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Contextual factors and implementing the Housing First intervention: a literature review

Adriana Pinheiro Carvalho (https://orcid.org/0000-0001-9548-0577) [1]
Juarez Pereira Furtado (https://orcid.org/0000-0001-6605-1925) [2]

Abstract *Housing First (HF) has spread on the international scene as an evidence-based intervention to overcome homelessness among people with mental health problems. In Brazil, the HF has been adopted as a reference in the development of initiatives geared to people living in the streets who make harmful use of drugs. Studies point to the need for greater understanding of the dynamics of implementation in different settings. Thus, using the literature review method, we analyzed the factors that facilitate and hinder the implementation of HF. Sixty-eight papers published from 2003 to 2020 were selected from the PubMed, Scopus, PsychoINFO, Embase, Lilacs, and Scielo databases. We identified factors in four dimensions: intervention characteristics, implementation context, institutional aspects, and implementation process. The unavailability of housing, the lack of coordination of the services needed by residents, and the resistance of implementing agents to the HF principles are factors that hinder the implementation. In turn, agents with values, attitudes, and skills converging with the model and continuing education appear as facilitators. We point out the need to understand and favor the HF integration process in the existing social protection systems.*

Key words *Housing, Homeless people, Mental health, Implementation science*

[1] Programa de Pós-Graduação em Saúde Coletiva, Faculdade de Medicina, Universidade de São Paulo. Av. Dr. Arnaldo 455 2º andar sala 2214, Cerqueira César. 01246-903 São Paulo SP Brasil. adriana.pinheirocarvalho@gmail.com
[2] Departamento de Políticas Públicas e Saúde Coletiva, Universidade Federal de São Paulo. Santos SP Brasil.

Introduction

The understanding of housing as a social right that plays a fundamental role in the exercise of citizenship is the central argument for the creation of supported housing interventions[1,2], such as Housing First[3]. Originally developed in the United States in 1992[4], Housing First (HF) seeks to face the homeless situation among people with mental health problems by offering permanent housing integrated with housing, clinical, and community integration support services[3].

HF differs from traditional services for People Living on the Streets (PLS) by providing access to housing without fulfilling requirements, such as adherence to health treatments or drug use abstinence. The fundamental assumption the model assumes is that the stability and security of permanent housing are decisive for addressing other issues, such as harmful drug use[3,5]. In this sense, although support services are offered, they are made available independently of the house, and beneficiaries decide whether they want to and how they will participate (type of follow-up, intensity, and frequency).

HF was disseminated in the United States[4], Canada[6], European countries[7], and Australia[8] through experimental projects, integrated with evaluative research, which showed its greater effectiveness than traditional housing interventions for PLS. In these studies, length of stay is the main indicator of effectiveness used, represented by the percentage of people (which in the HF reaches 80%) who remain in the house for more than two years[9].

Positive results are also reported for community integration[10], decreased use of alcohol and other drugs[11,12], and HIV control[13]. Comparative analyses also show that HF is associated with lower costs caused by the reduced use of other public services, such as shelters, hospitals, and prisons[14].

Recent years have witnessed an increased discussion about HF in Latin American countries and the implementation of initiatives inspired by the model in Uruguay[15] and Chile. In Brazil, in 2014, the Federal Government adopted the HF as a reference for the development of a set of local experiences of specific supported housing for PLS who are drug users[16-18]. Currently, the model is being debated in the country as a solution to the lack of housing for PLS in general[19,20] and was established as a national program – First Housing Program – linked to the current Ministry of Women, Family, and Human Rights[21].

HF rapid expansion resulted in different modifications to the original US proposal, generating uncertainties as to how local particularities influence the intervention's effectiveness[5], and the need for greater understanding of the implementation processes of this type of program in different scenarios is pointed out[22].

Breaking with the "first treatment" approach, which requires the beneficiary to show prior skills for housing stability, implies significant changes in PLS care policies, at individual, organizational, and political levels, attaching complexity to the HF and its implementation process[23,24]. Such a proposal for transformation requires involving different interest groups, considering local characteristics, and significantly adapting existing service delivery systems[2] – that is, the so-called contextual factors.

In the global setting of the expanding Housing First as a promising intervention in confronting the PLS situation, it is essential to understand how the model has been implemented and the variables underlying this process. We identified a study that discusses aspects of the implementation of the set of experimental projects developed in Canada[26]. However, we did not find a critical synthesis about the influence of contextual factors in the implementation of the HF model. Thus, the study proposed to identify and discuss the aspects that facilitate and hinder the implementation of the HF to support the development of the original proposal and address the challenges arising from its adaptation to different contexts, including the Brazilian one.

Methods

The survey of papers was carried out in March 2020, in the PubMed, Scopus, PsychoINFO, Embase, Lilacs, and SciELO databases because they contain a significant number of indexed journals and are a reference in the field of health. We used the word strings "*housing first*" associated simultaneously with "*implementation*", "*translation*", "*fidelity*", "*dissemination*", "*variation*", and "*application*". The search was performed by cross-referencing subjects, titles, and abstracts. We opted to not filter the publication date to retrieve all works published up to the search date.

The selection followed the following eligibility criteria: empirical study published in a scientific journal in any language or year; intervention defined as *Housing First* and aimed at PLS, regardless of whether other population groups are included; and evaluation or description of factors related to implementing HF interventions. The elements reported as complicators and facilitators

of the implementation process were considered contextual factors in this review.

All publications retrieved from the databases were organized and duplications removed with the Mendeley Reference Manager. Subsequently, the papers were exported to the Rayyan software[27], where titles and abstracts were analyzed and papers that did not meet the eligibility criteria described above were excluded. The resulting papers were read in full, excluding ineligible ones. Finally, the bibliographic references of the selected papers were manually checked for inclusion of other previously unidentified eligible studies. The process was carried out by two independent researchers with previous experience in housing in mental health. Any disagreement was resolved through a discussion between the two researchers.

Data was extracted from the selected papers by a researcher and verified by another peer throughout the process to ensure accuracy. The following information was extracted: publication data (authorship, country in which the study was carried out, journal subject area, and year of publication); study design (objective, method, research participants, and theoretical framework); characteristics of the intervention and the context (implementation phase, funding agency, related sector policy, organization responsible for management and implementation, institutional arrangement, target audience, housing type, and support services offered); and factors that hampered or facilitated implementation.

The contextual factors extracted from the papers were listed and grouped into four dimensions, based on the Consolidated Framework for Implementation Research (CFIR)[25], an analytical model used in the field of health to identify and understand the contextual factors that influence the implementation process. The similarities between the factors evidenced by the studies were also identified, grouped, and described. Finally, the data were synthesized based on the interpretation of the relationship between contextual factors and the dimensions of Housing First, narrating how the internal and external elements of the intervention influence the process of implementing the model.

Results

A total of 377 works were identified, from which 68 papers were selected, meeting the eligibility criteria defined in the study (Figure 1).

Characteristics of studies and interventions

The 68 selected papers cover the 2003-2020 period, and most were published between 2014 and 2020 (Chart 1) and in journals classified in the field of Health, which cover 37 publications, underscoring the Mental Health sub-area, with ten papers. Then, the journals in the fields of Housing and Urbanism stand out, with 11 publications; Social and Political Sciences, with eight publications; and Community Psychology, with six publications. Fewer papers (between one and four) can be found in journals in the fields of Social Work and Drugs. The lack of studies before 2003 can be explained by the fact that the use of the term Housing First emerged in scientific publications in 2001[4].

Most studies addressed the implementation of HF in the United States and Canada, totaling 85% of the analyzed studies. The European and Australian contexts make up the rest of the studies with six and four papers, respectively. Data produced through qualitative methods (72%), using focus groups and interviews predominate, and three studies were exclusively quantitative[28-30]. Most studies had more than one interest group as a source of information, and workers and managers were the most involved (n=43), followed by beneficiaries (n=35).

The papers that explain the methodological designs indicate evaluative approaches (n=11), case study (n=15), ethnography (n=4), and grounded theory (n=7). The 18 studies that provide a theoretical or conceptual framework point to Symbolic Interactionism, Constructivism[31,32], implementation science frameworks[30,33-39], change and transformation theories[23,40-43] and Street Level Bureaucracy[44,45].

In general, the implementation was approached based on the binomial of housing structuring and support to residents, and parameters were the quality of the actions carried out and fidelity to the original HF model. A smaller set of papers explored the initial moment of implementation, especially aspects related to planning and local conditions for implementing the intervention. Four papers focused on sustainable interventions[46-49].

Almost a third or 21 studies analyzed HF pilot interventions, 18 of which stemmed from the Canadian project *At Home Chez Soi*[6], the largest HF experimental study ever developed[12], which evaluated the results and the process of implementing the model in five cities in the country and attended to approximately 2,000 PLS with

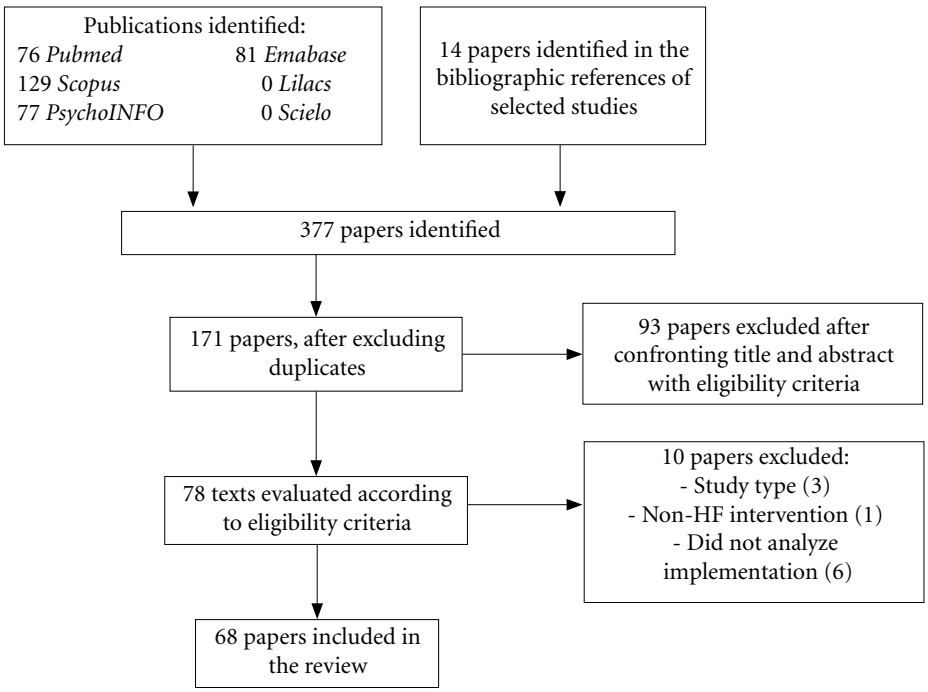

Figure 1. Paper selection flowchart.

Source: Authors.

mental health problems. Also in the Canadian context, we identified studies that examined interventions linked to another initiative financed by the Federal Government to expand the HF – the *Homelessness Partnering Strategy* (HPS)[43]. In U.S. research, studies of programs derived from the *Full-Service Partnerships* (FSPs)[12] project, financed by a mental health service fund of the State of California (*Mental Health Services Fund – MHSF*) and the initiative signed between the federal housing and urbanism sector – *US Department of Housing and Urban Development (HUD)*, and supported housing services for veterans – VA's Supportive Housing Services (VASH)[43]. The *Housing First Europe*[7] pilot project and the *Inner-City Integrated Services* Coalitions[43] initiative stand out among European and Australian studies.

Most studies did not inform the legal nature of the organization responsible for the (public or private) intervention, the funding source and the management model adopted. Among those that did, the following stand out: mental health and housing as the sectors responsible for the intervention; federal government sources as the main funding source; and NGOs, such as the institutions providing the services underpinning the interventions.

The studies essentially addressed HF programs implemented in urban areas and three surveys included initiatives developed in rural areas[50-52]. Of the papers that specified the characteristics of the beneficiaries of the interventions, PLS with mental health problems or drug use was the predominant target audience. Some programs assisted PLS in specific situations: young people[53], black people with mental health problems[54], women with children[42], people assisted in penal system services[55], and war veterans[40,41].

The type of housing and support services offered by the programs is not specified in all studies. We identified programs that used dispersed individual apartments, congregated units in which the participants lived with other beneficiaries in the same building, and finally those that adopted the two housing options.

Support services are predominantly offered through Case Management or integrating Case

Chart 1. Papers included in the review.

Implementation aspect	Study	Author, Title, Journal	Country
Implementation of support to residents	E1	Barrenger SL *et al.* Discursive Processes Creating Team Culture and Recovery Orientation among Housing First Providers. Am J Psychiatr Rehabil. 2015 Jul 3;18(3):247-64.	USA
	E2	Andvig ES *et al.* Harm reduction in a Norwegian housing first project: a qualitative study of the treatment providers' practice. Adv Dual Diagn. 2018;11(1):4-15.	Norway
	E3	Tiderington E, Stanhope V, Henwood BF. A qualitative analysis of case managers' use of harm reduction in practice. J Subst Abuse Treat. 2013 Jan;44(1):71-7.	USA
	E4	Watson DP *et al.* Housing First and harm reduction: A rapid review and document analysis of the US and Canadian open-access literature. Harm Reduct J. 2017;14(1).	USA
	E5	Greenberg B *et al.* Supportive housing best practices in a mid-sized US urban community. Housing, Care Support. 2013;16(1):6-15.	USA
	E6	Collins SE *et al.* Exploring transitions within a project-based housing first setting: Qualitative evaluation and practice implications. J Health Care Poor Underserved. 2012;23(4):1678-97.	USA
	E7	Stanhope V. The ties that bind: Using ethnographic methods to understand service engagement. Qual Soc Work. 2012;11(4):412-30.	USA
	E8	van den Berk-Clark C. The Dilemmas of Frontline Staff Working with the Homeless: Housing First, Discretion, and the Task Environment. Hous Policy Debate. 2016;26(1):105-22.	USA
	E9	Brothers S *et al.* Food insecurity among formerly homeless youth in supportive housing: A social-ecological analysis of a structural intervention. Soc Sci Med. 2020 Jan 1;245:112724.	USA
	E10	Worton SK. Examining peer networking as a capacity-building strategy for Housing First implementation. J Community Psychol. 2020 May 18;48(4):1147-62.	Canada
Adapting the HF to a specific context	E11	Ecker J *et al.* Implementation evaluation of a housing first program in a small Canadian City. Can J Community Ment Heal. 2014;33(4):23-40.	Canada
	E12	Nolin D, Jetté J. Specific features of urban and rural areas: A comparative study on the results of the At Home/Chez Soi project in New Brunswick. Can J Community Ment Heal. 2015;33(4):125-40.	Canada
	E13	Stefancic A *et al.* Implementing Housing First in rural areas: Pathways Vermont. Am J Public Health. 2013;103 Supp 2:S206-209.	USA
	E14	Jetté J *et al.* The implementation of a Housing First intervention in Canadian rural region Can J Community Ment Heal. 2015;33(4):41-59.	Canada
	E15	Austin EL *et al.* VA's expansion of supportive housing: Successes and challenges on the path toward housing first. Psychiatr Serv. 2014 May 1; 65(5):641-7.	USA
	E16	Kriegel LS *et al.* Implementation and Outcomes of Forensic Housing First Programs. Community Ment Health J. 2016;52(1):46-55.	USA
General aspects of the implementation	E17	De Ara CGG *et al.* Housing first: At home recovery of severe mental disorder. Rev Med Suisse. 2017;13(575):1605-9.	Switzerland
	E18	Fleury M-J, Grenier G, Vallée C. Evaluation of the implementation of the Montreal at home/chez soi project. BMC Health Serv Res. 2014;14(1).	Canada
	E19	Benjaminsen L. Policy Review Up-date: Results from the Housing First based Danish Homelessness Strategy. Eur J Homelessness. 2013;7(2):109-31.	Denmark

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Chart 1. Papers included in the review.

Implementation aspect	Study	Author, Title, Journal	Country
Institutional aspects	E20	Nicholls CM, Atherton I. Housing First: Considering components for successful resettlement of homeless people with multiple needs. Hous Stud. 2011;26(5):767-77.	USA
	E21	Weinzierl C, Wukovitsch F, Novy A. Housing First in Vienna: a socially innovative initiative to foster social cohesion. J Hous Built Environ. 2016;31(3):409-22.	Austria
	E22	Kertesz SG *et al.* Making Housing First Happen: Organizational Leadership in VA's Expansion of Permanent Supportive Housing. J Gen Intern Med. 2014 Nov 21;29(4):835-44.	USA
	E23	Nelson G, Worton SK, Macnaughton E, Tsemberis S, MacLeod T, Hasford J, *et al.* Systems change in the context of an initiative to scale up Housing First in Canada. J Community Psychol. 2019 Jan 1 47(1):7-20.	Canada
Evaluation or analysis of the intervention using as a parameter the fidelity to the HF model	E24	Gilmer TP *et al.* Variation in the implementation of California's full service partnerships for persons with serious mental illness. Health Serv Res. 2013; 48:2245-67.	USA
	E25	Greenwood RM *et al.* Implementations of housing first in Europe: Successes and challenges in maintaining model fidelity. Am J Psychiatr Rehabil. 2013;16(4):290-312.	Europe
	E26	Kertesz SG *et al.* Housing first on a large scale: Fidelity strengths and challenges in the VA's HUD-VASH program. Psychol Serv. 2017;14(2):118-28.	USA
	E27	O'Campo P *et al.* Strategies to balance fidelity to Housing First principles with local realities: lessons from a large urban centre. J Health Care Poor Underserved. 2015 May;26(2):536-53.	Canada
	E28	Macnaughton E *et al.* Implementing Housing First Across Sites and Over Time: Later Fidelity and Implementation Evaluation of a Pan-Canadian Multi-site Housing First Program for Homeless People with Mental Illness. Am J Community Psychol. 2015 Jun 1;55(3-4):279-91.	Canada
	E29	Nelson G *et al.* Early implementation evaluation of a multi-site housing first intervention for homeless people with mental illness: A mixed methods approach. Eval Program Plann. 2014 Apr;43:16-26.	Canada
	E30	Stergiopoulos V *et al.* Moving from rhetoric to reality: Adapting Housing First for homeless individuals with mental illness from ethno-racial groups. BMC Health Serv Res. 2012;12(1).	Canada
	E31	Gilmer TP *et al.* Fidelity to the housing first model and variation in health service use within permanent supportive housing. Psychiatr Serv. 2015 Dec 1;66(12):1283-9.	USA
	E32	Gilmer TP *et al.* Fidelity to the housing first model and effectiveness of permanent supported housing programs in California. Psychiatr Serv. 2014;65(11):1311-7.	USA
	E33	Macnaughton E *et al.* Navigating complex implementation contexts: Overcoming barriers and achieving outcomes in a national initiative to scale out housing first in Canada. Am J Community Psychol. 2018;62(1-2):135-49.	Canada
	E34	Gilmer TP *et al.* Variations in full service partnerships and fidelity to the housing first model. Am J Psychiatr Rehabil. 2013;16(4):313-28.	USA
	E35	Watson DP *et al.* The Housing First Model (HFM) fidelity index: designing and testing a tool for measuring integrity of housing programs that serve active substance users. Subst Abus Treat Prev Policy. 2013;8(1):16.	USA
	E36	Fenwick K *et al.* Exploring Variation in Housing First Implementation: The Role of Fit. Hum Serv Organ Manag Leadersh Gov. 2019;43(5):392-406.	USA

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Chart 1. Papers included in the review.

Implementation aspect	Study	Author, Title, Journal	Country
Housing structuring process	E37	Dickson-Gomez J *et al.* Identifying variability in permanent supportive housing: A comparative effectiveness approach to measuring health outcomes. Am J Orthopsychiatry. 2017;87(4):414-24.	USA
	E38	Chen PM. Housing first and single-site housing. Soc Sci. 2019;8(4).	USA
	E39	Zerger S *et al.* Understanding Housing Delays and Relocations Within the Housing First Model. J Behav Health Serv Res. 2016;43(1):38-53.	Canada
	E40	Pankratz C, Nelson G, Morrison M. The implementation of a rent assistance program and its impacts on recovery outcomes for individuals experiencing chronic homelessness. Can J Community Ment Heal. 2018;37(1):49-63.	Canada
	E41	Henwood BF, Stanhope V, Padgett DK. The role of housing: a comparison of front-line provider views in housing first and traditional programs. Adm Policy Ment Heal Ment Heal Serv Res. 2011 Mar; 38(2):77-85.	USA
	E42	Colombo F, Saruis T. Social innovation and local welfare: A comparative case study on housing first in Italy and Sweden. Vol. 33, Journal fur Entwicklungspolitik. Mattersburger Kreis fur Entwicklungspolitik; 2017. p. 85-111.	Italy
	E43	Kertesz SG *et al.* The role and meaning of interim housing in housing first programs for people experiencing homelessness and mental illness. Am J Orthopsychiatry. 2014;84(4):431-7.	Canada
	E44	Verdouw J, Habibis D. Housing First programs in congregate-site facilities: can one size fit all? Hous Stud. 2018;33(3):386-407.	Australia
	E45	Bullen J, Baldry E. 'I waited 12 months': how does a lack of access to housing undermine Housing First? Int J Hous Policy. 2019;19(1):120-30.	Australia
	E46	Bullen J, Fisher KR. Is Housing First for Mental Health Community Support Possible During a Housing Shortage? Soc Policy Adm. 2015;49(7):928-45.	Australia
Pre-implementation factors (planning, agenda building, ongoing training)	E47	Hasford J *et al.* Knowledge translation and implementation of housing first in Canada: A qualitative assessment of capacity building needs for an evidence-based program. Eval Program Plann. 2019 Aug 1;75:1-9.	Canada
	E48	Worton SK *et al.* Understanding Systems Change in Early Implementation of Housing First in Canadian Communities: An Examination of Facilitators/ Barriers, Training/Technical Assistance, and Points of Leverage. Am J Community Psychol. 2018;61(1-2):118-30.	Canada
	E49	Nelson G *et al.* Collaboration and involvement of persons with lived experience in planning Canada's At Home/Chez Soi project. Health Soc Care Community. 2016;24(2):184-93.	Canada
	E50	Macnaughton E, Nelson G, Goering P. Bringing politics and evidence together: Policy entrepreneurship and the conception of the At Home/Chez Soi Housing First Initiative for addressing homelessness and mental illness in Canada. Soc Sci Med. 2013;82:100-7.	Canada
	E51	Nelson G *et al.* Planning a Multi-site, Complex Intervention for Homeless People with Mental Illness: The Relationships Between the National Team and Local Sites in Canada's At Home/Chez Soi Project. Am J Community Psychol. 2013;51(3-4):347-58.	Canada
	E52	Keller C *et al.* Initial implementation of housing first in five Canadian cities: How do you make the shoe fit, when one size does not fit all? Am J Psychiatr Rehabil. 2013 Oct 1;16(4):275-89.	Canada

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Chart 1. Papers included in the review.

Implementation aspect	Study	Author, Title, Journal	Country
Influence of implementation on program results	E53	Aubry T, Nelson G, Tsemberis S. Housing first for people with severe mental illness who are homeless: A review of the research and findings from the at Home-Chez soi demonstration project. Can J Psychiatry. 2015;60(11):467-74.	Canada
	E54	Davidson C *et al.* Association of housing first implementation and key outcomes among homeless persons with problematic substance use. Psychiatr Serv. 2014 Nov 1;65(11):1318-24.	USA
	E55	Appel PW, Tsemberis S, Joseph H, Stefancic A, Lambert-Wacey D, P.W. A, *et al.* Housing first for severely mentally ill homeless methadone patients. J Addict Dis. 2012 Jul 1;31(3):270-7.	USA
Perception of interest groups on the implementation of the HF	E56	Henwood BF *et al.* Examining provider perspectives within housing first and traditional programs. Am J Psychiatr Rehabil. 2013 Oct 1;16(4):262-74.	USA
	E57	Volk JS *et al.* The at home / Chez Soi project: Community partners' perspectives on the implementation of housing first in Moncton. Can J Community Ment Heal. 2015;33(4):77-90.	Canada
	E58	Felton BJ. Innovation and Implementation in Mental Health Services for Homeless Adults: A Case Study. Community Ment Health J. 2003;39(4):309-22.	USA
	E59	Johnsen S, Teixeira L. "Doing it Already?": Stakeholder Perceptions of Housing First in the UK. Int J Hous Policy. 2012;12(2):183-203.	United Kingdom
	E60	Macnaughton EL, Goering PN, Nelson GB. Exploring the value of mixed methods within the at home/chez Soi housing first project: A strategy to evaluate the implementation of a complex population health intervention for people with mental illness who have been homeless. Can J Public Heal 2012;103:S57-62.	Canada
	E61	Kennedy J, Arku G, Cleave E. The experiences of front-line service providers of Housing First programme delivery in three communities in Ontario, Canada. Int J Hous Policy. 2017;17(3):396-416.	Canada
	E62	Kennedy J *et al.* Service providers' perspectives and residents' experiences with the implementation of "Housing First" program in the city of London, Ontario, Canada. Hous Soc. 2016;43(2):82-102.	Canada
Participant eligibility process	E63	Osborne M. Who Gets "Housing First"? Determining Eligibility in an Era of Housing First Homelessness. J Contemp Ethnogr. 2019;48(3):402-28.	USA
	E64	Anderson-Baron JT, Collins D. Not a "forever model": the curious case of graduation in Housing First. Urban Geogr. 2018;39(4):587-605	Canada
	E65	Namian D. Governing homelessness through instruments: a critical perspective on housing first's policy instrumentation. Crit Policy Stud. 2020 Jul 2;14(3):303-18.	Canada
Sustainability	E66	Kumar N *et al.* Sustaining housing first after a successful research demonstration trial: Lessons learned in a large urban center. Psychiatr Serv. 2017;68(7):739-42.	Canada
	E67	Nelson G *et al.* What Happens After the Demonstration Phase? The Sustainability of Canada's At Home/Chez Soi Housing First Programs for Homeless Persons with Mental Illness. Am J Community Psychol. 2017;59(1-2):144-57.	Canada
	E68	Stergiopoulos V *et al.* Dynamic Sustainability: Practitioners' Perspectives on Housing First Implementation Challenges and Model Fidelity Over Time. Res Soc Work Pract. 2016;26(1):61-8.	Canada

Source: Authors.

Management and Assertive Community Treatment (ACT). Both are community-based care models indicated by the HF as a proposal to operationalize the support offered to residents. The ACT is most often used for people with great need for mental health support and Case Management for those with moderate needs[56]. Studies that addressed programs that used only the ACT appear less prominently[29,47,50,57-59].

Factors that influence the implementation of the HF

The difficulties and facilities faced in the HF implementation process are analyzed here based on four dimensions: characteristics of the proposal, context in which the intervention was introduced (beneficiaries, network of local services, and community), institutional aspects (values, attitudes, competencies, resources, and coordination of program actions) and the process of implementing the proposal (selection of participants, housing structuring, and offering support to beneficiaries). In Chart 2, the factors are grouped as they represent barriers or facilitators and the respective sources indicated according to the numbering of the studies established in Chart 1.

Discussion

Transposing an intervention proposal to concrete situations finds support and resistance in the local context[60,61]. In the specific case of Housing First, it appears that the set of evidence available on the effectiveness of the intervention confers legitimacy to the model, favoring its perception as a more effective solution than other interventions in addressing the problem of the homeless situation[62]. However, since the proposal is externally conceived, implementing agents may perceive that the local capacities are not properly considered in the planning and implementation of the intervention and that the model carries low permeability for adaptations[34,62].

Still regarding the characteristics of the proposal that challenge implementation, the HF model can be perceived as complex due to the level of change in attitude required from implementers, the need for interaction between agents and institutions with different cultures and institutional practices, besides the lack of program operational clarity. It should also be noted that, when the opportunity for implementation takes place through pilot projects, after the demonstration period, the uncertainty about the sustainability of the intervention also seems to influence the lack of engagement[62,63].

Attitudes that deviate from the fundamentals established in the HF[35,46,64,65], especially with regard to focusing the program on people with more complex needs (such as those who make heavy use of drugs and have low adherence to health treatments), compromise critically the implementation of the model. For example, the establishment of criteria and time limits for the permanence of participants in the program[44,66,67] threatens the model's assumption of housing stability and reduces the capacity to interrupt the logic of temporary housing, marked by the alternation between life on the streets, public institutions, and poor housing.

These and other practices that would account for the model's assumptions may be associated with broader reproduction of social inequalities[68,69], which may represent a greater challenge when the implementation occurs in settings of such unequal social relationships, as in the Brazilian case[70]. This debate has been addressed in the public policy literature on discretion, including a Brazilian study in the field of care related to drug use[71].

Overcoming barriers to accessing housing while ensuring intensive support to residents is the central process for implementing the HF, a robust mission that requires technical, organizational and governance capacity. While the HF model admits that professionals from the two areas of the program (housing and clinical) work both separately and in the same team[56], differences in these arrangements directly impact the regularity and intensity of monitoring residents[26,63,72-75]. Obstacles to the adequacy of clinical support predominate in different contexts, even in the Canadian experience[76], considered the most consistent with the original HF model. These limitations may partially explain the interventions that fail to achieve improvements in the health status of residents[74,77]. It is noteworthy that factors of other dimensions, such as housing far from the teams' base and turnover of professionals, also interact, disfavoring the quality of monitoring residents.

The use of mixed care arrangements[78] that ensure attention to the diversity and complexity of residents' needs and clearly defined roles are strategies that can reduce conflicts between professionals with different institutional cultures and promote greater implementation capacity.

Chart 2. Factors influencing the implementation of the HF systematized from the studies referenced in Chart 1.

Factors	Barriers	Facilitators
Intervention characteristics		
Intervention source	· Model formulated by external agents (E18, E49, E58, E51) · Specificity of the emerging intervention area (mental health) (E18)	
Evidence	· Insufficient evidence on the effectiveness for drug users (E59) · Perception that the model adopts strategies already used (E59)	· Perception of HF as a more effective solution than other models in solving homelessness(E58) · Robust evidence on HF effectiveness (E49)
Model logic	· Low permeability of the model to the context (E18, E62) · Conceptual and operational uncertainty about Harm Reduction in the HF model (E63,64) · Little clarity on the operationalization of housing support(64) · Model requires a high degree of interaction with organizations and agents from different sectors (E18, E47) · Model presupposes a change in paradigm, values, and attitudes (E18, E47)	
Implementation context		
Characteristics of beneficiaries		
Attitudes and customs	· Severedrug use (E20, E28, E41, E40) · Non-payment of rent(E18) · Conflict with landlord and support team(E62) · Failure to attend meetings agreed with the support team (E2, E18) · Negative perception of experiences in previous services (E61) · Unauthorized guests in the house (E38, E40) · Resistance to using public food services and inability to prepare food (E9) · Cultural and linguistic diversity of residents (E30)	
Needs and resources	· Difficulty in meeting the health, work, and education needs of residents (E3, E27, E29, E61, E62) · Lack of flexibility for family accommodation (E61) · Isolation and solitude (E18, E28, E37, E38, E60) · Lack of minimum income (E9, E18, E42, E57, E62) · Lack of public transport (E29) · Little opportunity to enter the labor market (E14) · Little involvement of participants in program evaluation (E11, E68)	· Computer and internet access (E13) · Residents' participation in service planning (E54)
Service network and community		
Receptivity to HF proposal	· Organizations not very permeable to the new model (E16, E17, E18, E19, E20, E25, E26, E42, E47, E51, E56, E58) · Lack of engagement of local government authorities (E18, E20) · Perception that the new intervention harms existing traditional services (E58,45) · Local traditional service agents feel disqualified (E48, E58)	· Credible political agents help build the implementation agenda (E50)
Structure	· Low number of services available to meet the needs of residents (E25, E28, E37, E62)	· Existence of a community network of support services that complements the intervention offerings (E9, E29)
Stigma	· Attitudes of intolerance, stigma, prejudice and discrimination by landlordsand neighbors (E12, E14, E20, E29, E38, E57, E60)	

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Chart 2. Factors influencing the implementation of the HF systematized from the studies referenced in Chart 1.

Factors	Barriers	Facilitators
Institutional aspects		
Context of the responsible organization	• Organization outside the local network (E58) • Organizationoutside the field of mental health (E18) • Lack of experience in the integration of homeless people (peers) as team members (E49) • Organizational culture not aligned with the Harm Reduction approach (E48)	• Previous experience with housing services for people living in the streets (E30) • Involvement in defending the rights of the public served (advocacy) (E62)
Values, beliefs and attitudes of managers and staff	• Difficulty in breaking with the logic of treatment first and adopting the Harm Reduction approach (E4, E17, E19, E42, E61, E62) • Moral judgment about the merit of housing (E25) • Lack of team adherence to the participant's choice of housing (E43) • Authoritarian, stigmatizing and hostile attitudes (E1, E24, E26) • Ambiguity regarding the length of stay of beneficiaries in the program (E64) • Conflicting priorities and expectations between housing workers and case management teams (E39)	• Team and managers with values, skills and attitudes aligned with the model's objectives (E24, E29, E34, E49) • Positive attitudes of senior management (allocation of resources, performance monitoring, and participation of mid-level managers) (E15) • Leadership of the local manager (decision-making skills, clear and direct communication, promotion of a cooperative atmosphere) (E29)
Managers and staff capacities and competencies	• Lack of understanding of the HF principles (E48) • Unqualified staff and practical repertoire of essential implementation competencies (harm reduction, motivational interview, user-centered planning, racial approach (E4, E6, E27, E29, E30, E33, E35, E36, E57)	• Clarity on the HF model (E20) • Ability and autonomy to make clinical judgments (E3) • Ability to maintain a good relationship with lessors (E60) • Team with previous experience in supportive housing services (E24, E29, E34) • Good communication with people with severe mental disorder (55) • Staff capable of integrating alcohol and drug care with mental health support (17)
Continuing education	• Lack of technical supervision for the team (E18) • Lack of training to deal with housing problems (moving and relocating) and mental health problems (E26, E29)	• Permanent technical training and supervision conducted by experienced people on the HF model (E52)
Coordination of program actions	• Lack of coordination between internal teams (housing and clinical support) (E18, E20, E27, E33, E57, E60, E66, E68) and with other service providers to meet the multiple needs of residents (E6, E58, E18, E24, E27, E29, E30, E34, E48, E62, E66) • Little clarity in defining the roles and competencies of housing and clinical support teams (E29, E57) • Support team overloaded by the accumulation of clinical and housing support tasks (E7, E15, E26, E29)	• Governance structure that defines roles and responsibilities, resolves conflicts, articulates a network of services and has good communication (E15, E20, E29, E49) • Permanent spaces for planning and intersectoral discussion with the different agents involved (E18, E30) • Partnership with government servicesand sectors to facilitate access to housing units and income transfer benefits (E29) • Partnership with landlords to resolve conflicts and favor housing maintenance (E29)

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Chart 2. Factors influencing the implementation of the HF systematized from the studies referenced in Chart 1.

Factors	Barriers	Facilitators
Implementation processes		
Eligibility	• Use of eligibility criteria that disadvantage groups with less access to public services and more vulnerable (E5, E36, E26, E66, E63, E65) • Expectation of meeting housing readiness requirements (treatment and degree of functionality) (E34) • Excessive discretion of the team in the eligibility of participants (E8, E46) • Restriction of choice of type and place of residence to participants due to the level of support need and past behavior (E16, E25)	
Housing structuring		
Access to real estate in the private market	• Prejudice and stigma by the landlordss(E1, E11, E14, E40, E60) • Landlordsspecific rental requirements for program participants (criminal background check, credit history) (E17, E37, E38) • Scarcity of affordable housing in desirable locations(E11, E14, E15, E16, E18, E19, E20, E27, E28, E29, E33, E36, E38, E39, E43, E45, E60, E61, E62, E68) • Lack of interest of the real estate market (private and public companies) in supporting the intervention (E42) • Difficulties in negotiating (time and skill) with landlords (E20) • Lack of a structured mechanism to search for housing (E26, E36)	
Access to public property	• Lack of funding for social housing programs (E27) • Low program integration with the public housing sector (E15, E21) • Limitation on the amount of social housing available (E25)	
Access to housing subsidies	• Inadequate and insufficient subsidies to pay for rent, structuring, and housing maintenance (E8, E15, E19, E20, E26, E33, E37, E39, E40, E42, E48, E60, E61, E62) • Limited experience of local governments in granting housing subsidies to people living in the streets (E20) • Difficulty in sharing program costs between the sectors involved in the intervention (E17)	

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However, more robust governance structures are required to ensure the coordination of services in cases where housing and clinical support modalities are provided by different institutions or belong to different systems. Regardless of the arrangement adopted, there is a concern that those responsible for clinical monitoring are not burdened with solving problems of structuring and maintaining homes and end up adopting a passive posture vis-à-vis investing in psychosocial rehabilitation[73,79].

Specific difficulties in putting into practice the Harm Reduction proposal are attributed to the lack of conceptual and operational clarity of this approach within the HF, besides the agents' lack of a practical repertoire of skills essential to its implementation, emphasizing motivational interview techniques, user-centered planning and clinical management of crisis situations[52,63,65,80]. On the other hand, the quantity and quality of interaction between the team and users are a determining factor for the construction of

Chart 2. Factors influencing the implementation of the HF systematized from the studies referenced in Chart 1.

Factors	Barriers	Facilitators
Support to residents	• Difficulty in maintaining regularity and intensity of clinical support to residents (E5, E6, E26, E30, E44, E53) • Prevalence of housing support duties over supporting adaptation and recovery process(E68) • Houses far from the team's base (E11, E12, E14, E37, E68) • Difficulty keeping a 24-hour support team (E11) • Use of controlling and demanding practices (E32, E68) • Turnover of professionals and managers (E18, E28) • Lack of resources for the complete structuring of support services (E11) • Insufficient teams to ensure intensive support to residents (E14, E19, E26, E57, E62) • Difficulty in realizing the inclusion of peers in the team (E52)	• Mixed care arrangement (case management and assertive treatment in the community) (E13) • Use of remote technology to monitor residents (E13) • Implementation of actions for the economic stabilization of participants (request for income transfer benefits and financial planning) (E2) • Work with neighbors and landlordsto prevent crisis situations (E2) • Knowledge about available and appropriate community resources for beneficiaries (E2) • Involvement of peers in establishing a positive relationship between resident and staff (E10, E29) • Separation between clinical and housing support team (E41) • Consideration of socioeconomic aspects (race, age, gender) when choosing the residents' support team (E3)

Source: Authors.

positive relationships that favor the practice of Harm Reduction and Recovery[59,81], and the offer of support geared to addressing the economic insufficiency of the residents[81]. Managers and teams with values, attitudes, and technical skills aligned with the HF principles, and offering continuing education, are the driving elements of the implementation process.

Limitations of existing community services, which act complementarily to the HF to meet the multiple needs of residents, indicate that the barriers historically faced by this public to access basic goods and services (health, minimum income subsidies, public transport, and communication means) require stronger local partnerships and agreements to overcome them. Failure to meet these needs adversely affects implementation, albeit in other ways. For example, the lack of transport and telephone hinders maintaining bonds with family and friends, participating in city life, and scheduling follow-up visits, which are factors associated with the residents' feelings of isolation and loneliness[82]. The same can be said for their lack of engagement and adherence to the program, which can be influenced by negative experiences in similar programs, lack of transportation to attend services, and irregular offer of services in the network.

Difficulty in accessing adequate and sufficient housing and housing subsidies, reported in more than half of the studies analyzed and found in all countries represented in the review, appears as a persistent factor inhibiting the materialization of the other central component of the HF proposal: facilitated access to permanent housing, respecting the choice of the participants. Besides the housing system's local conditions, which include limitations of the social housing policies and the private real estate market, the unavailability of housing is also associated with the stigma and prejudice of property owners towards applicants for tenancy, which hampers structuring of dwellings in the desired time and place and implies recurrent relocation of participants as a result of

conflicts and evictions. As the housing system is one of the biggest challenges not only to the HF implantation process, but also to the proposal's scaled and sustainable development, the debate on its implementation must consider the globally experienced housing crisis and its regional and local particularities[83].

The systematization of contextual factors in the proposed dimensions and in the difficulties and facilities categories was an important exploratory instrument to identify relevant issues in the experience of implementing the HF, and the different levels at which they operate (individual, institutional and social). However, this division must be relativized, since the aspects underlying the context are related to each other and are seen as barriers or facilities in different degrees of importance and intensity, depending, for example, on the stage of implementation of the HF.

It is noteworthy that there is no consensus in the literature about the boundaries that delimit the context and that, for some evaluators, the dimensions considered in this study, for example the design of the proposal, can be external to the context and restricted to the intervention[60]. On this issue, we believe that, in our case, the adoption of a comprehensive concept of context was advantageous as it resulted in an overview of factors that subsidized perspectives for future in-depth research and potentially included realities of several contexts. On the other hand, the selection criteria adopted for this review, especially the set of words and the type of publication – which was restricted to empirical studies published in scientific journals – potentially limited the identification of a greater number of factors.

The significant number of papers, almost a third of the total analyzed, addressing the same Canadian pilot study – *At Home/Chez Soi*, and the prevalence of a group of seven researchers who are authors in more than a quarter of the publications, are two very relevant aspects. From the perspective of the characteristics of the analyzed studies, we should emphasize that most of the selected studies do not sufficiently characterize the local conditions of the health, social assistance, and housing social policies in which HF programs are developed, which reduces the ability to analyze which strategies can be adopted in particular circumstances of public policy outside the North American, European, and Australian contexts. In this sense, the reading of the factors systematized here, in dialogue with an in-depth description of the political context and the social protection system of the countries in which the HF was consolidated, can contribute to better adapting the model to the Latin American needs.

Since the object of intervention of the HF, at least in Brazil, is located in the field of public policy (meeting the need for social protection of PLS people who use drugs or have mental health issues), the understandings and proposals formulated on the adaptation of the model nationally should consider the modes of production of Health and Social Assistance services and their existing work processes, and the political disputes surrounding mental health public care. Dimensions related to living in the Brazilian reality, for example, the ideal of home ownership and the high presence of informality in property leasing processes, must also be considered.

Conclusion

This study aimed to understand the challenges and opportunities for implementing this intervention through a literature review. We presented a set of factors relevant to the implementation process of this type of intervention, organized into four dimensions: intervention characteristics, implementation context, institutional aspects, and implementation process. We found that the unavailability of housing, the lack of coordination of the services required by residents and the resistance of implementing agents to the HF principles are the main factors that hinder the implementation. In turn, agents with values, attitudes, and skills converging with the model and continuing education are facilitating elements.

We believe that the study of the literature carried out achieved its objective, providing a set of relevant elements in the analysis, formulation, and improvement of interventions that aim to guarantee the right to housing for people with mental health support needs, besides pointing out aspects relevant to the Housing First expansion process itself. The scope of the contextual dimensions considered provided an opportunity for a broad understanding of the implementation process at structural and relational levels, which can be analyzed in-depth from theoretical frameworks and delimited references.

We point out the relevance of producing new knowledge that favors the integration of HF interventions to existing social protection systems, a decisive process for their implementation and sustainability within the scope of public policy.

Collaborations

The two authors participated in the design, analysis and interpretation of data, and the drafting of the paper.

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