez Soi* project are important, both because it is the largest and arguably most comprehensive study of Housing First ever conducted, but also because it was conducted in Canada. The study used a randomized trial design in which individuals were assigned at random to the Housing First option or 'treatment as usual' (i.e. they could receive any other homelessness-related service available). Exactly 2149 people participated in the study, 81.5% of whom were absolutely homeless at the time (the rest were precariously housed). The preliminary results after 12 months (21 and 24 month follow up studies will follow) indicate very promising improvements across all of the domains cited in the literature above. For instance, in terms of housing stability:

> "Over 900 individuals from our shelters and on our streets who have not been well served by our current approach are now housed in adequate, affordable and suitable settings. Eighty six percent of participants remain in their first or second unit (as of August 2012). At 12 months those in the Housing First intervention had spent an average of 73% of their time in stable housing. In contrast, those in treatment as usual (TAU) spend only 30% of their time in stable housing" (Goering et al., 2012:6).

In addition to housing stability, the Housing First group showed a dramatic reduction in service usage, compared with the TAU group:

- 7,497 fewer nights in institutions (largely residential addiction treatment).
- 42,078 fewer nights in shelters.
- 6,904 fewer nights in transitional housing or group homes.
- 732 fewer emergency department visits.
- 460 fewer police detentions.
- 1,260 fewer outpatient visits.
- 34,178 fewer drop-in centre visits.

Because this is a comparative analysis, the *At Home/Chez Soi* team is also looking at the differences between the five sites, in order to understand the impact of Housing First on key sub-populations, but also in order to find out the importance of the following on success: contextual differences (the local funding, service delivery and policy contexts), city size (ranging from Moncton to Toronto), and the supply of affordable housing. In addition, the project has employed a broad range of methodologies, including qualitative interviews with key informants, process analysis, and action research with project participants, in order to understand issues related to planning and implementation and bringing landlords on board (260 different landlords). Finally, and for quality assurance purposes, research was conducted on the perspectives and experiences of clients of the program.

Does Housing First Save Money?

A key claim of Housing First is that it saves money compared to treatment as usual.

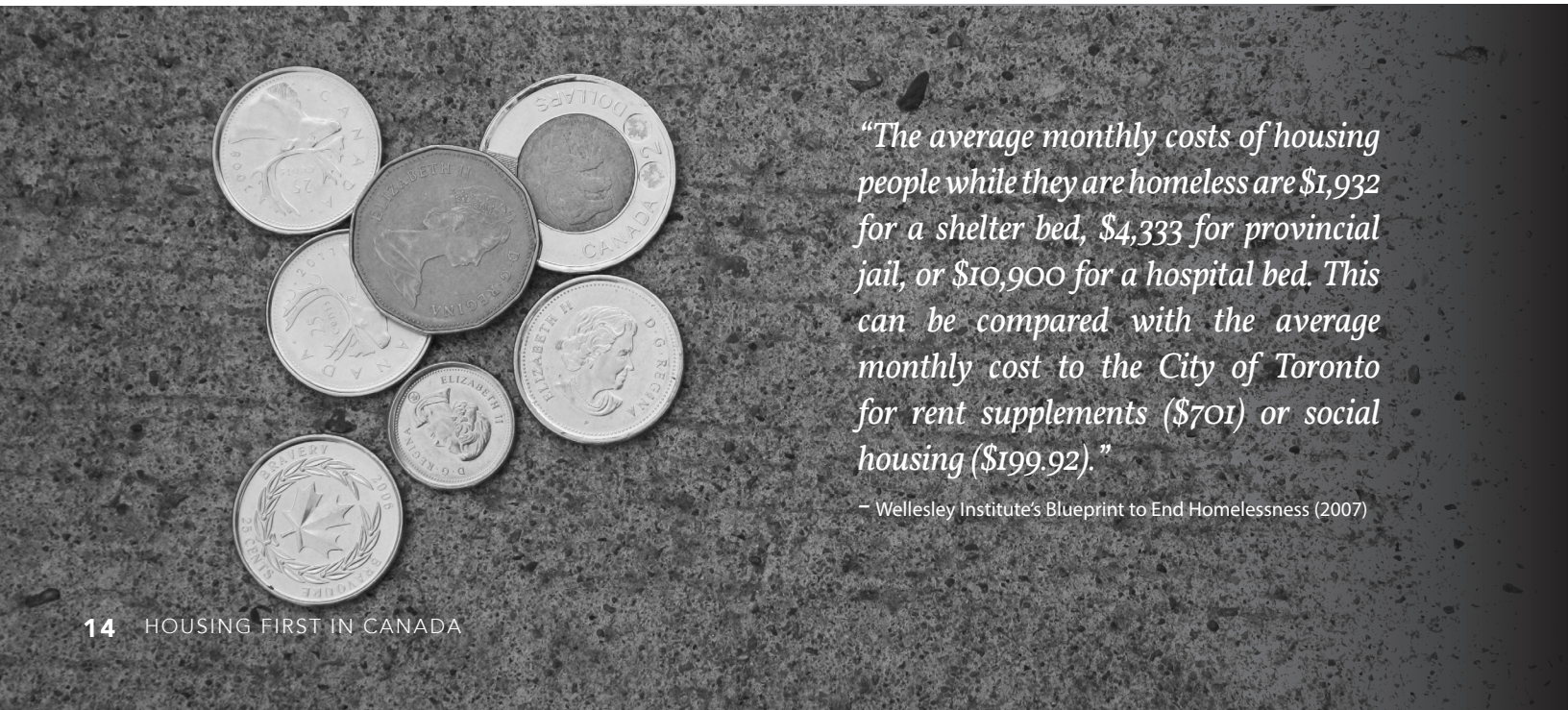
According to a recent report, The Real Cost of Homelessness (Gaetz, 2012) there are plenty of studies that demonstrate that the traditional response to homelessness is expensive, and that it may be easier and cheaper to provide people with housing and supports (Laird, 2007a; Eberle et al., 2001; Palermo et al., 2006; Shapcott, 2007; Pomeroy, 2005; 2008). For instance, in the Wellesley Institute's Blueprint to End Homelessness (2007), it is argued that the average monthly costs of housing people while they are homeless are $1,932 for a shelter bed, $4,333 for provincial jail, or $10,900 for a hospital bed. This can be compared with the average monthly cost to the City of Toronto for rent supplements ($701) or social housing ($199.92).

The *At Home/Chez Soi* project has done some interesting analyses comparing the average shelter, health and justice costs of those in Housing First against those receiving treatment as usual. The project has also conducted an analysis comparing High Service Users against the whole group. The findings are illustrative.

For instance, it was found that implementing Housing First requires an additional investment of over $4000 per person, per year. For the full group (ranging from high to low needs) there is a return of $7 for every $10 spent on Housing First. If one focuses only on the high service user group (10% of the sample) arguably the group with the most complex mental health and addictions issues, there are even greater savings; for the high service users, an investment in Housing First saves almost $22,000 per year.

One caution is that this analysis is done on homeless individuals who have health, mental health and addictions issues. In some cases their health costs may rise, as they now have access to mainstream services that were not being utilized prior to their involvement in the program. Additionally, we do not know the cost impact of those with lower levels of need, who may require short term or intensive case management (ICM), but may not require more expensive ACT team supports. That is, for Housing First programs that more broadly target homeless populations not defined by mental illness, the cost recovery may be different.

Nevertheless, a key finding from this work is that targeting high needs, high service using homeless populations will actually save money. The myth that the chronically homeless have too many complicated needs, or who are too difficult and ultimately too expensive to house is undone by the results of the *At Home/Chez Soi* study.



"The average monthly costs of housing people while they are homeless are $1,932 for a shelter bed, $4,333 for provincial jail, or $10,900 for a hospital bed. This can be compared with the average monthly cost to the City of Toronto for rent supplements ($701) or social housing ($199.92)."

– Wellesley Institute's Blueprint to End Homelessness (2007)

Conclusion

There is a growing interest in Housing First as a key approach to reducing and potentially ending homelessness in Canada and around the world. In 2013, the Government of Canada signaled its support for Housing First in its five year renewal of the Homelessness Partnering Strategy. As many communities move to adopt, adapt and implement Housing First, there are many questions.

Housing First is an intervention rooted in the philosophy that all people deserve housing, that housing is a human right, and that adequate housing is a precondition for recovery. It works by moving people who are homeless into independent and permanent housing as quickly as possible, with no preconditions (readiness or sobriety). Once housed, people are provided with additional services and supports as needed and based on their choice.

This framework document is meant to outline key features of the approach, and to clarify some questions about its application. It provides a clear definition, and identifies core principles against which communities can measure the fidelity of their own efforts. The ***core principles of Housing First*** include:

1. *Immediate access to permanent housing with no housing readiness requirements.*
2. *Consumer choice and self-determination.*
3. *Recovery orientation to services.*
4. *Individualized and client-driven supports.*
5. *Social and community integration.*

Further, there is a clear statement of the distinction between different levels of engagement with Housing First, from adopting it as a ***philosophy***, integrating it as a ***systems approach***, deploying it as a ***program***, and identifying what kinds of ***teams*** deliver the service. Housing First involves, at its most basic, providing homeless people with access to housing that is safe and affordable. Clients should have choice in the kind and location of housing, and different kinds of housing can be accessed through the model, including scattered-site rental housing, congregate housing, social housing or permanent supportive housing, for instance. But Housing First means more than simply putting a roof over one's head. Supports of different kinds should be offered, including housing support, clinical supports and complementary supports. Given that Housing First is a client-driven model, individuals and families participating in the program should have a say in the nature and extent of supports provided.

Does Housing First work? One of the key challenges in developing effective responses to homelessness is ensuring there is a solid evidence base for interventions. Housing First exists as one of the few interventions that can be declared a Best Practice, and the weight of evidence that it is effective in providing housing stability for chronically and episodically homeless individuals is overwhelming. The *At Home/Chez Soi* project, funded by Health Canada to the Mental Health Commission of Canada, was a five city study that explored the process of implementing Housing First, and that evaluated the effectiveness of the program outcomes. In undertaking this evaluation, the project took into account the significance of contextual factors such as city size, rental housing market, and needs of sub-populations. This is the most extensive study of Housing First ever conducted, and it will deepen understanding of the efficacy of Housing First as a program model.

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APPENDIX A

Pathways to Housing operating principles:

- Housing is a basic human right;
- There should be:
  - respect, warmth and compassion for service users;
  - a commitment to working with service users for as long as they need;
- Scattered site housing using independent apartments (i.e. homeless people should not be housed within dedicated buildings but within ordinary housing);
- Separation of housing from mental health, and drug and alcohol services (i.e. housing provision is not conditional on compliance with psychiatric treatment or sobriety);
- Consumer choice and self – determination (i.e. delivering mental health and drug and alcohol services with an emphasis on service user choice and control; basing treatment plans around service users' own goals);
- A recovery orientation (conveying a positive message that recovery is possible for service users;
- A harm reduction approach (i.e. supporting the minimization of problematic drug/alcohol use but not insisting on total abstinence).

Core principles of Housing First adopted by the Calgary Homeless Foundation and the Canadian Alliance to End Homelessness:

1. Consumer choice and self-determination;
2. Immediate access to permanent housing with the support necessary to sustain it;
3. Housing not conditional on sobriety or program participation; and
4. The ultimate goal of social inclusion, self-sufficiency, and improved quality of life and health.

Read the case studies at
www.homelesshub.ca/housingfirstcanada