

## **Housing First: Overview of the Evidence Base**

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Housing First entails the provision of immediate, permanent, low-barrier, nonabstinence-based supportive housing to people experiencing chronic homelessness (1, 2). Supportive service provision (including outreach; intensive case management; psychiatric, medical and/or nursing care; substance-use counseling; connections to external service providers; and assistance with basic needs) is predicated on assertive engagement, not coercion and uses a harm reduction approach in addressing substance use. Specifically, residents are housed as quickly as possible and are not required to achieve abstinence, attend treatment, engage with services, or achieve psychiatric stability before receiving housing. This low-barrier approach contrasts with the housing approach used in the decades leading up to the 2000s, known variously as the linear, “continuum-of-care” or “treatment-first” approach, in which increasingly permanent housing (i.e., moving from a shelter to transitional housing to permanent housing) is contingent on fulfilling various criteria, including psychiatric stability, treatment adherence, and abstinence from alcohol and other drug use (3).

### **Initial research supported the efficacy of scattered-site and single-site Housing First**

Two primary types of Housing First, differentiated principally by the separation (scattered-site) or clustering (single-site or project-based) of housing units, have been evaluated. The scattered-site approach has been in use since the early 1990s (4). In this approach, residents are offered a choice of housing units scattered throughout a larger community and can access supportive services via an assertive community treatment model.

Research on the scattered-site approach has accumulated for well over two decades. In the early 2000s, randomized controlled trials conducted in the US showed that, compared to the linear model of housing, scattered-site Housing First was associated with less time to housing, improved housing retention and stability, higher perceived choice, and no differences in substance use outcomes (4-6). Larger multisite randomized controlled trials were subsequently conducted in Canada and have largely supported and extended the US research findings. Compared to participants who received the linear housing approach, scattered-site Housing First participants overall have shown strong, positive, long-term effects, including greater housing stability, improved community functioning, and reduced alcohol-related harm and money spent on alcohol (7, 8).

In the single-site Housing First approach, residents are provided with individual units within a single building and can elect to receive on-site supportive services (Malone et al., 2015). An nonrandomized controlled evaluation, which used propensity score weighting to accommodate potential group imbalance, showed that single-site Housing First was associated with reduced utilization of publicly funded services (i.e., shelter, jail, ER, emergency medical services, sleep-off facilities, safety-net hospital) and associated costs (i.e., \$4 million in cost offsets during the first year) (9). Subsequent studies have shown significant longer-term reductions in county jail bookings and time incarcerated (10), decreased alcohol use and alcohol-related harm (11), and strong housing retention in a population traditionally characterized as unmotivated for and unsuccessful in housing (12, 13). Additional qualitative studies indicated that moving into single-site Housing First improves residents' connection to service providers, increases their sense of stability and strengthens community-building (14, 15). Other single-site Housing First programs have been evaluated alone or alongside scattered-site Housing First programs and have shown similarly positive effects on psychiatric and housing stability (16, 17).

## **Strong evidence of sustained impact in Housing First's third decade**

The most recent systematic reviews and meta-analyses have shown that Housing First and permanent supportive housing, more broadly, is effective (18), with promising initial findings for youth as well (19). Housing First is effective in increasing housing stability – even up to six years subsequent to initial move-in (20) – and reducing high-cost emergency medical services and hospitalizations (21, 22). Importantly, Housing First and permanent supportive housing are more effective in creating housing stability than time-limited, supportive housing models (e.g., rapid rehousing; 23). Some individual studies have indicated positive impacts on alcohol outcomes (7-9, 11). Overall, systematic reviews have shown mixed impact – but decidedly no negative impact – on mental health, substance use and mortality outcomes (20, 24, 25). Thus, studies to date support Housing First and permanent supportive housing in increasing housing stability, improving health outcomes, and reducing costs compared to usual, continuum-of-care models of housing.

A small number of more recent studies have started to generate, test and review potential mechanisms or correlates of Housing First outcomes, especially drawing on the largest RCT of Housing First, the At Home/Chez Soi trial. In this context, O'Campo et al (26) applied path analysis to model longitudinal associations between early service engagement, health status, and social connectedness with later quality of life and recovery outcomes. Residents with higher scores on those constructs had better health outcomes overall; however, the study did not take into account causality or temporality. In an additional follow-up with this sample (27), greater housing stability was associated with older age, being from a nonindigenous ethnic/racial minoritized group, having lower baseline substance use, being from a higher SES group, having healthcare and being in a better networked urban area. Risk factors for instability included longer histories of homelessness, recent incarceration, identifying as Indigenous, higher substance use, cognitive disability, and residence in Winnipeg—where structural inequities, low vacancy rates, and poor housing stock may undermine stability. Although these observational designs preclude causal interpretation, secondary analyses from this project has established that these variables can be measured over time and should be explored in future research to better understand what mechanisms drive Housing First's successful outcomes.

## **Next steps for Housing First: Sustaining its effectiveness and supporting its evolution**

Over the past 25 years, research has consistently supported Housing First as an effective model for achieving long-term housing stability, reducing high-cost service utilization, and improving the most severe health-related outcomes. However, the literature remains mixed and inconclusive regarding its effects on more nuanced self-reported outcomes such as mental health, substance use, and health-related quality of life. Emerging studies have begun to test plausible mechanisms (e.g., service engagement, provider-resident relationships, peer connection) that may help explain how Housing First produces its effects.

Moving forward, additional research is needed to identify and strengthen strategies that support physical and mental health within Housing First and permanent supportive housing programs, and to rigorously test the model's underlying mechanisms of action. Ongoing program evaluation is also essential to ensure fidelity to core Housing First principles. As economic conditions, environmental crises, and client needs continue to evolve, sustained research will be critical to optimizing implementation and impact. Given its strong evidence base and continued success in addressing chronic homelessness, Housing First is and should remain a cornerstone of national and international efforts to end homelessness.

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