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Putting Housing First

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Putting Housing First

The At Home/Chez Soi project has conclusively demonstrated the effectiveness of the Housing First approach to rapidly and cost-effectively reduce homelessness for individuals living with mental illness

"People have known for some time that they weren't getting the outcomes they wanted by investing in shelters and short-term support," says Paula Goering, RN, PhD, principal investigator for the Mental Health Commission of Canada's At Home/Chez Soi project. "And there's been a lot of rhetoric. It's really important to have reliable empirical evidence."

Involving 2,148 participants and more than 200 service providers, 260 landlords and property management companies in five cities, and more than 1,200 housing units, this randomized controlled pragmatic field trial — the largest study of its kind in the world — has indeed generated that evidence. It was commissioned at a time when homelessness was on the rise in many communities across the country. At the same time, studies were showing promising evidence of the effectiveness of the Housing First approach. Most of these, however, were based on American programs or had methodological limitations. In 2008, the federal government allocated $110 million to the Mental Health Commission of Canada (MHCC) to undertake a research demonstration project on the Housing First approach in Canada.

Goering, an affiliate scientist at the Centre for Addiction and Mental Health and a professor in the University of Toronto department of psychiatry, was named by the MHCC to co-lead the project, which meant contributing to its design, putting together the research team and helping to oversee implementation.

In contrast to the traditional "treatment, then housing" approach, Housing First involves the immediate provision of permanent housing and wraparound supports to individuals experiencing homelessness and living with serious mental illness. Housing First is built on the simple notion that people are better able to move forward with their lives if they have a place to call home.

The MHCC launched the five-year project in 2009, comparing the Housing First approach with existing ways of dealing with homelessness in Winnipeg, Moncton, Vancouver, Montreal and Toronto. By implementing the project in these five sites, the researchers were able to learn how to adapt and modify Housing First in different contexts. In Winnipeg, the project focused on the urban aborigi-

According to the 2013 State of Homelessness in Canada report, at least 200,000 Canadians experience homelessness in a given year, and at least 30,000 are homeless each night. Homelessness costs the Canadian economy an estimated $7 billion a year, for things like shelters and day programs, as well as the costly emergency care, policing and incarceration associated with homelessness. Although many factors can lead to homelessness, an estimated 25 to 50 per cent of people who are homeless in Canada live with a mental health disorder.

nal population; in Moncton, rural homelessness; and in Vancouver, people with substance use issues. In Montreal, there was a vocational component, and in Toronto, the research targeted the ethnoracial population, including new immigrants who didn't speak English.

"The scope and size of the project was very unusual — Housing First had never been tested on this scale before," Goering says. "With a budget of $110 million, we could design it from scratch, using best practice." The project included a standardized definition of Housing First and used fidelity assessments to monitor the quality of implementation.

The research team recruited the more than 2,000 participants, mostly from shelters or the streets. A computer program randomly selected 1,158 individuals to receive the Housing First intervention, while a control group of 990 received treatment as usual, including being offered information by the research team about existing services available in their communities. Of those selected for the Housing First group, 62 per cent were deemed to have "moderate needs" and received Intensive Case Management (ICM). The ICM programs were provided by case managers with a staff-to-participant ratio of 1:16. Services were provided seven days a week, 12 hours a day. The 38 per cent considered to have "high needs" received Assertive Community Treatment (ACT). The ACT teams included a psychiatrist, a nurse and a peer specialist. The staff-to-participant ratio was 1:10, with staff available seven days a week and crisis coverage around the clock.

Participants were interviewed at baseline and every three months for up to two years. Information was also gathered from the programs

What is Housing First?

Housing First is based on five principles: immediate access to housing with no housing readiness conditions, consumer choice and self-determination, recovery orientation, individualized and person-driven supports, and social and community integration. First popularized in New York in the 1990s, Housing First is a revolutionary approach to addressing chronic homelessness by first moving people into housing, and then providing additional supports and services as needed.

One of its distinguishing features is that there are no preconditions imposed on the participants, such as bringing substance use under control or being stabilized on medications. The approach contrasts sharply with the long-standing belief that people who are homeless need to be "ready" before they can live independently.

Participants have a choice about where they would like to live and are subsidized so that they pay no more than 30 per cent of their income towards their housing. They also have choice in terms of what services they receive, and when they start using them. Options include physical and mental health services, education and employment support, substance use treatment, and community connections.

Housing First has a recovery orientation, focusing on individual well-being and incorporating a harm-reduction approach to substance use and addictive behaviours.

Along with housing, participants receive support from one of two types of Housing First teams — Assertive Community Treatment teams and Intensive Case Management teams — designed to meet the needs of specific target populations.

An important part of the Housing First strategy is to help people integrate into their community by emphasizing housing models that do not stigmatize or isolate them and by providing opportunities to engage socially and participate in meaningful pursuits.

(e.g., number of service visits) and from national and provincial administrative data sources for health and justice service use before and throughout the study. Followup rates (the number of participants who completed their final interview) were between 77 and 89 per cent. Eighty-five participants were known to have died during the study. The primary outcomes measured at all sites were housing stability, community functioning and quality of life. Secondary outcomes were mental illness symptoms and substance use problems.

"The most important result is that homeless individuals with mental illness and other problems can be permanently housed," says Goering. "They don't have to rely on shelters and acute care. Permanent stable housing in the community

Moving forward

"I was one of the lucky ones," says Trevor, a participant in the Vancouver At Home project.

Living in a shelter at the time, Trevor had been homeless on and off since the age of 21. "I never lived in a single dwelling for more than a year. My behaviour or the housing wasn't healthy, so I'd invariably end up homeless."

The 44-year-old was diagnosed with bipolar disorder at age 12. "I've had lots of highs and lows in my life," he explains. "There were even times I had great success in my career as a welder; I love creating things."

Trevor noticed people coming to the shelter to interview some of the residents. He asked one of the staff members about it and got an interview. He fit the requirements and was randomly selected to be part of the Housing First group.

He was assigned a mental health team and a case manager — a registered nurse — who helped him find units to look at. "I chose a place in North Vancouver," he says. "It was spacious, but there weren't many resources for someone on a lower income. I had the option to move if I wanted, and a place became available in a nice little neighbourhood called Mount Pleasant.

"I'm very choosy about who I'll let into my home," he adds. "It's like, I now have something valuable to guard."

The mental health team set him up to meet regularly with a psychiatrist, and his family doctor got him on medication, which, he says, has made a world of difference. He meets with his case manager about once a month. Those meetings have had an unexpected benefit.

"I hadn't talked to my older brother for about 10 years. But I realized there's a parallel between my relationship with my case manager and the one I have with my brother. Both just want to help me out and stay in touch. It's actually really nice to know there's somebody out there who thinks about you from time to time."

Trevor now has a part-time job with the Portland Hotel Society, a social service provider in Vancouver, delivering hot meals by bicycle to the different hotels in the Downtown Eastside. "I'm in great shape; I've lost 15 pounds," he jokes.

"The At Home project got me to the point where I could settle down enough, be relaxed enough not to have to worry about having a roof over my head or food in my stomach. Once I got to that level, I was able to think 'what the hell do I want to do next?'"

Trevor also joined the At Home Vancouver Speakers Bureau. He has presented to 200 people at an At Home all-team meeting and has been interviewed by a radio station in Victoria. "Reducing the stigma of mental illness and advocating for more housing for homeless people with mental illness is something I feel strongly about."

Trevor's goals include finding more "decent friends" and getting enough employment to get off social assistance. "This experience has made me want to be more of a productive member of society. I just want to keep moving forward."

Shoes. "When I was homeless there was a certain bush in a park that I would sleep in sometimes. One night it was very cold and I found an empty beer case lying nearby and I gathered a small amount of wood and made a fire to keep warm. I put my feet close to the fire and fell asleep. When I woke up my shoes were melted to my already blistered and bloodied feet and I had to walk several miles to the nearest hospital to get treatment. All they did was give me some juice, a sandwich and a tube of Polysporin. When I left I had no shoes at all. I had no place to go so I went back to where I was and when I did manage to get some shoes I had to wear size eleven runners on size nine feet because they were so swollen. That should never happen to any human being anywhere let alone in this country especially if they haven't done anything wrong and they're just sick."

plus appropriate care does improve their lives."

Indeed, in the last six months of the study, across all cities, 62 per cent of Housing First participants were housed for the entire time, 22 per cent some of the time, and 16 per cent none of the time. For treatment as usual participants, the numbers were 31 per cent, 23 per cent and 46 per cent, respectively.

Results also show that the Housing First approach makes better use of public dollars than treatment as usual, especially for those who had higher service use. By shifting participants away from expensive services such as emergency rooms and police detentions, savings averaged $21,375 per person for those with high needs and $4,849 per person for those with moderate needs. Cost-effectiveness was most evident for the 10 per cent of participants with the highest service use costs at the start of the project, a group for which every $10 invested in Housing First resulted in an average savings of $21.72.

"The Housing First approach isn't something new," says Goering. "We've just been able to show that you can use it in different contexts and that it has important economic implications."

Goering points out that 13 per cent of participants weren't able to achieve stable housing within the program. This group tended to have longer histories of homelessness, lower educational levels, more connection to street-based social networks, more serious mental health conditions and some indication of greater cognitive impairment. "We might just need to modify our approach for that group and try to be more flexible and creative in terms of the housing models offered to them."

School. "This is the university that I got my degree from and subsequently worked at for a number of years before I became ill. It just goes to show that not all the people on the street lack education, skills, or a good work history. So remember, if you're looking at this it could have just as easily been you!"

“The most important result is that homeless individuals with mental illness and other problems can be permanently housed. They don’t have to rely on shelters and acute care”

“We’re really proud of her”

Tiffany* is not your ordinary university student. For one, she used to work in the sex trade. Tiffany also has a long history of drug and alcohol dependence and has tried to take her own life several times. And for three years, Tiffany was homeless, living on the streets of Toronto, in and out of shelters.

But today, she is completing a degree in social work, living in a comfortable apartment and raising her young daughter.

Jo Connelly is one of the At Home program managers based in Toronto. “In a treatment as usual approach, a worker might say, ‘Tiffany’s in the sex trade, she’s addicted, she won’t be successful living independently.’ She probably would have been told to go someplace like a shelter. Instead, she’s been properly housed and has been able to move forward, step by step, with the support she needs. It hasn’t always been easy, but we’re really proud of her.”

Tiffany was one of the participants randomly selected to receive the Housing First intervention. According to Connelly, “She brought the sex trade and drugs into her first place, which caused her to lose her housing. When that happened, we were able to discuss what was going on, why the landlord was upset and what she could do differently the next time. She’s now doing well in another place and has learned a lot of life skills.”

The Ontario government is providing long-term funding so that the people helped by the At Home project in Toronto will continue to get the support they need to stay in their apartments.

“I’m so glad it’s not a time-limited program,” says Connelly. “It’s about what the person needs to be successful. Tiffany is still working on old issues like her anger and how she copes with stress. Being able to maintain her relationship with her case manager and stay in her place is really important.”

**Name has been changed*

Living Room. “When you’re living on the street you can never relax. You never know if somebody is going to try and rob or hurt you. Now I can sit in my apartment and not be afraid. I can watch TV, choose who I want to be with, and basically have a normal life.”

My Kitchen. “I love to cook. On the street it’s hard to get a decent meal. Now my fridge is full and I can choose what and when I eat. I’m so much healthier now, and I get so much satisfaction in doing something I love to do. I can even invite people over for a meal. Beats the hell out of a food kitchen.”

Garbage. "When you're on the street, people look at you like garbage. They don't know who you are, what you've done, or why you're out there. Half of the homeless people in Winnipeg are mentally ill. In our affluent society nobody should be left without a home just because they are sick, but because people don't know they don't care. Maybe it's time we started educating them."

Mary Lou Holm is a nurse case manager with the Toronto project, working on its multidisciplinary ACT team to support participants with the highest needs. She and the other nurses help coordinate medications and administer injections of drugs such as anti-psychotics, along with their other case management duties.

The benefit of the ACT team, Holm says, is availability. "We can see a crisis starting and intervene before it becomes full blown. We can connect with the psychiatrists on the team right away and get the participant into a safe bed or adjust medication, instead of hospitalizing them. Instead of falling into a big pothole, the person might just experience a little bump in the road."

"The project has had an influence above and beyond what we had hoped for, and we are really pleased with the uptake locally, provincially and nationally," says Goering.

Because At Home/Chez Soi has been so successful, there have been efforts to continue the housing and support activities, despite the official project ending in 2013. All five sites have received funds to continue to follow the participants in the longer term.

"We have a sense that for some of them, improvements in areas such as health or employment are going to take a longer time, so it's great we're going to be able to follow these individuals for another couple of years," Goering says.

In fact, the federal government is shifting its Homelessness Partnering Strategy to be more aligned with a Housing First approach. The 2013 budget included $600 million for a five-year renewal of the strategy to support communities to reduce homelessness and facilitate the implementation of the Housing First approach across Canada.

The project has already attracted international attention; it is being replicated in France and is receiving ongoing interest from other countries.

One of the more innovative ways the MHCC is getting the word out is through a partnership with the National Film Board to produce *Here At Home*, a series of online documentaries. Goering says, "The NFB did a remarkable job, and the documentaries are a very effective tool for teaching and in meetings with policy-makers."

While the project has clearly been transformative for participants, it's also had a big impact on those working on it. Goering says it has been the most gratifying experience of her career. "It has really stretched me, because the magnitude of the undertaking was so much greater than anything I had ever done before. And for the skeptics who said the project couldn't or shouldn't be done, we think the results speak for themselves." ■

LEAH GELLER IS A FREELANCE WRITER IN OTTAWA.

About the images: The photos included with this article are from Focusing the Frame, a participant photography project that was part of At Home/Chez Soi. Participants at the Winnipeg site were given digital cameras and supported by two mentors and a photography consultant to learn about photography and take photos over a six-month period. Focusing the Frame was developed to give participants a voice and visually represent their experiences being part of At Home/Chez Soi.