

Housing First

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Summary

What is Housing First?

Housing First differs from other homelessness services because it immediately provides homeless people with either secure independent or communal housing. This means that Housing First gives homeless people 'housing first' before it does anything else. Housing First 'separates' housing and support. This 'separation' means that homeless people are immediately given secure housing *without* being required to enter psychiatric treatment or becoming abstinent from drugs and alcohol. In addition, homeless people can *remain* in the secure housing provided by a Housing First service without there being any expectation that they comply with psychiatric treatment or stop drinking alcohol or using drugs. Housing First services use a 'harm reduction' approach that attempts to stabilise and reduce mental health problems, problematic drug and alcohol use. Housing First services also have a 'recovery orientation' that aims to encourage homeless people away from behaviour that is causing them harm.

Housing First was originally developed by the organisation Pathways in New York. Since the Pathways Housing First service was first established, several different forms of Housing First service have appeared in the USA and in a number of EU member states including Denmark, Finland, Ireland, France, Hungary, the Netherlands, Portugal, Austria and the UK. These services all share a similar philosophy but can work in quite different ways. The three main *groups* of Housing First service are:

- **Pathways Housing First (PHF)**,
- **Communal Housing First (CHF)**
- **Housing First 'Light' services (HFL)**¹

Pathways Housing First (PHF)

- PHF works with 'chronically homeless people'² who are characterised by severe mental illness, problematic drug and alcohol use, nuisance behaviour, low-level criminality, sustained worklessness and long periods living in homelessness shelters and on the street.
- PHF provides independent housing with security of tenure immediately or as soon as possible to a chronically homeless person.
- PHF provides low-level support designed to promote housing stability, service brokerage (to connect chronically homeless people to essential services) and also *directly* provides psychiatric, drug and alcohol, social work, medical and other services. The team providing these services is *mobile* and visits people using the

¹Please note that the acronyms PHF, CHF and HFL are used consistently within this report hereafter

² The US Federal government defines a chronically homeless person as either an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more; or an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years. The term is used more and more frequently in European contexts to describe long-term homeless people with more complex needs.

service in their homes or at other agreed locations.

- PHF services give considerable choice and control to chronically homeless people by following a harm reduction model which allows them to continue drinking alcohol and using drugs. Chronically homeless people can choose not to use the psychiatric and drug and alcohol services that are made available by PHF whilst remaining in the housing provided by PHF. This is called a 'separation' of housing and support.

Communal Housing First (CHF)

- CHF services are focused on chronically homeless people.. CHF offers communal housing (single rooms or apartments) with security of tenure provided immediately in a building only lived in by homeless people using the CHF service. The communal housing has often been specifically modified, or designed, to provide a service for chronically homeless people. Support and medical services are situated in the same building or are very nearby.
- CHF provides communal housing with security of tenure immediately to a chronically homeless person.
- CHF directly provides psychiatric, drug and alcohol services and medical services and may also use service brokerage to arrange access to other services.
- CHF services give considerable choice and control to chronically homeless people as part of following a harm reduction model. If chronically homeless people opt not to use the services that are on offer, or choose not to stop drinking and using drugs, this does not place their housing in the CHF service under threat.

Housing First 'Light' (HFL)

- HFL is delivered by using ordinary private rented or social housing and a team of mobile support workers.
- HFL provides independent housing with security of tenure immediately or as soon as possible to a homeless person.
- HFL may be used to help *prevent* homelessness where an individual or household who has never been homeless is assessed as being at risk of homelessness.
- HFL provides low-level mobile support services designed to help promote housing stability.
- HFL uses service brokerage to arrange access to psychiatric, drug and alcohol services and medical services where these are required and may also use service brokerage to arrange access to education, training and other services where these are needed.
- HFL services do not directly provide medical, psychiatric or drug and alcohol services.
- HFL can support chronically homeless people but may also be used for other groups of homeless people, including homeless people with *lower* support needs. The other groups that might be targeted by HFL services can include young homeless people and homeless families.

- HFL services give considerable choice and control to homeless people as part of following a harm reduction model. If homeless people do not use the medical and support services which can be arranged, or choose to continue drinking alcohol and using drugs, this does not place their housing under threat.

The differences between PHF, CHF and HFL services are summarised in Table S.1

Table S.1: Broad Types of Housing First Services

Service offered	Pathways Housing First	Communal Housing First	Housing First Light
Housing with security of tenure in private rented sector or in social housing provided immediately or as soon as possible	Yes	No	Yes
Offers communal housing (single rooms or apartments) with security of tenure provided immediately in a building only lived in by homeless people using the service	No	Yes	No
Homeless people have to stop using drugs	No	No	No
Homeless people have to stop drinking alcohol	No	No	No
Homeless people have to use mental health services	No	No	No
Harm reduction approach	Yes	Yes	Yes
Uses mobile teams to provide services	Yes	No	Yes
Directly provides drug and alcohol services	Yes	Yes	No
Directly provides psychiatric and medical services	Yes	Yes	No
Uses service brokerage	Yes	Yes	Yes
Provides support to promote housing stability	Yes	Yes	Yes

Evidence in favour of Housing First

The bulk of evidence about Housing First is American. There is also some evidence from Europe and in particular from Finland. Large scale testing of the Housing First model is occurring across the European Union and within France. For example, Housing First Europe³ is a Social Experimentation project funded in the framework of the PROGRESS programme of the European Commission. It will evaluate and provide mutual learning on 10 Housing First projects in European cities and deliver conclusions in 2013. France is implementing a major social experimentation called “Un Chez-soi d’abord”⁴ to test the effectiveness of Housing First services for homeless people with mental illness

There is very strong evidence from the USA that PHF services provide stable housing for chronically homeless people with very high support needs and a long history of homelessness. There is more limited evidence on CHF and HFL services that also show success in providing stable housing for homeless people. There is some evidence that by promoting housing stability and following a harm reduction approach, Housing First services can stabilise and in some cases reduce mental health problems and problematic use of drugs and alcohol.

PHF has shown far more success in providing housing stability for ‘chronically homeless’ people than ‘staircase services’. Staircase services require homeless people to move through a series of ‘steps’ before they are given access to housing. They often require abstinence from alcohol and drugs. There is strong evidence that the ‘staircase’ approach fails to

³<http://www.servicestyrelsen.dk/housingfirsteurope>

⁴<http://www.developpement-durable.gouv.fr/Programme-Chez-Soi-d-abord.html>

provide stable housing for the majority of chronically homeless people who use staircase services.

The Global Influence of Housing First

Housing First has become globally important because of the unparalleled success that it has shown in providing stable housing and accommodation for chronically homeless people. Housing First has been central to Federal homelessness strategy in the United States under both the Bush and Obama administrations. Housing First services have been integrated into the homelessness strategies of France, Denmark, Finland, Ireland, the Netherlands and Sweden and are being widely tested in pilot programmes across many EU Member States. The Jury for the *European Consensus Conference on Homelessness*, held in Brussels in December 2010, recommended that 'housing-led' approaches were the most effective solution to homelessness and that the different forms of Housing First service were good examples of these 'housing-led' services.

The Case for Housing First

There are three main reasons to consider using Housing First services in France.

- The core philosophy of Housing First is the reason for the success that has been achieved in delivering stable housing and accommodation for formerly chronically homeless people. The Housing First philosophy can be drawn upon without copying the detailed operation of Housing First services working in the USA. The ideas of Housing First can be used to design services that can be used to reduce long-term homelessness in different countries with different welfare systems. An example of this has been the use of the Housing First philosophy to effectively redesign homelessness services in Finland.
- Housing First is highly flexible. The core philosophy has been adapted from the PHF model and employed in CHF and HFL services that can be focused on both chronic homelessness and on other forms of homelessness.
- Housing First services can support other types of homelessness services, for example, by stopping very long stays in emergency accommodation beds by chronically homeless people. It is important to note that Housing First is *not* designed to *replace* all existing homelessness services and has been used as one part of a mixture of services to respond to homelessness. By supporting the work of other homelessness services, Housing First services can potentially enhance their capacity to respond to issues such as migrant homelessness and homelessness among families with low support needs in France.

1 Introduction

About this Report

The report is intended to act as an introduction to Housing First and is designed to help stimulate and inform debate. It is not a blueprint of how to run Housing First services in France, because the existing evidence on Housing First is concentrated on other countries and the Housing First model will need to be adapted to the specific conditions in France to work well. A Housing First service in Paris would not face the same situation or challenges as a Housing First service in another country, or a Housing First service working in another city or in a rural Department within France.

The report describes what Housing First is, how it works, explores the evidence base and then discusses the case for the wider use of Housing First in France. The report is intended for all the organisations involved in tackling homelessness in France, including NGOs, social workers, policy makers, regional councils, social and private housing providers, health professionals and elected officials.

Housing First has become increasingly important within strategic responses to homelessness across the economically developed World. However, there can be some confusion about what is meant by 'Housing First'. This is because new 'Housing First' services do not always follow the same model. Various forms of 'Housing First' services exist in Denmark, Finland, France, Hungary, Ireland, the Netherlands, Portugal, the USA and the UK⁵. This report describes the three main types of 'Housing First' services and reviews the evidence base for each one.

The report is a summary that uses broad definitions to try to encompass both the philosophy and operational reality of Housing First services. The descriptions are broad because they encompass sometimes very different services that share several elements of a core philosophy. It is very important to note that the sections on Communal Housing First (CHF) and Housing First Light (HFL) describe a *range of services* rather than providing a description of a single, specific type of service.

The report argues that Housing First services would be effective in France. There is very strong evidence that Housing First can produce housing stability – a permanent exit from homelessness – for a majority of those chronically homeless people with very high needs who have been homeless a long time. Achieving very high rates of housing stability for this group of chronically homeless people is not something that other types of homelessness services, including the 'staircase' model, have been able to achieve. This report does not suggest that Housing First is a 'perfect' homelessness service or that Housing First services are able to deal effectively with all the forms of homelessness, such as homelessness amongst migrants who face administrative or legal barriers to welfare and housing, as well as family homelessness, which exist in France. However, it is argued that the small group of very vulnerable people spending years on the streets and in beds in emergency accommodation can be significantly reduced by Housing First. Furthermore, it seems that elements of the Housing First philosophy can provide policy makers and service providers with useful insights into how to address other forms of homelessness e.g. amongst people with lighter support needs.

⁵<http://www.servicestyrelsen.dk/housingfirsteurope>

The Structure of the Report

The rest of the report is structured as follows:

- **Chapter 2** focuses on Pathways Housing First. The chapter begins by describing the PHF model and then reviews the evidence on the effectiveness of PHF.
- **Chapter 3** looks at 'Communal Housing First' and follows the same structure as Chapter 2, describing how CHF services work and reviewing the evidence on the effectiveness of the CHF approach.
- **Chapter 4** looks at Housing First 'Light' services and again follows the same structure as chapters 2 and 3, describing HFL services and reviewing the evidence.
- **Chapter 5** discusses the use of Housing First services in France, looking at why Housing First has become globally influential, exploring some of the questions that have been raised about whether or not Housing First is suitable for France and finally summarises the case for considering using Housing First in France.

2 Pathways Housing First (PHF)

Introduction

This chapter looks at the original Housing First service model which was developed by Pathways in New York City. The chapter begins by looking at the origins of the Pathways service and then moves on to discuss its philosophy and operation. Finally, the evidence base for Pathways Housing First is discussed.

Origins

Problems with 'staircase' services

The 'staircase' model is widely used in the USA⁶ and in several European countries⁷ to try to end enduring 'chronic' homelessness among people who have high rates of severe mental illness and problematic use of drugs and alcohol. Each staircase service has a series of steps that are designed to make a chronically homeless person increasingly 'ready' for housing. Chronically homeless people are expected to achieve goals that a staircase service sets for them in order to progress from one step to the next. These 'steps' involve moving between accommodation, with each step allowing a chronically homeless person more independence until they finish the process with access to their own home. At the end of the 'staircase' a chronically homeless person is supposed to be able to live independently in their own home and to no longer have problems related to severe mental illness and drug and alcohol use⁸. Staircase services have strict rules about behaviour, compliance with psychiatric treatment and also the use of drugs and alcohol.

During the 1990s a series of evaluations in the USA reported that staircase services were expensive to operate and failed to end the homelessness of most of the chronically homeless people they worked with⁹. Chronically homeless people quite often became 'stuck' in staircase services, unable to 'climb' to the next 'step'. In addition, chronically homeless people were also frequently abandoning staircase services¹⁰ because of harsh rules

⁶Collins, S.E.; Clifasefi, S.L.; Dana, E.A. *et al* (2011) 'Where harm reduction meets Housing First: Exploring alcohol's role in a Communal Housing First setting' *International Journal of Drug Policy* doi: 10.1016/j.drugpo.2011.07.010

⁷ Sahlin, I. (2005) 'The staircase of transition: Survival through failure' *Innovation* 18, 2, pp.115-136; Busch-Geertsema, V. and Sahlin, I. (2007) 'The Role of Hostels and Temporary Accommodation' *European Journal of Homelessness* 1 pp.67-93; Johnsen, S. and Teixeira, L. (2010) *Staircases, Elevators and Cycles of Change: Housing First and Other Housing Models for People with Complex Support Needs* London: Crisis.

⁸ Ridgway, P. and A. M. Zippel (1990) 'The paradigm shift in residential services: From the linear continuum to supported housing approaches' *Psychosocial Rehabilitation Journal* 13, pp. 11-31.

⁹Gulcur, L., A. Stefancic, *et al.* (2003). 'Housing, hospitalization and cost outcomes for homeless individuals with psychiatric disabilities participating in Continuum of Care and housing first programmes' *Journal of Community and Applied Social Psychology* 13, 2, pp. 171-186.

¹⁰ Bebout, R. R.; Drake, R.E. *et al.* (1997) 'Housing status among formerly homeless dually diagnosed adults' *Psychiatric Services* 48, 7, pp. 936-41;

requiring total abstinence from drugs and alcohol¹¹. Conditions within some staircase services in the US were also criticised as being inhuman because of their extensive and strictly enforced rules and because staff had a hostile and judgemental attitude towards homeless people¹². Only a minority of chronically homeless people were being helped by expensive staircase services that took quite a long time to achieve results¹³. Research in Europe has reported very similar problems with staircase services in countries that include Sweden¹⁴. The experience of homeless people using staircase services can be one of a series of disruptions or 'ruptures' as they move between 'steps' in a programme and have to readjust to a new living environment with new rules several times before they are eventually able to have a settled home. This can mean that homeless people never feel secure while they are in the staircase, because each step except the last step (if they progress that far) is not a permanent home, i.e. they are unable to settle because they know each step is temporary.

What is Pathways Housing First?

The Pathways Housing First service, founded by Dr Sam Tsemberis, first appeared in New York in 1992¹⁵. Pathways Housing First (PHF) has the following key characteristics¹⁶:

- provides independent housing with security of tenure immediately or as soon as possible to a chronically homeless person.
- provides support designed to promote housing stability, service brokerage to connect chronically homeless people to essential services
- *directly* provides psychiatric, drug and alcohol, social work and medical services. The team providing this support is *mobile* and visits people using the service in their homes or at other agreed locations.
- give considerable choice and control to chronically homeless people by following a *harm reduction* model. Chronically homeless people can choose not to use the psychiatric and drug and alcohol services that are made available by PHF and can still remain in the housing provided by PHF. This is called a 'separation' of housing and support.

The PHF Philosophy

¹¹Dordick, G. A. (2002) 'Recovering from Homelessness: Determining the "Quality of Sobriety" in a Transitional Housing Program' *Qualitative Sociology* 25, 1, pp. 7-32; Carr, E. S. (2006). "'Secrets keep you sick': Metalinguistic labor in a drug treatment program for homeless women." *Language in Society* 35, 5, pp. 631-653.

¹² Dordick, G. A. (2002) op cit; Lyon-Callo, V. (2000) 'Medicalizing Homelessness: The Production of Self-Blame and Self-Governing within Homeless Shelters' *Medical Anthropology Quarterly* 14, 3, pp. 328-345.

¹³ Devine, J. A., Brody, C.J. et al (1997) 'Evaluating an alcohol and drug treatment program for the homeless: An econometric approach' *Evaluation and Program Planning* 20, 2, pp. 205-215; Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an international review* Edinburgh: Scottish Government.

¹⁴ Sahlin, I. (2005) op cit.; Busch-Geertsema, V. and Sahlin, I. (2007) op cit.

¹⁵ Ridgway, P. and Zippel, A.M (1990) *Ibid*; Tsemberis, S. (2010a) *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction* Center City, Minnesota: Hazelden.

¹⁶ Tsemberis, S. (2010b) 'Housing First: Ending Homelessness, Promoting Recovery and Reducing Costs' in I. Gould Ellen and B. O'Flaherty (eds) *How to House the Homeless* Russell Sage Foundation: New York.

The Pathways organisation takes the view that PHF is not simply a different way of delivering services to chronically homeless people. Instead Pathways believes that PHF represents a shift in the *philosophy* of service delivery to homeless people which is in part a reaction against the approach that has been taken by staircase services. The founder of Housing First has often been critical of what he sees as the failure of staircase services in the USA, criticising both their operational effectiveness and how the staff in staircase services regard chronically homeless people¹⁷. The PHF philosophy is described as following these principles:

- Housing as a basic human right.
- Respect, warmth and compassion for all clients (a 'client' is a chronically homeless person using the PHF service).
- A commitment to working with clients for as long as they need.
- Scattered site housing, independent apartments (that clients should live in the community in ordinary apartments, not in a single apartment block).
- Separation of housing and services.
- Consumer choice and self-determination.
- A recovery orientation.
- Harm reduction.

Housing First: Housing as a 'Basic Human Right'

PHF is 'housing first' because the service works by immediately providing chronically homeless people with an apartment, or providing an apartment as quickly as possible¹⁸. Unlike staircase services, there is no requirement that the chronically homeless person completes a training programme to be made 'housing ready' before they move into an apartment.

In New York, apartments are provided through an arrangement with a private landlord. In many cases, the PHF signs a lease or tenancy agreement with the landlord and asks the service user to sign a sub-tenancy or sub-lease with PHF. This is intended to guarantee the housing rights of the service user while providing reassurance to the private landlord.

PHF avoids concentrating the people using its service within single apartment blocks¹⁹. The reason for this policy is that PHF seeks to reintegrate formerly homeless people into mainstream community life, something that would be difficult if all PHF service users were concentrated in one or two apartment buildings.

It is made clear by PHF that, unlike in a staircase service, housing is not provided as an incentive to stop using alcohol and drugs or as an incentive to comply with psychiatric or detoxification treatment. Instead housing is provided as a 'basic human right'. This means housing is provided to someone using a PHF service on the following basis:

¹⁷Tsemberis, S. (2010a) *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction* Hazelden: Minnesota, p. 18.

¹⁸Immediately where possible; sometimes there may be a short wait in temporary accommodation but this is not supposed to exceed four weeks.

¹⁹ Ibid.

- There is *no* requirement to stop or reduce alcohol or drug consumption in order to receive and to remain in housing provided via PHF.
- There is *no* requirement to comply with treatment for mental health problems or with detoxification treatments in order to receive and remain within housing provided via PHF.

Respect, Warmth and Compassion for Clients

PHF places particular emphasis on showing respect, warmth and compassion to the chronically homeless people using its services. The terms ‘respect’, ‘warmth’ and ‘compassion’ are used in the general sense. As noted, Pathways argue that this makes their service philosophy different from that of staircase services because of evidence that staff in some US staircase services can have judgemental attitudes towards homeless people²⁰.

A Commitment to Working with Clients as Long as They Need

The PHF model is designed to provide support for as long as is needed. There may be a point at which services are reduced because someone is coping well on their own and services might eventually be withdrawn because an individual becomes fully independent. PHF does not stop supporting a formerly chronically homeless person if they lose the housing they have been provided with by the PHF service (for example, for breaking the terms of the tenancy agreement). While the PHF service will not keep rehousing a service user again and again, the PHF service will give an individual who has lost the housing they were provided with two, three or more chances depending on their needs. PHF services will also stay in contact with someone if they return to homelessness, are imprisoned for short periods or have to enter hospital (including psychiatric care)²¹.

Scattered Site Housing, Independent Apartments

The use of ordinary housing is one of the key features of PHF. In the context of New York, there is very little social rented housing available and there are not the resources available to buy or develop housing because of the costs that would be involved, so private renting is the only option. There are some areas of New York where PHF cannot afford the rent for housing, which means the PHF project is not active throughout the city. Within the financial limitations of the PHF service, homeless people are allowed some choice about which area they live in and what sort of housing they have. The PHF approach is summarised in the guidance:

*This scattered site feature of the housing model helps ensure that people with psychiatric disabilities are not all housed together in one building but are integrated into the buildings and into their communities. In this model, clients [people using the PHF service] don't move into a ready-made unit of a housing program – they move into their own apartments in their neighbourhood of choice.*²²

A key goal of this approach is to promote social inclusion. PHF operates on the assumption

²⁰ Dordick, G. (2002) op cit.

²¹ Tsemberis, S. (2010a) op cit.

²² Tsemberis, S. (2010a) op cit. 22.

that in living alongside other citizens and being within an ordinary neighbourhood in ordinary housing, the formerly chronically homeless people using PHF are brought back into contact with 'normal' life. Support is also provided to enable service users to establish and maintain new friendships and relationships and to get back in contact with their family if they have one.

In addition, PHF seeks to reconnect formerly chronically homeless people with paid work, through the provision of support services that are designed to enable access to training and education and help with getting into employment. Through this rehousing in the community, the fostering of positive social and family relationships and help to become economically active in paid work, PHF seeks to 'resettle' formerly chronically homeless people back into society.

Separation of Housing and Services

A person using PHF does *not* have to receive support related to severe mental illness and problematic use of drugs and alcohol if they chose not to. Their housing will not be affected if they refuse to use drugs and alcohol services or to comply with psychiatric treatment. This is described as the 'separation' of housing from support, because being given and being allowed to stay in housing is not dependent on accepting treatment and support services.

This 'separation' of housing and services is *not* total. PHF service users have to agree to a weekly visit from PHF staff to check on their well-being and to ensure there are no problems with the apartment²³.

Consumer Choice and Self-Determination

Consumer choice and self determination refer to the emphasis within the PHF on enabling chronically homeless people to make their own decisions about where and how they live their lives and, to a considerable extent, what services and support they use. This means that the people receiving PHF services can act as (to use the American terminology) as 'consumers' and exercise 'self determination'.

In practice, this means that the people receiving a PHF service can decide what their own goals are (this is what is meant by self-determination), for example to drink less alcohol, to cease drinking alcohol and, because this flexibility exists within the PHF model, not to set themselves any goals about how much alcohol they drink. The PHF model is built around an assumption that chronically homeless people will generally not, when given access to housing and support, opt to refuse all support and choose courses of action that are harmful to their own well-being.

As noted, the consumer choice and self-determination offered by PHF are not limitless. Alongside the compulsory weekly support visit, someone using a PHF service must comply with the terms of their lease, just the same as any other tenant. However, the level of control given to people using PHF services is sufficient to mean that they can and do get into difficulty:

Honouring client [people using PHF services] self-determination is especially important in times of difficulty, such as when clients deplete their financial resources, when a landlord threatens eviction, or when a client has relapsed into

²³ Tsemberis (2010a) op citp. 48.

addiction. In these situations, staff must resist the impulses to control or resolve a chaotic situation. Instead, staff must make every effort to help clients explore their options during a crisis²⁴.

A Recovery Orientation

The 'recovery orientation' of PHF refers to a focus on encouraging people using PHF services in the right direction. This is not viewed as contradicting the emphasis on 'consumer choice' in the PHF model. Staff are expected to encourage people using PHF services to believe that they can permanently cease to be homeless, can stop using drugs and alcohol and get treatment that will help with their mental health problems.

The recovery orientation in PHF services is designed to also encourage a greater degree of self-reliance among the people using PHF services. Over time, staff are expected to maximise the extent to which people using PHF services do things for themselves, encouraging and reinforcing their ability to live independently.

Harm Reduction

Harm reduction is an approach to stopping people making heavy or dangerous use of drugs and alcohol that does not require abstinence from drugs and alcohol. Harm Reduction is also a means of reducing the harmful consequences of mental health problems. The emphasis is on minimising the risks associated with problematic behaviour and/or drug and alcohol use and trying to reduce, with the hope of eventually ending, those behaviours that harm an individual.

The PHF harm reduction approach works by emphasising to an individual the aspects of their life that are being harmed by their behaviour. Extensive support is made available - if a chronically homeless person decides to use it -to help them end behaviour that causes them harm.

From the Pathways perspective, harm reduction should not be viewed as an 'alternative' approach to treatment; the ultimate goal of harm reduction is the same as for services trying to enforce abstinence and compliance with treatment, to engage people with severe mental illness with psychiatric services and to end problematic drug and alcohol use²⁵. However, harm reduction is centred on respecting an individual's current wishes and behaviour, with the aim of encouraging an individual to use services rather than 'requiring' an individual to use services or stop using drugs and alcohol.

Delivering a Pathways Housing First Service

There is extensive guidance on the delivery of a PHF service in the 'manual' written by the founder of PHF, Sam Tsemberis, which is entitled *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction*.²⁶In addition, guidance is available on the Pathways website.²⁷

This section provides a summary overview of the operation of PHF, including information on the following areas:

²⁴ Tsemberis (2010a) op citp. 27.

²⁵ Tsemberis (2010a) op citp. 30.

²⁶ Tsemberis, S. (2010a) op cit.

²⁷ www.pathwaystohousing.org

- Which groups of homeless people is a PHF service designed to help?
- What are the aims of a PHF service?
- How is the service accessed?
- How is a PHF service delivered?
- What does a PHF service cost?
- Risk management

Which groups of homeless people is PHF designed to help?

PHF is targeted *only* at chronically homeless people. The needs, characteristics and experiences of chronically homeless people can include:

- A disrupted childhood and/or experience of the child care system.
- Problematic/addictive use of drugs, including illegal drugs
- Problematic drinking of alcohol (i.e. unhealthy or dangerous levels of consumption).
- Severe mental illness, i.e. psychiatric conditions that are severe enough to impede capacity to live independently, secure and sustain work and which in some instances might represent a risk to an individual or to those around them.
- Low level criminality, including 'survival' crime to feed and clothe themselves and also crime to sustain problematic drinking and/or drug use.
- Nuisance behaviour, sometimes linked to low self esteem, poor mental health and to drug and alcohol use.
- Poor physical health, linked to poor diet, alcohol and drug consumption, poor physical environment (i.e. living on the street and in emergency accommodation for sustained periods).
- Sustained worklessness, linked to low educational attainment, health and support needs.
- Alienation from mainstream society, linked to poor self-image and low self-esteem and sustained exclusion from ordinary social and economic life.
- Repeated and sustained homelessness.

What are the aims of a PHF service?

PHF is 'housing first' but it is not 'housing only'. Through a harm reduction led philosophy that emphasises choice and control for the people using the PHF service, a series of goals are pursued:

- Housing stability, including developing the capacity of formerly chronically homeless people to live largely or wholly independently over time.
- Reductions and where possible cessation of problematic drug and alcohol use.
- Reductions in criminal behaviour (if present).
- Reductions in severe mental illness and other mental health problems among service

users.

- Improvements in physical health by emphasizing well-being and ensuring contact with medical services where necessary.
- Reengagement with normal social and community life, developing friendships, re-establishing family ties where possible and developing and sustaining successful personal relationships.
- Engagement with work related activity, including productive activity that is similar to work, education and training as well as securing paid work where this is possible and practical.

PHF is a service intended to deal with the consequences of repeated and sustained homelessness among people with high support needs in a number of ways. Alongside tackling homelessness through the provision of stable housing, PHF is also intended to promote positive outcomes in terms of social and economic inclusion and in terms of health and well-being, using a harm reduction framework that separates housing and support and which emphasizes choice for people using the PHF service.

How is the PHF service accessed?

The PHF service in New York takes referrals from homelessness services. There can also be referrals from psychiatric services and prisons, either when someone has been referred to those services from a situation of homelessness or seems likely to become homeless on leaving. There is also the capacity to take self-referrals from chronically homeless people who decide they need help²⁸. Each individual who is referred to PHF is assessed individually.

The process of ‘engagement’ with service users is not something that PHF expects to be completed very quickly. According to the PHF manual, trust has to be established with service users who have sometimes become used to being promised suitable housing by staircase services, only to find a great many conditions and requirements being placed upon them once they started using a staircase service. PHF therefore aims to emphasize service users’ choice and control, seeking to give the service user confidence in the service and adopting an approach that is focused on asking service users *how* PHF can help, rather than behaving like a staircase service which *tells* people using services what to do²⁹. For this reason, the initial meeting with a potential service user is at a venue they choose (within safety constraints) and there is a requirement to allow the service user to control the pace at which their engagement with PHF moves.

Locating an apartment centres on taking into account a service user’s preferences before making an offer of an apartment. Service users are shown the apartment, to check that it is acceptable to them, before they are asked to sign a lease. In the case of the New York PHF service, the process of securing suitable private rented housing usually takes place within two to four weeks.

PHF offers a full property management service to private rented landlords, meaning all aspects of housing management are handled by PHF, including rent collection³⁰. As noted, this enables access to private rented apartments because the lease or tenancy is often

²⁸ Tsemberis, (2010a) op cit.

²⁹ Tsemberis, (2010a) op cit, p. 41.

³⁰ Tsemberis, (2010a) op cit

signed by PHF, not by the person using the service and any issues with rent collection or other housing management issues are handled by PHF. This means a private landlord need do nothing but collect the rent.

How is the PHF service delivered?

PHF is not a very complex service. Essentially PHF immediately places chronically homeless people in ordinary rented apartments and provides them with services that are delivered by a mobile team of workers and professionals who visit them in their apartments or another venue which they have chosen.

PHF service users must accept a weekly visit, devote 30% of their income to paying rent, and sign a lease or sub-lease agreement for their apartment. The three requirements of the PHF service are as follows:

- A weekly home visit from PHF staff
- Signing a lease or sub-lease, which gives the service user some housing rights alongside responsibilities for the apartment they living in.
- Signing rental agreements guaranteeing 30% of available income be devoted to payment of rent.

The core components of a PHF service are:

- **Ordinary apartments**, in the USA these are usually found in the private rented sector, but PHF could also use social housing. Apartments are furnished by the PHF project. A housing specialist within the PHF team arranges access to suitable housing. Chronically homeless people using PHF must usually be in receipt of welfare benefit payments linked to severe mental illness in order to make a contribution to the rental costs of their apartment.
- **Support with maintaining housing stability and living an independent life.** This might include assistance with claiming welfare benefit payments to which a service user is entitled, help in getting used to living independently and learning about their neighbourhood, help managing relationships with the private landlord, maintaining their home, budgeting and shopping. The main mechanism for this is the weekly home visit to each service user in the apartment by a PHF staff member.
- An **Assertive Community Treatment (ACT)** team of mobile support workers. This part of the service is closely modelled on the ACT teams developed in mental health services in the US. A PHF ACT team includes a Team Leader who coordinates the services provided, along with a part-time psychiatrist, a part time provider of primary medical care (either a doctor or nurse-practitioner³¹) and a full time nurse. In addition, the ACT team will include a qualified social worker, usually with specialist knowledge of mental health, and specialists in supported employment, a drug and alcohol specialist and an administrative assistant. The ACT team must also include a 'peer specialist'. This is an individual qualified to provide support who has been through the experience of chronic homelessness themselves. Alongside

³¹A nurse practitioner has some of the training used for doctors and is qualified to a higher level than an ordinary nurse, though their training is less extensive than for a doctor. A nurse practitioner can prescribe some drugs.

providing practical support, the 'peer specialist' is also seen as a 'living illustration' that 'recovery'³² from chronic homelessness is possible.³³ An ACT team may also include what is termed a 'family specialist'; this is essentially a worker whose role centres on positive reconnection between a formerly chronically homeless person and their family. In addition, an ACT team may also include a 'wellness management and recovery specialist', a role that centres on helping a formerly chronically homeless person develop and manage positive personal relationships and which encourages a generally healthy lifestyle.³⁴ The ACT team provides intensive support. A ten person ACT team would be responsible for around 70 formerly chronically homeless people, a ratio of one staff member for each seven service users. The ACT team works with service users with the following characteristics:

³² 'Recovery' is a term used by PHF to describe the process by which someone ceases to be a chronically homeless person.

³³ Tsemberis, S. (2010a) op cit.

³⁴ Ibid.

- Severe mental illness (e.g. manic depression, bi-polar disorder) without problematic drug or alcohol use.
 - Severe mental illness and low use of drugs and/or alcohol.
 - Severe mental illness and heavy use of drugs and/or alcohol.
- An **Intensive Case Management (ICM)** team. The ICM is also based on a service model used for people with mental health problems in the US. The ICM team has a service brokerage role. This means that the ICM connects a service user with services they need that are not directly provided by PHF, this can include support services, medical services and welfare benefit payments that can be accessed by any US citizen but can also include specialist services, such as support with problematic drug use. The ICM refers service users to external services and supports them in accessing those services. The ICM team also provides some direct support itself. ICM team staff are each assigned up to 20 service users. The ICM team works with service users with the following characteristics:
 - Mental health problems (e.g. depression) without problematic drug or alcohol use.
 - Mental health problems with low use of drugs and/or alcohol.
 - Mental health problems with heavy use of drugs and alcohol.

What does PHF cost?

While it is more economical than the staircase approach (see discussion under Evidence of Effectiveness) , the PHF service is not a low cost service. PHF provides an extensive range of support services. A sample budget provided in the manual on PHF produced by Pathways suggests that a PHF scheme can be developed and run for one year at a cost of \$1.5 million (approx. €1.23 million)³⁵. It is difficult to exactly cost the service for France because the salaries, housing costs and other operating costs will not be the same as is the case for New York. There are important differences in context, these centre on the amount of welfare payments available to chronically homeless people, which will be significantly higher in France and also the fact that social housing is available to use in France. Using US costs, a PHF team handling 70-80 chronically homeless people would cost approximately €482,500 in direct salary costs for one year of operation.

To these costs must be added: benefits for employees transport for the mobile workers, furniture purchase, medical supplies, moving expenses, apartment maintenance (on behalf of private landlords) and costs for transport. The PHF sample budget adds another €270,000 to cover these costs, another €57,000 for administrative and supervisory costs and a further €287,000 for an office in which the team are based, taking the total budget to about €1.23 million.

A French PHF service would probably have *lower* direct costs. There are several reasons for this. Direct salary costs may be less because France has extensive healthcare provision that would be accessible to service users, i.e. it might not be necessary to directly employ as many medical professionals in a French PHF service. If a French PHF service were able to

³⁵ Tsemberis, S. (2010a) op cit p. 219-222.

mobilise the social housing stock to implement PHF, there might be less reliance on housing specialists. In addition, if a PHF service was operated by a medium or large size French NGO, many administrative tasks could be handled by existing bureaucracy, rather than requiring dedicated staffing. Some of the additional costs of the PHF service might be less in France, for example public transport is much more widely available and cheaper than in the USA.

Risk management

Delivering a service by using mobile support that is provided to people in their own homes presents a number of risks that are not present in a communal service. The evidence base on how PHF manages risk is not extensive, although there is some descriptive information in the PHF manual³⁶. The key risks that could potentially arise centre on someone using the PHF service becoming seriously ill, or overdosing, and the possibility that a service user might harm themselves or (less likely) harm someone else, including one or more staff from the mobile support services. The techniques used to manage risk are:

- Assessment of needs on referral to the service. PHF would not refuse to engage with a chronically homeless person because they were seriously ill, very likely to overdose or presented a potential risk to themselves or others. However, judgements are made about how practical it is for PHF to support each individual.
- Twenty-four availability of one member of the ACT or ICM team by mobile telephone.
- Keys to apartments are held by the ACT/ICM team and by the housing staff as well as by the service user.
- Checks on service users by the PHF staff, including the weekly visit.

Summary of PHF service delivery

- PHF works with 'chronically homeless people' who are characterised by severe mental illness, problematic drug and alcohol use, nuisance behaviour, low-level criminality, sustained worklessness and long periods living in homelessness shelters and on the street.
- PHF provides independent housing with security of tenure immediately or as soon as possible to a chronically homeless person.
- PHF provides low-level support designed to promote housing stability, service brokerage (to connect chronically homeless people to essential services) and also *directly* provides psychiatric, drug and alcohol, social work, medical and other services. The team providing these services is *mobile* and visits people using the service in their homes or at other agreed locations.
- PHF services give considerable choice and control to chronically homeless people by following a harm reduction model which allows them to continue drinking alcohol and using drugs. Chronically homeless people can choose not to use the psychiatric and drug and alcohol services that are made available by PHF but can remain in the housing provided by PHF. This is called a 'separation' of housing and support.

³⁶ Tsemberis, S. (2010a) op cit.

Evidence of effectiveness

Housing Stability

There is very strong evidence that PHF produces a high level of housing stability among chronically homeless people in the US. Beyond the evidence from the studies of the PHF in New York, there is also strong evidence from a number of other American cities where PHF models have been implemented.³⁷

PHF has delivered unprecedented levels of housing stability among chronically homeless people, often more than *doubling* the success rates reported by staircase services. In 2004, a study on PHF in New York reported that 80% of PHF service users were stably housed after two years. Over time, the success rates reported by PHF have increased, with housing stability rates of 88% being reported³⁸. By contrast, research on staircase services reported that, at best, housing stability was being produced for 30-40% of the chronically homeless people using staircase services³⁹. The founder of the PHF service in New York has describes the main success of PHF in very simple terms:

*Housing First ends homelessness. It's that simple.*⁴⁰

Housing First has become globally important in homelessness policy because of what PHF has achieved in delivering housing stability for chronically homeless people (see final chapter).

Changes in Drug and Alcohol Use

There is evidence that PHF achieves the goal of harm reduction in drug and alcohol use among formerly chronically homeless people. Alcohol use and drug use tend to stabilise and also fall among people using PHF services and there is no evidence that PHF services produce any increase in drug or alcohol use⁴¹.

Some US academics have raised concerns that PHF does not produce large enough improvements in problematic drug and alcohol use⁴². There are arguments about whether it is better to deliver total abstinence for a minority of chronically homeless people, which is what 'staircase' services try to deliver, or harm reduction for a greater number (with only relatively few becoming abstinent), which is what PHF delivers⁴³. There have also been

³⁷Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an international review* Edinburgh: Scottish Government; Johnsen, S. and Teixeira, L. (2010) op cit.

³⁸Tsemberis, S. (2010b) op cit.

³⁹Bebout, R.R.; Drake, R.R. *et al* (1997) op cit; Pleace, N. (2008) op cit; Tsemberis, S. (2010b).

⁴⁰Tsemberis, S. (2010a) op cit p. 4.

⁴¹Kertsez, S.G.; Crouch, K.; Milby, J.B.; Cusimano, R.E. and Schumacher, J.E. (2009) 'Housing First for Homeless Persons with Active Addiction: Are we overreaching?' *The Milbank Quarterly* 87, 2, pp. 495-534; Tsai, J.; Mares, A.S. and Rosenheck, R.A. (2010) 'A Multisite Comparison of Supported Housing for Chronically Homeless Adults: "Housing First" Versus "Residential Treatment First"' *Psychological Services* 7, 4, pp. 219-232.; Padgett, D.K.; Stanhope, V.; Henwood, B.F. and Stefanic, A. (2011) 'Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programmes' *Community Mental Health* 47 pp. 227-232.

⁴²Lipton, F. R., Siegel, C. *et al* (2000) 'Tenure in supportive housing for homeless persons with severe mental illness' *Psychiatric Services* 51,4, pp. 479-86; Tsai *et al* (2010) op cit

⁴³Collins, S.E. (2011) op cit.

criticisms that PHF does not work with the very heaviest users of drugs and alcohol at the same rate as staircase services do⁴⁴.

The counter argument is that PHF tends to reduce alcohol and drug use among *many* of the people using it, most of whom *remain* with the PHF service. By contrast, while a US staircase service might eventually produce an end to drug and alcohol use for some of the chronically homeless people using it, such staircase services tend to eject, or be abandoned by, between 60-70% of chronically homeless people before an end to drug or alcohol use has been achieved⁴⁵. Pathways has accepted that it is not always possible for PHF to engage with people making extremely heavy use of drugs and alcohol, but also reports that it is working with a group of chronically homeless people who very often have problematic use of drugs and alcohol⁴⁶.

To set the findings of the research on PHF (and staircase) services in context, it is important to note that problematic drug and alcohol use are generally quite difficult to treat. Service outcomes for people with problematic drug use who are *not* homeless may be little or no better than for service outcomes for homeless people with drug problems⁴⁷.

Changes in Mental Health

There is evidence that housing conditions and housing stability have direct impacts on mental health and that the wrong housing in the wrong neighbourhood can be 'toxic' to mental health. This means there may be particular benefits to mental health when someone is given some choice about where they live⁴⁸. While these are difficult concepts to measure, it seems a sense of safety, security and privacy at home promotes good mental health. Homelessness disrupts or removes all that is associated with feeling 'at home'⁴⁹.

Some research in the US by Padgett has argued that PHF gives service users the dignity and control of having one's own home and home life. Padgett has argued that in providing chronically homeless people with their own 'home' in which they can make their own choices, PHF creates a stable platform from which a recovery from mental health problems can begin⁵⁰.

More generally there is some evidence from evaluative research showing that mental health tends to improve among users of PHF services. Scores on short questionnaires designed

⁴⁴ Tsai *et al* (2010) *op cit*; Padgett *et al* (2011) *op cit*.

⁴⁵ Pearson, C. *et al* (2007) *op cit*.

⁴⁶ Tsemberis, S. (2010b) *op cit*.

⁴⁷ McKeganey, N., Bloor, M., Robertson, M., Neale, J. and MacDougall, J. (2006) 'Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study', *Drugs: education, prevention and policy* 13, 6, pp. 537-550.

⁴⁸ Srebnik, D.; Livingston, J.; Gordon, L.; King, D (1995) 'Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness' *Community Mental Health Journal*, 31, 2, pp. 139-152.

⁴⁹ Padgett, D. (2007) 'There's no place like (a) home: Ontological security among persons with a serious mental illness in the United States' *Social Science and Medicine* 64, pp. 1925-1936

⁵⁰ *Ibid*.

to assess mental health⁵¹ also tended to improve⁵². However, there is no expectation that formerly chronically homeless people using PHF services should comply with psychiatric treatment, which means that access to treatment for severe mental illness or mental health problems may not occur for people using PHF services⁵³.

Criticism of the extent to which PHF can deliver improvements to mental health takes two main forms. First, there are the arguments that because there is no requirement that chronically homeless people using PHF services comply with psychiatric treatment, mental health problems can go untreated. The second criticism centres on what PHF services are able to deliver in terms of housing choices. Some researchers have the view that necessary compromises resulting from limited funds for PHF can mean that neither the housing nor the neighbourhoods where the housing is located are beneficial to mental health⁵⁴.

Social Inclusion

PHF is intended to improve the social inclusion of chronically homeless people by housing them as independently as possible in ordinary neighbourhoods and communities. PHF is based on an assumption that social inclusion is being generated because chronically homeless people are living in the community alongside other citizens and are not physically separated from other people in a separate service or apartment block.

Evidence on whether or not social inclusion is being promoted by PHF is not extensive. There has been some work that suggests that users of PHF 'feel' more included in society than was the case when they were homeless,⁵⁵ but a sense of social inclusion can vary according to individual perception. There is research suggesting that intolerance and hostility towards people with support needs, or even simply towards people on lower incomes, can be an issue in socially and economically mixed neighbourhoods⁵⁶ and this may sometimes be an issue for people using PHF services.

Economic Inclusion

PHF seeks to promote economic inclusion, which in the context of the US means access to education, training and paid employment. There is evidence that securing work can improve self-esteem, promote social inclusion and generate benefits in mental and physical health for formerly homeless people. However, these benefits are associated with work that offers fair

⁵¹ A short series of questions that are used to test mental well-being which are 'validated' measures that are repeatedly tested to ensure that results are consistent and they are a good indicator of mental health. The example used in some evaluations of PHF was the Colorado Symptom Index (CSI).

⁵² Greenwood, R.M.; Schaefer-McDaniel, N.J.; Winkel, G. and Tsemberis, S. (2005) 'Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness' *American Journal of Community Psychology* 36, 3/4, pp. 223-238.

⁵³ Tsemberis, S. (2010a) op cit.; Gilmer, T.P.; Stefanic, M.A.; Ettner, S.L.; Manning, W.G. and Tsemberis, S. (2010) 'Effect of Full-Service Partnership on Homelessness, Use and Costs of Mental Health Services and Quality of Life among Adults with Serious Mental Illness' *Archive of General Psychiatry* 67,6, pp. 645-652.

⁵⁴ Tabol, C.; Drebing, C. and Rosenheck, R. (2009) 'Studies of "supported" and "supportive" housing: A comprehensive review of model descriptions and measurement' *Evaluation and Program Planning* 33 pp. 446-456

⁵⁵ Yanos, P.T.; Barrow, S.M. and Tsemberis, S. (2004) 'Community Integration in the Early Phase of Housing Among Homeless Persons Diagnosed with Severe Mental Illness: Successes and Challenges' *Community Mental Health Journal* 40, 2, p.133- 150

⁵⁶ Bretherton, J. and Pleace, N. (2011) 'A Difficult Mix: Issues in achieving socioeconomic diversity in deprived UK neighbourhoods' *Urban Studies*, Volume 48 Issue 16, pp. 3429 - 3443.

pay and is rewarding⁵⁷.

There is no real evidence that PHF has been able consistently to secure access to education, training or paid employment. In part, this is because this aspect of Housing First services has not been systematically investigated. There is evidence that it is relatively difficult to secure access to paid employment for homeless people, particularly those with a criminal record or history of drug use⁵⁸, because employers are reluctant to employ this group of people, even during times of relative economic prosperity.

Cost effectiveness

In the US, PHF is seen as cost effective because it significantly reduces the amount of time that chronically homeless people spend outside a settled home. Producing housing stability among formerly chronically homeless people has four main potential cost-saving effects⁵⁹:

- Reductions in the use of emergency homeless shelters by chronically homeless people who often make repeated and sustained use of emergency homeless shelters (this has been demonstrated). Some estimates are that the 10% of the US homeless population who are chronically homeless may use up to 50% of the bed spaces that emergency shelters have available during the course of one year⁶⁰, because they occupy beds for such long periods of time.
- Reductions in the use of emergency medical and psychiatric services as chronically homeless people using PHF have direct access to psychiatric and medical services and may experience improvements in health and well-being (this has been demonstrated). Studies in the US have suggested that there is reduced use of emergency psychiatric treatment and that net savings have been produced ranging from \$4,000 to \$8,880 a year for each formerly chronically homeless person using a PHF service (€2,900 to €6,400)⁶¹.
- Reductions in arrests and imprisonment for chronically homeless people using PHF services, producing savings in expenditure on criminal justice services (this has been demonstrated).
- If PHF were to demonstrate effectiveness in getting formerly chronically homeless people into paid work, meaning they were no longer reliant on welfare benefit payments, there would be a cost saving (this has yet to be demonstrated).

Pathways has estimated the relative costs of its services on a per-night basis and drawn a broad comparison with other services. The comparison is broad, because chronically homeless people would not tend to stay in the most expensive places for very long periods

⁵⁷ Rio, J., Ware, L., Tucker, P., Martinez, J. (2008) *Ending Chronic Homelessness through Employment and Housing: A Program and Policy Handbook for Successfully Linking Supportive Housing and Employment Services for Chronically Homeless Adults* New York: Corporation for Supportive Housing and Advocates for Human Potential.

⁵⁸ Kemp, P. and Neale, J. (2005) 'Employability and problem drug users', *Critical Social Policy* 25, 1, pp. 28-46.

⁵⁹ Culhane, D.P. (2008) 'The Cost of Homelessness: A Perspective from the United States' *European Journal of Homelessness* 2, pp. 97-114; Culhane, D.P.; Gross, K.S.; Parker, W.D. *et al* (2008) 'Accountability, Cost-Effectiveness, and Program Performance: Progress Since 1998' National Symposium on Homelessness Research http://works.bepress.com/dennis_culhane/22

⁶⁰ Kuhn, R. and Culhane, D.P. (1998) 'Applying cluster analysis to test a typology of homelessness by pattern of public shelter utilization' *American Journal of Community Psychology* 26, 2, pp. 207-232.

⁶¹ Tsemberis, S. (2010a) *op cit*, p. 187-188.

(Table 2.1).

Table 2.1: Relative costs of PHF compared to alternatives in the USA according to Pathways

Service	Cost per night (\$)	Cost per night (€)
PHF	\$57	€42
Emergency homeless shelter	\$73	€54
Jail	\$164	€120
Hospital ER	\$519	€381
Psychiatric hospital	\$1,185	€869

Source: Pathways⁶²

A large scale study in New York found that 95% of the costs of providing PHF were covered by the *savings* to health, criminal justice and other services that PHF generated. The study looked at 4,679 homeless people placed in PHF type housing in New York and compared utilization of public shelters, public and private hospitals, and correctional facilities with a matched control group. Each unit of permanent supportive housing saved \$16,282 per year in public costs for shelter, health care, mental health, and criminal justice. These savings offset nearly all of the \$17,277 cost of implementing the PHF package of housing and support. Almost all the costs of providing a PHF service were effectively met by saving money that would otherwise have been spent elsewhere⁶³.

A recent review of PHF and other Housing First costs in the US identified a potential limitation to the cost effectiveness of PHF and other Housing First services⁶⁴. This limitation is that the cost offsets are greatest when PHF services are used with chronically homeless people with the *highest* levels of need. When people using PHF and other Housing First services have slightly lower levels of need, the financial benefits of PHF and other Housing First services can be less clear⁶⁵. Some commentators in the US have responded to this criticism by arguing that purely economic evaluation of PHF and other Housing First services is not the basis on which policy decisions should be made⁶⁶.

⁶²http://www.pathwaystohousing.org/content/our_model

⁶³ Culhane, D.P., Metraux, S. & Hadley, T. (2002). 'Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing' *Housing Policy Debate*, 13, 107-163.

⁶⁴ Culhane, D.P. (2010) *Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration* White Paper Commissioned for New York State Office of Mental Health and NYC Department of Homelessness Services http://works.bepress.com/dennis_culhane/94

⁶⁵Kertesez, S.G. and Weiner, S.J. (2009) 'Housing the Chronically Homeless: High Hopes, Complex Realities' *Journal of the American Medical Association* 301, 17, p. 1823.

⁶⁶ Culhane, D.P. (2008) op citp. 109.

3 Communal Housing First Services

Introduction

The PHF philosophy has become very influential. However, different NGOs and governments have taken some of the ideas on which PHF is based and have altered those ideas to create their own versions of 'Housing First'. There are now many different examples of Housing First service and one *group* of services can be broadly defined as 'Communal' Housing First services. This chapter describes the origin of this group of services, explores the differences in how they operate compared to PHF, looks at the evidence on the effectiveness of CHF services and finally provides a description of how CHF services are delivered.

It is important to note that this chapter describes a range of services that operate in broadly similar ways, rather than providing a description of a single, specific type of service.

Origins

As the influence of PHF spread across the US, some NGOs took some of the elements of the PHF philosophy and applied them to staircase services. These services retained the physical structure of a staircase service, but the way in which the service was delivered was very different⁶⁷. Some new Communal Housing First services have also been developed.

Communal Housing First (CHF) was the result of applying Housing First principles to communal homelessness services. CHF services give considerable choice and control to service users, including choices over the range of support they receive and whether or not to stop using drugs and alcohol. CHF offers communal housing (single rooms or apartments) with security of tenure provided immediately in a building only lived in by homeless people using the CHF service. Housing is also provided on permanent or long-term basis, there is no expectation that service users will move out, which means there is no programme to create 'housing readiness' or any 'steps' to climb.⁶⁸ These forms of 'Housing First' service have started to sometimes be described as 'Project-Based Housing First' (PBHF) services in the US⁶⁹, though it is perhaps clearer to describe them as Communal Housing First services, in which groups of chronically homeless people and support staff are all within one building.

What is Communal Housing First?

CHF services are not all the same. Some services have been developed as new services, others are modifications of staircase services. All draw on the ideas developed for PHF services, but different CHF services do not all reflect the philosophy of PHF to the same extent. CHF services do however share some basic characteristics. The basic features of CHF services are:⁷⁰

⁶⁷ A studio apartment contains a living area, kitchen and sleeping space, sometimes in one room and a bathroom.

⁶⁸ Pearson, C.; Locke, G. *et al* (2007) *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness* Washington DC: HUD

⁶⁹ Collins, S. *et al* (2011) *op cit*; Pearson, C. *et al* (2007) *op cit*; Larimer, M.E.; Malone, D.K.; Garner, M.D. *et al* (2009) 'Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems' *Journal of the American Medical Association* 301, 13, pp. 1349-1357.

⁷⁰ Pearson, C. *et al* (2007) *op cit*.

- Housing in a building that is only for chronically homeless people using the service (larger services might employ several buildings). The type of housing on offer varies between CHF services, some have small self-contained apartments, some have single rooms and some have only semi-private spaces in communal living areas⁷¹. All offer some security of tenure. The variety of living arrangements offered by CHF services is considerable, and some would not be considered by many commentators to be housing in the true sense.
- Support is provided on site, with the staff delivering the support being based within the building (or nearby if more than one building is used). The range of support on offer varies between services. Some mirror the extensive service provision of PHF services, including mental health and drug and alcohol services, other CHF services might have less extensive support services and make more use of service brokerage (arranging access to externally provided services).
- Housing is either long-term or permanent; there is no pressure or expectation on service users to move out of the CHF service, though those wishing to move on may be supported to do so.
- Service users have choices over whether or not to use support services and have a role in setting their own goals.
- CHF service users have the option to continue drinking and using drugs, they can also refuse to work with psychiatric services, and this does not impact on their right to stay, i.e. people can stay in the housing provided by the service and continue to drink and use drugs, or chose not to engage with mental health services.
- CHF services follow a harm reduction and recovery orientation model.

CHF Philosophy

CHF services do not always operate in the same way as one another. This makes a detailed discussion of CHF philosophy difficult, because CHF services are not consistent. However, it is possible to *compare* the basic CHF philosophy with the PHF philosophy:

- **Housing as a basic human right.** Those CHF services that offer a single room or a semi-private space in a shared environment could be said to provide *accommodation* but are *not* providing housing. In the case of CHF services that offer self-contained studio apartments with secure tenures it could be argued that 'housing' is being provided. Not everyone would necessarily share that view because concentrating formerly homeless people in one place may segregate them and limit their social integration⁷².
- **Respect, warmth and compassion for all clients** (service users). A CHF service does adopt a non-judgemental attitude, with staff treating chronically homeless people as individuals worthy of respect, warmth and compassion.
- **A commitment to working with clients as long as they need.** A CHF service does make an open ended commitment to working with homeless people for as long as they might need the service. Some CHF services will encourage and support people to move on, but they are designed to offer permanent accommodation.

⁷¹ Collins, S.E. *et al* (2011) op cit.

⁷²Tsemberis, S. (2011) op cit.

- **Scattered site housing, independent apartments.** A studio apartment in a CHF accommodation block does give someone their own front door, but it is a front door within a block in which the staff support team and other service users are the only neighbours. The single rooms and the 'semi-private' living spaces offered in some CHF schemes cannot offer the privacy or independence of an apartment. Chronically homeless people using CHF services are also physically isolated from other citizens, rather than living among them in the way that PHF service users do. CHF therefore does *not* offer scattered site housing and independent apartments.
- **Separation of housing and services.** PHF separates housing and services because it gives chronically homeless people 'housing first' without expecting them to accept drug, alcohol and mental health services. A CHF service does not expect homeless people to be 'housing ready'. CHF services will not force service-users to move out if they do not use the drug, alcohol or mental health services which are offered to them. Whether this is comparable to PHF is debatable, because it is sometimes only *accommodation* – or just one type of housing in a block with other service users – that is being offered by the CHF service.
- **Consumer choice and self-determination.** The choices offered by PHF are not limitless, service users have to accept a weekly visit from a support worker, have to follow the terms of their lease or tenancy agreement and have only some choices about where to live set by the available budget. However, the PHF model offers more choice and control than a CHF model because it is designed to provide service users with a range of options about where and how they will live. In addition, service users in a PHF model are physically separated from the mobile support services that are on offer to them, whereas the users of CHF are generally on the same site as the support services. CHF services offer far more 'consumer choice' than a staircase service, because they allows chronically homeless people choices about which services to use and whether or not to drink and use drugs, but they do not allow chronically homeless people any choice about where to live.
- **A recovery orientation and harm reduction**⁷³. CHF services do follow the recovery orientation and the harm reduction approach which together form the seventh and eighth elements of the PHF philosophy.

In summary, a CHF service shares many aspects of the PHF philosophy, but it differs in one important respect, in that some CHF services offer 'accommodation' or a single housing option first, rather than genuine community-based 'housing' first. Such services may offer some security of tenure and may even be a self-contained apartment, but it will be an apartment in an apartment block that is designed only for chronically homeless people. This is not the same as the ordinary apartments that are scattered across a community which are used by PHF services.

The Housing First philosophy and CHF services in Finland

In February 2008, the Finnish government introduced a strategy that was intended to halve long term (i.e. chronic) homelessness. Finland decided on an approach that involved

⁷³ Tsemberis, S. (2010a) op cit, p. 18.

extensive use of a CHF service model⁷⁴ and developed the 2010-2012 'Name on the Door' programme. A key part of the strategy was to redesign and modify what were defined as 'residential homes' (i.e. institutional communal accommodation with on site services) to make them into 'residential units' that would be supported using services that followed a Housing First philosophy. The main goals were⁷⁵:

- to provide secure permanent housing with a tenancy agreement to long-term (chronically) homeless people;
- to reduce the use of conventional homelessness shelters/emergency accommodation by *changing* these services into blocks of supported, rented apartments;
- the prevention of eviction by means of housing advice services and financial support;
- drafting plans for individual rehabilitation and services (i.e. involving chronically homeless people in planning and choosing their own support services);
- provide guidance in the use of normal social welfare and health services (i.e. provide service brokerage services), and
- promote social inclusion for formerly homeless people.

The second goal of the Finnish strategy was very close to the goals of CHF services in the USA⁷⁶. Finland sought to alter the way in which existing communal homelessness services worked by using the PHF philosophy as a reference point. However, while some US service providers sought only to *modify* the operation of existing staircase services, Finland embarked on an extensive programme of refurbishment and new building that was designed to deliver one person apartments for chronically homeless people. There has been some policy within debate in Finland as to how far an approach largely based on a CHF model can fully reflect the philosophy of PHF⁷⁷.

Delivering a Communal Housing First Service

Unlike PHF, there is no standardised or agreed set of guidance on how to deliver a CHF service. This is because CHF services vary in the detail of their operation.

This section looks at the operation of CHF in six respects:

- Which groups of homeless people is a CHF service designed to help?
- What are the aims of a CHF service?
- How is the service accessed?

⁷⁴ Busch-Geertsema, V. (2010) *The Finnish National Programme to Reduce Long-Term Homelessness: Discussion Paper* Peer Review: Finnish national programme to reduce long term homelessness <http://www.peer-review-social-inclusion.eu/peer-reviews/2010/the-finnish-national-programme-to-reduce-long-term-homelessness>

⁷⁵ Luomanen, R. (2010) *Long term homelessness reduction programme 2008-2011* Peer Review: Finnish national programme to reduce long term homelessness <http://www.peer-review-social-inclusion.eu/peer-reviews/2010/the-finnish-national-programme-to-reduce-long-term-homelessness>

⁷⁶ Larimer, M.E. *et al* (2009) *op cit*.

⁷⁷ *Social Innovation Europe* interview with JuhaKaakinen 2011 <http://www.socialinnovationeurope.eu/magazine/local-development-and-communities/interviews/ending-homelessness-finland>

- How is a CHF service delivered?
- What does a CHF service cost?
- Risk management

Which groups of homeless people is a CHF service designed to help?

Like PHF services, CHF services in the USA are designed primarily to help chronically homeless people (see Chapter 2). In Finland, the term 'long-term homeless' is used to describe the group of homeless people that CHF services are designed to help, but this group is defined in a very similar way to 'chronically homeless people' i.e. people with mental health problems, problematic alcohol/drug consumption and other complex support needs which mean they could not access housing without support⁷⁸.

Sometimes, as in Finland, the main target group for CHF services are chronically homeless people who have been in the homelessness shelter system for a long time. CHF services may also be targeted on individuals who are judged to be at risk of chronic homelessness, such as people with a history of homelessness who have high support needs and who are about to leave psychiatric hospital or the prison system without any home of their own to go to. Some CHF services in the USA are focused on chronically homeless people with the very highest support needs only. In practice this means that CHF services are designed for:

- Chronically homeless people who have been using homelessness services for a long time.
- Chronically homeless people with high levels of need associated with mental health problems and problematic alcohol and drug consumption.
- People thought to be at risk of chronic homelessness because of their history and/or their characteristics.

What are the aims of a CHF service?

The key aim of a CHF service is to provide stable housing that will reduce the harm that chronic homelessness has caused to an individual. Alongside providing a stable and secure place in which to live, CHF services are intended to help minimise and where possible reduce mental health problems and the use of drugs and alcohol that are strongly associated with chronic homelessness. In the USA and Finland, services are being used as a replacement for staircase and emergency accommodation services that were found not to be effective in ending the homelessness of most of the people who used them. In both countries, CHF services are primarily used to reduce sustained street homelessness among very vulnerable chronically homeless people. The key objectives are:

- To provide a stable, secure living situation that ends a life of living on the street and in emergency homelessness services.
- To reduce the harm caused by sustained chronic homelessness on the people who

⁷⁸Busch-Geertsema (2010) op cit.

have experienced it, such as poor diet, exposure to the weather and dangers of living on the street and in emergency shelters and health problems associated with being homeless for a long time.

- To reduce the harm of severe mental illness, mental health problems and problematic alcohol and drug use that are often associated with chronic homelessness.
- In the USA, to increase the cost effectiveness of homelessness services by redirecting expenditure on chronic homelessness from homelessness shelters, emergency health services, psychiatric services and the criminal justice system into more effective services. There may also be a goal to reduce expenditure on chronic homelessness by health and criminal justice services.
- In some situations, the reason for using CHF services approaches as opposed to PHF is to provide a lot of affordable housing over a relatively short time frame using existing infrastructure.

One difference in the aims of the Finnish approach is that the CHF services are intended for a chronically homeless population that is viewed as likely to *decline* over time. This is because a range of preventative measures are being put in place to reduce the rate at which people become chronically homeless. Eventually, this could mean that provision of CHF services will be reduced and might, at least theoretically, cease altogether.

How is a CHF service accessed?

Referrals for CHF services come from existing homelessness services and health, mental health and drug and alcohol services as well as from different parts of the criminal justice system. Some services may be focused on a particular population, such as the long-term homeless population in Finland or chronically homeless people who are the heaviest users of medical services in the USA.

How is a CHF service delivered?

The delivery of CHF services can involve the design and building of an entirely new service, such as an apartment block or communal housing with single rooms, which is designed to accommodate and support chronically homeless people with on-site support, care and medical services. The delivery of CHF can involve the modification of existing staircase and other shared or communal accommodation for homeless people. In some cases, a change is made to the design of an existing building, for example a shared sleeping area or single rooms in a former staircase service might be replaced with small apartments. In Finland, the modification of existing emergency and short-term shelters for homeless people into self contained apartments through the *Name on the Door* project has created a form of CHF.⁷⁹

The most important aspect of a CHF service is the use of a 'Housing First' philosophy. A CHF service is different from a staircase or emergency shelter service in five ways:

- Providing housing immediately without any requirement that drug and alcohol use stop.
- The use of a harm reduction approach in response to problematic drug and alcohol use and mental health problems.
- Choice and control being given to chronically homeless people using the service over whether or not they use the drug and alcohol and mental health services that are on

⁷⁹http://www.asuntoensin.fi/en/housing_first/ (website available in Finnish and English)

offer.

- The separation of tenancy and support, meaning that chronically homeless people can stay even if they choose not to use the mental health, drug and alcohol services that are made available.
- Security of tenure.
- An emphasis on non-judgemental approaches to homelessness and homeless people, which is part of providing support within a framework of harm reduction.

Alongside providing accommodation, a CHF service will also offer:

- Support workers who are available on site, sometimes on a 24-hour basis, these workers may help access outside services that are not provided on site, they may also provide low level support, answering questions and providing information as well as listening and talking to service users.
- Drug and alcohol support services that follow a harm reduction philosophy and which are available on site.
- Mental health services that follow a harm reduction philosophy and which are available on site.
- They may be provision of services that are designed to enable social and economic integration, however, the available evidence on CHF services does not suggest these are provided by any service that has been evaluated⁸⁰.

What does a CHF service cost?

The costs of a CHF service will vary considerably. Some services take an existing staircase service and extensively modify its philosophy and approach, changing how the service operates and sometimes the range of supports it offers. What this means in financial terms is difficult to quantify because it will vary between services. Some staircase services have extensive drug, alcohol and mental health services which require an alteration in philosophy, but which may not require any more expenditure, in order to create a CHF service. In other cases, where existing buildings are modified to create a CHF service, or an entirely new building is constructed, the development costs to provide a CHF service can be considerable.

As noted above, while precise or typical costs are not available because CHF services vary considerably, the Finnish programme has created 1,250 units of CHF accommodation and some other housing at a cost of some €201.1 million⁸¹. In the USA, a CHF service for which a purpose built building was developed cost some \$12 million in building and setting up costs, with an estimated additional typical daily cost of \$37 (€28) per day for providing services to each service user⁸².

As is the case with PHF services, CHF is not necessarily cheaper than existing homelessness services (see further discussion under Evidence of Effectiveness). CHF services can be relatively expensive to develop and to deliver. While there is evidence that CHF either cost no more than the existing expenditure on chronic homelessness by health

⁸⁰*Social Innovation Europe* interview with JuhaKaakinen 2011 <http://www.socialinnovationeurope.eu/magazine/local-development-and-communities/interviews/ending-homelessness-finland>

⁸¹ Luomanen, R. (2010) op cit

⁸²Larimer, M.E. *et al* (2009) op cit.

and criminal justice services and may in some cases (particularly when working with people with particularly high support needs) cost less overall, CHF services are not a 'low cost' homelessness service.

Risk management

CHF services differ from PHF services in how they are able to manage risk and in the nature of the risks they face. One difference is that unlike PHF services, a CHF service can continually monitor the well-being and behaviour of a formerly chronically homeless person because the support services are either in the same building or are very close by. This may be more of a challenge for PHF services, which can be some distance away from a formerly chronically homeless person who is living in an apartment in an ordinary neighbourhood. This might mean that the management of risks associated with formerly chronically homeless people with very high support needs may be less challenging for a CHF service than is the case for a PHF service. However, risk management is not a part of CHF service delivery which has been evaluated systematically or which has been directly compared with PHF services.

Although it may be easier to monitor chronically homeless people in a CHF service and for services to reach them very quickly if a problem or emergency occurs, the communal nature of CHF services can also present challenges for risk management. The challenges centre on several or many formerly chronically homeless people sharing communal living areas or living next to each other in self-contained apartments. In Finland, there are some concerns that the disruptive behaviour of some individuals, or the disruptive behaviour of groups of chronically homeless people associating with one another, may be having a detrimental effect on the effectiveness of CHF services⁸³. The perceived risk in Finland has two aspects. First, there is a concern that exposure to other drug and alcohol users may make the process of reducing harm associated with drug and alcohol consumption more difficult in CHF services and second, some chronically homeless people might find some CHF services rather distressing environments in which to live.

Summary of CHF service delivery

The CHF service model can be summarised as follows:

- CHF services are focused on chronically homeless people. These services are delivered in communal buildings that are only lived in by people using the CHF service. This can be single rooms with shared living areas or individual self-contained apartments in an apartment block. The accommodation has often been modified, or designed, to provide a service for chronically homeless people. Support and medical services are situated in the same building or are very nearby.
- CHF provides communal housing in a shared building with security of tenure immediately to a chronically homeless person.
- CHF directly provides psychiatric, drug and alcohol services and medical services and may also use service brokerage to arrange access to other services.

⁸³Kettunen, M. and Granfelt, R. (2011) op cit.

- CHF services give considerable choice and control to chronically homeless people as part of following a harm reduction model. If chronically homeless people opt not to use the services that are on offer, or choose not to stop drinking and using drugs, this does not place their housing in the CHF service under threat.

Evidence on effectiveness

Housing stability

Some CHF services do not deliver true 'housing' stability because they do not offer self-contained housing. CHF services may provide a single room or semi-private area in a shared block that is accommodation rather than "ordinary" housing. The evidence on CHF services in the USA shows that these services do create a stable living situation, in that most of the service users do not often return to homelessness⁸⁴. CHF services can end sustained street homelessness and also sustained use of emergency beds in homeless shelters, but while the chronically homeless people using these services are accommodated, it is sometimes difficult to see them as being 'housed' in the sense that an ordinary citizen in their own apartment is 'housed'.

The extent to which CHF services are providing 'housing' when they offer self contained apartments that are available only to chronically homeless people using the CHF service is debatable. By some criteria, CHF services like some of those in Finland are offering 'housing' because people using the service are provided with their own apartment and have some security of tenure. Yet these services do not offer any choice about where to live, the 'housing' is only accessible to people using the service and is physically separated from the rest of the community because it is in one or more purpose built or converted buildings. Staff providing services will also often be on site. From some perspectives, these services are delivering 'housing' stability, from others, such as that of Sam Tsemberis, the founder of PHF, these services are not actually offering what most ordinary citizens would recognise as 'housing' and therefore only delivering 'accommodation' stability⁸⁵.

In Finland, success has been reported in creating greater stability in housing or accommodation for long term homeless people. Again, it is important to note that Finnish services that follow a CHF model may offer long term, secure, tenure that is not always intended to be permanent. There can be encouragement for some service users to move on to fully independent apartments in the community. Since the introduction of a 'Housing First' strategy in Finland, overall levels of *long-term* homelessness have either been reduced, or been halved, in the participating municipalities⁸⁶. However, it has also been noted that some

⁸⁴ Larimer, M.E. *et al* (2009) op cit; Hanratty, M. (2011) 'Impact of Heading Home Hennepin's Housing First programs for long-term homeless adults' *Housing Policy Debate* 21,3, pp. 405-419.

⁸⁵Tsemberis, S. (2011) *Observations and Recommendations on Finland's "Name on the DoorProject" From a Housing First Perspective* Housing First Finland http://www.asuntoensin.fi/files/1242/Tsemberis_2011_-_Observations_and_Recommendations.pdf

⁸⁶Kettunen, M. and Granfelt, R. (2011) *Observations from the first year of the Finnish Name on the door project – recommendations for the long-term homelessness reduction programme for years 2012-2015* http://www.housingfirst.fi/en/housing_first/reading_room/general_reading/observations_and_conclusions/ Note: While the programme has had a specific effect in reducing long-term homelessness, overall homelessness levels in Finland have not yet fallen.

of the reports of higher rates of stability are anecdotal and that there are not as yet extensive data showing sustained stability in accommodation or housing⁸⁷.

Changes in Drug and Alcohol Use

The research available on CHF services in the US suggests a pattern of stabilisation and at least some reduction in drug and alcohol use, which is similar to the results reported for PHF. Two studies found that CHF services that allowed chronically homeless people to drink alcohol in their rooms saw this pattern, but again, did not report that alcohol consumption had actually stopped among most service users.⁸⁸

Evidence on the Finnish experience is mixed. Some reports suggest that there has been a reduction in alcohol consumption in some CHF services in Finland⁸⁹. Other research has indicated that management of high levels of drug and alcohol use among some residents of CHF services has sometimes been problematic, in that tolerance of high levels of drug and alcohol use in what is communal housing has sometimes been difficult to manage. There are some concerns about high rates of drug and alcohol use in blocks of CHF apartments and it is being suggested that more provision should be made to enable people to move away from CHF services and into their own independent apartments⁹⁰. These arguments are linked to a possible limitation of CHF services in respect of drug and alcohol use, the evidence that exposure to high levels of use (and therefore to various sources of supply) can make reduction and recovery from problematic alcohol and drug use more difficult for some people⁹¹.

Changes in mental health

US research does not suggest that CHF services deliver significant improvements in mental health, although there is no evidence to suggest that mental health deteriorates as a consequence of using CHF services⁹². There is also some evidence showing that use of emergency mental health services is significantly reduced among chronically homeless people using some CHF services⁹³.

There has not been a detailed evaluation of the impacts of the Finnish Housing First programme using CHF services on mental health. As already noted, there are some emerging concerns about whether CHF services containing a number of long term homeless people with high support needs are always suitable places in which to recover from mental health problems, as well as from problematic drug and alcohol use⁹⁴.

Social and economic inclusion

There is no clear evidence that CHF models promote either social or economic inclusion.

⁸⁷ Busch-Geertsema, V. (2010) op cit.

⁸⁸ Larimer, M.E. *et al* (2009) op cit; Collins, S.E. *et al* (2011) op cit.

⁸⁹ Luomanen, R. (2010) op cit, p. 31.

⁹⁰ Kettunen, M. and Granfelt, R. (2011) op cit.

⁹¹ Pleace, N. (2008) op cit.

⁹² Sadowski, L.S.; Kee, R.A.; Vanderweele, T.J. *et al.* (2009) 'Effect of a Housing and Service brokerage Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomised Trial' *Journal of the American Medical Association* 301, 17, pp. 1771-1778.

⁹³ Larimer, M.E. *et al* (2009) op cit.

⁹⁴ Kettunen, M. and Granfelt, R. (2011) op cit.

The chronically homeless people using CHF services are accommodated in physically separate blocks, which in at least some cases are architecturally distinct from surrounding buildings and houses. Promoting economic inclusion, in the sense of enabling people into work related activity, education, training or paid employment can present a challenge for any service providing support to chronically homeless people, though dedicated employment programmes have achieved some positive outcomes⁹⁵. In Finland, there has been some discussion of how to socially and economically include people living within CHF services⁹⁶.

Cost effectiveness

There is evidence from the US and from Finland that CHF services can generate significant 'cost offsets'. These 'cost offsets' are reductions in expenditure on emergency medical services, including drug and alcohol and mental health services as well as hospital emergency facilities, and the result of less contact with criminal justice systems by chronically homeless people. When in stable and secure accommodation, chronically homeless people generally have less contact with emergency services, with the police and also make much less use of emergency homelessness shelters⁹⁷. Development and running costs for some US and Finnish CHF services tend to be quite high, with a US study indicating savings of some \$12 million (€9.1 million) from a new CHF service that had cost \$11 million to develop (€8.3 million)⁹⁸ and the Finnish programme providing 1,250 units of CHF and other housing at a cost of some €201.1 million⁹⁹.

⁹⁵ Burt, M.R. (2007) *Evaluation of LA's HOPE: Ending Chronic Homelessness through Employment and Housing Final Report* Los Angeles: City of Los Angeles Community Development Department

⁹⁶ *Social Innovation Europe* interview with JuhaKaakinen 2011 <http://www.socialinnovationeurope.eu/magazine/local-development-and-communities/interviews/ending-homelessness-finland>

⁹⁷ Culhane, D.P. *et al* (2008) *op cit*.

⁹⁸ Larimer, M.E. *et al* (2009) *op cit*.

⁹⁹ Luomanen, R. (2010) *op cit*

4 Housing First ‘Light’ Services

Introduction

In both Europe and in the USA, there are low-intensity homelessness services that use mobile workers to support formerly and potentially homeless people living in independent apartments. These services were sometimes developed at the same time as the PHF service but there are also some services that were operating before PHF existed. This group of services has either adopted parts of the PHF philosophy or have independently developed a philosophy that is similar to the ideas of Housing First. This chapter describes the origins of what this chapter terms ‘Housing First Light’ (HFL) services, explores the differences between HFL and PHF services, provides a description of how HFL services are delivered and finally looks at the evidence on the effectiveness of HFL services.

It is important to note that this chapter describes a range of services that operate in broadly similar ways, rather than providing a description of a single, specific type of service.

Origins

HFL services immediately provide housing with security of tenure to homeless people and support them in their own housing by using low-intensity mobile support services. In the UK, low intensity mobile services were first developed to resettle people who had been long-term residents of large dormitory homelessness services¹⁰⁰. These services were then used by social housing providers to stop housing management problems including rent arrears, nuisance behaviour and abandonment of housing by ‘vulnerable’ homeless people¹⁰¹. HFL services then began to *replace* the use of emergency accommodation for homeless people with high needs, using immediate access to housing with low intensity mobile support. Eventually these services extended beyond the social housing sector and began using both social and private rented housing, becoming the single most common form of homelessness service in the UK¹⁰². In the USA, HFL services have been used in experiments looking at alternatives to the staircase services that failed to end the majority of chronic homelessness¹⁰³.

What are HFL services?

HFL services are not a single type of service. These services have sometimes been developed with reference to the PHF philosophy and have sometimes been developed

¹⁰⁰Dant, T and Deacon, A (1989) *Hostels to Homes? The Rehousing of Single Homeless People* Aldershot: Avebury

¹⁰¹ ‘Vulnerable’ homeless people had priority access to social housing under the terms of the 1977/1978 homelessness laws (this group included many chronically homeless people) see Pleace, N. (1995) *Housing Single Vulnerable Homeless People* York: University of York <http://www.york.ac.uk/inst/chp/publications/PDF/pleace.pdf>

¹⁰² Pleace, N. and Quilgars, D. (2003) *Supporting People: Guide to Accommodation and Support Options for Homeless Households* London: Homelessness Directorate; Johnsen, S. and Teixeira, L. (2010) op cit.

¹⁰³Tabol, C.; Drebing, C. and Rosenheck, R. (2009) ‘Studies of “supported” and “supportive” housing: A comprehensive review of model descriptions and measurement’ *Evaluation and Program Planning* 33 pp. 446-456; Caton, C.L.M.; Wilkins, C. and Anderson, J (2007) ‘People who Experience Long Term Homelessness: Characteristics and Interventions’ Paper given at the *National Symposium on Homelessness Research* and accessed on 6th September 2010 at <http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm>

wholly independently without reference to the ideas of Housing First. The term 'Housing First Light' is used to refer to this group of services in this document, but in the countries in which these services operate they are known as 'supported housing' services, as 'resettlement services' as 'tenancy sustainment' and as 'homelessness support services' and sometimes referred to using other terminology¹⁰⁴. All services of this type share a number of broad characteristics:

- Like PHF and CHF services, these services provide 'housing first', meaning that homeless people are placed immediately (or as quickly as possible) into independent housing without any requirement that they are 'housing ready'. Sometimes this housing is scattered throughout a municipality, city or region, sometimes it is concentrated in specific apartment blocks. HFL services provide access to housing in several ways
 - An HFL service might be provided directly by a social housing provider and use its own social housing stock.
 - An HFL service may function independently and work in cooperation with social housing providers and private rented housing providers to provide homeless people with housing.
 - An HFL service may not have direct access to any housing, instead it will provide support to a homeless person or household so that they are able to access private rented or social housing.
- Housing is separated from support, meaning that access to housing and security of tenure is not linked to whether or not a homeless person accepts the support services that are offered, including mental health and drug and alcohol services.
- There is no requirement for abstinence from drug and alcohol use.
- HFL services use a *service brokerage* model, i.e. support workers enable access to mainstream health and welfare services for homeless people, ensuring they receive all the support they are entitled to. Support workers might also arrange access to specialist services, such as drug and alcohol detoxification or psychiatric services¹⁰⁵. HFL services might also facilitate access to education, work-related and employment related services, as well as services designed to promote social inclusion.
- HFL services use *low* intensity support, centring on service brokerage and on limited support with housing-related needs. Alongside arranging access to welfare and health services, an HFL worker might also provide advice and assistance with dealing with electricity bills, ensuring the rent is paid and ensuring a homeless person is eating healthily. A worker might only see a homeless person using an HFL service once a week, or less, and HFL services are often designed to gradually withdraw support as a homeless person becomes better equipped to live independently.
- An HFL service can be used for homeless people with a *range* of support needs.

¹⁰⁴ Tabol, C. *et al* (2009) op cit.

¹⁰⁵ Goldfinger, S. M., R. K. Schutt, *et al* (1999) 'Housing placement and subsequent days homeless among formerly homeless adults with mental illness' *Psychiatric Services* 50, 5 pp. 674-9; Hickert, A.O. and Taylor, M.J. (2011) 'Supportive Housing for Addicted, Incarcerated Homeless Adults' *Journal of Social Service Research* 37, pp. 136-151

This means that an HFL service may support chronically homeless people but that it may also support homeless people with *lower* levels of support need.

- An HFL service can be focused partially or largely on homelessness *prevention*, such as some UK ‘tenancy sustainment services’, targeting people who have been identified as at risk of homelessness who have not actually ever been homeless.

Services following this basic model operate in a number of EU member states¹⁰⁶. However, the extent of these services is difficult to map because, with the exception of France,¹⁰⁷ and a few other countries, databases of homelessness services are often not available at the national level. As noted, services of the HFL type are the most common form of homelessness service provided in the UK¹⁰⁸, but these services are less common than staircase services in the USA and may be less common than CHF services¹⁰⁹.

HFL philosophy

HFL services vary in how they operate and in the range of support that they provide¹¹⁰. As noted above, it is important to remember that although the term ‘Housing First Light’ is used in this document, there are services of this type that were developed independently of the ideas of Housing First and, while they reflect the philosophy of Housing First, were operating before ‘Housing First’ services appeared. This makes a detailed discussion of HFL philosophy difficult, because HFL services are not consistent, but it is possible to *compare* broad ‘HFL’ philosophy with the PHF philosophy:

- **Housing as a basic human right.** HFL services work by immediately providing or arranging housing for homeless people. These services may operate by providing mobile support services to a single apartment block, but HFL services can use apartments or houses scattered throughout a municipality or city.
- **Respect, warmth and compassion for all clients** (service users). An HFL service does adopt the same non-judgemental attitude as PHF, with staff treating homeless people as individuals worthy of respect, warmth and compassion.
- **A commitment to working with clients as long as they need.** An HFL service can make an open ended commitment to working with homeless people for as long as they might need the service. HFL services will often encourage and support people to live independently and may be designed with the intention that support levels are reduced over time. Some HFL services operate with time limits, providing support for a set period of six or nine months. This use of set time periods of support has sometimes been discouraged, as the needs of homeless people are not predictable, with more flexible arrangements being encouraged¹¹¹. For example, arrangements by which support can be quickly redeployed in the case of a crisis.
- **Scattered site housing, independent apartments.** Many HFL services do provide scattered, independent apartments. The extent to which they offer choice about

¹⁰⁶Busch-Geertsema, V. (2005). "Does re-housing lead to reintegration? Follow-up studies of re-housed homeless people." *Innovation* 18, 2, pp. 202-226.

¹⁰⁷ Marpsat, M. (2007) 149 *Documents de travail Services for the Homeless in France: Description, official statistics, client recording of information* INED

¹⁰⁸Centre for Housing Research (2010) *Supporting People Client Records and Outcomes: Annual Report 2009-2010* (St Andrews: University of St Andrews).

¹⁰⁹ Tabol, C. *et al* (2009) *op cit*.

¹¹⁰ Tabol, C. *et al* (2009) *op cit*; Pleace, N. and Quilgars, D. (2003) *op cit*; Jones and Pleace (2010) *op cit*; Busch-Geertsema *et al* (2010) *op cit*.

¹¹¹Pleace, N. and Quilgars, D. (2003) *op cit*.

where to live may vary. Some services primarily make use of private rented housing, while others may be more reliant on social housing, which can limit the range of housing options available to homeless people. Some HFL services may group homeless people together in neighbourhoods or in apartment blocks, which does not reflect the PHF philosophy.

- **Separation of housing and services.** An HFL service provides access to housing with security of tenure without a requirement that service users use drug and alcohol services or mental health services. Unlike PHF services, HFL services rely primarily on service brokerage, rather than using a mixture of directly provided health and support services and service brokerage.
- **Consumer choice and self-determination.** As is the case for PHF services, HFL services do not offer limitless housing choices. There will be a requirement to agree to the terms of a lease for their housing and there may also be a requirement to agree to a minimum number of visits by a support worker.
- **A recovery orientation and harm reduction.** HFL services do follow the recovery orientation and the harm reduction approach, which together form the seventh and eighth elements of the PHF philosophy.

In summary, an HFL service shares many aspects of the PHF philosophy. However, HFL services may not fully adopt all eight key aspects of the PHF philosophy, compromising on issues such as the duration for which support is provided or the extent to which apartments are scattered. As is the case with CHF services, a less than complete adoption of the PHF philosophy would not be seen by Pathways as meaning that a service could truly be a form of 'Housing First'¹¹². The point at which a service becomes, or ceases to be, Housing First is debatable. However, HFL services *are* 'housing first' in the sense that they separate housing and support, do provide 'housing first' and adopt a non-judgemental harm reduction led approach. For these reasons, HFL services can be viewed as following much of the PHF philosophy.

Delivering a Housing First Light Service

This section looks at the operation of HFL services in six respects:

- Which groups of homeless people is a CHF service designed to help?
- What are the aims of a HFL service?
- How is the service accessed?
- How is a HFL service delivered?
- What does a HFL service cost?
- Risk management

Which groups of homeless people is a CHF service designed to help?

HFL services can be used to support chronically homeless people. HFL services are also employed to support *other* groups of homeless people with varying levels of need. These other groups of homeless people can include:

- **Individuals and households assessed as being at risk of homelessness but who have not actually become homeless.** This might include people whose support needs have placed their housing stability at risk, for example because

¹¹²Tsemberis, S. (2011) op cit.

they have not paid rent or created a nuisance due to mental health problems or problematic drinking of alcohol. Some HFL services can be largely or entirely focused on this form of homelessness *prevention*.

- **Groups of homeless people with particular needs.** For example HFL services might be focused on young homeless people, homeless and potentially homeless people with mental health problems or homeless families and use workers who are specifically trained for that group of homeless people. An HFL service for homeless families might, for example, include workers who were familiar with providing parental support, education and social services for children.

In the USA, the Homelessness Prevention and Rapid Re-housing Program (HPRP) uses what can be broadly defined as an HFL model alongside direct financial support of families and other households who are risk of becoming homeless. Workers are provided for a period of up to 18 months for households at risk of becoming homeless and provide service brokerage that is focused on ensuring housing stability for the household at risk of becoming homeless¹¹³. In the UK, there are examples of HFL services that are focused on specific groups, such as HFL services for homeless families containing someone with high support needs and HFL homelessness prevention services for people who are at risk of homelessness because of nuisance behaviour means they are threatened with eviction¹¹⁴.

What are the Aims of a HFL Service?

The primary aim of an HFL service is to ensure housing stability. HFL services are designed to either prevent a return to homelessness for people who have already been homeless, or to prevent a potentially homeless person or household from becoming homeless.

An HFL service may have a number of secondary aims, which may be specific to the particular groups of homeless people and potentially homeless people it is designed to assist. For example, an HFL service working with chronically homeless people will have the goal to minimise the risks to housing stability from severe mental illness and problematic drug and alcohol use through the use of service brokerage to arrange the necessary mental health and drug and alcohol services. By contrast, an HFL service for young homeless people might concern itself particularly with the social and economic exclusion of the young people it is working with, focusing on access to education, training and employment as well as promoting housing stability.

The aims of an HFL service can include:

- Promoting housing stability.
- Reductions and where possible cessation of problematic drug and alcohol use (if present).
- Reductions in criminal behaviour (if present).
- Reduction and where possible an end to severe mental illness and mental health problems among service users (if present).
- Improve physical health by emphasizing well-being and ensuring contact with medical services where necessary.
- Reengagement with normal social and community life, developing friendships, re-

¹¹³<http://www.hudhre.info/index.cfm?do=viewHprpProgram>

¹¹⁴Jones, A. *et al* (2002) *Firm Foundations: An evaluation of the Shelter Homeless to Home service*, London: Shelter; Jones, A. *et al* (2006) *Addressing Antisocial Behaviour: An independent evaluation of the Shelter Inclusion Project*, London. Shelter.

establishing family ties where possible and developing and sustaining successful personal relationships.

- Engagement with work related activity, including productive activity that is similar to work, education and training as well as securing paid work where this is possible and practical.

How is an HFL service accessed?

As the operation, focus and nature of HFL services is subject to variation, there is no set mechanism by which referrals are made to HFL services. Some HFL services may accept referrals from homelessness services including emergency shelters; daycentres or soup kitchens and HFL services may also work in cooperation with mental health and social work services. Some HFL services are operated by social housing providers and may be accessed primarily by new tenants who have been homeless and existing tenants who may be at risk of homelessness. It is possible that individuals may be able to self refer to some services, but this will depend on the specific arrangements and which groups of homeless people an HFL service is working with.

How is an HFL service delivered?

HFL services use a combination of mobile support workers and ordinary housing. An HFL service moves homeless people into housing immediately or as soon as possible, and/or seeks to stabilise the situation of a potentially homeless person who is at risk of losing their existing home when it has a homelessness prevention role. As noted, HFL services are primarily low intensity support services that rely heavily on service brokerage. The mobile support workers employed by an HFL service will provide:

- Low intensity support with the domestic management of a home, this might include:
 - Advice and support in claiming welfare benefits
 - Advice and support on cooking healthy meals
 - Advice and support on managing household bills
 - Advice and support on managing any existing debt
 - Support in securing furniture, kitchen appliances such as cookers and fridges for unfurnished housing (some services may provide furnished apartments).
- Service brokerage, which can include helping service users to access to health care, psychiatric services, drug and alcohol services, social work support, legal advice, education, training, debt and money management advice and education, training and employment related services.
- Low intensity support with issues such as isolation and boredom, though this will not necessarily be offered by all HFL services.

An HFL service will *not* directly provide any of the following services, though, as noted, an HFL service will seek to arrange access to these services via service brokerage, when these forms of support are required:

- Psychiatric services.
- Health care.
- Drug and alcohol services.

- Social work support.
- Education, training and employment related services.
- More intensive support with social isolation.

One large American research review suggests some core components that are a necessary part of any HFL service¹¹⁵:

- Settled housing should be provided *immediately*. Homeless people have a right to housing and without housing in place successful and sustained exits from homelessness will not be possible.
- Housing provided should be affordable, adequate and located in a suitable neighbourhood.
- No requirements or conditions about staying in housing.
- Housing and mobile support services are separate.
- Support staff are a mobile team, they are physically separate from where service users live.
- Choice in housing options for service users.
- Housing provided should be integrated with housing for non-service users (i.e. it is scattered across a community and not within one apartment block, this is not an approach followed by all HFL services).
- Housing is long term or permanent.
- Normal tenancy agreements are used.
- Housing does not look any different from housing around it (appearance fits with neighbourhood).
- Service users have privacy (own front door).
- Individualised and flexible social support.
- 24/7 crisis cover.
- Services are nearby.
- Shared decision making, i.e. person-centred planning and person-centred delivery of services, which involves homeless people in the choices made about the services they are offered and provided with.

This list of minimum requirements does not list the duration of the service, which in the case of PHF and CHF models is not fixed. Alongside the other elements necessary to deliver an HFL service, setting no limit on the time for which formerly chronically homeless people can have support might also be included as an essential part of an HFL service.

What does an HFL service cost?

HFL services do not exist in one form and have not been subject to extensive systematic

¹¹⁵Tabol, C. *et al* (2010) p.448 op cit. This work reported a concern that HFL services in the USA were not consistent and sought to describe what were thought to be the key components of a successful service.

evaluation, which means that it is difficult to be precise about costs¹¹⁶. The direct cost of providing an HFL service can be quite low, as the service provision centres on a mobile team of support workers, which means that an office base, salary costs, administrative support and a travel budget are the main forms of expenditure. Unlike a PHF service, HFL does not directly employ highly qualified staff such as psychiatrists or nurse practitioners and unlike a CHF service, there is no expenditure on developing or renovating a specially designed building in which to house homeless people and support services.

An HFL service will however also generate additional costs for other services. Service brokerage by HFL services enhances access to health, social work, drug and alcohol services and a wide range of other service provision for homeless and potentially homeless people, raising the expenditure for those services. There is the potential that an HFL service may still reduce total expenditure by other services, because service brokerage is being used, rather than expensive emergency provision. For example, it is cheaper for health services for an HFL to enable access to a family doctor for a homeless person through service brokering than to have a homeless person seek treatment in the emergency facilities in a hospital. The promotion of housing stability may also improve mental health, help stabilize drug and alcohol consumption and reduce contact with the criminal justice system in much the same way as for PHF services.

Risk Management

There are a number of risk management issues that are present when supporting vulnerable people with complex needs in the community. These issues centre on the potential that someone might overdose, commit harm to themselves or to others or become seriously ill and not be able to summon assistance. Some HFL services will seek to manage these risks through the assessment process, not allowing homeless people who are judged to represent a risk that cannot be properly monitored or managed by an HFL service.

In some cases, HFL services supporting people with different levels of need will provide relatively more support to people judged to represent a higher risk and relatively less support to those who are judged to be low risk. The mobile support workers will also maintain contact and check on the well-being of people using the service on a regular basis. A well run HFL service should use service brokerage to ensure that where risks are present that the homeless or potentially homeless person concerned has specific support in place. For example, if someone has risks associated with severe mental illness, HFL workers should ensure that person is being monitored and cared for by appropriate psychiatric services. The techniques used to manage risk in HFL services can be summarised as:

- Using assessment processes to ensure that individuals or households who represent a risk that is difficult to manage are referred to more appropriate services.
- Using service brokerage to ensure that, where risks linked to health or support needs are present, that appropriate external services are in place to monitor and manage those risks.
- Monitoring of the well-being of service users through contacts and visits by mobile support workers.

Summary of the HFL service model

¹¹⁶Tabol, C. *et al* (2010) *op cit*

The HFL service model can be summarised as follows:

- HFL is delivered by using ordinary private rented or social housing and a team of mobile support workers.
- HFL provides housing with security of tenure immediately or as soon as possible to a homeless person.
- HFL may be used to help *prevent* homelessness where an individual or household who has never been homeless is assessed as being at risk of homelessness.
- HFL provides low-level mobile support services designed to help promote housing stability.
- HFL uses service brokerage to arrange access to psychiatric, drug and alcohol services and medical services where these are required and may also use service brokerage to arrange access to education, training and other services where these are needed.
- HFL services do not directly provide medical, psychiatric or drug and alcohol services.
- HFL can support chronically homeless people but may also be used for other groups of homeless people, including homeless people with *lower* support needs. The other groups that might be targeted by HFL services can include young homeless people and homeless families.
- HFL services give considerable choice and control to homeless people as part of following a harm reduction model. If homeless people do not use the medical and support services which can be arranged, or choose to continue drinking alcohol and using drugs, this does not place their housing under threat.

Evidence on effectiveness

Housing stability

There is some evidence that HFL services can deliver housing stability by using low-intensity support and service brokerage. While the UK has achieved sustained reductions in chronic homelessness, direct evidence on the effectiveness of the HFL services used in the UK is either out of date, or limited to statistical data collected at the point at which homeless people ceased to use HFL services¹¹⁷. More comprehensive evidence on HFL services is available in the US which suggests high rates of housing stability for formerly chronically homeless people can be delivered by these services¹¹⁸.

It is important to remember that HFL services are much more *reliant* on external services, particularly when supporting chronically homeless people, because they do not provide as many services as PHF or CHF. The HFL service brokerage model requires external

¹¹⁷Centre for Housing Research (2010) op cit.

¹¹⁸Edens, E.L.; Mares, A.S.; Tsai, J. and Rosenheck, R.A. (2011) 'Does Active Substance Use at Housing Entry Impair Outcomes in Supported Housing for Chronically Homeless Persons?' *Psychiatric Services* 62, 2, pp. 171-178; Tabol, C. *et al* (2009) op cit; Hickert, A.O. and Taylor, M.J. (2011) op cit.

psychiatric services, drug and alcohol services and other services to be available so that the HFL support workers can connect homeless people to those services. An HFL service therefore requires a 'service rich' environment, as it cannot function well without access to the services homeless people and chronically homeless people need. This is because the mobile support workers cannot provide all the support homeless people need themselves and use service brokerage to arrange it. Research within the UK has linked failures within HFL services to required external services being underfunded (and thus difficult to access) or because external services, such as health and social work, failed to cooperate with an HFL service¹¹⁹. This means that success in delivering housing stability for an HFL service is far more dependent on what other services are available to homeless people than is the case for a PHF or CHF service.

Changes in Drug and Alcohol use

The evidence on HFL services is less extensive than for PHF and CHF services. However, there is some research that suggests a similar pattern exists, in that alcohol and drug use stabilise and may fall, but tend not to stop altogether among homeless people using HFL services. Some research has emphasised that HFL services can achieve high rates of housing stability without there being any expectation of abstinence from drugs or alcohol¹²⁰. There is no systematic evidence that HFL services increase drug or alcohol use.

Changes in Mental Health

There is evidence that housing with security of tenure is of benefit to mental health and well-being, but there is no systematic research on the impact of HFL services on mental health. Some statistical evidence from the UK indicates improvement in mental health among homeless and potentially homeless people using HFL services, but these data do not employ recognised and validated clinical measures¹²¹. Having housing with some security of tenure will often benefit mental health, as feeling that there is nowhere secure to live can undermine mental health, but this is only if that housing is adequate and feels safe. Housing with some security of tenure that is in poor condition or in a location that feels unsafe, for example because of high levels of crime, will not benefit mental health¹²². In other words, much may depend on what sort of housing an HFL service is able to arrange for someone with mental health problems.

Social and economic inclusion

Some statistical evidence from the UK indicates that improvements in social and economic engagement do occur when homeless and potentially homeless people are using HFL services. However, these statistics are not based on tested measures of social or economic inclusion and cannot be assumed to be robust, the indicators used are also very restricted. What evidence there is suggests limited gains in social inclusion but no effect on economic inclusion¹²³. There is no systematic evidence on the extent to which HFL services may

¹¹⁹Pleace, N. and Quilgars, D. (2003) op cit.

¹²⁰Tabol, C. *et al* (2009) op cit; Hickert, A.O. and Taylor, M.J. (2011) op cit.

¹²¹Centre for Housing Research (2010) op cit.

¹²²Dupuis, A. and Thorns, D. (1998) Home, home ownership and the search for ontological security, *Sociological Review*, 48, pp. 24-47.

¹²³Centre for Housing Research (2010) op cit.

influence social and economic inclusion.

Cost effectiveness

HFL services have not often been subject to detailed cost analysis¹²⁴. The total costs are difficult to calculate because of the reliance of HFL services on service brokerage, as while the costs of delivering an HFL service can be calculated, the HFL will create costs elsewhere as it connects homeless and potentially homeless people to health, social care and welfare services, as well as to other support services. In addition, as HFL services are also used as a homelessness prevention service for people who are risk of homelessness, but who have not actually been homeless, cost effectiveness can be difficult to assess because it involves projection of the costs of homelessness that was thought to be at risk of occurring, but which did not actually occur.

There is the potential for HFL services to reduce overall costs on the same basis as for PHF and CHF services, simply creating housing stability appears to reduce the use of emergency medical services and reduce the rate of contact that some homeless people have with the criminal justice system. However, PHF and CHF have their cost effectiveness assessed on the basis of working with chronically homeless people, individuals who tend to have a high financial cost for emergency services. HFL services would seem likely to generate similar savings if working with chronically homeless people, but, as is the case with PHF services, the savings may be less obvious if the homeless people with whom a HFL service is working have lower support needs. This is because homeless people with lower support needs may make much less use of emergency health services and have less or little contact with the criminal justice system, so delivering housing stability for this group may generate less of a financial saving. As noted above, there are strong humanitarian reasons for not assessing the effectiveness of HFL and other Housing First services in simply financial terms¹²⁵.

¹²⁴Tabol, C. *et al* (2009) op cit; Hickert, A.O. and Taylor, M.J. (2011) op cit.

¹²⁵Culhane, D.P. (2008) op cit

5 Housing First in France

Introduction

This final chapter considers the applicability of the Housing First service model to France. The chapter begins by looking at the global influence of Housing First. The second part of the chapter considers some of the questions about the applicability of the Housing First approach to France. The chapter concludes by listing three reasons why it is worth considering using Housing First services in France.

The Global Influence of Housing First

During the 1980s, enduring street homelessness and sustained use of shelter beds among a small group of people with very high support needs appeared in many societies with advanced welfare systems¹²⁶. This 'chronic homelessness' was a difficult problem to solve. Policy failure occurred at four levels:

- Chronically homeless people sometimes became semi-permanently resident in staircase services or other supported housing which failed to re-house them.
- Chronically homeless people often became caught in a 'revolving door', repeatedly returning to homelessness after making use of services, such as staircase services, that, while they temporarily stopped street homelessness, did not provide a lasting solution.
- A small number of chronically homeless people were not reached by any services or abandoned staircase services because of their strict regimes and requirement for abstinence from drugs and alcohol. This remained in the emergency beds in homelessness shelters for very long periods, restricting the capacity of homelessness shelters.
- Public expenditure on attempts to counteract chronic homelessness was often considerable but was – at best - only partially effective.

In New York in the 1990s, Pathways Housing First achieved something that had not been achieved before. The PHF service targeted chronically homeless people and produced lasting housing stability for the majority of this group of very vulnerable people, using a mix of ordinary private rented apartments and mobile support services. As variations of the Housing First model were introduced elsewhere in the USA, including Communal Housing First and Housing First Light models, similar successes in achieving housing stability were reported.

The level of success that Housing First services have shown in delivering housing stability for chronically homeless people has never been seen before. It is this success that has led to Housing First being incorporated in homelessness strategies in Denmark, Finland, Portugal, the Netherlands and Ireland, as well as within France.

Housing First has become very influential because it is the first homelessness service that can clearly demonstrate that it provides an *enduring* solution that provides housing stability for the majority of chronically homeless people. There is strong evidence that Housing First does what no other homelessness service has managed to achieve, providing *lasting*

¹²⁶Daly, G.P. (1996) *Homeless: policies, strategies, and lives on the street* London: Routledge.

solutions to the most *extreme* form of homelessness.

The Jury for the *European Consensus Conference on Homelessness* held in Brussels in December 2010. The Jury recommended that 'housing-led' approaches were the most effective solution to homelessness and that the different forms of Housing First service were examples of these services¹²⁷. The Jury identified as 'housing-led' all those approaches to homelessness which focus on:

- Access to permanent housing as the primary response to all forms of homelessness.
- Prevention of loss of housing.
- Provision of adequate mobile support services on the basis of need.

Questions About Using a Housing First Approach in France

Housing First services can deliver housing or accommodation stability for most chronically homeless people, something that has not been achieved by other homelessness services. This achievement makes the Housing First model worthy of consideration in France.

The other arguments in favour of Housing First centre on two sets of benefits:

- Some evidence that housing stability has a positive effect on the well-being of chronically homeless people, including improvements in mental health, stabilisation and some reductions in problematic drug and alcohol use.
- Evidence that, whilst improving outcomes for homeless people, Housing First services can generate significant cost savings for other services, in particular by reducing the use made of emergency medical services, homelessness shelters and the level of contact between chronically homeless people and criminal justice systems.

The idea of Housing First has met some resistance in France¹²⁸. There are several reasons to be cautious about the introduction of the Housing First model in France and these include¹²⁹:

- **The limits of Housing First:** While the evidence that Housing First can deliver housing stability for most chronically homeless people is very strong, some critics have suggested that some models of Housing First service cannot always work with people who present a high risk. There are also uncertainties about how far some Housing First services are able to bring an end to problematic use of drugs and alcohol and the extent to which Housing First services are able to improve social inclusion for homeless people.
- **Housing First "is not designed" for France:** Housing First is not a French

¹²⁷*European Consensus Conference on Homelessness: Policy Recommendations of the Jury* <http://ec.europa.eu/social/main.jsp?catId=88&langId=en&eventsId=315&furtherEvents=yes>

¹²⁸Houard, N. (2011) 'The French Homelessness Strategy: Reforming Temporary Accommodation, and Access to Housing to deliver 'Housing First': Continuum or Clean Break?' *European Journal of Homelessness* 5, 2, pp. 83-98.

¹²⁹Pleace, N. (2011) 'The Ambiguities, Limits and Risks of Housing First from a European Perspective' *European Journal of Homelessness* 5, 2, pp. 113-127.

innovation. Housing First was developed in the USA, a country with a radically different and far more restricted welfare system than exists in France. The concern here is that a foreign service design cannot simply be 'imported' into France and expected to work well¹³⁰.

¹³⁰Johnsen, S. and Teixeira, L. (2010) op cit.

- **Housing First cannot address all forms of homelessness:** Housing First has shown the greatest success in working with chronically homeless people. This group may not exist in quite the same form or to the same extent in France, not least because its welfare system is very different from that in the USA. In addition, France has forms of homelessness, such as homelessness amongst migrants with precarious legal or administrative status, which Housing First services are not explicitly designed for.

The remainder of this chapter will discuss each of these reasons for caution before concluding that Housing First has much to offer in the French context, albeit taking account of a certain number of risks and preconditions.

The Limits of Housing First

Housing First may not be able to deliver an end to problematic drinking and alcohol use for all chronically homeless people or meet all other needs of the chronically homeless people that use these services. The founder of PHF, Sam Tsemberis, has himself noted there are limitations and accepted that PHF cannot always work with individuals who represent a serious risk or have extremely high needs¹³¹.

The counterargument is simple. No homelessness service can deal with all aspects of homelessness or meet all the needs of all homeless people. To claim that Housing First, that any homelessness service can 'solve' all the problems of all homeless people would not be realistic¹³². The advocates of Housing First do not argue it is the solution to every aspect of homelessness, but there is very strong evidence that it *is* an answer to the most distressing and damaging part of chronic homelessness. Housing First stops the physical homelessness of chronically homeless people and it stops most of them from becoming homeless again. Having a stable home immediately improves the situation and well-being of chronically homeless people. Housing First may not answer all their needs, but the majority of chronically homeless people are in a much better situation than they were before they had contact with a Housing First service.

Housing First is “Not Designed” for France

The second reason for caution is that Housing First is not a French innovation, it is an 'import' from the USA. It is certainly the case that a model like the New York PHF model could not simply be transferred to French cities without adaptation. There are aspects of the operation of PHF in New York that make little sense in the French context. The focus on only private rented housing, for example, makes less sense in France which has both social and 'very' social housing available. France also possesses a far more extensive welfare and healthcare system, meaning that the direct provision of services such as psychiatrists and nurse practitioners in PHF might also make less sense, particularly when service brokerage could enable chronically homeless people to access the extensive health and welfare services that exist

However, the core aspects of the Housing First philosophy are not closely linked to any one society or welfare system and can be adopted in a wide range of situations. Importantly, the evidence shows that the success of Housing First stems not from those parts of the

¹³¹Tsemberis, S. (2010a) op cit.

¹³²Busch-Geertsema, V. (2005) op cit.

design that are specifically linked to a particular welfare regime but from the general philosophy of:

- Providing housing immediately or as soon as possible.
- Promoting choice and control for homeless people and treating them with compassion and respect.
- Following a harm reduction approach and separating housing and support services. This means allowing homeless people to continue drinking alcohol and using drugs - and to choose not to use the psychiatric and drug and alcohol services that are made available – while at the same time allowing homeless people to remain in the housing or accommodation provided.

The core ideas of Housing First have already been adapted and used in flexible ways. The combination of secure housing and mobile support services can be used to respond to the needs of a wide range of homeless people, including those groups who need only limited short term assistance, those with high needs and specific groups, such as young homeless people or homeless families. The Finnish implementation of Housing First has involved the development of a Finnish service for a Finnish context, it has not involved a simple ‘copying’ of American services.

Much of the evidence drawn upon in this report has been American. This is because it is the USA where Housing First services are most developed and where the most research has been done. Evidence on Housing First is however developing at European level as well as at national and local level within Member States. As mentioned previously, the European Consensus Conference on Homelessness devoted much attention to housing-led and Housing First approaches. Housing First Europe¹³³ is a Social Experimentation project funded in the framework of the PROGRESS programme of the European Commission. It will evaluate and provide mutual learning on 10 Housing First projects in European cities. The project was launched in August 2011 and will report in 2013. Its outcomes will give a more detailed insight into the operation of Housing First services in Europe than is possible at present. This will inform greater clarity on the potentials and limits of the approach and its impact on homeless people’s lives. .

In France, a major social experimentation called “Un Chez-soi d’abord” is being carried out to test the effectiveness of Housing First services for homeless people with mental illness¹³⁴. A randomized control trial over four sites (Paris, Lille, Marseille, Toulouse) will evaluate a Pathways-type service for this target population. The total study population will be 800 people. Half of this population will be randomly allocated to the experimental programme and the other half will continue to receive the conventional service offer available to them. The evaluation will compare both the outcomes for beneficiaries and cost effectiveness of these services. The results will provide a more detailed insight into the effectiveness of the approach and the key elements for success in the French context.

Housing First cannot address all forms of homelessness in France

The third reason for caution centres on the differences that may exist between the

¹³³<http://www.servicestyrelsen.dk/housingfirsteurope>

¹³⁴<http://www.developpement-durable.gouv.fr/Programme-Chez-Soi-d-abord.html>

nature of homelessness in France and homelessness in the USA. There is almost certainly a significantly higher rate of general homelessness and a higher rate of 'chronic' homelessness in the USA. However, survey evidence shows that the French homeless population does appear to include a small group of chronically homeless people, including homeless individuals who have difficulty accessing welfare services¹³⁵. This means it is likely that there is a group of chronically homeless people who could benefit from Housing First services in France. However, there are other groups of homeless people in France, including families and migrants with precarious legal or administrative status.

In considering this question, it is vitally important to note that Housing First is not the only *part* of the homelessness strategy in the USA. Federal policy in the USA assumes that there are three groups of homeless people, which are chronically homeless people, episodically homeless people and transitionally (temporarily) homeless people. The first two groups have high support needs, with chronically homeless people having the highest needs, and people who experience episodic homelessness (i.e. they keep becoming homeless again after a few weeks or months away from the street or homelessness shelters) also having high needs. The third group, of temporarily homeless people, is by far the largest group and also tends to have low needs compared to other homeless people. This group includes individuals, couples and families children, all of whom are similar in characteristics to poor people who are housed. This third group is targeted by extensive preventative services including the 'Homelessness Prevention and Rapid Re-Housing Program' (HPRP), which provides assistance with rent and some low level support services that can be classified as Housing First Light (HFL) services.

The USA recognises multiple forms of homelessness and uses a *mixture* of preventative, low level and Housing First services to counteract these different forms of homelessness. Beyond this, the USA also employs not just one form of Housing First service but what are in reality multiple forms of Housing First following the Pathways Housing First (PHF), Communal Housing First (CHF) or Housing First Light (HFL) approaches outlined in this report. Housing First is therefore not seen as the 'only' solution to homelessness in the USA,. The chronically homeless group which is addressed by most Housing First services is clearly not the only target of homelessness policy. Other forms of homelessness exist and other services, besides Housing First, are in place to try to deal with those forms of homelessness. Finland, too, does not confine its homelessness strategy or services simply to Housing First.

There are particular issues with migrant homelessness in France. A high proportion of the places in homelessness services in Paris have been reported as being taken up by Eastern European and African migrants, both with documents and without documents¹³⁶. An argument that has been presented against Housing First is that it would undermine the capacity of homelessness services to support those service users who due to their administrative or legal status face specific barriers to accessing permanent housing. Housing First in this sense has been presented as a threat to unconditional shelter in France that could lead to increases in homelessness in Paris and other cities. However, this argument assumes that Housing First would 'replace' all other forms of homelessness service. This would not be the case if something like the American or Finnish approach to Housing

¹³⁵Brousse, C. (2009) 'The Homeless Support Network: A segmented world' in *F2009/06 Economie et Statistique: Special Issue on the Homeless* (English Version) INSEE: Paris, pp. 17-42

¹³⁶Horréard, J. P. (2007) Migration and Homelessness in Paris, *Homelessin Europe Autumn 2007: Social Demographic Change and Homelessness*(Brussels: FEANTSA).

First were followed in France, where Housing First is just one type of the several forms of homelessness services, including homelessness prevention, which are used.

It is also worth noting that Housing First could have a beneficial effect in increasing the capacity of homelessness shelters and daycentres in France. Adopting a Housing First approach does not mean abandoning existing services where there is a need for them. In the USA, a key argument for Housing First has been that it reduces the use of homelessness shelters significantly. This was because it was found that chronically homeless people, while representing perhaps 10% of all homeless people, stayed in shelters for so long that they used 50% of the beds that were available during the course of a year (i.e. each chronically homeless person used a bed in homeless shelter many times, meaning it could not be used by other homeless people). As Housing First services took chronically homeless people out of the shelter system, those beds became available again. Over time, it is true that it was hoped that some reductions on spending on shelters could occur in the USA, as fewer beds would be needed overall due to Housing First. In France, Housing First might be used to allow shelters to better meet the needs of those who are homelessness and are unable to access housing immediately, such as migrants that face barriers due to their legal or administrative status.

Why use Housing First in France?

There are three main reasons to consider using Housing First services in France.

- The core philosophy of Housing First is the reason for the success that has been achieved in delivering stable housing and accommodation for formerly chronically homeless people. The Housing First philosophy can be drawn upon without copying the detailed operation of Housing First services working in the USA. The ideas of Housing First can be used to design services that can be used to reduce chronic and other forms homelessness in different countries with different welfare systems. An example of this has been the use of the Housing First philosophy to effectively redesign homelessness services in Finland.
- Housing First is highly flexible. The core philosophy has been adapted from the Pathways Housing First (PHF) model and employed in Communal Housing First (CHF) and Housing First Light(HFL) services that can be focused on both chronic homelessness and on other forms of homelessness.
- Housing First services can support other types of homelessness services, for example by stopping very long stays in emergency accommodation beds by homeless people that could access permanent housing. It is important to note that Housing First is *not* designed to *replace* all existing homelessness services and has been used as one part of a mixture of services to respond to homelessness in the USA and Finland. By supporting the work of other homelessness services, Housing First services can potentially enhance the capacity of the overall homeless service provision and ensure that the needs of diverse groups within the homeless population are met.

It is important to end this discussion with a note of caution. Housing First services are effective if they follow the harm reduction approach and other core elements of the Housing First philosophy. A service is not 'Housing First' if it adopts some of the core elements of this

philosophy and not others. For example a service that gives immediate access to housing and uses mobile support services, but which requires abstinence from drugs and alcohol, is *not* a Housing First service. Similarly, a service that requires chronically homeless people or other homeless people to complete one or more steps in a programme to make them 'ready for housing', before granting access to secure housing is still following a staircase model, it is not Housing First. Adoption of the core philosophy of Housing First cannot be partial. Although there is some scope for flexibility, immediate access to housing, the separation of housing and support and a harm reduction approach are crucial elements of the Housing First philosophy and of the effectiveness of the approach. . This core philosophy can be adapted to a range of operational contexts and service delivery models but the key principals must be addressed in order to end situations of homelessness.