The Discourse of Consumer Choice in the Pathways Housing First Model

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❯ **Abstract_** *This article focuses on the discourse of consumer choice produced in the Pathways Housing First (PHF) model manual. Relying on Foucauldian discourse analysis, the discourse is examined as embedded in a wider societal discursive formation – an advanced liberal way of governing subjects. The discourse is formed from seven statements organized in relation to each other: 1) emphasizing clients' own choices is an alternative to traditional professional care, 2) clients are capable of making their own choices, 3) choice-making strengthens clients' self-determination and individual mastery, 4) more choice opportunities increase clients' motivation and commitment and lead to recovery, 5) choice does not mean absolute choice – certain limits exist, 6) efforts are made to reduce risks related to choices, but repeated failures diminish client choices, and 7) 'never-ending' failures might mean the end of clienthood in the PHF programme. The discourse echoes the ethos of advanced liberalism; subjects are governed to make them responsible choice-makers with the main aim being the achievement of 'recovered' people. Clients whose choices are repeatedly regarded as wrong, and whose recovery processes are accordingly considered unsuccessful, risk being excluded from the PHF programmes and forced into a position where individual choice-making is no longer possible.*

❯ **Keywords_** *homelessness, housing first, consumer choice, responsibilization, advanced liberalism, discourse analysis*

Introduction

During the 1950s and 1960s in the US as well as in many European countries, psychiatric hospitals began to close down. In their place, various linear residential treatment (LRT) programmes – sometimes referred to as the continuum of care model or the staircase model – were developed, with the common denominator being the idea that the client needs to go through a series of steps, each step linked to a certain type of treatment and other services, and each step bringing the client closer to the goal: an ordinary flat of one's own. However, evaluations of these programmes have shown that clients can easily become stuck on a particular step and do not proceed in their housing careers, or are evicted or denied services because of strict rules (Pleace, 2008). The Pathways Housing First (PHF) model began to gain acceptance in the USA and later on also started to attract interest in many European countries as a result of longitudinal research (e.g. Tsemberis and Asmussen, 1999; Gulcur *et al*., 2003) that strongly supported the efficacy of PHF model (Gulcur *et al*., 2003; Pleace, 2008).

The Pathways to Housing organization, which is a non-profit corporation set up in New York City in 1992, is widely recognized as the originator of the Housing First (HF) model (Tsemberis, 2010). The PHF model specifically addresses homelessness accompanied by mental health and addiction problems and is credited as a unique approach in that it recommends "providing services through a consumer driven treatment philosophy and providing scattered-site housing in independent apartments" (Tsemberis, 2010, p.4). The PHF approach, as a model of service delivery, is distinct not least since it recommends a consumer-driven process to end homelessness, which means that the PHF invites the homeless individual – variously and interchangeably referred to as the client, the consumer, the participant and the tenant – "to be their own decision-makers – to drive the process themselves" (Tsemberis, 2010, p.8). This kind of a consumer choice is stated as one of the core principles of the PHF model.[1]

There are many words to describe the relationships of users with welfare services. The concept of *client,* associated with professionalism and 'clientism' emerging in post-war services, wherein the professional's judgement is seen to have priority in dealing with the client's needs and problems (Powell *et al*., 2009). Over the last three decades another word – *consumer* – has become well established. In contrast to

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[1] The stated principles of the PHF model are: (1) housing as a basic human right; (2) respect, warmth and compassion for all clients; (3) a commitment to working with clients for as long as they need; (4) scattered-site housing, independent flats; (5) separation of housing and services; (6) consumer choice and self-determination; (7) a recovery orientation and (8) harm reduction (Tsemberis, 2010, p.18).

professionalism and to the concept of client, it refers to an economic kind of rela-
tionship, where the user acts on the basis of his/her needs and interests, makes
service choices freely and individually, and carries the risks of these choices (Clarke
et al., 2007). It has been claimed that citizens in western societies are increasingly
understood as citizen-consumers rather than as collective and political actors
(Clarke *et al*., 2007). In the PHF-model the idea of consumerism is strong, but its
discourse of consumer choice also has elements of professionalism and 'clientism',
as we will show.

In this article we focus on the notion of *consumer choice* and analyse *how the
discourse based on it is produced in the PHF model* presented in the Housing First
manual (Tsemberis, 2010). The author of the manual is Sam Tsemberis, founder of
Pathways to Housing. In addition to this internal reading of the consumer choice
discourse, we aim to analyse its relations to wider, societal discourses. The ideas
and strategies based on consumer-driven services spread to a wide range of policy
contexts in the last decades of the twentieth century, and can "be observed in
national contexts from Finland to Australia, advocated by political regimes from left
to right, and in relation to problem domains from crime control to health" (Miller and
Rose, 2008, p.212). Following Miller and Rose (2008, p.18), we connect consumer
choice to the *advanced liberal way of governing subjects* emphasizing "the active,
choosing, responsible and autonomous individuals obliged to be free, and to live
life as if it were an outcome of choice."

We start out by describing the introduction and relative popularity of the PHF model
in the US and later in Europe, as well as its main characteristics. We then briefly
define consumerism and its links to advanced liberalism. Next we account for the
type of discourse analytical approach applied, before presenting an in-depth
analysis of how the discourse of consumer choice is produced within the PHF
model. This specific discourse is then linked to a more general trend in western
welfare societies, namely the discursive formation of advanced liberalism, and more
specifically its way of governing subjects. Finally, we discuss the main findings.

The Pathways Housing First (PHF) Model

Since the PHF model was created in response to the problems identified in the LRT
programmes, its philosophy cannot really be understood without understanding
the premises of the LRT approaches, which are still predominant in combating
long-term homelessness in the US and European countries. The LRT model
emphasizes the need to enhance the 'housing readiness' of homeless clients. This
is achieved by encouraging sobriety and demanding compliance with treatment,
deemed as preconditions for successful transition to independent housing (Johnsen

and Teixeira, 2010). The basic assumption here is that many homeless clients are incapable of managing independent housing and of setting goals for themselves, and in order to develop these necessary skills they need transitional housing and continuum of care systems. Further, the model categorizes special housing units as 'rungs on a ladder'. Homeless individuals are, ideally, to move steadily upwards on this ladder, beginning at a shelter and ending with an apartment of one's own (Padgett, 2007), and eviction might be used as punishment for the clients who relapse into alcohol use (Tsemberis *et al*., 2004). Thus, housing must be earned (by compliance with rules and regulations), and housing is represented as a privilege.

In contrast to LRT approaches to combating homelessness, the PHF approach puts a priority on immediate access to independent housing. In addition to a flat, homeless clients are offered treatment and support, although clients may refuse treatment without immediate consequences for their housing status and tenure. A harm reduction approach is applied, meaning that the risks associated with such a choice should be prevented or the harms related to them reduced. Housing is regarded as a basic human right and homeless people are viewed as competent individuals capable of making their own choices. Tsemberis (2010, p.16) claims that "not only are consumers capable of making choices, they are far likelier to stay in housing programs that allow them greater choices." The separation of housing and support services is a basic principle of the PHF model, and one of its defining characteristics is that support and treatment is provided flexibly by multidisciplinary PHF teams.[2] Weekly visits by the PHF team are mandatory but the type, sequence and intensity of support and treatment services are decided by the client in direct contrast to LRT approaches, where these are determined by professionals, and where access to housing is conditional upon the client's acceptance of a certain type and intensity of support. However, as will be illustrated in this article, the client does receive help from the PHF team in deciding, and in crisis situations decisions are made by the PHF team (Tsemberis, 2010). Immediate access to independent housing, the separation of housing and support, and the highly individualized support services provided by multidisciplinary teams (based on the idea of harm reduction) may be seen as the defining features of the PHF model.

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[2]   There are two types of PHF teams providing treatment and support: the ACT (Assertive Community Treatment) teams provide treatment and support to clients with 'severe psychiatric disabilities', and the ICM (Intensive Case Management) teams provide services to clients with 'moderate [psychiatric] disabilities'. As stated in the PHF manual, both types of clients "may also have alcohol and other substance abuse problems", and both types of PHF teams "are community-based and interdisciplinary, and both meet clients in their own environments to flexibly provide a wide array of support and treatment services" (Tsemberis, 2010, p. 77).

As mentioned, the PHF model began to win acceptance in the US after the first related longitudinal study was published, and has also, since then, become very popular in Europe, not least because the research showed better results for the PHF model with regard to housing resettlement and sustainment outcomes when compared with traditional models (e.g. Tsemberis and Asmussen, 1999; Gulcur *et al*. 2003; Tsemberis *et al*., 2004; Padgett *et al*., 2006; Atherton and McNaughton Nicholls, 2008; Pleace 2008, 2011). Research results also show that the PHF programmes are cost effective; costs are lower in comparison with people remaining homeless as well as in comparison with traditional models (Gulcur *et al*., 2003; Culhane, 2008; Culhane and Metraux, 2008; Atherton and McNaughton Nicholls, 2008; Tsemberis, 2010). In fact, Willse (2010, p.168) claims that in order to understand what made it possible for the PHF model to win acceptance in the US, one has to understand "the economic dimension of the invention of chronic homelessness". Through the research put forward by Culhane and colleagues, the PHF model has become regarded as a more economically viable and efficient solution than other models. From this perspective, it is limited economic resources, rather than the needs and wants of homeless individuals, that motivated the policy change (Willse, 2010).

Over the last ten years, the PHF model and its variants have attracted growing interest internationally. The model has been replicated or applied in the homelessness strategies of over a hundred cities in the US and Canada, and has been implemented in Europe as well (Tsemberis, 2010), yet few researchers have discussed the ambiguities of the model and the difficulties and risks involved in the implementation of the PHF model in a European perspective (Atherton and McNaughton Nicholls, 2008; McNaughton Nicholls and Atherton, 2011; Pleace, 2011; Hansen Löfstrand, 2012).

Consumerism and Advanced Liberalism: Choices and Responsibilities

Consumerism in public services has spread across western welfare societies in recent decades. It claims that service users' own preferences, i.e. their 'felt needs', rather than expert-led need definitions should be the first priority in organizing services (Needham, 2009). The assumption is that a right to make choices of their own makes the aim to strengthen service users' own expertise more real. As Glendinning (2008) points out, there are strong arguments for emphasizing user choice; it can be seen as fundamental to achieving citizenship, social inclusion and independence, it can be claimed to reduce power inequalities between care providers and receivers, and the capacity to exercise choice and control in one's own life can be regarded as an important care outcome in itself. In consumerism, service users are seen as individual and rational actors who know what they need and who make

decisions that maximize their preferences (Fotaki, 2009). Seeing service users as consumers is rooted in rational choice theories 'borrowed' from neoclassic economics. According to these theories, people make decisions by comparing the benefits and costs of existing choices from their own point of view (Greener, 2007).

Consumerism is often introduced as a taken-for-granted 'good idea' in policy level rhetoric in changing welfare states, yet researchers have presented plenty of concerns and critical comments about it. One serious criticism is based on the premise of understanding service users as rational calculative actors who can make the right choices. Miller and Rose (2008) define this development as advanced liberalism, entailing a new idea of the subjects to be governed; subjects are understood as autonomous and responsible individuals who can freely choose their way of behaving and acting. Furthermore, when advanced liberalism emerged, it brought along novel strategies of activation and novel professionals of activation (Miller and Rose, 2008). Rose (1996, 2000) connects this development to the discourse of reponsibilization, meaning that citizens are expected to become 'enterprising selves' who can manage and empower themselves, and thus produce their own independence and well-being (see also Kemshall, 2002; Clarke, 2005; Scourfield, 2007; Teghtsoonian, 2009). However, along with the increased opportunity to make choices, service users have to carry the risks of making potentially 'bad' or 'wrong' choices; they may face blame and even punishment if they make the 'wrong' choices (Kemshall, 2008).

Analysing the Statements of Consumer Choice and the Subject of Government in the PHF Manual

Sam Tsemberis wrote the Housing First manual (2010) as a guide for planning and structuring PHF model-based policies and programmes. It clarifies the philosophy and the principles of the model, and offers concrete tools for, and examples of, implementations of the model. The manual contains plenty of descriptions of how clients ought to be encountered, how they should be guided towards self-determination and recovery, and what their rights and responsibilities are during the process. Consumer choice as one of the core principles of the PHF model is strongly present in the manual, although it is not introduced under a separate heading; rather, it is referred to and combined with several other topics throughout the book.

In the analysis of the manual, we apply Foucauldian discourse analysis. This means firstly that we approach discourse as a group of statements that are organized in relation to each other, forming a system (Foucault, 1972), and we examine how statements related to consumer choice are created and organized in a systematic way in the manual (Kendall and Wickham, 1999). Our second special interest is in

how the discourse produces the PHF clients as subjects, i.e. the attributes and expectations connected to clients, and the kinds of subject positions the discourse invites them to take (Hall, 2001).

The third step in the analysis is to read the PHF discourse as embedded in a larger discursive formation called advanced liberalism. By 'discursive formation', we refer to a type of discourse that appears simultaneously in various policies, texts and institutional sites sharing a common style, strategy, political drift or pattern etc., and in this case in particular a common way of constructing subjects (Hall, 2001). When analysing the PHF consumer choice discourse as part of the widespread discursive formation of advanced liberalism, we pay special attention to govern-mentality (Foucault, 1991), i.e. how clients are constructed as subjects of govern-ment. In the advanced liberal way of governing, consumer choice is essential, as is explained by Miller and Rose (2008, pp.213-214):

> "The enhancement of the powers of the client as customer – consumer of health services […] – specifies the subject of rule in a new way: as active individuals seeking to 'enterprise themselves', to maximize their quality of life through acts of choice, according their life a meaning and value to the extent that it can be rationalized as the outcome of choices made or choices to be made."

The problem within advanced liberalism is "to find means by which individuals may be made responsible through their individual choices for themselves and those to whom they owe allegiance", i.e. how to regulate people's self-regulation (Miller and Rose, 2008, p.214). Accordingly, the expressions of endeavours to regulate clients' self-regulation are important in examining the discourse of consumer choice in the manual.

In practical terms, we conducted the analysis by reading the manual and picking out all the sentences, sections and chapters dealing with client choice. We then coded these individual findings according to the premises and rules connected to client choice. We identified seven codes in total. Following Foucauldian discourse analysis, we call these codes the statements of the discourse of consumer choice in the PHF model. In the next section, we present and analyse these statements one by one, using illustrative extracts from the manual. We explicate how they form an organized system and how this system creates subjects and subject positions, and we demonstrate the similarities between the internal PHF discourse and the larger discursive formation of advanced liberalism.

The Discourse of Consumer Choice in the PHF Model

Statement 1: Emphasizing clients' own choices is an alternative to traditional professional care

The manual discusses and defines a specific relationship between clients and professionals as an important cornerstone of the PHF model. This is often done by contrasting old and 'bad' forms of relationships with the new and more functional ways used in the PHF to create relations with clients:

> "The general philosophy and practice of traditional mental health care system, at the core, is to tell clients, 'This is what you *need* to do'. In stark contrast, PHF continually asks, 'How can we help?' and then listens to the answers" (Tsemberis, 2010, p.41, emphasis in original).

> "Most traditional supportive housing programs are highly structured and permit only a narrow range of client choices. By limiting choice, these highly structured programs discourage autonomy, and they erode the very skills recovering people need to function effectively in the community. In sharp contrast to such programs, client-determination drives the PHF philosophy" (Tsemberis, 2010, p.26).

> "Clients' service plans are based not on clinical assessments of their needs, but on the clients' treatment goals" (Tsemberis, 2010, p.27).

Sometimes the manual explicitly points out the differences between a traditional system (linked to the LRT model) and the PHF model ('In stark/sharp contrast…'), but most often it indicates the content of bad and good relationships. How, then, are the features of a non-functional client-professional relationship defined? In the above three extracts, just like in the manual in general, these features include the following: professionals define client needs on their behalf (clinical assessment); relationships are based on structured (pre-defined) programmes; clients are treated in an authoritarian and judgmental manner; clients are confronted so that they feel attacked and coerced; client autonomy is discouraged and client skills eroded, and, all in all, clients' own choices are limited. These 'bad' features comprise something that can be understood as top-down professional power. The client-professional relationship in the PHF is to be read inversely from these features: professionals listen to clients and ask how they can help them (clients as experts); clients are encouraged to define their own needs; the relationship is a collaborative one in which plans are discussed and made jointly; clients are treated with respect and without judgment; change is not insisted upon; client autonomy is underlined; and, all in all, clients' own choices form the basis for the work.

Hence, both models and their related discourses (re-) produce knowledge about clients and certain kinds of actions associated with clients as subjects. In the above excerpts, Tsemberis accounts for these perceived differences. Accordingly, two mutually distinctive images of the traditional LRT models and the PHF model are constructed as binary opposites. The essential distinction has to do with the way the subject is produced or positioned in relation to the professional expertise. Within the traditional and LRT-related discourse – at least as it is discursively constructed in the manual – clients are positioned as 'incompetent', in need of professionals as experts and thereby objects of professional interventions, rather than subjects with their own wants and wishes to be realised. Within the PHF-related discourse, in contrast to this image and as evidenced in the next statement, clients are positioned *from the outset* as competent and capable of making their own choices, and clients' own definitions of situations, as well as their needs and wants, constitute the point of departure of, and shape, professional intervention.

Statement 2: Clients are capable of making choices of their own

Emphasizing client's own choices – one of the core principles in the PHF model – presupposes the discursive positioning of clients as subjects *capable* of making their own choices. Again, this is represented as a major distinction from the LRT approaches, which are based on the representation of clients as incapable. According to the manual, the latter representation of clients is based on 'erroneous assumptions' (Tsemberis, 2010, p.16). Through the PHF-related discourse of consumer choice, the manual claims new knowledge entailing "a new conception of the subjects to be governed" (Miller and Rose, 2008, p.212); clients are represented as subjects of a certain kind:

> "… in light of a growing body of research that indicates consumers as capable of setting their own goals and, with support, living independently without first living in transitional settings. Indeed, the evidence suggests that not only are consumers capable of making choices, they are far likelier to stay in housing programs that allow them greater choice" (Tsemberis, 2010, p.16).

In this extract, the construction of clients as consumers is related to their capability to set their own goals, i.e. to make reasonable choices regarding their future. Respecting this capability and allowing clients the freedom to make choices of their own is claimed to produce good outcomes, as the freedom to make one's own choices increases the likelihood that clients stay in housing programmes. According to the experiences of the PHF programmes and related research, the first preference of clients is almost always an independent flat. However, clients are not only capable of making choices, but also of making rational, responsible and correct choices regarding their own future. Understanding this 'double capability' is presented as a big discovery of the PHF and related models. As Leonard I. Stein,

co-founder of the assertive community treatment model, quoted by Tsemberis (2010, p.92), puts it: "When we moved our services out of the hospital and started working with people in their own community, we discovered that people were capable of so much more than we had imagined possible."

Interestingly, the 'discovery' that clients are capable of so much more than previously imagined simultaneously produces subject positions for clients of the PHF model where 'doing much more' is actually expected. Capable people can take on more responsibilities in their own lives and they have the right to do so. What's more, they are expected to exceed expectations and to excel at responsible choice-making. Hence, the statements internal to the discourse of consumer choice analysed thus far create a firm and justified basis for the shift towards governing 'in the name of freedom' (Rose, 1999), and for the production of self-regulating actors as entailed in the PHF model. The discourse produces subjects "that are to do the work on themselves" in order to "achieve responsible autonomy" (Rose, 2000, p.334).

Statement 3: Choice-making strengthens clients' self-determination and individual mastery

Although clients are, in principle, defined as capable of choice-making from the very moment they enter the PHF programme, there is still work to do in order to strengthen the capability or capacity of the client further. The manual constructs this as a positive circle. Through the opportunity to make choices of their own, clients' self-determination and sense of individual mastery increase and this further increases the capacity for responsible choice-making.

> "By making their own choices in difficult circumstances, clients learn about how they deal with the decision-making process, and they become better equipped to make sound decisions in the future" (Tsemberis, 2010, p.27).

> "Every opportunity to make a decision increases the client's sense of ownership, self-confidence and mastery" (Tsemberis, 2010, p.59).

As in the above extracts, making one's own choices is not 'just' choice-making, but also a learning process with positive outcomes in and of itself. The process facilitates improved decision-making and equips clients with greater self-confidence and mastery of the process. The aim is responsibilization, i.e. to (re-) construct clients as self-reliant and self-determined actors. This is something that clients could not achieve completely by themselves, but can with the support of the PHF.

> "PHF takes a client-centred approach that ends homelessness for people who have remained homeless for years. From the point of engagement, PHF empowers clients to make choices, develop self-determination, and begin their individual journey toward recovery and community integration" (Tsemberis, 2010, p.12).

Instead of doing things for clients, the PHF teaches and supports clients to do things for themselves and to take ownership of their own lives (Tsemberis, 2010). In this sense, the PHF model could – as will be elaborated below – be regarded as an example of the novel strategies of activation and responsibilization associated with 'advanced liberalism' (Miller and Rose, 2008).

Statement 4: More choice opportunities increase clients' motivation and commitment and lead to recovery

The last extract, illustrating the third statement of the discourse of consumer choice, refers to the clients' individual journeys to recovery and community integration. This leads us to the fourth statement: more opportunities to make choices means increased client motivation, and it leads to recovery. The ultimate goal of the PHF is neither consumer choice nor better self-determination and individual mastery – it is recovery. Lacking self-esteem and skills of self-management are problems to be overcome through motivation and empowerment, whereby the individual is to accept responsibility for change and moving towards the goal of recovery, something that is not possible without the client having his/her own motivation and commitment. Hence, the positive circle is completed with still other elements; having more opportunities to make one's own choices strengthens clients' self-determination and individual mastery as well as their motivation and commitment, and this helps lead to recovery:

> "With the PHF program recovery begins with client choice and self-determination. Clients' service plans are based not on clinical assessments of their needs, but on the clients' own treatment goals. This approach helps clients stay motivated and engaged with the team" (Tsemberis, 2010, p.27).

> "Its overarching concept is that change is possible and that the desire for change must come from the individual. PHF teams can increase this motivation in a variety of ways, but the client is ultimately responsible for, and in control of, making the change" (Tsemberis, 2010, p.155).

Tsemberis argues that if clients can make their own choices, especially regarding their own treatment, they become more motivated and participate more fully in the PHF programme. Another side of this client choice 'coin' is responsibility – client choice brings responsibility for the process of one's own change and recovery. The PHF model underlines the importance of change as a result of the clients' *own* choice-making and self-management skills. Although governing is

not based on coercion, professional power is still present. The ultimate goal is change (recovery). Governing is based on freedom through regulating clients' self-regulation so that they become more responsible actors; creating an alliance between professionals and clients is seen as an important tool where the need for clients to get engaged with PHF professionals can be achieved by respecting the choices and decisions of clients:

> "Treating clients in a non-judgmental manner and allowing them to make their own decisions – even when the team disagrees – is the key to building strong therapeutic alliances. For wellness and recovery to occur, there needs to be a *fundamental shift in power from the clinician as expert to the client as expert.* Decisions of treatment are ultimately made by the client" (Tsemberis, 2010, p.158, emphasis in original).

What is meant by recovery is not explicitly defined in the manual. In general, as in the above extract, it implies wellness and integration into the community. Just living in a flat of one's own is probably not equal to recovery; while having a home of one's own is said to be the most important goal of homeless clients, this goal is also defined as a means to the end goal of recovery:

> *"Moving into an apartment of their own creates a fundamental change in clients' motivation; it increases their investment in participating in the program and becoming an active participant in their recovery"* (Tsemberis, 2010, p.82, emphasis in original).

Hence, while a flat of one's own might be regarded as an end goal of homeless clients, they are expected to change their view of what the goal really is after the commencement of, and during, the PHF programme, and capable and responsible clients will sooner or later come to realize that there is another more basic and more important goal – recovery.

Statement 5: Choice does not mean absolute choice – certain limits exist

Again, client choice is a highly valued principle in the PHF model, especially because of its positive effects on the recovery process. According to the manual (Tsemberis, 2010), clients' choices include the type, sequence and intensity of services and treatment options, as well as the type of housing (almost all choose a flat of their own), its location, furnishings and other personal amenities. However, within the discourse of consumer choice there are also certain limits; clients cannot choose to reject weekly flat visits by programme staff or refuse treatment plans, and they are not allowed to disagree with the terms and conditions of a standard lease, including paying 30% of their income in rent (Tsemberis, 2010). Thus, choice does not mean absolute choice. Rather, in order to be a client in the PHF programme, clients must accept certain institutional demands and responsibilities. If they do

not choose to agree with these, their clienthood will be called into question. When it comes to services and treatment, the limits of client choice is justified, for instance, in the following way:

> "Self-determination in the PHF program means that clients are encouraged and supported in selecting which priorities to address as they begin to build the life that they want. *There are some non-negotiable requirements, however. All clients are required to meet with program staff at least once a week. The channels of communication between clients and program staff must be kept open – especially in times of relapse and crisis. Although these meetings are mandatory, client self-determination remains the touchstone of the PHF program"* (Tsemberis, 2010, p.27, emphasis in original).

> "The home visit is truly a requirement that must not be waived, *because of its many valuable functions*" (Tsemberis, 2010, p.49, emphasis in original).

> "Clients who are reluctant to accept the weekly visit are often the ones who need it most. Resistance to the visit may mean the client is in a crisis and avoiding the PHF team" (Tsemberis, 2010, p.35).

> "In crisis situations, such as when a client is having a psychotic episode and has become afraid of the team, the team must be very assertive and see the client very frequently – even if the client resists these visits – in order to try to avoid hospitalization" (Tsemberis, 2010, p.95).

Thus, although the self-determination and priorities of clients are emphasized, there are some simultaneous 'non-negotiable requirements' for which good professional reasons are presented; without weekly visits there is no real communication between professionals and clients. Interestingly, home visits are regarded as especially important in situations where clients explicitly resist them (i.e. do not want to choose them). This is, again, justified with good professional reasons; the reluctance to make the 'right' choice in such a situation is, according to the professional definition of the situation, a sign of a psychotic episode, and without professional intervention the client's situation can become even worse. Here, the good intentions of professionals motivate the curtailment of clients' choices or choice-making.

Requirements concerning housing form another area where the possibilities for choosing and not choosing are limited:

> "Client choice is a central guiding principle of the PHF program, but also one of the concepts most frequently misunderstood by those seeking to replicate the program – and even by PHF staffers and clients themselves. In the housing world, *choice* does not mean *absolute choice.* Choice of the first apartment is tempered by the economic realities of the rental market and by the state or federal 'fair

market value' rent stipend. There is no choice about signing a lease or paying the rent, and there is no choice regarding lease violations. The client faces the same responsibilities and consequences that other renters do. The main difference is that most other tenants in scattered-site housing do not have a case manager looking after their interests" (Tsemberis, 2010, p.71, emphasis in original).

This extract begins with the reminder that client choice is an important principle in the PHF model, and follows with an explanation as to why unlimited choice-making is not possible in the housing world. First, clients cannot make unrealistic flat choices because "naturally, some housing and neighborhood choices are restricted by affordability of neighborhoods and units" (Tsemberis, 2010, p.22). Secondly, clients cannot choose not to fulfil normal tenant responsibilities.

Hence, what we have seen is that there are certain limits to the choice-making of clients. Within the PHF-related discourse of consumer choice, clients are positioned *from the outset* as competent and capable of making their own choices, possibly also realizing their true potential as *responsible* choice-makers within the framework of the PHF, through a relatively high degree of freedom of choice. However, there are certain requirements that must be accepted – certain rules for the self-regulating actors that are not possible to reject. If the 'right' choices are not made (e.g. if home visits are rejected), the position of the client as a competent choice-maker is heavily circumscribed or even, in situations of repeated failures, completely altered.

Statement 6: Efforts are made to reduce risks related to choices, but repeated failures diminish client choices

The opportunity for clients to make choices of their own might bring risks and even failures, which are accepted as part of the PHF model. However, this acceptance does not mean that risks should be entirely the responsibility of the clients. Instead, the model underlines the importance of recognizing risks associated with possible choices ('wrong' choices) so that they can be either prevented or the harms related to them reduced (the principle of harm reduction) (Tsemberis, 2010). For instance, if clients choose to use drugs or refuse medication, professionals try to reduce the possible harm that could be caused by these choices. However, 'wrong' choices leading to repeated failures are not accepted indefinitely without consequences, and this non-tolerance is connected to housing requirements in particular.

"When the client demonstrates disruptive behaviors, the program manages risks by restricting choice, but still keeps the door open and continues to work with the client through the crises until another unit is found. Every client gets a second chance and a third chance, and then everyone begins to have doubts about the possibility of housing the client successfully (…). Each failure slightly diminishes

client choice. The first apartment failure is often expected: the second is even understandable, but by the third, there is no longer the assumption that the team will proceed with looking for another unit under the same contract. At this point the client must actively persuade the housing agency and the team that this time it will be different – and describe how it will be different. This is not simply a verbal commitment. The 'walk must match the talk'" (Tsemberis, 2010, pp.71-72).

Conduct such as disruptive behaviour, not signing a lease, not paying rent or destroying furniture is referred to as a violation of the housing requirement (Tsemberis, 2010). If clients 'choose' to commit such violations repeatedly, there are consequences – i.e. increasingly restricted opportunities to make one's own choices regarding housing. To a certain extent, failures belong within the PHF model but only to a certain extent – the fourth failure is not regarded as 'normal'. At this critical stage, clients are responsible for persuading both housing agencies and professionals that their habits will change in the future.

Statement 7: 'Never-ending' failures might mean the end of clienthood in the PHF programme

According to the manual, the majority of PHF clients use their right to make their own choices responsibly – i.e. they acquire the preferred self-management skills – within a short period of time, or they succeed after a small number of failures (Tsemberis, 2010). However, at the same time, the discourse also includes the idea that some clients cannot manage the freedom of living independently.

"Still there are a few clients who cannot manage the freedom of living independently. This is discovered after several apartments are 'lost' and after several unsuccessful relocations. For these clients, a different type of housing arrangement is needed. A building with a secured front door will often do the trick because the client cannot control the front door and will need someone to manage that for him or her" (Tsemberis, 2010, pp.73-74).

In the above extract, the distinction is made between the many clients who have proven to be capable of responsible choice-making and the few that are incapable of making their own choices. This is 'discovered' by staff. If clients are resisting the responsibilization process, the subject position changes – professionals become the only ones capable of choice-making when clients are not, i.e., when they do not accept their responsibility or refuse to govern themselves. Clients incapable of making their own choices need someone to make the choices for them; since they "cannot control the front door", they "need someone to manage that for him or her" (Tsemberis, 2010, pp.73-74). For these clients, a different type of housing arrangement than that which can be provided by the PHF programme is thought to be needed, and they can no longer choose to stay in the PHF programme.

Advanced Liberalism, Governmentality and the PHF Discourse of Choice

Within the discourse of consumer choice in the PHF model, it is claimed to be necessary to break away from expert-led, professional care models and instead take the clients' own choices as a starting point. Clients are positioned *from the outset* as actually or potentially competent and capable choice-makers. However, at the same time, the choice-making capabilities of clients are seen as in need of further strengthening in order for them to realize their true potential as *responsible* choice-makers. Choice-making is furthermore represented as an essential tool for individual mastery. Responsible choice-making is *not* an end goal in itself, but a *means* to achieve the ultimate goal of recovery. Moreover, within the PHF model, there are certain limits for the choice-making of clients. There are 'right' choices and there are 'wrong' choices. Making 'wrong' choices (e.g. choosing not to pay rent or resisting the PHF teams' home visits) is represented as individual 'failures'. These are tolerated, and regarded as natural to some extent, but *repeated* 'failures' means that the choice-making of clients is curtailed. In such situations the position of the client as a responsible choice-maker is altered. Repeated 'failures' might, for some, mean the end of clienthood in the PHF model.

The internal PHF discourse outlined above bears a stamp of the larger discursive formation of advanced liberalism. It produces subjects "that are to do the work on themselves" in order to "achieve responsible autonomy" (Rose, 2000, p.334). The very idea of consumer choice is linked to the advanced liberal way of governing subjects emphasizing "the active, choosing, responsible and autonomous individuals obliged to be free, and to live life as if it were an outcome of choice" (Miller and Rose, 2008, p.18). Individuals are *obliged* to fulfil themselves. However, within advanced liberalism, "there are always rules of regulation for the self-regulating actors" (Larsson *et al*., 2012, p.11; Miller and Rose, 2008). The problem within advanced liberalism lies in finding the means through which "individuals may be made responsible through their individual choices". The actively responsible individual of advanced liberalism is shaped, and his or her capacities, competences and wills are governed, yet this is generally done "outside the formal control of the 'public powers", with this way of governing from a distance creates individuals who "appear to act out their most personal choices" (Miller and Rose, 2008, p.214). This does not mean that the role of the state (or 'the public powers') has ceased and programmes targeting citizens who are "unable to accept their moral responsibility as citizens" have proliferated (Miller and Rose, 2008, p.102). The aim of such programmes is to monitor and reshape the conduct of these citizens. The PHF model can be described as an example of such a programme. Within the PHF model, the PHF teams could be described as examples of 'new experts of conduct', and subjects are construed as 'actually or potentially' active 'in their own self-

government' (Miller and Rose, 2008, p.105). The target group of the PHF model – homeless people with mental illness and addiction – constitute an example of the category of 'abjected persons' discussed by Miller and Rose (2008), and as such:

"… their alienation is to be reversed by equipping them with certain active subjective capacities: they must take responsibility, they must show themselves capable of calculated action and choice, they must shape their lives according to a moral code of individual responsibility and community obligation" (Miller and Rose, 2008, p.105).

As mentioned previously, within the discourse of consumer choice in the PHF model, choice-making is not a goal in itself. The ultimate goal is recovery, to be achieved through motivation and empowerment, which then becomes a matter of experts trying to teach, or sometimes coax, clients to conduct themselves in the required 'responsible' manner (Miller and Rose, 2008). Hence, although empowerment is linked to the strengthening of clients' own choice-making capabilities, it does entail professional efforts to reform the conduct of clients in relation to the norms of the PHF model. Certain types of behaviour are seen as amenable to reform through 'empowerment'. The PHF teams, as an example of a type of 'new experts of conduct' within advanced liberalism, apply a "new way of managing professional-client relations" (Miller and Rose, 2008, p.107) in order to reach the goal of changing the clients' conduct. Within the discourse, autonomy is represented as the "capacity to accept responsibility" (Rose, 2000, p.334), and 'repeated failures' as the inability to become responsible. The latter, as we now know, might mean the end of clienthood in the PHF model. Thus, for clients who repeatedly choose to refuse to govern themselves in the preferred manner, harsh measures are regarded as entirely appropriate (Rose, 2000). Hence, in the PHF model – just as in traditional professional care models – the continuation of clienthood is conditional to some extent upon conduct. On the one hand, the PHF model aims at re-affiliating the excluded through the strategy of empowerment and the strengthening of individual choice-making capabilities, thus producing the subject position of the active and responsible choice-maker. On the other hand, the very same strategy produces a notion where this goal is seen as unattainable for some individuals, who are then excluded from the PHF model. This is perceived as the only right thing to do, since they are represented as in need of something other than what can be offered by the PHF model.

Conclusion

In this article we have analysed the discourse of consumer choice in the PHF model as displayed in the Housing First manual. We have demonstrated how seven related statements form the discourse, and how the discourse has clear similarities with the wider discursive formation called advanced liberalism. When conducting this analysis, our aim has not been to claim that the PHF model has been intentionally based on the ideas of advanced liberalism, but rather to make it clear that the model was not born in a vacuum but echoes prevailing societal discourses. Neither has our aim been to downgrade the principle of consumer choice in the model, but to discuss its complexity. Emphasizing clients' own choices is a good premise for all kinds of professional work, yet it becomes complicated in institutional practice. We argue that, in the end, clients' choices are often the results of negotiations between clients and professionals. The concept of *an informed choice* is helpful here (Greve, 2009). It refers to the fact that clients do not make their choices totally on their own. Instead they are governed to make 'right' choices.

As was explained in the beginning of this article, the PHF model has been constructed as an alternative to the LRT model and its erroneous assumptions (Tsemberis, 2010). There is no doubt that the PHF model has many advantages when compared with LRT programmes. Housing as a basic human right, the separation of housing and support, and belief in the capacity of homeless people to succeed in independent housing are principles that have challenged LRT-based institutional practices and their deficiencies. However, having analysed the discourse of consumer choice in the PHF model, our conclusion is that the two models should not be seen as entirely different, as they both aim to support clients' independence, motivation and recovery; in other words, both aim to render people as self-responsible as possible. In both models a distinction is made between 'capable' and 'incapable' clients, the difference between them being that LRT programmes define clients as incapable of independent living and choice-making from the outset, but, if successful, 'capable people' are produced.

Both programmes can also fail some clients, who can then easily get stuck in a situation of homelessness or at the lowest level of special housing without any real choice in improving their housing conditions. In the PHF model, clients are initially regarded as capable of living in independent housing and making their own choices. Even after a first, a second and sometimes also a third 'failure', they are still regarded as (at least potentially) capable. After 'failing' several times, clients need to earn another chance, and if they are not successful in persuading the professionals involved to give them yet another chance they might become categorized as 'incapable' and thus in need of another kind of service than the PHF. The question is whether there are real or proper service choices available for these

'excluded' clients or whether they end up in choiceless situations similar to those of homeless people in LRT programmes who are not given the opportunity to proceed from the lowest housing levels. As the PHF manual claims, the share of clients assessed as not succeeding in the PHF model and defined as needing another solution is very small (and clearly smaller than the share of unsuccessful clients in the LRT programmes) (Tsemberis, 2010). However, the risk that some homeless people still might end up in choiceless situations should be taken seriously when implementing the PHF model in different countries, in different societal contexts and in different client groups.

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› **References**

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