

***'Housing First'* – A Review of Experiences**

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Abstract: In this paper we provide a review of the US *Housing First* approach and assess what it can contribute to policy for addressing multiple needs homelessness.

Housing First involves the explicit incorporation of permanent housing at an early stage of social and health support packages for homeless individuals who have multiple needs. This approach is in contrast to approaches that assert the need for successful treatment prior to resettlement (Continuum of Care/Staircase of Transition).

Evaluations of *Housing First* suggest that even those whom might be considered the most difficult to house can, with help, successfully maintain a tenancy of their own. It is argued here that by examining *which* components of *Housing First* may be important, and *why* these components contribute to greater housing stability, clearer understanding of effective intervention can be ascertained.

Two case studies of *Housing First* programmes in New York (Pathways to Housing and Project Renewal) are presented. Significant components are identified as (1) access to permanent housing, (2) integrated and holistic support services separate from the provision of housing, and (3) access for clients who have been rejected by other programmes. It is suggested that one locally based agency managing both the housing and assertively providing holistic and non time-limited support packages may be important factors in the success of *Housing First*. However a further caveat is added that to robustly assess the effectiveness of

Housing First (and homelessness policy *per se*) what ‘success’ refers to in the resettlement of formerly homeless people requires continued consideration.

Nevertheless, the evidence for the effectiveness of *Housing First* is compelling and makes a strong case for its incorporation into policy aimed at deeply excluded homeless people.

Introduction

In this paper we examine experiences from two *Housing First* programmes in the US. The *Housing First* approach involves providing individuals who are homeless and have multiple needs (Rosengard *et al*, 2007) with the option of a permanent tenancy immediately on enrolment to a programme. Once in housing, support is assertively provided (Felton, 2003) but there is no obligation on the part of the client to comply with treatment. Housing is separated from treatment compliance, and viewed as an essential component required for individuals to be capable of managing the multiple needs that they have, and to resolving ‘chronic’ homelessness (Tsemberis *et al*, 2004). Rather than becoming ‘housing ready’, independent permanent housing is viewed as the first step that is possible regardless of the support needs a homeless individual manifests.

This approach appears to be in contrast to prevailing programmes operating in the US (and Europe) where treatment to address multiple needs is deemed necessary prior to successful resettlement. On the far side of this spectrum sits *Continuum of care* approachesⁱ advocating a ‘staircase’ out of homelessness, (Sahlin, 1998) ‘treatment first’ (Padgett *et al*, 2006) and the need for a phased resettlement (Seal, 2005). With this approach it is intended that individuals work through stages of supported accommodation and treatment before

reaching a point where they are deemed capable of independent living. However if an individual is unsuccessful, for example not maintaining sobriety or not engaging with support services, then they will be prevented from moving along the continuum and remain homeless (McNaughton, 2008).

Housing First and *Continuums of Care*, whilst contrasting, also illustrate the spectrum of provision that can be used to address multiple needs homelessness. Programmes with elements similar to *Housing First* do operate outside of the US. However it is in the US that *Housing First* has had an explicit policy drive, and robust evaluations of *Housing First* programmes there have found a much higher success rate than *Continuum of Care* programmes operating in the same context (Tsemberis & Eisenberg, 2000; Padgett *et al*, 2006). The reasons for this, and lessons that can be learnt from *Housing First* programmes, that may be applicable elsewhere, are therefore important to identify.

It is postulated in this paper that by identifying *which* components of *Housing First* are significant and *why* these components may contribute to greater housing stability, then a clearer framework for the genesis of successful interventions can be arrived at that cuts across the plurality of services and approaches currently operating. This framework would contribute to more effectively addressing multiple needs homelessness in different contexts. To do so, we take a three stage approach: firstly, we briefly review *Housing First* and draw out significant components; secondly, we present two detailed case studies using two programmes currently operating in New York; and, thirdly, we examine why these components, in operation, may contribute to successful outcomes in the resettlement of those making up the most chaotic and excluded of the homeless population.

Housing First

The evidence gathered in support of the US model of *Housing First* in recent years has been impressive (with the caveat that much of it has focussed on one pioneering agency, Pathways to Housing, in New York). Randomized large scale studies comparing *Housing First* with traditional ‘treatment first’ continuum approaches report significantly higher rates of housing stability among *Housing First* clients (Tsemberis & Eisenberg, 2000). Tsemberis *et al* (2004) report that they achieved a retention rate of approximately 80 percent over two years using a *Housing First* approach, a figure that challenges assumptions the hold drug using or mentally ill homeless people to be incapable of maintaining their own independent tenure. Further, Culhane and colleagues (2002) demonstrated the cost effectiveness of permanent supportive housing programmes, such as *Housing First*, for stabilising the most in need and chronically homeless shelter population. In their analysis of large scale data sets, they concluded that homeless mentally ill people used \$40,451 of services in a year. This *reduced* by \$16,281 when provided with supportive housing, mainly due to a decrease in emergency service uptake and arrest. The cost of providing housing and support therefore led to an overall net reduction. Similar findings from an analysis of *Housing First* in Denver have also been reported (Perlman & Parvensky, 2006).

Housing first programmes in the US have proliferated with increased funding for permanent supported housing programmes made available as part of the Department of Housing and Urban Development’s policy to address chronic homelessness (Culhane & Metraux, 2008). *Housing First* has also been implemented in Toronto, Canada (Toronto Shelter Support & Housing Administration, 2007) and projects in other countries manifest elements of *Housing First*. Social Rental Agencies in Belgium, for example, have seen social welfare organisations become increasingly involved in housing issues (De Decker, 2002). In a recent study of transitions through homelessness in the UK *ad hoc* versions of what

approximated *Housing First* were operating, with a number of participants accessing a social rented tenancy immediately from an unsupported hostel, with the advice of resettlement workers, and then being supported to maintain their housing long term (McNaughton, 2008).

So there are elements of *Housing First* evident outside of the US. However it is in the US that the model explicitly referred to as *Housing First* exists and it has become the basis of programmes in many states. Several of these have been the focus of robust evaluations. Given the evidence produced, we chose to examine the US experience, and use two specific cases of projects in New York.

Components of Housing First in the US

Clients are enrolled on *Housing First* programmes randomly, on a first come first served basis (Stefancic & Tsemberis, 2007) or are specifically selected because they have repeatedly failed to work through continuum type programmes, and will not engage with mainstream support services (Perlman & Parvensky, 2006). So for example in some jurisdictions information on individuals who have had repeated contact with emergency homeless services is passed on to a *Housing First* agency. The agency provides assertive outreach in an attempt to engage and enrol these individuals onto their programme, provide them with housing and support to maintain them. *Housing First* programmes tend to work with clients who have been excluded or unable to maintain accommodation within traditional models.

There is no single definition of *Housing First*. However, there are central features common to most of the US programmes (Pearson *et al*, 2007; National Alliance to End Homelessness, 2007; Padgett *et al*, 2006) and important components of *Housing First* can be identified. These are specifically: (1) immediate access to permanent housing; (2) provision of a range of services, which are separated from eligibility for housing or risk of eviction; and

(3) as previously discussed, working with clients who have been unable to move out of homelessness, and are often excluded from mainstream services.

To illustrate how these three components operate in practice two case studies of *Housing First* programmes in New York are outlined below. These cases are taken from data collected during a research trip by one of the authors in April this year. The fieldwork included interviews with staff and observational site visits. The two agencies used as cases are Pathways to housing and Project Renewal. The first has been selected because they are pioneers of the *Housing First* approach and there is a considerable evidence base available on the outcomes of their work, whilst the second involves a different client group and thus provides a demonstration of the approach's potential versatility.

Case Studies of *Housing First* Programmes

Case study 1 - Pathways to Housing

Pathwaysⁱⁱ was founded by a psychologist in 1992, the aim being to provide permanent housing (and treatment) for chronically homeless and mentally ill people, in New York city. To be eligible to enrol on Pathways programme clients must have: (1) An axis 1 mental health diagnosis (a clinical disorder such as depression, anxiety, or schizophreniaⁱⁱⁱ); (2). Be chronically homeless, so for example be known to have been in a shelter for two years on or the streets for three months; and, (3) Be eligible for public assistance funds.

Pathways only work with those diagnosed with a severe mental illness. Their clients are eligible for public assistance as they are deemed permanently disabled (they are usually eligible for Medicaid, which can be used to fund some of their treatment through ACT teams (see below)). Pathways thus work with individuals who have experienced long term homelessness and that have often previously been unable to access or maintain mainstream

services, due to their high support needs. Pathways accept clients who fit the criteria on a 'first come first served' basis, and make no prior assessment as to how able (or otherwise) clients are likely to be able to maintain a tenancy.

Once a client is accepted onto the Pathways programme (after referral from a homeless shelter, outreach agency, or hospital) they will be offered a permanent apartment as immediately as possible, often within a week or two. Once they agree on an apartment, they choose furnishing and household goods and are supported to move in and settle there. Pathways hold the lease of nearly 600 privately rented apartments. Their housing department locate and inspect the apartments, agree the lease, liaise with landlords, and are responsible for maintenance if repairs are required that the landlords are not liable for. The rents are paid by the agency through HUD (Department of Housing and Urban Development) permanent supportive housing grants or public assistance section eight vouchers and contributions from residents (30 per cent of clients social security income is paid towards their rent, as is standard in the US). Pathways therefore have a 'bank' of apartments that clients can move into or between depending on their needs, without them ever being without their own housing or requiring the landlords permission for these moves. Their clients have been unable to access private rented tenancies previously because they could not guarantee the rent, had no references or credit rating, or because landlords did not want to house people with support needs, that have a history of institutional living and long term homelessness. By going through Pathways such limitations to access to private rented housing are negated, and landlords are assured the properties will be managed and rent paid.

Pathways provide support to clients through localised Assertive Community Treatment Teams (ACT teams) (Salyers & Tsemberis, 2007). ACT teams consist of nurses, psychiatrists, employment support workers, substance use support workers, peer workers, family specialists, and so on. All of the staff remain informed about and work with all of the

clients as required in a holistic manner. Staff draw on their specialism, and also provide some group sessions such as music therapy, cooking, or relaxation for clients in community settings or the team's offices. The medical staff distribute and manage the clients' medication. The ACT team have at least 6 contacts with each client a month and approximately 80 per cent of these contacts are in the community (such as the client's apartment or cafes). So clients have access to integrated and holistic support services, alongside permanent housing.

The onus is on ensuring clients maintain their housing. The only stipulations to ongoing engagement is six contacts with an ACT team staff member per month and that incomes are managed by Pathways. Clients will not be evicted from the programme unless they commit a serious crime or are violent towards the staff. Pathways have a retention rate of almost 90 per cent (the percentage of clients that maintain an apartment, although they may have moved multiple times between Pathways apartments if required). The support of the ACT team or length of time that someone can live in their apartment is indefinite, and should circumstances change (such as a partner moving in) this will be accommodated.

Pathways therefore implement three significant components of *Housing First* previously identified – access to permanent housing (in this case privately rented); integrated and holistic services (through their ACT teams); and a service to those often excluded from other services. However they provide services only to a distinct group that have previously been excluded from other services – those with severe mental ill health. Implementing *Housing First* in this manner is not without challenges. New York has a tight housing market making obtaining adequate and affordable apartments difficult. Most properties that would be suitable are located in the lower cost outer Boroughs. Staff also report difficulties with drug dealing taking place in the apartments necessitating the client to move to another location. A further complication is that Pathways is not exclusively a 'homelessness' agency, their main

focus being support of the severely mentally ill. The eligibility criteria for their support mean that those homeless individuals with *other* support needs (such as active substance users without a diagnosis of mental ill health) cannot be offered support. To assess whether different client groups have significance to how different components of *Housing First* are implemented, a second case study (Project Renewal) is outlined below.

Case study 2 - Project Renewal

Another agency operating a *Housing First* programme in New York is Project Renewal^{iv}. Formed in 1967, Project Renewal manages large shelters and congregate supportive housing in New York. They also provide training and rehabilitation services for homeless substance misusers. Their services have traditionally been abstinence based, with clients expected to have a sustained period of being ‘clean and sober’ to access them. Therefore it was a major shift (and a means to address a recognised gap in service provision) when they were one of the eleven agencies nationwide that successfully obtained pioneering HUD *Housing First* grants for permanent supportive housing in 2003. Project Renewal was the only of these agencies that focuses on substance misusers as opposed to the severely mentally ill. Despite this substantive difference, Projects Renewals project operated, and continues to operate, in a similar manner to Pathways.

Project Renewal’s *Housing First* project (In Homes Now) provide access to permanent mainstream housing as soon as someone is enrolled on the programme. In the same manner as Pathways, their apartments are privately rented. Project Renewal have housing officers who liaise with landlords, obtain the lease, and inspect the properties. Thus Project Renewal notably also hold the leases of the properties used. Support to clients is provided by a central team of staff based at one office, in a holistic, integrated manner. Staff are trained in a range of specialisms, including substance misuse, family experts, counsellors,

housing and so on. They are expected to provide a holistic package of care and advice to each client, they also have a psychiatric nurse that attends twice a week, and they hold classes and drop in sessions at their office. Clients are referred to the programme from Project Renewal shelters. These clients are chosen because they have been long term shelter residents, unable to remain abstinent or engage with support services previously. It is a harm reduction based programme, their clients therefore do not have to address or be reducing their addiction, or engage with substance misuse services, to obtain or maintain an apartment.

The support they offer is not time limited however and clients can remain with them indefinitely. Project Renewal report a 75 per cent success rate for the In Homes Now *Housing First* project – 75 per cent of those that have enrolled on the programme have either maintained their apartments, moved to another stable tenancy, or into a long term substance use programme (and will return to an In Homes Now apartment on completion). There is no expectation that clients will enter substance use programmes. However, doing so is encouraged and, if requested, facilitated. So Project Renewal's *Housing First* project: provide clients with permanent housing (once again, privately rented); provide integrated and holistic support services (but with less medical reach than that of Pathways); and, provide a service to clients that have been unable to access other services due to their active substance use.

Pathways and Project renewal have differences in their approaches that are nonetheless still in the framework of *Housing First*. Pathways have more substantial medical teams given that they are specifically intended to work with mentally ill clients whose health needs are on average greater. So *Housing First* programmes both operating in similar contexts (New York) with similar clients (multiple need long term homeless) have differences in operation, which is mainly due to the nature of the primary diagnosis their clients have. Both do however illustrate three identified important components of *Housing First*.

Both offer immediate permanent housing without treatment compliance. This housing is privately rented, with the agency holding the lease and acting as a mediator between the landlord and client. They provide integrated and holistic support to their tenants based on principles of harm reduction. Stipulations to remain within programmes are kept to an absolute minimum. They also share a higher success rate than that reported by traditional programmes that require sobriety or treatment compliance, in the same city (Tsemberis & Eisenberg, 2000). Further, they tend to work with clients who have extremely high support needs and that have been unable to engage with traditional services, posing questions as to *what* it is about how these programmes operate that explains this outcome.

Why these components may lead to greater success in resettlement

So far three important components of *Housing First* projects have been identified. How these components are implemented in practice has been described. Understanding why these components are effective may provide a basis for developing practices in other cities or countries. In this section we thus consider each component one by one and draw out possible reasons for the contribution made by these individual parts.

1 - Access to permanent housing

An important element of *Housing First* is the type of housing for which clients are helped to attain tenancies. *Housing First* approaches represent a form of social housing (as defined by Fitzpatrick & Stephens, 2007) ,of using government subsidies to pay for private rented tenancies as part of a health and social support package for homeless people who have multiple needs. For the landlords the model provides a constant rental income and management of the tenancy (for example, Pathways housing department arrange repairs if the

landlord is not liable). For the clients, the agency holding the lease and sub-letting it to them provides a means to access the private rental market where a lack of reliable income and support needs had previously been a barrier.

This incorporation of housing and health issues are not unique to US *Housing First* projects. Parallels can be drawn with social rental agencies in Belgium, with welfare and support provided to vulnerable individuals by agencies that let privately rented properties in which to accommodate them. This property is rented at below market price, with the landlord accepting this due to the assurance of rent payment and maintenance of the tenancy by the social rental agencies (De Decker, 2002). Another example is the Coastal Homeless Action Group (CHAG) in Ipswich, UK^v. They facilitate access to permanent privately rented tenancies for homeless/multiple needs clients. CHAG hold the leases for these properties and sub-let them to their clients. The housing is paid for by Housing Benefit.

These projects suggest that developing *Housing First* in contexts other than the US is plausible. This said, there are significant differences to private rented sectors and legislation between countries. Future research into the explicit applicability of using private rented housing for those with multiple needs, in different locations, could be a useful addition to the lacuna in this area.

The *type* of tenancy is also important, utilising mainstream housing markets and avoiding institutionalisation. This may reduce the potentially stigmatising and residualising effect that can occur when a high concentration of vulnerable and excluded individuals are housed together (Fitzpatrick & Stephens, 1999). In Pathways to housing, clients are helped to find private rented accommodation in blocks in which no greater than 10 percent of residents are fellow programme participants (Tsemberis & Eisenberg, 2000).

Contrast such an approach to the prevailing situation in the UK. Fitzpatrick & Pawson note the 1977 Housing Act led to a '*tendency for the [social rented housing] sector to house*

even greater concentrations of the poorest and most disadvantaged households' (Fitzpatrick & Pawson, 2007: 170). Due to their perceived inability to pay rent or maintain their tenancies households with the most complex multiple needs are often currently excluded from mainstream social housing (Fitzpatrick & Stephens, 2007). The alternatives offer little comfort. Homeless hostels have been recognised as creating an environment in which people are brought into contact with others who are misusing drugs (Neale, 2001); hardly conducive to reducing or ceasing drug use or treatment of mental ill health. The *Housing First* approach therefore offers the prospect of a means by which private rented housing could be utilised to provide an environment in which people with complex mental health and addiction problems are more integrated to the wider community.

Potentially, the provision of housing as a first step for those with multiple needs could have important ramifications for the psychological process of individuals trying to address 'deep' exclusion (Pleace, 1998). For example, compared to homelessness, having a house may in itself provide the motivation and stability to begin to address drug misuse or access health care. Having an independent tenancy brings with it not only privacy but also a sense of security, which is an important part of motivating people to take control of their own lives (Padgett, 2007). Returning to homelessness must be extraordinarily demotivating (as has been discussed by participants in a recent study of transitions through homelessness (McNaughton, 2008)).

Housing First therefore illustrates a model that can (and has in various guises) been used to provide housing to those that are otherwise ineligible or excluded from social housing and are unable to secure private rented tenancies of their own. With support provided alongside this, these individuals may then have a greater chance of maintaining these tenancies, and the supporting agency can act to mediate this access to housing with landlords.

2 - Integrated and holistic services, separate for housing

Housing First programmes in the US consist of sizeable multi-disciplinary teams to support clients, including, nurses, psychiatrists, drug misuse councillors and peer supporters (Tsemberis *et al*, 2004). A further distinction is the integrated nature of the care. Both Pathways and Project Renewal offer each client the whole gambit of health, budgeting, social support and advice from one *Housing First* team. Clients have contact with any of the staff on that team. The locus of this holistic support is one single integrated point of contact through the team's office space. This provides continuity for the service users, important because poor quality information and a lack of 'joined up' provision of care is often criticised in reviews of homelessness services (Cranes & Warne, 2005; Bevan & Van Doorn, 2002).

That the support is not time limited is also an important consideration - rather than move onto another agency once a single issue is resolved (as is often the case in continuum approaches) the clients develop a long term relationship with the support team even if their circumstances change. Clients are aware that this relationship is ongoing for as long as they require it, providing a degree of stability on which to hold. Given that the clients are deeply excluded, with a range of support needs, and have previously found agencies difficult to engage with, this continuity and security could be important factors in generating a positive relationship between them and the support staff.

The combination of early housing and readily available, integrated social and health care support are likely to contribute to the success of *Housing First*. Community Mental Health Teams (CMHT) already operate in parts of Europe (predominantly the UK), but often will not work with multiple need clients (particularly those actively using substances). However, versions of CMHTs, providing a holistic approach offering integrated care and access to housing (perhaps through private rentals) for those with multiple needs in localised

settings, would not appear impossible to develop in other contexts (and similar programmes already exist, for example in Belgium, (De Decker, 2002)).

An effective homelessness policy requires both components – housing and support. Providing housing or support on its own is not sufficient. This has long been recognised by homelessness researchers in the UK (Pleace, 1995) and beyond (Toro, 2007). Does *Housing First* really then offer anything new to our understanding? Perhaps instead it fills a gap. A particularly notable feature of the US experience of *Housing First* has been the focus on groups previously excluded from services, whose social and health problems seem deeply entrenched and particularly intractable. We consider the significance of this point next.

3 - Providing a service to previously excluded groups

The most vulnerable and deeply excluded groups can be excluded from support services due to their problems, creating a vicious cycle (Rosengard *et al*, 2007). The shift in approach illustrated by *Housing First* provides a means with which to include individuals who continue to misuse substances or have high support needs into independent housing. *Housing First* can therefore be seen as a means to plug a gap that previously existed at least in the US, but possibly elsewhere. Questions could be posed as to how ‘just’ this system is however – that those with lesser support needs or that are maintaining sobriety continue to be excluded from housing, and may experience the damage of long term homelessness. The extent to which the approach could be widened to be accessible to anyone who is homeless is unclear. Whilst permanent supportive housing programmes, such as *Housing First* have been found to be cost effective with the most in need – most notably due to a reduction in hospitalisation and use of emergency services that accompanies stable housing (Culhane *et*

al, 2002; Gulcur *et al*, 2003) – realistically it may be too costly to roll out to all groups and therefore has to be ‘rationed’ (Pearson *et al*, 2007).

This is a paradox at the heart of these programmes, with homeless individuals having to experience the effects of long term homelessness prior to becoming eligible for this support, and only then being eligible if they have failed in mainstream services. The insistence on a multiple need diagnosis means that some people will be left homeless until such time as they have more severe mental health or substance misuse problems. To provide universal access to *Housing First* may be untenably expensive, however by not doing so the problems that it is intended to address continue to be allowed to fester among all but the most severely in need. Prevention of these problems at entry point may be a greater use of resources for the future. Further research and economic analysis is needed to provide ground on which to widen the debate.

Assessing ‘success’ in the resettlement process

A point of departure can also be made here by considering the extent to which *Housing First* really marks a ‘successful’ solution at all. When someone is stably housed they may be in a better position to access support services, and stabilise their lifestyle. However, what has been found in the research into *Housing First* outcomes is that there is little *significant* difference in behaviour or outcome between those who enter *Housing First* or *continuum* programmes other than the level of housing stability they attain (Tsemberis *et al*, 2004; Pearson *et al*, 2007). In other words, problems such as substance use often remains the same, only their housing circumstances improve.

When homeless people with multiple needs are housed they are unlikely to find other individual and structurally generated problems such as poverty or mental illness evaporate – housing alone does not equate health, wealth or wisdom (paraphrasing Busch-Geertsema,

2005). If someone is provided with a permanent tenancy with support and few conditions, even being moved repeatedly where necessary, they will be more likely to maintain housing than those who have to comply with treatment. *Housing First* as a policy is therefore a means to 'save' people from homelessness, and indeed is designed in such a way that it would be particularly difficult for a client to not maintain their housing. However the evidence as to further benefits beyond maintaining housing (albeit an important outcome) remains underwhelming. Pearson and colleague's (2007:xxvi) review of *Housing First* programmes, conducted for HUD was cautious in its endorsement, recognising that whilst '*direct placement in housing solves the elemental problem of homelessness (.) the dilemma is that it does not necessarily resolve other issues that may impede housing success*' and that in addition '*housing problems do occur*'. They also note that any programmes where actions such as drug use are 'allowed' are problematic for government policies, and in tension with law and order agendas. Nonetheless, whilst by no means the perfect solution, a *Housing First* approach may represent a pragmatic means for working with homeless people with particularly challenging mental health or addiction problems.

Discussion

Housing First may be a pragmatic means by which to manage the most costly and in need of the homeless population, rather than a 'revolutionary' solution to the problems they represent. McNaughton (2008), in a recent study of transitions through homelessness in the UK, argued that those who were stably housed at the end of the research were 'trapped individuals', no longer making a transition out of homelessness, feeling as if they were making no transitions at all, perceiving themselves to have few opportunities for meaningful occupation of time, and experiencing an acute sense of isolation. Substance misuse, and poor

physical and mental health, continued to feature highly. It has been postulated by Somerville (1992) that when experienced by deeply excluded individuals homelessness may be a manifestation of ‘rootlessness’ (characterised by anomie, alienation and disassociation from society) rather than simply housing-related ‘rooflessness’. Is it the rootlessness or rooflessness that needs to be tackled first? Can one be addresses without that other? And which strategies can be identified that are most successful for doing so? (For example, the principles of *Housing First*, or of *Continuums of Care*).

Further research needs to be conducted to ascertain the roots of the problem, and how they interact (Fitzpatrick, unpublished). It could be that other causal factors yet to be identified or conceptualised may actually explain the generation of multiple needs homelessness, and why some individuals avoid or fall foul of support services, despite apparently similar characteristics to those who manage to engage effectively. (Further research on this will shortly be underway in the UK, with a programme of new research into multiple needs homelessness recently announced^{vi}).

The complexity of the problem indicates that, rather than a clear cut formula, a spectrum of services is required. Aspects of *Housing First* are currently employed sporadically by European services. A more systematic and thus holistic implementation could potentially provide a more effective service delivery.

Conclusion

In this paper an attempt to delineate some important components of *Housing First* has been made, specifically immediate access to permanent housing (in the cases presented here, privately rented); and integrated and holistic services that are not time limited. Whilst not an explicit component of *Housing First*, most services operating currently also provide a service

for those excluded elsewhere. Case studies have been presented to illustrate how these components operate in practice. The next step has been to consider *why* these components may contribute to greater housing stability and engagement with services. In this way lessons may be gleaned from *Housing First* that can be used in the development of homeless services operating across different contexts, and with differing constraints.

The following have been identified as important. Firstly, in the context of current housing markets, using private rented tenancies managed by the support agency allows for immediate access to housing for those previously homeless and who would otherwise not be able to achieve their own tenancy. This housing provides a location for them to stabilise their life, and it has also been suggested generate motivation to do so (Padgett, 2007). Whether or not this system would be tenable in other locations without requiring below market level rental costs may remain a challenge. Secondly, support services being provided by the same agency that manages the housing, including a range of specialisms across the staff team, can provide more holistic, integrated and consistent support. That this support is not time-limited or punitive may also increase client's sense of security and trust, with potentially beneficial consequences.

Housing First approaches entails a switch in perspective that marks a policy departure regarding multiple needs homelessness – that people often deemed incapable of maintaining a tenancy are actually able to do so. How such tenancies are resourced and allocated requires some form of rationing however, and the process behind this currently represented by *Housing First* programmes, that work with only the most deeply excluded, may be questionable. Is it justifiable to exclude those who are not yet in such need?

We conclude that by providing access to housing and services for the most severely excluded *Housing First* approaches offer a model with which to approach multiple needs homelessness more effectively – a pragmatic means with which to manage the most in need

of the homeless population - rather than a 'revolutionary' solution to the deep rooted problems they represent.

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ⁱ This continuum model refers to the progress through stages to independence that an individual works through. In practice support services (at least in the UK) do not actually join up to offer a seamless continuum, that covers all aspects of an individuals needs. So for example some mental health teams will not work with individuals actively using substances; there may be a lack of counselling or other services available for an individual in supported accommodation to be referred to; or there may be a lack of bed space in accommodation that is deemed more appropriate for an individual than that which they are currently in. Each of these cases can lead to barriers in progress that are service rather than user led. Continuums of care may be offered by individual agencies, however the access to other services that make up such as continuum they have will be ad hoc and at times limited (See McNaughton, 2005 for an evaluation). This concept does not therefore refer to an explicit policy in the UK, rather a principle of care.

ⁱⁱ See www.pathwaystohousing.org

ⁱⁱⁱ In the US five axis are used to define mental health. Axis 1 includes clinical disorders such as depression, anxiety, bipolar, schizophrenia, and eating disorders and excludes personality disorders and learning disabilities which are axis 2 (see www.dhs.state.or.us/caf/safety_model/procedure_manual/appendices/ch4-app/4-5.pdf)

^{iv} See www.projectrenewal.org

^v CHAG contact, Jim Overbury.

^{vi} http://www.esrcsocietytoday.ac.uk/ESRCInfoCentre/opportunities/current_funding_opportunities/index.aspx