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Addictions & Mental Health Ontario

Addictions Supportive Housing Literature Review

Johnston Consulting

September 2013

Table of Contents

Introduction

In August 2011 the Ontario Federation of Community Mental Health and Addiction Programs received funding from the Ministry of Health and Long-Term Care (MOHLTC) to undertake a review of Ontario's newly developing Addiction Supportive Housing (ASH) Programs. The Federation commissioned Valerie Johnston and Janine Gates of Johnston Consulting to undertake that review.

This document is the first of four related reports:

- ***Addictions Supportive Housing: Literature Review***
- *Addictions Supportive Housing: Provincial Snapshot*
- *Addictions Supportive Housing: Report on Client Focus Groups*
- *Addictions Supportive Housing: Evolving Practices – Interim Report*

Together, those reports present a comprehensive picture of the ASH programs funded in Ontario, and an early assessment of their performance. This literature review provides information about current approaches and best practices in addiction supportive housing programs in other jurisdictions. Findings from this study were used to inform the review of Ontario's ASH programs.

Methodology

This literature review sought information in respect to four key issues:

1. Links between problematic substance use and homelessness[1],
2. Model(s) and approach(es) of supportive housing in use for people who have substance use problems
3. Positive outcomes that accrue from supportive housing services for this population
4. Policy and planning issues

Our search included the academic literature (research studies and theoretical papers) and the grey literature (unpublished reports, government documents and program evaluations) published between 2001 and 2011.

[1] Homelessness is a broad term that can encompass a range of housing conditions, and can be understood on a continuum of types of shelter. Abs*olute homelessness* is a narrow concept that includes only those living on the street or in emergency shelters. *Hidden or concealed homelessness* includes people without a place of their own who live in a car, with family or friends, or in a long-term institution. R*elative homelessness* is a broad category that includes those who are housed but who reside in substandard shelter and/or who may be at risk of losing their homes. (Homelessness in Canada, http://intraspec.ca/homelessCanada.php)

Keywords such as '*Supportive Housing', 'Supported Housing', 'Housing', 'Homeless', 'Housing First'*, and *'Treatment-First'* combined with '*Addiction', 'Substance Use/Abuse', 'Chemical Dependence'*, along with *'Addict',* and *'Substance'* (to return more results), were used to search the following databases: PsycInfo, Psychology @ Pro Quest, Intraspec.ca, Psychological Index, and PubMed.

A scan of the unpublished literature was conducted by searching the websites of national and international government and non-governmental organizations that work in the area of housing for the target population. Specifically, the following organization websites were searched: Canadian Centre on Substance Abuse; Centre for Addiction and Mental Health; Centre for Addictions Research BC; Community Action on Homelessness; Fredvictor.org; Homeless Hub; Here to Help; Intraspec.ca; NIABY.com (Not in Anyone's Back Yard); National Center for Biotechnology Information (ncbi.nlm.nih.gov); the Ontario HIV Treatment Network; Region of Waterloo Social Services; Substance Abuse and Mental Health Services Administration (samhsa.gov); Vancouver Coastal Health; and the Wellesley Institute (Toronto)

More than 1000 titles were identified in the initial search. A scan of those titles and abstracts narrowed the number of potential documents to 93. From a further review of the titles and abstracts of these documents, 69 papers were identified for full text review and analysis, including:

- 39 research studies
- 21 grey literature documents
- 3 theoretical or conceptual papers
- 3 program descriptions
- 3 statistical reports

An annotated bibliography was developed to provide further information about the range of research available (presented in Appendix B).

Challenges and Limitations of the Review

1. *Lack of conclusive evidence*
   Supportive housing is a relatively new type of program. A small but growing evidence base has been developed, however it is difficult to conclusively identify best practices or assess the effectiveness of various approaches based on research that is still in early stages. Researchers note that, despite preliminary evidence for the effectiveness of some approaches more research is needed to strengthen the evidence base and to develop evidence of effectiveness for specific population groups (e.g. women, youth, Aboriginal and first peoples), and/or for varied types and levels of severity of substance use (Patterson et al.; 2007; Kraus et al, 2006; Frankish et al., 2005; Zerger, 2002).

2. *Inconsistency of definitions*

Terminology varies from one jurisdiction to another, and clear definitions are not consistently offered in the literature. For example, the terms "supportive housing" and "supported housing" are not always defined clearly or used consistently in the literature. While some studies use those terms interchangeably, others use the terms to refer to different approaches to providing housing supports (Kirsh et al. 2009). Key features and components of supportive housing (such as harm reduction, support, and case management) are also variably defined in the literature. Even the definition of 'homelessness' differs among and within jurisdictions.

3. *Complex health issues of people who are homeless*
   It is widely acknowledged that people who are chronically homeless often experience a multitude of health issues, the complexity of which can present challenges to assessment and diagnosis. The experience of both practitioners and researchers in addiction and mental health treatment services has demonstrated that substance use and mental health problems often co-occur, and may come to light over time rather than being identified at assessment. Moreover, one highly visible issue may 'mask' other issues (including physical health problems). When assessing the effectiveness of a model or approach for people who are homeless, the interactions of multiple health concerns may make it particularly difficult to 'single out' any one health issue (i.e. problematic substance use only, or for mental health problems only, or for concurrent disorders only).

4. *Integration of mental health and addiction sector in planning and policy*
   In discussions related to policy and planning issues, problematic substance use is sometimes categorized as a 'subset' of an array of mental health issues; conversely, it is sometimes identified as a completely separate clinical area from mental health. Most often however - and particularly in the Canadian literature - problematic substance use and mental health are discussed as conjoint issues which must be addressed in an integrated manner. Many of the recommendations for policy and planning have been framed as applicable to both addiction and mental health, whether as separate but collaborating, or as integrated, sectors.

5. *Reliability and accuracy of self report*
   In a significant percentage of the research documents reviewed, findings were based on client/tenant self-report rather than on objective measures. Consequently, the accuracy of some data may be affected by the limits of the vocabulary, self-insight, or candor of the people who responded to surveys or participated in interviews. The consistency of data across studies may also be compromised by differences in terminology, understanding, and beliefs across various regions and countries. For example, conceptions of 'severe' and 'moderate' substance use may vary from one jurisdiction to another –making it difficult to compare baseline data or to interpret the relative levels of change reported in respect to substance use.

6. *Diversity of models and approaches*
   Supportive housing for people who have substance use problems represents a diverse set of services, the components of which, to date, have not been well defined. Significant variations in program models are common, even among programs that are based on 'branded' or standardized models. For example, the *housing first* model that was originally developed by Pathways Housing First, New York City (Pathways) is well defined. Although wide uptake of the *housing first* model has been reported, the practices of many *housing first* programs are not consistent with those defined by Pathways. According to Pleace (2011), there has been significant 'drift' from the Pathways model; projects described as *housing first* in the USA include dedicated blocks of specialist accommodation with on-site staffing, floating support services that do not provide or arrange housing, and various modified staircase models. Pleace (2011) emphasizes that a clear understanding of the programs that are being delivered under the rubric of *housing first* is needed to assess their effectiveness. In this review, we have differentiated between the *housing first model* which was has been well defined by Pathways, and the *housing first approaches* that have evolved from the original model.

Findings

Notwithstanding the challenges and limitations noted above, our review of the literature yielded substantial information in respect to the four key issues identified as the focus of this review.

Links between problematic substance use and homelessness

Numerous links between homelessness and problematic substance use have been identified in the literature. Evidence gathered in several jurisdictions indicates that people who are homeless have significantly higher rates of problematic substance use than the general population. For example:

- A study in Scotland (Kemp et al. 2006) found that problem drug use among people who are homeless was at least seven times greater than among the general population.
- A study in Australia (Teesson et al. 2003) found that homeless people were three times more likely to have an alcohol-use disorder than the general population, and six times more likely to have a drug-use disorder.
- In Toronto, Grinman (2010) conducted a study in 2004-05 of the prevalence of drug use among a random sample of homeless individuals. Data was collected from 603 single men, 304 single women, and 284 adults with dependent children who were receiving shelter and meal program services; lifetime prevalence of regular use of at least one drug was reported by 712 individuals (60%).

Research has also demonstrated that problematic substance use may be both a pathway to *and* a consequence of homelessness.

- A number of studies support the theory that problematic substance use is a *pathway* to homelessness. Research reveals that approximately two-thirds of homeless people cite alcohol and/or other drugs as a major, and at times primary, reason for becoming homeless (Glasser, I. and Zywiak, W.H. 2003; Fountain, J. et al. 2003; O'Toole, T.P. et al. 2004 cited in Didenko 2007).
- Teesson and colleagues (2003) found that problematic use of substances increases as a *consequence* of homelessness - as a way of coping with the stresses of 'street life'. Fountain and colleagues (2003) reported that drug or alcohol use was one of the factors that precipitated loss of housing, and that, overall, substance use and dependence had increased the longer subjects had been homeless.

Links between homelessness and problematic substance use extend well beyond questions of cause-or-effect relationships. In a comprehensive review of the academic and grey literature, Frankish and colleagues (2005) found confirmation of "what is known anecdotally" – that the interaction between homelessness, problematic substance use, and mental health problems is complex and significant. Frankish and colleagues identify several issues that impact housing and homelessness for people who have substance use problems, including:

Individual variables

- Such as a lack of job skills, family breakdown and problematic substance use

Societal variables

- Such as poverty, high housing costs, labour market conditions and discrimination

People who are homeless and have substance use problems have often been described as 'hard to serve', or 'noncompliant'. However some authors dispute these descriptors and argue that gaps in engagement arise from a complex range of barriers to service. For example, Frankish and colleagues (2005) note that:

- Other needs such as procuring drugs, food, and shelter may take precedence over service engagement
- Negative experiences with treatment services in the past may create reluctance to trust or engage
- Rates of trauma are significantly higher among people who are homeless compared to the general population

Co-occurring homelessness and problematic substance use has been found to generate significant costs both to the individual and to society. Larimer et al. (2009) report that 'chronically homeless' individuals who have severe alcohol problems often have health conditions that require costly health care services. Mortality data for these individuals are similar to those found in developing countries; the average age at death is estimated to be 42 to 52 years, with an estimated 30% to 70% of deaths being related to substance use.

In 2000, Hwang examined mortality among men using homeless shelters in Toronto Ontario, and found increased mortality at younger ages than in the general population. He attributed his findings to the association of homelessness and a high prevalence of physical disease, mental illness, and substance abuse. He also cited the association of homelessness with exposure to the elements and an increased risk of infections such as tuberculosis and human immunodeficiency virus (HIV) disease, among other factors.

Findings from a Toronto survey of women who are homeless (Street Health, 2007) identify several health care issues and gaps, including:

- High levels of physical and sexual assault, and of serious mental distress (depression, anxiety, suicide)
- Lack of access to substance use programs (21% of those who used alcohol or drugs had tried to access detoxification or treatment in the past year, but were not able to do so)
- Lack of access to primary health care and post natal care
- Frequent use of hospitals as a source of health care (61% had visited a hospital emergency department in the past year, on average 4 times; and 24% had been hospitalized at least one night)

The multiple impacts of co-occurring substance use problems and homelessness on individual health, the health care system, and other social systems highlight the importance of effective supportive housing for this population.

Models and Approaches

Supportive housing for people who have substance use problems has been developed in a variety of configurations, which differ across seven dimensions:

Dimension	Configurations
Length of stay in housing	▪ Housing may be permanent or transitional, with some jurisdictions providing options for both types
Substance use goals of tenants	▪ Harm reduction approaches may include programs that require goal setting, as well as those that have no requirement for goals to abstain from or reduce substance use. Reduction of substance use may be encouraged and supported. ▪ *Treatment first* programs commonly require a commitment to abstinence or change goals.
Substance use in housing	▪ Ground rules range from no restrictions on substance use; to some restrictions (particularly in congregate housing - e.g. in shared areas); to monitored use of substances (administered or provided by program staff); to abstinence requirements
Requirements for engagement with services	▪ The provision of services in conjunction with housing is pivotal to all models, however requirements to engage in services vary. They range from optional involvement (i.e. services provided if requested by the tenant); to mandatory, with housing contingent on participation in programs/services, with numerous variations between the two
Spectrum of services	▪ Services configurations range from intensive services delivered on-site by fully integrated, interdisciplinary teams to less intensive support services provided off site.
Types of services	▪ Case management and housing support, instrumental or practical support, life skills and/or employment/vocations counselling, and substance use counseling or treatment services, and physical health and mental health services
Physical configuration of housing	▪ Scattered individual units in market rental buildings, rented by the individual from a private landlord, often with support and assistance from a support worker. ▪ Purpose built or dedicated, congregate housing in which all or most of tenants are receiving supports. Often, on-site staff provide daytime or 24 hour support. Apartments may be designated alcohol and drug free to will support individuals who have made a commitment to abstinence goals, particularly in the early stages of recovery.

Within the above array of options, approaches to addictions supportive housing are commonly discussed as either *treatment first* or *housing first approaches*.

Treatment first[2] **approaches** place priority on supporting recovery from problematic substance use - i.e. on abstinence or reduction of substance use (Tsemberis et al. 2004).

- *Treatment first* approaches are rooted in a traditional recovery intervention approach, often provided within a stepped or continuum of care framework.
- Counselling or treatment services may be provided within or along with permanent or transitional supportive housing to support tenants in achieving their abstinence or harm reduction goals.
- *Treatment first* approaches may offer or require participation in a range of substance use services – beginning with outreach; including treatment, aftercare, transitional housing; and permanent supportive housing.

Housing first **approaches** focus on providing permanent, independent housing to people who are homeless, including those who may have substance use problems (Zamprelli, 2005).

- *Housing first* approaches are based on the principle that housing is a right, and therefore not contingent on the tenant's substance use goals or involvement with treatment services.
- Tenants often have access to a multi-disciplinary Assertive Community Treatment (ACT) team, and receive whichever individual services and assistance they need and want to maintain their housing. Tenants are not required to accept services or assistance, although it is assertively provided – there is considerable encouragement for clients to engage.
- For those who have substance use problems, a harm reduction philosophy may encourage, but not require, substance use goals that will reduce use and associated harms.

Both of these approaches seek to help people who are homeless to be housed and to achieve greater stability in other areas of their lives. However the two approaches have, at their core, differing values and guiding beliefs about how positive change can best be facilitated and supported through the provision of supportive housing.

- The primary focus of the *housing first* approach is to assist people who are homeless in attaining stable, secure housing. The guiding belief is that stable housing will allow people to address the barriers to employment, problematic substance use issues, and other health issues (City Spaces, 2008). *Housing first* approaches have a recovery orientation that place significant emphasis on individual choice and control (e.g. basing

[2] In the literature, the treatment first approach may also be known as the "continuum of care" approach, or the "staircase" model

treatment plans around the service users' own goals); they separate housing from mental health and substance use services (Pleace, 2011).

- The primary focus of *treatment first* approaches is to assist people who have substance use issues in achieving abstinence (or reducing use and related harms) and providing transitional or permanent housing that will support those goals. A guiding belief is that treatment services and recovery supports are important paths to enabling people to be "housing ready" (Zamprelli, 2005).

Elements of Treatment First and Housing First Approaches

It is important to note that, while *housing first* approaches have, as their reference point, the formal, well-defined model that was developed by Pathways Housing First, *treatment first* approaches have not evolved from a single guiding model. Consequently, '*treatment first'*, as a category of supportive housing, is extremely broad – a wide range of program types may describe themselves (or be seen as) espousing a *treatment first* approach.

***Treatment first* approaches** require the participation of tenants in a recovery program, however the level and nature of that participation can take a variety of forms.

- In some instances, *treatment first* approaches operate as one component of a continuum of care or 'staircase' model, in which tenants access supportive housing as part of a stepped process after completing other, more intensive, phases of treatment and achieving success in reaching their goals. This stepped approach is thought by some to be necessary preparation for "housing readiness" – i.e. readiness to maintain independent housing or to live successfully in a congregate setting.
- Some *treatment first* programs appear to operate as fully staffed transitional housing models, in which having access to both housing and services is thought to support tenants in building a foundation from which they can fully reintegrate to the larger community (e.g. employment, market rental housing).
- Some programs provide congregate housing that requires abstinence from alcohol and other drugs. This approach is thought to support tenants' recovery by ensuring a 'safe, drug-free' home, in which they can benefit from social and recovery connections with other tenants. Some congregate housing allows substance use and may prescribe areas in which use is permitted ('wet' and 'damp' models). In some staffed congregate housing, use of alcohol is monitored by staff, who may also administer it.
- *Treatment first* programs may require that, to maintain their housing, tenants must be actively involved in treatment or counseling services provided by or in association with the housing provider.
- Some programs require that people be in active recovery. For example, within its 'Addictions Supportive Housing' program, Vancouver Coastal Health provides rent supplements and support for people who are in recovery from addiction and want to live in an alcohol and drug free environment. Housing may be permanent or long term

(for individuals who continue to need support), or transitional, with individuals moving out of their units when they are ready and able to access other housing options.

Housing first approaches have evolved from the model that was pioneered by Pathways Housing First. The Pathways model articulates clearly defined criteria for access to its housing. The following describes those criteria and other features of that model (Tsemberis et al. 2004):

- Individuals must be homeless and have a psychiatric disability and/or substance use disorder. Priority is given to the most vulnerable people, including the street homeless, women, seniors, and people who have physical health problems.
- A history of violence and/or incarceration does not disqualify an applicant from entering the program.
- Abstinence from psychoactive substances is not a requirement. Tenants choose whether or not to use alcohol or other drugs, and whether or not to take medications. A harm reduction approach is employed to support individual choice.
- Tenants are strongly encouraged, but not required to:
    - Meet with their service coordinator at least twice a month,
    - Pay 30% of their income on rent, and
    - Participate in a money-management program.

Two features are central to the Pathways model:

- Treatment and support services are provided by ACT teams, which include members with a range of expertise, such as substance use specialists, mental health workers, nurses, psychiatrists, peer support workers and family specialists.
- Services aim to increase personal efficacy, meet basic needs, enhance social skills, increase employment opportunities, and enhance quality of life.

The majority of services offered in the Pathways model are provided in the tenant's apartment or neighbourhood. Supports range from assistance with shopping for groceries, to mental health, substance abuse, and physical health treatment, as well as services designed to meet the tenant's needs for assistance with vocational, educational, and recreational issues. When services cannot be provided directly by the team, necessary referrals are made to other providers. Tenants are not required to attend treatment (Tsemberis et al. 2004).

Housing provided by Pathways is permanent, not transitional. In the event of a crisis, the tenant is assured that the apartment will remain in his/her possession, and that the crisis itself will not be a reason for eviction. Problems related to substance use are managed collaboratively by the tenant and the support team. Services are intensified during crisis periods so that tenants can retain their housing. Decisions about intervention are made by the tenant himself or herself, unless (s)he presents a danger to self or others (Tsemberis et al. 2004).

A blended approach to housing first and treatment first housing

Among Canadian providers of supportive housing, Vancouver Coastal Health has shown notable leadership in research, policy development and service planning to address the needs of homeless people. The 2006 framework developed by Vancouver Coastal Health sets out a three-pronged approach to addressing problematic substance use and other complex problems that may jeopardize housing retention. Both *treatment first* and *housing first* approaches are utilized in that framework:

A THREE PRONGED APPROACH TO SUPPORTIVE HOUSING

Affordable, supported low barrier housing uses a housing first approach to engage people who are not yet ready to engage in addiction treatment services as a requirement to access housing. Low barrier housing units include rooming houses, hotels, and social housing developments, and provide high or low intensity support. To access this option, individuals need to be willing and able to be safely housed without risk to other tenants, staff or themselves. Services focus not only on safe and secure housing, but also work with tenants to create linkages with substance use treatment, medical, and mental health services. On-site supports assist individuals to gain basic daily living skills which will improve their capacity to maintain housing, bolstered through intensive case management and physician support from the Community Health Centres.

Affordable supported transitional and permanent housing is provided for people who are actively engaged in recovery-focused addictions and/or mental health treatment. The program provides rent subsidies and support services for people who have a serious dependency on alcohol or other drugs. Tenants must have been referred by a treatment provider, be actively engaged in addiction treatment, and be willing to engage in developing an individual recovery plan. Housing is generally transitional (18 to 24 months) in nature. It is believed that individuals in recovery from addiction may be in a position to obtain market housing as they acquire employment, or may be able to access affordable social housing.

Affordable housing for individuals who can live independently includes programs to help low and modest income households. These programs provide affordable housing options that may be particularly helpful for singles who have an addiction and/or mental illness. It is thought that these units will help individuals with who have substance use problems to focus on recovery without being drawn to low-rent areas where inadequate accommodation and ready access to drugs can make recovery more difficult.

Positive Outcomes of Supportive Housing

Considerable evidence of the effectiveness of supportive housing has emerged over the last several years. Housing retention has been studied as a key measure, and several studies have also examined the use of emergency and other health care services, and their related costs. Some studies have considered health and quality of life outcomes. The extent and nature of changes in substance patterns and the potential or actual reduction of harms from problematic substance use are less well studied.

The literature confirms that providing housing with supports is an effective intervention for individuals who have severe addiction and/or mental illness (Frankish et al. 2005; Patterson et al. 2007). Examples of specific findings include:

- The critical impact of affordability on housing stability is highlighted in studies conducted in 1996 (Hurlburt et al.) and 2002 (CMHS). Both studies demonstrated that individuals who had access to rental subsidies, regardless of the intensity of the services provided, had a significantly greater probability of finding independent stable housing.
- Frankish et al. (2005) note that housing combined with appropriate supports is linked to increased housing stability, decreased homelessness, and a reduction in the frequency and duration of hospitalizations. Frankish also found that more well-defined and integrated housing support services, such as Assertive Community Treatment (ACT) teams, are more effective than traditional case management in reducing homelessness and symptom severity.
- In a Canadian review of seven supportive housing programs, Kraus (2005) found that supportive housing can result in positive outcomes for participants, including improved health, reintegration into the community, increased income through employment, and improved ability to access and maintain permanent housing.

Some studies have identified potential or actual cost savings:

- Reduced costs for crisis and emergency services have been identified by Culhane et al. (2002), Martinez & Burt (2006), and Tsemberis & Eisenberg (2000).
- Pomeroy(2005) examined the costs of addressing homelessness through institutional and emergency response systems (such as psychiatric hospitals, treatment centres, and emergency hostels and shelters) compared to purpose-designed community-based supportive housing. Costs in four Canadian cities were analyzed: Montreal, Toronto, Halifax and Vancouver. The study indicates that the cost of community-based services is significantly lower than that of institutional or emergency services, even when calculation of the cost of supportive housing includes the investments required for both new construction and intensive supports.

There is preliminary evidence of the effectiveness of both *housing first* and low barrier approaches. Examples include:

Housing retention

- In their studies of outcomes from the Pathways Housing program (in New York), Tsemberis and Eisenberg (2000) found that between 85 and 90 percent of participants were still housed at five-year follow-up. In a subsequent study, Tsemberis (2005) found that, over a five year period, 88% of tenants in Pathways Housing First program remained housed, compared to 47% of residents in a “standard” housing program.
- An analysis of longitudinal studies found that tenants in the Pathways Housing First program have had better housing retention outcomes than those in ‘staircase’ models (Tsemberis et al., 2004; Pleace, 2008; Atherton and McNaughton-Nicholls, 2008; Pearson et al., 2009; Johnsen and Teixeira, 2010; cited in Pleace 2011).

Substance use

- A study of tenants of Pathways Housing First showed that, after twenty four months of residence, people who have co-occurring substance use and mental health problems were no more likely to use drugs or alcohol than their *treatment first* counterparts (Pagett et al. 2006

Utilization/cost of emergency/acute care services

- Tenants in *housing first* programs make less use of emergency shelters and emergency medical services, and are less likely to get arrested than when they were homeless (Culhane, 2008; Tsemberis, 2010b cited in Pleace 2011).
- Compared with a comparable group of continuum of care clients, the *housing first* tenants were found to have fewer psychiatric admissions, fewer emergency admissions, fewer arrests and – at least for Streets to Homes' clients in Toronto – reduced drug use (Gulcur et al., 2003; Toronto Shelter Support & Housing Administration, 2007; Tsemberis et al., 2004, cited in Atherton et al., 2008).
- In a Finnish *housing first* program, tenants' use of social and health care services was reduced by half compared to their use of such services while they were homeless (Busch 2010).
- Edens et al. (2011) compared outcomes for participants in a low demand supportive housing program who had high levels of substance use at the time of their entry into housing with outcomes of participants who reported no substance use. During a 24-month follow-up: the number of days housed increased dramatically for both groups; high-frequency substance users maintained higher, though declining, rates of substance use; and the total health costs declined for both groups over time.

Outcomes of a Housing First Approach in Ontario

A survey of Toronto's Streets to Homes program conducted by Toronto Shelter, Support, and Housing Administration (2007) identified several positive outcomes. It should be noted that, of the total tenant population, 23% identified use of drugs and/or alcohol as the main reason for becoming homeless. Findings include the following:

- Overall, 91% of those surveyed said their lives had improved since moving into housing: 70% said their health had improved, 72% reported improved personal security, 69% said sleeping had improved, 60% said their level of stress had improved, and 57% said their mental health had improved.
- Respondents reported that their alcohol and other drug use had reduced. Of those who use alcohol, 17% said they had quit drinking since moving into housing, while 32% said they were drinking less. Of those who said they used drugs, 31% said they had quit using drugs completely, and 42% had decreased their use.
- Respondents also reported reduced use of emergency health resources, including: a 38% reduction in ambulance use, 40% decrease in emergency room use, and 25% reduction in individuals requiring a hospital stay. However, individuals were making use of routine

medical services more frequently once in housing, including a 32% increase the use of family doctors and 71% increase in use of psychiatrists.

- Reductions in other emergency services were also reported, including a 75% decrease in the number of individuals using police 'detox', a 56% decrease in the number of individuals arrested, and a 68% reduction in those using jail detention.

Discussion

Although numerous studies highlight the promise of *housing first* approaches, more work is required before specific models and approaches can be conclusively identified as best practices[3]. People who have substance use problems are a heterogeneous group; additional research must be undertaken to identify the approaches that produce optimal outcomes for specific populations. Patterson and colleagues (2007) note that a strengthened base of evidence will support matching of the needs of service users with effective service types. Some authors identify the need for studies that focus on people who have substance use problems but do not have mental health issues[4]. Others highlight the need for research into effective approaches to supportive housing for people who use alcohol only or other specific drugs only.

Studies have demonstrated that women - the fastest growing sub-population of homeless people - have specific and distinct needs for both shelter and service in transitioning from homelessness to 'home' (Fotheringham et al. 2011). Street Health (2007) emphasizes the importance of women-only harm reduction housing; comprehensive, multidisciplinary, low-barrier models of health care; trauma-informed service delivery; and increased availability of women-only withdrawal management and treatment options. Studies of programs 'targeted for women' suggest that gender specific approaches have been successful (Zerger, 2002); however additional research is needed to determine the effectiveness of *housing first* approaches for women (Fotheringham et al. 2011).

Research is also required to identify the impact of various supportive housing approaches on health, quality of life, and substance use outcomes. Patterson (2007)[5] notes that "*the impacts of housing on outcomes other than those related to residential stability and hospitalization have not been consistently studied and that the studies that have been conducted do not yield consistent results. The evidence for the greater impact of particular supported housing types is inconsistent, both in the comparisons that have been used and in their findings*".

Finally, the effectiveness of various *housing first* approaches must be assessed. As already noted, *housing first* approaches may differ from each other significantly along several key dimensions. Atherton et al. (2008) contend that that there is no single definition of *housing first*:

[3] For the purpose of this document, a "best practice" is defined as one that has consistently shown results superior to those achieved with other means, and that is used as a benchmark.

[4] CASAHOPE is currently conducting research to determine the effectiveness of housing first approaches for tenants who have substance use problems but do not have mental illness (Morgenstern et al. 2011).

[5] Page 55

"*Pathways itself has reacted to the diversity of Housing First services by issuing detailed guidance on what it now refers to as Pathways Housing First services and it is also developing a fidelity scale*[6]*".* Atherton notes that *housing first* is not a "cure all" solution that can be applied everywhere - local contexts require tailoring to meet local needs. The evolution of the *housing first* model can be seen as a positive direction, in that modifications may be made to reflect the needs of specific communities and jurisdictions. Clearly, research studies must ensure a thorough understanding of the approaches that are actually being implemented in order to assess their impact.

[6] A housing first fidelity assessment and evaluation based on the Fidelity Scale is available through Pathways Housing First, New York

Implications for policy and planning

Recommendations from the Canadian 'grey literature'

A number of Canadian studies have provided high-level analysis of issues and thoughtful recommendations for planning of supportive housing at the program and system levels. In a comprehensive analysis of studies on homelessness, Frankish and colleagues (2005) identify the importance of involving a wide range of stakeholders (including all levels of government, service providers, health professionals, researchers, community groups and homeless people themselves) in planning. Frankish and colleagues also suggest that public discourse is needed to identify measures by which efforts to reduce homelessness or improve the quality of life of homeless people will be judged.

To support planning and evaluation of supportive housing (and other initiatives to reduce homelessness) Frankish and colleagues (2005) suggest three strategic priorities:

1. A nationwide effort to achieve a core, consensus definition and a set of indicators related to the definition and extent of homelessness.
2. Clear definitions and measures for a) the health status of homeless (and at-risk) groups; b) the use of health and social services by homeless people; and c) the relationship between homelessness and the broader determinants of health (e.g., income, education, employment, social support, gender, culture, etc.).
3. The development of research infrastructure, including: mechanisms for the reliable collection of data; an "evaluability" assessment of publicly funded projects; and a model of program evaluation that will support focused measurement and provides sufficient time and resources for appropriate assessment of homelessness interventions and their effects.

In a study for the government of Canada, Kraus et al. (2006) examined a variety of supportive housing approaches, and identified a number of actions that should be considered in policy development and planning, including:

- Support acknowledgement of the legitimacy and effectiveness of both abstinence-based and harm reduction approaches
- Provide a range of supportive housing programs that offer both harm reduction and "drug and alcohol free" options, including those that utilize *housing first* approaches
- Recognize the importance of housing in any program created to address the needs of people with substance use and/or mental health issues
- Examine the role and effectiveness of transitional housing

- Support achievement of positive change and personal goals through appropriate services
- Provide federal and provincial leadership in an integrated system of mental health and substance use services
- Acknowledge the critical impact of staff skills and knowledge, and support professional development

Krause et al. also suggest several directions for further research, including:

- The advantages and disadvantages of dedicated and scattered housing
- The impacts of integrating residents who are abstinent and those who continue to use drugs/and or alcohol
- Improved methods and resources for systematically gathering data about outcomes for people who are homeless, including data on medium and longer term outcomes
- Strategies and key elements for success for maintaining housing stability in the community
- The role of staff and the qualities, training, composition of teams, salaries, etc. necessary for success
- Organizational leadership that supports innovative responses

In a comprehensive study that drew upon diverse sources of information (including published literature, academic experts, decision-makers and key informants), Patterson and colleagues (2007) provide a thoughtful analysis of strategies and practices. The study was prepared to help inform future directions in housing and support for people who have severe addictions and/or mental illness in British Columbia. Their recommendations, while too detailed to include in the body of this report, are provided, in summary, in Appendix A.

Issues that may impact the uptake of *housing first* approaches

Housing first approaches are being discussed with interest in Europe and have already been implemented in several European countries. Atherton and colleagues (2008) and Pleace (2011) have authored "Think Pieces" for the *European Journal of Homelessness* which examines the potential benefits of *housing first* approaches. Their observations - and some of the thought provoking questions they have posed - merit consideration in the Canadian health care environment.

Atherton and colleagues (2008) assert that *housing first* approaches may have the potential to play an important role in addressing homelessness. However the potential

of those approaches to improve the health and quality of life of tenants (including substance use problems) is, in Atherton's view, less certain: *"North American experience suggests that people with multiple problems, including drug misuse and mental illness, can maintain stable tenancies even if their other problems remain unresolved"*[7].

Notwithstanding the success of *housing first* approaches in producing positive housing retention outcomes, Atherton and colleagues question whether those approaches may fall short of providing an adequate response to the needs of homeless people who have substance use problems and other complex health needs: *"housing first, as a policy, is a means by which to save people from homelessness, and indeed it is designed in such a way that it would be particularly difficult for a client not to maintain their housing. When homeless people with multiple needs are housed, they are unlikely to find that other individual and structurally generated problems, such a poverty or mental illness, evaporate*[8]*.*

In their analysis of findings from North American studies, Atherton and colleagues (2008) note relatively modest success in respect to substance use outcomes: *"Evidence suggests no deleterious effects on mental health or increased substance use, and possibly some benefits"*.[9] In the view of these authors, assertive health and social supports play a critical role in ensuring that *housing first* approaches go beyond a simple response to homelessness: "T*he effectiveness of the model results from the provision of housing at an early stage of engagement as part of an integrated and comprehensive support package"*.[10]

Pleace (2011) acknowledges the success of *housing first* approaches - and particularly the Pathways Housing First program - in improving housing retention for homeless people with substance use and/or mental health problems. However, Pleace also suggests that *housing first* approaches have limitations, and calls into question their effectiveness in counteracting the harm of problematic drug and alcohol use. Based on his analysis of the literature (Lipton et al., 2000; Kertesz et al., 2009; Tsai et al., 2010, cited in Pleace, 2011) Pleace advances the argument that abstinence-based supportive housing is needed by people for whom substance use threatens well being.

Both Atherton and colleagues (2008) and Pleace (2011) raise questions about the potential legal or policy barriers that may arise in respect to *housing first* approaches. Tenants have the right to choose to continue using drugs without fear of eviction in *housing first* programs; however that choice can, in the case of illicit drug use, raise concerns about acceptance of criminal acts. Client choice and harm reduction are core

[7] Page 292
[8] Page 294
[9] Page 289
[10] Page 290

values of *housing first* approaches. However, if those values are not coherent with strategies that focus on cessation of problematic drug use, they may not be viewed sympathetically by policy-makers. Policy and legal barriers can cause distortions in the *housing first* model; for example, Atherton and colleagues note that: *"there are examples of housing first projects in the US where drug misuse has not been tolerated*[11]*".* Supportive housing programs and workers may be placed in an untenable position by legal barriers to harm reduction. Atherton and colleagues, for example, cite a UK legal case in which two shelter workers were imprisoned for permitting the supply of heroin on the hostel premises.

Concluding Remarks

Notwithstanding the questions that have been raised about supportive housing approaches, and the need for improved evaluation and a stronger evidence base, it is clear that supportive housing has significant potential to generate positive outcomes for individuals who are homeless and have substance use problems.

With its core emphasis on client choice, *housing first* may also have the potential to be a catalyst for a seismic shift in our systemic responses to people who are homeless:

> *"Beliefs and attitudes suggesting that homeless people with multiple needs cannot maintain tenancies of their own are unsustainable in light of current research. Such assumptions perpetuate stereotypes, essentially blaming individuals where wider structural deficiencies in welfare services and housing markets may be at fault. The explicit recognition of people's abilities that is central to Housing First would act as a direct challenge to those who continue to believe otherwise, encouraging the development of more appropriate, humane and effective services."* (Atherton et al. (2008)

[11] Page 298

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APPENDIX A: Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia

In 2007, the Centre for Applied Research in Mental Health and Addictions (CARMA) prepared a comprehensive report for the BC Ministry of Health, Mental Health and Addictions Branch. The full report is available on line at http://www.carmha.ca/publications/documents/Housing-SAMI-BC-FINAL-PD.pdf.

The report provides current information with regard to the scope of homelessness, recommended solutions, and an analysis of associated costs.
Patterson and colleagues developed detailed recommendations, including:

Planning housing and adjunctive supports:

- Integrated planning and communication
- Income assistance
- Supply of low-cost housing
- Crisis orientation (beyond crisis intervention, move towards prevention)
- A variety of supported housing options, including Housing First and Low Barrier Housing
- Multidisciplinary treatment teams
- Harm reduction
- Integrated mental health and addiction services
- New affordable housing
- Preservation of existing affordable housing
- Homeless services information system (i.e. a comprehensive database on social, health, and housing services).
- Distribution of services (in the areas where individuals with substance use issues are living, and where they access services)
- Discharge policies and practices (hospital protocols for people with no fixed address, to ensure housing arrangement and follow-up)
- A Provincial Mental Health and Addictions strategy
- A range of housing options (wet and dry, scattered and dedicated, and a variety of service options for residents)

Evidence-based and promising practices:

Outreach and Engagement

- Meets immediate and basic needs for food, clothing, and shelter.
- Non-threatening, flexible approach to engage and connect people to needed services.

Housing with Appropriate Supports

- A range of options from transitional and Low Barrier Housing to permanent supported housing.
- Combines affordable, independent housing with flexible, supportive services.

Multidisciplinary Treatment Teams/Intensive Case Management

- Provides or arranges for an individual's clinical, housing, and other rehabilitation needs.
- Features low case loads (10-15:1) and 24-hr service availability.

Integrated Treatment for Concurrent Disorders

- Features coordinated clinical treatment of both mental illness and substance use disorders.
- Reduces alcohol and drug use, homelessness, and the severity of mental health problems.

Motivational Interventions

- Helps prepare individuals for active treatment; incorporates relapse prevention strategies.
- Must be matched to an individual's stage of recovery.

Modified Therapeutic Communities

- Views the community as the therapeutic method for recovery from substance abuse.
- Have been successfully adapted for people who are homeless.

Self-Help Programs

- Often includes the 12-step method, with a focus on personal responsibility.
- May provide an important source of support for homeless people.

Involvement of Consumers and Recovering Persons

- Can serve as positive role models, help reduce stigma, and make good team members.
- Should be actively involved in the planning and delivery of services.

Prevention Services

- Reduces risk factors and enhance protective factors.
- Includes supportive services in housing, discharge planning, and additional support during transition periods.

Other essential service components and characteristics, which include:

- Primary Health Care
- Mental Health and Substance Abuse Treatment
- Psychosocial Rehabilitation
- Income Support and Entitlement Assistance
- Employment, Education, and Training
- Services for Marginalized Groups (including women and Aboriginal peoples)
- Low Barrier Services
- Crisis Care

- Family Self-Help/Advocacy
- Criminal Justice System Initiatives (including diversion, treatment and re-entry)
- Reduced Barriers (e.g. application and wait list procedures)
- Cultural Competence, including:
    - Locations close to one's cultural community and informal sources of support
    - Family-based supportive housing models
    - Space within the housing setting to accommodate extended family
    - Housing structures (particularly in congregate housing) that include 'communal spaces' for group cultural and religious activities
    - Recognition, in the design of housing, of the importance of faith to the individual user and sufficient provision for the practice and expression of that faith
    - Housing structures that are smaller in scale "so that they don't invoke the look and feel of an institution"
    - Culturally appropriate physical design, interior design and decoration
    - Availability of gender-specific housing options
    - In-house anti-racism, anti-oppression, and anti-discrimination standards, policies and enforcement mechanisms
    - Availability of culturally preferred and appropriate food (in group settings).
    - Culturally relevant community development and recreational activities nurturing a sense of community among tenants within congregate living situations

APPENDIX B: Annotated Bibliography

BC Housing (2006). BC Housing BCH Service Plan 2011/12 – 2013/14. *Housing Matters,* from http://www.bchousing.org/resources/About%20BC%20Housing/Service_Plan/2011/Service_Plan_2011-14.pdf

This Canadian Service Plan outlines British Columbia's priorities for housing those in need and details their plan strategies for achieving BCH program goals over three years.

GOALS:

- Implementing programs and initiatives that support the provincial housing strategy, *Housing Matters BC* – from creating housing and support options for those in greatest need through to ensuring consumer protections for new home buyers.
- Breaking the cycle of homelessness.
- The completion of new supported housing developments through partnerships with local governments, charitable sources and housing providers. This will enable homeless people to regain their dignity and independence
- Alleviate concerns residents may have about homelessness in their community.
- Provide a more integrated response in facilitating the transition of homeless individuals from the street to stable housing, with the emergency shelter services and homeless outreach programs, and government and community partners.

DEFINITIONS

Assisted Living: Self-contained apartments for people who need some support services, but do not need 24-hour care. Services provided include daily meals, social and recreational opportunities, assistance with medications, mobility and other care needs, a 24-hour response system and light housekeeping.

Co-operative Housing: A housing development in which individual residents own a share in the co-operative. This share grants them equal access to common areas, voting rights, occupancy of an apartment or townhouse and the right to vote for board members to manage the co-operative. Each member has one vote and members work together to keep their housing well managed and affordable.

Core Housing Need: Households in core housing need are those who currently reside in housing that is either in need of major repair, does not have enough bedrooms for the size and makeup of the household, or costs 30 per cent or more of their total income, and who are unable to rent an alternative housing unit that meets these standards without paying 30 per cent or more of their income.

Emergency Shelter: Short-stay housing of 30 days or less. Emergency shelters provide single or shared bedrooms or dorm-type sleeping arrangements, with varying levels of support to individuals.

Housing Providers: Non-profit housing societies and housing co-operatives that own and manage subsidized housing developments. This term can also include private-market landlords through whom BC Housing provides rent assistance to low-income households.

Non-Profit Housing: Rental housing that is owned and operated by community-based, non-profit societies. The mandates of these societies are to provide safe, secure, affordable accommodation to households with low- to moderate-incomes. Most non-profit housing societies receive some form of financial assistance from government to enable them to offer affordable rents. Each society operates independently under the direction of a volunteer board of directors

Single Room Occupancy Hotel: These hotels provide long-term accommodation in single rooms, typically without private bathrooms or kitchens.

Social Housing: Includes both public housing and housing that is owned and managed by non-profit and co-operative housing providers.

Subsidized Housing: Housing for which the provincial government provides a subsidy or rent assistance, including public, non-profit and co-operative housing, as well as rent assistance for people living in private-market housing. It also includes emergency housing and short-term shelters.

Supportive Housing: Housing that provides ongoing supports and services to residents who cannot live independently and are not expected to become fully self-sufficient.

Supportive Housing Registration Service: With the goal to facilitate the transition from homelessness and emergency shelter use to permanent, supportive housing, SHR provides a single point of access for applicants seeking low-barrier supportive housing. The service manages the allocation of supportive housing units in the Vancouver SROs acquired by BC Housing and select City of Vancouver-owned supportive housing sites.

METHODOLOGY

This strategic plan outlines the organizational structure, strategic context and directions, and Performance measurement Framework to achieve their five goals:

- Goal 1: Respond to Gaps in the Housing Continuum
- Goal 2: Protect and Manage Existing Housing for the Long-Term
- Goal 3: Provide Access to Appropriate Housing and Services for Vulnerable British Columbians
- Goal 4: Improve the Quality of Residential Construction and Strengthen Consumer Protections
- Goal 5: Organizational Excellence

KEY FINDINGS

2011/12 priorities include:

- Developing new units of supported housing through the *Provincial Homelessness Initiative*
- Completing new rental units for low- and moderate-income seniors through the *Seniors' Rental Housing* initiative
- Completing retrofits and repairs to social housing buildings through the *Housing Renovation Partnership*
- Developing a portfolio management framework to ensure asset align with their mandate and to anticipate emerging housing need and demand
- Working collaboratively with non-profit partners on initiatives and strategies to protect the long-term sustainability of the sector
- Reducing and offsetting greenhouse gas emissions to achieve carbon neutrality, as well as enhancing their leadership role within the housing sector to promote environmental sustainability
- Collaborating with the residential construction industry to raise the bar of professionalism in the residential construction industry and protect consumers.

Brunette, M., Mueser, K. & Drake R. (2004). A review of research on residential programs for people with severe mental illness and co-occuring substance use disorders. *Drug Alcohol Rev, 23,* 471–481, from http://www.dartmouth.edu/~dcare/pdfs/fp/DrakeRobert-AReviewOfResearch.pdf

OBJECTIVES

This US study examined the effectiveness of residential programs for people with dual disorders, because of the increasing number of such programs becoming available. Controlled studies of residential programs for people with dual disorders were reviewed.

KEY DEFINITIONS

Stays are categorized as short-term (average stay 6 months or less) or long-term (average stay longer than 6 months).

"Dual diagnosis" or "dual disorders" indicate the co-occurrence, or comorbidity, of severe mental illness and substance use disorder.

METHODOLOGY

This review is limited to controlled studies. The authors identified studies for review by searching computerized databases: MEDLINE, PsycLIT, Cochrane Library and Project CORK. The authors also tried to identify unpublished reports through the National Institute of Mental Health, the National Institutes of Alcoholism and Alcohol Abuse, the

National Institute of Drug Abuse, the Substance Abuse and Mental Health Services Administration and state Departments of Health and Human Services.

KEY FINDINGS

Substance use disorder is the most common and clinically significant co-morbidity among clients with severe mental illnesses, associated with poor treatment response, homelessness and other adverse outcomes. Residential programs for clients with dual disorders integrate mental health treatment, substance abuse interventions, housing and other supports. Ten controlled studies suggest that greater levels of integration of substance abuse and mental health services are more effective than less integration. Because the research is limited by methodological problems, further research is needed to establish the effectiveness of residential programs, to characterize important program elements, to establish methods to improve engagement into and retention in residential programs and to clarify which clients benefit from this type of service.

Burt, M. R. & Wilkins, C. (2005). Taking Health Care Home: Baseline Report on PSH Tenants, Programs, Policies, and Funding. *Corporation for Supportive Housing*, from http://www.rwjf.org/files/research/66288.final.pdf

OBJECTIVES

In 2003 the Robert Wood Johnson Foundation awarded the Corporation for Supportive Housing (CSH) $6 million over two years for a 'Taking Health Care Home' initiative (THCH). CSH is working with states and localities through THCH to demonstrate how they can create supportive housing that ends homelessness for people with chronic health conditions including mental illness, alcohol and chemical dependency, and HIV/AIDS, and how that experience can be replicated on a national scale.

METHODOLOGY

This US report analyzes survey data from 63 agencies and 149 projects involved in developing and operating permanent supportive housing (PSH) in each of the THCH sites.

KEY FINDINGS:

- Through loans, grants and technical assistance, CSH's Taking Health Care Home initiative spurred the creation or addition to the pipeline of more than 22,000 units of permanent supportive housing for chronically homeless individuals and families. Other CSH programs created an additional 33,600 units of such housing through those activities, and the organization's public policy efforts led to the creation of almost 84,000 units, for a total of just under 140,000 units.

- 'Taking Health Care Home' spurred changes in federal, state and local policy and funding designed to tackle long-term homelessness through supportive housing. For example:
    - U.S. departments of Housing and Urban Development and Health and Human Services have created a demonstration program to provide vouchers for rental housing with services for chronically homeless individuals and families.
    - Portland/Multnomah County in Oregon created a 10-year plan to address homelessness, and the state legislature approved $16.4 million in lottery-backed bonds and interest earnings in 2007 for supportive housing.
    - Seattle/King County created a local tax to pay for supportive housing services. The county also established the Homeless Housing Funders Group, a public-private collaboration to coordinate capital, service and operating funds for supportive housing and create a pipeline of new units for adults and families.

- CSH offices and public agencies in five states used $900,000 in matching funds to leverage $7.5 million in public and private investment in supportive housing.

- In 2007, the U.S. Department of Housing and Urban Development reported a 30 percent drop in chronic homelessness.

The results show that program success is associated with more housing units, funding, changes in policies (for example, prioritizing hardest-to-serve populations for next available unit), and more trainings for service providers.

City Spaces Consulting Ltd. (2008). A Response to Homelessness in Nanaimo: A Housing First Approach. *Relevant Best Practices,* from http://intraspec.ca/080107_Nanaimo_BP_Research_MG.pdf

OBJECTIVES

This Canadian paper introduces the concepts of housing first and harm reduction and focuses on the community context in Nanaimo, BC. The purpose is to highlight the most successful approaches and strategies, and the role and responsibility of local government in relation to these approaches.

As a best practices summary, the paper builds on key research and data sources that have well-documented the impacts of adopting housing first and harm reduction into local strategies and methods.

KEY DEFINITIONS

Housing First: the direct placement of homeless individuals into stable housing. Support services are available to tenants through assertive engagement, but active participation in these services is not required. A low demand, low threshold approach accommodates substance use, so sobriety is not a precondition and relapse does not result in clients losing their housing.

Harm Reduction: An approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence. Examples of harm reduction programs include needle exchange services, substitution therapy and safe consumption sites.

Continuum of Supports: A holistic approach to addressing the needs of homeless individuals within a community plan, including all supports and services needed to assist a homeless person or someone at risk of becoming homeless to become self sufficient, where possible. The continuum includes homelessness prevention services, emergency shelter, outreach, addiction services, transitional housing and other support services.

KEY FINDINGS

This document reviews the concepts of housing first and harm reduction and highlights the strategies found to be effective towards resolving the problems of homelessness and improving the quality of life for persons with mental health and addictions issues.

The key elements or reasons for success are reported to include:

- A continuum of housing and support services to address homelessness
- Availability of a range of housing options and provision of housing choice
- Comprehensive, intensive and integrated services
- Flexible and client-centred services
- Low demand/low barrier models
- Uniquely qualified staff who are well trained and client-focused
- Client participation in social, non-street related activities required?
- A collaborative approach among agencies and service providers
- Stable funding and commitment
- Monitoring and assessment of program outcomes

Municipalities also play a key role in:

- Providing leadership
- Problem solving across internal city departments
- Building partnerships between service providers and government agencies
- Developing affordable housing strategies
- Developing policies and pilot innovative initiatives
- Streamlining funding and program initiatives
- Monitoring outcomes and efforts

Culhane, D. P., Metraux, S. & Hadley, T. (2001). The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections, and emergency shelter systems: The New York-New York Initiative. ***Housing Policy Debate, 5*****, 107-140, from From**
http://www.campaign4housing.org/pdfs/Culhane_NY_NY.pdf

OBJECTIVES
To examine service use by formerly homeless people with SMI (Severe mental illness) before and after being placed into a large housing program in New York City (NYC). Administrative data from public health, psychiatric, criminal justice, and shelter service providers are used to assess the aggregate level of service demand, pre- and post-intervention, for the study group and for a matched set of controls. The extent to which reductions in services are present and are attributable to a NY/NY housing placement is assessed, and the degree to which service reductions offset supportive housing costs is measured.

METHODOLOGY
Data on 4,679 homeless people with severe mental disorders placed in supportive housing in New York City between 1989 and 1997 were merged with administrative data on the utilization of public shelters, public hospitals, Medicaid-funded services, veterans' inpatient services, state psychiatric inpatient services, state prisons, and the city's jails. A series of matched controls who were concurrently homeless but were not placed in housing were similarly tracked through administrative records.

KEY FINDINGS
Adjusting for demographic and other pre-intervention differences between the cases and controls, regression results reveal that homeless people placed in supportive housing experience marked reductions in shelter use, hospitalizations (regardless of type), length of stay per hospitalization, and time incarcerated. Prior to placement in housing, homeless people with severe mental illness used an average of $40,449 per person per year in such services (in 1999 dollars). Placement in housing through the New York/New York program (NY/NY) was associated with a reduction in service use of $16,282 per housing unit per year, adjusting for concurrent changes in the controls' service use patterns. Unit costs per year for the supportive housing are estimated at $17,277, which would result in a modest cost of $995 per unit per year over the first two years of placement. Overall, the NY/NY initiative, which included some licensed community mental health residences as well, resulted in a net cost of $1,908 per unit per year, or $6.9 million. The potential benefits and challenges of further public investment in supportive housing for homeless people with severe mental disabilities are discussed.

Culhane, D. P., Metraux, S. & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate, 13,* 107–163.

OBJECTIVES
This study used a pre/post design and a matched control group to evaluate the New York-New York Agreement, a joint state- and city-funded initiative to develop supportive housing for people who were homeless and had a severe mental illness in New York City.

METHODOLOGY
The study analyzed administrative records from seven service systems to estimate the impact of supportive housing placement on services utilization for two years post placement as compared to two years prior to placement. The primary limitation of the study is that it did not involve randomization. It is possible that there was sample selection bias, and that people were selected for housing only if they were sufficiently stable or had received sufficient treatment before program entry. The pre-intervention average cost of $40,500 per person per year suggests that a heavy service-using population was targeted for the intervention and that such high utilization made it possible to achieve such a high degree of offsetting costs.

KEY FINDINGS
The study found that supportive housing placement was associated with declines in hospitalizations, incarcerations, and shelter stays. Ninety-five percent of the costs of the supportive housing were offset by service reductions ($17,200 per unit per year), resulting in an estimated net annual cost of the supportive housing programs of approximately $1,000 per unit per year. While an advantage of the study was its inclusion of multiple systems to measure impacts on services use and costs, it did not include all potential costs, including police and court costs, emergency medical transport, and emergency room costs

DesJarlais, D., Braine, N. & Friedmann, P. (2007). Unstable housing as a factor for increased injection risk behavior at US syringe exchange programs. *AIDS Behavior, 11,* 878-884.

OBJECTIVE
To assess variation in injection risk behavior among unstably housed/homeless injecting drug users (IDUs) across programs in a national sample of US syringe exchange programs.

KEY DEFINITIONS

Unstable housing/homelessness: operationally defined as having lived on the street or in a shanty or living in a shelter or single room occupancy hotel (SRO) at any time in the 6 months prior to the interview.

Receptive sharing: operationally defined as having injected with a needle or syringe that had been used by someone else in the 30 days prior to the interview.

METHODOLOGY

About 23 needle exchange programs were selected through stratified random sampling of moderate to very large US needle exchange programs operating in 2001-2005. Subjects at each program were randomly sampled. Risk behavior interviews were collected using audio-computer assisted self-interviewing (A-CASI). Six very large and nine moderate-to-large programs had at least 50 subjects who reported unstable housing, and these 15 programs were used in the analyses.

KEY FINDINGS

At each of the 15 programs, unstably housed exchange participants were approximately twice as likely to report 'receptive sharing' than were stably housed participants. There was considerable variation among the 15 programs in the percentages of unstably housed participants (range from 35 to 74%, $P < 0.0001$), and in the percentages of unstably housed participants who reported receptive sharing (range from 8 to 52%, $P < 0.0001$). The programs clearly differ in the extent to which they are attracting unstably housed 'injection drug users' as participants. The consistency of more frequent injection risk behavior among unstably housed exchange participants and the lack of significant variation in the odds ratios for increased injection risk suggest that none of the programs were "better" or "worse" at reducing injection risk behavior among unstably housed participants. Reduction in injecting risk behavior among syringe exchange participants may require greater efforts to provide stable housing or the development of dramatically new interventions to reduce injecting risk behavior among IDUs with persistent unstable housing.

Eberle, M., Kraus, D., Hulchanski, D. & Pomeroy, S. (2001). Homelessness: Causes and Effects. Volume 3 . ***The Costs of Homelessness in British Columbia.*** **Prepared for Ministry of Community, Aboriginal and Women's Services, from: http://intraspec.ca/Vol3.pdf**

OBJECTIVES

This Canadian study estimated the government cost impacts of two approaches for addressing chronic homelessness among individuals:

1. Providing temporary accommodation in emergency shelters and needed health care, criminal justice and social services — the emergency or reactive approach.

2. Providing permanent supportive housing and needed health care, criminal justice and social services — the prevention approach.

The purpose is to explore the relative costs to the British Columbia government for a series of services that are, to some degree, publicly funded. These do not represent the total costs of providing that service. In addition to the subsidies paid by government, a service provider might also receive revenue from other sources including rents and user fees from its clients and charitable donations. Thus, the effective cost of providing a service may be higher than the cost incurred by government.

KEY DEFINITIONS

The homeless individuals included in this study are those people who are literally without shelter and who live on the street. These same people sometimes stay in emergency shelters for accommodation. The second group of people included in this study is housed, formerly absolute homeless individuals. The costs estimated are government costs.

METHODOLOGY

This study is used case histories and service use records, and begins with a review of existing published literature on the relationship between homelessness and the health care, criminal justice and social services systems. It found growing interest in estimating the costs of homelessness. While few published studies were located that dealt specifically with this issue, a number are currently underway. Completed studies find that additional costs are incurred to serve homeless individuals compared to others, even low-income individuals. In addition to reviewing the substantive findings of published cost studies, the literature review called for guidance on methodological issues.

KEY FINDINGS

Homeless individuals tended to use more costly emergency type services than the housed individuals. For the homeless individuals in this study, the cost of service use exclusive of housing was 33 per cent higher than the housed individuals for the one year time period. When the costs of housing are included, the data showed that providing adequate supportive housing for these homeless individuals saved money.

The prevention approach proved to be more cost-effective than the emergency or reactive approach for this small sample. Focusing on reducing the use of costly government funded health care, criminal justice and social services through the provision of supportive housing for homeless people makes good sense from financial perspective. This approach also has the benefit of improving the quality of life and well-being of homeless people.

The interviews and service records suggest that in most cases, housing had a positive impact on people's lives. While supportive housing is cost-effective compared to emergency shelters, emergency facilities will continue to be an important component of the housing continuum. Emergency shelters are not meeting current needs, and emergency capacity to meet crisis and other needs will continue to be necessary.

Supportive housing is best viewed as an option for the chronic homeless—people who tend to be continual users of some combination of emergency shelters, hospital emergency wards and the criminal justice system.

These preliminary findings suggest if minimizing government costs is a goal, public policy and service delivery must be focused on the prevention of homelessness.

Fountain, J., Howes, S., Marsden, J. Taylor, C. & Strang, J. (2003). Drug and alcohol use and the link with homelessness: Results from a survey of homeless people in London. ***Addiction Research and Theory,*** **11(4), 245-256.**

OBJECTIVES
This UK study sought to examine the links between homelessness and drug and alcohol use.

METHODOLOGY
A community survey using a structured questionnaire was used with 389 homeless people currently or recently sleeping rough (on the streets) in London. Data were collected on respondents' histories of homelessness and of substance use, and dependence on the main substance used in the last month was measured.

KEY FINDINGS
In the month before the interview, 83% (324) of the sample had used a drug, 36% (139) were dependent on heroin and 25% (97) on alcohol. Sixty-three per cent (244) reported that their drug or alcohol use was one of the reasons they first became homeless, but the majority (80%, 310) had used at least one additional drug since then.

Overall, drug and alcohol use, injecting, daily use and dependency increased the longer the respondents had been homeless. A clear link exists between substance use and homelessness: initiatives to tackle homelessness must also tackle the drug use of homeless people.

Frankish, C.J., Hwang, S.W. & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health,* 96(2), S23-S29, from: http://journal.cpha.ca/index.php/cjph/article/view/1493/1682

OBJECTIVES
Report was undertaken to provide an overview of homelessness research and to stimulate discussion on strategic directions for research.

METHODOLOGY
The authors identified studies on homelessness, with an emphasis on Canadian research. Studies were grouped by focus and design under the following topics: the scope of homelessness, the health status of homeless persons, interventions to reduce homelessness and improve health, and strategic directions for future research.

KEY FINDINGS

- A definition of 'homelessness' was developed that reflects its scope and heterogeneity. Competing explanations of homelessness were explored; homeless people suffer from higher levels of disease and the causal pathways linking homelessness and poor health are complex.
- Efforts to reduce homelessness and improve health have included biomedical, educational, environmental, and policy strategies. Significant research gaps and opportunities exist in these areas. Strategic research will require stakeholder and community engagement, and more rigorous methods. Priorities include achievement of consensus on measuring homelessness, health status of the homeless, development of research infrastructure, and ensuring that future initiatives can be evaluated for effectiveness.
- Initiatives to address homelessness require the involvement of a wide range of stakeholders, including all levels of government, service providers, health professionals, researchers, community groups and homeless people themselves. Both horizontal integration across various sectors, and vertical integration across levels of governments, and within communities are needed.
- The diversity of values, beliefs and perspectives on homelessness must be acknowledged, and public discourse is needed on the causes of homelessness in Canada and the appropriate response to this problem. Consensus needs to reached on the definition of homelessness and the measures by which efforts to reduce homelessness or improve the quality of life of homeless people will be judged.
- Researchers need to design and conduct studies on homelessness that are policy relevant and develop strategies to translate their research into policy and practice. There has been little research evaluating the effects of policy on homelessness or quality of life among the homeless and the vast majority of programs for homeless people have not been evaluated. Many of the

evaluations that have been conducted are of modest quality, but at the present time, the resources and expertise that would allow for a robust evaluation are often not available at the local level.

The authors suggest three strategic priorities:

1. A nationwide effort to achieve a core, consensus definition and set of indicators related to the definition and extent of homelessness.
2. Clear definitions and measures for a) the health status of homeless (and at-risk) groups; b) the use of the health and social services by homeless people; and c) relations between homelessness and broader, non-medical determinants of health (e.g., income, education, employment, social support, gender, culture, etc.).
3. The development of research infrastructure. This effort would include the development of demonstration projects or surveillance systems that could reliably collect data on the indicatorsof homelessness. Government funded projects that purport to address either the processes or outcomes of homelessness should be subjected to an “evaluability” assessment. This effort could move research toward a model of program evaluation that sets realistic expectations in terms of measurement of focussed aspects of homelessness, and one that provides sufficient time and resources to allow for appropriate assessment of homelessness interventions and their effects.

Hickert, A. O. & Taylor, M. J. (2011). Supportive housing for addicted, incarcerated homeless adults. *Journal of Social Service Research, 37*(2), 136-151.

OBJECTIVES
This study examined outcomes for clients (*N* = 102) of a new supportive housing intervention.

METHODOLOGY
The use of formal treatment, jail contact, and community stability were compared pre- and post-housing.

KEY FINDINGS
Jail bookings and residential substance abuse treatment significantly declined post-housing, while clients improved in income level, access to food, and housing stability. Results from official justice and treatment system data suggest that supportive housing can lead to significant changes. Future research is necessary to understand the relationship between client characteristics and outcomes.

Homeless link, Housing Corporation, London Housing Foundation (2007). Clean Break. Integrated housing and care pathways for homeless drug users, *Research Summary*, from: http://www.homeless.org.uk/sites/default/files/cleanbreak_0.pdf

OBJECTIVES
This report focused on how housing and treatment services can work together more effectively to support treatment outcomes and reduce the risk of homelessness among drug users engaging in treatment.

KEY FINDINGS
The lack of appropriate housing for 'drug users' leads to:

- Housing in which people who are trying to reduce or abstain from substance use live alongside those still 'actively using'
- Inappropriate referrals to existing supported housing
- Lack of supportive housing for some people who are forced to 'sleep rough'
- An increased risk of relapse and wasted investment

Service users emphasized the importance of:

- Separation from 'active drug users' for people who are seeking to end/reduce their substance use
- Good quality housing as a reward/incentive for positive treatment outcomes
- Support with drugs and housing at the same time
- Access to ongoing support post-treatment.

Solutions developed included:

- Development of a systems approach that links housing and treatment agencies together in a mutually supportive way.
- Greater joint working relationships between housing and treatment agencies to enable a more holistic response to the complex needs of homeless drug users.
- Clearer pathways that are understood by all relevant agencies to and between housing and treatment services.
- Greater flexibility and capacity amongst housing providers to respond effectively when needs and levels of problematic drug use change.
- Development of a stronger evidence base from which to build local support for investment in and access to services for 'drug users'.
- A multi-agency approach that pools resources and creates added value to the delivery of supportive housing.

Jason, L.A., Olson, B.D., Ferrari, J.R., Majer, J.M., Alvarez, J. & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. Addiction, 102, 1114-21

OBJECTIVES

This US study assessed the effectiveness of community-based supports in promoting abstinence from substance use and related problems.

KEY DEFINITIONS

Oxford Houses are democratic, self-run recovery homes.

METHODOLOGY

Individuals (n = 150) discharged from residential substance abuse treatment facilities were assigned randomly to either an Oxford House recovery home or usual after-care condition and then interviewed every 6 months for a 24-month period. Hierarchical linear modeling was used to examine the effect of predictive variables on wave trajectories of substance use, employment, self-regulation and recent criminal charges. Regressions first examined whether predictor variables modeled wave trajectories by condition (Oxford House versus usual after-care), psychiatric comorbidity, age and interactions.

KEY FINDINGS

At the 24-month follow-up, there was less substance abuse for residents living in Oxford Houses for 6 or more months (15.6%), compared both to participants with less than 6 months (45.7%) or to participants assigned to the usual after-care condition (64.8%). Results also indicated that older residents and younger members living in a house for 6 or more months experienced better outcomes in terms of substance use, employment

and self-regulation. Oxford Houses appear to help stabilize many individuals who have substance abuse histories.

Kemp, P. A., Neale, J. & Robertson, M. (2006). Homelessness among problem drug users: prevalence, risk factors and trigger events. *Health and Social Care in the Community, 14,* 319-328.

OBJECTIVES
This paper uses data from a prospective cohort study of 877 problem drug users entering treatment in Scotland to extend knowledge of homelessness and drug misuse in three important respects.

- First, the prevalence of homelessness among problem drug users is investigated;
- Second, key risk factors for homelessness among problem drug users are identified; and
- Third, trigger events associated with movements into or out of homelessness by problem drug users over time are explored.

METHODOLOGY
Data were collected during two waves of interviewing which were conducted 8 months apart.

KEY FINDINGS
Thirty-six per cent of problem drug users entering treatment were homeless at either or both interviews, a prevalence rate that is at least seven times greater than the general population. While many of the risk factors found to be associated with homelessness are common to homeless people in general, at least one homelessness risk factor – recent drug injection – is clearly specific to those who take drugs. Movements into homelessness among problem drug users were associated with recently losing residency of children, other recent family problems and worsening general health. Movements out of homelessness were associated with not having recent family problems. The findings provide empirical support for the good practice guidelines now being published by UK Government, but also suggest that the relatives of problem drug users should be offered increased assistance to help them deal with the many stresses that having a drug-dependent family member can generate.

Eberle, M. & J Woodward & Assocaites Inc. (2005). Review of alcohol and drug free housing for people in recovery from substance use. *Executive Summary prepared for Prepared for Vancouver Coastal Health*, from: http://www.niaby.com/CityHallReports/ADFhousingExecutiveSum.pdf

OBJECTIVES
This report presents an overview of seven initiatives that provide alcohol and drug free supported housing. Three of the initiatives are from Canada, two are from the U.S., one is from the U.K., and one is from Australia.

METHODOLOGY
Selection criteria included programs where the housing:

- Is provided to individuals following a treatment or supportive recovery program;
- Is a place to live rather than a place to receive treatment (e.g. treatment programs are not
- provided on site)
- Supports the recovery process and some support is available to the residents/tenants;
- Has some connection to treatment services; and
- Is available to the residents/tenants for longer than most treatment programs (e.g.1-2 years).

KEY FINDINGS
The seven housing initiatives profiled in this report show that while not all clients are able to maintain abstinence while in alcohol and drug free housing, these programs can result in positive outcomes for many participants. These include better health, reintegration into the community, increased income through employment, and ability to access and maintain permanent housing.

Kraus, D. (2001). Housing for people with alcohol and drug addictions: An annotated bibliography. *The City of Vancouver, Housing Centre*, from http://vancouver.ca/commsvcs/housing/pdf/Kraus.PDF

OBJECTIVES
This report was prepared for the City of Vancouver to assist in their development of Segal Place, a social housing project at 55 East Hastings. The City is interested in studies of the effect of offering housing as an intervention for people with issues relating to the use of substances, including alcohol and drugs.

KEY DEFINITIONS
Wet housing: units in which the use of drugs and alcohol is tolerated.
ADF housing: alcohol and drug-free (ADF) living alternatives.

METHODOLOGY

This report provides an annotated bibliography of 32 studies that consider the role of housing for people with alcohol and drug use issues. Topics that are addressed include:

- The relationship between alcohol and drug services and housing for homeless or at-risk individuals.
- Different types of approaches/housing models such as supported housing, a continuum approach, housing where the use of drugs and alcohol is permitted, and alcohol and drug-free housing.
- Components of a comprehensive strategy to address the needs of individuals with issues related to the use of alcohol and drugs.

KEY FINDINGS

The literature demonstrates the importance of housing in providing alcohol and other drug treatment and recovery services to homeless and homeless at-risk individuals.

There is a need for communities to be able to provide access to a comprehensive package of services and types of housing including entry level shelters where alcohol and drug use is permitted, post-detoxification stabilization services, residential recovery facilities, transitional housing, low demand (wet) housing, supported housing, and permanent housing, some of which is alcohol and drug-free.

Further research is necessary to determine how housing and support/treatment models can meet the needs of people who have co-occurring substance use and mental health problems.

Although it is clear that housing is a necessary pre-condition for addressing the needs of individuals with issues related to the use of alcohol and drugs, the provision of housing alone is not a guarantee that people will be able to maintain sobriety or achieve housing stability. In many cases, some form of support or treatment will be necessary. The nature and level of needed services will vary with each individual.

Kraus, D., Serge, L. & Goldberg, M. (2006). Housing and services for people with substance abuse and mental health issues. *Report prepared by the Social Planning and Research Council of BC (SPARC BC) for the Housing and Homelessness Branch, Human Resources and Social Development Canada*, from:
www.sparc.bc.ca/component/.../68-report-housing-and-services.pdf

OBJECTIVES

The purpose of this report is to highlight key findings from two studies that the authors recently completed for the federal government. These are:

- Homelessness, Housing, and Harm Reduction: Stable Housing for Homeless People with Substance Use Issues, prepared for Canada Mortgage and Housing Corporation
- Services to Homeless People with Concurrent Disorders: Moving Towards Innovative Approaches, prepared for the Housing and Homeless Branch (HHB) of Human Resources and Social Development Canada.

METHODOLOGY

Both studies involved a review of relevant literature and preparation of case studies through interviews with agency key informants. A total of 21 case studies were completed: 13 for the CMHC study, and 8 for the HHB study. Interviews were also conducted with 3- 4 residents involved with 16 of the case studies

KEY FINDINGS

The CMHC study examined innovative approaches to providing housing stability for homeless people with substance use issues, many of whom are living with concurrent disorders (substance use and mental health issues). All of these projects incorporate a harm reduction approach.

The authors recommend:

1. **Housing First**. Policies and programs for addressing homelessness need to allow for a housing first approach so that people who are homeless can have direct access to permanent housing, with support as needed and wanted.
2. **Housing responsive to client needs**. The importance of housing must be recognized in any program that is created to address the needs of people with substance use and mental health issues. This includes housing where the residents feel safe and where the housing providers understand their tenants. A range of options is necessary, including stable housing that incorporates a harm reduction approach or is alcohol and drug free – but above all is responsive to the wants and needs of the residents.
3. **Permanent and transitional housing**. The issue of transitional housing needs to be reconsidered as a program and policy response to homelessness. In situations where suitable, permanent housing is not available, and for clients who will require ongoing support, there is a fundamental question of why transitional housing (with a maximum length of stay) should be considered as a viable program option. The CMHC and HHB studies raise serious questions as to the role that transitional housing plays in contributing to the cycle of stability/instability.
4. **Approach to services**. Policies and programs should be based on the principle of "putting the client at the centre". Some approaches that seem to be consistent with this approach include developing trusting and respectful relationships with clients, flexible support (i.e. being available when needed), using techniques such as motivational interviewing, focusing on strengths and capacities of each individual, and presenting real opportunities for positive changes and achieving personal goals.

5. **Harm reduction**. There is increasing awareness of the concept of harm reduction, yet it is not widely understood. This report recommends greater education and information about harm reduction and how it can work. Increased understanding and information about the potential for harm reduction to achieve positive outcomes should result in greater support and acceptance.
6. **Integration of services**. There is a need to move towards an integrated system of mental health and substance use services for homeless persons with concurrent disorders. This report recommends that the federal and provincial governments take a leadership role in promoting and implementing the integration of mental health and substance use services. It is clear that when services are offered to people in a seamless manner, successful outcomes are possible, and clients can move forward in their lives.
7. **Approach to substance use**. In developing new programs, policy makers should move away from an either/or approach and acknowledge that both abstinence-based and harm reduction initiatives can successfully meet the needs of different clients. Consistent with a client-centred philosophy, clients should be able to choose programs that will help them achieve their own goals. This approach should help to end the cycle of people entering programs, leaving when they relapse, and trying again.
8. **Staff**. Another critical factor for success that is strongly underlined in both the CMHC and HHB studies is the importance of staff – the relationships that they form with the clients, and the qualities that are essential – being flexible, nonjudgemental, honest, trustworthy, and having commitment and patience. Programs for people with substance use and/or mental health issues need to recognize the importance of staff. Programs require sufficient funding to attract and maintain skilled staff, to provide ongoing staff training and to hire enough staff. At the same time, agencies need support and guidance to determine what kind of training and skills staff are needed to work effectively with people with concurrent disorders.
9. **Meaningful activities**. Agency key informants and clients who participated in interviews identified the need for recreational, occupational and vocational support. Many participants made it clear that they need to keep busy and wish to be productive members of society – through volunteer or paid employment. Programs for people with substance use and mental health issues need to build in opportunities for their clients to engage in activities that are meaningful to them, and help them achieve their personal goals.

Further research directions

1. **Dedicated and scattered site housing**. There is a need to learn more about the advantages and disadvantages of dedicated housing compared to a scattered sites approach, and under what circumstances it will be more advantageous to choose one approach over the other.

2. **Community integration**. The two studies raise questions about what are some of the best ways to help people who have been homeless develop social networks and become integrated into the community.
3. **Co-existence of residents who are abstinent and those who continue to consume**. The studies identified concerns about what happens in dedicated buildings when some residents become abstinent while others continue to consume. It would be useful to identify successful strategies for dealing with the co-existence of residents who are abstinent (particularly those who are newly abstinent) with those who aren't.
4. **Better outcome data**. One of the greatest challenges posed by this study was the analysis of outcomes and trying to understand the effectiveness of the various programs and approaches undertaken by the initiatives profiled. As with all research on homelessness, the information on outcomes is very limited; often only anecdotal information is available. There is need to identifying the best methods to systematically gather data about outcomes. The systematic collection of outcome data must recognise that the participating organizations will require additional funding. Organizations may also require some research expertise in setting up the data collection methods for such outcome research.
5. **Data on medium and long-term change over time**. The information gathered in this study does not yield strong data on the stability over time of clients that were served. Information about medium and longer term outcomes in a sample of the individuals would allow comparison of outcomes and an ability to draw conclusions about what kind of intervention, for what kind of clientele is most effective.
6. **Better understanding of what constitutes long-term supportive environments**. Some key informants and participant interviews emphasize that clients need environments that are supportive in the long run. It would be useful to better understand what an ideal environment would be. For example, is removing people from their previous neighbourhood a positive practice, since they are away from the influences that might lead to a relapse or do they also leave all support and social networks? How do people integrate into "mainstream" society? Are there specific supports that can help them?
7. **Strategies to help clients access and maintain housing stability in the community**. There is a need to identify and document the key elements for success that make it possible for some agencies to help their clients access and *maintain* scattered site housing within private and non-profit buildings.
8. **A range of treatment and housing options in smaller communities**. This study points to the need for a range of options for this client group to ensure long-term stabilisation. However, it is not clear how realistic it is to expect such a range outside of the large urban centres. There is a need to better understand the options and possible means to deliver such a range, no matter where the potential client may live.

9. **Better understanding of organisations and the role of staff**. This is a key component and there is a need to know more about staff qualities, training, composition of teams, salaries, etc. needed for success.
10. **Organizational leadership**. It would be most interesting to learn what it is about certain organizations that creates an environment where, even in a context of constant and high demands, they are able to develop and implement innovative responses to meet their clients' needs.

Martinez, T. E. & Burt, M. R. (2006). Impact of permanent supportive housing on the use of acute care health services by homeless adults. *Psychiatric Services, 57*(7), 992-999.

OBJECTIVES
This US analysis examined the impact of permanent supportive housing on the use of acute care public health services by homeless people with mental illness, substance use disorder, and other disabilities.

METHODOLOGY
The sample consisted of 236 single adults who entered supportive housing at two San Francisco sites, Canon Kip Community House and the Lyric Hotel, between October 10, 1994, and June 30, 1998. Eighty percent had a diagnosis of dual psychiatric and substance use disorders. Administrative data from the city's public health system were used to construct a retrospective, longitudinal history of service use. Analyses compared service use during the two years before entry into supportive housing with service use during the two years after entry.

KEY FINDINGS
Eighty-one percent of residents remained in permanent supportive housing for at least one year. Housing placement significantly reduced the percentage of residents with an emergency department visit (53 to 37 percent), the average number of visits per person (1.94 to .86), and the total number of emergency department visits (56 percent decrease, from 457 to 202) for the sample as a whole. For hospitalizations, permanent supportive housing placement significantly reduced the likelihood of being hospitalized (19 to 11 percent) and the mean number of admissions per person (.34 to .19 admissions per resident).
Providing permanent supportive housing to homeless people with psychiatric and substance use disorders reduced their use of costly hospital emergency department and inpatient services, which are publicly provided.

Neale, J. & Kennedy, C. (2002). Good practice towards homeless drug users: Research evidence from Scotland. *Health and Social Care in the Community, 10(*3), 196-205.

OBJECTIVES
The aim of the paper is to further understanding of how best to provide support to homeless drug users by examining good practice from the perspectives of both service providers and service users.

METHODOLOGY
Data were collected from 48 semi-structured interviews (12 with staff and 36 with clients) conducted in six case study agencies (three homelessness agencies and three drug agencies). Interviews were audio-recorded and the data were analysed using Framework.

KEY FINDINGS
Findings from the study revealed that good practice related to five broad areas. These were: (1) staffing; (2) agency environment; (3) support provided; (4) service delivery; and (5) agency aims and objectives. Similarities between the views of service providers and users were evident. However, differences of opinion suggested that the best definitions of good practice are achieved by consultation with a range of stakeholders (including staff and clients). Data also showed that good practice is fundamentally related to the qualitative and intangible aspects of service provision, and not just to more easily quantifiable inputs, processes, outputs and outcomes. The paper concludes by arguing that evaluation frameworks must accommodate this complexity, and thus, begin to portray good practice in a more accurate and meaningful light.

The Ontario HIV Treatment Network (2009). Rapid Review Response: Housing and Harm Reduction, from http://www.ohtn.on.ca/Documents/Knowledge-Exchange/RR_housing_harm-reduction.pdf

OBJECTIVES
This Canadian literature review examined housing first and abstinence-based programs to explore the type and effectiveness of housing programs for people who are homeless or at risk of homelessness and use substances to help them access and maintain stable housing.

KEY FINDINGS
Some of the issues that revolve around housing readiness and access to housing illustrate the “grey zones” that appear in a harm reduction approach. Thus some projects did have expectations of behavior and participation, benefiting from the supports offered, refusing services offered, and agreeing to a psychiatric report. While

some of the harm reduction approaches have a certain number of expectations, behavioral issues that might jeopardize a client's tenancy are addressed through support and building open, non-judgmental relationship with each resident. Motivational interviewing is used to help clients develop the desire to make positive changes through the process of articulating and pursuing their own personal goals."

There is increasing awareness of the concept of harm reduction, but it is not widely understood. There is a need for greater education on harm reduction and methods on how it can work in different settings. Similarly, while many communities have progressed towards adopting housing first approaches and introducing initiatives to respond to homelessness, community leadership is essential to raise awareness and foster cooperation among major stakeholders."

Assuming a client-centered approach and focusing on individual goal setting may be the most flexible and responsive program to client needs and help to end the cycle whereby people enter programs, leave when they relapse, and try again. A client centered approach, however, does not negate the possibility of abstinence or reduction of substance use. "A client-centered approach requires access to a range of housing options – that is, wet and dry, scattered and dedicated – as well as a variety of service options for the residents. This allows clients to decide what is best for themselves, effectively reducing the chances of relapse."

Housing pilots and programs with harm reduction approaches require solid governance frameworks and organizational structures to ensure cohesive approaches to housing and service delivery, including ongoing review and monitoring efforts to ensure effectiveness and accountability to users, funders and the general public.

Policy makers need to move away from an either/or approach (abstinence based or harm reduction) and acknowledge that both types of initiatives can meet the needs of different clientele.

Padgett, D., Gulcur, L. & Tsemberis, S (2006). Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice, 16*, 74-85, from: http://www.pathwaystohousing.org/Articles/PTHPublications/Padgett_RSWP_Jan_06.pdf

OBJECTIVES
This research examines the contrast between housing first and treatment first program philosophies.

KEY DEFINITIONS
H**ousing first program:** offers immediate permanent housing without requiring treatment compliance or abstinence)

METHODOLOGY
This study draws on data from a longitudinal experiment contrasting a housing first program and treatment first programs for 225 adults who were homeless with mental illness in New York City.

KEY FINDINGS
After 48 months, results showed no significant group differences in alcohol and drug use. Treatment first participants were significantly more likely to use treatment services. These findings, in combination with previous reports of much higher rates of housing stability in the housing first group, show that "dual diagnosed" adults can remain stably housed without increasing their substance use. Thus, housing first programs favoring immediate housing and consumer choice deserve consideration as a viable alternative to standard care.

Pathways to Housing. (2005). Providing Housing First and Recovery Services for Homeless Adults With Severe Mental Illness. *Psychiatric Services, 56*(10), from: http://ps.psychiatryonline.org/article.aspx?articleid=90635

KEY FINDINGS
Describes Pathways to Housing

Patterson, M., Somers, J., McIntosh, K., Shiell, A. & Frankish, C. J. (2007) Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia. ***Centre for Applied Research in Mental Health and Addiction Faculty of Health Sciences, Simon Fraser University,*** **from:**
http://www.carmha.ca/publications/documents/Housing-SAMI-BC-FINAL-PD.pdf

OBJECTIVES
Provides up-to-date information with regard to the scope of the housing problem, recommended solutions and associated costs.

KEY DEFINITIONS
Absolutely homeless: people who live on the streets, cycle through shelters and rooming houses, as well as those at imminent risk of becoming homeless – people who live in substandard or illegal accommodation and lack support for their mental illness and/or addiction.
SAMI: (Severe Addiction and/or Mental Illness) includes all of the major Axis I disorders as defined by the Diagnostic and Statistical Manual (DSM-IV-TR), focusing on those individuals whose functional capacity is seriously compromised. This definition includes severe forms of substance use, eating, and anxiety disorders as well as mood and psychotic disorders.

METHODOLOGY
The Centre for Applied Research in Mental Health and Addiction Faculty of Health Sciences, Simon Fraser University (CARMHA) drew upon diverse sources of information including published literature, academic experts, decision-makers and key informants throughout BC in order to generate answers to some of the most pressing questions regarding the needs of this population. This report focuses on adults between the ages of 19 and 80 years, recognizing that homeless youth (with or without SAMI) have a number of unique needs which are an appropriate focus of concern in their own right.

KEY FINDINGS
A multitude of reports and studies over the past decade have established wide-spread consensus on what is needed to combat homelessness: a coordinated system to provide a continuum of supported housing options; programs to increase the supply of low-cost housing and preserve existing low-cost housing; measures to address affordability; education and advocacy to win public support; the involvement of homeless people in creating strategies for homelessness. A great deal of interest and support has developed around homelessness and SAMI in BC; it is time to build on these first steps.
The population of absolutely (street) homeless adults with SAMI (approximately 11,750) can be used as a starting point for describing the need for new units and services.

Podymow, T., Turnbull, J., Yetisir, E. & Wells, G. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. *Canadian Medical Association Journal*, *174*(1).

OBJECTIVES
Examines the shelter-based Managed Alcohol Project (MAP) was created to deliver health care to homeless adults with alcoholism and to minimize harm; its effect upon consumption of alcohol and use of crisis services is described as proof of principle.

METHODOLOGY
Subjects enrolled in MAP were dispensed alcohol on an hourly basis. Hospital charts were reviewed for all emergency department (ED) visits and admissions during the 3 years before and up to 2 years after program enrolment, and the police database was accessed for all encounters during the same periods. The results of blood tests were analyzed for trends. A questionnaire was administered to MAP participants and staff about alcohol use, health and activities of daily living before and during the program. Direct program costs were also recorded.

KEY FINDINGS
Seventeen adults with an average age of 51 years and a mean duration of alcoholism of 35 years were enrolled in MAP for an average of 16 months. Their monthly mean group total of ED visits decreased from 13.5 to 8 ($p = 0.004$); police encounters, from 18.1 to 8.8 ($p = 0.018$). Changes in blood test findings were nonsignificant. All program participants reported less alcohol consumption during MAP, and subjects and staff alike reported improved hygiene, compliance with medical care and health. Interpretation: A managed alcohol program for homeless people with chronic alcoholism can stabilize alcohol intake and significantly decrease ED visits and police encounters.

Pomeroy, S. (2006). Proactive vs. reactive responses to homelessness: A costing analysis. *Presentation to The Alliance to End Homelessness Community Forum. Ottawa, ON*,from: intraspec.ca/ProactiveversusReactiveResponsestoHomelessness.ppt

KEY FINDINGS
Cost analysis concluded:

- Supportive and Residential programs are an effective investment
- Opportunities for improving use of existing resources and redirecting new investment to community services
- Focus on prevention and diversion

Pomeroy, S. (2005). The Cost of Homelessness: Analysis of Alternate Responses in Four Canadian Cities. *Report Prepared for National Secretariat on Homelessness*, from http://www.homelesshub.ca/%28S%28qnvqxzm21q15fm55lmumwy45%29%29/ResourceFiles/Cost_of_Homelessness_Pomeroy_English.pdf

OBJECTIVES
The primary research question examined is the relative cost of addressing homelessness through institutional and emergency response systems, such as psychiatric hospitals and treatment centres and emergency hostels and shelters compared to purposefully designed community based supportive and affordable housing.

METHODOLOGY
The cost analysis used two approaches. The first approach examined a cross section of existing institutional, emergency and supportive housing in each city. Costs were extracted from recent financial statements or obtained directly from operators.

One issue in using the costs of existing service providers is that they typically operate in premises that are either owned outright by the operator, or were funded and receive ongoing subsidies based on historic building costs that are no longer realistic. Accordingly a second step in the costing process involved the development of cost estimates assuming the premises were built at today's costs.

The new developments are assumed to carry ongoing subsidies to fully amortize the capital cost of this new development (based on assumption that any rent payments used to support operating and mortgage financing derive from income assistance and are thus an indirect additional public cost).

In both cases, support service costs are added to the property operating and debt servicing costs to determine total ongoing cost estimates. These current costs are then compared against a range of institutional and emergency operations. Comparisons are on a per day and annualized basis.

KEY FINDINGS
- Community/residentially based options – even when a fairly high level of service is provided are cost effective. Institutional uses often incur daily costs well in excess of $200/day and depending on facility and city reaches as high as $600/day.
- Emergency services also tend to involve higher costs than the community/residentially based options. On a daily basis costs to operate emergency shelters – providing a bed, three meals and minimal supports, are in the order of $25-$110. The low end reflecting only overnight dormitory style accommodation; the high end including 24/7 service and a higher degree of

support services; these vary across cities, facilities and across client groups. They are lower for singles than families, although if determined on a per person basis this later variation would be much narrower (the high end reflects mainly meal allowances for a 4 person household living in a motel).
- The cost estimates for transitional and supportive housing suggest a wide range mainly due to the very diverse range of client types. However, even at the high end (roughly $60 per day) these are lower than institutional and emergency costs.

On an annualized basis costs in existing responses, averaged across the four cities are:
- Institutional responses (prison/detention and psychiatric hospitals): $66,000 to $120,000;
- Emergency shelters (cross section of youth, men's women's, family and victims of violence): $13,000 to $42,000;
- Supportive and transitional housing: $13,000 to $18,000; and
- Affordable housing without supports (singles and family): $5,000 to $8,000.

Stein, J. Dixon, E. & Nyamathi, A. (2008). Effects of psychosocial and situational variables on substance abuse among homeless adults. *Psychology of Addictive Behaviors, 22* , 410-416.

OBJECTIVES
Finding direct and indirect influences of salient psychosocial and situational variables on problem substance use among homeless people is important in designing evidence-based, effective, and relevant interventions for this special population

METHODOLOGY
A stress-coping paradigm in conjunction with situational items specialized for homeless people was used to explore predictive relationships in a sample of homeless adults (N = 664) among (a) psychosocial variables of self-esteem, social support, positive and negative coping, and emotional distress, (b) situational variables of homelessness history and quality of recent housing, and (c) outcomes of alcohol use, injection drug use (IDU), and non-IDU.

KEY FINDINGS
Lower self-esteem predicted greater emotional distress, lower positive coping, greater negative coping, and more alcohol use. Social support predicted less emotional distress and more positive coping. Chronic homelessness predicted more emotional distress, less positive coping, greater alcohol use, and IDU. Poor housing was associated with more alcohol use and IDU. Substance abuse interventions among the homeless should have a dual focus that includes attention to psychological issues and negative coping patterns

while also addressing situational, environmental factors, including encouraging provision of permanent supportive housing.

Tsemberis, S. & Asmussen, S. (1999). From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model *Alcoholism Treatment Quarterly* 17.1/2 (1999): 113-131.

OBJECTIVES
This paper describes essential elements of the Consumer Preference Supported Housing (CPSH) Model of homelessness prevention in use at Pathways to Housing, Inc in New York City.

METHODOLOGY
In a randomized controlled study, individuals who are currently homeless and have psychiatric disabilities and/or substance abuse problems are randomly assigned to either the CSPH intervention or an intervention using the linear continuum model. Participants will be followed for a period of one year and the study will provide feedback regarding the effectiveness of the CSPH model.

KEY FINDINGS
The intervention prevents homelessness by engaging and housing homeless substance abusers with psychiatric disabilities who have been viewed by other programs as "treatment resistant" or "not housing ready". The CPSH model is built on the belief that housing is a basic right for all people. As opposed to the housing continuum model, housing is based on consumer choice and is not connected to compliance or treatment. Housing is provided immediately, and there are separate criteria for housing and treatment needs. Support services are aimed at integration of mental and substance abuse services.

Tsemberis, S., Gulchur L. & Nakae M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

OBJECTIVES
The authors examined the longitudinal effects of a Housing First program for homeless, mentally ill individuals' on those individuals' consumer choice, housing stability, substance use, treatment utilization, and psychiatric symptoms.

METHODOLOGY
Two hundred twenty-five participants were randomly assigned to receive housing contingent on treatment and sobriety (control) or to receive immediate housing without treatment prerequisites (experimental). Interviews were conducted every 6 months for 24 months.

KEY FINDINGS
The experimental group obtained housing earlier, remained stably housed, and reported higher perceived choice. Utilization of substance abuse treatment was significantly higher for the control group, but no differences were found in substance use or psychiatric symptoms.
Participants in the Housing First program were able to obtain and maintain independent housing without compromising psychiatric or substance abuse symptoms.

Tsemberis, S. & Eisenberg, R. (2000). Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. *Psychiatric Services* 51 (4): 487–93.

OBJECTIVES
This study examined the effectiveness of the Pathways to Housing supported housing program over a five-year period. Unlike most housing programs that offer services in a linear, step-by-step continuum, the Pathways program in New York City provides immediate access to independent scatter-site apartments for individuals with psychiatric disabilities who are homeless and living on the street. Support services are provided by a team that uses a modified assertive community treatment model.

METHODOLOGY
Housing for the Pathways sample of 242 individuals housed between January 1993 and September 1997 was compared a citywide sample of 1,600 persons who were housed through a linear residential treatment approach during the same period. Survival analyses examined housing tenure and controlled for differences in client characteristics before program entry.

KEY FINDINGS
After five years, 88 percent of the program's tenants remained housed, whereas only 47 percent of the residents in the city's residential treatment system remained housed. When the analysis controlled for the effects of client characteristics, it showed that the supported housing program achieved better housing tenure than did the comparison group.

The Pathways supported housing program provides a model for effectively housing individuals who are homeless and living on the streets. The program's housing retention rate over a five-year period challenges many widely held clinical assumptions about the relationship between the symptoms and the functional ability of an individual. Clients with severe psychiatric disabilities and addictions are capable of obtaining and maintaining independent housing when provided with the opportunity and necessary supports.

Vancouver Community, Vancouver Coastal Health. (2006). A Mental Health & Addictions Supported Housing Framework, from http://vancouver.ca/commsvcs/housing/supportivehousingstrategy/pdf/VCHSuppHouFramework.pdf

OBJECTIVES
This plan, specifically focused on Vancouver, is an update of the previous strategic planning and is designed to link with the *City of Vancouver Homeless Action Plan* (2005).

KEY FINDINGS
The City plan to address homelessness identifies the need for both independent affordable housing and supported housing for a broad range of vulnerable populations over the next 10 years. The VCH plan looks at a similar timeframe; however, this plan focuses specifically on the housing needs of individuals with mental illness and /or substance use issues and co-occurring chronic health conditions. While not addressed in this plan, housing and support planning and development related to individuals with physical disabilities, acquired brain injuries and seniors with health conditions are being undertaken simultaneously.

Vancouver Community, Vancouver Coastal Health. (2007). Supportive Housing Strategy for Vancouver Coastal Health's *Mental Health & Addictions Supported Housing Framework , from* *http://vancouver.ca/commsvcs/housing/supportivehousingstrategy/pdf/StrategyJune2007.pdf*

OBJECTIVES

This Strategy builds on the Vancouver Coastal Health (VCH) document *A Mental Health & Addictions Supported Housing Framework,* April 2006.

KEY DEFINITIONS

Supportive housing: affordable housing that provides opportunities for individuals to stabilize their personal situation and re-establish connections with the community. The housing is linked to support services that are voluntary and flexible to meet residents' needs and preferences. The level of support may vary: in some instances, support services are provided through on-site staff, while in others support may be delivered on an outreach basis. Housing may be located in social housing buildings where all the units are supported (dedicated), or social housing buildings where some of the units are supported (mixed), or in scattered market apartments with rent supplements. The relationship between the resident and landlord is generally governed by the Province's Residential Tenancy Act.

Addictions Supported Housing: for people in recovery from addiction who want to live in an alcohol and drug free environment

Low Barrier Housing: for people not yet be engaged in any treatment

Mental Health Supported Housing: for people engaged in mental health treatment

KEY FINDINGS

In June 2005 City Council adopted the Homeless Action Plan (HAP) that identified actions which the City, other levels of government, the community and business can take to address the problem of homelessness. One of the actions was: *"The City to work with Vancouver Coastal Health and the Provincial Government to develop a strategy to locate supportive and transitional housing throughout the city."* This Strategy is the implementation of that recommendation.

This document defines supportive housing, discusses how it is developed and operated, looks at who is housed, and how they access housing, and makes recommendations for the future.

There are several other companion documents provided by VCH including:

- *A Mental Health and Addiction Framework for Services*
- *Housing for People with Substance Use and Concurrent Disorders: Summary ofLiterature and Annotated Bibliography*
- *Review of Alcohol and Drug Free Housing for People in Recovery from Substance Use – Executive Summary*
- These documents can be accessed through the City's web site (http://www.vancouver.ca/housing/ supportivehousingstrategy/).

Wynn, M. (2006). Concurrent Disorders and Housing Project: Needs Report. *Toronto, ON: Centre for Addictions and Mental Health*, from http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/cd_housing_needs_report0306.pdf

OBJECTIVES

The Centre for Addiction and Mental Health is interested in improving housing options and housing stability for individuals living with concurrent disorders. As a first step to developing a tangible learning tool for housing providers, an informal needs assessment was conducted to capture the perspectives of housing providers, people living with concurrent disorders, and family members of persons living with concurrent disorders.

KEY DEFINITIONS

Concurrent disorders are any co-occurrence of mental health and substance use problems.

METHODOLOGY

Through a survey of 59 housing providers and interviews with sixteen individuals, the reality of finding, maintaining and providing housing for persons living with concurrent mental health and substance use problems, and the knowledge gaps housing providers would like to have addressed, were identified.

KEY FINDINGS

The results of the needs assessment demonstrate the need and support for a learning tool for housing providers. It also demonstrates a common understanding between housing providers and people living with concurrent mental health and substance use problems in terms of the housing challenges they face. Housing providers recognize the need for high levels of support for potential and actual tenants. Potential and actual tenants recognize that their concurrent mental health and substance use problems can create behaviours that can be difficult for others to cope with. Both groups recognize the need for teamwork and case management by a range of community agencies, people living with concurrent mental health and substance use problems, their families,

other tenants in a facility, and trained and accessible support workers. Housing providers perceive that, with support and training, they can do more for their tenants/residents.

The needs assessment results provide a map for the development of a learning tool in the form of a low-cost workshop and written materials. This resource needs to provide factual information on concurrent disorders, and address both mental illness and addiction. It needs to include a skill-building component that will allow housing providers to assess their current situation and take steps to enhance the way that they relate to their tenants with concurrent disorders and improve the outcomes for themselves and these tenants.

Zamprelli, J. (2005). Homelessness, housing, and harm reduction: Stable housing for homeless people with substance use issues. *Research Highlight: Socio-economic Series 05-027*. Prepared for Canada Housing and Mortgage Corporation, from http://www.cmhc-schl.gc.ca/odpub/pdf/64031.pdf?lang=en

OBJECTIVES

The purpose of this study was to investigate the effectiveness of innovative housing programs for persons who are homeless or at risk of homelessness and who use substances (e.g. drugs, alcohol, or other substances). The research specifically examined which housing interventions and factors that incorporate a harm reduction approach best help this population access and maintain stable housing.

Three research questions were addressed:

1. How effective are innovative or alternative residential housing programs for homeless people with substance use issues, especially those that incorporate high-tolerance or harm reduction into a supported living environment?
2. To what degree is secure and stable housing crucial to successful substance use treatment models?
3. Do harm reduction strategies, as part of supportive housing, enhance the stability and longevity of housing tenure for homeless people with substance use issues?

KEY DEFINITIONS

Harm reduction: an approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence. This study makes a distinction between approaches that are primarily a “tolerance of consumption” and approaches that actively engage clients in making positive changes in their lives.

Housing first: the direct provision of permanent, independent housing to people who are homeless. Central to this idea is that clients will receive whatever individual

services and assistance they need and want to maintain their housing choice. The housing is viewed primarily as a place to live, not a part of treatment.

METHODOLOGY

The researchers undertook a literature review and profiled 13 initiatives in Canada, the U.S. and the U.K. Twelve of these projects are providing housing and services to people who are homeless or at risk of homelessness and who use substances. A thirteenth program was in the planning stages. All the projects incorporate a harm reduction approach. Information for the case studies was obtained through interviews with service provider personnel most knowledgeable about the program. In addition, the researchers sought to obtain written documentation about the initiative, such as annual reports, policies, and evaluations, if available. The researchers also conducted face-to-face interviews with 33 individuals who were living in (or had lived in) housing provided by the case study agencies and/or who were receiving services from these agencies. Interview guides were used for all interviews.

KEY FINDINGS

1. Based on a review of the literature and the programs profiled in this report, a harm reduction approach combined with supportive housing can be an effective way to address the needs of homeless people who are dealing with substance use issues.

2. The literature is clear that effective treatment for homeless people with substance use issues requires "comprehensive, highly integrated, and client-centred services, as well as stable housing". Housing is essential both during and following treatment. The literature review also found growing evidence that supported housing is essential *regardless* of treatment. In the programs profiled in this report, safe and secure housing was identified as a key factor that makes it possible for residents/program participants to address their substance use issues and to become abstinent, reduce their substance use, or reduce the negative impacts of their use.

3. The programs profiled in this report found that the participants had undergone a number of positive changes since they became involved. One of the most frequent changes noted was stable housing tenure. Using a harm reduction approach which provided for flexibility and focused on the individual needs of each client was identified as a key factor for success.

Zerger, S. (2002). Substance abuse treatment: What works for homeless people: A review of the literature. *National Health Care for the Homeless Council*, from http://www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf

OBJECTIVES
This paper consisted of a literature review examining underlying issues, and assumptions, engaging and retaining homeless in treatment, and a review of specific treatment modalities

METHODOLOGY
Reviewed results from the fourteen research demonstration projects on alcohol and other drug abuse treatment for homeless persons (NIAAA/NIDA Cooperative Agreement grantees).

KEY FINDINGS
This review reveals significant deficits in the research literature, including: 1) a need for better understanding the effectiveness of integrated versus linked services, which model is desirable and for whom, and; 2) a need for better understanding the importance of staff approach to care. The experience of Health Care for the Homeless projects has much to offer in these areas, and should be explored by future researchers.
Themes:

- It is essential to develop treatment programs that not only focus on the addiction but also address the tangible needs of homeless clients, particularly housing, income support, and employment.
- Dropout rates are high for this population no matter what type of intervention was provided. Part of the reason for this may be associated with a lack of motivation for treatment. Since motivation for treatment seems to be positively related to retention and outcomes, there is therefore a need to develop flexible, low demand interventions which can accommodate clients who are not willing to initially commit to more extended care. Hopefully, clients can be gradually brought into more intensive treatment modalities when their motivation increases.
- Clients in both experimental and control groups seemed to improve significantly by the end of treatment. However, with a few exceptions, treatment modality did not appear to differentially affect outcomes in most cases.
- Treatment outcomes appeared to be particularly positive after treatment, but seemed to diminish overtime. This suggests the need for longer-term, continuous interventions for this population**.** Aftercare needs to address not only the maintenance of sobriety, but also the tangible needs and social isolation of clients.
- It appears that there are certain subgroups of clients who will have more positive outcomes than others, most notably those with higher educational attainment,

with less severe substance use, less criminal involvement, and those who are less socially isolated. This type of information may be useful for matching clients to appropriate treatment services**.**

- Much of this research begins with the premise that homelessness is a static variable. Researchers examine efficacy of specific treatment modalities and techniques to engage or retain homeless individuals in treatment with the understanding that outcome "success" resides in the individual. This underlying assumption obscures the social and economic causes of homelessness, drawing our attention away from structural solutions.
- "Controlled" quantitative research which uses design features such as randomization into "treatment" and "control" groups, is most frequently funded because of the scientific rigor the design provides. However, in addition to the methodological complexities raised when using such designs with homeless individuals, it raises serious ethical concerns as well. Issues of coercion and control must be taken into consideration, especially seriously when studying experiences of persons in very vulnerable situations. The growing body of qualitative research on substance abuse treatment and homeless individuals has been helpful in articulating the implications of some of these concerns, and should be considered as a meaningful and appropriate method for increasing our knowledge.
- This research seems to conclude that programs targeted for women have been successful. There remains a need to better understand the efficacy of programs targeted toward other specific subpopulations of homeless persons, especially youth and adolescents.