In Review

Housing First for People With Severe Mental Illness Who Are Homeless: A Review of the Research and Findings From the At Home–Chez soi Demonstration Project

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Objective: To provide a review of the extant research literature on Housing First (HF) for people with severe mental illness (SMI) who are homeless and to describe the findings of the recently completed At Home (AH)–Chez soi (CS) demonstration project. HF represents a paradigm shift in the delivery of community mental health services, whereby people with SMI who are homeless are supported through assertive community treatment or intensive case management to move into regular housing.

Method: The AH–CS demonstration project entailed a randomized controlled trial conducted in 5 Canadian cities between 2009 and 2013. Mixed methods were used to examine the implementation of HF programs and participant outcomes, comparing 1158 people receiving HF to 990 people receiving standard care.

Results: Initial research conducted in the United States shows HF to be a promising approach, yielding superior outcomes in helping people to rapidly exit homelessness and establish stable housing. Findings from the AH–CS demonstration project reveal that HF can be successfully adapted to different contexts and for different populations without losing its fidelity. People receiving HF achieved superior housing outcomes and showed more rapid improvements in community functioning and quality of life than those receiving treatment as usual.

Conclusions: Knowledge translation efforts have been undertaken to disseminate the positive findings and lessons learned from the AH–CS project and to scale up the HF approach across Canada.

D'abord chez soi pour les personnes souffrant de maladie mentale grave qui sont sans abri : une revue de la recherche et des résultats du projet de démonstration At Home–Chez soi

Objectif : Offrir une revue de la littérature de recherche existante sur le Logement D'abord (LA) pour les personnes souffrant de maladie mentale grave (MMG) qui sont sans abri, et décrire les résultats du projet de démonstration At Home (AH)–Chez soi (CS) terminé récemment. L'approche LA représente un changement de paradigme de la prestation des services de santé mentale communautaires, grâce auxquels les personnes souffrant de MMG qui sont sans abri sont soutenues par un traitement communautaire actif ou une gestion de cas intensive pour emménager dans un logement régulier.

Méthode : Le projet de démonstration AH–CS comportait un essai randomisé contrôlé mené dans 5 villes canadiennes entre 2009 et 2013. Des méthodes mixtes ont été utilisées pour examiner la mise en œuvre des programmes de LA et les résultats des participants, en comparant 1158 personnes recevant LA avec 990 personnes recevant des soins réguliers.

Résultats : La recherche initiale menée aux États-Unis montre que LA est une approche prometteuse, qui donne des résultats supérieurs en ce qui concerne l'aide aux gens à sortir rapidement de l'itinérance et à s'établir dans un logement stable. Les résultats du projet

de démonstration AH–CS révèlent que LA peut être adapté avec succès à différents contextes et pour différentes populations, sans perdre son intégrité. Les personnes recevant LA ont eu des résultats de logement supérieurs et ont fait preuve d'améliorations plus rapides du fonctionnement communautaire et de la qualité de vie que ceux recevant le traitement régulier.

Conclusions : Des initiatives de transfert des connaissances ont été prises pour diffuser les résultats positifs et les leçons tirées du projet AH–CS, et pour étendre l'approche LA à tout le Canada.

Beginning in the 1970s, deinstitutionalization created significant challenges for community mental health and housing services in provinces across Canada.¹ The main objective of deinstitutionalization was to replace institutional care with community-based housing and treatment. Unfortunately, achieving this objective fell well short of the mark.¹ Subsequently, in the early 1990s, when changes in federal policy led to a significant reduction in the creation of affordable housing units, large numbers of people with severe psychiatric disabilities living on deficient fixed incomes across Canada were no longer able to access housing² and found themselves among the homeless population.^{3,4}

Since this deinstitutionalization, there have been 3 broad categories of housing: custodial housing; specialized, single-site housing with on-site supports; and scattered-site, independent apartments, which include both social housing and private market housing with off-site support.^{5,6} In a historical review of different housing approaches in response to deinstitutionalization,⁷ custodial housing was identified as the first type of housing initially available in the 1970s. Custodial housing consisted primarily of board and care homes and single-room occupancy hotels with limited on-site support, typically operated by for-profit agencies.⁷ As a result of the inadequacy of the supports provided by custodial housing, as well as the growing demand for housing in the face of a growing number of people with mental health problems experiencing homelessness, specialized, single-site housing with on-site support (supportive housing) began to be developed in the mid-1980s.⁸ Supportive housing, such as board and care homes, also congregated people with psychiatric

Clinical Implications

- Based on the extant research, HF programs should be developed to end chronic homelessness among people with SMI.
- The integration of addictions treatment, vocational training, and social opportunities into HF programs is needed to improve their non-housing outcomes.
- The development of other types of supportive housing programs is needed for HF recipients who are unsuccessful in leaving homelessness.

Limitations

- The short length of follow-up in studies precludes being able to draw conclusions about longer term-outcomes of HF.
- Quantitative measures may not be sensitive enough to show the positive impacts reported by HF recipients in qualitative interviews.

disabilities together in residential settings where they had their own room or studio but shared some common living and dining areas.

Although single-site, specialized housing with on-site support was an improvement, compared with custodial housing, it was criticized because of its tendency to segregate people with mental illness from others in the community and it often failed to meet its primary objective of preparing people to live independently.^{5,9,10} A new approach in community mental health services emerged in the 1970s and 1980s, where people leaving institutions were provided with the necessary portable service supports, including ACT and ICM, to live in regular housing as tenants.^{9–13}

In the early 1990s, Pathways to Housing in New York City began using supported housing, composed of independent apartments rented from community landlords and providing intensive off-site supports to house people who had been chronically homeless and diagnosed with severe psychiatric disabilities and addiction problems. These people were assisted to move directly from the street into apartments without any pre-conditions.¹⁴ The Pathways program became known as HF, to contrast it from the standard practice of supportive housing, which typically required treatment and sobriety, with the goal of stabilizing people prior to providing housing. HF provided rental assistance and furniture and eliminated access barriers by moving people immediately into regular private market rental

Abbreviations

ACT	assertive community treatment
AH	At Home
CS	Chez soi
HF	Housing First
HPS	Homelessness Partnering Strategy
ICM	intensive case management
MHCC	Mental Health Commission of Canada
QoL	quality of life
RCT	randomized controlled trial
SMI	severe mental illness
TAU	treatment as usual

housing, along with providing support services through ACT or ICM.¹⁵

Our paper provides a review of the extant research literature on HF for people with SMI who are homeless. The first section presents the theoretical framework of HF and describes the program's logic model. In the next section, research on the effectiveness of HF is reviewed, with an emphasis on the results of the recently completed AH–CS demonstration project that entailed an RCT of HF in 5 Canadian cities.¹⁶ Finally, the last section describes the knowledge translation and policy changes that resulted from the findings of the AH–CS project.

Theoretical Framework of the Pathways' Approach to Housing First

Principles

Four key theoretical principles are central to the Pathways' HF model¹⁷:

- 1) Immediate provision of housing and consumer-driven services.
- 2) Separation of housing and clinical services.
- 3) Providing supports and treatment with a recovery orientation.
- 4) Facilitation of community integration.

Provision of Consumer-Driven Services

Consumer choice is the core value that drives the provision of both housing and support services. Consumers are encouraged to select the type of housing and neighbourhood and the type, sequence, and intensity of services that best meets their needs. This builds a sense of personal mastery, ownership of the housing, and encourages active participation in treatment. HF developed, in part, because most consumers who were homeless said that housing was the first thing they wanted.

Separation of Housing and Clinical Services

Housing and services are separated geographically, functionally, and conceptually. The housing is composed of independent apartments, owned primarily by community landlords, scattered throughout the community. The support services are provided by off-site, community-based mental health teams (ACT or ICM) that are located in the community, separate from housing staff, but teams and staff are expected to work closely together in the best interest of service recipients. Tenants have standard leases, and they have the same rights and responsibilities as any other tenant; moreover, they do not have to meet treatment requirements to obtain or to keep their housing. There is simply a requirement for a weekly program visit. If consumers relapse or leave their apartment for treatment, they will not lose their connection to their support team. Because housing and services are separate, the team can relocate tenants and provide support even if they leave for long-term treatment.

Adoption of a Recovery Orientation

There are numerous practice dimensions that are intended to support recovery for people with psychiatric disabilities.¹⁸ The core program principle of consumer choice is actually undergirded by a more profound assumption concerning psychiatric disabilities, which is that most people with psychiatric diagnoses are in fact capable of making reasonable choices, even as they continue to struggle with psychiatric symptoms. The teams support the consumer when the choice made results in failure, and failure does not mean discharge from the program or relinquishing the opportunity to make further decisions. The HF approach supports recovery by using a respectful and hopeful approach, building on people's strengths, and celebrating the successes, small and large, along the way.

Facilitation of Community Integration

Community integration refers to program dimensions that pertain to facilitating a sense of belonging and participation in activities with nondisabled people in the community. The program does not rent more than 20% of the total number of units in a building, in an effort to ensure that program participants live in integrated housing with a range of diverse tenants. Consumers are encouraged to develop a map of their community and to use the available amenities, such as shopping for goods, transportation, participating in cultural, entertainment, and spiritual activities, and to access health care and self-help support as well as other resources available in the community.

Program Logic Model

A program logic model is a visual representation of both the program's theory of action (how the program is intended to be implemented) and its theory of change (the presumed causal pathway about how program activities lead to outcomes).¹⁹ The program logic model presented below provides a description of the inputs, principles, activities, and outcomes of HF (online eTable 1).

The 2 main domains or inputs of HF are the housing and support services components. HF requires both rent supplements and support services. Next, are the 4 principles of HF that we described in the previous section. These principles guide the implementation of specific program activities. Concretely, as the approach is based on the principle of consumer choice, the first task is to assist the consumer in rapidly procuring housing that he or she prefers. A housing specialist is a team member (or a staff member from another agency) who assesses consumer housing preferences, helps the consumer to apply for public financial assistance, and negotiates with landlords and the organization providing the rent supplement.¹⁵ Next, aligned with the principle of the separation of housing and services, an ACT or ICM team member engages with the consumer to develop an individualized recovery plan.

Once the individual is stably housed, the service team or support worker employs 3 program activities to promote HF outcome goals. First, staff members operate from a

philosophy of choice, recovery, and community integration. These components form the value base that guide the work of program staff.²⁰ Second, HF provides consumers with a wide array of both clinical support and tenancy-related services. Recognizing that the needs and goals of consumers are complex, there is a need to connect consumers with various services (for example, health and social services), community resources (for example, employment and education), and informal sources of support (for example, peer support and family). Third, to provide high-quality services to consumers, ACT and ICM programs must adhere to a set of program fidelity standards (for example, a low staff-to-consumer ratio, on-call support, regular home visits, team meetings, and other organizational features).

These program activities should lead to the immediate outcomes of rapid housing, new relationships with landlords and neighbours, the development of a working alliance with support workers, reduced use of emergency services, hospitalization, and involvement in the criminal justice system, increased participation in treatment, and increased access to public benefits. In the medium and longer term, this program should lead to increased community integration, social support, and QoL, and improved clinical outcomes and functioning, compared with in the longer term.

With HF, there is a concern that there may be a drift away from the key components of the program model over time and when the program is implemented in different contexts. For example, a study conducted in 6 countries in the EU found considerable variation to the HF model.²¹ A fidelity scale has been developed that measures the adherence to the key program activities of the HF approach described in the program logic model.²²

Recent research has demonstrated that fidelity to the HF model is important for achieving positive outcomes. In the Full Service Partnership study, results showed that HF fidelity was positively correlated with housing outcomes.²³ Another study found that HF fidelity was related to greater housing retention and reduced use of stimulants or opiates.²⁴

Research on the Effectiveness of Housing First

Online eTable 2 presents the findings of the research on the effectiveness of HF.

Initial Research

Initial research on the effectiveness of Pathways' HF was conducted in large American cities and consisted of 2 single-site RCTs and 5 quasi-experimental studies.^{25–36} In the 2 RCTs, the outcomes of recipients of HF that included ACT were compared with people receiving standard care^{27–32} or services available through a residential continuum model that transitions people from single-site transitional settings with on-site services and requiring participation in treatment and sobriety toward eventual independent living.³² Both of these studies showed HF yielding better housing outcomes that included exiting homelessness earlier and remaining as stably housed as tenants in regular housing.

One of the RCTs also reported that, compared with people receiving standard care, recipients of HF spent fewer days in psychiatric hospitals.²⁷ No differences emerged between the 2 groups regarding improvements in the severity of psychiatric symptoms or substance use.^{28–30}

Findings from 2 quasi-experimental studies also showed HF with ACT producing better housing outcomes than standard care.^{25,26,36} Mixed findings are reported for nonhousing outcomes, with either no differences in level of improvement over time or results favouring HF with decreased use of inpatient and emergency department services, decreased involvement in the justice system, and improved QoL, compared with outpatient mental health services,³⁴ and decreased substance use³⁵ and a lower likelihood of leaving substance use treatment, compared with standard care.³⁶

A recent review of the research on permanent supportive housing that included an examination of HF characterized the level of evidence for its effectiveness as being moderate.³⁷ To date, methodological limitations of the research include the small number of trials with small samples, the receipt of a range of varying services by comparison groups, and the narrow focus on housing outcomes.

The At Home—Chez soi Pan-Canadian Demonstration Project

In 2008, the federal government of Canada allocated \$119 million to the MHCC to conduct a multi-city research demonstration project testing the effectiveness of HF as an approach to address homelessness among people with SMI and a history of homelessness. The project, known as AH–CS entailed a pragmatic RCT of HF in 5 cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton. The trial was intended to evaluate the effectiveness of HF relative to existing services available in each city.

The project examined delivering HF to 2 different groups of people with SMI based on their level of need. People assessed with a high level of need received HF with ACT. Conversely, people with a moderate level of need were provided with ICM. HF tested in the study was based on the Pathways approach described earlier. The implementation of the approach was ensured through the application of intensive training and technical support and the conduct of 2 implementation evaluations and 2 assessments of fidelity during the 5-year period of the project. Mixed methods of data collection were used to evaluate outcomes, which included quantitative data from structured interviews with all participants using standardized measures and qualitative data with a subgroup of participants, collected through in-depth interviews. A detailed description of the study methods is presented in the published study protocol.³⁸

Study Participants

Online eTable 3 presents the demographic and clinical characteristics of the participants in the AH–CS project. The study enrolled a total of 2148 people, of whom 1198

were assigned to receive HF and 950 were randomized to receive TAU. In line with the eligibility criteria, all participants were diagnosed at enrolment as having one or more SMI (that is, 34% with a psychotic disorder and 71% with a nonpsychotic disorder). About two-thirds (67%) were also diagnosed as having a substance use problem, and more than 90% reported having 1 or more chronic physical health condition. Eighty-two per cent of participants were absolutely homeless, while the other 18% were precariously housed, living in rooming houses or single-room occupancy hotels and having experienced 2 episodes of homelessness in the last year. The average total time homeless for participants was close to 5 years (that is, 58 months).

Fidelity Findings

HF programs that were implemented as part of the AH–CS Demonstration Project received training and ongoing technical assistance and scored significantly higher than the Full Service Partnership program in California, in which personnel were neither trained on the model nor necessarily adhered to the HF model.³⁹ Moreover, it was found that program fidelity in AH–CS improved over time, from early to later implementation.⁴⁰

In the Canadian AH–CS project, researchers also found that fidelity was directly related to the outcomes of housing stability, community functioning, and QoL.⁴¹ While fidelity is important, so too is adaptation. In AH–CS, HF programs were adapted to ethnoracial factors of program participants, community size, and existing services, while still maintaining fidelity to the key components of the Pathways model.^{42,43} Thus it is possible to have both fidelity to and adaptation of HF, which are important for program success and community relevance.

Quantitative Outcome Findings

Overall, in line with findings from the American studies, HF proved to be more effective than TAU in assisting people to exit homelessness and achieve stable housing.³⁹ Specifically, during the course of the 2-year study, HF participants spent 73% of their time in stable housing, compared with TAU participants spending 32% of their time in stable housing. As shown in Figure 1, superior housing outcomes were evident for HF recipients, compared with those receiving TAU in all 5 cities. In the last 6 months of the study, 62% of HF participants were housed all of the time, compared with 31% of TAU participants; 16% of HF participants were housed none of the time, compared to 46% of TAU participants. People with high needs receiving ACT and people with moderate needs receiving ICM experienced similarly superior housing outcomes, compared with those receiving standard care.^{44–46}

In addition to these differences in housing outcomes, HF participants also showed greater improvements, on average, in community functioning and QoL than TAU participants.³⁹ Significant differences in QoL between HF participants receiving ICM were sustained throughout the 24 months of the study.⁴⁴ In contrast, significant differences

in improvements in QoL between HF participants receiving ACT were present at 12 months⁴⁵ but no longer at 24 months.⁴⁶ Although HF participants receiving ICM and ACT showed more rapid improvements in community functioning than TAU in the first 18 and 12 months of the study, respectively, the differences between groups were attenuated such that they were no longer present at 24 months.^{44–46}

An examination of the small proportion of people (13%) who were unable to achieve housing stability after 1 year of receiving HF found them to have longer lifetime histories of homelessness, to be less likely to have completed high school, to report a stronger sense of belonging to their street social network and a better level of QoL while homeless, and to present with more serious mental health conditions.⁴⁷ However, sex, ethnic origin, diagnosis of depression, substance use, arrests, contact or detention by police, or community functioning were not predictive of having poor housing outcomes.

Qualitative Outcome Findings

A subgroup of participants ($n = 195$) participated in in-depth qualitative interviews at baseline and at the 18-month follow-up. Based on how these people described changes in their lives, the content of the follow-up were classified into 1 of 3 categories: positive, negative, or mixed. The positive changes included 3 overlapping themes that reflect the following transitions: from streets to home, from home to community, and from the present to the future. A comparison of the life changes of the 2 groups found 61% of people receiving HF, compared with only 28% of those from the TAU group.⁴⁸ Moreover, 36% of people receiving TAU described having experienced a negative life course since the start of the study, compared with only 8% of those in the HF group. A further analysis of the interviews identified living in stable housing and having positive social and supportive contacts as key factors behind positive life courses. In contrast, negative social contacts, social isolation, and continued substance use were cited as significant contributors to negative life courses.

Knowledge Translation

Knowledge translation efforts have been undertaken to disseminate the positive findings and lessons learned from the AH–CS project and to scale up the HF approach across Canada. The Interactive Systems Framework—knowledge translation, support system, and service delivery system—provide a useful lens for understanding this process of knowledge transfer.⁴⁹ First, regarding knowledge translation, the project findings were translated into the user-friendly, web-based Canadian HF toolkit.⁵⁰ More than 10 000 Canadians visited this website in the first 4 months following its launch in 2014. Second, a support system to assist communities in adopting the HF approach has been developed by the MHCC. Pathways to Housing National was retained to provide training and technical assistance to 18 Canadian communities during a 3-year period.

Figure 1 Site-specific per cent of time in stable housing in 3-month periods during 24 months

Additionally, this initiative is in the process of creating Regional HF Networks that will support provincial and local stakeholders in HF implementation. Third, through the MHCC's sustained work with the federal government regarding project outcomes, the federal government renewed its HPS program, which provides funding to 61 communities for services for homeless people.⁵¹ Moreover, HPS shifted its approach such that 65% of the funding for Canada's 10 largest communities must be allocated to HF programs as of 2015. This policy shift has created a favourable context for communities to adopt HF. Research funded by the MHCC and the Canadian Institutes of Health Research is currently under way to understand the sustainability of the AH-CS programs and the scaling up of HF across Canada.

Conclusion

Building on housing and support models developed in response to homelessness among people with psychiatric disabilities, HF represents a paradigm shift in how those with severe and persistent mental illness are assisted to leave homelessness and attain housing stability. The AH-CS project reveals how this approach can be adapted in cities of different sizes and with diverse populations in Canada.

In addition to achieving very large effects in terms of housing outcomes, compared with standard care in the community, HF also produces rapid improvements in community functioning and QoL. A major challenge faced by HF programs is how to adapt and target the support provided to its participants during the longer term to

improve the outcomes in other areas, including mental health, physical health, substance use, education, work, community integration, and ultimately, recovery.

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