Evidence at a glance:
Pathways Scattered Site Housing First vs. Single Site Supportive Housing

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Created by the Canadian Housing First Network Community of Interest (CHFN-COI).

Currently, the Pathways Housing First (HF) scattered site model and various approaches to single site housing are being used to provide housing for people experiencing homelessness. Since single site housing is gaining more traction in many Canadian communities, it is timely to review the evidence base and key features of scattered site and single site approaches. In this summary, we compare and contrast the two approaches.

Definitions

Scattered site. Pathways HF is an evidence-based approach to ending homelessness among people with mental illness, other complex needs (e.g., addictions, chronic health issues) and long periods of homelessness. HF combines rent supplements with support, typically in the form of Assertive Community Treatment (ACT) or Intensive Case Management (ICM) (Tsemberis, 2015). With a rent supplement, participants can access normal market housing that is scattered throughout the community. The focus of HF is to provide people with housing immediately, rather than providing "treatment first" before they can access housing. As well, the Pathways model has a clear theory of how to end homelessness and promote recovery that is based on key principles, including choice and community integration (Aubry, Nelson, & Tsemberis, 2015). The HF theory of change (Nelson & MacLeod, 2017) outlines the key ingredients of HF that have been tested and shown to promote the intended outcomes of housing stability, increased community integration, and improved quality of life (O'Campo et al., 2022).

Single site. Single site supportive housing includes a number of different housing programs. These include residential treatment (the "treatment first" approach), single site versions of HF and group living (Nelson & Caplan, 2017; Nelson & MacLeod, 2017a). Group living can consist of separate apartments in one building for each individual or people living in one dwelling with their own bedrooms and some shared spaces (e.g., kitchen; living

room). Single site supportive housing is a varied mix of different approaches. Typically, support services are delivered on-site. What all of these approaches have in common is that people live in one building and reside with other people who have a variety of mental illnesses and/or addictions. Moreover, because of the programs varying by size, characteristics of buildings, nature of support, single site supportive housing approaches lack a theory of change (Nelson & MacLeod, 2017a). Whereas HF aims to integrate the individual into the community, single site housing can lead to segregation by limiting the setting to people with experiences of homelessness, mental illness, and/or addictions and clustering this population in identifiable specialized housing.

Historical antecedents

Both scattered site and single site housing have their roots in the mental health field, beginning in the 1960s with the advent of deinstitutionalization of people with serious mental illness (Nelson & MacLeod, 2017b). Prior to the 1960s, these individuals were removed from their communities and placed in psychiatric hospitals.

The homelessness problem emerged in the 1980s, fueled in Canada over the last 30 years by the gradual erosion of the construction of new affordable housing combined with a growing population. Hopper and Barrow (2003) have argued that housing for homeless people has a different genealogy than housing in the field of mental health. However, there is overlap between the mental health sector and the homelessness sector with regard to housing. People with serious mental illness have been significantly impacted by homelessness, with many becoming chronically homeless.

Scattered site. Pathways HF has its roots in the disability rights movement, which includes people with physical, developmental, and psychiatric disabilities (Carling, 1995). Carling's emphasis on "supported housing" with the philosophy of "choose, get, and keep" housing for people with mental illness was a precursor to Pathways HF for homeless people with mental illness and addictions. Similarly, Ridgway and Zipple (1990) critiqued the dominant continuum of residential services and argued for supported housing, so that individuals would move from being clients to tenants. With the growing homeless population in the 1980s, Tsemberis (2015) introduced the Pathways HF model to provide supported housing to homeless people with mental illness and addictions.

Single site. In the early days of deinstitutionalization, single site approaches dominated the landscape. Halfway houses (Cometa, Morrison, & Ziskoven, 1979; Rog & Raush, 1975) and residential treatment (Carpenter, 1978; Colten, 1978) continued to reflect the institutional

model's assumption that people with mental illness were not ready to live on their own and required treatment before they could live independently (Nelson & MacLeod, 2017b). A danger with these single site programs is that they may replicate many of the features of the institutions that they were designed to replace, thus becoming "mini-institutions" in the community. While there were some innovative single site programs, like the Fairweather Lodge and Soteria House, these programs did not become widespread (Nelson & Caplan, 2017).

Choice

Scattered site. A key principle of supported housing and Pathways HF is that participants have choice and control over their housing and support. Having a rent supplement is central to facilitating choice and control. Choice is important for philosophical and empirical reasons. First, scattered site HF views housing and self-determination as human rights. People have the right to housing and to choose where they live. Second, there are several empirical reasons to support choice and control. Research has consistently found that around 85 per cent of people with serious mental illness want to live independently in their own house or apartment (Richter & Hoffman, 2017). Having choice and control over one's housing and support services is associated with positive mental health outcomes (Greenwood & Manning, 2017; Martins et al., 2016; Piat, Seida, & Padgett, 2019). In addition, choice and control over housing and support services is significantly greater for people living in their own apartments than for those living in single site housing (Nelson et al., 1999; Nelson et al., 2007). In summary, research has shown the benefits of having choice or control over housing and supports (Nelson & Aubry, 2020a).

Single site. A significant limitation of single site options is that they provide limited choice and control. People who are homeless are often given the option of living in a single site setting, but no alternative options. As well, once they move into single site housing, they often are not able to leave and access other subsidized housing in the community because the housing subsidies that are provided are attached to the housing and not to the tenants.

Outcomes

Scattered site. The Pathways HF scattered site approach has generated a great deal of evidence to support it. In a New York City randomized controlled study, researchers found that HF participants were significantly less likely to be homeless or use psychiatric hospitals and incurred lower housing costs than those in the usual treatment group (Gulcur and colleagues, 2003). Another randomized controlled study in New York City suburb found that

HF participants were significantly less likely to be homeless over the four years of follow-up than participants in the usual treatment group (Stefancic & Tsemberis, 2007).

In Canada, the five-city At Home / Chez Soi project used a randomized controlled trial (RCT) design and found that compared with usual treatment, Pathways HF participants had significantly better outcomes in terms of ending homelessness sooner and achieving housing stability and experiencing improvements in quality of life and community functioning outcomes (Aubry et al., 2015). In another randomized controlled trial, researchers in France found that compared with usual treatment, the HF group was more stably housed, spent significantly less time in hospital, and had significantly better quality of life over the two years of follow-up (Tinland et al., 2020). Recent systematic reviews have found that scattered site HF reduces homelessness, but there is mixed evidence on its impact on psychosocial outcomes (Aubry et al., 2020; Jacoby et al., 2022; Kilaspey et al., 2022; Moledina et al., 2022). Based on the research that includes multiple randomized controlled trials conducted in different countries, it is clear that scattered site HF is an effective evidence-based program for ending chronic homelessness for people with mental illness and/or substance use problems.

Comparisons of scattered site and single site approaches. Early studies of single site approaches found that a number of them had hospitalization outcomes that were superior to usual treatment (Nelson & MacLeod, 2017a), but these studies did not focus on people experiencing homelessness. Most recent research on single site models has compared single site with scattered site Pathways HF for people experiencing homelessness.

In a quasi-experiment, Pearson, Montgomery, and Locke (2009) compared housing stability among Pathways HF participants in New York City with participants in the Downtown Emergency Services Center in Seattle (a single site program) and the Reaching Out and Engaging to Achieve Consumer Health program in San Diego. While all three programs had positive impacts on housing stability, the Pathways HF program had the highest levels (92 per cent) compared with the other two programs (80 per cent). Tsai, Mares, and Rosenheck (2012) compared HF with residential treatment every three months for two years and found that HF resulted in significantly more days in their own housing, fewer days incarcerated and more choice over treatment.

Using a RCT design, Goldfinger et al. (1999) compared a single site model called Evolving Consumer Households with scattered site HF for homeless people with mental illness. While there were no differences in housing or hospitalization outcomes between the

groups after 18 months, problems interacting with others and conflict were common among those living in the single site setting (Schutt, 2011).

Another RCT (Siegel et al., 2006) compared Pathways HF with a single site model (individual units in one hotel). While the two groups experienced similar housing stability at 6, 12, and 18 months, the Pathways participants reported significantly greater housing satisfaction.

In the At Home / Chez Soi research, the Vancouver site used a RCT design to compare the Pathways HF model with a single site model (individual units in a former hotel, the Bosman). After 24 months, both the scattered site and single site programs significantly reduced housing instability (Somers et al., 2017) and improved quality of life (Patterson et al., 2013). However, the scattered site participants had reduced criminal offences (Somers et al., 2013) and emergency department use (Russolillo et al., 2014), and reported being more integrated into their community (e.g., "I feel like I belong where I live") compared with those in the single site program (Patterson, Moniruzzaman, & Somers, 2014).

In summary, single site models generally appear to achieve similar housing stability outcomes to scattered site HF programs. However, other outcomes, such as re-offending and choice, control, and satisfaction favour the Pathways HF scattered site model.

Costs

Scattered site. Using a societal perspective and self-report data, Latimer and his colleagues (2019, 2020) conducted the most comprehensive economic analysis of scattered site housing as part of the Canadian At Home / Chez Soi Demonstration Project. His findings showed that HF with ACT for people with a high level of needs cost on average across the five cities $20,367 (2016 CAD) per person per year (Latimer et al., 2019). The reduction in use of health and social services along with involvement in the justice system and income support over a two year period offset 69% of this cost. Cost-effectiveness analyses found that each additional day of stable housing cost $41.73.

In contrast, HF with ICM for people with moderate needs found the program costs averaged $14,496 (2016 CAD) per person per year (Latimer et al., 2020). Of this amount, 46% was offset by costs associated with a reduction in services for those individuals in the HF program. The study estimated that each additional day of stable housing associated with participation in the HF program cost $56.08 per day per year.

Also based on comprehensive costing using a societal perspective and self-report data, Tinland and her colleagues (2020) reported that the average cost of HF with ACT support

was €14,000 (2016 EUR). The entire amount was offset through savings related to decreased health service use and, notably, because of length of stay in psychiatric hospitals compared to individuals receiving treatment as usual. Projection of costs over a 35-year period for people receiving HF estimated that each additional day of stable housing would cost €5.31 (Lemoine et al., 2021).

Single site. To date, two studies compared individuals in single site housing matched with a group of individuals in treatment as usual. Using administrative records, Larimer and colleagues (2009) reported reduced use of emergency services, inpatient hospital stays, sobering centre stays, and jail time over the first year in the program, such that the overall cost of the program ($13,440 USD, year not specified) was fully offset by savings ($42,964 USD year not specified), producing $29,524 in savings.

Similarly, cost offsets exceeding single site supportive housing were found in a study by Srebnik and her colleagues (2013). In particular, individuals receiving single site supportive housing that included case management services combined with access to an addiction specialist and registered nurse showed cost offsets ($36,579 USD year not specified) associated with reduction in services (i.e., emergency rooms, sobering centre, hospitalizations, and jail bookings) that exceeded the cost of the supportive housing ($18,600 USD year not specified).

Comparison of scattered site and single site approaches. In comparing costs associated with scattered site to costs associated with single site using a combination of administrative and self-report data, Dickey and her colleagues (1997) found that the cost of the single site program associated with housing and onsite services that included ICM was $56,434 (USD 1994). In comparison, the cost of scattered site housing with ICM was $29,838 (USD 1994). Thus, the single site program was nearly twice as costly as the scattered site program. The At Home / Chez Soi research did not compare the cost of the single site program (the Bosman hotel) with that of the scattered site model.

How You Can Use this Research

Debates about scattered site vs. single site approaches are important for policy, planning and practice regarding homeless people with complex needs.

Policy

1. In Canada, the National Housing Strategy aims to create more affordable housing, which is sorely needed. It should be available to people with varying income levels so

that people living on a low income, people with mental illness and people with histories of homelessness have choice beyond single site housing that congregates individuals with histories of homelessness in one building. Limiting choice to single site housing ignores people's preferences about where they want to live and works against community integration by creating new segregated institutional housing in the community (Nelson & Aubry, 2020b).

2. The Government of Canada has also proposed a portable housing benefit (a rent supplement) for people living on low income. This policy should be robust and implemented on a wide scale. The portable housing benefit is an indispensable component of HF that promotes choice and control (Nelson & Aubry, 2017).

Planning

1. Currently, there are discussions about purchasing hotels, motels, other large buildings, or modular homes to provide permanent housing. Research on the effectiveness of these alternatives is lacking. Planning new programs should be evidence-based. There is ample evidence on the effectiveness of HF.

2. Congregate settings, like hotels or other large buildings, do not promote choice or community integration. Based on preference surveys of consumers, only a small percentage of individuals wish to live in a single site setting. More attention should be paid to expanding the option of scattered site apartments that are consistent with HF principles.

3. There is a need for housing in communities for people leaving homelessness to include supportive housing with on-site support (Padgett, Henwood, & Tsemberis, 2016). It should be available for those individuals who choose this option because they want more structure or to live in a community and for others who find out they require more support after attempting to live on their own in scattered site housing. Also, there is evidence that some individuals continue to experience housing instability after two years of participation in a Housing First program (Roebuck et al., 2023). These individuals may also benefit from single site housing with onsite support.

4. When communities conduct point-in-time counts of the homeless population, it would be valuable to include questions about preferences in terms of housing and support. This is how the HF approach began in New York City, by listening to the

preferences of people who were homeless.

Practice

1. Some communities are working to expand "treatment first" programs, such as rehabilitation programs in shelters that result in individuals having longer stays. It has become abundantly clear that treatment programs intended to prepare individuals for living independently in the community are not necessary (Goering et al., 2014). HF programs should be expanded and adequately resourced with sufficient rent supplements and well-trained staff and intensive support services, including ACT (Nelson & Aubry, 2018).

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The Canadian Housing First Network Community of Interest (CHFN-COI) is intended to assist communities across Canada to develop, evaluate, and improve Housing First (HF) programs

based on the Pathways model tested, adapted, and shown to be effective in the At Home/Chez Soi Demonstration Project. This CoI is supported by Evidence Exchange Network (EENet), which is part of the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health. For more information, visit www.eenet.ca/housing-first.