Housing First Europe: Next Steps

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Introduction

I have been invited by the Editor to provide commentary on the final report of the Housing First Europe (HFE) project authored by Dr. Volker Busch-Geertsema (2013). For this purpose, I have reviewed the report as well as the article published in the August 2014 edition of the European Journal of Homelessness (Busch-Geertsema, 2014). My commentary will focus on the findings in the report and comparing them to previous research on Housing First including the At Home / Chez HF multi-site demonstration project in Canada (Goering *et al*., 2014) on which I served on the National Research Team and Co-Lead of the Moncton site. The HFE entailed a multi-site evaluation of Housing First (HF) projects in five cities, namely Amsterdam, Budapest, Copenhagen, Glasgow, and Lisbon. Lessons from the evaluations were shared with five other European cities that were planning or implementing Housing First projects.

Although the evaluations conducted in the five cities used different methodologies and were conducted on different timetables, they were intended to answer the same research questions relating to providing a profile of service consumers in each of the projects, their support needs, satisfaction with services, housing and other outcomes, costing, and lessons learned. The methodologies included either qualitative and narrative interviews (Budapest and Copenhagen) or structured quantitative interviews (Amsterdam, Glasgow, and Lisbon) of a portion of HF service users combined with administrative data on the characteristics of the HF service users and length of time housed. HF service users were interviewed twice in two of the cities (Glasgow and Lisbon) and only once in the other three cities and there were no comparison groups at any of the sites. It is noted in the report that the choice of the evaluation design and methods are a function of the modest budget allocated for the research (Busch-Geertsema, 2013). In contrast, the At Home / Chez (AHCS) project in Canada was allocated $110 million CAD (approximately ¢75

ISSN 2030-2762 / ISSN 2030-3106 online

million) by the federal government and as a result was able to conduct a large cross-site randomized controlled trial in five Canadian cities following study participants for a period of two years (Goering *et al*., 2014).

To some extent, the individual evaluations conducted in each of the cities serve as case studies of these pilot projects. Given the rich findings provided in the HFE report, I fully expect that they have been useful for program development and improvement purposes in each locale. At the same time, I also view the cross case study analysis conducted by Busch-Geertsema (2013; 2014) as value-added even though different evaluation designs and methods were used and there were differences in the cohorts of pilot participants at the different sites. In particular, the cross case study analysis produced useful lessons from an examination of the commonalities and differences of the programs, the populations they served, and the social welfare contexts in which they were located.

Interestingly, the HF projects in four of the five sites represented the first attempts at piloting this new approach to addressing homelessness for people with complex needs. In fact, it was only in Copenhagen that the implementation of HF was part of a broader national strategy. In my view, this fact makes the kind of limited evaluation research that was undertaken as fitting since the focus is on new pilot programs that can be expected to evolve further as they mature.

Busch-Geertsema (2013) assessed four of the five projects as following in large part the eight broad principles of the Pathways Housing First model; he noted that this assessment is based on information provided in the individual evaluation reports and by individual site representatives at HFE meetings. So the available data is secondary in nature and relatively limited and does not allow for conducting a more fine-grained fidelity assessment focusing on program structures and service characteristics (Nelson et al., 2014; Stefanic, Messen, Drake, and Goering, 2013). It is very clear that the program in Budapest, although following some of the principles of HF, was different with the support being less intensive and available for a time limited relatively short period.

Interestingly, all of the sites with the exception of Copenhagen assisted individuals to access scattered-site housing in the community rather than single-site congregate housing. In the case of Copenhagen, the HF program placed individuals in congregate housing initially but over time gravitated towards scattered housing because of negative experiences of their program participants with congregate facilities. Also, in both Glasgow and Copenhagen because of its availability, the HF programs housed individuals in social housing rather than private market housing which has been the norm in North American HF programs (Goering *et al*., 2014; Tsemberis, 2010).

Although only Copenhagen configured its services into an ACT team, the support elements of the projects other than Budapest reflect HF principles in terms of their level of intensity (1: 3 to 1: 11), client-centered nature, services delivered at home and in the community, and the availability of staff for emergencies on a 24/7 basis. The level of intensity of these pilot HFE projects is impressive and exceeds what is often typically offered when intensive case management is delivered as part of the HF service package (Goering *et al*., 2014; Tsemberis, 2010).

Target Group

Similar to recipients of studied HF programs in the U.S. and Canada (Goering *et al*., 2014; Rog, 2014), all of the HFE sites with the exception of Budapest targeted typically single people with longstanding histories of homelessness and substance abuse problems who were unemployed and receiving some form of social assistance. Lisbon had the highest proportion of individuals with a psychiatric diagnosis although it is likely in my view that many individuals in the other projects who presented with addictions also had an undiagnosed psychiatric problem. In Budapest, the study participants were recruited because of where they lived (i.e., in a forest) and included a majority of persons who lived with other family members, partners, or friends. As well, the majority of participants relied on some form of employment or activities for survival and did not receive social benefits.

High proportions of recipients of HF in American and Canadian programs have a concurrent disorder (i.e., diagnosable mental health problem and substance use problem) and also tend to be single and have a long-term history of homelessness (Aubry, Ecker and Jetté, 2014; Goering *et al*., 2014; Rog *et al*., 2014). Although HF has been questioned as an approach for people with addictions (Kertesz, Crouch, Milby, Cusimano, and Schumaker, 2009), there is no empirical evidence of it achieving different or worse outcomes with this population. In fact, in the AHCS project, severity of addictions was not a predictor of HF recipients achieving housing stability in the first year of the program (Goering *et al*., 2014).

Similar to the support needs of participants in North American HF programs described in research (Mental Health Commission of Canada, 2012; Tsemberis, 2010), community support in the early stages of the HFE programs focused on practical matters related to finding and moving into housing, organizing finances, and addressing immediate mental health and physical health needs. Longer-term needs of HFE participants include assisting individuals with vocational planning, participation in meaningful community activities, and social isolation.

Retention Rates

The housing retention rates reported in the HFE project report are very impressive with three of the HF programs having rates that exceed 90 percent while Lisbon had a 79 percent retention rate among its participants, and Budapest had the lowest retention rate at 33 percent. It is important to note that these retention rates are based on whether or not individuals were housed at the point of the follow-up evaluation and that the follow-up time varied within and across sites. It does appear from the information provided in the HFE report that a large portion of these individuals experienced housing stability over the course of receiving HF. The much lower retention rate in the Budapest project is explained as being the result of the program only being able to offer support of a low intensity and only for a time-limited period. As well the services did not include the provision of a rent supplement.

In determining housing retention, an "intent to treat" calculation was not applied wherein recipients who had moved into more institutional accommodations or whose living situation was unknown were not counted in the denominator for calculating the retention rate. This type of calculation likely contributes at least in part to the retention rates in three of the HFE exceeding those reported in American and Canadian studies on HF (Goering *et al*., 2014; Rog *et al*., 2014). However, the HFE results on housing retention provide important evidence that HF is effective in assisting a large majority of individuals to exit homelessness and achieve housing stability in quite diverse European contexts. As noted in the report, the HFE projects lacked a control group receiving standard care. As a result, it is not possible to determine whether or not the housing retention outcomes are superior to standard care.

In the AHCS project in Canada, 14 percent of participants were identified as failing to achieve housing stability in the first year of receiving HF services (Goering *et al*., 2014). The HFE housing retention rates also show a small percentage of individuals with additional needs who appear to be non-responders to HF at least in terms of exiting homelessness. It is critical for HF programs to determine how best to respond to these additional needs so that these individuals do not fall through the cracks and continue experiencing chronic homelessness. The use of more structured single site housing programs with on-site support may be worth considering for some of these individuals either as a transitional step or on a longer-term basis (Yamin *et al*., In press).

Methodological Constraints

Given the cross-sectional research design in three of the five sites, the small sample size, and the reliance on perceived impact or changes by participants or staff, the interpretation of the results on non-housing outcomes (i.e., mental and physical health, substance use, community functioning, recovery, and quality of life) reported in the HFE report has to be done cautiously. Moreover, again the lack of a control group in the HFE project precludes being able to attribute positive changes to receiving HF services. To date, studies conducted in the U.S. have shown inconsistent results as it applies to non-housing outcomes (Aubry *et al*., 2014; Rog *et al*., 2014). The ACHS study did find HF recipients to experience improvements in community functioning and global quality of life that exceeded those of people receiving standard care over a two-year period (Goering, 2014). However, the effects in these areas were relatively small in nature. Interestingly, qualitative research on a subsample of participants in the ACHS study uncovered broader and even transformative changes in the lives of HF recipients that did not appear to be captured by the quantitative methods that were used (Goering *et al*., 2014).

Poverty and Unemployment

Findings with respect to the low employment rates and financial difficulties of HF recipients in the HFE project are not surprising and consistent with findings in American and Canadian studies (Goering *et al*., 2014; Rog *et al*., 2014). HF programs have typically focused on assisting individuals with housing and community functioning and vocational outcomes are not targeted unless it is part of an individual's recovery plan. As a consequence, it would seem unrealistic to expect significant improvements in the areas of employment and finances. In fact, HF participants who are housed and unemployed continue to live in significant poverty even after the financial assistance received for rent. Their poverty places significant limitations on their ability to engage in meaningful leisure and social activities.

The poor employment outcomes, that are consistent with previous research on HF (Aubry *et al*., 2014; Goering *et al*., 2014; Rog *et al*., 2014) suggest that in evolving HF programs, there is a need to find ways of integrating supported employment (i.e., Individual Permanent and Support; [IPS]) in the delivery of services. The Montreal site in the AHCS demonstration project examined the effectiveness of adding this type of service to their HF program delivered to people with moderate needs (Latimer *et al*., 2014). Individuals receiving IPS did have greater success at becoming employed compared to the comparison group (i.e., 34 percent vs. 22 percent). However, this difference was not significant.

The reported positive results in the HFE report concerning relationships with housing providers and resolution of neighbourhood conflict are important evidence of the ability for individuals exiting homelessness to become integrated in scattered-site regular housing. The fact that eviction occurred in only a small number of cases even when HF recipients encountered difficulties with neighbours or housing providers demonstrates the important mediating role played by HF service providers in these contexts (Busch-Geertsema, 2013). Working with 260 landlords and property managers in the five sites, the AHCS project reported similar results with only a small number opting to discontinue renting to HF participants (Goering *et al*., 2014).

Costs of Housing First

The costing analysis conducted as part of the HFE evaluation was limited by the resources for the project and the information available from each of the sites and focused simply on costing of the programs. Moreover, complete costing of the HF programs was only conducted on three of the five sites (Amsterdam, Budapest, Lisbon; [Busch-Geertsema, 2013). It is noted in the HFE report that the costs of HF services compare favourably to those of existing services. Research on cost-effectiveness and cost-benefit of HF is at a very early stage with only a very small number of studies actually conducting comprehensive or societal costing analyses (Aubry *et al*., 2014). Moreover, the purported savings associated with reduction of acute care services and implication in the justice systems, may have been oversold. The AHCS project found that across all participants $10 invested in HF produced cost offsets (i.e., costs associated with reduction of use of health, social, and justice services) of $7.61 (i.e., $9.60 for high need participants receiving HF with Assertive Community Treatment and $3.42 for moderate need participants receiving Intensive Case Management).

Conclusion

In summary, I congratulate Dr. Busch-Geertsema and the researchers conducting the individual site evaluation research for the very useful cross site analysis presented in the HFE final report. The work provides detailed case studies of HF programs including their outcomes at an early stage of program development in very different contexts. It shows the value of conducting multi-site research even when there are differences in the populations, interventions, and methods used in the different sites. I agree with the directions set out in the report for future research on HF that involve cost-effectiveness research, research on the use of the HF approach with subgroups in the population like youth, and more in-depth and comparative evaluation studies of the different types of community support that can be provided in the HF approach including Assertive Community Treatment, Intensive Case Management, and Critical Time Intervention. Other areas worthy of investigation at this stage include an investigation of the relationship between fidelity and program outcomes, examination of the characteristics of nonresponders to HF, evaluation of longer-term outcomes of HF, and research on how the HF approach can be supplemented to more effectively address addictions, unemployment and social isolation. The current multi-site randomized controlled trial in France can be expected to provide further advancements on the use of HF in a European context.

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