Housing First: Lessons from the United States and Challenges for Australia

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Abstract

Efforts to end long-term homelessness have embraced a Housing First approach. Housing First emphasises rapid placement of clients into independent, permanent accommodation and eschews traditionally favoured requirements that clients demonstrate sobriety or success in treatment programs prior to being offered housing. Although housing retention rates are superior to those obtained from traditional programs, some claims made on behalf of the Housing First approach remain controversial. The present article reviews results from Housing First research to date, as well as challenges and concerns that remain in regard to clinical outcomes, fidelity of implementation and application in the Australian context.

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1. Introduction

The prevalence of visible homelessness has spurred increased policy attention on developing Housing First initiatives for chronically homeless individuals. The expression 'Housing First' is applied when programs combine permanent community-based housing with support services that assist chronically homeless individuals to sustain their housing and work toward a community-based recovery and reintegration. Housing First eschews traditional 'linear model' preconditions of sobriety or treatment before individuals are offered independent accommodation (O'Connell, Kaspro and Rosenheck 2009; Johnsen and Teixeira 2010). An implicit assumption in the linear approach is that chronically homeless people cannot sustain accommodation without 'restoration of behavioural self-regulation' (Kertesz et al. 2009, p. 500), yet Housing First initiatives have attained superior housing outcomes, compared to linear approaches. Indeed, the success of Housing First in the United States has resulted in worldwide interest.

Despite credible housing outcomes, a number of issues remain unsettled. For example, uncertainty surrounds the question of whether Housing First programs can reliably confer significant medical and behavioural benefits. Additionally, contradictory evidence besets the attractive claim that it costs less to house chronically homeless individuals than to leave them homeless. Successful implementation of Housing First remains a complex undertaking that involves collaboration across domains such as health, housing and public finance. These complexities mean that findings may not apply across national or cultural boundaries (Durlak and DuPre 2008; Busch-Geertsema 2014). This may be important for

countries, such as Australia, since Housing First emerged in North America. This article examines how developments in North America, both of the Housing First model and the evidence base, align with the Australian experience.

2. Background

2.1 Definition and Enumeration

There is no universally accepted definition of homelessness. The most common US definition is limited to people sleeping outdoors or in other places not meant for habitation and those residing in temporary shelters. In contrast, Australian policy-makers favour a broad definition that encompasses people living temporarily with family and friends, as well as those living in severely overcrowded housing. The Australian Bureau of Statistics estimated there were 105,237 homeless persons in 2011, with 6,813 (or 6 per cent) sleeping outdoors or in places not meant for habitation (Australian Bureau of Statistics 2012). In the United States, there were 549,928 persons who were homeless on a single night in January 2016, with just under one-third (32 per cent) sleeping outdoors or in a place unfit for human habitation (Office of Community Planning and Development 2016). Most people who experience homelessness have a single episode, but some become chronically mired in homelessness. This highlights another important difference between the two countries: the United States has an official definition of chronic homelessness, whereas Australia does not. In the United States, it is estimated that chronically homeless persons account for approximately 15 per cent of the homeless population

but because chronic homelessness is not defined in Australia, policy-makers often use counts of people sleeping outdoors (rough sleepers) as a proxy (Parsell 2014).

Among the long-term homeless, the prevalence of substance misuse and mental health issues is high, as is the likelihood of sexual or physical victimisation and traumatic brain injury. Although the physical health of the long-term homeless is poor, classic illnesses of social deprivation (tuberculosis, trench fever, pellagra) are dwarfed by morbidity and mortality attributable to more common illnesses of advanced societies: physical trauma, heart disease, cancer and drug overdose (Baggett et al. 2013). Additionally, homeless persons accrue costly services across the health, social service and criminal justice sectors (Culhane, Metraux and Hadley 2002), each of which represents a publicly funded crash landing for persons whose life is frequently chaotic.

3. Housing First

3.1 Rationale and Definition

Housing First emerged because of shortfalls in what was achieved by the more traditional stairway, or linear approach, in which clients had to proceed through sequential care settings (emergency shelter, residential recovery program).

Successful participation in treatment for behavioural problems was construed as making the client 'housing-ready', so as to avoid crises after an eventual placement.

The approach suffered shortfalls, reflected in data suggesting roughly 30–50 per cent of clients achieved housing after 1–2 years (Kertesz et al. 2009).

Problems affecting the linear programs seem predictable in retrospect. Some clients required housing but were unwilling or unable to participate in typical group-based residential treatment programs. Others lacked a substance use or mental disorder and were excluded from linear programs altogether. Patients with addictions could not always achieve levels of abstinence desired by housing providers, with the result that successfully treated populations often remained homeless (Kertesz et al. 2007).

Housing First approaches treat housing as a human right and prioritises client agency in determining what kinds of treatments are attempted (Tsemberis 2010). Because the terms 'permanent supportive housing', 'supported housing' and 'Housing First' are often used interchangeably (Tabol, Drebing and Rosenheck 2010), some clarification is needed. Some refer to 'permanent supportive housing' as any housing arrangement that includes housing and services (Lipton et al. 2000), regardless of the treatment approach. Others affirm that a permanent supportive housing approach should explicitly draw on Housing First practices. Generally, a Housing First approach includes these key features: (i) the absence of sobriety or treatment preconditions for housing; (ii) an emphasis on rapid placement into permanent housing; and (iii) the assurance of sufficient support services in a community context, understanding that the intensity and duration of these services (including potential graduation) depend both on client need and self-determination.

The US-based Pathways to Housing Program (Tsemberis 2010), often considered an exemplar of the Housing First approach, includes some additional elements, some of which have been embraced by others. These include: (i) a modern philosophy of harm reduction, coupled with client engagement through motivational interviewing (Miller and Rollnick 2004); (ii) physical and programmatic

separation of housing and services (thus eschewing single-building accommodation); and (iii) an emphasis on community reintegration. Finally, some (though not all) Housing First initiatives recruit persons perceived to have the greatest medical vulnerability or the greatest barriers to housing success.

Housing delivery varies across Housing First programs. The scattered-site approach provides financial support for private market rental units, with staff who check in with the client and broker services. This approach is tied to an expectation that chronically homeless people want to live in normal housing in normal neighbourhoods (Stefancic and Tsemberis 2007). A project-based approach clusters clients in a single apartment building, with services on the first floor or nearby (Larimer et al. 2009; Collins et al. 2012). For some clients, it offers a sense of community and reduces transit time for caregivers. However, such congregate arrangements can sometimes draw neighbourhood opposition and/or prove difficult to manage.

3.2 Implementation

Adoption of Housing First faces numerous organisational and clinical challenges. Communities and front-line staff require material support and cross-agency collaboration to select clients, search for landlords, secure move-in funds and furniture, provide interim shelter and deliver clinical support (Austin et al. 2014). Leaders of government and non-governmental services can provide impetus and help to assure integration of effort between and within agencies (Kertesz et al. 2014). When Housing First is interpreted to mean *only* the relaxation of traditional

expectations for housing entry, absent robust service supports, disappointment, eviction and blowback are likely (Kertesz et al. 2015).

Formal analyses of fidelity to the Housing First approach are uncommon (Benston 2015). While some programs have trouble eliminating traditional preconditions (Gilmer et al. 2015), a common vulnerability is the assurance of adequate treatment and recovery supports (Macnaughton et al. 2015; Austin, Pollio and Kertesz 2016). Challenges include the assurance of an appropriate staff-to-client ratio and accessibility 24 h per day, 7 days per week. Also, front-line staff may adopt a passive stance in regard to clinical recovery (Tiderington 2015; Austin, Pollio and Kertesz 2016). While this passivity may appear aligned with the removal of preconditions to housing entry, it fits poorly with the aspiration that Housing First be a clinical endeavour and not just a housing program (Tsemberis 2010).

4. Evidence from North America

4.1 Housing Outcomes

Studies of effectiveness of Housing First have considered housing outcomes, clinical status indicators and economic expenditures, with varying results. One systematic review identified 14 studies based on 12 randomised controlled trials, with 11 trials demonstrating superior housing outcomes for persons receiving a Housing First-like intervention. For example, a Canadian multi-site randomised controlled trial involving 1,198 homeless persons with moderate-level needs (the Chez Soi study) reported that at 2 years' follow-up, persons in the intervention group achieved 63–77 per cent

of time housed in the prior 24 months, compared to 24–39 per cent in the ‘usual care group’ (Stergiopoulos et al. 2015). These results differed little from an earlier small randomised controlled trial in New York (Tsemberis, Gulcur and Nakae 2004). At present, just one study assessed outcomes for longer than 4 years (which were favourable) (Stefancic and Tsemberis 2007).

Favourable housing results should not obscure some scientific limitations (Benston 2015). Most studies suffer from imprecise definitions of the housing intervention and inconsistencies in entry or eligibility criteria. Attrition has been relatively high. Outcomes are often self-reported, which has some limitations. Studies have not consistently designated their interventions as ‘Housing First’ and few evaluated fidelity of the housing intervention. The net impact of these limitations is that policy-makers embracing Housing First should attend to fidelity of implementation or they risk outcomes worse than those reported from trials.

4.2 Clinical Impacts

The relationship between homelessness and poor health is often bi-directional, with poor mental or physical health contributing to homelessness and homelessness standing in the way of successful restoration of health. Randomised trials have typically found no or minimal benefit for standard health measures (Sadowski et al. 2009; Benston 2015; Stergiopoulos et al. 2015; Aubry et al. 2016). Indeed, most studies show improvement both for individuals entering the housing intervention and for individuals entering traditional programs.

Despite negative findings for typical physical and mental health measures, it is premature to suggest that Housing First interventions confer no clinical benefit. First,

most such studies assess outcomes at 1–2 years. It could take longer for recovery to take effect. Additionally, some positive results are reported in control of HIV (Buchanan et al. 2009) and in indicators of community functioning or well-being (O'Campo et al. 2016). Additionally, one Chez Soi trial site reported reductions in alcohol use (Kirst et al. 2015). Finally, persons entering housing programs include many who are quite sick. A significant number die in housing shortly after moving in (Henwood, Byrne and Scriber 2015). Future studies of Housing First will need to carefully consider how this 'already quite sick' group influences analysis.

4.3 Economic Claims

It is often claimed that it is cheaper to house chronically homeless persons than to leave them homeless (Gladwell 2006). Indeed, one organisation reported that providing 'permanent housing for chronically homeless individuals costs one third the cost of leaving these individuals on the streets'.¹ While politically appealing, these and other similar claims reflect weak study designs.

More rigorous studies sometimes show credible cost offsets in regard to emergency department and inpatient use, justice system involvement and the use of other welfare services. However, findings are inconsistent. Some studies report a decline in service use, relative to either a comparison group (Gulcur et al. 2003; Larimer et al. 2009; Sadowski et al. 2009; Basu et al. 2012) and/or pre-intervention levels (Culhane, Metraux and Hadley 2002; Martinez and Burt 2006). Conversely, the large multi-site randomised trial from Canada, Chez Soi, reported no trial arm difference in service use, a difference that might reflect the comparative generosity

of Canadian health service delivery to both trial arms (Stergiopoulos et al. 2015; Aubry et al. 2016).

The two studies to report overall net cost savings (Gulcur et al. 2003; Basu et al. 2012) had limitations. One assumed that averting a day of hospitalisation saved US\$7,485, a figure that exceeds any mainstream estimate for hospital costs in a way that inflated apparent savings (Basu et al. 2012). A few studies assume that housing costs can be allocated on a per-day basis (Culhane, Metraux and Hadley 2002; Gulcur et al. 2003; Basu et al. 2012), when housing programs accrue expenses even when clients are absent from apartments.

In sum, for all but the most 'expensive' chronically homeless persons, cost savings do not exceed the cost of providing Housing First (Culhane, Metraux and Hadley 2002; Kertesz et al. 2016). The strongest evidence of this comes from the Canadian Chez Soi trial that involved 2,000 participants. Goering et al. (2014) reported that for every C\$10 invested in Housing First services, savings were C\$9.32 for high-need clients and C\$3.42 for moderate-need participants. Importantly, high-need clients accounted for only 10 per cent of the sample. Housing First can almost 'pay for itself', but only when it targets a costly clientele who represent only a very small portion of the chronically homeless. In summary, the economic impact of Housing First is important but probably not as large as is often claimed.

5. Housing First in Australia

Australian interest in Housing First initiatives gathered momentum in 2008 when, as part of the white paper on homelessness called *'The Road Home: A National*

Approach to Reducing Homelessness' (Department of Families, Housing, Community Services and Indigenous Affairs 2008), the federal government committed to offering supported accommodation to all rough sleepers by 2020. Seizing on evidence from the United States, the government committed to funding 'Street to Home' scattered-site housing programs, as well as 'Common Ground' congregate facilities in every state and territory. This represented a radical departure from what was possible under prior service arrangements and confirmed the government's willingness to try new approaches. The latter decision, however, emerged less from research data and more from 'intuition and direct personal experiences' (Parsell, Fitzpatrick and Busch-Geertsema 2014).

Street to Home projects in Melbourne, Sydney and Brisbane target chronically homeless individuals, based on vulnerability to premature death, using a Vulnerability Index tool (OrgCode Consulting, Inc. and Community Solutions 2015). Whether such tools represent a scientifically defensible method of allocating resources, however, remains disputed (National Alliance to End Homelessness and Office of Policy Development and Research, U.S. Department of Housing and Urban Development 2015). Despite the presence of Street to Home and Common Ground facilities in every state, most have not been subject to any form of rigorous, public evaluation. Also, although some evaluations use longitudinal designs, these have typically been limited to tracking participants for 1 year (Parsell, Tomaszewski and Jones 2013) or 2 years (Johnson and Chamberlain 2015). Only one Australian study imposed a randomised controlled trial methodology to assess impact (Johnson et al. 2014). Although they did not explicitly label the Journey to Social Inclusion program 'Housing First', the program shares similarities with a Housing First approach.

Despite these evidentiary limitations, results thus far echo findings from overseas: these include strong, statistically significant housing outcomes and reductions in intensity and frequency of service use relative to pre-intervention levels, although these are not always statistically significant. Similar to overseas research, Australian studies report little behavioural change, particularly in regard to addiction and illicit drug use. Similarly purported economic savings are smaller than claimed. The Journey to Social Inclusion trial, which involved just under 100 participants, reported that for every A\$1 invested, there was a A\$0.32 return to the community (Johnson et al. 2014).

Although there is a clear need to improve the Australian evidence base for Housing First, there are other equally important questions to address. First, there remain considerable differences in how Australian Housing First programs operate. This raises the question of whether there should be a 'standard' Housing First model or set of operational standards to which all Australian Housing First services should conform. These issues foreshadow a second question: How might Australian policy-makers and service providers best manage the tension between program fidelity and adaptations to local conditions to ensure that program outcomes remain high? Australia's social, economic and cultural conditions differ markedly from the United States and the development of Australian Housing First models should reflect these differences. However, the development of a unique Australian Housing First model should identify and articulate the key elements of these models that help to sustain housing and clinical improvements.

6. Conclusion

A Housing First approach has much to offer. The evidence from overseas and, to a lesser extent from Australia, show that Housing First has disrupted settled assumptions about the capacity of chronically homeless persons to maintain housing. The success of Housing First has led to worldwide interest. Housing First services can be found in many countries including France, Finland, England, Germany, as well as in Australia.

In the processes of transferring Housing First to different countries, it is equally clear that there are now diverse views on what constitute the core components of a Housing First approach (Johnson, Parkinson and Parsell 2012). Whether local adaptations of the Housing First model reflect enhancements or represent 'unwelcome model drift' (Stefancic et al. 2013, p. 242) has yet to be established. Also, even in instances where the desired instantiation of Housing First is well articulated, there are challenges to implementing the approach with sufficient support for clients and landlords. The drift away from many of the original concepts, coupled with limited appreciation of the challenges to effective implementation of the model, has created a risk of underperformance. If underperformance is accompanied by outsized claims regarding the economic or health benefits Housing First can deliver, then there is risk of policy overreach. The outcome of such overreach is, customarily, blowback and recrimination if and when promised benefits do not emerge.

Against these risks, however, lies a promising array of benefits in terms of housing outcomes, clinical gains and community benefits that result from alleviation of homelessness. Finally, Housing First aligns plausibly with a moral posture that prioritises efforts to remediate the plight of the communities' most vulnerable citizens.

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Endnote

1. See <<https://cmtysolutions.org/sites/default/files/housingfirstfactsheet-zero2016.pdf>>.

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