‘Housing First’ as a means of addressing multiple needs and homelessness

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› **Abstract**_ *This paper considers the effectiveness of Housing First and its applicability to the European context. Housing First approaches explicitly incorporate secure tenures as an intrinsic part of support packages for homeless people who have mental health and substance misuse problems. We contend that the evidence from the growing body of research in North America makes a compelling argument for the explicit incorporation of housing at an early stage as an effective means of addressing homelessness. The North American studies suggest that even those who might be considered most difficult to house can, with help, successfully maintain their own tenancies. Evidence suggests no deleterious effects on mental health or increased drug misuse and indeed, possibly some benefits. Economic analysis also demonstrates advantages, the cost of providing support to people in Housing First programmes being considerably less than if they were to remain homeless. The introduction of a Housing First approach, however, is by no means a simple philosophy that can be applied everywhere. Rather, local contexts will require some tailoring to meet local needs. Research is therefore needed to highlight obstacles to implementation and means by which these can be overcome. Furthermore, housing on its own is not a solution. Rather, having a secure tenure has to be seen as a part of an integrated support package.*

› **Key words**_ *homelessness, Housing First, drug misuse, independent tenancy, support services.*

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Introduction

A particularly challenging issue for housing providers is how to meet the needs of homeless people who have complex problems, such as those with poor mental health or who are misusing drugs. Homelessness, mental illness and addictions are associated in complex ways, each having underlying causes in common, while contributing to and exacerbating each other. Service providers thus face a dilemma: should housing needs be addressed early, or does doing so make failure and a return to homelessness more likely?

It is on this dilemma that we focus in this paper, specifically considering an approach that has been developed in the United States, namely *Housing First.* This model, as its name suggests, places emphasis on getting clients into housing at an early stage; the assumption being that people with mental health or substance misuse problems are capable of coping in their own tenancy. Services are still provided, but housing is not predicated on successful engagement. Such an approach contrasts with an alternative model, *Continuum of Care*, which requires clients firstly to address their drug misuse and mental health issues. Clients progress up what Sahlin (2005) refers to as a 'staircase of transition' with an independent tenure being the ultimate objective. Moving up a step involves successfully addressing problems and demonstrating abilities to cope with day-to-day activities. Failure results in moving down the staircase, with independent housing becoming an evermore distant possibility.

We begin the paper by outlining in detail the *Housing First* approach, contrasting it to the *Continuum of Care* model. Research into the effectiveness of the two approaches is then reviewed, highlighting encouraging outcomes that have been demonstrated for *Housing First* in North American contexts. The next part of the paper considers the extent to which a *Housing First* model might be replicated in European situations, using the UK as a case study. Our contention is that the current evidence indicates that people can indeed maintain tenancies even if they have drug misuse problems, but housing alone is not enough. *Housing First* is, in our view, a misnomer. Rather, the effectiveness of the model results from the provision of housing at an early stage of engagement as part of an integrated and comprehensive support package.

A comparison of *Housing First* with the *Continuum of Care* approach

The *Housing First* approach has become synonymous with the work of the 'Pathways to Housing', agency, based in New York and operating since 1992. 'Pathways' was set up by a psychologist, Sam Tsemberis, as a response to the problems he saw facing mentally ill patients who had no alternative housing options other than to access shelters or live on the street[1].

In the *Housing First* approach, access to an independent tenancy comes first. A considerable amount of support is then available to clients. They do not have to accept this assistance, although it is 'assertively provided' (Salyers & Tsemberis, 2007); in other words, there is considerable encouragement for clients to engage. However, refusal to use treatment services, a relapse, or other problems will not lead to eviction. Clients can be moved to other 'Pathways' apartments if problems develop; this can happen several times if necessary, the ultimate aim being to ensure that housed status is maintained. Only violence towards staff would lead to termination of the client's programme involvement[2]. Tenancies are found in apartment blocks in which no more than 15% of other residents are programme clients, hence getting away from institutionalised accommodation (Stefancic & Tsemberis, 2007). For the clients, choice is a central component. They choose their apartment, furnishings, the location and times of contact with support workers, and so on (Tsemberis *et al.*, 2004). The apartments are privately rented, but 'Pathways' holds the leases and manages the properties. Clients are viewed as being capable of remaining stably housed even if they have serious mental health issues or are misusing drugs.

In contrast, *Continuum of Care* approaches highlight 'treatment first' (Padgett *et al.*, 2006) and the need for a phased 'staircase of transition' to deal with individual problems and needs, leading eventually to resettlement in a secure tenure (Sahlin, 2005; Seal, 2005). Social workers assist clients throughout the process, with progression to the next stage only occurring if and when capacities, such as successfully addressing drug misusing behaviour, are demonstrated (Seal, 2005). Housing becomes an end goal to be achieved rather than a component in a person's recovery. The view taken is that individualised needs and problems are the key issue: get clients off drugs, assist them to learn life skills and then he or she will be in a position to manage a tenancy of their own. Place the client into independent housing too early

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1 It is an important point to make however that there is no single definition of *Housing First*. The term is applied in the US to a range of programmes amidst growing concerns that it is not always implemented well (Pearson *et al.*, 2007; Stefancic and Tsemberis, 2007). 'Pathways' are currently developing a 'Fidelity Model' for their approach (Interview with Tsemberis, 2008).

2 Interview with Sam Tsemberis, April 2008.

and a return to homelessness will ensue. Clients are viewed as being incapable of coping with a tenancy unless and until problems are addressed and resolved. The ethos is cessation of problematic behaviour and a high demand for treatment compliance before someone is deemed 'housing ready' (Sahlin, 1998).

However, the appropriateness of the *Continuum of Care* approach has been called into question in recent years not only by its apparent failure in many instances (Sahlin, 1998) but also by successes shown with *Housing First* (Padgett *et al.*, 2006; Tsemberis & Eisenberg, 2000).

Considering the effectiveness of *Housing First*

North American experience suggests that people with multiple problems, including drug misuse and mental illness, can maintain stable tenancies even if their other problems remain unresolved. Tsemberis *et al.* (2004) report that clients randomly allocated to *Housing First* had around an 80% retention rate in housing over a two-year period. As Tsemberis *et al.* point out, such a success rate represents a serious challenge to ideas that hold mentally ill or drug-using individuals to be incapable of maintaining their own tenancy. They found that the degree of residential stability was significantly greater than for those in a *Continuum of Care* control group (Tsemberis *et al.*, 2004). Similar and supporting evidence comes from a recent survey by 'Streets to Homes', a project in Toronto, Canada, which also employs a *Housing First* approach that found some 90% of clients still in stable housing one year after being housed. Of those still in stable accommodation, 85% perceived ongoing tenure to be secure and believed themselves to have a positive future (Toronto Shelter Support & Housing Administration, 2007).

Notably, the success of the *Housing First* has in no way been the result of less challenging clients being targeted. The programmes in the US have, so far, been aimed only at the chronically homeless who have particularly problematic health and social support needs (Pearson *et al.*, 2007). These clients are randomly enrolled on *Housing First* programmes on a 'first come first served' basis (Stefancic & Tsemberis, 2007) or selected because they have repeatedly failed to work through a *Continuum of Care* and would not engage with mainstream support services (Perlman & Parvensky, 2006). They are not therefore 'cherry picked' on the basis of 'housing readiness' but rather the opposite, which makes the apparent success of *Housing First* programmes all the more remarkable.

Not only is successful maintenance of a tenancy more likely amongst *Housing First* clients, but health and well-being also seem to benefit. Compared with a comparison group of *Continuum of Care* clients, the *Housing First* tenants had fewer

psychiatric admissions, lower emergency admissions, fewer arrests and – at least for *Streets to Homes*' clients in Toronto – reduced drug use (Gulcur *et al.*, 2003; Toronto Shelter Support & Housing Administration, 2007; Tsemberis *et al.*, 2004).

Providing housing and making available substantial levels of support, suggest that *Housing First* approaches will involve considerable expense. Culhane *et al.* (2002), however, have demonstrated that when all costs are taken into account the converse is true. They concluded that homeless mentally ill people in New York used $40,451 (approximately €62,800) of services in a year. This *reduced* by $16,281 (approximately €25,200) when they were provided with supportive housing, mainly due to a decrease in emergency service uptake and arrests. The cost of providing housing and support therefore led to an overall net cost reduction[3].

Why has *Housing First* achieved such positive outcomes? An important part of the success of the 'Pathways to Housing' project in New York may have been the type of housing which clients occupied. As noted earlier, Pathways' clients were housed in blocks in which no more than 15% of residents were fellow programme participants (Stefancic & Tsemberis, 2007). This approach is in contrast to other examples of projects which have relied on communal hostels to a greater extent (Pearson *et al.*, 2007). Hostels have been recognised as 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 illness. Not all clients in the Toronto 'Streets to Homes' *Housing First* programme had their own tenancy, some residing in hostels. The client survey, however, noted that those living independently perceived themselves to be happier with their housing situation (Toronto Shelter Support & Housing Administration, 2007). Having an independent tenancy is a component of well-being in its own right, which is an important part of motivating people to take control of their own lives.

The provision of assertive services is likely to have significantly contributed to helping people maintain their tenancy and to address their social and health problems. The New York and Toronto programmes consist of sizeable support teams, including nurses, psychiatrists, drug misuse councillors and peer supporters (Toronto Shelter Support & Housing Administration, 2007; Tsemberis *et al.*, 2004). Clients of the 'Pathways to Housing' project in New York, however, were found to use services *less* than those in the *Continuum of Care* control group. Such a result is not surprising, given that maintaining or achieving housing status was not predicated on service engagement. Furthermore, it has also been suggested that the integrated nature of the services offered by Pathways' teams

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3 Similar findings from an analysis of Housing First in Denver have also been reported (Perlman and Parvensky, 2006).

explains their clients lower contact with services – they holistically received support and housing through one integrated package and did not require contact with other services (Tsemberis *et al.*, 2004).

The combination of early housing and readily available, integrated social and health care support may explain the success of *Housing First*; the two components interact to produce improved outcomes. However, it has long been recognised that an effective homelessness policy requires both components (Pleace, 1995; Toro, 2007). Given this recognition, does *Housing First* really offer anything new for homelessness policy? We contend that it does, but with some caveats which are considered next.

Several criticisms could be levelled at *Housing First.* In the US, some commentators have argued that permanent supportive housing programmes are a means to *'real-locate the lifeboats*' rather than solve structural poverty, individual multiple needs, or a US housing 'crisis' (Culhane & Metraux, 2008). On this reading, *Housing First* as a policy is a means by which to 'save' people from homelessness, and indeed it is designed in such a way that it would be particularly difficult for a client not to maintain their housing. When homeless people with multiple needs are housed, they are unlikely to find that other individual and structurally generated problems such as poverty or mental illness evaporate. This was recognised by Shinn & Baumohl who note that "*preventing homelessness is not identical to ending poverty, curing mental illness, promoting economic self-sufficiency, or making needy people healthy, wealthy and wise"* (Shinn & Baumohl, 1999: 13-1).

As we have already noted, studies based on the New York 'Pathways' programme have not found significantly lower levels of drug use amongst *Housing First* clients (Tsemberis *et al.*, 2004). Such a finding could be considered surprising given that their clients would have been in independent tenures and, consequently, away from the potentially subverting peer pressures experienced in communal hostels. However, outcomes were measured after periods of two years or less, a relatively short time given the long-term, even chronic nature, of the problems concerned. Indeed, that drug misuse was no worse despite a reduced use of services is notable. Furthermore, these findings have to be balanced against that of another study that did demonstrate marked reductions in drug use (Toronto Shelter Support & Housing Administration, 2007). Further research is thus needed to more clearly ascertain the implications of secure independent tenures for drug use.

Housing First should not be seen as a cure-all solution. The results of research are encouraging, but even these highlight that not everyone involved remained housed. Tsemberis *et al.* (2004) found a significantly greater time in stable accommodation for *Housing First* compared with *Continuum of Care* clients, but there was still by no means complete success. Those who did not remain housed represent an

important group for whom further research is needed. Furthermore, the presence of assertive services highlights that ongoing support is a crucial component. Housing, on its own, is not enough.

As will have been clear throughout this section, the evidence base for *Housing First* is almost entirely built on North American experiences. What relevance do these findings have to the European context? It is to this question we turn next.

Housing First in the European context

In this section we consider the potential applicability that programmes like *Housing First* may have outside of the US, and specifically for Europe. We will touch on examples of projects across the European Union which have many elements of the *Housing First* model, before using the UK situation as a more detailed case study.

There are various examples of organisations in Europe that have developed capacity to support their clients both with housing and with wider social needs. In Belgium, there are welfare organisations that have become increasingly involved in supporting people to maintain independent tenancies in response to the move towards closing large scale institutions and moving former residents into the community (De Decker, 2002). Early housing interventions are a feature of social legislation in Denmark, where municipalities have to refer 25% of public housing that becomes vacant to socially vulnerable groups; social support has also to be made available (Benjaminsen & Dyb, 2008). In Norway, 'Project Homelessness', a four year national project that has been carried out in seven municipalities by four organisations, has targeted homeless people with drug misuse or mental health problems with the aim of getting them into their own houses with support (Dyb, 2005). There are thus already numerous examples of projects that have elements of a *Housing First* model implicit.

There are also various examples of projects that have components of a *Housing First* approach in the UK; notably the use of private rented tenancies by local authorities to address housing needs (Quilgars, 2008). These schemes often exclude those with high support needs, however, although there are others that provide specifically for more vulnerable populations. For example, 'Lead Tenancies' in Scotland have used grants to encourage landlords to renovate dilapidated properties and make accommodation available to vulnerable individuals (Rugg & Rhodes, 2004). Coastal Action Housing Group (CHAG) in Ipswich[4] facilitates access to permanent privately rented tenancies for homeless/multiple-needs clients. There is no requirement of service compliance or time demanded in supported accommodation before clients move in

[4] CHAG contact, Jim Overbury.

to their tenancy. CHAG holds the leases for these properties and sub-lets them to its clients. The housing is paid for by Housing Benefit. CHAG reports that from 2005 to 2007 it housed 134 people in private tenancies. Only six of these tenancies failed. Sixty-three people are still CHAG tenants and another sixty-one have moved into new tenancies and live independently[5]. There are other examples: the mental health agency 'Rethink' trains private landlords to support tenants with mental illness to maintain their tenancies and integrate into the community[6]; 'Supported Lodgings' provides young people with accommodation in a family home with support provided (Holmes, 2008). These projects indicate that approaches of the *Housing First* type could work in other contexts, although further evaluation is needed to draw firmer conclusions as to their impact for those who are most vulnerable, such as people with drug misuse problems.

In the rest of this section we consider whether these examples are beacons of a new future for homelessness policy or exceptions whose *Housing First* approach has limited applicability elsewhere. Four issues are focussed upon: homeless populations; current services; legalities; and housing.

Homeless populations

The extent to which *Housing First* could be replicated elsewhere might be limited if the homeless population were to differ substantially from those included in the North America studies on whom the evidence base largely rests. It might be argued that people who are homeless in the UK, where there is a more developed welfare state, only become homeless if they have more severe problems (although we know of no evidence to substantiate such a claim). That having been said, all 'Pathways to Housing' clients had severe and deeply entrenched mental health and drug misuse problems. These individuals, for whom we might be particularly sceptical of a positive prognosis, were able successfully to maintain tenancies (Siegel *et al.*, 2006). The evidence, therefore, indicates that even those with particularly severe problems, who might be perceived to be the least able to maintain a tenancy, are able, with support, to succeed within a *Housing First* framework. There is thus no reason to believe that *Housing First* would not work for homeless people in Europe, even for those with particularly challenging problems.

Perhaps the *Housing First* approach is less suitable for addressing certain groups in the homeless population such as the young homeless? The average age of clients in the North American studies tended towards people in their late 30s and early 40s. People who become homeless in their teens or early twenties may have

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5 Private correspondence, Jim Overbury, May 2008.

6 Rethink, information found at http://www.rethink.org/how_we_can_help/our_services/housing.html (last accessed 15 August 2008).

fewer personal resources with which to cope in their own tenancy; for example, their social networks may be less resilient while life skills such as financial management are less developed (Quilgars *et al.*, 2008). However, as previously discussed people with severe mental health problems and co-occurring drug misuse – a group for whom expectations of success are likely to be lower – experienced greater housing stability with *Housing First* compared with *Continuum of Care* programmes. Younger people with multiple needs may, therefore, also benefit from *Housing First*. Additionally, addressing homelessness at an early stage could prevent the longer-term damage reported alongside homelessness, such as increased exposure to drug use (Neale, 2001) or violence (Newburn & Rock, 2005).

Current services

'Pathways to Housing' Assertive Community Treatment support teams (ACT) include a variety of integrated expertise, such as drug misuse specialists, nurses, psychiatrists, peer support and family specialists. Services such as Community Mental Health Teams (CHMT) already operate in the UK, for example, but often will not work with multiple-needs clients (those still actively using substances for example). Extended versions of these, offering integrated care and access to housing for those with multiple needs in localised settings, would appear to be possible. There are already some CMHT teams working in partnership with Local Authority housing departments in an attempt to address homelessness in the UK[7]. The key distinction in the US is that their ACT teams have access to permanent housing that they manage, while being highly integrated and holistic, providing more than specialist health care. UK service providers may therefore have to increase their involvement in the housing sector to more fully fulfil the criteria required to implement *Housing First.*

Coordinating support services is likely to represent a considerable challenge in European contexts, where provision has often been spread across many different agencies. Edgar *et al.* (2000) note that funding streams meant that nobody had overall responsibility for support packages in the UK during the early part of the 2000s. As a result, low-level preventative support was often lacking, with resources focussed on intensive (and thus high-cost) packages. People often received more support than was really necessary, whilst many others, even those who really needed comprehensive packages, were missed altogether. The 'Pathways' ACT teams have been integrated entities; they bring together a range of specialisms, rather than co-ordinating many different organisations. The 'Supporting People'

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[7] See for example http://www.tunbridgewells.gov.uk/upload/public/attachments/15/MH_Housing_protocol_05_v2.doc and http://www.camden.gov.uk/ccm/content/contacts/categories/contacts-for-homelessness-mental-health.en;jsessionid=DC63ACFF69DEEC6AACADF30851B06E78.node2 (pages last accessed 15 August 2008)

programme in the UK has recently brought together different funding streams for housing-related support (Communities and Local Government, 2007). One of the aims of the programme has been to foster interagency working to overcome disciplinary boundaries that have often led to vulnerable individuals not receiving much-needed support. The example of Community Mental Health Teams provides further evidence that effective service coordination can be achieved.

Legalities

The implementation of the 'Pathways' project in New York has, as we have discussed, included a substantial degree of client choice. Of particular note is the fact that clients have the right to choose to continue using drugs without fear of eviction. This acceptance of criminal acts has raised concerns in the US at an administrative level (Preface in Pearson *et al.*, 2007). In the UK context, questions are raised by the notorious *Wintercomfort case*, in which two Cambridge hostel workers were imprisoned for permitting the supply of heroin on hostel premises. The UK's current legal situation, rightly or wrongly, could preclude choice. There are examples of *Housing First* projects in the US where drug misuse has not been tolerated; however, the implications of insisting on abstinence are unclear, whether for maintaining tenancies, engaging with drug misuse services or for any other outcome. A *Continuum of Care* approach would effectively be created if the use of illicit drugs were to lead to automatic eviction. Whether a *Housing First* approach could truly be created whilst the threat of eviction for drug use exists is questionable. In the UK, a proportion of the homeless population currently find themselves without accommodation on release from prison (Neale, 2001). A possible compromise could be to ensure that people convicted of drug offences do not lose their tenancy.

Housing

New York has one of the tightest and most expensive housing markets in the US. For this reason the majority of 'Pathways' tenancies are located in the lower-cost outer boroughs of the city. Finding decent, affordable apartments is a constant challenge, but as 'Pathways' show, it is one that is not impossible to address[8]. For the landlords, the model provides a constant rental income and management of the tenancy (for example, 'Pathways' housing department arranges repairs if the landlord is not liable). For the clients, the agency holding the lease and sub-letting it to them provides the means to access the private rental market which would otherwise, because of low income and absence of supporting references, have been unavailable. Developing *Housing First* approaches in different locations might be difficult, given the limited availability of affordable housing. Affordability will not be the same, even across single countries (in the UK for example, affordability is a

8 Interview, Sam Tsemberis, April 2008.

greater problem in the south east than it is in the rest of the country). Therefore, localised strategies that respond to local markets to obtain properties for multiple-needs clients are likely to be more effective. Nevertheless, as the case of *Housing First* in New York shows, such programmes can be implemented even in locations with particularly tight housing markets.

Discussion

We have presented much of this paper as a stark contrast between *Housing First* and *Continuum of Care*. In reality, services fall between these two extremes. De Decker (2002) notes how welfare organisations in Belgium were increasingly confronted with housing problems and thus came to be more involved in supporting and helping people to maintain their tenancies. The structural changes that led to this development, such as de-institutionalisation and moves towards 'care in the community', have been experienced elsewhere. Treating housing as entirely separate from social care and unrelated to it, has become increasingly untenable. In other European countries there are examples of services developing more holistic approaches, for example: homeless services in Scotland, discussed by Doherty and Stuttaford (2007); 'Project Homelessness' in Norway (Dyb, 2005); and the use of social legislation in Denmark (Benjaminsen & Dyb, 2008). Moving towards a *Housing First* approach would thus entail a change in emphasis rather than a complete *volte face*.

Not every *Housing First* project has followed exactly the same path in North America (Pearson *et al.*, 2007). Differences have included the type of tenure into which people are assisted. Only non-communal types of tenure were used by the 'Pathways to Housing' project in New York, an approach that contrasts with other projects claiming to use a *Housing First* model, but that have used hostel type accommodation (such as the 'Downtown Emergency Center' in Seattle[9]). The make-up of support teams has also differed from one *Housing First* project to another. The implications of such differences for outcomes are currently unclear but are being investigated (Pearson *et al.,* 2007; Padgett et al., 2006). There may thus be room for some flexibility so that services can tailor policies to their local resources. However, we contend that *Housing First* is set aside from other programmes such as hostels by the access to mainstream tenancies that it provides. Furthermore, we assert that programmes using hostel type accommodation are failing to provide one of the basic precepts of *Housing First*.

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9 http://www.desc.org/ (last accessed 22 August 2008)

An explicit *Housing First* approach in Europe deserves serious consideration. Beliefs and attitudes suggesting that homeless people with multiple needs *cannot* maintain tenancies of their own are unsustainable in light of current research. Such assumptions perpetuate stereotypes, essentially blaming individuals where wider structural deficiencies in welfare services and housing markets may be at fault. The explicit recognition of people's abilities that is central to *Housing First* would act as a direct challenge to those who continue to believe otherwise, encouraging the development of more appropriate, humane and effective services. As we have discussed, differences exist between North America, where *Housing First* has been pioneered, and Europe, but these are not insurmountable obstacles. There are already structures in place that represent opportunities to be harnessed. Indeed, many organisations already have certain features of *Housing First*.

More research into *Housing First* in the European context is needed. Such research could provide momentum, giving policy-makers and service-providers greater confidence in using a *Housing First* approach. There is a need, therefore, to develop research that can inform policy-makers and service-providers about the extent to which *Housing First* can be applied, the problems that would have to be confronted and the means with which to address issues where they arise. Whilst isolated examples exist, the degree to which other projects could replicate the approach successfully is open to question. For example: how would projects cope with limited housing availability, especially if the housing market were to become even more constrained in an economic downturn? How can people with addictions to illicit drugs be maintained in tenancies in different legal contexts? And how can diverse organisations from across health and social sectors be effectively brought together and coordinated so as to provide a seamless service?

This all said, the currently available research already provides strong evidence that many who are currently homeless would be quite capable of maintaining a tenancy if given the opportunity and, crucially, the support. The contention that people who are homeless would not be able to remain stably housed is becoming increasingly tenuous, even where the individuals concerned have mental health problems or are coping with an addiction to drugs. Indeed, having the stability of a secure tenancy and the independence afforded by having a place of one's own are important components in addressing those issues. *Housing First* is not a cure-all solution. Ongoing support has been a feature of successful programmes to date. Even then, there continue to be cases where individuals return to homelessness, an issue that deserves further research. However, these are cautionary notes and in our view *Housing First* deserves serious consideration in European policy agendas.

› References

Benjaminsen, l. and Dyb, E., (2008) The effectiveness of homeless policies – variations among Scandinavian countries, *European Journal of Homelessness*.

Communities and Local Government, (2007) *Independence and opportunity: our strategy for Supporting People*, London, Communities and Local Government.

Culhane, D. and Metraux, S., (2008) Rearranging the deck chairs or reallocating the lifeboats? : homelessness assistance and its alternatives, *American Planning Association*, 74, 1, 111.

Culhane, D., Metraux, S. and Hadley, T., (2002) Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing, *Housing Policy Debate*, 13, 1, 107-163.

De Decker, P., (2002) On the Genesis of Social Rental Agencies in Belgium, *Urban Studies*, 39, 2, 297.

Doherty, J. and Stuttaford, M., (2007) Preventing homelessness among substance users in Europe, *Journal of Primary Prevention*, 28, 245-263.

Dyb, E., (2005) *Prosjekt bostedsløse – Evaluering av et fireårig nasjonalt prosjekt* [Project Homeless – Evaluation of a four-year national project] Byggforsk's series of publications 7-2005 (Oslo: Norwegian Building Research Institute)

Edgar, B., Doherty, J. and Mina-Coull, A., (2000) *Support and Housing in Europe.* Bristol, The Policy Press.

Gulcur, L., Stefancic, A., Shinn, S., Tsemberis, S. and Fischer, S.N., (2003) Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes, *Journal of Community & Applied Social Psychology*, 13, 2, 171-186.

Holmes, J., (2008) *Making a difference: supported lodgings as a housing option for young people*. London, Communities and Local Government http://www.communities.gov.uk/documents/housing/pdf/makingadifference.pdf (last accessed 6 October 2008).

Neale, J., (2001) Homelessness amongst drug users: a double jeopardy explored, *International Journal of Drug Policy*, 12, 4, 353-369.

Newburn, T. and Rock, P., (2005) *Living in fear: violence and victimisation in the lives of single homeless people*, London, Crisis.

Padgett, D.K., Gulcur, L. and Tsemberis, S., (2006) Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse, *Research on Social Work Practice*, 16, 1, 74-83.

Pearson, C., Locke, G., Montgomery, A. and Buron, L., (2007) *Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*, U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

Perlman, J. and Parvensky, J., (2006) *Denver housing first collaborative cost benefit analysis and programme outcomes report*, Denver, Colorado Coalition for the Homeless.

Pleace, N., (1995) *Housing single vulnerable homeless people*, York, Centre for Housing Policy, University of York.

Quilgars, D., (2008) *The private rented sector: supply options for homeless and low-income households*, Report prepared for the Scottish Government.

Quilgars, D., Johnsen, S. and Pleace, N., (2008) *Youth homelessness in the UK*. York, Joseph Rowntree Foundation.

Rugg, J. and Rhodes, D., (2004) *Lead tenancy schemes in Scotland*. Edinburgh, Scottish Executive Social Research.

Sahlin, I., (1998) *The Staircase of Transition*. European Observatory on Homelessness. National Report from Sweden 1997', Lund: Department of Sociology.

Sahlin, I., (2005) The staircase of transition: Survival through failure, *Innovation*, 18, 2.

Salyers, M. and Tsemberis, S., (2007) ACT and Recovery: Integrating Evidence-Based Practice and Recovery Orientation on Assertive Community Treatment Teams, *Community Mental Health Journal*, 43, 6, 619-641.

Seal, M., (2005) *Resettling homeless people*, Lyme Regis, Russell House Publishing.

Shinn, M. and Baumohl, J., (1999) Rethinking the prevention of homelessness, in Fosburg, L. and Dennis, D. (eds.), *Practical lessons: the 1998 National Symposium on Homelessness Research*, US Department of Housing and Urban Development/US Department of Health and Human Services.

Siegel, C., Samuels, J., Tang, D., Berg, I., Jones, K. and Hopper, K., (2006) Tenant Outcomes in Supported Housing and Community Residences in New York City, *Psychiatric Services*, 57, 7, 982.

Stefancic, A. and Tsemberis, S., (2007) Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention. *The Journal of Primary Prevention*, 28, 3, 265-279.

Toro, P., (2007) Toward an International Understanding of Homelessness, *Journal of Social Issues*, 63, 3, 461-481.

Toronto Shelter Support & Housing Administration, (2007) *What Housing First means for people: results of streets to homes 2007 post-occupancy research*, Toronto, Toronto Shelter, Support & Housing Administration.

Tsemberis, S. and Eisenberg, R., (2000) Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities, *Psychiatric Services*, 51, 487-493.

Tsemberis, S., Gulcur, L. and Nakae, M., (2004) Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis, *American Journal of Public Health*, 94, 4, 651-656.