HOUSING FIRST:
WHERE IS THE EVIDENCE?

Jeannette WAEGEMAKERS SCHIFF PhD
John ROOK PhD

Faculty of Social Work, University of Calgary

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Jeannette Waegemakers Schiff, PhD & John Rook, PhD

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Housing first – Where is the Evidence?

Despite new federal and provincial government initiatives to assist with housing, in the last ten years the number of homeless persons continues to increase. With this increase a sizable number of sub-populations have emerged: families with children, people with mental illnesses, those with a primary substance use issue, immigrants and refugees, youth and seniors. The premise that most homeless people are without housing because of functional skill deficits grew out of historical impressions that hobos of the Great Depression were all alcoholics and those thereafter came from the mental illness deinstitutionalization movement of the 1960s and 1970s. The ongoing move to community treatment saw many persons who had become reliant on the care of others thrust into the community without the financial and ancillary supports required for housing stability (Metraux, et al., 2010).

Because of the high prevalence of mental health and substance use issues in the homeless population (sometimes a cause of homelessness, but often a consequence of life on the streets), in the last twenty-five years, in most instances programs for people who are homeless modeled their re-housing programs after the format used for those with mental illness and addictions issues. The result was a "treatment before housing" approach across the spectrum of homeless service providers. In other words, people need to resolve their mental health and/or addictions issues before they can be ready for housing.

In the last ten years a radical transformation has occurred in the attitudes and practices guiding housing programs that provide emergency and long-term housing for homeless people. This shift evolved from linear or step-wise models of either coupling housing with treatment, or of requiring treatment prior to obtaining permanent housing (Treatment Continuum – TC) (Padgett, et al., 2006), to a priority placed on housing without treatment expectations (Brown, 2005). The latter approach has been labelled *housing first* (HF) and has rapidly acquired wide-spread adoption by communities with 10-year plans to end homelessness in Canada and the U.S. (e.g. Calgary, Toronto, Minneapolis, San Diego, New York) and by mental health service providers seeking housing stability for clients (Newman & Goldman, 2008).

Fuelled by some scientific evidence (Atherton & McNaughton Nicholls, 2008), and increasingly made popular by press and housing authorities developing "10 year plans" to eradicate homelessness, *housing first* has emerged as an increasingly popular approach to addressing homelessness. (The HF approach was embraced by all levels of government in Canada, as evidenced by the *Streets to Homes* initiative in Toronto and the housing initiatives in Calgary). Despite the rapid uptake of this approach, there is the absence of "best practice" evidence to support this. "Best practice" is commonly understood to imply evidence-based techniques or interventions that have been demonstrated to work well with most persons and have the least potential for adverse results. To the extent that there was some, but not conclusive, evidence that HF was effective for those with mental illness and co-occurring mental illness, the Mental Health Commission of Canada (Mental Health Commission of Canada, 2010), introduced a large, multi-site study of HF in five Canadian cities (referred to as the At Home/Chez Soi project). This project is examining the approach in various political contexts and with differing target populations, thereby including the multi-cultural dimensions essential to Canadian adoption of this approach. Although early results are promising, conclusive answers will not be available for several years. In the interim, adoption of the HF approach is rapidly growing.

Speedy implementation of a new initiative is often fraught with issues of fidelity in replicating the model program in other locations (McGrew, et al., 1994). Our search uncovered three founding programs that can be considered *housing first* models. Because of their differences, we begin this review with a brief description of each and then turn our attention to the evidence base for *housing first* as reported in the academic literature. Because of the limited documentation of this approach, we will further the understanding of *housing first* by reviewing government documents and reports that provide an insight on this evolution and its current public acceptance. Finally, we critically examine the assumptions and gaps in the literature that require further evidence-based data.

Three Founding Programs

It is widely assumed that *housing first* was developed as an approach to rapidly house absolute homeless individuals with mental health and addictions issues who were served by the *Pathways to Housing* program in New York City (Tsemberis & Elfenbein, 1999; McNaughton Nicholls & Atherton, 2011). Begun in 1992, the *Pathways to Housing* model has been highly successful in housing and maintaining housing for dually diagnosed individuals with a history of homelessness (Tsemberis, et al., 2004b). Well before this, in 1977 a community organization, *Houselink* (Adair et al., 2007; Houselink, 2011b), founded a housing program for those discharged from psychiatric facilities in Toronto. It was and continues to be, based on the values that housing is a right and individuals have a right to participate in the operation of the organization as partners. This is the earliest record, in our review, of housing as a right for those experiencing deinstitutionalization. *Houselink* has promoted housing without treatment requirements for over 30 years.

The term, *housing first*, had its origins in another highly successful program, *Beyond Shelter*, which originated in 1988 in Los Angeles. It coined the term *housing first* for a program dedicated to the rapid re-housing of homeless families by minimizing the use of shelter and transitional housing in order to quickly place families into permanent housing. Although using the same terminology, these three agencies have had different views of what constitutes *housing first*.

The *Houselink* and *Pathways to Housing* programs emerged exclusively out of the mental health and concurrent disorders service field. We start with the oldest, in Toronto. *Houselink* (Houselink, 2011a) has been providing an array of housing options for those with a history of mental illness with and without substance use issues, in a variety of settings: scattered site apartments, agency-owned apartment buildings, and congregate care in varying levels of intensity. All tenants are covered under the Landlord and Tenant Act of Ontario. There is no requirement for treatment (mental health) adherence or abstinence from substance use. It has a recovery-oriented program philosophy and thus the support services provided are mutually agree on. However, there is no Assertive Community Treatment team to provide 24/7 service (Carpinello, et al., 2002). Unlike the programs in California and New York, *Houselink* provides an array of support, social and rehabilitation services to all tenants. Housing is available to single individuals as well as couples and families with dependent children. It also engages members who are not housing tenants. Finally, it provides work opportunities for members within the organization. In this context, its organizing philosophy is more in line with operating principles of the International Center for Clubhouse Development (ICCD, 2012), which focus on recovery and encourage member participation as colleagues in organizational operations.

Both the New York and Toronto models of *housing first* programs provide an array of support services to persons with histories of mental illness and neither preclude individuals who have had criminal justice system involvement. In Toronto, the recently established (2009) unified intake system for housing for persons with histories of mental illness now provides a centralized intake process and individuals seeking housing in the *Houselink* program must specify their preference, as they cannot apply directly to the organization. Unlike *Pathways to Housing*, which provides individual accommodation, *Houselink* owns most of its units and has both single and shared units. It is the shared units that most often become available, as they are least preferable for tenants (Nelson, et al., 2003) . While the *Pathways to Housing* model is limited by the number of housing support vouchers allocated, *Houselink* is limited by units available in the organization. Of these three organizations, *Houselink* is the only one to stress the now well- accepted importance of community, culture, consumer participation and recovery in its organizational principles.

At *Pathways to Housing* (New York), prospective tenants (as they are termed), are identified by two intake streams: first, by program outreach workers who approach those sleeping rough and second, by hospital discharge staff seeking rapid accommodation for dually diagnosed individuals scheduled to be discharged from hospital (D. Padgett et al., 2006). Prospective clients are engaged in conversations around individualized housing and, when an agreement is made, the prospective tenant is shown available accommodation, usually a bachelor

style or one-bedroom apartment in a place acceptable to them, at scattered-site locations. During this negotiation phase the prospective tenant either remains un-housed and unsheltered, or in hospital or municipal shelter. When funding (usually a Section 8 voucher, which acts as a rental subsidy to the landlord) is secured, the process of obtaining basic furniture and household equipment is initiated along with establishment of move-in plans. While individuals are not required to be clean and sober, or in compliance with mental health treatment, two conditions are placed on tenants. The agency assumes representative payee status for the tenant so that rent and utilities are paid before a person receives the monthly allotted living subsidy. The agency also requires that tenants accept contact from a member of the organization's Assertive Community Treatment (ACT) team on a regularly scheduled basis. 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 defence 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. If there is a housing failure (loss) the support worker will continue to engage the client in order to obtain new accommodation as quickly as possible. There are no time-limits on the support services delivered by the ACT team so that discharge is initiated only by a client/member. Only single men and women are accommodated and *Pathways to Housing* has no couples or family oriented program or accommodation.

Beyond Shelter (Beyond Shelter, 2011), in Los Angeles, which coined the term "*housing first*," takes a somewhat different approach to housing, probably because its target population, homeless families who have dependent children, need immediate shelter and cannot be left in "rough sleeping" arrangements, or sequestered in hospital wards. Thus the program provides (Appendix Three) immediate shelter in an emergency family hostel, but actively seeks a suitable placement so that families can be permanently housed as quickly as possible (rapid re-housing). Housing may be available in several different forms: as scattered site apartments and multi-unit apartment buildings with various types of landlord-tenant and rent subsidy arrangements. A service plan is developed and support services are provided for six to twelve months. Housing needs and preferences are taken into account and there is no indication if there are pre-requisites for sobriety. Services may be provided on site or off-site depending on circumstances. Thus this model is time-limited in its active post-housing intervention. However, by nature of the clientele served, fewer families are expected to have the functional deficits of those with serious mental illness and substance use issues. It is a model that has achieved significant success in housing families and has been recognized by the United Nations as one of "100 international best practices" in housing and re-settlement. A replication of this model was implemented by the Peel Family Shelter Program, a special Salvation Army initiative, in Mississauga, ON in 2002.

Fig.1 Peel Family Shelter

In the Peel Family Shelter, services include: case management for parents and children, assistance in securing housing and employment, children's drop in program, child and youth programs, life skills classes, spiritual support, and ongoing access to community resources. There is an on-site office for Ontario Works (public assistance) to provide assistance to families with their financial needs. The staff team includes Case Workers, Resource Workers, Front Line Workers, Kitchen Coordinator, Child and Youth Worker, ECE Worker and Management. Volunteers, students and community groups continue to provide a helping hand with a multitude of tasks. Like its California counterpart, this shelter aims to provide a complete needs- assessment, access to support services and permanent housing. In Los Angeles, this process takes one to six months. In Mississauga, the aim is to provide permanent residence within thirty days. Thereafter ongoing support is provided for at least one year and service recipients are welcome to stop by the Shelter for additional support. There are reports of other Canadian organizations

that have many elements of a *housing first* approach, such as the *Phoenix Program* in Regina and *Streets to Homes* in Toronto. However, none have been the subject of research studies.

The map below shows the disparate locations and dates of origins of the three main programs that were originally founded on HF principles. From the disparate locations it appears possible that the individual programs may not have known of each other's existence but that each was responding to increasingly valued consumer issues: empowerment, the right to self-determination, recovery (in mental health and addictions) and the right to determine personal living style and location, in so far as feasible. The proliferation of the three program models was also affected by the leadership styles within the organizations and the political climate that favoured research in housing (related to those with a mental illness or dual diagnosis). Research funding in the U.S. also tended to favour mental health issues, while both mental health and housing programs were not recipients of much funding in Canada. Thus the likelihood of data supporting the programs was more likely to occur in the mental illness and substance abusing service provider community in New York.

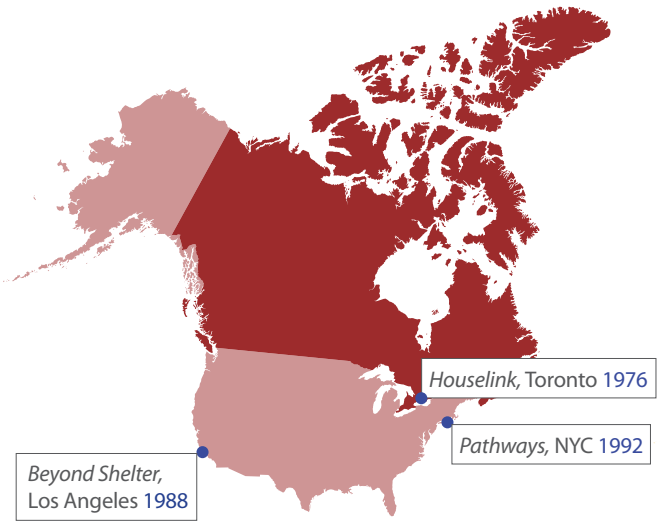


Fig.2 Location and start dates of original *Housing first* programs

Program Fidelity Standards

There are some basic principles which guide all three programs. They do not require demonstration of housing readiness (although tenants cannot be incapacitated by psychiatric symptoms to preclude independent living). Housing location and type is by choice to the extent of local availability (including affordability). Support services, ranging from case management to assertive community treatment are available, but not required, for all. There are no requirements for absolute sobriety but a harm reduction approach is advocated. That is, tenants will not lose housing because of substance use. In addition, *Houselink* stresses the existence of a supportive community of tenants and includes families with dependent children as well as couples in the housing program. Both *Houselink* and *Beyond Shelter* house persons in an array of accommodations, including designated apartment buildings as well as scatter site units, agency owned and operated as well as by contract with private landlords. *Pathways to Housing* uses only a scatter-site approach of single tenant apartment units and does not own any of its own housing. The other two founding programs use a variety of housing options, including owning some of their own buildings. Of the three founding programs, only *Pathways to Housing* has worked with investigators to define program standards specific to the uniqueness of its program (Tsemberis, 2011). In preliminary work, these have been identified as "no housing readiness requirements, individualized services, a harm reduction approach, participants choosing the type, frequency and sequence of services, and housing that is scatter-site and otherwise available to persons without disabilities" (ibid). Since the other two pioneering agencies have used a variety of housing options, we question if the scatter-site model is essential to a *housing first* approach, or if it should be an option among several. We also note that the intentional communities philosophy used by *Houselink* may be an important component to a supportive environment for some persons seeking to deal with challenging disabilities. Within the context of the evidence-based practice research considered below, we note that fidelity to *housing first* principles has not been explicitly articulated and impacts the generalizability of all results.

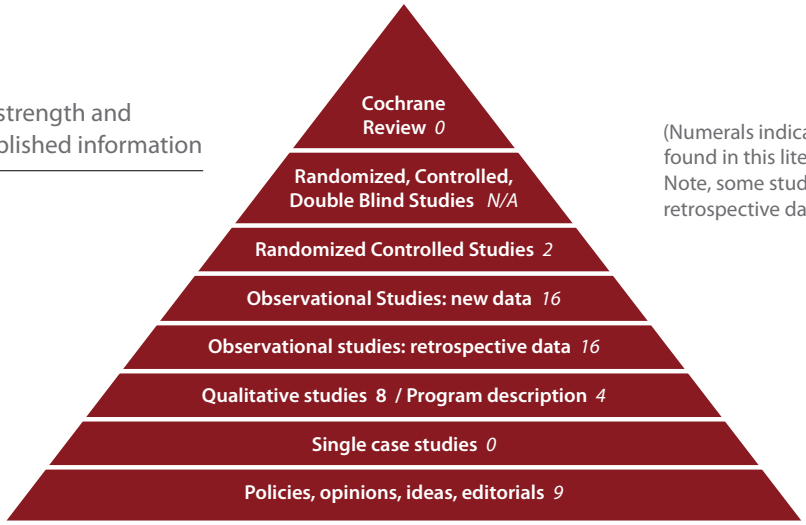
Evidence-based practice

Given the plethora of information, including research studies of various kinds (quantitative and qualitative, evaluative and cost-benefit), there is a pressing need to have an established ranking of the validity, reliability and generalizability of results across different groups of people and contexts. For validation, results must be replicated across at least a similar group of persons, but by a separate (independent) research team. Studies with the most rigorous scientific standards constitute the hallmarks from which the valid "best practices" are determined. This process allows service providers to determine the effectiveness and efficacy of new interventions. It also provides opportunities to identify groups for whom it is not proven to be effective or instances where it may result in further harm. Psychotropic drugs are an excellent example of where the specificity of effect is determined by age and in many instances limited to certain age groups, such as not for children or adolescents. Shumway and Sentell (2004) provide a succinct description of evidence-based practice that is used in the behavioural science field.

> There are ..... objective standards for evaluating the scientific rigor of research and the resulting quality of evidence for the efficacy and effectiveness of interventions. Various hierarchical systems exist for evaluating the quality of evidence. In both efficacy and effectiveness research, large, well-controlled randomized trials provide the highest-quality evidence, followed by smaller randomized trials, nonrandomized group comparisons, systematic observational studies, and unsystematic, observational studies. Overall, research designs that minimize bias and maximize generalizability yield the highest-quality evidence. Effectiveness studies also emphasize relevance to routine practice settings. Evidence from studies that reflect the characteristics of practice settings, such as public-sector and managed care settings, will be more persuasive than studies from purely academic research settings. Evidence of treatment effectiveness in diverse client populations—reflecting heterogeneity in age, gender, culture, social class, psychiatric diagnosis, and health status—increases both the relevance and the generalizability of published evidence. (p650)

A pyramid, which is often used to rank studies and reports in medical and behavioural sciences, includes all information from animal studies to systematic reviews of the literature. In the social and behavioural sciences, animal studies are not typically included in this pyramid and instead concentrate on the sequential steps from ideas and opinions to randomized, controlled studies using human subjects. Double blind studies are not possible with psychosocial interventions because there is no practical way to mask those in placebo and clinical groups from the individuals providing the interventions. For purposes of this evidence-based practice review we examined all articles in the academic and grey (government and research institute) literature. Because of the paucity of literature we did not rank anything according to the prestige of the journal in which the study or opinion was published. The following pyramid delineates the number of each type of published study in this review.

Fig.2 Pyramid of the strength and reliability of published information



(Numerals indicate the number of articles found in this literature review on HF. Note, some studies used new and retrospective data)

Housing first: what the literature indicates.

While there are three different program models, each with unique characteristics, all share a common philosophy of providing housing without treatment or abstinence requirements. All adhere to a consumer preference model, in so far as is logistically and financially possible. Stabilization, return to and integration in the community are valued and programs targeted towards those with mental health issues have a history of employing program tenants (mental health consumers) in staff positions where appropriate. None are based on a peer-run housing program. All three programs have engaged in evaluation of outcomes and program efficiency in order to document their effectiveness. Despite a long history of consumer oriented-housing by these three agencies, *Pathways to Housing*, the youngest of the three, is the only one that has engaged in research to document its efficacy by means of a large, multi-year randomly assigned research design – a gold standard of best practices in a field where the ultimate - a double blind study - is not feasible.

The housing and homeless literature has become vast and all-encompassing, with considerable contributions in the last ten years. In order to limit this search to those items concerned with a housing or re-housing strategy that address immediate need rather than treatment before housing, the search strategy started with a designation of the term *housing first* and was expanded to include the term "rapid re-housing." Additional descriptors were derived from the most widely accepted sub-groups of homeless individuals, by age: youth, adults, seniors; by demographic descriptors: families, Aboriginal people, immigrants and refugees; and by psycho-social/behavioural issues: mental health, addictions, domestic violence.

There has been a proliferation of information and debate about housing for homeless persons in the last decade. A quick look at all citations for *housing first* and homeless(ness), including magazines and newspapers, found 1,701,978 results for the years 2000 to 2011. When the search was narrowed to homeless families the results decreased to 1,648. A look at items using the term "rapid re-housing" brought up 684 citations, many of them describing local initiatives that have developed over the last three years. These numbers are a reflection of the tremendous public interest that has been brought to the issue of homelessness and re-housing, but do not reflect the evidence for effective or best practice programs and interventions. When we limited the search to items in the academic literature a different picture emerges.

An extensive search of the academic and grey literature, including government documents and material from organizations that have a mandate to work with homeless persons, found 121 unduplicated references. The terms "homeless," "*housing first*," and "rapid re-housing," in combination with one or more of the following: mentally ill, substance users/abusers, addiction, families, youth and justice/criminal justice were searched in the following data bases: PsycINFO, Social Work Abstracts, Abstracts in Social Gerontology, AARP Ageline Social Services Abstracts, Sociological Abstracts, SocINDEX, Medline, Family Studies Abstracts, Family & Society Studies Worldwide, World Wide Science, and Google Scholar. Of the citations, 84 originated in the academic and grey (government reports) literature and in addition, there were numerous magazine and newspaper articles (Eggerston, 2007; Burke, 2011; Fitzpatrick, 2004) as well as multiple housing websites that detail *housing first* approaches (National Alliance to End Homelessness, 2011; United States Interagency Council on Homelessness, 2006; United States Department of Housing and Urban Development, 2011) .

Examining only academic journals that dealt with re-housing and *housing first* approaches narrowed the field to 66 articles. Of these, 6 dealt with housing policy, and the other 60 came from health, mental and behavioural health and psychology and public health fields. The major themes that emerged from this group included 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. Despite the fact that a HF approach presents itself as housing before treatment, all of the articles reviewed include a focus on what would be considered treatment outcomes: decreased mental health symptoms, hospitalization, decreased substance abuse, and harm reduction. This puts into question whether HF programs are indeed about

housing separate from treatment, or if the audience for these studies expects to see improved mental health outcomes in all housing programs.

Of these, nine reviewed housing policy in the light of a *housing first* approach, typically including the *Pathways to Housing* model as a springboard for contrast and further discussion. In the nine policy-related papers, four focused specifically on policy reformation to move from a treatment first model of community integration to an immediate housing and subsequent support services format (Robbins & Monahan, 2009; van Wormer & van Wormer, 2009; Tsemberis & Elfenbein, 1999; Crane, Warnes, & Fu, 2006). Two articles examined British and Canadian (Toronto) approaches (Falvo, 2009; McNaughton Nicholls & Atherton, 2011) , and one advocated a move from policy initiatives driven by political forces to one mitigated by scientific evidence (Stanhope & Dunn, 2011).

The cost-effectiveness of a HF approach is mentioned in many of these research and policy reports. A specific analysis of the relative costs compared to a continuum of care approach is explored by the *Pathways to Housing* program (Gulcur, et al., 2003; Tsemberis et al., 2004b) as well as the REACH program in San Diego, which looks at the cost effectiveness of a *housing first* approach that uses "Full Service Partnerships of housing and support services" (Gilmer, et al., 2010; Gilmer, et al., 2009). These reports clearly show a cost savings – although not necessarily large –in the HF approach. The Gulcur et al., (2003) cost analysis of *Pathways to Housing* versus treatment-as-usual showed a significant positive difference for the HF model. However, this cost analysis was basic in that it failed to examine the multiple treatment and societal costs associated with being housed or homeless (the control and experimental groups). Thus the literature on cost effectiveness shows, at this time, no significantly greater costs associated with the increased deployment of wrap-around or ACT team services in a HF approach. The longer-term savings across multiple service sectors, including health, housing and justice systems has not been systematically analyzed.

Internationally, the Australian government is moving towards a *housing first* philosophy (Johnson, 2011), but as yet there are no research results that examine this in the context of that political climate. The European Collaborative on homelessness (Feantsa), has explored *housing first* as a strategy within various national contexts (Atherton & McNaughton Nicholls, 2008), but has also not produced any quantitative research results (McNaughton Nicholls & Atherton, 2011). One report from Finland (Tainio & Fredriksson, 2009) documents the introduction of a *housing first* approach but cautions that the evidence of applicability across all sub-sectors of the homeless population is not established. Thus the primary source of data on the efficacy and effectiveness of a HF approach has been presented by American researchers, primarily in major U.S. cities (urban areas). The majority of these quantitative American studies have relied on data from the *Pathways to Housing* research program in New York City (11 out of 17), or on multi-site studies that include *Pathways to Housing* as one of the programs (an additional 3).

The qualitative literature has become recognized as an important component to developing an understanding of the complexities of a psycho-social intervention such as housing. Thus the eight studies that look at housing in the context of lived experience do so by both examining recipient preferences and that of providers (Burlingham, et al., 2010; Schiff & Waegemakers Schiff, 2010). These reports also include a look at issues of fidelity to the Assertive Community Treatment program, a linchpin of the HF model (Matejkowski & Draine, 2009; Neumiller et al., 2009), HF as an approach for those with primary substance abuse issues (Padgett, et al., 2011; Padgett et al., 2006), provider reactions (Henwood, et al., 2011), and best practices (McGraw et al., 2010). The following chart breakdowns by primary focus the HF literature. Some articles focused on more than one issue or subject population so totals do not necessarily add up to the 35 that were reviewed. The items selected were classified as:

TABLE 1

Major Characteristics of *Housing first* Studies		
Type of study	**No. of Studies**	**Studies *Using Pathways to Housing* Data**
Quantitative studies of HF	17	11 (3 multi-site)
Qualitative Studies	8	4 (one multi-site)
Program descriptions	4	3
Program outcome	15	11
Policy review	4	N/A
Health outcomes	6	
Cost-effective studies	7	2
Population studied		
• Mentally ill/Psychiatric disabilities	22	
• Dual diagnosis	5	
• Substance Users	3	
• Mixed Population	4	
• Physically ill/disabled	3	
• Women	2	
• Providers	2	
• Single Adults	29	

Focus of *Housing first* Studies: Single Site, Single Adults

All of the HF studies found in the literature focus on single adults, the majority of whom are identified as having a mental illness, serious mental illness, with (dually diagnosed) or without a substance abuse problem. All these studies came from U.S. service providers in major metropolitan areas. There were no studies that addressed issues of diversity, ethnicity, and only one that looked at concerns of Aboriginal persons (Schiff & Waegemakers Schiff, 2010). In Canada, and elsewhere, the homeless sector is considered to consist of a number of sub-groups: youth, families, seniors, Aboriginal people, immigrants and refugees, those with a mental illness with and without a substance abuse problem, and substance abusers. At the present time no research literature addresses these groups and whether or not HF will be appropriate for them. Within a Canadian context, the acceptability and accessibility of housing that is culturally and ethnically suitable, as well as housing that is appropriate for families, youth and seniors is of utmost importance (Waegemakers Schiff, et al., 2010). The Mental Health Commission of Canada has a multi-city study of HF programs for the mentally ill and dually diagnosed (Mental Health Commission of Canada, 2010) that takes ethnicity, age and other distinguishing characteristics into account. However, the results of this project are several years away from publication. In the interim, the only study that examines HF in the Canadian context is one prepared for the *Streets to Homes* (S2S) program in Toronto (Falvo, 2009). The S2S report relies on key informant interviews and post program enrolment data to support the program's claims of success. Without statistical evidence, this information falls into the realm of "professional opinion" rather than a robust quantitative study.

Multi-Site Studies

Multi-site studies have the advantage of being able to compare interventions across different geographic and political landscapes and discern if essential characteristics of a program can be easily transported. However, they have the challenge of meeting the standards of scientific rigour across different service units, sometimes subject to differing operational rules established by state, province, and local authorities. The four multi-site studies that include HF as an intervention all come from one collaborative and examine different outcome aspects. Thus they lack true independence of data that would allow for a robust comparison of these studies.

In the Collaborative Initiative to End Chronic Homelessness (CICH), eleven communities were selected by the U.S. Departments of Housing and Urban Development, Health and Human Services, and Veterans Affairs to provide housing, mental health and primary health services in a collaborative fashion to persons deemed chronically homeless. The CICH includes Chattanooga, Tennessee; Chicago, Illinois; Columbus, Ohio; Denver, Colorado, Fort Lauderdale, Florida; Los Angeles, Martinez and San Francisco, California; New York City, New York; Philadelphia, Pennsylvania; and Portland, Oregon (Tsai, et al., 2010). Some of the communities use HF, but refer to it as independent *housing first* (IHF) in this literature, and others provide "residential/transitional treatment first." The specifics of these plans vary across communities (Mares & Rosenheck, 2009), but each plan includes strategies for providing permanent housing, linking comprehensive supports with housing, increasing the use of mainstream services, integrating system and services, and ensuring the sustainability of these efforts (Tsai et al., 2010),.

There are three quantitative, and one qualitative, studies in the multi-site reports produced from the CICH that examine HF and supportive housing and include *Pathways to Housing* as a participating site. The CICH provided funding to support implementation of and research on best practices that support clients in their housing. The sites included in the report on this large multi-site initiative (McGraw et al., 2010) examined the use of ACT and MI (Motivational Interviewing) across sites using a retrospective qualitative analysis of all CICH documents. The main findings indicate that lack of understanding of the model, failure to use all model elements, including incomplete and inadequately trained teams, as well as interagency teams and competing mandates from government funders interfered with implementation.

The first comparison of HF in three programs, San Diego (REACH program), Seattle (DESC) and NYC (PTH) - all part of the 11 site CICH study -, used a convenience sample of 80 participants across the three sites (Pearson, et al., 2009) and obtained some of the client data retrospectively and through administrative and case manager report analysis. The study reports an 84% housing retention rate, which is in keeping with previous retention data from the *Pathways to Housing* program and suggests that the model works to keep people sheltered. The small samples (25, 26 and 29) respectively across these sites and the lack of longitudinal follow-up (24 months) precludes robust analysis of the results and does not allow for predictability of housing stability in the HF model.

A second report in the CICH initiative used the same HF sites as above (REACH, DESC and PTH) and compared client satisfaction and non-coercion, two key features of the HF approach, in two supportive housing programs, Project Renewal and The Bridge, both located in NYC (Robbins & Monahan, 2009). This study also used convenience samples of residents, and while the total study sample size was sufficiently large (N-139), the number of participants at each site ranged from 17 to 47 with only one site having more than 30 participants. Thus a robust statistical analysis was not possible. Given these limitations, the results do indicate that the HF model was positively correlated with non-coercion, freedom of choice regarding treatment for mental health or substance misuse and a harm reduction tolerance to substance use. However, the two models were not significantly different in housing satisfaction for participants.

The study by Tsai and colleagues (Tsai et al., 2010) examined whether IHF or residential treatment first (RTF) models were more successful in housing and maintaining housing for this cohort and found the IHF clients reported more days in their own housing, more housing choice and less days incarcerated. There were no differences in clinical (symptom) or community

integration outcomes. The study was limited by the lack of control over the time spent in residential/transitional housing (which varied from less than two weeks to over three months), the problem of attrition occurring in the study group after 24 months, and the relatively low (59.1%) rate of housing recipients willing to participate in the study. Without a control group at each site, there is the potential of large variability in the reported results.

Scientific strength of the quantitative studies

The 18 studies that used quantitative data included 11 articles that were based on New York City area participants in PTH programs, two in California, one in Illinois, and four that had data from multiple sites. The over-reliance in the literature on data coming from the *Pathways to Housing* program can readily be seen in the following breakdown. All of the NYC articles used the *Pathways to Housing* as one, or the sole, unit of investigation. Eleven articles stem directly from *Pathways to Housing* data. Two introduce the program and provide outcome data to support a HF approach. Seven use the same data set, the original NY Housing Study, to examine various parameters of the outcome. Three of the four multi-site studies include *Pathways to Housing* as a participating program. While the *Pathways to Housing* data has participant numbers to produce reliably significant results, the multi-site studies may allow for program comparisons across the country.

The most rigorous of the studies reviewed is the *Pathways to Housing* program's original controlled study with random assignment into control and experimental groups (Tsemberis, et al., 2004a). This work examined housing satisfaction, consumer choice, housing retention, substance use, treatment utilization and psychiatric symptoms over 24 months in 225 individuals randomly assigned to either a HF or a "treatment as usual" group. The results indicate significant positive change in all but the substance abuse area, and most importantly showed that dually diagnosed, hard to place consumers, would retain housing most of the time (80%) over two years (Tsemberis et al., 2004a; Tsemberis, et al., 2003). The research protocols were well established and the robust significance of the findings was quickly disseminated. This also led to an additional six articles using the same data set to report on a variety of different outcomes, including cost outcomes (Gulcur et al., 2003), substance use and justice system involvement (D. Padgett et al., 2006), community integration (Gulcur, et al., 2007), and delivery issues such as adopting best practices (Greenwood, et al., 2005), using full-service partnerships (Fischer, et al., 2008) and research issues such as adopting best practices (Greenwood et al., 2005) maximizing follow-up (Stefancic, et al., 2004) and assuring treatment fidelity (Tsemberis, et al., 2007).

Beyond the data from the original PTH program, there has also been several articles that examine the *Pathways to Housing* model in a suburban setting (New York City area) looking at long-term shelter users (Stefancic & Tsemberis, 2007) and a comparison of HF and treatment as usual persons (Fischer et al., 2008). The first study confirmed that long-term shelter users can be successfully housed, but that adherence to the program model of separation of housing and clinical issues was important. The program used a *Pathways to Housing* satellite office as one of the service providers, a county-based HF unit and a control group. Although this study attempted to use random assignment, it was unable to control for this through two cohorts of clients entering the program. In addition, lack of demographic data on the second cohort made it difficult to describe many participants. Finally, it would be a stretch to consider the sections of the county included in the study as "suburban" in that many have more city than suburb characteristics and the wealthier areas of the county were not included in the study. The study examining the court system in the Bronx (Fischer et al., 2008) also used a *Pathways to Housing* cohort to examine whether sheltered homeless persons were more or less likely to commit a crime, either violent or non-violent. This study used the original *Pathways to Housing* research data to examine criminal behaviour in sheltered and unsheltered homeless individuals and found a relationship between severity of psychotic symptoms and non-violent criminal behaviour, but did not find that HF immediately reduced criminal activity. Since the study used self-reporting on criminal activity it is difficult to establish if any sub-group in this cohort was more likely to under-report such activity. Regardless of research limitations, it does not appear that HF directly impacts criminal behaviour except for perhaps a small, psychiatrically unstable sub-group.

Outside of the New York area studies, two other single site projects examined aspects of a HF approach. San Diego County's project

REACH, which is one of the 11 city CICH sites, presents outcomes of a full-service partnership (FSP) program where individuals are offered housing and a complete array of integrated services. Program results (T. P. Gilmer et al., 2009) show a sharp decline in mean days spent homeless, use of emergency room, inpatient and justice system services. Although mental health service usage increased, along with increasing costs, this engagement is a benefit, rather than net expense, and was factored into the conclusion, which purported that the full-service, HF approach is cost-effective. A second control-group (Gilmer et al., 2010) examination of the FSP program again showed cost-effectiveness and also indicated that FSP clients reported a greater life satisfaction than the control group.

A recent study used a single site program to conduct a blind, randomized trial in Chicago, under the auspices of the Housing for Health Partnership. The program provides housing and case management for homeless people with HIV (Buchanan, et al., 2009). Unlike HF programs, it required sobriety or treatment for substance abuse before housing. We mention it here because the result of immediate housing for this very vulnerable group produced dramatic improvements in health and HIV status and may thus be a practical housing (almost first) option for this high risk group.

The Qualitative Studies

Qualitative studies may enhance the ability to understand the multi-faceted aspects of housing homeless persons. In light of the lack of outcome evidence, they are unable to determine "best practices." To the extent that they provide indicators of important ancillary issues, such as provider views of housing and the acceptable neighbourhood characteristics, they can inform the implementation of programs in greater specificity. Thus we have included these in the review of the literature.

Eight qualitative studies examined some of the facets involved with a *housing first* approach. ACT teams are considered essential components of a HF approach and three studies looked at their implementation (Neumiller et al., 2009), fidelity (Matejkowski & Draine, 2009) and inclusion as best practices (McGraw et al., 2010) in HF programs and compared them to intensive case management (Buchanan et al., 2009) and motivational interviewing (McGraw et al., 2010). Consistent conclusions across studies was that the ACT team, implemented according to ACT fidelity standards, is essential to stability in housing for the chronically mentally ill who have had long periods of homelessness. The inconsistency of implementation of all of the components of a *Pathways to Housing* model has led to the development of HF standards by P2H. However, these have not yet been tested or promulgated (private conversation) (Canadian Mental Health Association, 2004).

The meaning of "home" (D. K. Padgett, 2007), and the needs and preferences, especially of women with substance abuse problems has also been explored within the context of HF philosophy (Schiff & Waegemakers Schiff, 2010; Burlingham et al., 2010). In all three of these studies, privacy, safety and security were highlighted as critical features of acceptable housing to persons with a mental illness or substance abuse problems. While the two studies that looked at women with substance abuse issues (Schiff & Waegemakers Schiff, 2010; Burlingham et al., 2010) were not equivocal about their need for housing without a treatment context in the early phase of sobriety, the study examining ontological security, which focussed on a sub-group of the P2H original study participants, supported the need for privacy and security in the context of a person's own housing, thereby reinforcing the HF model. The experiences and attitudes of service providers in treatment first and *housing first* programs was explored through a series of interviews (Henwood, et al., 2011) with NYC providers. The authors note that paradoxically, the treatment first providers were more preoccupied with securing housing and the HF providers with securing treatment. This affirms the HF model but also supports the stance that the importance of treatment is not neglected in HF programs.

One report used a mixed qualitative and quantitative methodology to examine the neighbourhood and housing characteristics of persons in a HF program and a treatment first continuum (Yanos, et al., 2007). One half of the cohort in this study was drawn from the original *Pathways to Housing* study and consisted primarily of persons who had been continually housed for three or more years. The study lacks predictive value because of its small sample size (N= 44) and because participants may have self-selected housing type. No conclusions regarding community integration and housing type could be drawn.

The Canadian Context

As mentioned earlier, there have been no systematic studies of a *housing first* approach in Canada. At Home/Chez Soi, a major project sponsored by the Mental Health Commission of Canada (2010), promises to provide a five city analysis of *housing first* interventions that include attention to cultural and ethnic concerns and are framed in the Canadian context. Preliminary information from this large and complex study indicates that a HF approach is effective across a wide variety of geographical settings and with different homeless groups reflective of Canadian cultural and ethnic heterogeneity. While preliminary results show that HF approaches are effective, final data is needed before it is determined if HF applies across all the diverse populations studied. One promising aspect of this multi-site research program is the promise that it will help to explain how HF approaches may work with the various populations that are part of the initiative.

One limitation of all of the HF studies results from their focus on individuals with a mental illness or dual diagnosis, who are primarily single with no dependents. These studies ignore the complexities that families, single parent adults and multi-generational households present, and which may not address the efficacy of HF approaches for other homeless and high risk groups such as youth and seniors. The "*Streets to Homes*" housing initiative in Toronto uses a general *housing first* approach and has been acclaimed as a successful project. However, the project has not been independently reviewed, there is no refereed literature on its success and most of the data comes from a single report (Falvo, 2009) of program process and reported outcomes rather than rigorous research.

What is the evidence?

The apex of research findings usually consists of a rigorous review and analysis of quantitative research found typically in a Cochrane review. These reviews start by considering the number and quality of double-blind, randomly assigned studies and examine the methodological soundness of the study before accepting its conclusions. All conclusions from this "gold standard" of clinical trials are then assembled and conclusions drawn. A second phase would examine studies that have participants randomly assigned (see the pyramid model, p. 7). Observational studies and studies using retrospective data command sequentially less scientific soundness and receive proportionately less value in the overall review conclusions.

In the instance of best practices in *housing first*, there is a dearth of research that would qualify for a Cochrane analysis. A Cochrane Review of supported housing in 2007 (Chilvers, et al., 2007) failed to identify the *Pathways to Housing* program in its review process, perhaps because it failed to include all relevant databases that would cite this work. We include it because this study focuses on a specific supported housing program with a special set of operational values. Thus the only study using randomized assignment of participants is the New York study of the *Pathways to Housing* program (Tsemberis, Rogers, et al., 2003; Tsemberis, et al., 2003). While a number of articles emerge from this initiative, all rely on the same data set and thus cannot be considered independent studies for purpose of validating the results. The three multi-site studies sponsored by CICH include the *Pathways to Housing* program as a comparison program and offer study sites from across the U.S. However, as mentioned above, they lack scientific soundness because of problems with sample size, use of retrospective data and lack of random assignment.

A comprehensive cost-benefit analysis includes a variety of costs associated with a specific intervention. Such cost include inpatient and community-based, mental health and addictions treatment, physical health, shelter and income, use of the justice system as well as emergency services of various sorts. Benefits include reduced use of support services, employment – and a reduction of income transfer entitlements, among others. In a

well conducted study there are also actuarial efforts to quantify increased health, social contact and quality of life. Studies that examine only costs associated with different interventions fall far short of a true comparison. (Jones et al., 2003)

The cost analysis articles from San Diego (Buchanan et al., 2009; Gilmer et al., 2009), provide an analysis of basic cost of mental health and justice system services, but not benefits of this intervention and thus do not meet the hallmark of a rigorous review of the financial implications of the interventions. The Denver *Housing first* Collaborative Cost Benefit Analysis & Program Outcomes Report (Perlman & Parvensky, 2006) provides only analysis of the health and emergency service records of participants. Although it reports a significant savings in emergency and health service utilization, this is still an incomplete picture of all resources needed and used in this HF initiative. The same lack of full methodological rigour can be ascribed to the *Pathways to Housing* cost analysis (Gulcur et al., 2003). While they show that the HF approach is not significantly more expensive than housing through the continuum of care, these studies underestimate the benefits of the additional treatment interventions (which make up most of the increased cost) on HF participants.

The evidence, to date, comes primarily from governmental agencies and non-profit organizations, which have adopted a HF approach to rapid re-housing of hard to place individuals. These communities include Toronto (Street to Homes), the Calgary Homeless Foundation, the Alex Community Health Centre *Pathways to Housing* program (Calgary), the five cities involved in the Mental Health Commission of Canada national housing study which uses the *Pathways to Housing* models, modified for a Canadian context. In the U. S., they include the eleven cities in the CICH studies, Minneapolis, Washington, Portland, and NYC. In Europe, HF has been implemented in Dublin (Ireland) and Stockholm (Sweden), among others. This recognition comes with the acceptance that even when additional costs for supports and extra services are factored in, HF is an effective model for addressing homelessness even in a chronically unsheltered population.

Conclusions

In this report, it is immediately obvious that the literature review on *housing first* programs features the New York *Pathways to Housing* programs. With relatively sparse external scientific evidence or research on the model, it is nonetheless supported by the US department of Housing and Urban Affairs (HUD) and has been declared a "best practice" by the United States Interagency Council on Homelessness (USICH).

A brief overview of the literature shows the following: there are only eighteen quantitative studies, eleven of which use data from two *Pathways to Housing* studies. The first of these is a rigorous, randomly controlled, longitudinal (4 year) study of 225 individuals with a diagnosis of a serious mental illness along with concurrent substance abuse. Robust results strongly support a 'housing before treatment and independent of treatment' (*housing first*) approach. The second study, which was at a suburban New York City location, examined a population of chronic shelter users who were housed through one of two HF oriented programs or "treatment as usual", which entailed sobriety services before permanent housing. This study also documents that the HF model was highly effective (68% to 80% housing retention depending on the HF program provider), but that implementation of the original model resulted in higher compliance. The second study was less rigorous than the first in that demographic data was only available for a first cohort and recruitment issues led to an unregulated additional group of participants. In both studies there is reason to speculate that the service providers knowledge of their participation in a major research study may have resulted in their greater attention to tracking and keeping study participants housed.

Pathways to Housing also participated as one of 11 sites in four reports of a multi-site HF research project. Each of the three quantitative reports examines one aspect of the HF strategy. Results are limited as they are reported after 24 months, as further results at 48 months would be more definitive in housing

retention. Because the number of participants at each site was small, robust analysis is not possible. The studies also suffer from lack of consistency in participant selection and program delivery (Pearson et al., 2009; Robbins & Monahan, 2009; Tsai et al., 2010). While they report favourable results for a HF approach, the weakness of the methodology makes these reports less than robust. A fourth report offers a qualitative methodology that looks at the impact of ACT and MI services on implementing these programs. While the title refers to "best practices" it is ambiguous about whether this implies a HF approach or the ACT and MI treatment approaches (which are elsewhere considered best practices on their own). While suggestive of what impedes program effectiveness, within the definition of best practice research, it does not contribute to the robustness of the HF research.

There are seven journal articles that look at costs and these focus for the most part on the health and justice systems. Seven qualitative studies examine the needs and preferences of clients as well as provider views on *Housing first*. There are also four program descriptions, three of which are modeled on the *Pathways to Housing* program. There is however no data presented. Double blind studies are non-existent.

Until 2008, most HF research, including outcome studies and program evaluations, were conducted by Sam Tsemberis, the founder of the New York *Pathways to Housing* program. Since 2007 there have been relatively few external program evaluations and no double blind studies. One of the earliest external evaluations looked at the *Pathways to Housing* program and two others, which were selected for their use of the *housing first* model and because they had enough intakes for the data to be significant.[1] Before 2007 there were several cost benefit analyses completed[2] and there have been several since. In a report from Seattle Washington,[3] savings were significant when people were housed even if they were allowed to consume alcohol. There are numerous cities which show a decrease in shelter bed occupancy and this is attributed to *housing first* policies.[4]

Given the paucity of highly controlled outcome studies, we examined the process whereby HF had so rapidly become accepted as a "best practice." Declaring the *Housing first* model a best practice appears to be a political decision rather than a scientific research decision. In 2003 Philip Mangano, the executive director of the United States Interagency Council on Homelessness, was pushing to include alternative housing approaches (Economist, 2003). In 2008, through the McKinney-Vento Homeless Assistance Grants, $25 million was made available in order to show the effectiveness of rapid re-housing programs designed to reduce family homelessness. The following year, the US President signed the American Recovery and Reinvestment Act of 2009 which allocated $1.5 billion to HPRP (Homeless Prevention and Rapid Re-Housing Program). In that same year, President Obama signed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act which reauthorized HUD's Homeless Assistance programs. The HEARTH Act supports the prevention of homelessness, rapid re-housing, consolidation of housing programs, and new homeless categories. Finally, with regard to the political involvement related to housing and *housing first*, on June 22, 2010, the United States Interagency Council on Homelessness' document Opening Doors: Federal Strategic Plan to Prevent and End Homelessness was submitted to the Obama Administration and Congress. This comprehensive housing strategy names *Housing first* as a best practice for reaching the goal of ending chronic homelessness by 2015.[5]

We can safely conclude that HF has been shown to be effective in housing and maintaining housing for single adults with

1. Carol L. Pearson, et. Al., The Applicability of Housing first Models to Homeless Persons with Serious Mental Illness, US Department of Housing and Urban Development, July 2007, available on the web at: www.huduser.org/portal/publications/hsgfirst.pdf
2. See Denver Housing first Collaborative: Cost Benefit Analysis and Program Outcomes Report.
3. This April 2009 a study in the Journal of the American Medical Association determined that Seattle Washington saved over $4,000,000 for 95 chronically homeless individuals with serious substance abuse issues by providing them with housing and support services.
4. In Boston, there has been a significant drop in homeless individuals but an increase in family homelessness. See the report by Brady-Myerov, Monica, "Homelessness On The Decline In Boston", WBUR Radio, Boston, September
5. The report, Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, is available on the USICH website at www.usich.gov/opening_doors/

mental illness and substance use issues in urban locations where there is ample rental housing stock. There is no "best practices" evidence in the form of randomly assigned, longitudinal studies on families, youth, those with primary addictions, those coming from a period of incarceration, and those with diverse ethnic and indigenous backgrounds. There are, however, reports of substantial reductions in homelessness and associated costs for those who employ an HF approach (Perlman & Parvensky, 2006; Colorado Coalition for the Homeless, 2006). We also have observed that in spite of the lack of rigorous studies, many communities that have adopted a HF approach report and confirm housing retention and lowered cost of service delivery across a number of sub-groups in the homeless population, in Canada (Baptist, 2010; Calgary Homeless Foundation, 2011), the United States (Willse, 2008; United States Interagency Council on Homelessness, 2006) as well as Ireland (CornerStone, 2009), the UK and other counties in the European Union (Atherton & McNaughton Nicholls, 2008; Tainio & Fredriksson, 2009; Jensen, 2005; Mental Health Weekly, 2004; "MH agencies among the collaborators in initiative for homeless veterans," 2011).

We note that in Canada, the Homeless Hub (Hub, 2011) has become a large repository for both academic articles, government reports, especially from Canadian sources, and the free press, on housing and HF issues in Canada. While these reports come from the popular press, they confirm the vast and rapid uptake of this approach despite the availability of, by generally accepted research standards, rigorous confirmation of outcomes and lack of adverse consequences. Thus the evidence appears to be in reported program outcomes and cost savings in a number of diverse geographic areas. Since more persons, regardless of age or disability (if any) are being housed and, with appropriate supports, remaining housed, the *housing first* approach has achieved its primary purpose, and mitigated against the inevitable poor social and health consequences of homelessness. It is important to note, that for fundamental human services, such as housing, evidence of "best practice" may be found in sources other than those based on clinical trials of a medical model of research (Shumway & Sentell, 2004). To that end, the evidence of best practice in housing is retention of domicile, as reported by program outcome data, and, despite lack of rigorous multiple clinical trials, *housing first* overwhelmingly meets that requirement for a majority of the homeless population.

Appendix 1: National *Housing first* Logic Model

Objective: To ensure that the hardest to house people in Canada are adequately housed.

Method: A Prevention Model (for those who are precariously housed) and an Intervention Model (for those who are in need of housing) are detailed.

1st level: Activities

The *Housing first* Program Logic Model has two activities:

- Development of a Prevention Model flow chart;
- Development of an Intervention Model flow chart.

2nd level: Outputs

The outputs for the activities are:

- Literature Review;
- Design of the two Program Models;

3rd level: Immediate Outcomes

The immediate outcomes are:

- The Literature Review is completed;
- The two Program Models are designed;

4th level: Intermediate Outcomes

The intermediate outcomes are:

- Increased capacity of homeless and housing stakeholders to develop and improve preventative and intervention programs;
- Increased use of best practices, information and research among stakeholders;
- Increased uptake of housing options in communities;
- Increased governmental awareness of *housing first* as a viable housing model; and a
- National shared understanding of *housing first* model.

5th level: Long-Term Outcome

The long-term outcomes are:

- Housing for the most difficult to house and those with precarious housing, which is more appropriate and relevant;

6th level: Ultimate Outcome

The ultimate outcome is:

- All precariously housed and those in need of housing are appropriately housed.

Appendix 2: *Housing first* Logic Model

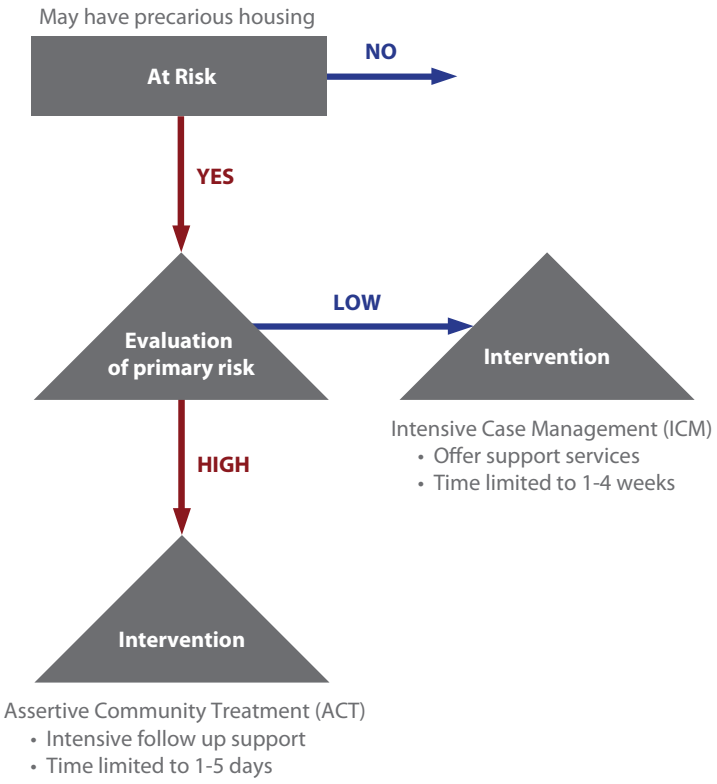
Appendix one provides the sequence of components used in one approach to logic models often found in management and program evaluation methodologies. It generally provides a list of resources and activities used to achieve targeted program goals. Since prevention and intervention strategies target different groups of persons, either at high risk of losing housing or those who are absolutely homeless, we have developed two separate models to indicate strategies for each group.

In addition, we feel that a logic model based on a decision tree format is also of particular importance. This format allows programs to recognize priorities and develop strategies that can deal with the complex issues most commonly present for families and persons with ongoing homelessness (the so called chronically homeless). Used in concert, these two approaches will help programs manage the complex process of housing and housing retention across wider groups of people.

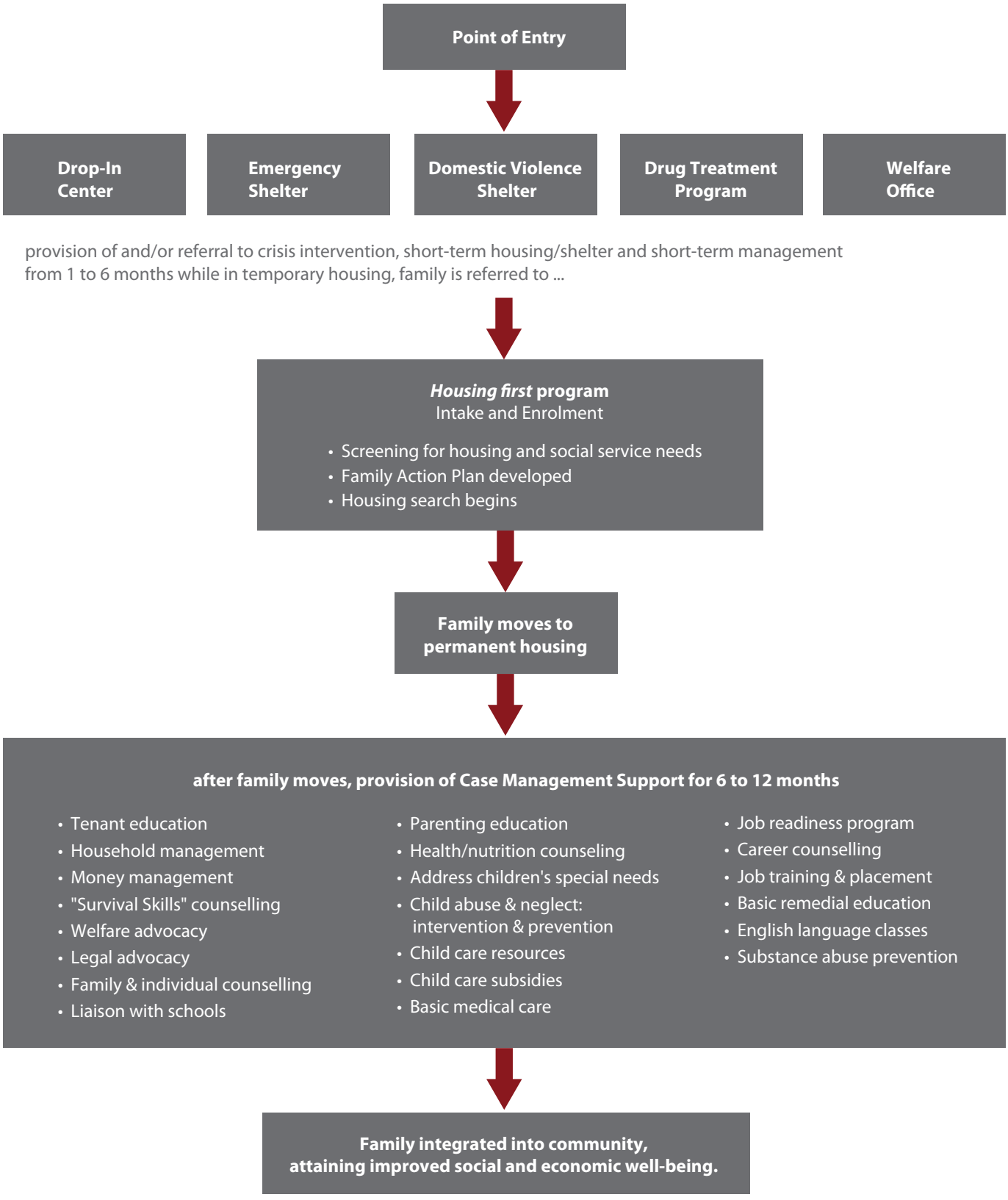
***Housing first* logic model**						
	Activities	**Outputs**	**Immediate Outcomes**	**Intermediate Outcomes**	**Long Term Outcome**	**Ultimate Outcome**
Prevention Model	To Develop a Flow Chart	• Complete Literature Review • Design Program Model • Increase numbers of Canadians who maintain housing	• The Literature Review is completed • The two Program Model is designed	• Increased capacity of homeless and housing stakeholders to develop and improve preventative and intervention programs; • Increased use of best practices, information and research among stakeholders; • Increased uptake of housing options in communities; • Increased governmental awareness of *housing first* as a viable housing model; and a • National shared understanding of *housing first* model.	• Housing for the most difficult to house and those with precarious housing which is more appropriate and relevant	• 100% of precariously housed and those in need of housing are appropriately housed.
	To determine housing vulnerability	• Risk is assessed	• Agencies trained in use of Assess-ment tool	• Agencies begin using the tool	• All agencies use the tool	• All at risk individuals and families are assessed
	To determine intervention level	• All at risk are offered an evaluation	• Agencies begin assessing clients	• Clients are streamed to appropriate services	• Clients access services	• Clients graduate from service
	To ensure all remain or are housed	• Housing is available for all clients	• Agencies locate housing	• Clients are offered housing according to need	• Clients obtain housing	• Clients remain housed

***Housing first* logic model** *(continued)*						
	Activities	**Outputs**	**Immediate Outcomes**	**Intermediate Outcomes**	**Long Term Outcome**	**Ultimate Outcome**
Intervention Model	To develop a Flow Chart	• Complete Literature Review • Design Program Model • Increase number of Canadians who achieve housing stability	• The Literature Review is completed • The two Program Model is designed	• Increased capacity of homeless and housing stakeholders to develop and improve preventative and intervention programs • Increased use of best practices, information and research among stakeholders • Increased uptake of housing options in communities • Increased governmental awareness of *housing first* as a viable housing model; and a • National shared understanding of *housing first* model.	• Housing for the most difficult to house and those with precarious housing which is more appropriate and relevant	• 100% of precariously housed and those in need of housing are appropriately housed.
	To determine housing vulnerability	• Vulnerability is assessed	• Clients are offered vulnerability assessment and shelter	• Clients accept shelter bed	• Clients remain in shelter while housing options are evaluated	• All clients are housed inside
	To determine supports required	• Service needs are assessed	• Client service plan is written	• Clients begin receiving services	• Clients complete service plan	• Client wellbeing is increased
	To provide appropriate housing	• Clients are matched to available housing	• Client is offered appropriate housing	• Client accepts housing	• Client retains housing	• All clients remain successfully housed

Prevention Model: Precarious Housing



Appendix 3


Point of Entry
Drop-In Center
Emergency Shelter
Domestic Violence Shelter
Drug Treatment Program
Welfare Office
provision of and/or referral to crisis intervention, short-term housing/shelter and short-term management from 1 to 6 months while in temporary housing, family is referred to ...
Housing first program
Intake and Enrolment
• Screening for housing and social service needs
• Family Action Plan developed
• Housing search begins
Family moves to permanent housing
after family moves, provision of Case Management Support for 6 to 12 months
• Tenant education
• Household management
• Money management
• "Survival Skills" counselling
• Welfare advocacy
• Legal advocacy
• Family & individual counselling
• Liaison with schools
• Parenting education
• Health/nutrition counseling
• Address children's special needs
• Child abuse & neglect: intervention & prevention
• Child care resources
• Child care subsidies
• Basic medical care
• Job readiness program
• Career counselling
• Job training & placement
• Basic remedial education
• English language classes
• Substance abuse prevention
Family integrated into community, attaining improved social and economic well-being.

Appendix 4: Academic (Research) Articles covered in this review

Broner, N., Lang, M., & Behler, S. A. (2009). The Effect of Homelessness, Housing Type, Functioning, and Community Reintegration Supports on Mental Health Court Completion and Recidivism. [Article]. Journal of Dual Diagnosis, 5(3/4), 323-356. doi: 10.1080/15504260903358801

Buchanan, D., Kee, R., Sadowski, L. S., & Garcia, D. (2009). The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial. [Article]. American Journal of Public Health, 99(S3), S675-S680.

Burlingham, B., Andrasik, M. P., Larimer, M., Marlatt, G. A., & Spigner, C. (2010). A House Is Not a Home: A Qualitative Assessment of the Life Experiences of Alcoholic Homeless Women. [Article]. Journal of Social Work Practice in the Addictions, 10(2), 158-179. doi: 10.1080/15332561003741921

Crane, M., Warnes, A. M., & Fu, R. (2006). Developing homelessness prevention practice: combining research evidence and professional knowledge. Health & Social Care in the Community, 14(2), 156-166. doi: 10.1111/j.1365-2524.2006.00607.x

DeSilva, M. B., Manworren, J., & Targonski, P. (2011). Impact of a Housing first Program on Health Utilization Outcomes Among Chronically Homeless Persons. Journal of Primary Care & Community Health, 2(1), 16-20. doi: 10.1177/2150131910385248

Fischer, S. N., Shinn, M., Shrout, P., & Tsemberis, S. (2008). Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time. [Article]. American Journal of Community Psychology, 42(3/4), 251-265. doi: 10.1007/s10464-008-9210-z

Gilmer, T., Stefanic, A., Ettner, S., Manning, W., & Tsemberis, S. (2010). Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. Archives of General Psychiatry, 67(6), 645-652. doi: http://dx.doi.org/10.1001/archgenpsychiatry.2010.56

Gilmer, T. P., Manning, W. G., & Ettner, S. L. (2009). A cost analysis of San Diego County's REACH program for homeless persons. Psychiatric Services, 60(4), 445-450. doi: 10.1176/appi.ps.60.4.445

Greenwood, R. M., Schaefer-McDaniel, N. J., Winkel, G., & Tsemberis, S. J. (2005). Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness. American Journal of Community Psychology, 36(3), 223-238.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes. Journal of Community & Applied Social Psychology, 13(2), 171-186.

Gulcur, L., Tsemberis, S., Stefancic, A., & Greenwood, R. M. (2007). Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness. [Article]. Community Mental Health Journal, 43(3), 211-228. doi: 10.1007/s10597-006-9073-4

Henwood, B., Stanhope, V., & Padgett, D. (2011). The Role of Housing: A Comparison of Front-Line Provider Views in Housing first and Traditional Programs. Administration and Policy in Mental Health and Mental Health Services Research, 38(2), 77-85. doi: 10.1007/s10488-010-0303-2

Henwood, B. F., Weinstein, L. C., & Tsemberis, S. (2011). Creating a medical home for homeless persons with serious mental illness. [Column/Opinion]. Psychiatric Services, 62(5), 561-562. doi: http://dx.doi.org/10.1176/appi.ps.62.5.561

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