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‘Doing it Already?’: Stakeholder Perceptions of Housing First in the UK

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ABSTRACT *When first developed in the United States, ‘Housing First’ was highly controversial given its departure from mainstream ‘linear’ service models for homeless people with complex support needs. It has nevertheless since been heralded as presenting a key ‘antidote’ to chronic homelessness and is being replicated across North America and Europe with what might be regarded as ‘evangelical’ fervour. Reception to Housing First has been noticeably more reserved in the UK to date. This paper explores the reasons underpinning many UK stakeholders’ scepticism about the model. It argues that this derives, in part, from the fact that Housing First implementation in the UK would not represent the scale of paradigm shift that it has elsewhere, thus the model is considered far less revolutionary. Furthermore, whilst most stakeholders find aspects of the approach very attractive, ideological and pragmatic reservations dictate that robust evidence derived from pilot projects in Britain will be required – especially as regards outcomes for individuals with active substance misuse problems – before any wholesale ‘conversion’ to Housing First is likely in the UK.*

KEY WORDS: Homelessness, complex support needs, housing first, housing models, policy transfer, UK

Introduction

Homeless people with complex support needs such as substance misuse and/or mental health problems have become a policy priority in recent years in the UK. There has been growing acknowledgement that they are disproportionately failed by existing service interventions and thus at greater risk of repeat homelessness and ‘deep’ social exclusion (Cabinet Office, 2007). Such individuals are frequently referred to as ‘service resistant’ or ‘difficult to engage’ (Making Every Adult Matter [MEAM], 2009), and are often known by name among street outreach workers, health teams, the police and local authority directors alike (Hampson, 2010). Calls at the national level for the development of more effective approaches to housing this group (Communities and Local Government [CLG], 2008a; St Mungo’s, 2009) have prompted stakeholders in the homelessness sector to look to new housing models, including those developed abroad, to see what might be learned regards better meeting their needs.

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Of particular interest has been the 'Housing First' approach, given evidence of its success accommodating long-term homeless people with serious mental health problems in the US. Housing First departs significantly from mainstream approaches in developed countries by bypassing transitional forms of accommodation, such as hostels, and placing vulnerable homeless people directly into independent tenancies with intensive support, without insisting that they first undergo treatment for mental illness and/or substance misuse problems. It was initially considered a radical, even 'reckless', approach, and was resisted by service providers and politicians given fears that housing people without requiring psychiatric treatment and sobriety would exacerbate psychiatric symptoms and drug misuse (Greenwood *et al.*, forthcoming). The model has, nevertheless, since been championed by key political figures, and endorsed by the federal government as a 'central antidote' to homelessness in the US (US Interagency Council on Homelessness, 2008). As a consequence, Housing First is now a common feature in service networks there: indeed, almost every one of the more than 250 US cities with 10-year plans to end chronic homelessness includes a Housing First component (Greenwood *et al.*, forthcoming).

The model is also being replicated elsewhere with what could be regarded as 'evangelical' fervour. Housing First projects have been, or are currently being, developed in: Canada, Portugal, Finland, the Netherlands, Ireland, France, Hungary, Denmark, Belgium, Austria, Sweden and Australia (Tainio & Fredriksson, 2009; Fitzpatrick, 2010; Johnsen & Teixeira, 2010; Goering *et al.*, 2011; Houard, 2011; Johnson *et al.*, 2012). Significantly, it is being endorsed strongly in policy terms at the European level. The recent European Commission 'peer review' of the National Homelessness Strategy in Portugal, for example, urged member states to integrate a Housing First approach in their homelessness strategies (Fitzpatrick, 2010). Similarly, citing evidence of the effectiveness of Housing First in the US, the jury of the European Consensus Conference on Homelessness called for a shift from the use of transitional accommodation as the predominant solution to homelessness toward increased access to permanent housing with support, in what they called 'housing-led'¹ approaches (European Commission & Federation of National Organisations Working with the Homeless [FEANTSA], 2011).

This receptivity to Housing First has not been emulated in the UK to date, however, albeit that Britain's first Housing First pilot project was in progress at the time of writing (see Johnsen & Teixeira, 2010). This paper explores the perceptions underpinning many UK stakeholders' apparent reservations regarding the model. It draws upon a review of the evidence base of the effectiveness of Housing First for homeless people with complex support needs, and assessment of its potential transferability to the UK. A broad definition of complex needs was employed, to include homeless people with moderate-to-severe mental health problems and/or active substance misuse problems (drugs, alcohol or poly-substance misuse).

The study involved a comprehensive review of international literature and a series of in-depth interviews with 19 key stakeholders in the UK, US and Australia. The

15 UK-based interviewees included central government policy-makers in housing, mental health and substance misuse fields, each of whom had a particular remit regarding people with multiple and complex needs, together with senior managers of services specifically targeted at homeless people with complex needs.² The remaining interviewees included providers of Housing First projects (or derivations thereof) in the US and Australia, and researchers who had reviewed the efficacy of housing models for homeless people with complex needs in these contexts. Interviewees were identified via a combination of snowballing techniques and a review of national homelessness service directories and practitioner journals. The small scale of the study dictates that interviewees' opinions should be viewed as indicative, rather than (statistically) representative, of those held within UK homelessness and allied social care sectors.

The next section of the paper provides an overview of the historical development and key principles of Housing First, as well as the evidence base regarding its outcomes. This is followed by a discussion of UK stakeholders' understandings of the model and views regarding its potential effectiveness for homeless people with complex support needs in the UK. The paper argues that scepticism regarding the model's efficacy in the UK derives, at least in part, from the fact that implementation would not represent the scale of paradigm shift that it has elsewhere, thus UK stakeholders tend to regard the model as less revolutionary. Further, while UK stakeholders consider aspects of Housing First very attractive, and most believe it might valuably complement existing provision for extremely 'service resistant' rough sleepers, many are sceptical that the scale of positive outcomes recorded elsewhere would be reproduced on UK soil. Many also remain firmly wedded to a 'treatment first' philosophy, such that substantial evidence of Housing First's effectiveness in the UK will be required if the model is to be widely embraced in this context.

Challenging the Status Quo: The Development, Key Principles and Outcomes of Housing First

The Housing First model was devised in the US during the early 1990s by Dr Sam Tsemberis, psychologist and founder of the Pathways to Housing (henceforth 'Pathways') organisation in New York. It was initially targeted at chronically³ homeless people with severe mental health problems (including, for example, schizophrenia, psychotic disorder, bipolar disorder, depressive disorder or post-traumatic stress disorder). Many service users were reported to have also had (past or present) co-occurring substance misuse problems (Tsemberis & Eisenberg, 2000).

The model's development was largely a response to the shortcomings of existing 'linear' approaches to service delivery for this group. Linear approaches, dominant in most developed nations (Johnsen & Teixeira, 2010), aim to 'progress' homeless people through a series of separate residential services toward independent living (Ridgway & Zippel, 1990). They are founded on a 'treatment first' philosophy and

only place clients in 'normal' independent housing when they exhibit evidence of 'housing readiness'. Moves into accommodation offering better conditions in terms of space, freedom and security of tenure are conditional upon compliance with support programme, psychiatric stability and sustained abstinence from substance misuse (Sahlin, 2005; Pleace, 2008; Hansen Loftstrand, 2010). Such pathways are sometimes applied very rigidly; hence clinical crises such as relapse may result in demotion to earlier stages or ejection from programmes altogether (Dordick, 2002).

It is now widely recognised that the demands of linear treatment first systems are such that homeless people with complex support needs rarely reach the final stage, that is, achieve independent living (Kertesz *et al.*, 2006; Pearson *et al.*, 2009). Further, recent evaluations note that staff working within treatment first programmes often find themselves, ironically, 'consumed with the pursuit of housing', that is, focusing more on assisting clients to manoeuvre through the housing system than addressing clinical concerns and/or overlooking mental health or substance misuse issues if making them explicit might jeopardise a client's chances of moving into more permanent accommodation (Henwood *et al.*, 2011).

The Pathways Housing First model (henceforth PHF), represented a significant departure from linear approaches, on both practical and ideological grounds (Kresky-Wolff *et al.*, 2010). It essentially bypasses transitional accommodation by placing vulnerable homeless people direct from the street (or emergency shelters) into permanent independent accommodation, with comprehensive support delivered to them in their home or neighbourhood. As the name implies, the model is founded upon a 'housing first' as opposed to a 'treatment first' philosophy. It does not attempt to 'fix' clients to make them 'housing ready', but rather is premised on the assumption that the best place for someone to prepare for independent living is in independent accommodation (Kertesz *et al.*, 2009). Importantly, PHF also regards housing to be a fundamental human right, not something that should be earned or used to entice people into treatment or sobriety (Tsemberis, 2010b).

PHF is defined by a number of key characteristics as outlined in key publications including, for example: Tsemberis and Asmussen (1999), Tsemberis and Eisenberg (2000), Tsemberis *et al.* (2004), Padgett *et al.* (2006), Stefancic and Tsemberis (2007), Pearson *et al.* (2009) and Tsemberis (2010a, 2010b). First, it involves immediate (or relatively immediate) *provision of independent accommodation in mainstream housing*. In the US this is typically in the form of private rented scatter-site apartments leased by the provider. No more than 20 per cent of housing units in any single building are used to accommodate clients so as to promote community integration and mitigate potential stigma associated with residential concentrations of vulnerable people. The housing should be affordable, and 30 per cent of tenants' income is paid directly to the provider toward rent and utility costs.⁴

Second, there is *no requirement regarding 'housing readiness'*, that is, high threshold admission criteria regarding sobriety, basic living skills, or motivation to change. Third, PHF deploys a *harm reduction approach* to substance misuse and psychiatric

problems. This separates clinical issues from housing issues, such that a clinical crisis (e.g. relapse during or after treatment for addiction) does not result in loss of housing. There is no expectation that users enter treatment for either mental health or substance abuse problems; they may refuse both without compromising their eligibility for housing. That said, PHF endorses a 'recovery orientation', wherein staff should convey the belief that recovery (from mental illness, etc.) is possible for all service users.

The fourth key element is provision of *permanent housing and support*: apartments are kept available to service users even if they are temporarily hospitalised or incarcerated. They are only ever evicted for the same reasons that other building tenants would be: such as non-payment of rent, creating unacceptable disturbances to neighbours or other violations of a standard lease. Eviction does not result in termination of support and evictees are, wherever possible, re-accommodated in new apartments.

Fifth, PHF provides *integrated and comprehensive community-based support*. Service users with very high-level needs are supported by multidisciplinary Assertive Community Treatment (ACT) teams which comprise social workers, nurses, psychiatrists, peer counsellors (former homeless persons with similar experiences) and employment workers. Those with less intensive service needs are enrolled in Intensive Case Management (ICM) programmes, through which they receive housing and clinical support, together with adjunct services such as psychiatric and medical treatment from community-based providers. ACT and ICM staff are located off-site, but are on-call 24-hours a day, seven days a week, and provide most services in a client's home or neighbourhood. Support is not time limited, thus enabling long-term continuity of care.

The sixth element relates to PHF's *consumer choice* approach. Service users are offered choice regarding their apartment (insofar as housing availability allows), as well as the type, sequence and intensity of support services received. They are expected to meet with a member of staff frequently, typically once per week,⁵ in order that providers can exercise due duty of care. Service users can nevertheless determine when and where these meetings occur and choose whether to engage with case managers or other specialist services over and above this minimum requirement.

Finally, according to early PHF literature such programmes should *target the most vulnerable* homeless people, that is, those who face multiple obstacles to housing stability. According to Pathways, these individuals often have multiple 'disabling conditions' such as homelessness, severe mental illness and/or substance misuse problems. Many experience difficulty succeeding in traditional services and/or are resistant to service interventions.

Given the extent of its departure from orthodox responses to homelessness, it is perhaps no surprise that Housing First was resisted so strongly in the early days of implementation. It did, after all, represent a form of 'disruptive innovation' which challenged the philosophical grounds on which mainstream models were based and threatened incumbent approaches and agencies (Greenwood *et al.*, forthcoming).

Pathways thus incorporated a substantial evaluation component into their programme with the aim of evidencing outcomes. Key evaluations included the influential four-year randomised controlled trial New York Housing Study (NYHS) and its successor the longitudinal qualitative New York Services Study (NYSS) (Padgett *et al.*, 2006; Stanhope & Dunn, 2011). Reports derived from these robust studies, and other evaluations in the US, have combined to produce a substantial body of literature documenting the outcomes of Housing First in its country of origin.⁶

The most widely heralded Housing First outcomes relate to housing retention, which have been described as ‘exemplary’ in comparison to linear approaches, which are reportedly ‘moderate at best’ for this client group (Kertesz *et al.*, 2009). Results from the NYHS, for example, reveal that the PHF programme sustained an 80 per cent housing retention rate over two years (Tsemberis *et al.*, 2004), and, at the end of the evaluation, Housing First clients were stably housed 75 per cent of the time during the previous six months, compared to 50 per cent of the time among those in the continuum of care control group (Padgett *et al.*, 2006). The relocation rate – wherein clients are moved into a second apartment – can be as high as 20–30 per cent (Tsemberis, 2010b), but such outcomes nevertheless fundamentally challenge the pervasive assumption that chronically homeless people with co-occurring mental health problems and/or substance dependencies are incapable of sustaining an independent tenancy (Tsemberis & Eisenberg, 2000; Padgett *et al.*, 2006; Atherton & McNaughton-Nicolls, 2008).

Evidence also points consistently to the cost-effectiveness of Housing First programmes, in that they present substantial cost offsets via the reduction in clients’ use of expensive services such as hospital emergency rooms (Gulcur *et al.*, 2003; Larimer *et al.*, 2009). Perlman and Parvensky (2006), for example, calculated net savings of US\$4,745 per service user in the Denver Housing First Collaboration over two years after programme costs were accounted for. Such cost savings are widely acknowledged as having been pivotal in ‘selling’ the model to policy-makers (Kertesz & Weiner, 2009; Greenwood *et al.*, forthcoming). That said, Tsemberis himself notes that caution should be exercised in the interpretation of Housing First cost analyses, as these seldom involve random assignment or control groups and study populations are frequently chosen based on their presumed heavy use of services, thus potentially overestimating cost reductions (Tsemberis, 2010a).

As compared with the (almost uniformly positive) evidence on housing and cost outcomes, evidence regarding clinical outcomes has been mixed. Some studies indicate that impacts on levels of impairment related to psychiatric symptoms have been either marginally (non-significantly) positive or neutral (e.g. Tsemberis *et al.*, 2004; Padgett *et al.*, 2006; Pearson *et al.*, 2009). Tsemberis *et al.* (2004) documented reduced incidence of psychiatric hospitalisation after two years, and Greenwood *et al.* (2005) found that lower levels of psychiatric symptoms were associated with greater choice in treatment and housing under the Housing First programme. Larimer *et al.* (2009) report that users of a Housing First programme for chronically homeless

people with severe alcohol problems experienced a reduction in both overall alcohol consumption and likelihood of drinking to intoxication over time, and early PHF evaluations indicate that drug consumption does not increase, despite Housing First tenants' lesser use of treatment services (Tsemberis *et al.*, 2004).

However, Kertesz *et al.* (2009) note that present knowledge regarding the effectiveness of Housing First for people with severe and active addiction is incomplete, and call for assertions that the model can 'solve' homelessness to be tempered on these grounds. After conducting secondary analysis of Pathways data they concluded that the addiction severity of PHF clients at point of recruitment was 'lower than that normally seen in homeless persons' in the US (Kertesz *et al.*, 2009, p. 519), as fewer than 20 per cent of the intervention sample had more than four days of drug use (or 28 days of alcohol use) in any six-month period, including at baseline (Padgett *et al.*, 2006). More recently, while all participants involved in a study of substance use outcomes had a history of drug or alcohol misuse (a prerequisite for study inclusion), only 7 per cent of PHF clients (and 17 per cent of treatment first participants) were actively using at the point of enrolment (Padgett *et al.*, 2011).

On a related note, with a few notable exceptions (e.g. Larimer *et al.*, 2009; Edens *et al.*, 2011), the Housing First literature tends to be light on detail about the severity and nature of substance misuse, and the thresholds utilised are often low. Many reports note rather vaguely that dually diagnosed PHF clients have 'a diagnosis or history of' alcohol or substance misuse yet fail to specify: (a) whether these issues continue to affect them at point of recruitment; and (b) if so, how severe such problems are (see, for example, Tsemberis *et al.*, 2004). Padgett *et al.* (2011, p. 229) provide greater detail, but nevertheless acknowledge that their definition of 'substance use' over the course of 12 months: 'ranged from a single episode of crack cocaine smoking to sporadic use of drugs and/or alcohol to complete relapse into addiction and heavy use'.

That said, recent findings as regards the potential effectiveness of Housing First for people misusing substances are promising. For example, of the eight (of total 27) of Padgett *et al.*'s (2011) Housing First participants who reported using substances during the year after enrolment, all remained enrolled in the programme, including the two individuals who relapsed into addiction; whereas of the 31 (of 48) treatment first clients who reported using drugs or abusing alcohol during the study, 26 'went AWOL' (that is, left the programme prematurely). Further, when comparing outcomes for 'high-frequency substance users' and 'abstainers' housed under the Collaborative Initiative on Chronic Homelessness (see below), Edens *et al.* (2011) discovered that the number of days housed increased dramatically for both groups (with no significant differences between them), but also that mental health and subjective quality of life outcomes were poorer for high frequency users.

Few Housing First studies have explicitly considered issues such as financial wellbeing, the strength of social support networks and/or participation in meaningful activity, but those that do conclude that these areas remain problematic for many

clients (Padgett, 2007; Toronto Shelter Support and Housing Administration, 2007; Yanos *et al.*, 2007). Padgett (2007, p. 1934), for example, reported that while Housing First offered consumers ontological security, that is, a sense of wellbeing arising from constancy in one's social and material environment, other core elements of recovery such as 'hope for the future, having a job, enjoying the company and support of others, and being involved in society' had only been partially attained by service users.

McNaughton Nicholls and Atherton (2011) thus argue that, impressive housing retention statistics aside, the non-housing outcomes of Housing First are 'underwhelming'. A similar conclusion is drawn by Johnson *et al.* (2012) who note that existing evidence on non-housing outcomes highlights limits to Housing First that rarely feature in public and policy discourses (see also Pleace, 2011, on this issue). They argue that while the evidence base on Housing First is impressive, to date 'the tendency has been to over simplify or ignore some of the complexities and problems identified in the literature' (Johnson *et al.*, 2012, pp. 11–12), and thus urge policy-makers and practitioners to not lose sight of goals around recovery and social inclusion when searching for 'new', 'bold' and 'evidence-based' solutions.

While we would echo their sentiments as regards not losing sight of broader goals, it could be argued that such critiques apply a higher threshold for assessing 'success' to the Housing First model than would typically be the case for linear approaches accommodating this client group. After all, there is little evidence that other (linear) service models are effective at counteracting sustained worklessness or social isolation (Jones & Pleace, 2010). To discredit Housing First on grounds that it has not fully 'normalised' service users, that is made them 'healthy, wealthy and wise' (Shinn & Baumohl, 1998), would arguably involve employing unrealistic expectations – especially given the time-frames (of two to four years) upon which existing Housing First evaluations draw.⁷ Housing First proponents regard stable housing to be a platform from which the (often long and complex) process of recovery from mental illness, substance misuse, and/or social isolation might *begin* (Tsemberis, 2010b; Henwood *et al.*, 2011), not as a remedy to any or all of these problems *per se*.

Such debates aside, evidence of PHF's success in accommodating chronically homeless people with severe mental illness meant that it was soon supported by the US Federal Government. The \$35 million Initiative to End Chronic Homelessness in 2003 represented a particular watershed for the model, as nine of the 11 agencies funded utilised a Housing First approach (Greenwood *et al.*, forthcoming). Federal Government endorsement led to the reorientation and 'rechristening' of many existing services, such that many US treatment and housing providers adopted the Housing First label, but not its philosophy (Caton *et al.*, 2007; Pleace, 2008, 2011; Pearson *et al.*, 2009; Greenwood *et al.*, forthcoming). Similarly, as it has proliferated in other countries, a number of projects following some, but not all, of the operational principles have been branded as Housing First. Common deviations from the model's core tenets include: the interpretation of 'housing first' as 'housing only', that is,

provision of housing without any associated support services; provision of housing 'immediately' after a period of mandatory treatment; and provision of housing only in the form of temporary, rather than permanent, accommodation (Greenwood *et al.*, forthcoming). Furthermore, some purported 'Housing First' projects offer congregate accommodation as opposed to scatter-site housing; impose time limitations on provision; misinterpret the consumer choice mandate such that clients may refuse *all* contact and services; or employ greater selectivity in service user recruitment by requiring willingness to undergo treatment, for example (Perlman & Parvensky, 2006; Pearson *et al.*, 2007, 2009; Stefancic & Tsemberis, 2007; Tainio & Fredrikson, 2009; Toronto Shelter Support and Housing Administration, 2007).

Evaluations comparing different Housing First project outcomes in the US indicate that those with closer fidelity to the Pathways approach report the highest housing retention rates (Pearson *et al.*, 2007, 2009; Stefancic & Tsemberis, 2007), and Pathways representatives have insisted that 'it is essential to ensure that agencies adopting a Housing First approach implement it in the form in which it has demonstrated the greatest effectiveness' (Stefancic & Tsemberis, 2007, p. 276). The Pathways team is thus in the process of developing a scale that assesses project fidelity across a number of dimensions (Tsemberis, 2010b). Advocates of PHF argue that deviations are significant because inclusion of weak fidelity projects dilutes evidence regarding its effectiveness (Greenwood *et al.*, forthcoming). Furthermore, variation leads to confusion among providers regarding differences between Housing First and alternative models. Housing First is not a franchise, but questions are increasingly being asked about the appropriateness of labelling projects as such when they deviate substantially from PHF's core philosophy (Atherton & McNaughton-Nicholls, 2008; Pleace, 2008). Equally, however, some scholars argue that other countries should not attempt to develop exact replicas of the Pathways model, rather that transparent 'programme drift' is an essential prerequisite for the development of responsive Housing First approaches outside the US (Johnson *et al.*, 2012). The challenge, they say, lies in identifying the elements critical to the success of Housing First programmes and adapting them to maximise effectiveness in different contexts (Atherton & McNaughton-Nicholls, 2008).

Against the backdrop of such debates, the following section draws upon interviews with key stakeholders in the homelessness and allied social care sectors within the UK to outline their understandings of, and receptivity to, Housing First.

UK Stakeholder Perceptions of Housing First: 'Doing it Already'?

All UK stakeholder interviewees were at least partly familiar with the Housing First model, but the majority had incomplete knowledge of its core philosophy and implementation. Each understood that it places homeless people directly into independent tenancies, with support, without an interim period in transitional accommodation. Some also knew that it is based on a harm minimisation approach to substance

misuse. Yet, there was little awareness regarding the consumer choice dimension to Housing First, most notably the absence of conditions requiring service users to undergo treatment for substance misuse or mental health problems.

It is thus perhaps not surprising that some stakeholders believed that they and/or other UK service providers were ‘doing it already’. A number of projects were identified as evidence of Housing First operationalisation in the UK, albeit that none were publicly branded as such. The most commonly cited example was London’s Clearing House, the lettings service for former rough sleepers, which has capacity to place street homeless people directly into either registered social landlord or private rented flats. A number of ‘dispersed hostel’ and private rented sector lettings schemes which have been used to place rough sleepers into independent tenancies with floating support were also identified as further examples of Housing First at work on UK soil. These schemes do exhibit some of the key features of the model: most notably accommodation of rough sleepers in ‘ordinary’ housing without them having to first ‘do time’ in hostels. They do, however, depart from the key principles of PHF in significant ways. Three deviations are particularly noteworthy.

First, the projects are used exclusively for homeless people with medium- or low-level support needs, or at least those that are deemed ‘low risk’ even if their support needs are more complex. For example, street outreach workers are told they should not refer clients to the Clearing House scheme if they have ‘such high support needs that their tenancy is likely to fail’ (Broadway, 2008). Similarly, providers of private rented sector resettlement schemes acknowledged that rough sleepers’ eligibility was determined by the perceived likelihood of them being able to successfully maintain a tenancy. As one service manager explained:

We do put rough sleepers straight into flats! We already do it. The difference is that ... we provide a lot of assessment beforehand to make sure that we are quite confident the person will be able to cope in that situation. (UK homelessness service provider)

Second, service provision in such schemes is time-limited, with tenancy support often limited to six months. Tenancy support can in theory continue for as long as necessary under the Clearing House initiative, but eligibility for flats, issued on two-year renewable Assured Shorthold Tenancies, terminates when individuals are deemed to no longer require support to live independently. No scheme thus provides the ‘permanent’ accommodation and support characteristic of PHF.

Third, eligibility is usually strongly contingent on evidence of service user ‘engagement’. In the vast majority of cases,⁸ clients are required to comply with holistic support plans which address not just housing needs but also treatment for identified addiction or mental health problems. The schemes thus fail to separate housing issues from clinical issues, a key tenet of PHF (see above). They also contravene the PHF

principle of consumer choice as regards whether or not service users participate in treatment.

When asked about their views on the likely effectiveness of a (Pathways-style) Housing First approach for homeless people with complex support needs in the UK, stakeholders identified a number of aspects that they considered very attractive. Virtually all acknowledged the potential benefits of bypassing the existing hostel system with this client group, given recognition of the damaging impact that such environments can have, especially when a large proportion of other residents lead 'chaotic' lifestyles revolving around substance misuse (May *et al.*, 2006). Similarly, some believed the prospect of avoiding hostels might in itself increase service users' willingness to engage with other services:

It might be that some of the people who've been around the system a bit and are pissed off by having to go through support plans and feeling like they've got some 20 year-old keeney talking to them when they're 45 and they've been there and done that . . . So if someone gave them a flat and treated them like a grown-up, it might engender a change in their outlook. (UK homelessness service provider)

Moreover, all stakeholders viewed the relaxation of time-limitations and provision of long-term support to be a key strength of the model. This, they believed, would allow greater room for the 'haphazard' realities of addiction recovery, which typically involves cycling back and forth through a number of stages, including relapse (Prochaska & Di Clemente, 1986). They also believed that the stability afforded by long-term housing and greater consistency of staff support would mitigate the inadvertent dis-incentivisation of progress inherent in the current (primarily linear) system:

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

For these reasons, the general consensus amongst UK stakeholders was that Housing First could potentially provide a valuable complement to existing provision for homeless people with complex support needs. There was evidence of a particular appetite to trial it with some of the 'entrenched' rough sleepers for whom previous interventions had consistently failed and/or are unwilling to consider other types of accommodation, such as so-called '205'⁹ rough sleepers prioritised for intervention

under the Mayor of London's drive to end rough sleeping in the capital by 2012 (Teixeira, 2010).

This appetite has not, however, been translated into action to the extent that might be expected given the enthusiastic way the model has been embraced overseas (Fitzpatrick, 2010); the first UK pilot was only developed, in Glasgow, in 2010 (Johnsen & Teixeira, 2010). Indeed, stakeholder interviewees highlighted a range of issues which explain, at least in part, why Housing First has not 'taken off' in the UK to the same extent. First, and related to the point above about (misguided) beliefs that the UK is 'doing it already', Housing First is not regarded as 'revolutionary', because it does not represent the scale of departure from existing service provision that it has elsewhere. Harm reduction approaches to substance misuse, for example, have been mainstream for many years in the UK (McKeganey, 2006), which was not the case in the US where there has historically been strong ideological opposition to harm reduction (Wormer, 1999). In addition, floating support programmes which deliver support to tenants in their homes and neighbourhoods are already well established in the UK. While these would need to be adapted to provide the longevity and breadth of support endorsed by Pathways, the overall approach to tenancy support does not depart dramatically from that which already exists. Furthermore, holistic 'client-centred' approaches which are flexibly implemented have already been recognised as best practice and endorsed at central government level (CLG, 2008a). Recent developments, most notably the personalisation agenda with its individualised budgets (CLG, 2009; Cabinet Office, 2010), have allowed greater room for clients to shape the manner in which they are supported, albeit that programmes are still premised on service users' willingness to 'engage' in the first place (see below). Moreover, it is already taken as a given that structural factors such as problems with housing affordability are major contributors to homelessness in the UK (Fitzpatrick, 2005), hence the elevation of long-term housing as a solution is not seen as so very radical.

Second, key actors in the UK have major reservations about Housing First on ideological grounds, and this has seriously constrained receptivity to the model. Although linear approaches tend to be implemented more flexibly in the UK than in many other places, with providers commonly enabling homeless people to 'skip' stages for example (Johnsen & Teixeira, 2010), a treatment first philosophy still prevails. Most support agencies require evidence that a service user is capable of maintaining a tenancy, that is of 'housing readiness', before placing them into independent accommodation, and many interviewees believed firmly that absence of this criterion would set vulnerable individuals up to fail:

Independent tenancies can work, but not . . . for someone that's been on the street for 20 years. Any homelessness provider will tell you the chances of that tenancy breaking down within six months are incredibly high . . . I think moving them on too quickly and just plonking them into independent living after a short spell in a hostel . . . is a recipe for failure; they'll be back out on

the street in no time . . . You need time to work with them, you need to work with them quite intensively. (UK homelessness service provider)

For many, such risk averseness is borne, at least in part, out of previous failures of floating support schemes. Existing schemes generally offer low-level, generic, time-limited support which is conditional on service user compliance. These can work very effectively with tenants who have low-level needs, but have proved to be inadequate for people at the higher end of the support need spectrum (CLG, 2008b). Such provision is a far cry from the intensive, holistic, long-term support endorsed by Housing First advocates. Providers' risk averseness may also in part reflect the fact that they operate in a competitive contract-driven market governed by performance targets (Hampson, 2010), where they perceive there to be little room for 'failure'.

Some UK stakeholders also questioned the 'fairness' of a system which offers long-term independent housing to individuals they fear are at increased risk of jeopardising their tenancies. The belief that homeless people need to 'earn' housing by at least engaging with support services was elevated in contexts where housing demand far outweighs supply. On this point, a number of stakeholders noted that the lack of conditionality as regards service-user engagement under Housing First stands in contradistinction to the 'tough love' agenda evident in UK homelessness policy, wherein service receipt is becoming increasingly conditional on compliance with support plans (Johnsen with Fitzpatrick, 2009):

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

Allied with such issues is an intractable belief that housing professionals and clinicians are best placed to assess when service users are 'ready' to live independently and/or to identify who are most likely to sustain their accommodation in the long term. This belief has however been called into question recently (Chilvers *et al.*, 2006). Stefancic and Tsemberis (2007), for example, point out that some housing projects report lower retention rates despite carrying out more extensive selection of consumers during recruitment. This, they argue, is symptomatic of housing providers' and clinicians' inability to successfully predict which clients will successfully maintain housing. Similarly, mental health and substance misuse practitioner interviewees acknowledged that equivalent uncertainties exist in their fields, and that existing treatments in either are far from perfect:

It's almost impossible to predict who's going to do well. Some of the people who are most tantalising do terribly . . . Yet, other people who look awful actually surprise us and that's the same throughout psychiatry . . . Statistically

if you've got a long duration of untreated psychosis you're not likely to do as well as somebody who's only been ill for a couple of months, but beyond that it's very difficult to say. (UK mental health practitioner)

The third area of UK stakeholder reservations was pragmatic, founded on operational concerns. Many were particularly concerned about the risk of service users being either victims or perpetrators of antisocial behaviour: for example, if they were to be harassed by (former) drug using peers or dealers seeking to use their home as a base for consumption or dealing, or if activities associated with their own substance misuse were to disturb neighbours. The following comments are illustrative:

The group we're talking about are vulnerable to a very specific risk issue which is that when they move into their own flat . . . associates that they've had from their life on the street or their drug life . . . [will soon] be knocking on the door . . . Before you know it the guy has been sent out to get some milk in the morning for the coffee and he's come back and the door is shut and they won't let him back in and then the dealers are coming . . . And I say all that because I've seen it happen several times. (UK substance misuse service provider)

It would worry me if people could choose only to be engaged a few times a month . . . It doesn't matter how good it is for the individual, I think you've got to think about the community as well . . . And if the person has been leading a chaotic life and, you know, brings some of their chaos to that housing situation . . . I think it would have a huge impact. (UK homelessness service provider)

The Housing First literature provides little guidance on the management of such risks (Pleace, 2008), but does note that tenants may be moved into alternative accommodation on multiple occasions if necessary, and that friction with neighbours can sometimes be addressed via mediation (Tsemberis, 2010b; McNaughton-Nicholls & Atherton, 2011).

Fourth, stakeholders suspected that if the model were to be replicated in the UK neither outcomes nor cost savings would be in the same league as in the US, because of perceived differences in the availability and quality of alternative provision in the two nations.

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

The problem I have with a lot of US research is that they're comparing [interventions] with nothing. You know, 'We've got this great service', but the service they've got, if you compare it with treatment as usual, that's nothing

for most people in the States, and that exaggerates the effectiveness of these models. (UK mental health practitioner)

Related to this, concerns about how Housing First would be resourced, given the way budgets are ‘split’ between UK government departments (Hampson, 2010), served as a major deterrent for some service providers and commissioners. A central government representative described this issue as follows:

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

Finally, several stakeholders questioned the comparability of US Housing First tenants with the client group of interest here, particularly as regards substance misuse patterns. This is significant given that some scholars’ deem the addiction severity of people entering most US Housing First programmes to be ‘relatively modest’ (Kertesz *et al.*, 2009), and in light of the fact that PHF relocation rates (where problems necessitate a move to a new apartment) are elevated when a high percentage of clients have ‘severe addiction disorders’ (Tsemberis, 2010b). Accordingly, some stakeholders expressed suspicion that the scale of drug use may be greater in the UK, and ‘substances of choice’ different, thus potentially restricting the effectiveness of Housing First:

You really need to consider the details of the client group that you’re dealing with. Are they homeless plus psychosis, homeless plus psychosis plus alcohol, plus crack [cocaine], or whatever? I have a hunch that different subgroups are going to have quite different outcomes. (UK mental health practitioner)

Conclusion

Clearly, implementation of Housing First would not represent anything akin to the scale of paradigm shift in either practice or ideology in the UK as it did in the US, or indeed as has its replication in many other countries. It is largely for this reason that Housing First is not regarded as so radical, or ‘revolutionary’, in the UK, and thus is not being promoted with the evangelical fervour apparent elsewhere. Furthermore, most stakeholders in the UK’s homelessness and allied social care sectors remain firmly wedded to a ‘treatment first’ philosophy, believing that placing people with complex needs in independent accommodation before they are ‘housing ready’ risks setting them up to fail. The foundations of such views are tenuous given: first, the impressive housing retention outcomes achieved in Housing First programmes; second,

acknowledgement that treatments for mental health and substance misuse problems are imperfect (that is, do not 'work' for everyone, all of the time); and, third, concession that neither clinicians nor housing providers are able to predict with accuracy who will respond positively to treatment or resettlement. The potential influence of such views on Housing First replication in the UK should not be underestimated, however, for the adoption of new interventions is known to be greatest when they are compatible with adopters' current values (Dearing, 2008).

That said, other reservations expressed by UK stakeholders have rather firmer foundations, especially given the current absence of evidence regarding the effectiveness of Housing First outside the US, where almost all evaluations have been conducted to date.¹⁰ Evidence regarding the model's efficacy elsewhere will undoubtedly soon be forthcoming given the rapidity with which the model is being replicated and the widespread inclusion of evaluations within pilot programmes (see, for example, Busch-Geertsema, 2011; Goering *et al.*, 2011). At present, however, one can only speculate what influence contextual factors such as welfare regimes, homelessness policy, housing availability, and the characteristics of the homeless population will have on the model's transferability, and efficacy, outside the US. Debates about fidelity to PHF will in all likelihood be pivotal in such analyses, given evidence that policy transfer can fail if 'borrowing' countries omit components crucial to effectiveness in the nation of origin, or pay insufficient attention to economic, social, political and ideological differences between the two contexts (Dolowitz & Marsh, 2000).

At present there remains an acute gap in the knowledge base regarding the effectiveness of Housing First for homeless people with severe and active drug misuse problems (Kertesz & Weiner, 2009). Further research is needed on the nature and severity of substance misuse among Housing First clientele and on what, if any, impact this might have on programme outcomes. Ideally such research should provide much greater detail than is currently available regarding: the *type* of substances used (e.g. whether stimulants, depressants and/or hallucinogens, etc.); the *nature* of misuse (how much is being consumed, how often and via which means); and the *severity* of addiction. The weak evidence base in this area is of particular concern in the UK given that people with 'chaotic' drug (or poly-substance) problems comprise a significant proportion of the homeless population who would normally be targeted under Housing First programmes, these being individuals who face 'multiple barriers' to housing and/or have difficulty coping in mainstream services. UK providers are (understandably) worried about how the risks associated in accommodating such individuals in independent scatter-site housing might be mitigated. It is imperative that such issues be explored fully, given the risk of worsening addiction (thereby further compromising the health and wellbeing of vulnerable people) and obligations to protect neighbours from potential adverse effects.

Most UK stakeholders consider at least some aspects of Housing First highly attractive, and are open to its replication in principle. It seems, nevertheless, that at present few are prepared to stick their head above the parapet and take the 'risk'

of implementing it themselves. Some reservations about the model are ideological; others based on more pragmatic operational concerns. Whatever the balance of these, it seems that robust evidence derived from pilot projects on British soil will be required – especially as regards outcomes for individuals with active substance misuse problems – before any wholesale ‘conversion’ to Housing First is likely in the UK.

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Notes

1. The jury uses the term ‘housing-led’ as a broader concept encompassing approaches that aim to provide housing with support as the initial step in addressing *all* forms of homelessness, that is, not just with the narrowly-defined client group typically supported under Housing First programmes (European Commission & FEANTSA, 2011).
2. Many of these agencies had developed projects branded ‘innovative’ by other stakeholders in the UK homelessness sector (Johnsen & Teixeira, 2010). Some, but not all, exhibited one or more elements of a Housing First type approach.
3. In the US, people are defined as chronically homeless if they have a disabling condition and have either been continually homeless for a year or more or have experienced at least four episodes of homelessness in the past three years (US Department of Housing and Urban Development, 2007).
4. The clinical diagnosis of a mental illness, coupled with chronic homelessness, means that PHF consumers are eligible for Federal Government Section 8 housing vouchers. These rental subsidy vouchers are paid directly to Pathways, thus minimising the risk of service users falling into rent arrears.
5. Guidance on the frequency of meetings, and minimum ‘requirements’ regarding these, varies within PHF literature. Early reports note that service users must agree to meet with staff twice per month (e.g. Tsemberis & Asmussen, 1999; Tsemberis Eisenberg, 2000), but more recent guidance specifies that programme requirements include ‘weekly’ home visits (e.g. Stefancic & Tsemberis, 2007; Tsemberis, 2010b).
6. See, for example: Tsemberis and Eisenberg (2000), Tsemberis *et al.* (2004), Gulcur *et al.* (2003, 2007), Greenwood *et al.* (2005), Padgett *et al.* (2006, 2011), Perlman and Parvensky (2006), Padgett (2007), Stefancic and Tsemberis (2007), Toronto Shelter Support and Housing Administration (2007), Pearson *et al.* (2007, 2009), Yanos *et al.* (2007), Larimer *et al.* (2009), Kresky-Wolff *et al.* (2010), Henwood *et al.* (2011).
7. For further debate on what constitutes ‘success’ in homelessness interventions, see Busch-Geertsema (2005), Busch-Geertsema and Fitzpatrick (2008), and Culhane and Metraux (2008).

8. It is worth noting that the London Clearing House scheme is an exception, however. Access to Clearing House flats is implemented rather more flexibly, especially since the Mayor promised to end rough sleeping in the capital by 2012, and the advent of the rough sleepers '205' initiative which prioritised interventions for the city's most 'entrenched' rough sleepers (Teixeira, 2010). The usual one nomination policy for Clearing House flats has been relaxed for individuals classified within the '205' group (Broadway, 2010).
9. The individuals targeted under the London Delivery Board's '205' rough sleepers initiative, so named because there were 205 in number, had been street homeless for five or more years out of the last 10 and/or been witnessed sleeping rough 50 times or more over that period (Teixeira, 2010). Even with this group, however, it seems that providers are only willing to consider trialling the model with those who do not have 'chaotic' drug problems and/or histories of antisocial behaviour. That is, although some of them might be classified as 'high needs', their behaviour is stable enough that they are not considered 'high risk'.
10. Although see Falvo's (2009) evaluation of Canada's early 'version' of Housing First, Toronto's Streets to Homes programme.

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