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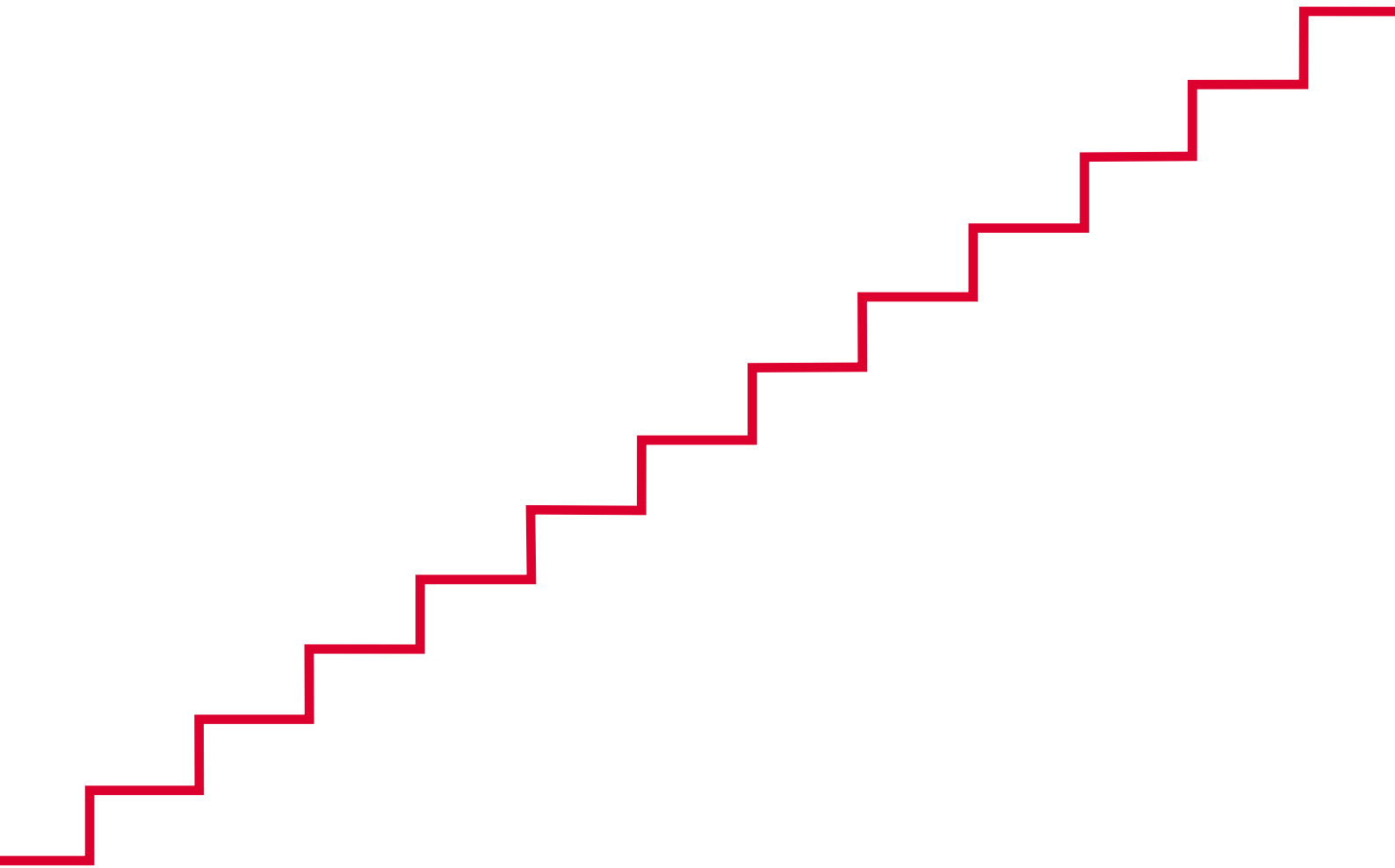
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Staircases, Elevators and Cycles of Change

'Housing First' and Other Housing
Models for Homeless People with
Complex Support Needs

Sarah Johnsen & Lúgia Teixeira



THE UNIVERSITY *of York*

Crisis

About Crisis

Crisis is the national charity for single homeless people. We are dedicated to ending homelessness by delivering life-changing services and campaigning for change.

About CHP

The Centre for Housing Policy (CHP) at the University of York was established in 1990 with the support of the Joseph Rowntree Foundation. In size, financial strength and reputation, CHP is now one of the leading housing research centres in Europe.

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1. Introduction

Homeless people with complex support needs, together with other groups suffering from ‘deep and persistent exclusion’ (Cabinet Office, 2007) or ‘multiple disadvantage’ (DWP, 2010) have become a policy priority in the UK because they are disproportionately ‘failed by’ and/or apparently ‘resistant to’ existing service interventions (Hampson, 2010). Many were included within the remit of the previous Government’s Public Service Agreement 16 (PSA 16) ‘Socially Excluded Adults’ and/or ‘Adults facing Chronic Exclusion’ (ACE) initiatives, and the challenges they face have recently been highlighted in the voluntary sector’s ‘Making Every Adult Matter’ manifesto (MEAM, 2009). Under the new Coalition Government the language may have changed (referring to ‘multiple disadvantage’ rather than ‘social exclusion’, for example) but homeless people with complex needs continue to be a policy priority (Cabinet Office, 2010)¹.

The recent *No One Left Out* rough sleeping strategy in England calls for the development of more effective approaches to housing this group (CLG, 2008), particularly those who are homeless for prolonged periods (sometimes referred to as the ‘stock’ homeless) and/or those who fall back into homelessness after failing to sustain a tenancy (i.e. ‘returner’ homeless) (Cebulla et al., 2009). The previous Government’s ambitious target of ending rough sleeping in England by 2012 (CLG, 2008) acted as a significant driver for developments in this area. It seems the new Coalition Government is unlikely to support this goal at the national level, but will nevertheless encourage local authorities to set their own targets for reducing rough sleeping. The Coalition Government has also set up an inter-Ministerial Working Group to address the issue. In London, the Mayor has also promised that by the end of 2012 no one will be living on the city’s streets, and no one ending up there will sleep out a second night.

To drive this process, he set up the London Delivery Board – the first action of which was to work with the 205 most ‘entrenched’ rough sleepers in the capital².

Many providers are thus looking at new and different models, including those developed overseas, when adapting their own services to better meet the needs of this often ‘difficult to engage’ group. To inform this process, the Centre for Housing Policy (University of York) and Crisis have reviewed the evidence base regarding the effectiveness of both ‘orthodox’ and ‘innovative’ models of supported housing for homeless people with complex support needs. The study assessed existing evidence regarding what ‘works’ for homeless people with complex support needs and drew together ‘lessons learned’ in other developed countries.

This report summarises the findings of the study, which was funded by the Economic and Social Research Council. It involved a review of international literature and a series of interviews with 19 key stakeholders in the UK, US and Australia³. The UK-based interviewees included policy makers, commissioners, and practitioners working in the homelessness, mental health and substance misuse fields. The overseas participants included homelessness service providers and researchers who had reviewed the efficacy of different housing models in those countries.

This research focuses on homeless people with complex support needs, clearly a vulnerable segment of the homeless population. For the purposes of the study, homeless people with complex support needs were defined as those with moderate-to-severe mental health problems and/or active substance abuse problems (drugs, alcohol, or polysubstance misuse). The study focused on adults aged 25 and older, given consensus

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that existing 'transitional' models are often appropriate for young homeless people (Quilgars et al., 2008).

The report begins with a review of international literature (Chapter 2), providing an overview and critique of 'linear' housing models which prevail in many developed countries, as well as the 'Housing First' model which has been increasingly embraced in recent years in the US. The next chapter (Chapter 3) examines developments in the UK, noting that the predominant approach to housing homeless people here, as in many other developed countries, is linear in nature. Chapter 3 also explores the extent to which a Housing First model might be replicated in the UK and argues that its implementation here would not represent as much of a paradigm shift in either philosophy or practice as its inception in the US did, and that it could potentially play a valuable role as 'part of the mix' of provision for this group. The report concludes, in Chapter 4, with a discussion of the implications of findings for policy and services, as well as for future research on provision for homeless people with complex support needs.

2. The international evidence base

This chapter reviews international literature on housing models for homeless people with complex support needs. The evidence base regarding housing interventions for this group is, in fact, limited. Caton et al. (2007: 29) report that in the US the development and implementation of innovative programmes for homeless people with complex support needs have outpaced the conduct of rigorously designed research focused on this population, such that “while available research suggests promising approaches and implications for practice, it sometimes falls short of meeting the highest standards for defining evidence-based practice”. The same is true – and arguably more so – in the UK given the comparative lack of large-scale longitudinal research in the homelessness field and/or rigorous independent evaluations of service interventions (Fitzpatrick et al., 2009; Pleace, 2008). After their recent call for evidence regarding mental health and street homelessness in England, for example, St Mungo’s (2009: 47) concluded that academic and clinical research on relevant interventions was ‘woefully absent’.

The evidence drawn upon in this review thus varies in terms of its methodological rigour. Some of the interventions referred to have been subject to robust independent evaluation; some assessed using less sophisticated methods; others barely evaluated at all. Accordingly, some of what follows refers to ‘practice based evidence’ (Caton et al., 2007) emerging from the experiences of practitioners – some of which is published, some not. Informal reports of promising outcomes can valuably inform service development and implementation (Caton et al., 2007), and Pawson (2006) notes that even methodologically weak studies can yield ‘nuggets of wisdom’ to similar effect. We do however need to be careful not to (mis)interpret ‘received wisdom’ as ‘sound evidence’, given indications that practitioners’

assertions about the effectiveness of particular practices, or likelihood of particular groups successfully maintaining independent accommodation, are sometimes inaccurate or unfounded (Chilvers et al., 2009; Stefancic and Tsemberis, 2007).

An additional caution must be noted regarding the comparability of evidence drawn from very different contexts⁴. To date, almost all robust studies regarding housing interventions for this group emanate from the US (see Section 2.2). It is, as Atherton and McNaughton-Nicholls (2008) note, difficult to draw general conclusions regarding interventions used in contexts with different welfare regimes, scales of homelessness, client characteristics, service networks, and housing stock. Literature on policy transfer highlights the potential pitfalls of de-contextualising interventions developed elsewhere. Dolowitz and Marsh (2000), for example, note that policy transfer can lead to policy failure if: the ‘borrowing’ country is *uninformed* about the way a policy operates in its home country; the transfer is *incomplete* because components crucial to its effectiveness are omitted; or the transfer is *inappropriate* because insufficient attention is paid to economic, social, political and ideological differences between the two contexts. Factors such as housing supply and regulation, for example, will shape not only the accessibility of provision but also providers’ willingness to ‘take risks’ with vulnerable groups.

Existing literature thus offers many insights that might guide service development and implementation on the ground (Caton et al., 2007), but we must be careful to avoid what Kertesz et al. (2009) refer to as ‘over-reach’, that is, the over-generalisation of research results. It would, for example, be unwise to assume that the findings of a study assessing the effectiveness of an intervention with one

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particular client group would necessarily hold true for others, or would necessarily be replicated in another context where welfare entitlements and/or service availability may be very different.

With these important caveats in mind, the following subsections provide an overview of linear housing models – the predominant approaches to housing homeless people in the developed world – and contrast these with the newer Housing First model which has become increasingly popular in the US. The evidence base regarding the effectiveness of these and other permanent supportive housing models is then reviewed.

2.1 Linear Housing Models

2.1.1 Philosophy and approach

The prevailing approach to housing homeless people in the developed world – most notably the US, Europe and Australia – can be described as 'linear' in nature. The most well known is the 'continuum of care' which has historically been predominant in the US. Whilst the exact form of the service varies, the model essentially involves 'progressing' homeless people through a series of separate residential services – typically emergency shelter programmes, transitional housing and supportive housing (Wong et al., 2006) – toward independent living, wherein:

In each setting ... the client is to become stabilized clinically and to learn specific skills. Once the client's level of functioning improves, or his or her need for services lessens, the client 'graduates' and moves to a more normalized and less restrictive setting.

(Ridgway and Zippel, 1990: 12)

Similarly, in Sweden and many other European nations, the 'staircase' metaphor is used to describe shelter/housing systems where an individual's housing becomes progressively more 'normal' as they:

... ascend step by step from the streets to a regular dwelling of their own via low-standard shelters ... training flats, and transitional flats. The higher they climb, the better their conditions in terms of physical standard and space, freedom and security of tenure.

(Sahlin, 2005: 117)

There may be as many as five or six stages to these processes, with the end point being either general needs or permanent supported housing – albeit that there is a recognition that some clients will stop moving when they reach the most 'housing-like' setting deemed appropriate to their needs (Pleace, 2008).

In both the continuum of care and staircase models, placement of clients in 'normal' independent housing is only contemplated when they exhibit sufficient evidence of 'housing readiness'. They are founded on a 'treatment first' philosophy which require detoxification and sobriety before enabling access to independent housing (Padgett et al., 2006). Progress is conditional on evidence of sustained abstinence from substance misuse; residents may be sent back/down a stage or ejected altogether if they relapse (Dordick 2002; Sahlin, 2005) as sobriety is assumed to be a necessary precondition for achieving independent living (Hansen Lofstrand, 2010). Progress along the continuum or up the staircase is also conditional upon acceptable behaviour and compliance with treatment/support programmes (Gordon, 2008; Sahlin, 2005).

2.1.2 Evidence of effectiveness

It is widely acknowledged that linear approaches do 'work' in terms of bringing many street homeless people indoors and preparing them for independent living (Gulcur et al., 2003), as transitional housing programmes enable them to attain the resources and skills needed to bridge the gap between the street and settled accommodation (Kresky-Wolff et al., 2010)⁵.

Some commentators have concluded on the basis of the evidence available that the linear approach can work particularly well with people who are willing to engage with rehabilitation programmes and are able to cope with shared housing arrangements (Tainio and Fredriksson, 2009).

However, a number of academics have recently argued that the evidence base regarding the efficacy of transitional supported housing for homeless people with complex support needs and other vulnerable groups is actually very weak (Caton et al., 2007; Chilvers et al., 2009). *The Cochrane Review*, for example, argues that in the absence of robust research comparing different types of intervention for people with severe mental health problems – particularly dedicated supported housing schemes vis-à-vis independent tenancies with outreach support. The question of whether the benefits of supported housing outweigh the risks is currently only a matter of opinion, debate and informal report as “no one intervention has been shown to be more effective than another in making a difference to symptoms, future use of services, quality of life, or other measures of importance” (Chilvers et al., 2009: 6).

In this vein, the continuum of care and staircase models have been subjected to criticism – some of which has been severe – in recent years (e.g. Sahlin, 2005; Hansen Lofstrand, 2010). Many critiques have centred on their high attrition rate, that is, the loss of service users between stages (Gulcur et al., 2003; Pleave, 2008). This is commonly attributed to:

- the stress of constant change as clients move between projects;
- the reduction in support at each stage which may not suit people with multiple needs;
- use of standardised (‘one size fits all’) support programmes;
- lack of service user choice/control; and

- the ineligibility/rejection of potentially problematic clients (Tsemberis and Asmussen, 1999; Sahlin, 2005; Wong et al., 2006).

Many homeless people with complex needs are unable to meet the demands of such a system and therefore fail to progress to the ‘end’ of the continuum or reach the top ‘step’, that is, achieve independent living (Kertesz et al., 2006). This, Sahlin (2005) argues in relation to the Swedish context, means that the staircase system has lost credibility in the eyes of some homeless people, as they are reluctant to persist after having been humiliated by the rules, surveillance or harsh sanctions of projects, or because they feel let down despite good conduct and patience.

More fundamentally, critics have targeted the principles underpinning continuum of care / staircase approaches – deeming them illogical given the dissonance between linear rehabilitative approaches and the highly variable process of recovery from mental health problems:

The course of psychiatric disorders, and of recovery and rehabilitation, are highly variable, nonlinear, and unique to each individual. Requiring a certain type of progress to occur in a certain time frame can spell failure.

(Ridgway and Zippel, 1990: 12)

Likewise, it is widely acknowledged that addiction recovery is not a linear process, but rather involves cycling back and forth through a number of stages (Carver, 2004; Gregoire and Burke, 2004; West, 2006). Prochaska and Di Clemente (1986) added the ‘relapse’ stage to their influential transtheoretical ‘cycle of change’ model of recovery in recognition of the fact that relapses are in many senses inevitable. When applied rigidly, as in Sweden for example (Sahlin, 2005), linear approaches arguably allow little room for the often haphazard process of addiction recovery.

Many academics have also objected to the rhetoric of 'social improvement' (Hoch, 2000) and emphasis on the 'deficiencies' of homeless people (Sahlin, 2005) underpinning these models. Such a view, Hansen Lofstrand (2010) argues, neither challenges the presupposition that homelessness is a result of addiction, mental illness and general 'deviance', nor provides an effective mechanism by which homeless people can (re)establish themselves on the *regular* housing market without having to navigate their way through a complex service system.

Continuum of care / staircase models have been subjected to severe criticism in many countries (but not the UK – see below) as a result of such concerns and in light of emerging evidence of the much better housing outcomes associated with an alternative, Housing First, model (Atherton and McNaughton-Nicholls, 2008; Pleace, 2008). It is to this model that discussion now turns.

2.2 The 'Housing First' model

2.2.1 Philosophy and approach

The Housing First model essentially 'bypasses' transitional stages characteristic of linear models by placing the most vulnerable homeless people directly from the street or emergency shelters into permanent independent tenancies, with comprehensive yet non-compulsory, support. As the name implies, the model is founded upon a 'housing first' rather than 'treatment first' philosophy, thus marking a paradigm shift in the approach to housing vulnerable people in many countries (Kresky-Wolff et al., 2010; Ridgway and Zippel, 1990). It does not attempt to 'fix' clients to make them 'housing ready', but rather is premised on the assumption that the best place to prepare for independent living is in independent accommodation.

The model was first developed in the US, and its inception is generally attributed to Dr Sam Tsemberis, a psychologist based in the Pathways to Housing organisation (henceforth referred to as 'Pathways') in New York. In its early days, the model targeted chronically⁶ homeless people with severe mental illness, and has subsequently been used with chronically homeless people with substance misuse problems (Larimer et al., 2009). The Housing First model, or variants thereof (see below), has been or is being replicated in many other countries including Canada, Australia, Japan, Finland, the Netherlands, and Ireland (Gordon, 2008; Loopik, 2008; Tainio and Fredriksson, 2009).

In contrast to linear models, Housing First separates treatment from housing, considering the former voluntary and the latter a fundamental need and human right (Padgett et al., 2006). Advocates of Housing First argue that by providing permanent, independent housing without prerequisites for sobriety and treatment, and by offering (but not insisting upon engagement with) other support, the model removes some of the

major obstacles to obtaining and maintaining housing for chronically homeless people.

Key elements of the model, as endorsed by Pathways in the US – see for example Tsemberis and Asmussen (1999), Tsemberis and Eisenberg (2000), Tsemberis et al. (2004), Stefancic and Tsemberis (2007), Padgett et al. (2006), Pearson et al. (2009) – include:

- Immediate provision of *independent accommodation* in ‘normal’ private rented scatter-site housing leased by the provider. No more than 15 per cent of housing units in any single building are used to accommodate clients so as to promote community integration.
 - *No requirement regarding ‘housing readiness’*; that is, an absence of high threshold admission criteria regarding sobriety, basic living skills, or motivation to change. Consumers may refuse clinical services, such as taking psychiatric medication, seeing a psychiatrist, or working with a substance use specialist. Housing is regarded as a basic human right, not something that should be earned or used as an enticement into treatment or sobriety.
 - Deployment of a *harm reduction*, rather than abstinence, approach to substance misuse. This separates clinical issues from housing issues, such that a clinical crisis (e.g. relapse) does not result in eviction. There is no expectation that users enter treatment for either mental health or substance abuse problems; they may refuse both without compromising their housing.
 - Provision of *permanent* housing and support. Apartments are permanent and kept open for service users if they are temporarily incarcerated or hospitalised, and access to support is not time-limited.
- Consumers only risk eviction⁷ for the same reasons as other building tenants such as non-payment of rent, creating unacceptable disturbances to neighbours, or other violations of a standard lease.
- Respect for *consumer choice* regarding: a) choice of apartment and furnishings; b) levels of engagement with support; and c) the location and times of contact with support workers. Clients must express an interest in receiving housing, but may refuse services (such as seeing mental health or substance use specialists). The only requirement is that they meet with staff a minimum of two times per month in the first year⁸, and participate in a ‘money management’ programme⁹.
 - Provision of *integrated and comprehensive community-based support* to consumers through multidisciplinary Assertive Community Treatment (ACT) teams. ACTs comprise social workers, nurses, psychiatrists, peer counsellors (former homeless persons with similar experiences) and employment workers. The teams are located off-site, but are on-call 24 hours a day, seven days a week, on a time-unlimited basis and provide most services in a client’s home or neighbourhood.
 - *Targeting of the most vulnerable* consumers – that is, those who have difficulty coping with or succeeding in traditional services and/or are resistant to service interventions¹⁰ – and then accept these consumers on a first-come, first-served basis.
- The Housing First model has been increasingly embraced in recent years within the US due, in part, to the positive housing outcomes reported (see Section 2.2.2 below), but also the US Federal Government’s endorsement of and provision of funding for Housing First approaches¹¹.

This led to the reorientation and 'rechristening' of many existing services, such that a wide range of projects following some, but not all, of the operational principles of the Pathways model are branded as 'Housing First' (Caton et al., 2007; Pleece, 2008; Pearson et al., 2009). One US stakeholder interviewee described the impact of such evolution as follows:

Government at the local level has been saying that they intend to have a Housing First approach in their community, and so what that means is the local providers just start saying 'Yes, we're doing Housing First here', and it turns out they're really not at all, it's transitional housing where they're trying to fix people up and then move them on. And that's sort of the antithesis of Housing First.

(US homelessness service provider)

Departures from the Pathways model have also been evident in other countries as Housing First has been replicated internationally (Atherton and McNaughton-Nicholls, 2008; Gordon, 2008). The most common deviations from the Pathways approach include:

- the use of communal/congregate accommodation as opposed to (or as well as) scatter-site housing;
- greater selectivity in client recruitment (e.g. requiring evidence of willingness to engage with support);
- the lease of housing from providers that disallow drug-use on site (thus compromising Housing First's harm reduction philosophy); and
- imposition of time limitations to provision (see for example Legander, 2006; Pearson et al., 2007, 2009; Perlman and Parvensky, 2006; Stefancic and Tsemberis, 2007; Toronto Shelter Support and Housing Administration, 2007).

This degree of variation in implementation makes it difficult to draw firm conclusions regarding the effectiveness of Housing First, but existing literature identifies a number of key outcomes, which are summarised below.

2.2.2 Evidence of effectiveness

Almost all existing evidence regarding Housing First outcomes is drawn from the US (Atherton and McNaughton-Nicholls, 2008) – the most well-known and robust of which come from the Pathways evaluations (Gulcur et al., 2003, 2007; Padgett, 2007; Padgett et al., 2006; Tsemberis and Eisenberg, 2000; Tsemberis et al., 2004; Yanos et al., 2007). Other influential studies of programmes following a Housing First approach in North America include: Pearson et al. (2007, 2009), Perlman and Parvensky (2006), Larimer et al. (2009), Kresky-Wolff et al. (2010), Stefancic and Tsemberis (2007), and Toronto Shelter Support and Housing Administration (2007).

The most widely heralded outcomes of Housing First relate to housing retention. These have been described as exemplary in comparison to those of linear approaches, which are reportedly 'moderate at best' (Kertesz et al., 2009). The Pathways Housing First programme sustained an 80 per cent housing retention rate over two years (Tsemberis et al., 2004). At the end of the four-year Pathways evaluation¹², Housing First clients were stably housed 75 per cent of the time during the previous six months, compared to 50 per cent of the time amongst homeless people in the continuum of care control group (Padgett et al., 2006). Moreover, Tsemberis and Eisenberg (2000) reported that the risk of discontinuous housing was approximately four times greater in linear as compared with Pathways samples. Such statistics, the Pathways evaluators and other commentators have argued, fundamentally challenge prevailing assumptions that chronically homeless people with co-occurring mental health problems and/or substance dependencies are incapable of

maintaining an independent tenancy (Atherton and McNaughton-Nicholls, 2008; Padgett et al., 2006; Tsemberis and Eisenberg, 2000).

Clinical outcomes have been more mixed, but are generally positive on balance. With regard to physical health, a study comparing the outcomes of Housing First-based housing and case management programmes with a 'usual care' group showed that Housing First clients spent fewer days in hospital and made fewer emergency department visits (Sadowski et al., 2009; see also Martinez and Burt, 2006). In terms of mental health, the Pathways evaluations reported no significant differences in psychiatric symptoms between Housing First clients and the continuum of care control group (Tsemberis et al., 2004), but showed reduced incidence of psychiatric hospitalisation at 24 months (Gulcur et al., 2003). Other studies, however, suggest that Housing First impacts on the level of impairment related to psychiatric symptoms and substance misuse have been limited (e.g. Pearson et al., 2009).

When assessing patterns of substance misuse, Tsemberis et al. (2004) reported that Housing First clients did not increase their use of drugs or alcohol at 24 months, despite their lesser use of treatment services in comparison to clients in linear provision. Similarly, Padgett et al. (2006) discovered that after four years there was no difference in alcohol and drug use, though a non-significant trend toward lower alcohol use by the Housing First group was identified. Larimer et al. (2009) reported similar outcomes from a Housing First programme for chronically homeless people with severe alcohol problems, in that residents experienced a reduction in both overall alcohol consumption and likelihood of drinking to intoxication over time.

Many reports conclude that Housing First is a highly cost-effective approach, which offsets costs via a reduction in clients' use of expensive emergency services (Gulcur

et al., 2003; Larimer et al., 2009; Loopik, 2008; Perlman and Parvensky, 2006; see also Culhane et al. 2002; Martinez and Burt, 2006). An evaluation of the Denver Housing First Collaboration, for example, calculated that total emergency-related costs (such as use of shelters and hospital emergency rooms) declined by 73 per cent, or an average of \$31,545 per client, in the 24 months of participation, as compared with the 24 months prior; thus generating a net cost saving of \$4,745 per participant after programme costs were accounted for (Perlman and Parvensky, 2006). A number of commentators do however emphasise that cost benefits are likely to be less marked if the model were to be employed with 'less severely debilitated' individuals (Kertesz and Weiner, 2009; Larimer et al., 2009).

Existing literature provides limited information on service user satisfaction with Housing First programmes, and the evidence that does exist is mixed. In one study of five housing programmes across the US, interviews with 136 residents revealed no differences in housing satisfaction between Housing First and supportive housing residents' satisfaction with their housing (Robbins et al., 2009). In contrast, a survey of 88 Housing First programme users in Toronto demonstrated that the vast majority were satisfied with their housing and had seen improvements in nearly all quality of life indicators – with 82 per cent reporting that their outlook for the future was more positive, for example (Toronto Shelter Support and Housing Administration, 2007). Similarly, Padgett's (2007) study involving 39 of the original Pathways recruits – including those who had both positive and negative housing outcomes – indicated that the provision of housing served as marker of ontological security, that is, the feeling of wellbeing that arises from a sense of constancy in one's social and material environment.

Only a few studies explicitly consider issues such as social isolation, community

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integration, and/or participation in meaningful activity – and findings indicate that these areas remain problematic. Padgett (2007: 1934) for example, concluded that despite the ontological security offered by Housing First (see above), “other core elements of psychiatric recovery such as hope for the future, having a job, enjoying the company and support of others, and being involved in society ... have only been partially attained”. Similarly, Yanos et al. (2007: 712) concluded that many of the 44 Pathways clients involved in their study – whom had been stably housed for an average of three years – seemed to live “lives without any involving pursuits or set of meaningful social connections”.

Data on the financial wellbeing of Housing First customers is especially sparse. The few studies mentioning such outcomes suggest that the model is effective in ensuring clients receive all the welfare benefits to which they are entitled (Perlman and Parvensky, 2006), but that many continue to live in poverty. For example, 68 per cent of the study of 88 Housing First customers surveyed in Toronto reported that they did not have enough money to live on after paying rent (Toronto Shelter Support and Housing Administration, 2007).

2.2.3 The fidelity debate

Studies comparing the outcomes of different Housing First programmes indicate that those most closely aligned with the Pathways model tend to report the best housing retention rates. The first US federal government commissioned multi-site study of the implementation and outcomes of Housing First – which involved Pathways and two other providers across three cities – concluded that those allowing greater flexibility in programme rules and responsiveness to housing issues generated greater levels of housing stability (Pearson et al., 2007, 2009). Similarly, when comparing the outcomes of a Pathways project and a Housing First programme provided by a newly formed consortium, Stefancic and Tsemberis (2007) attributed the variation in 47-month housing

retention statistics, which were 78 per cent and 57 per cent respectively, to the different approach used to enrol clients. The consortium apparently rejected clients that were eligible but whom clinicians did not consider appropriate for immediate placement in permanent housing. Stefancic and Tsemberis (2007) suggest that new Housing First providers may still be reluctant to work with people who are traditionally ‘difficult to house’, and conclude that the consortium’s poorer housing retention (despite carrying out a more extensive selection of clients) demonstrates that housing providers and clinicians are not able to successfully predict which applicants will be able to maintain housing.

Debates surrounding the differential implementation and outcomes of Housing First have prompted Pathways to create a ‘fidelity scale’, currently under development, which will measure project fidelity to the Pathways model along both structural and philosophical dimensions (www.pathwaystohousing.org, accessed 18/3/10). The fidelity debate highlights two important issues which appear to influence client experiences and outcomes in significant ways. First, it draws attention to the relative merits of scatter-site versus congregate/communal supported housing programmes for homeless people with complex support needs. Advocates of scatter-site housing emphasise its ‘normalising’ influence, described by one stakeholder interviewee as follows:

[When] the building itself is filled with chronically normal people ... it makes the person who is a little bit more idiosyncratic, let's say, behave more like one of those chronically normal people. Because the environmental influence is actually in the direction of conformity all the time, and so you find the person that was a bit off acting more normal, you know? ... All of those people are providing a very healing, normative environment.

(US homelessness service provider)

Kresky-Wolff et al.'s (2010) summary of the 'lessons learned' under the US Federal Collaborative Initiative to Help End Chronic Homelessness (CICH) is also informative. They reviewed data from 11 projects funded under the scheme – all of which claimed to be guided by the Housing First philosophy, but only two of which attempted to replicate the Pathways approach through exclusive use of scatter-site housing. Scatter-site units were reported to foster client recovery by growing a sense of responsibility and stability, but were sometimes associated with social isolation, and were costly in terms of the time and resources required for travel to meet clients. Regarding congregate/clustered accommodation, Kresky-Wolff (2010) reported that staff valued opportunities for regular informal contact with clients which were said to promote trust-building, as well as encourage a shared feeling of community among staff and clients and use of support services to enhance recovery.

The second key issue highlighted by the fidelity debate centres on the issue of consumer choice. A wealth of evidence confirms that the vast majority of homeless people express a preference for mainstream self-contained housing (Busch-Geertsema, 2002, 2005), and that those offered the greatest housing choice are more likely to report greater satisfaction with it (Toronto Shelter Support and Housing Administration, 2007). This issue is, however, very complex. For example, when comparing outcomes for homeless mentally ill people randomly assigned to either independent apartments or 24-hour staffed shared living sites over an 18 month period, Goldfinger et al. (1999) discovered that the stronger participants' baseline preference for independent living, the more days they subsequently spent homeless. They thus advocate consideration of consumer preferences in interventions, but caution that focusing on this without paying attention to other factors will not improve housing outcomes.

The influence of consumer choice in relation to clients' levels of engagement does not appear to have been the subject of explicit research attention, but a study by Lipton et al. (2000) provides evidence that greater consumer choice and control in this area can have a positive impact on housing outcomes for 'service resistant' clients (see also Caton et al., 2007). In that study, Lipton et al. (2000) compared tenancy sustainment over five years of homeless people with serious mental illness who were placed (but not randomly assigned) into high, moderate and low intensity housing – categorised according to the amount of structure imposed and the degree of independence offered to tenants – and discovered that housing retention rates were best in the lowest demand group.

2.2.4 Who does Housing First 'work' for?

As is the case with almost all housing models for homeless people with complex needs (Caton et al., 2007), there is a major lack of definitive evidence regarding which subgroups are most and/or least likely to experience positive outcomes under Housing First (Kertesz and Weiner, 2009). Existing evidence does however give some, albeit tentative, indications as to which groups the model *may* be more effective for.

The majority of Housing First studies have involved evaluations of projects catering for chronically homeless people with severe mental illnesses, that is, DSM-IV diagnoses such as schizophrenia, psychotic disorder, affective disorder, bipolar disorder, depressive disorder, and post-traumatic stress disorder (see for example Tsemberis and Eisenberg, 2000; Padgett, 2007; Padgett et al., 2006). Existing literature provides compelling evidence as to the effectiveness of Housing First with this group, especially as regards housing retention. This, Lipton et al. (2000) suggest, may be because individuals with severe mental illness have a heightened vulnerability to move (back) into unstable living arrangements when placed in 'high intensity' settings with tightly

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scheduled routines, high levels of surveillance, and intensive programme participation requirements.

Many of the clients with severe mental health problems in such studies were reported to have had current, or past, co-occurring substance misuse problems. Very little detail is however provided about the type or severity of their substance misuse (although see Larimer et al., 2009¹³). A number of academics have recently argued that uncertainty remains regarding the applicability of Housing First programmes for people with severe and active addiction (Kertesz et al. 2009; Kertesz and Weiner, 2009). Kertesz et al. (2009) assert that the addiction severity of people entering most Housing First programmes is in fact 'relatively modest'. Indeed the fact that less than 20 per cent of the dually diagnosed Pathways clients used (any) illicit drugs on more than four days in six months (or consumed alcohol on more than 29 days), including at baseline, is in itself telling (Padgett et al., 2006; see also Padgett, 2007). Similarly, whilst approximately half of the 80 participants in the HUD-commissioned multi-site Housing First study (see above) were judged by case managers to be using drugs or alcohol, 'severe impairment' resulting from substance use affected only 20 per cent (Pearson et al., 2009).

A significant body of research demonstrates that substance abuse is a predictor for shorter tenure or tenancy failure in supported housing programmes (Lipton et al., 2000; Culhane et al., 2002; Fichter and Quadflieg, 2006; Malone, 2009; Mares et al., 2007; Wong et al., 2006). One US stakeholder interviewee acknowledged that the vast majority of tenancy breakdowns amongst his organisation's Housing First clientele were of people involved in drug misuse, particularly those at the pre-contemplative stage of Prochaska and Di Clemente's (1986) 'cycle of change':

The group that we lose in this programme, I would say almost all of them are because of addiction ... Because it's independent apartments in the community, people with severe addiction problems tend to figure out ways to use the apartment as a commodity where ... they'll get free drugs in order to allow for others to be there using. And so it becomes a lease violation, really, that triggers the attention of the landlords or the police or somebody, that ends up in them losing their apartment...
(US homelessness service provider)

Dual diagnosis has also been shown to reduce housing retention (Goldfinger et al., 1999). The experiences of the Pathways programme, however, indicate that while it reduces housing tenure in both Housing First and linear control programmes, dually diagnosed Pathways tenants maintained a higher rate of housing retention as opposed to the comparison sample (Tsemberis and Eisenberg, 2000).

Very few studies have examined associations between clients' demographic characteristics and Housing First effectiveness. None of the studies referred to above report relationships between race/ethnicity and outcomes. With regard to age, when assessing housing retention amongst homeless adults with behavioural health disorders¹⁴, Malone (2009) discovered that younger age was associated with higher levels of housing failure. This may, he suggests, reflect the fact that the older cohort comprised people with less extreme needs as a result of premature mortality among those who had been in the cohort previously or, alternatively, that older people are less likely to leave their housing because of physical limitations (Malone, 2009). Other studies, such as Lipton et al.'s (2000) study of tenancy sustainment of homeless people with serious mental health problems have confirmed that older age is associated with longer tenure more generally.

All that said, one should not assume that any particular individual will necessarily succeed or fail on the grounds of them falling within/ outside any of the above groups. As noted earlier, Stefancic and Tsemberis (2007: 275) argue that the fact that some Housing First projects report lower rates of housing retention despite carrying out more extensive selection of consumers during recruitment is symptomatic of housing providers' and clinicians' inability to successfully predict which clients will successfully maintain housing. Indeed it may be that for some individuals the prospect of being allocated independent accommodation heightens their readiness to address substance misuse or other problems. As one US stakeholder interviewee emphasised:

The difficult part about this job is that ... there's no instrument, there's no assessment, there's no diagnosis, there's no way to figure out who would succeed in an apartment or not; unfortunately, because it would save us a lot of trouble! The only way to figure out who doesn't make it is to give them a chance...
(US homelessness service provider)

Mental health and addiction practitioners acknowledged that similar uncertainties exist in their fields, and that existing treatments in either are far from perfect:

It's almost impossible to predict who's going to do well. Some of the people who are most tantalising do terribly ... Yet, other people who look awful actually surprise us and that's the same throughout psychiatry ... Statistically if you've got a long duration of untreated psychosis you're not likely to do as well as somebody who's only been ill for a couple of months, but beyond that it's very difficult to say.
(UK mental health practitioner)

2.3 Permanent supportive housing models

A range of other permanent supported/ supportive housing models for homeless people exist in the US and elsewhere (Caton et al., 2007; Black, 2008; Gordon, 2008). Many are underpinned by a Housing First philosophy, but as Gordon (2008: 4) notes: "not all supportive housing uses a Housing First approach, and not all Housing First approaches use supportive housing". The typical defining elements of supportive housing, nevertheless, include: firstly, the provision of safe and secure (typically self-contained and usually permanent) rental housing that is affordable to people on very low incomes; and secondly, the provision of support by staff with appropriate skills and expertise on-site or nearby (Gordon, 2008).

Supportive housing projects have been developed for a wide range of target groups. Of those accommodating homeless people with complex support needs, Common Ground's 'Street to Home' programme is perhaps the best known. Originating in New York, this has been replicated in other North American cities and is rapidly expanding in Australia. Street to Home projects establish a registry of street homeless people and prioritise these for housing with the aid of a 'vulnerability index'¹⁵, then accommodates targeted individuals in self-contained apartments with on-site support. This approach to prioritising access has parallels with protocols used in some Housing First projects. For example, Seattle's Downtown Emergency Service Centre (DESC) maintains a waiting list and prioritises those at greatest risk due to mental ill health and other vulnerabilities (Pearson et al., 2009).

What makes Street to Home unique from other outreach schemes is the destination housing – this being mixed community housing, owned and managed by Common Ground, which accommodates homeless people with a variety

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of support needs and low income working people within the same buildings. The aim is to create a mixed community which will enable formerly homeless people to become part of 'normal' society by providing them with well-designed, affordable flats that are linked to the services they need to maintain their housing, restore their health, and (re)gain economic independence. Tenants pay 30 per cent of their income toward rent, whether the source is paid employment or government benefits. They can stay for as long as they wish on rent stabilised leases, and the average length of stay is 4.8 years. The overall eviction rate is extremely low, at less than one per cent (www.commonground.org, accessed 22/4/10).

Common Ground has accommodated homeless people in supportive housing since the organisation's inception in 1990, but discovered soon after developing Street to Home that its own eligibility criteria proved insurmountable for many of the street homeless people they were coming into contact with. Intake criteria were thus adapted: exemptions for people having experienced a recent eviction or felony conviction were dropped, as were requirements that they exhibit sobriety for a reasonable period of time, be compliant with mental health treatment, and offer full disclosure and consistent responses during intake.

The first Street to Home programme reduced street homelessness by 87 per cent in the 20-block Times Square neighbourhood during its first two years of operation. The Common Ground model has not, however, yet been subject to independent evaluation, hence its effectiveness in terms of housing retention and other outcomes for homeless people with complex support needs has not been tested fully. Rigorous assessment of the extent to which the model mitigates stigma, promotes community integration, avoids institutionalisation and so on would be invaluable – and arguably essential in light of its rapid expansion in other countries.

The provision of permanent accommodation with on-site support, such as the Common Ground model, is in part a response to calls for more long-term solutions in shared housing/community settings. A number of commentators argue that for *some* homeless people with complex support needs, fully independent housing may be neither a realistic, nor desirable, goal (Busch-Geertsema, 2005; Culhane and Metraux, 2008; see also Pleace, 2008). In this vein, Busch-Geertsema (2005: 221) asserts that:

Relative integration and relative autonomy must be seen as a realistic and valuable goal for those re-housed people who in all probability will remain excluded from 'normal' employment and will continue struggling with restricted resources, not least because of health problems, addiction and advanced age, but also because of structural problems in the labour market.

3. Developments in the UK

This chapter examines developments in housing models for homeless people with complex support needs in the UK. The first section examines linear approaches to housing homeless people, which predominate, despite the limited evidence base regarding their effectiveness for this group. Discussion then turns to the extent to which the Housing First model might be replicated in the UK and stakeholders' views on its potential efficacy here. The chapter concludes by examining other recent developments in interventions for homeless people with complex support needs in the UK.

3.1 Linear approaches dominant

As in many other developed countries (see Section 2.1), in the UK the predominant approach to housing non-statutory homeless people – regardless of their level of support needs – is linear (Shelter, 2008). In most urban areas, the vast majority spend periods of time in hostel and/or other transitional accommodation before moving into independent settled accommodation.

Stakeholder interviews indicated that a 'treatment first' philosophy prevails, with most support agencies requiring evidence of a service user's capability to maintain a tenancy, that is, 'housing readiness', before placing them into independent settled accommodation:

Independent tenancies can work, but not ... for someone that's been on the street for twenty years. Any homelessness provider will tell you the chances of that tenancy breaking down within six months are incredibly high ... so I would say you probably need ... [a] supported housing scheme probably for a year or two and then they move into an independent setting if they're ready.

(UK homelessness service provider)

The main problems we've had is when we've tried to get somebody into better accommodation without treating them, and that's gone badly wrong ... We've actually had to say 'Okay, we've got to treat this person for this before we actually try to change their housing status' ... Because people achieve an equilibrium wherever they are and if you've got, particularly a psychotic disorder, any change in your surroundings is going to be disturbing.

(UK mental health practitioner)

In some local authority areas – most notably the London Borough of Camden – 'pathways' through supported accommodation schemes have become increasingly formalised. These involve the designation of 'assessment beds', 'progress beds' and so on in various hostel and/or supported housing projects, with a penultimate stage akin to a 'trial tenancy' in a self-contained unit. Moves between (or within) projects are conditional on evidence of 'progress' (such as reduction in harmful behaviours associated with drug abuse, for example), and each stage offers progressively more space and independence.

Whilst linear in general projection, such pathways are often implemented much more flexibly in the UK than are the continuum of care / staircase models described above. They sometimes allow for 'horizontal', rather than downward or backward moves if a service user is at risk of abandonment or eviction from a particular setting (Homeless Link, 2010). Moreover, clients sometimes move directly into specialist projects after an initial needs/ risk assessment, bypassing interim stages in generic hostels. This being so, the analogy of an 'elevator' may be a more accurate depiction of how the UK system operates, than would be the 'staircase' descriptor more commonly associated with linear approaches elsewhere (see Section 2.1.1).

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That said, each stage is nevertheless time-limited, with maximum lengths of stay typically ranging between six months and two years¹⁶ largely because of the funding and outcomes framework determined by Supporting People. A number of interviewees did however acknowledge that the 'rules' on this were sometimes bent if providers feared moving an individual on would be detrimental to his/her wellbeing. The ability to exercise such discretion is largely determined by the attitudes of local authority commissioners, which vary:

We've kept people longer than technically we should but otherwise there was nowhere else for them to go ... I mean if you held to the letter of the law you probably shouldn't be doing some of this other stuff that's done in schemes, you know, or SP [Supporting People] would look down on it.

(UK homelessness service provider)

As Pleave (2008) points out, given the lack of formal evaluations of service interventions in the UK, there is very little evidence regarding the effectiveness of the types of transitional housing used in such pathways for homeless people with complex needs. Strengths of the linear approach highlighted by stakeholder interviewees, however, include:

- an ability to monitor changes in clients' clinical status and/or willingness to address underlying issues and amend levels of support accordingly;
- a tangible sense of progression or reward associated with a move to 'better' accommodation; and
- inspiration fostered by witnessing fellow residents make positive lifestyle changes and successfully progress into more independent accommodation.

Conversely, the weaknesses of the linear approach – many of which derive more from the way the service system is *implemented*

than the principles underpinning it *per se* – include:

- the potential damaging influence of hostels (especially large 'traditional' ones) on vulnerable people, resulting at least in part from the 'chaotic' lifestyles of other residents (May et al., 2006);
- inadequate expertise of hostel staff in dealing with people with complex needs (Randall and Brown, 2007; Van Doorn and Kain, 2007); and
- the inability of such a system to prevent social isolation, which is one of the greatest challenges presented by resettlement into independent tenancies (Busch-Geertsema, 2005).

Furthermore, one interviewee pointed out that the moves integral to any linear approach can inadvertently dis-incentivise progress:

The big problem about the UK homelessness system is we dis-incentivise normality or progress because whenever somebody's making great progress we say, 'Great, you don't need to see me now as a key worker' or 'It's time to move on because we're a high support project; you should go to somewhere else' ... I think lots of people, if you've got that hanging over you, [think] 'Where's this going? I'm really making progress but I'm going to have to move soon'. That's a real problem.

(UK homelessness service provider)

Whilst the linear model has not been subjected to the same level of critique in the UK as in many other contexts (see Section 2.1), such assessments are indicative of an increasingly common view that current hostel provisions here – whether or not they form part of a highly structured pathway – are not necessarily conducive to the 'recovery' of homeless people with complex support needs. The introduction of Supporting People and Places of Change improved overall

standards of physical infrastructure and service quality (Foord et al., 1998; Cloke et al., 2010)¹⁷, but:

- levels of eviction and abandonment amongst this group are high (Homeless link, 2010);
- many vulnerable people remain very reluctant to live in hostels, often as a result of prior negative experiences (Cloke et al., 2010; May et al., 2006);
- prolonged periods in even high quality hostels caused by shortages of move-on accommodation can have a detrimental impact on client motivation (Quilgars et al., 2008); and
- use of housing programmes relying on leverage and coercion can hinder recovery from substance misuse and/or mental health problems (Allen, 2003).

A number of providers have therefore begun to consider alternative forms of provision, developing innovative programmes of housing and support that target so-called ‘serial evictees’ or ‘recidivist rough sleepers’. Some exhibit elements of ethos or practice that might be, and sometimes are, described as ‘Housing First-ish’. The following section describes these developments, after providing an overview of stakeholder interviewees’ views of the Housing First approach more generally.

3.2 Deliberations regarding Housing First

3.2.1 Doing it already?

All UK stakeholder interviewees were familiar with the notion of Housing First, but the majority had only a partial understanding of the model’s characteristics. They all knew that it places homeless people directly into independent tenancies, with support, without an interim period in transitional accommodation. Some also understood that it is based on a harm minimisation approach to substance misuse. Yet, there was little awareness amongst interviewees regarding the consumer choice dimension to Housing First, most notably the lack of requirement that clients accept support above a minimal level of engagement. Thus, whilst it seems that UK providers are generally familiar with the basic *process* of Housing First, they are not necessarily fully aware of the *philosophy* underpinning it.

It is therefore perhaps not surprising that a small number of stakeholder interviewees claimed that the UK homelessness sector is ‘doing it already’. The most commonly cited example of a purported ‘Housing First-ish’ intervention was London’s Clearing House – the Rough Sleepers Initiative lettings service for former rough sleepers – which has the capacity to place individuals into studio or one-bed flats directly from the street. Before 2008 the Clearing House offered Assured Tenancies with support, regardless of a client’s level of support needs, thus was effectively a permanent form of housing for people who had experienced street homelessness. Assured Shorthold Tenancies are now used, along with a requirement that residents move on if/when they no longer need support (Broadway, 2010). Individuals are ineligible for the service if they have ‘such high support needs that their tenancy is likely to fail’ and/or are unwilling to engage with support (www.broadwaylondon.org, accessed

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12/5/10). The Clearing House is therefore 'Housing First-ish' in the sense that it can, theoretically, accommodate individuals in 'ordinary' housing directly from the street. It does however depart from the Housing First model (as advocated by Pathways, see Section 2.2.1) on a number of fronts – most notably that provision is not necessarily permanent¹⁸, is contingent on evidence of ongoing support needs and willingness to engage, involves a one-nomination policy¹⁹, and does not support individuals at the higher end of the support needs spectrum.

Similar parallels with, and departures from, the Housing First model are evident in a number of other projects in the UK. The parallels, some interviewees claimed, represent further evidence that the UK is 'doing Housing First already'. The Bournemouth Churches Housing Association (BCHA) Bridge project in Exeter, for example, places repeat street sleepers into a mixture of dispersed independent and shared (with one other person) RSL flats with intensive floating support (Shelter, 2008). This so-called 'dispersed hostel' provision is however time-limited with maximum two-year lets, and is also contingent on client engagement – thus also departs from some of the key tenets of Housing First endorsed by Pathways. Providers of projects such as this, and those operating similar schemes in the private rented sector (PRS), acknowledged that these tend not to target clients with very high support needs:

It's not that we don't take people who ... have drug problems, have this, have the other. We do but we do a very thorough assessment on will they be able to make a success, so we're not big risk takers in that scheme They may have had a history of being at the complex end but they're not chaotic at the point we're moving them in.

(UK homelessness service provider)

At the time of writing, Turning Point Scotland was establishing a pilot project in Glasgow which seems likely to adhere to more of the key principles of Housing First as defined in Section 2.2.1. This will target homeless people involved in drug misuse and house them in dispersed RSL flats with floating support available 24/7 (see Box 1). The pilot project will be independently evaluated and will therefore make a valuable contribution to the evidence base on the effectiveness of Housing First in the UK.

Box 1: Turning Point Scotland Housing First Project

Following a scoping exercise carried out in 2009, Turning Point Scotland is devising a pilot Housing First project in Glasgow. This will provide accommodation and support for 12 individuals aged 18 or over who are homeless and involved in drug misuse. The pilot is funded by Turning Point Scotland, the Big Lottery Fund, Greater Glasgow and Clyde Health Board, and Glasgow City Council.

A harm reduction approach will be integral to the project. The providers aim to foster an environment where clients feel able to be totally honest about the challenges associated with addiction, such as relapse, without fear of jeopardising their service eligibility.

To be eligible, clients must exhibit a willingness to engage with support. They must also be motivated towards their own recovery, with a desire to decrease chaotic drug use.

Service users will be housed in scatter-site Housing Association properties on Short Scottish Secure Tenancies (SSSTs). Floating support will be provided 24/7 – with staff available between 9am and 10pm, and out of hours support provided by a call centre. On-call staff will deal with emergencies.

The staff team will include a service coordinator, two senior practitioners, three peer support workers and an occupational therapist. It is anticipated that each service user will also have a care manager within the local authority, with specialist addiction support provided by the joint Health and Social Work Community Addictions Team.

Wrap-around support in the areas of housing, substance misuse (harm reduction and relapse prevention), mental health, social inclusion, life skills and employability will be provided to clients in their homes. Effective joint working will be essential, and referrals made to other community services where appropriate.

An independent longitudinal evaluation of the three-year pilot has been commissioned and will report on outcomes in 2013.

3.2.2 Mixed views

UK stakeholder interviewees held mixed views regarding the potential efficacy of Housing First for homeless people with complex needs in the UK. Their stances fell along a continuum, ranging from 'pro' to 'anti' Housing First, with the overall balance of views lying somewhere in the middle, albeit weighted slightly toward the 'pro' end. Those largely in favour of Housing First viewed it as an innovative approach that may just 'work' for homeless people who have been revolving in and out of services for many years, and believe that it is thus worth trying. Those stakeholders, smaller in number, not in favour of Housing First claimed that it would be unlikely to generate better outcomes than existing provision and thus argued against its replication on those grounds. Most, however, were ambivalent – viewing many of the tenets of Housing First as attractive, but simultaneously anxious regarding operational issues and/or sceptical that the scale of outcomes reported in the US would be reproduced here.

Most stakeholder interviewees acknowledged the potential significant benefits of bypassing the existing hostel system with this particular group, given recognition of the weaknesses noted above (see Section 3.1). Some did however suspect that if the model were to be replicated here outcomes would not be in the same league as in the US because of the very different nature and quality of other provision:

The accommodation they [North American service providers] were comparing these good models with were dire. I mean really dire. You don't have anything, or not much left in the UK as bad as that standard. So these models, they sung out, you know what I mean, as being great in comparison.
(UK homelessness service provider)

The problem I have with a lot of US research is that they're comparing [interventions] with nothing. You know, 'We've got this great service', but the service they've got, if you compare it with treatment as usual, that's nothing for most people in the States, and that exaggerates the effectiveness of these models.
(UK mental health practitioner)

In a similar vein, several interviewees questioned the comparability of US Housing First tenants with the client group of interest here – particularly as regards the scale and patterns of substance misuse. As noted earlier, some commentators have suggested that the level of active illicit drug abuse amongst US Housing First clientele is relatively low as compared with the homeless population at large (Kertesz and Weiner, 2009; Kertesz et al., 2009). Whilst some reports focus explicitly on outcomes for severe alcoholics in the US (e.g. Larimer et al., 2009), virtually no details are given regarding which illicit substances are being used by those with co-occurring drug problems. Some interviewees reported suspecting that the scale of drug abuse may be greater amongst

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homeless people with complex support needs in the UK, and the 'substances of choice' different, thus making it difficult to infer what the likely outcomes here might be.

It depends on what the drug of choice was, because to be honest the least management problems I've ever [seen] in hostels and shared housing have been sort of heroin, IV drug users. As long as you can get over the making sure that dealing isn't happening ... Some of the more chaotic sort of drugs like crack and that make you aggressive and paranoid, it's so not a good mix and that would be harder to manage.

(Central government representative)

Related to this issue, interviewees expressed serious concerns about the risks of potential exploitation or harassment of very vulnerable clients when moving them into accommodation without on-site support. There were particular concerns that current or former drug users were at risk of having their flats appropriated by dealers or other users (a practice sometimes referred to as 'cuckooing'), or that they may be targeted by other people in the neighbourhood because they look and/or act 'different':

The group we're talking about are vulnerable to a very specific risk issue which is that when they move into their own flat ... their social network at that stage is often made of up associates that they've had from their life on the street or their drug life ... Before you know it they'll be knocking on the door ... Before you know it you've got three people in there. Before you know it they've stayed the night. Before you know it the guy has been sent out to get some milk in the morning for the coffee and he's come back and the door is shut and they won't let him back in and then the dealers are coming... And I say all that because I've seen it happen several times.

(UK service provider)

The community isn't that kind and forgiving, if they have somebody who's a bit eccentric in their midst.

(UK mental health practitioner)

Conversely, several expressed grave concerns about the potential impact that tenants might have on neighbours:

It would worry me ... if the person has been leading a chaotic life and, you know, brings some of their chaos to that housing situation ... I think it would have a huge impact.

(UK homelessness service provider)

Housing First literature provides little guidance on how such problems might be avoided, but report that tenants may be moved into another apartment elsewhere if problems develop; if necessary, this can happen multiple times, the aim being to ensure that their housing status is sustained (Atherton and McNaughton-Nicholls, 2008). UK stakeholder interviews noted that careful choice of flat and building design and the use of technology such as CCTV, might provide some safeguards for tenants and neighbours.

More generally, stakeholders suggested that the Housing First model departs from current UK policy agendas in two significant ways. First, they thought its overt emphasis on providing housing conflicted with the homelessness sector's recent emphasis on providing 'more than a roof' when combating homelessness (DTLR, 2002; see also CLG, 2008) by apparently elevating housing needs above other support needs – perhaps, they feared, to the detriment of support in areas such as strengthening social networks and establishing a sense of identity and purpose (Lemos, 2006; The Salvation Army, 2010).

That's where I think a lot of what our sector's come from isn't it? It's more than housing. That's what the big refrain is. It's not enough to give people a house. That doesn't solve the problem. Homelessness

isn't about a housing problem. It's about all those support issues and needs, and the reason people can't sustain their tenancy.
(UK homelessness service provider)

I think a ... simple Housing First narrative doesn't take into account what people are like ... because it's identifying just one element of peoples' lives that's an incredibly important thing and I think it's a necessary condition ... but it's not sufficient [for] somebody recovering.
(UK homelessness service provider)

Second, a number noted that the lack of conditionality regarding consumer engagement under Housing First stands in contradistinction to the increasing 'tough love' / interventionist agenda evident in UK homelessness policy, wherein some provision is becoming increasingly conditional on service users' compliance with support plans (Johnsen with Fitzpatrick, 2009), and the use of enforcement is increasingly seen as a legitimate means of encouraging people sleeping rough to take up the offers put to them.

I don't think it [government] would like the idea of fast tracking people or giving people preference without this conditionality, which is a big government theme isn't it ... It's about responsibility as well as rights ... [Housing First] seems to fly in the face of some of the direction that social policy's going.
(UK homelessness service provider)

Despite such cautions, there is clear evidence of a will to 'do whatever it takes' to accommodate and support homeless people with complex needs who regularly fall through the gaps of mainstream interventions. The majority of UK stakeholder interviewees agreed that Housing First could potentially play a valuable role as 'part of the mix' of provision for this group. The target of ending rough sleeping in England by 2012 (CLG, 2008) and particularly in London through

the work of the London Delivery Board with its focus on the most 'entrenched', has, in the view of interviewees, provide significant impetus for such innovation.

There [is] such a pressing emphasis on 2012 and ending rough sleeping, people are prepared to look at being creative if you're working with, you know, the most hardcore ... So, I think it's a unique time actually to be creative, you know, there is a real opportunity around rough sleepers, we can get some of that buy in from the government.
(UK homelessness service provider)

3.2.3 Not such a paradigm shift?

The implementation of Housing First in the UK would not represent anything akin to the paradigm shift in either practice or philosophy that its inception in the US did. The UK already has experience of placing rough sleepers directly into independent tenancies (albeit usually those with low/medium support needs), floating support provision is mainstream, harm minimisation approaches are well ingrained, and client-centred approaches are strongly endorsed by central government and local providers alike. Interestingly on this latter point, the personalisation agenda²⁰ (Cabinet Office 2010; CLG, 2008; HM Government, 2007) allows greater room for client preferences to shape *how* they are supported, but is still premised on their willingness to engage in the first place. It is this issue that would require the greatest shift in approach if providers were to develop schemes with a high degree of fidelity to the Pathways model (Section 2.1.1), together with relaxation of time-limitations on service receipt (see Section 3.4).

With regard to how it might be delivered, stakeholders believe that 'usual' floating support would be inadequate, as homeless people with complex support needs require more intensive support over a significantly longer timeframe than is standard at present. Some stakeholders reported that if their

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agency was to implement a Housing First project they would want to commission and control the support themselves; others felt that multi-agency support coordinated by a lead professional – much like the Common Assessment Framework (CAF) used with children at risk – would be effective²¹.

Floating support as it currently exists would not be able to meet that kind of need. I think one of the difficulties with floating support ... [is] increasingly it is becoming generic support. When we start talking about generic floating support, what it should be is high skilled, multi-disciplinary, high expertise. What often is there is the complete opposite: low skilled, low expertise, work with anybody but work with everybody in a very superficial way.

(Central government representative)

When you look at the really effective case management of rough sleepers leaving and staying off the streets, it does involve the probation worker, the mental health worker, the primary care nurse ... I think that multi-agency approach which is with a lead professional type arrangement to coordinate ... is the key model really.

(Central government representative)

Stakeholders generally liked the idea of being able to keep tenancies open for clients should they be hospitalised or incarcerated temporarily. Doing so not only affords stability at a time when vulnerable clients are particularly susceptible to repeat homelessness after discharge/release, but also lends weight to the 'integrity' of providers' care in the eyes of service users, which can be instrumental in motivating engagement. Existing Housing Benefit regulations enable payments to continue for up to 13 weeks if recipients are sentenced to prison (i.e. longer than sentences for the minor offences typical of this client group); up to 52 weeks if they are held in

custody pending a trial or sentencing; and up to 52 weeks if they are away from home because they are a hospital in-patient or receiving care approved by a doctor or other health professional²². Discretionary housing payments may also be used to keep rent payments going as a means of preventing homelessness.

Stakeholder opinions varied regarding the potential cost-effectiveness of a Housing First approach in the UK. Most thought it likely to be less expensive than high support hostel accommodation for this client group, but expect that the cost savings would not be as dramatic as those reported in the US given the much more extensive provision of existing supportive interventions (see also Pleace, 2008). Whilst appreciating the potential cost offsets in other domains such as health and criminal justice, some suggested that the government's split budgets²³ meant that cost savings would not be accrued by any one department. This, they argue, makes it much more difficult to 'make a case' for investment in such an intervention, despite the potential benefits. This may, however, become less of an issue if the Total Place²⁴ initiative (HM Treasury and CLG, 2010) – or something along similar lines – is rolled out by the Coalition Government.

One of the real challenges is that ... there isn't a mechanism to transfer the savings, so I can put homelessness ... Supporting People money ... into a client and that will save big time on unplanned admissions into A&E [accident and emergency hospital departments], into the policing issues, reduce neighbourhood concerns about crime. So I'll ... save money over here in the criminal justice system and the acute care system, but there is no mechanism for those savings to be redeployed...

(Central government representative)

3.3 Specialist transitional accommodation

Whilst some of the developments for homeless people with complex support needs in the UK have elements of ‘Housing First-ness’ about them, these are paralleled, and possibly outnumbered, by the creation of specialist high support transitional housing projects. These have been specifically adapted for this group and sometimes incorporate elements of low demand programmes including, for example:

- small, high quality non-institutional accommodation with a low client: staff ratio;
- creation of individually tailored ‘person-centred’ support plans that take into account client aspirations;
- assertive but patient engagement that aims to overcome barriers resulting from mistrust and/or the symptoms of mental health or addiction problems; and
- employment of high quality, professionally trained and ‘psychologically minded’ staff who understand the complexities of clients’ support needs and are not intimidated by challenging behaviour.

The Old Theatre and The Lodge in London are two notable examples (see Boxes 2 and 3). Both target people who have been especially resistant to mainstream hostel provision – with The Old Theatre only accepting referrals of people who have been excluded from other hostels at least three times, and The Lodge catering for long-term rough sleepers. In targeting such clientele, provisions such as these ‘buck the trend’ of what a number of stakeholders described as an escalating risk averseness within the UK homelessness sector:

People are very risk averse because so much of the funding is increasingly about what your outcomes are, so there’s that kind of levelling up in terms of people that you’re working with and do you want to take the risk because it might not work. (Central government representative)

Box 2: The Old Theatre

Opened approximately two years ago by Broadway, The Old Theatre is a 12-bed single site accommodation scheme for serially excluded rough sleepers with complex needs. All residents have been excluded from other hostels at least three times. The project offers high standard studio flats each offering a private bed/living room, bathroom and kitchen, as well as a communal laundry and meeting/training rooms. It provides 24 hour on-site support to ensure continuity of care and has a very low client:staff ratio (12 clients to 12 staff).

The project adopts a team approach to case work, such that a client can see any worker about their needs although they each have a lead keyworker to coordinate support and provide consistency. There are no blanket ‘house rules’; rather, rules are agreed on an individual basis via tailored contracts negotiated with clients. Clients are expected to: 1) meet with support workers regularly; 2) agree support plans goals and take action to achieve them; 3) attend weekly residents’ meetings; 4) agree an individual visitor policy and house rules; 5) respect other clients; 6) agree to not smoke or drink in communal areas; and 7) keep flats clean and follow health and safety advice.

An ‘inside out’ approach is utilised, such that if a resident abandons, staff will re-contact them via street outreach work. Residents’ rooms are held for them for 28 days to enable this process. If the client fails to return after this period, a 28-day abandonment notice is issued. To prevent such scenarios, staff at The Old Theatre work closely with outreach teams, particularly where an increased risk of abandonment has been identified.

Most clients stay at the project for approximately two years, but this rule is applied flexibly, with residents with particularly high support needs being able

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to stay for an extra two or even three years. All clients are expected to attend 'It's Your Move' tenancy training and staff members discuss move-on with clients on a regular basis.

Whilst it is still early days and no formal evaluation of The Old Theatre has as yet been conducted, initial outcomes are reported to be 'very positive'. Most notably, four clients with a long history of rough sleeping have remained in the project since it opened, their longest continuous stay in accommodation in six years. The project is said to be relatively expensive given the staffing level, but Broadway is confident that it offers value for money given the substantial reduction in clients' use of other services, particularly emergency medical provisions.

Box 3: The Lodge

The Lodge is a 40-bed B&B hotel opened by St Mungo's and the City of London Corporation to accommodate long-term rough sleepers, aged 40-65. This pilot project was funded by CLG under the Places of Change programme. It draws its inspiration from the privately-run Lindsay Hotel which had had some success in accommodating rough sleepers who had been reluctant to stay in mainstream homeless hostels. The building has been refurbished to a high standard and provides a communal TV lounge, dining area, laundry and kitchen for its 'guests'. Some of the rooms are en suite.

It is anticipated that guests will be able to stay for up to two years, and staff will assist them to find more settled accommodation where appropriate, depending on their needs. Given the clientele's resistance to orthodox key work approaches, The Lodge's support regime is described as very 'low key', in that staff engage with guests more

on the latter's terms, rather than expecting guests to comply with defined support plans.

Formal support is provided by the guest's outreach team (who support guests through their stay and move on) rather than staff members, though they work closely with outreach workers in terms of both information sharing and the resolution of any problems. If a guest abandons, residents' rooms may be held for them for one or two weeks, though this will be dependent on funds for service charge/rent being provided by the relevant local authority.

The Lodge opened in March 2010 and its outcomes will be monitored over time. One of the first residents is believed to have lived on the streets for the best part of 41 years, hence bringing him indoors is deemed a significant success in itself. The providers have not been overly deterministic about the model of delivery, thus it may be that the project evolves in response to the needs of the clientele.

Both The Old Theatre and The Lodge are recent developments – very in the case of the latter, which only opened in March 2010 – hence it is too early to assess overall outcomes. Initial outcomes are however reported to be very promising in The Old Theatre, with some residents who had previously revolved in and out of hostels successfully remaining for the duration of project operation. The Lodge's initial intake included individuals who had been 'out' (street homeless) for extremely long periods, in some cases decades and this alone, providers argued, should be viewed as a significant success when working with this client group.

Another high support specialist project, the Brent Dual Diagnosis project run by St Mungo's, has been operating for a few years and has reported positive outcomes

for homeless people with mental health and substance use needs. It offers 24 hour support, operates an approach of 'assertive engagement' involving daily structured group-work sessions, and has specialist treatment staff within an in-house support team, including a psychotherapist and substance use worker. Outcomes over the past three years have included reduced hospital admissions and increased client move on (with only one of the 18 moves having been an abandonment, all others were moves into lower support or PRS accommodation) (St Mungo's, no date).

These and other such projects offer high levels of support, but providers have different stances regarding the degree of 'interventionism' that should be employed and/or extent to which ongoing service receipt should be contingent upon service users' proactive engagement with the support on offer (Johnsen with Fitzpatrick, 2009)²⁵. Compare, for example, the following descriptions of staff approach:

Service provider: We have a very assertive approach to contact ... it's not laissez-faire, you know? I think if people are in your services ... part of the deal for receiving that accommodation and being there is that they have to connect with the services.

Interviewer: Are there consequences for people who don't engage?

Service provider: Well ultimately, it would be eviction because they're taking over a bed for someone that may connect and may want to move themselves on, but that's very much a last resort...

(UK homelessness service provider)

The support regime is very low key, so it's like you're getting a service rather than you're being key worked, so the staff engage with people a bit more on their own terms and it's kind of support by stealth, rather than being very overt

about it. So, you know, rather than sitting there and having a key working session, 'Now let's go through all these forms together' ... That's what they don't want, so it's finding a different way to engage with them.

(UK homelessness service provider)

There has not, to date, been any rigorous comparison of the relative outcomes of interventionist and non-interventionist approaches to transitional housing programmes for homeless people with complex support needs in the UK or elsewhere.

That said, Lipton et al. (2000) have shown that consumer choice in relation to levels of engagement can have a positive impact on housing outcomes for clients who are service resistant. Moreover, as seen earlier, transitional housing programmes with strict admissions procedures and participation requirements – that include evidence of sustained sobriety or a willingness to participate in treatment/structured activities as a condition of tenancy – have limited effectiveness in helping clients with complex support needs achieve housing stability (Barrow and Soto, 2000; Barrow et al., 2004; Caton et al., 2007; Kertesz et al., 2006).²⁶

3.4 Long-term supported housing

There was a virtually unanimous call amongst stakeholder interviewees for the relaxation of time-limitations associated with transitional supported housing for this client group, especially the two-year limit on stays in projects assigned 'temporary' accommodation under Supporting People. This ceiling, stakeholders claimed, is determined by commissioner demands rather than user needs, and is not founded on evidence regarding the time it actually takes for vulnerable individuals to prepare for independent living:

There is no evidence that says two years is optimal or desirable or practical or achievable or anything '-able'...
(Central government representative)

Echoing debates in international literature (see Section 2.3), there was also widespread consensus amongst stakeholders that long-term supported accommodation may be the best or indeed only 'realistic' option for some homeless people with complex needs, particularly those with severe/enduring mental health problems and/or cognitive impairment resulting from long-term substance abuse:

[For] people who've got [complex needs] ... there isn't necessarily any way that you can process them and take them through to a cure, particularly people [whose] alcohol problems have actually started to damage them intellectually and behaviourally. There isn't any going back from that, you know? We have to try out an environment where that can be managed and they feel happy and safe and secure ... then that's progress in itself and that is a fantastic achievement.
(UK homelessness service provider)

Whilst they are rarely branded 'permanent', some supported housing schemes that do not have limits on length of stay do exist in the UK and, as noted earlier, providers admit

to sometimes 'flexing' the rules on lengths of stay. Stakeholders called for the provision of much more non-time-limited supported housing schemes for people with complex support needs. They emphasised that units should be small, of very high quality physically, and expressed a general preference for a core and cluster model with 24/7 on-site support: They also expressed a general preference for a 'core and cluster' model consisting of self-contained units located around, or in close proximity to, staffed offices and communal living areas:

The ideal for me would be everywhere you'd build, if you ever had the space and resources, you'd build self-contained units with communal areas because I think that's the sort of perfect scenario where someone can have their own room and cook and things like that, but actually there is also an element of mixing, not just staying isolated in your flat...
(UK homelessness service provider)

Although noting the potential difficulties inherent in the provision of shared/communal housing schemes described above, stakeholders highlighted the potential of schemes with an element of sharing/communality to combat social isolation. They did nevertheless emphasise that placing people in shared/communal housing does not automatically generate 'community', but that social interaction may be fostered through provision of meaningful activities within projects and the wider community.

There are issues about people in that kind of accommodation actually spending their whole lives in their room, and so how much of a community and how much on a communal level is there really? There might be a communal physical environment but how communal are the people who live there ... and how are they supported to live communally...?
(Central government representative)

There is evidence of emergent developments in permanent supported housing for elderly homeless people with complex support needs – particularly long-term rough sleepers whose physical care needs are high but whose behaviour risks making them ‘unwelcome’ in general needs sheltered housing. Look Ahead, for example plans to develop specialist units for this group along the lines of ‘extra care schemes’ for older rough sleepers. It is anticipated that these will accommodate no more than 30-40 individuals, be staffed 24 hours, work very closely with relevant health professionals, and provide residents with ‘end of life’ accommodation.

Provision for frail/elderly individuals excepted, and despite the call for more long-term options for people with complex needs, there appears to be an aversion to use of the label ‘permanent’ as regards supported housing in the homelessness sector. This is borne out of fear that its use could rhetorically, if not practically, connote limits to providers’ aspirations for clients – when they are ardent that no artificial ceiling should ever be imposed on these. Stakeholders also highlighted a number of complex dilemmas associated with the provision of long-term/permanent supported housing, particularly fears about a potential mismatch of levels of support and need in the long term, equity issues, and the sustainability of such provision. Such issues highlight the challenges inherent in trying to achieve a balance between ensuring vulnerable people are given the stability afforded by long-term supported accommodation where appropriate, but are not at risk of acquiescing due to inflexibility in provision or a lack of alternatives.

Conclusion

Drawing upon a review of international literature and interviews with key stakeholders in the UK and overseas, this study sought to assess the prevalence and relative merits of different housing models for homeless people with complex support needs. Evidence regarding which 'work best for whom' is far from definitive, but is nonetheless useful in informing future service development for this highly vulnerable group.

As in many other developed countries, the predominant approach to housing homeless people with complex needs in the UK is linear, involving stays in transitional accommodation en route to long-term settled housing. This approach tends to be implemented more flexibly here than in many other contexts, however – with homeless people sometimes bypassing generic hostels and moving directly into specialist projects. The metaphor of an 'elevator' is thus perhaps more appropriate in the UK than is the 'staircase' descriptor more commonly associated with the linear model elsewhere.

That said, a 'treatment first' philosophy still prevails, wherein service users are only placed in 'normal' housing when they are deemed 'housing ready'. UK providers acknowledge the weaknesses associated with transitional accommodation for homeless people with complex needs, but remain wedded to the treatment first philosophy because of a widely held belief that placing them directly into independent tenancies without on-site support risks 'setting them up to fail'.

Such risk averseness is understandable in the current policy context, and given extreme shortages of available lets in areas such as London. Provider reservations are nevertheless largely founded on experiences of floating support schemes which offer relatively low level, generic, time-limited support which is conditional on service user compliance. Such

provision is a far cry from that endorsed by advocates of the alternative 'housing first' philosophy.

Housing First evaluations in the US pose a serious challenge to the view that homeless people with complex support needs are incapable of sustaining an independent tenancy without intensive intervention ('treatment') *prior* to placement. The outcomes reported provide compelling evidence that vulnerable individuals *can* sustain tenancies when provided with open-ended tailored support that has few, if any, requirements regarding user engagement.

The dominance of the linear 'treatment first' approach is further called into question by a number of inter-related dimensions: first, the model's structural dissonance with the complex realities of vulnerable people's lives, especially as they navigate the often haphazard cycle of addiction recovery; second, the widespread acknowledgement that treatments for mental health and addiction problems are not fail-proof; and third, growing concession that clinicians and housing providers are not always able to predict who will respond positively to treatment or resettlement.

Despite being sceptical that outcomes reported in the US would be reproduced to the same extent here, it seems that most UK stakeholders believe Housing First could potentially form a valuable 'part of the mix' of service provision, especially for the most so-called 'entrenched', 'hard to reach' or 'service resistant' rough sleepers. A willingness to trial Housing First, and other models offering different accommodation types and levels of user choice and conditionality, clearly exists. Commissioners and providers might also valuably consider integrating some of the elements of Housing First into existing provision, such as the relaxation of time-

limitations on service eligibility and tailoring of high quality multi-disciplinary support to individual needs.

The 2012 target to end rough sleeping in London, and similar albeit less formalised ambitions to reduce street homelessness elsewhere²⁷, represent key windows of opportunity for innovation in the development of solutions for this group. The numbers involved are, comparatively speaking, small – and while the cost savings are unlikely to be as extreme as in the US, it seems plausible that substantial savings will be generated.

Any new developments should, however, be rigorously evaluated. In the UK, as elsewhere, decisions regarding which interventions are most appropriate are often guided by assumption and conjecture rather than compelling evidence (Caton et al., 2007; Chilvers et al., 2009; Pleace, 2008). At present the existing body of evidence is both: a) limited (in terms of scope and rigour); and b) imbalanced (with the bulk drawn from US Housing First research). With respect to Housing First and alternative models of supported housing, the knowledge base would benefit substantially from:

- longitudinal studies examining five and ten year outcomes to assess the longevity of impacts;
- greater consideration of factors such as social isolation, financial wellbeing and community integration;
- calculation of the cost-effectiveness and value for money of different interventions;
- assessment of whether scepticism about the likely effectiveness of Housing First for active drug users is justified; and
- examination of recruitment and risk assessment practices, especially as regards avoiding possible negative impacts on clients and/or neighbours.

In addition, and more broadly, further exploration is needed regarding ‘what works for whom’, especially:

- the merits and demerits of scatter-site versus single site provision;
- the impact of different degrees of interventionism on service user experiences and outcomes; and
- factors influencing clients’ ‘readiness to change’, especially in relation to substance misuse.

Strengthening the evidence base in these areas will enable commissioners and providers to make more informed decisions regarding what to fund and how to deliver services most effectively. New and innovative schemes are continually being developed and replicated internationally. These should be assessed critically in a systematic and co-ordinated manner that is sensitive to context, so that this vulnerable group of homeless people might reap maximum benefit from policy and practice ‘lessons learned’.

Endnotes

- 1 However, it remains to be seen how this concern for the 'hardest to reach' will work in practice when set against the Government's new localism agenda.
- 2 The Mayor's London Delivery Board (LDB) brings together key people from the inner London boroughs Police, National Health Service, criminal justice system and voluntary sector to co-ordinate effective action. In Spring 2009, 205 of the most 'entrenched' and difficult to reach rough sleepers were identified as a priority by the LDB. The CHAIN database which records all outreach contacts in the capital was used to identify people sleeping rough who were considered entrenched according to the following definition: 'been seen sleeping rough in five or more years out of the last ten'; and/or 'been seen rough sleeping 50 times or more over that period' (Binfield, 2009). Coordinated case management through Communities and Local Government and the LDB has enabled boroughs and providers to work flexibly with this group and to pursue every possible action to ensure they are no longer sleeping out.
- 3 Of the total 19 interviewees, 15 were based in the UK (England and Scotland), three in the US, and one in Australia. Interviews explored stakeholders' views regarding: the prevalence various housing models; the strengths and weaknesses of each for homeless people with complex support needs, and various subgroups within this population; the desirability of, and potential challenges associated with, introducing any new models in the UK; and what should be deemed 'success' when working with this group. Given the small number of interviews conducted, the views expressed should be regarded as indicative, rather than representative, of views held within the homelessness sector.
- 4 These difficulties are compounded by the inconsistent use of terminology within the homelessness field, particularly when the same label (most notably 'Housing First' – see Section 2.2.3) is applied to interventions that differ significantly from one another.
- 5 As noted earlier, transitional housing programmes are generally deemed effective in supporting young homeless people – especially those who have spent prolonged periods in 'institutional' settings such as residential children's homes (Quilgars et al., 2008).
- 6 In the US, people are defined as chronically homeless if they have a disabling condition and have either been continually homeless for a year or more or have experienced at least four episodes of homelessness in the past three years (US Department of Housing and Urban Development, 2007).
- 7 It is important to note that the extent and nature of regulation of the private rented sector is very different in the US and UK contexts. Unlike many other developed countries, in the UK rents are not regulated and the private rented sector offers little security of tenure (Haffner et al., 2008; Rugg and Rhodes, 2008).
- 8 Details regarding the minimum level of client contact with staff are inconsistent in Pathways literature. Most reports indicate that clients must meet support workers twice per month (see for example Tsemberis and Asmussen, 1999; Tsemberis et al., 2004), but Stefancic and Tsemberis (2007) state that clients must agree to a minimum of one visit per week.

- 9 This ensures that 30 per cent of tenants' income is used towards rent and that essential bills, including food and utilities, are paid.
- 10 According to Pearson et al. (2009), most chronically homeless individuals are unable to meet or commit to the demands related to housing readiness (e.g. sobriety, basic living skills, personal hygiene, commitment to engage in treatment) required to participate in many supportive housing models.
- 11 Momentum around the development of new approaches to service delivery and provision of housing targeted at the chronically homeless population derived from 2000 when the National Alliance to End Homelessness (NAEH) campaigned for a plan to end homelessness in ten years. The US Department of Housing and Urban Development (HUD) set the goal of ending homelessness soon afterwards, and the Bush Administration endorsed this goal in its 2003 budget. In 2002, the Millennial Housing Commission called for ending chronic homelessness through the creation of 150,000 units of supportive housing, and the Administration reactivated the federal Interagency Council on Homelessness (ICH). The Collaborative Initiative to Help End Chronic Homelessness was launched in 2003 with funding provided by HUD, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the Department of Veteran Affairs (VA), with coordination by the ICH. Also, Policy Academies on Chronic Homelessness were established in every state and territory (Caton et al., 2007). From 1996 to 2005 the number of units of permanent supportive housing for homeless people in the US nearly doubled, from 114,000 to 208,700 (HUD, 2007).
- 12 The evaluation was a four-year randomised control trial known as 'The New York Housing Study'. It involved 225 individuals: 99 in the experimental Housing First group, and 126 in the continuum of care control group (Padgett et al., 2006).
- 13 One important exception, however, is a quasi-experimental study by Larimer et al. (2009) of Housing First outcomes for chronically homeless people with severe alcohol problems in the Downtown Emergency Service Centre (DESC) '1811 Eastlake' project in Seattle. This reported positive results in terms of reduced alcohol consumption, as well as use of publicly funded services (such as shelter and sobering centres, emergency medical services, drug detoxification and treatment etc.), but does not report on housing retention outcomes for either Housing First recipients or the wait-list control group. It should also be noted that the 1811 Eastlake project utilised single-site accommodation with on-site support (Larimer et al., 2009) – an approach that Atherton and McNaughton-Nicholls (2008) claims fails to adhere to one of the basic precepts of Housing First, that being provision of non-communal housing. Such findings do, however, echo those of earlier research which has indicated that housing programmes that operate a harm reduction approach with refractory alcoholics can lead to positive outcomes such as stabilisation of alcohol intake, reduction in emergency hospital visits, and fewer encounters with the police (Podymow et al., 2006).
- 14 'Behavioural health disorders' include serious mental illness and chronic substance abuse problems (Malone, 2009).

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- 15 The vulnerability index is a tool for identifying and prioritising members of the street homeless population according to the fragility of their health. It was developed by Boston's Healthcare for the Homeless, led by Dr Jim O'Connell. It is administered as a survey and identifies the most vulnerable people through a ranking system which takes into account risk factors (such as co-morbidity, advanced age etc.) and the duration of homelessness.
- 16 Or less, as in the case of designated 'assessment beds', for example.
- 17 It is important to acknowledge, however, that hostel standards are highly variable geographically – largely due to the uneven reach of various national initiatives implemented from the 1990s onwards (May et al., 2005, 2006).
- 18 There is no limit to the number of times that an Assured Shorthold Tenancy may be renewed should there be ongoing evidence of a need for support (Broadway, 2010).
- 19 Some degree of flexibility is, however, exercised regarding the one nomination policy with the 'London 205' group of rough sleepers (Broadway, 2010). For more information about the so-called 'RS205' initiative see Endnote 2.
- 20 Personalisation is likely to become increasingly important in shaping the way homelessness services are designed and commissioned. Action 9 of the rough sleeping strategy relates specifically to personalisation and rough sleepers: "We will promote more personalised services including testing individual budgets to increase the control people have over the services they need" (CLG, 2008). CLG commissioned four Personalisation pilots in the City of London, Exeter and North Devon, Northampton and Nottingham, where housing, third sector and adult social care agencies worked together to identify the most entrenched rough sleepers and develop personalised packages with the individuals concerned (CLG, 2009). In *Our Plan for Government*, the Coalition Government promise they "will extend the greater roll-out of personal budgets to give people and their carers more control and purchasing power" (Cabinet Office, 2010: 30).
- 21 One stakeholder interviewee suggested that a panel similar to Shelter's Multi-Agency Assessment Panel in Cornwall might provide a fruitful way forward. With this, a voluntary sector representative who is not directly involved in support delivery coordinates care plans and maintains the engagement of service users.
- 22 See www.shelter.org.uk, accessed 5/5/10.
- 23 Notably, Hampson and Hilbery (2010) are very critical of the way that budgets are split across departments – arguing that they induce a 'narrow focus on departmental concerns' and lack of clear ownership of problems.
- 24 Total Place was launched at Budget 2009 as a key recommendation of the former Government's Operational Efficiency Programme. *Total Place: A whole area approach to public services* sets out their vision of how Government would work with all public service bodies in places to give greater freedoms and flexibilities, and a new relationship with the centre (HM Treasury and CLG, 2010). The key features of this relationship included: freedoms from central performance and financial control; freedoms and incentives for local collaboration (including Support for local partnerships to use pooled individual budgets, and for joint working between local authorities and Job Centre

Plus and Primary Care Trusts); freedoms to invest in prevention; and freedoms to drive growth. The Coalition Government is set to take the reform of governance and delivery of public services to a whole new level. The Coalition's Programme for Government sets out a radical agenda for change based around the principles of localism and financial retrenchment (Cabinet Office, 2010). Regional and national agencies charged with the regulation, development and delivery of public sector services are to be disestablished. Power is to be devolved to local authorities and local communities to identify expenditure priorities for services as well as identifying the scale and location of new housing supply, regeneration programmes, and economic development. Local expenditure decisions will reportedly be made more transparent to local people and regulation of local government radically reduced. It is early days and it remains to be seen whether local agencies will cooperate in the interests of the most vulnerable in society.

- 25 Johnsen with Fitzpatrick (2009) note that the key axis differentiating homelessness projects is their stance on expectations of service users and the conditionality of service receipt. These, they argue, fall on a spectrum ranging from a range from firmly non-interventionist projects with very 'open door' policies and little if any expectation that service users should alter their lifestyle, to highly interventionist projects which assertively encourage service users to desist from damaging behaviours. The latter sometimes make service receipt conditional upon commitment to defined support plans. Interventionist approaches have become more commonplace in recent years (Johnsen with Fitzpatrick, 2009).
- 26 In fact, transitional housing has always been used as a technique to increase the effectiveness of substance abuse treatment programmes, even when housing is not conditional upon abstinence (Kertesz et al., 2006).
- 27 As noted earlier (Section 1), at the time of writing it was unclear whether (but appeared unlikely that) the new Coalition Government would support the previous government's 2012 target to end rough sleeping at the national level.

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