Housing First

A housing model rooted in harm reduction with potential to transform health care access for highly marginalized Canadians

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Housing First (HF) is a model for housing people who are homeless or at risk of homelessness that is gaining traction in North America.[1-6] It is based on the philosophy that housing is a basic human right, and one of its main pillars is that homeless or vulnerably housed people should be given immediate access to permanent housing that offers them optional individualized supports rooted in harm reduction, with an overarching goal of social and community integration.

People affected by homelessness are disproportionally affected by substance use disorders (SUDs), which accounts, in part, for much higher mortality rates among this population than is predicted based solely on income.[7,8] It is not surprising, then, that literature supports supportive housing interventions for people with SUDs who are experiencing homelessness, given that the physical environment is a key social determinant of health.[9] Indeed, proponents of HF programs argue that housing is a precondition for recovery from SUD and that it should not be offered on a conditional basis of "housing readiness," such as participation in mandatory programming with a focus on abstinence.[2]

While there is mixed evidence on the effects of housing on substance use patterns, there are numerous studies that highlight the physical health and wellness benefits of HF among people with SUDs.[10-13] Specifically, a key finding from HF research highlights its positive effect on housing stability, which, in turn, has been shown to improve numerous health outcomes, such as decreases in exposure to violence, decreases in behaviour associated with risk of HIV and hepatitis C virus infection, fewer accidental overdoses, and lower overall mortality among people who inject drugs.[10,14,15] Other HF studies have demonstrated reductions in emergency services use and suicidality, and improvements in wellness.[11-13]

In Canada, a national study (the At Home/Chez Soi research demonstration project) found that among homeless participants with mental illness, those in the HF intervention group were more than twice as likely to report positive changes related to housing stability, increased control over substance use, positive relationships, and social supports, as well as valued social roles, compared with those to whom housing was not offered (ie, treatment as usual).[11] While the treatment-as-usual group also reported some benefits, such as improvements in quality of life and community functioning, and a decrease in emergency department visits, they were also 4 times more likely to experience negative changes related to precarious housing, isolation, hopelessness, negative social contacts, and heavy substance use.

Whether HF projects are cost-efficient remains an area of active debate. While, overall, the literature suggests expenditures might outweigh savings,[16] it might also be argued that allocating resources to HF projects could be more cost-effective than traditional services when considering both patient outcomes and cost offsets. For instance, the At Home/Chez Soi project conducted a cost analysis and found varying degrees of cost savings. Their 2148 participants were identified as either "high need" or "moderate need," depending on the severity of their mental illness.[17] For the high-need group, every $10 invested resulted in an average cost reduction of $9.60 in other services, while the moderate-need group saw an average cost reduction of $3.42. The main drivers of cost reduction were the fewer emergency department visits, overnight shelter stays, visits to drop-in centres, and other institutional stays such as SUD treatment facilities, prisons, and jails. Along the same lines, other HF studies with adult participants, where the eligibility criteria did not include mental illness, showed total cost savings ranging from $1.17 to $2.84 for every $1.00 spent and a total cost rate reduction of 53% for housed individuals, relative to those waiting to be housed.[18,19] Conversely, another study evaluating permanent supportive housing for youth in California found a total cost increase of $13337 (US) per year, whereas permanent supportive housing programs with higher fidelity to the HF model had a larger increase in cost estimates ($17610 [US] per year).[20] Further studies are needed to delineate the cost efficiency of HF models for different populations and settings.

Unique opportunities for low-barrier supports

Housing First models currently exist in at least 15 Canadian towns and cities.[1,17,21] Housing First not only provides housing but can also embed in its framework easily accessible supports and programs for people with SUDs.

One Canadian example of these models is the PHS Community Services Society (previously known as the Portland Hotel Society, founded in 2003), a non-profit organization that provides supportive housing, harm reduction, and community services to underserved people in Vancouver and Victoria in British Columbia. The society's 22 buildings operate under an HF framework and have more than 1500 rental housing units.[22] People access housing via the province's supportive housing

registry and typically pay a low rental fee (eg, $375 per month). Multidisciplinary primary care and SUD treatment is offered to residents in 7 of the housing projects, with the type and level of services offered in each building reflecting the needs of its residents. These services might include family physicians, nurses, social workers, and clinical pharmacists, as well as peer support workers. Importantly, engagement with health care services is optional for residents, and there are no mandatory programs required to maintain their housing. These buildings prioritize harm reduction strategies and typically offer safe consumption areas. Supplies to support safer drug use practices are readily available and encouraged, and many buildings have front-desk staff on duty 24 hours a day, 7 days a week, who ensure resident health and safety. There are medication administration programs and a range of on-site wellness, cultural, and recreational groups in partnership with various community agencies. The embedded access to primary care and addiction treatment among the 7 buildings is a unique model that offers novel approaches to delivering health care services to an underserved, vulnerable population.

While there are some published descriptions of primary care outreach models for homeless or marginally housed populations, the evidence base for the effect of the clinical supports embedded in HF models on patient outcomes, particularly for patients with SUDs, is scant.[23-25] Anecdotally, people who are otherwise unattached to primary care and those who are disorganized and have difficultly attending scheduled appointments or walk-in clinics owing to severe mental illness or traumatic brain injuries tend to benefit greatly from this low-barrier access to care.

Housing as a lifesaving intervention

Jurisdictions across North America are grappling with the toll that the opioid epidemic, exacerbated by the global coronavirus disease 2019 pandemic, is taking on their communities, and they are devising actionable plans to improve the welfare of their most vulnerable citizens.[26] Despite the numerous challenges created by the pandemic, one unexpected secondary positive effect was the expansion of the capacity for many communities to provide health care outreach.[27-29] This expansion, in turn, affords unique opportunities to forge relationships with pre-existing HF models or with stakeholders who are advocating for this housing intervention. Given the benefits of housing stability on health and social outcomes among people with SUDs, family physicians should be screening people with SUDs for homelessness and prioritizing referrals to local housing resources as part of their treatment plans for patients experiencing homelessness or precarious housing. At the health care system level, we must advocate for and support efforts to provide HF models to those in need, for example, by calling upon our municipal and provincial or territorial governments to use funding from the National Housing Strategy's 10-year, $55 billion affordable housing plan for this evidence-based intervention.[30] In addition, and building on successful local experiences, integrating primary care and SUD services within HF models should be further explored as a way of offering lifesaving interventions to individuals who might not otherwise engage with health care services. It is time to start thinking of HF as having untapped potential for improving health care access for people with SUDs.

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Competing interests
Dr MacKinnon has worked for the PHS Community Services Society on one of its housing projects.

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