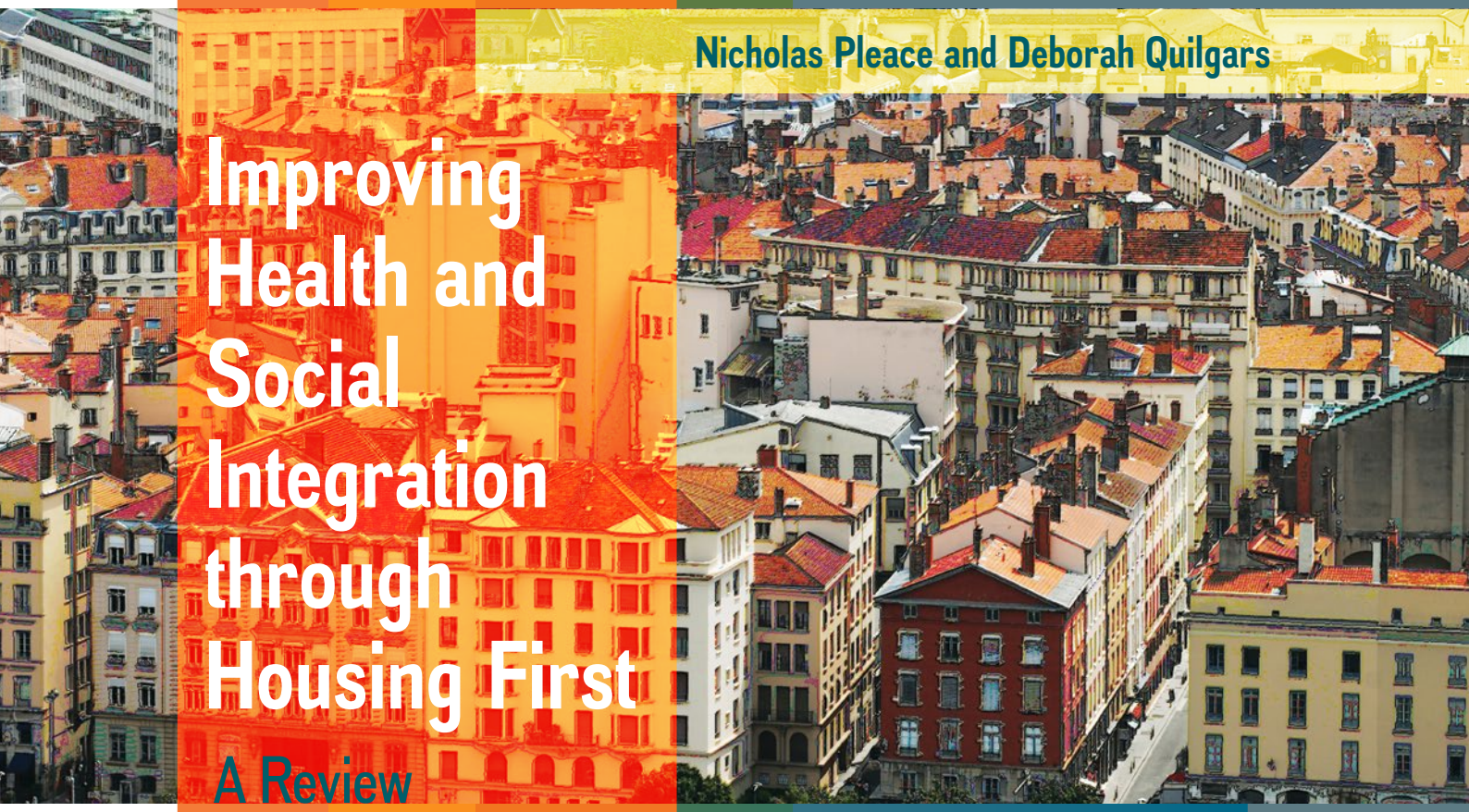
2013

Nicholas Pleace and Deborah Quilgars

Improving Health and Social Integration through Housing First

A Review



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Acknowledgements

Our thanks are due to Lisa Stirk who works as an Information Scientist at the Centre for Reviews and Dissemination (CRD) at the University of York and who conducted the search strategy for the review. Thank you also to Volker Busch-Geertsema for his very helpful comments on the draft report.

Responsibility for any errors lies with the authors.
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SUMMARY

Introduction

Housing First services provide chronically homeless people with ordinary housing in the community without expecting them to be 'housing ready' as traditional staircase homelessness services usually do. Support is provided by mobile support workers and specialist teams delivering Intensive Case Management and/or Assertive Community Treatment to address mental health problems and/or drug and alcohol issues. The provision of choice, within a harm reduction and recovery service orientation, is central to the Housing First philosophy.

It is generally accepted, across policy and academic networks, that the Pathways Housing First approach in the USA has proved successful in ending sustained and recurrent homelessness in chronically homeless people. Following this success, Housing First services (based on Pathways, though sometimes with adaptations) have been developed in Canada, Australia and a number of European countries (including the Netherlands, Denmark, the UK and Portugal). Similarly high levels of housing sustainment have been achieved to date. Results are awaited (due in 2015) from the major French Housing First initiative, Un Chez-Soi d'abord, for homeless people with mental health problems.

However, to date, less attention has been focused on what happens after homeless people have been successfully rehoused. This Review examined the available evidence on the extent to which Housing First services are effective in promoting health and social and economic inclusion. It also considered the extent to which these supports can be enhanced, and any potential limits to Housing First.

Housing First and Health Impacts

Mental health

The overall evidence on the impact of Housing First on mental health is mixed. Some evidence points to improvements, other to stabilisation. However, the evidence is clear that Housing First does not, overall, lead to any deterioration in mental health. The research suggests that Housing First is at least as good as Treatment First approaches in addressing mental health (whilst being more successful on housing sustainment).

There are also indications of a link between perceived feelings of 'choice' and mental health status. Whilst the relationship between these two variables requires further exploration, it suggests that the delivery philosophy/mode of Housing First is important.

There is also evidence that the use of Assertive Community Treatment with Housing First services (and Intensive Case Management to some extent) can help improve engagement with services, and mental well-being, compared to less intensive and brokered arrangements (and services that do not also provide housing).

Generally, the most positive evidence is associated with less hard outcomes (quality of life and 'ontological security'). It is possible that this is a result of less robust methods. However, it is also possible that this reflects the realities of living independently for people with mental health problems. That is, even if clinical measures of health status are little changed, people's subjective sense of well-being may have improved. This may have positive impacts leading to longer-term improvements in other areas.

The evidence indicates that improvements in mental health are more likely over time (a number of years), signalling the importance of long-term (ideally five years and longer) studies to measure the impact of Housing First.

The evidence base from non-Housing First homelessness services strongly suggests that a combination (but separation) of housing and support tends to deliver the best outcomes when working with homeless people with mental health problems.

Alcohol and drug issues

The available evidence on the effectiveness of Housing First services suggests that overall service utilisation is associated with stabilisation of drug and alcohol issues, rather than significant reductions in drug and alcohol use. There is some evidence of limited improvements in some cases, and with mental health, there is no evidence that drug and alcohol use increases following rehousing.

Harm reduction tends to occur in two senses, first, formerly chronically homeless people with drug and alcohol problems are successfully living in their own homes and second, drug and alcohol use is stabilised (and in some cases lessened).

Some successes have been recorded for projects specifically focussed on particular types of drug or alcohol use, for example, communal services for heavy alcohol users. A concern remains, however, as to whether chronically homeless people with high levels of substance misuse issues are always able to gain access into Housing First services.

There is evidence to indicate that linear residential treatment or staircase services can work for some chronically homeless people and result in someone ending their use of drugs and alcohol, but not lead to housing stability at the same high rates. There are strengths and weaknesses associated with harm reduction versus abstinence-based models, suggesting that a range of models need to be provided to homeless people in any one area.

Physical health

There is very limited evidence on the impact of Housing First services on homeless people's physical health. There is some evidence of improved engagement with services as a result of Housing First, but one large USA study found no change in physical health over 12 months. A UK study found that chronically homeless people using Housing First services had long term, limiting illnesses associated with drug and alcohol use.

Housing First and Social Integration

Housing First services seek to promote social integration, with the housing component seen as the key to achieving this goal, in terms of living in normal community settings and sharing the same socialisation and community opportunities as others. Specific services to promote community engagement appear rare, aside from the general support provided by mobile workers. Generally, the extent to which the efforts of Housing First services to promote social integration are *described*, or evaluated, in the literature is limited.

Social integration is poorly defined in most studies; conceptual development, alongside better measures of social integration, is needed to adequately assess the impact of services in this area. Most studies do not utilise a control or comparison group, making it difficult to assess the levels of integration compared to other members of the community. Studies are also rarely longitudinal. Future evaluations need to incorporate service users' priorities in terms of social integration.

Passing (community acceptance)

Existing evidence suggests that nuisance or disruptive behaviour may not be a major problem in many Housing First projects, despite concerns that this may be the case. Where problems are experienced, there are reports of Housing First services acting as effective intermediaries to resolve them.

Some US studies suggest that Housing First services, as well as other supported housing models, have a positive effect on criminality, partly as a result of convictions often being 'misdemeanours' associated with homelessness.

Joining (community participation)

One major US study showed small but statistically significant increases in community participation – for some though not all activities - amongst Housing First participants; however this effect disappeared after controlling for clinical symptoms. Another US study found that Housing First services were more likely to predict social integration – again on some indicators - than Treatment as Usual services.

Generally, Housing First studies indicate very varying levels of community engagement of service users within any one project.

Working (economic participation)

Available evidence does not suggest that Housing First services currently impact on levels of economic participation. One major US study found no change in employment after 12 months.

However, there are early indications that it may be possible for Housing First projects to have an impact in the area of training, education and other meaningful activity. Participation in these types of activity was reported for significant minorities of users in Housing First Europe and Canada.

Qualitative work indicates that employment is often a long term goal for Housing First participants, and that Housing First allows them to begin the process of 'envisioning' a future, however this may take many years to come to fruition.

Evidence from other homelessness services suggest that employment-led services meet with limited success, and that tying housing to education, employment and training support, may also have disadvantages. Housing and support services have generally delivered mixed results in this area, due to substantial barriers to achieving employment for homeless people.

Voting (political participation)

One US study reported an increase from 21% of service users saying they intended to vote to 31% saying they intended to vote over 12 months in a Housing First project.

Generally, however, the question of political participation is not one that has been explored by Housing First evaluations, or within homelessness services more generally. This represents a gap in the evidence base on Housing First services.

Conclusion

Existing evidence suggests that Housing First assists formerly homeless people to maintain independent living at the same time as at the very least stabilising, and sometimes improving, health status. Evidence on broader measures of social integration is particularly weak and in need of conceptual development. The evidence that does exist suggests relatively limited impacts in the areas of social integration. Qualitative evidence, however, suggests that the normalising effects of having one's own home delivers 'ontological security' and a base from which to consider other aspects of one's life.

Setting targets for social integration for Housing First services in the future is not likely to sit comfortably within the service philosophy of choice and self-determination. However, the provision of specific services to maximise social and economic opportunities could be something that Housing First providers consider to a greater extent in the future.

1. HOUSING FIRST, HEALTH AND SOCIAL INTEGRATION

Introduction

This chapter begins with a description of the context in which this Review was conducted and then moves on to detail the research questions and aims of the Review. Following these first three sections, the chapter then describes the methods which were employed to undertake the Review. This chapter concludes with an overview of the structure of this report.

Background to the Review

The successes of Housing First in ending chronic homelessness

Housing First is one of the most significant success stories in the history of homelessness policies and services. In the 20 years since the Pathways Housing First service first began to operate in New York, the Housing First philosophy has become a global phenomenon, dominating strategic level debates about how to reduce living rough (street homelessness) and homelessness among people with high support needs[1].

The Pathways Housing First approach proved particularly successful in ending sustained and recurrent homelessness among people with severe mental illness, poor physical health and problematic use of drugs and alcohol[2], a group referred to as 'chronically homeless people' in the USA[3]. Housing First started to become a global phenomenon when, influenced by the successful results of robust quasi-experimental and experimental trials of the Pathways Housing First (see later for details)[4], Federal Government in the USA supported additional evaluations of services based around a 'Housing First' approach. These pilot services were also successful in ending chronic homelessness[5]. The 2010 US Federal Strategic Plan to prevent and reduce homelessness, *Opening Doors,* had Housing First services at its core[6]. At the same time, the influence of Housing First was increasing across the European Union, with the Jury of the 2010 European Consensus Conference on Homelessness recommending

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

2 Tsemberis, S. and Asmussen, S. (1999) From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model, *Alcoholism Treatment Quarterly* 17(1-2), pp. 13-131; Tsemberis, S. and Eisenberg, R.F. (2000) Pathways to Housing: Supported Housing for Street-dwelling Homeless Individuals with Psychiatric Disabilities, *Psychiatric Services* 51 (4), pp. 487-93.

3 Kuhn, R. and Culhane, D.P. (1998) *Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data* (Departmental Papers (SPP) http://works.bepress.com/dennis_culhane/3).

4 Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S. and Fischer, S.N. (2003) Housing, Hospitalization and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes, *Journal of Community and Applied Social Psychology* 13 (2), pp. 171-186.

5 Pearson, C. L., G. Locke., Montgomery, A.E. and Buron, L. (2007) *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness* (Washington DC, Department of Housing and Urban Development). http://www.huduser.org/portal/publications/hsgfirst.pdf

6 http://www.usich.gov/

the use of 'housing-led' approaches to reducing homelessness, including Housing First models[7]. In 2013, a European Commission working document *Confronting Homelessness in the European Union* recommended the use of 'housing-led' approaches for reducing homelessness[8].

Housing First has become influential because it provides a highly effective response to recurrent and sustained homelessness among people with high support needs. Rates of housing sustainment of 84%[9], 86%[10], 97.5%, 93.8%, 92.9% and 79.4%[11] have been achieved by various models of Housing First service supporting formerly chronically homeless people in the USA, Canada, the Netherlands, Denmark, the UK and Portugal. There is evidence of falling 'long term' homelessness among people with high support needs associated with the implementation of the National 'Housing First' strategy in Finland (from 3,600 'long term' homeless people in 2008 to 2,730 in 2011, a fall of 33%)[12]. One study in New York reported that 88% of formerly chronically homeless people using Pathways Housing First were stably housed after five years[13].

Previous service models had not achieved this level of success in ending homelessness. Basic emergency accommodation or shelter services that provided a bed and food had been widely criticised as 'displacing' the problem of living rough or street homelessness, taking a high need population off the street and simply 'warehousing' them[14]. Services that had focused on behavioural modification, making chronically homeless people 'housing ready' by ensuring they were trained to live independently, were receiving treatment for mental health problems and were stable and were abstinent from drugs and alcohol had achieved some successes. These 'staircase' services did make 30-50 per cent of service users 'housing ready'. However, significant operational problems were also reported, as many chronically homeless people left due to strict rules or became 'stuck' in staircase services because they could not complete all the 'steps' that were required to make them 'housing ready'[15]. The rate of success that staircase services had in ending chronic homeless was far less than was being achieved by Housing First services.

7 http://www.feantsa.org/spip.php?article327&lang=en

8 European Commission (2013) *Commission Staff Working Document: Confronting Homelessness in the European Union* http://ec.europa.eu/social/BlobServlet?docId=9770&langId=en

9 At one year, Pearson, C. *et al* (2007) op. cit.

10 At one year, Goering, P.,Veldhuizen, S., Watson, A., Adair, C., Kopp, B.,Latimer, E. and Ly, A. (2012) *At Home/Chez Soi Interim Report* (Mental Health Commission of Canada) http://www.mentalhealthcommission.ca/English/document/5032/home-interim-report.

11 For various periods, see Busch-Geertsema, V. (2013) *Housing First Europe: Final Report* http://www.socialstyrelsen.dk/housingfirsteurope/copy4_of_FinalReportHousingFirstEurope.pdf

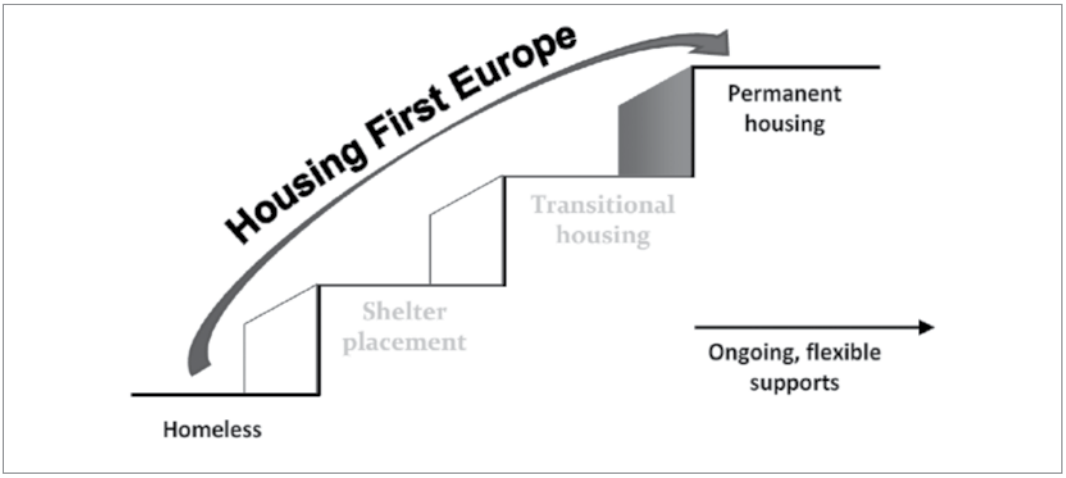
12 Kaakinen, J. (2012) op. cit.

13 Tsemberis, S. (2010a) op. cit.

14 Beasley, R.W. (1931) Homeless Men: Chicago, 1930-31, *The Social Services Review* 5 (3), pp. 439-446; Macgregor-Wood, S. (1976) Camberwell Reception Centre: A Consideration of the Need for Health and Social Services of Homeless, Single Men, *Journal of Social Policy* 5(4), pp. 389-399; Dant, T. and Deacon, A. (1989) *Hostels to Homes? The Rehousing of Single Homeless People* (Aldershot: Avebury).

15 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; Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review* (Edinburgh: Scottish Government).

Figure 1.1: Housing First compared to earlier homelessness service models



Source: Busch-Geertsema, V. (2013) *Housing First Europe: Final Report* http://www.socialstyrelsen.dk/housingfirsteurope/copy4_of_FinalReportHousingFirstEurope.pdf

Instead of using a series of steps or a 'staircase' to modify someone's behaviour so they were 'housing ready', the Housing First service model immediately re-housed chronically homeless people into ordinary housing in the community and provided them with mobile support services which were designed to help them live independently (Figure 1.1). The 'separation' of housing and support was central to the Pathways Housing First philosophy. Access to housing and continued residence in housing was not conditional on someone being 'housing ready', this meant they did not have to be receiving treatment for mental health problems or be abstinent from drugs and alcohol to either access or to remain in housing.

This was a reversal of the logic of earlier staircase and transitional or 'move on' housing services, which had been modelled on the assumption that chronically homeless people would not be able to live independently unless they learnt to manage their own home, had stable mental health and were not using drugs or alcohol. Instead, Pathways Housing First gave immediate or near immediate access to housing and provided support to maintain that housing. Housing First also emphasised respect for individuals, giving them choices about using mental health, drug and alcohol and other services and some choice over where to live, within the resources available. Access to Pathways Housing First was not entirely unconditional, people using the service had to agree to visits from support workers, agree to the conditions of a lease and make a set financial contribution to their rent. Two mobile support teams were also utilised in the model: an ACT (assertive community treatment) team for chronically homeless people with very high support needs and an intensive case management (ICM) team for chronically homeless people with high needs[16]. The Pathways Housing First approach had the following philosophy[17]:

16 An ACT team contains a team leader, part-time psychiatrist, a part-time doctor or nurse and a full-time nurse, a qualified social worker (mental health), specialists in supported employment, a drug and alcohol specialist and a 'Peer specialist' and sometimes a family specialist (reconnection) and 'wellness management and recovery specialist' (healthy lifestyle). An ICM team has a case management role, connecting people using Pathways Housing First to mental health, drug and alcohol, health and social work services, alongside other services to meet other needs. The ICM team also directly provides some practical and emotional support, see Tsemberis, S. (2010b) *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction* (Hazelden: Minnesota).

17 Tsemberis, S. (2010b) op. cit.

- Housing as a basic human right (clients do not have to be 'housing ready' to access or to retain housing).
- 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 (a maximum of 20% Housing First clients in any housing block)).
- Separation of housing and services (services will not stop if somebody has to leave the flat because of imprisonment, hospital stay or eviction; new alternative housing would be procured and services would continue to support the person).
- Consumer choice and self-determination (clients should be allowed to exercise some choice over where and how they live, within the resource constraints of the service; there should also be choice about setting of individual goals, type of services required, path and speed of recovery etc.).
- A recovery orientation (clients are supported and enabled to maximise their own health and well-being, though there is no requirement to use drug, alcohol or mental health services).
- Harm reduction (the goal of harm reduction centres on the reduction of alcohol and drug-related harm rather than simply trying to stop the use of drugs and alcohol).

Developments in the Housing First model

As the influence of Housing First became increasingly widespread, three trends became evident:

- Housing First services were appearing in multiple forms and often did not replicate the original service delivery model developed by Pathways in New York.
- Adherence to the *philosophy* of Housing First appeared to be more important in achieving success in ending chronic homelessness than exactly replicating the detailed operation of New York Pathways model of Housing First.
- Housing First services were relatively cost-effective, delivering better outcomes for equivalent levels of expenditure or delivering better outcomes for sometimes lower levels of expenditure.

Services based on the Pathways Housing First approach often used *different* operational models. Pathways used ordinary housing, scattered across a community. In the US and Finland, 'Housing First' services have emerged that do not use scattered housing but instead used congregate housing, i.e. blocks of apartments, to provide permanent housing in a 'Communal Housing First' approach. Finnish Housing First services are quite often based on the modification of existing emergency accommodation to make blocks of apartments to which a 'Housing First' service is provided[18]. Housing First services have also appeared which, like Pathways Housing First, use scattered housing and have an intensive case management (ICM) team but which, unlike Pathways Housing First, do not also have an ACT team[19].

18 Kaakinen, J. (2012) Long Term Perspectives: From Housing First to Ending Homelessness, presentation at *Housing First: A Key Element of European Homelessness Strategies*, hosted by the French Permanent Representation, Brussels. http://www.slideshare.net/FEANTSA/juha-kaakinen.

19 Pleace, N. (2012) *Housing First* (Paris: DIHAL). Pleace, N. and Bretherton, J. (2013) ' The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness' *European Journal of Homelessness* 7.2.

These various forms of 'Housing First' appeared to all be delivering similar levels of success in ending chronic homelessness despite not replicating the detailed operation of the Pathways Housing First approach. However, the services were similar in one respect - they closely followed the *philosophy* of Housing First. High rates of housing sustainment were achieved by services that separated housing and support, provided open-ended support, used intensive case management (and sometimes assertive community treatment) and which emphasised treating people with respect, compassion and also allowing them choices and control over their lives[20].

Some American evidence suggests Housing First costs no more, or only a little more, than existing services but is more effective at ending homelessness than those existing services[21]. There is also some evidence that Housing First is both more effective and actually cheaper to provide than staircase services[22]. This is significant, particularly in the context of the USA, as Housing First appears to be a service that is both more effective than existing responses and one which is cost neutral or delivers cost benefits.

Criticisms of Housing First models

There have been three main criticisms of the Housing First model in relation to housing sustainment:

- The goals that Housing First seeks to deliver are arguably more 'limited' than for 'staircase' services that aim to make chronically homeless people 'housing ready'. Housing First does deliver housing sustainment – ending homelessness - and uses harm reduction with a recovery orientation to try to maximise well-being. By contrast, staircase services seek to provide a 'total' solution, delivering someone who is capable of living independently because their mental health problems are being treated and their use of drugs and alcohol has ceased. The comparisons which show staircase services are significantly less successful than 'Housing First' can be argued to be unfair on some levels, because staircase services seek to deliver more[23].

- Housing First is not always successful in delivering housing sustainment. While the existing evidence shows that the Housing First approach engages successfully with a clear majority of chronically homeless people, there are people for whom the Housing First approach does not end homelessness, ranging between 3-20% of targeted populations. Beyond this, there are criticisms of Housing First in the US which suggest that chronically homeless people with the very highest support needs, may not always be reached by Housing First services[24].

- The evidence around the capacity of Housing First to actually reduce expenditure and deliver better outcomes needs careful consideration. In particular, Housing First demonstrates clear financial savings when ending homelessness among chronically homeless people who have very high needs and who make very high use of emergency medical services, other homelessness services and who

20 Ibid.

21 Culhane, D.P (2008) The Cost of Homelessness: A Perspective from the United States, *European Journal of Homelessness* 2(1), pp. 97-114.

22 Tsemberis, S. (2010b) op. cit.

23 Pleace, N. (2011) Exploring the Potential of the Housing First Model, in N. Houard (Ed) *Social Housing Across Europe (*Paris: DIHAL).

24 Kertsez, 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.

25 Kertesez, S.G. and Weiner, S.J. (2009) Housing the Chronically Homeless: High Hopes, Complex *Realities, Journal of the American Medical Association* 301(17), pp. 1822-1824; Rosenheck, R. (2010) Service Models and Mental Health Problems: Cost Effectiveness and Policy Relevance, in I.G. Ellen, and B. O'Flaherty, *How to House the Homeless* (New York: Russell Sage Foundation), pp. 17-36.

have frequent contact with criminal justice systems. When used for homeless people without these characteristics, Housing First may not generate the same level of savings or may not generate any financial savings at all[25].

These criticisms are not entirely without foundation. However, it is arguable that all three exaggerate the limitations of Housing First as an approach without acknowledging the successes that the model has achieved.

In relation to the first criticism, that Housing First delivers 'less' than staircase services, it could be argued that Housing First brings people to the point where they can live independently in a different way utilising a more gradual, choice-led approach. Further, the criticism assumes that all chronically homeless people can be brought to a point where they are 'housing ready' when the evidence is of high rates of failure in services modelled on that very assumption. In addition, Housing First does, for most of the people using Housing First services, bring an end to recurrent and sustained homelessness, something which staircase and transitional models fail to do. Housing First ends the unique distress of homelessness for most of the people using it.

One area of potential weakness for Housing First centres on the use of communal Housing First or single site models. These services, which provide accommodation in apartments in a single block, to which support services are delivered, have encountered issues with housing sustainment. Rates of housing sustainment may still be higher than for some staircase services, but there is evidence from Denmark[26] and Finland[27] that issues with resident mix, including groups of individuals with high needs and sometimes challenging behaviour living in the same space, can mean that housing outcomes are less stable[28] than for scattered housing models of Housing First.

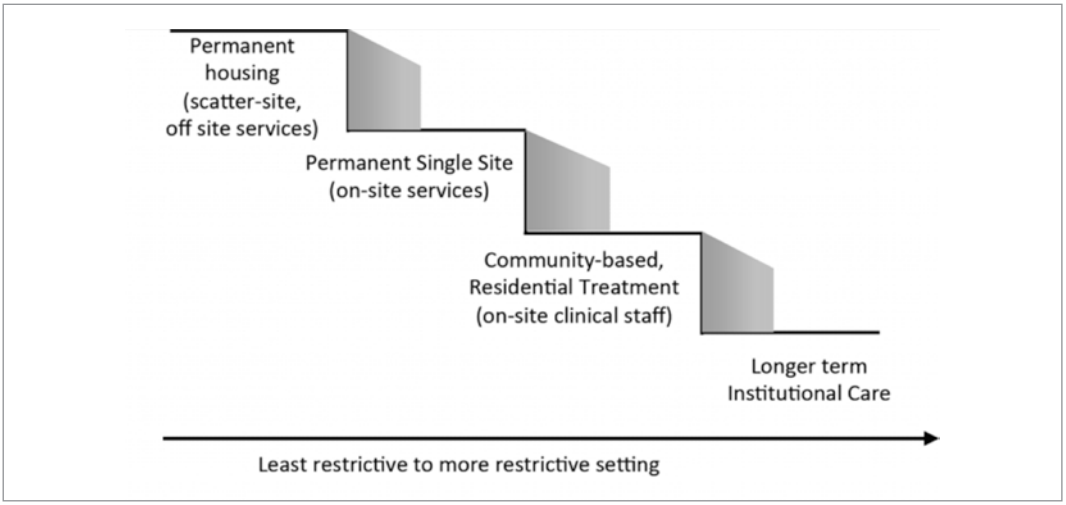
The second criticism is that Housing First cannot work for everyone who is homeless and has high support needs. This presumes that the model is being advanced as a sole solution for chronic homelessness, whereas it can be argued that Housing First is not presented as being a 'total solution' of all forms of chronic homelessness. Dr Sam Tsemberis, the founder of Pathways Housing First has argued for a kind of 'reverse' staircase approach, where Housing First services are the *starting point*, with services that provide more intensive support being available where someone is, at least initially, unable to live in ordinary housing (Figure 1.2).

26 Benjaminsen, L. (2013a) Rehousing Homeless Citizens with Assertive Community Treatment: Experiences from an ACT programme in Copenhagen (Copenhagen: SFI working paper 07:2013).

27 Kettunen, M. (2012) Implementing Housing First in Finland, presentation at *Housing First Partners Conference*, New Orleans.

28 The research in Denmark (Benjaminsen, L. 2013a) reported that while housing sustainment as a whole was comparable across a scattered site ACT model and communal models of Housing First, those living in communal models were less stably housed, i.e. more likely to experience moves rather than remain in the first housing they moved into.

Figure 1.2: A 'reverse' staircase beginning with Housing First



Source: Tsemberis, S. (2013) Presentation at the *Final Conference of Housing First Europe in Amsterdam*, http://www.servicestyrelsen.dk/housingfirsteurope.

The third criticism is centred on cost savings rather than cost *effectiveness*. The core argument in favour of Housing First is not that it generates cost savings but that it ends chronic homelessness at a much higher rate than other services achieved for broadly similar levels of expenditure. Housing First is a much more efficient use of public money and while it may not always generate significant savings, it has been argued elsewhere that the core purpose of a homelessness policy should always be to reduce homelessness rather than reduce expenditure[29].

The Research Questions

Housing First presents a solution to chronic homelessness that has not existed before. For the first time in decades it is possible to think in terms of providing lasting reductions in sustained and recurrent homelessness among people with very high support needs, including those with both severe mental illness and problematic use of drugs and alcohol. There is also scope to use Housing First for the prevention of chronic homelessness. Populations who are at potential risk of recurrent and sustained homelessness, such as former offenders with severe mental illness who are leaving prison[30] and other high need groups, such as some drug users[31] could be assessed and, where necessary, targeted with Housing First services to prevent them becoming homeless.

Housing First services have some limits to their effectiveness. As outlined above, they are not a total solution to chronic homelessness. Further, Housing First services are not designed to address those forms of homelessness in Europe, the USA or elsewhere, that occur among poor people, who do *not* have high rates of severe mental illness or drug use, and whose

29 Culhane, D.P (2008) op. cit.

30 Pleace, N. and Minton, J. (2009) *Delivering Better Housing and Employment Outcomes for Offenders on Probation* (London: Department for Work and Pensions).

31 Kemp, P. A., Neale, J. et al. (2006) Homelessness among Problem Drug Users: Prevalence, Risk Factors and Trigger Events, *Health and Social Care in the Community* 14(4), pp. 319-28.

reasons for homelessness are essentially social and economic. Some specific groups of homeless people, such as young people and women (and children) made homeless by domestic/gender-based violence may also require specially tailored forms of support.

There are three outstanding questions for Housing First services as a solution to chronic homelessness. These centre on what happens *after* a chronically homeless person has been successfully rehoused by a Housing First service. They are the core concern of this Review and can be summarised as follows:

- In addition to addressing homelessness, to what extent can Housing First services enable and promote improvements in *mental and physical health* for formerly and potentially chronically homeless people?

- Alongside addressing homelessness, to what extent can Housing First services enable and promote *social integration* for formerly and potentially chronically homeless people, including the promotion of economic integration, centring on paid employment?

- What role *should* Housing First take in enabling and promoting health, and social and economic inclusion for formerly and potentially chronically homeless people? What roles should other services take alongside Housing First in achieving these goals?

There are questions around the extent to which it is reasonable to expect Housing First to deal with such a wide range of issues. Addressing health and social and economic integration require a potentially wide range of interventions and may be too much to expect of any one service[32]. There is a danger in expecting too much from Housing First, not least because Housing First has delivered what is an almost unprecedented[33] level of success in ending chronic homelessness.

Nonetheless, there is considerable interest in investigating whether Housing First services can and should attempt to address these wider issues. This Review starting point was that Housing First appears to achieve more *variable* effects in respect of health[34] and social integration[35] than it does in terms of housing sustainment. If this is the case, there is a question about whether services can and should be enhanced in the future to meet a broader set of needs.

The Aims of the Review

This Review was undertaken to assess the international evidence base on the success of Housing First services in promoting health and social and economic integration for formerly homeless people using Housing First services. The Review aimed to answer three main groups of questions:

- What types of support are provided in Housing First to promote health and well-being? How effective are these supports? Are there ways in which these supports could be enhanced?

32 Busch-Geertsema, V. (2005) Does Re-housing Lead to Reintegration? Follow-up Studies of Re-housed Homeless People, *Innovation* 18(2), pp. 202-226.

33 Housing First is not entirely alone in delivering high rates of success in ending chronic homelessness, but it is the best evidenced example of such a service. In Finland, for example, a national homelessness strategy based around similar core principles was in development before the Finns became aware of the Pathways model (Kaakinen, J. (2012) op. cit.). Similarly Ireland's national strategic focus on housing-led services has been introduced into a context where some homelessness services were routinely following several of the core principles of Housing First (see Pleace, N. and Bretherton, J. (2012) *Finding the Way Home: Housing- led Responses and the Homelessness Strategy in Ireland* (Dublin: Simon Communities of Ireland)). In the UK, responses to chronic homelessness under the Rough Sleepers Initiatives included Tenancy Sustainment Teams which, while developed independently, replicate many aspects of the Housing First model (see: Lomax, D. and Netto, G. (2008) *Evaluation of Tenancy Sustainment Teams* (London: Department of Communities and Local Government)).

34 Rosenheck, R. (2010) op. cit.

35 Atherton, I. and McNaughton-Nicholls, C. (2008) 'Housing First' as a Means of Addressing Multiple Needs and Homelessness, *European Journal of Homelessness* 2, pp. 289-303.

- What types of support are provided in Housing First to promote social and economic inclusion? How effective are these supports? Are there ways in which these supports could be enhanced?

- Are there lessons from other areas of policy and practice that may be useful in enhancing the effectiveness of Housing First and other services in promoting health and well-being, and social and economic integration?

Research Methods

A rapid evidence assessment approach

This Review is based on an international Rapid Evidence Assessment (REA). The REA method streamlines traditional systematic review methods in order to synthesise evidence within a short timeframe. An REA can be an effective way of identifying lessons from existing practice where information may be scattered across different research disciplines and in different formats.

Unlike a systematic review, the REA uses broader criteria for the assessment of evidence, including research and studies that do not necessarily meet the highest possible standards. This can be useful in an emerging subject such as Housing First where the number of experimental and quasi-experimental studies is relatively small, but where there is also a body of less rigorous work that can add to the available evidence.

The REA covered service evaluations and research on Housing First services for homeless and potentially homeless people who are characterised by high support needs and recurrent or sustained homelessness. The REA also encompassed the use of other service models and strategic responses that might have applicability to enhancing the health, well-being and social and economic inclusion of chronically homeless people (focused on other homeless people and people with mental health problems).

The Review was international in scope. It included papers published in English as well as articles in French (the latter were translated for the research team). The review included studies undertaken since 1990 when the Housing First concept was first introduced.

The searches for the Review were carried out by a trained information specialist in the UK Centre for Reviews and Dissemination (CRD). CRD is part of the National Institute for Health Research (NIHR) and is a department of the University of York and undertakes systematic reviews evaluating the research evidence on health and public health questions for the UK National Health Service (NHS) and at international level.

The searches conducted for this Review are summarised in **Appendix 1**. A total of 1,258 references were retrieved. In addition, the researchers attended conferences in the USA and Europe in the summer of 2013 which reported on some of the most recent research on Housing First.

Limitations of this report

There are a number of limitations with this study. Firstly, the work was carried out by English researchers focusing primarily on research written or translated into English. While there was some facility to translate documents, France and other EU countries have an extensive body of homelessness research, not all of which was accessible to the research team for this report because of language. Second, one of the most important pieces of European research on Housing First, a major evaluation of Housing First taking place in France, which is a multisite randomised trial in Marseille, Lille, Toulouse and Paris, has not yet reported, and is not due to do so until June 2015. This large study is looking at 200 people using Housing First services in each of the four study sites, exploring cost effectiveness, benefits for other services and, using qualitative research, at recovery from health problems and development of social integration and citizenship[36].

36 Tinland, A., Fortanier, C., Girard, V., Laval, C., Videau, B., Rhenter, P., Greacen, T., Falissard, B., Apostolidis, T., Lancon, C., Boyer, L. and Auquier, P. (2013) Evaluation of the Housing First Program in Patients with Severe Mental Disorders in France: Study Protocol for a Randomised Controlled Trial, *Trials* 14 (309) http://www.trialsjournal.com/content/14/1/309.

There is also, as always when undertaking research on Housing First, an inevitable bias towards research and evaluation that has been undertaken in the USA. This bias occurs because by far the single largest evidence base specifically focused on Housing First services is currently found in the United States. Although the EU evidence base has been expanded significantly by the recent *Housing First Europe* project which reported in the Summer of 2013[37] (the results of which are included in this review) and, also outside the USA, a major Canadian evaluation is also underway and starting to report (the interim results are also included in this report), much of what is currently known about Housing First is based on American evidence. The potential limitations on drawing on an American evidence base centre on cultural, political and administrative differences, including the major differences between the availability and extent of welfare systems, social care and health care systems to the general population, which mean that American Housing First services are working in a sometimes radically different context to that found in France or elsewhere in the EU.

Another limitation to the evidence base that is worth noting is that most examples of Housing First are still relatively new services and the approach is not always very widespread. Even in the USA, where Housing First is firmly integrated into national, regional and local homelessness strategies, there is still extensive use of other homelessness service models, including abstinence-based staircase services and Housing First is not universally employed in responses to homelessness[38]. Some EU countries, such as Ireland, have a Housing First-led homelessness strategy (referred to as 'housing-led' services in Ireland[39]), but the strategic intent to introduce Housing First is not yet reflected in very widespread use of Housing First services. This means that the use of Housing First as a general strategy, as a long-term response to chronic homelessness, has not yet been investigated. There is as yet only limited evidence, drawn from Finland[40], as to what the longer-term strengths and limitations of a national or regional level 'Housing First'-led strategy might be.

The Structure of this Report

Chapter 2 summarises the research evidence on Housing First promoting health and well-being. The first section of the chapter looks at mental health, reviewing how Housing First services seek to enhance mental health and well-being, considering the strength and findings of the evidence base and then considering whether there may be valuable lessons from other homelessness- and related services that might help enhance Housing First service outcomes. The second section of the chapter looks at drug and alcohol use, considering the same range of questions as were explored in relation to mental health and the chapter concludes with a similar overview of physical health.

Chapter 3 considers the evidence base on four key aspects of the social integration of chronically homeless people in the community by Housing First services: being accepted into the community ('passing'); participating in the community ('joining'); employment and other types of economic inclusion ('working'), and; political participation ('voting'). As in Chapter 2, the ways in which Housing First services seek to promote social integration into the community are explored, the evidence base discussed and lessons from other homelessness- and related services that might be useful for Housing First considered.

Chapter 4 presents the conclusions of the Review. This chapter looks at the extent to which existing Housing First services, and the existing evidence base on those services can answer the questions about the health, well-being and social and economic integration of homeless people using Housing First services. The chapter concludes by considering what is realistic for Housing First services to seek to achieve and what relationships Housing First services may need to have with other forms of service delivery.

37 Busch-Geertsema, V. (2013) op. cit.

38 Collins, S.E., Malone, D.K., Clifasefi, S.L. Ginzler, J.A., Garner, M.D., Burlingham, B., Lonczak, H.S., Dana, E.A., Kirouac, M., Tanzer, K., Hobson, W.G., Marlatt, G.A. and Larimer, M.E. (2012) Project-Based Housing First for Chronically Homeless Individuals with Alcohol Problems: Within-Subjects Analyses of 2-year Alcohol Trajectories, *American Journal of Public Health* 102(3), pp.511-518.

39 Pleace, N. and Bretherton, J. (2012) op. cit.

40 http://www.housingfirst.fi/en/housing_first/housing_first_in_finland

2. HOUSING FIRST AND HEALTH

Introduction

This chapter begins by describing the support given to people with severe mental illness and mental health problems[41] using various models of Housing First service. The evidence base describing the effectiveness of Housing First in helping to improve mental health is then discussed. This discussion is followed by a consideration of whether there are lessons from other forms of homelessness service and related service provision that might be useful for Housing First services or strategic responses to homelessness that involve Housing First. These same questions are then considered in relation to drug and alcohol use among people using Housing First services and in relation to physical health.

Housing First and Mental Health Problems

The Housing First approach and mental health problems

The relationship between mental health and homelessness is a complex one. It has long been recognised that mental health problems can contribute to homelessness causation but also arise, or be worsened, by the experience of homelessness[42]. Poor mental health is very widespread among the chronically homeless people that Housing First services are primarily designed to support. Concerns have been reported, including within countries (including France and the UK) that have extensive, free, public health systems, that access to psychiatric and other mental health services may be inadequate and continuity of care may be poorer than for housed people[43]. Poor access to health services can occur because mental health problems exist alongside problematic drug and/or alcohol use. In addition, the lack of a secure home in which someone feels physically safe, uncertainty about the future and recurrent or sustained experience of isolation, poor social supports and exclusion from normal social, cultural and economic life may also represent potential risks to mental well-being[44].

The original Pathways Housing First project drew upon ideas developed for what was referred to as a 'supported housing model' designed to allow the successful resettlement of psychiatric patients from long-stay hospital. As would later be the case for Pathways Housing First itself, this 'supported housing model' was developed as an alternative to linear residential treatment or 'staircase' services. The staircase services had been used to resettle patients from long-stay psychiatric hospital but had encountered the same sorts of operational issues that would later arise when they were used for chronically homeless people. Some former psychiatric patients became 'stuck' in these staircase services, never reaching the point of being defined as 'housing ready' because they were not compliant with treatment, not thought to be engaged with training to live independently and/or using drugs and/or alcohol[45] .

41 From this point, we use the term 'mental health problems' to cover all forms of mental illness, including severe mental illness (SMI), unless a project is specifically provided for people with SMI.

42 Cohen, C.I. and Thompson, K.S. (1992) 'Homeless mentally ill or mentally ill homeless?' *American Journal of Psychiatry* 149, 6, pp. 816-821;

43 Henry, J.M., Boyer, L., Belzeaux, R., Baumstarck-Barrau, K. and Samuelian, J.C. (2010) Mental Disorders Among Homeless People Admitted to a French Psychiatric Emergency Service, *Psychiatric Services* 61(3), pp. 264-271.; Rees, S. (2009) *Mental Ill Health in the Adult Single Homeless Population: A Review of the Literature* (London: Crisis).

44 Quilgars D. and Pleace, N. (2003) *Delivering Health Care to Homeless People: An Effectiveness Review* (York: University of York).

45 Ridgway, P. and Zipple, A.M. (1990) The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches, *Psychosocial Rehabilitation Journal* 13, pp. 11-31.

Housing First services can be described as being designed to help address mental health problems in five main ways. It should be noted, however, that not all Housing First services provide the full range of support described here[46]. It must also be remembered that housing and support are 'separated' in Housing First (see Chapter 1).

- Direct provision of mental health treatment in services that use an assertive community treatment (ACT) team or equivalent provision of psychiatrists, specially trained mental health nurses and/or social workers with mental health training, if such treatment is requested. An ACT team is specifically designed to provide services to people who have both mental health problems and problematic use of drugs and/or alcohol.

- Intensive case management (ICM) that is designed to connect people using a Housing First service to required mental health services, should they request assistance with mental health problems.

- A recovery orientation which encourages, supports and enables people to engage with necessary services, while not requiring them to use those services and making it clear they have the option not to use mental health services.

- Providing an adequate, settled and secure home, in which people can exercise choice and control over how they live their lives and in which they can live in privacy.

- Supporting reintegration into mainstream social and economic life, including promoting social supports, community and neighbourhood participation and progress towards paid work (see Chapter 3).

Engagement with treatment, either provided directly by those Housing First services that have an ACT team or equivalent services and also via ICM by all forms of Housing First service is a goal of Housing First. However, engagement with treatment, while supported and encouraged through a harm reduction approach with a recovery orientation within Housing First, is ultimately self-determined, no-one is forced to use psychiatric or other mental health services by a Housing First service. This is in marked contrast to some earlier services such as some 'staircase' models that required compliance with treatment for mental health problems as a condition of being 'housing ready' and which would not re-house someone who was not receiving treatment for mental health problems.

The provision of adequate, settled housing is also designed to reduce risks to well-being by providing someone with the privacy and control over their own space that are central to what is regarded as being a 'home'. Some homelessness researchers have described this as a sense of 'ontological security', centring on the idea that people need a safe place to live in order to be mentally well. The concept of ontological security has origins both in the treatment of mental health problems and in the academic discipline of Sociology. Johnson and Wylie have described ontological security, in relation to homelessness, in the following terms:

> *Ontological security is the basic need we all have for safety, predictability and continuity in our day-to-day lives. In order to feel ontologically secure, we need to feel there is a sense of order and certainty in our world*[47].

Housing First is designed to provide a settled home, not simply accommodation that puts a roof over someone's

46 The Housing First Pathways model (as well as the French and Canadian Housing First trials, and the Lisbon project in Housing First Europe) is aimed at homeless people with a mental health problem. However this is not the case in all Housing First models, for example in the other European projects (see Busch-Geertsema, V. (2013) op. cit).

47 Johnson, G. and Wylie, N. (2010) *This is not living: Chronic Homelessness in Melbourne (*Melbourne: RMIT University and Sacred Heart Mission).

head, but a private, secure environment in which an individual can exercise the same choices and controls as anyone would expect to have in their own home. There are limitations to what Housing First can offer in terms of housing, permanent security of tenure may not be available and there may be compromises on the type or location of housing that is on offer, but the focus on providing a 'home' is central to what Housing First services are intended to do[48]. The provision of a settled home is seen by advocates of the Housing First approach as the foundation, or base, from which mental health can start to be improved. The idea of 'normal' life, in a 'normal' housing setting and in a 'normal' neighbourhood is central to the Housing First approach, giving people using Housing First services the choice, control and ordinary, ontologically secure, life that most people have to help them overcome mental health problems. The 'manual' for Pathways Housing First notes the following:

> *Clients soon discover that being a lease-holding apartment renter, decorating their own place, and living life on their own schedule is an enormous boost to one's autonomy, self-determination, mental health and dignity.*[49]

Housing First is also intended, should people using a Housing First service wish it, to provide support to individuals to maintain or to develop the friendships, partnerships and family relationships that many of us are fortunate enough to take for granted. Finally, there is also a stated goal of Housing First services reconnecting people with normal economic and social life, making them a part of the communities and neighbourhoods in which they live[50]. The role of Housing First services in promoting social inclusion within the community and in promoting participation in meaningful activity and paid work is explored in more detail in Chapter 3.

The effectiveness of Housing First

The two main measures used in the literature to measure the effectiveness of Housing First on mental health impacts have been clinical improvements in mental health symptoms and decreased use of psychiatric hospital admissions/stays. Attention has also been paid to engagement with, and outcomes of, mental health case management interventions. Other research has also looked more broadly at mental health and well-being through Quality of Life indicators. Finally, research has also been concerned with examining the 'ontological security' associated with having a place of one's own and how this may impact on health.

As summarised below, the overall evidence on the impact of Housing First on mental health is mixed. Some evidence points to improvements, other to stabilisation. However, the evidence is clear that Housing First does not, overall, lead to any deterioration in mental health. Generally, the most positive evidence is associated with less hard outcomes (quality of life and 'ontological security'). It is possible that this is a result of less robust methods. However, it is also possible that this reflects the realities of living independently for people with mental health problems. That is, even if clinical measures of health status are little changed, people's subjective sense of well-being may have improved. This may have positive impacts for longer-term improvements in other areas. There are also indications of a link between perceived feelings of 'choice' and mental health status.

The research also suggests that Housing First is at least as good as Treatment First approaches in addressing mental health, and that improvements over time (a number of years) are most likely.

- *Pathways to Housing versus Continuum of Care (USA)* – Housing First participants spent significantly

48 Padgett, D. (2007) op.cit.

49 Tsemberis, S. (2010b) op. cit. p. 54.

50 Tsemberis, S. (2010b) op. cit.

less time in hospitals than the Continuum of Care group over the 24-month study period[51]. However, there was no significant difference between Housing First participants and the control group on psychiatric symptoms (using the Colorado Symptom Index) at 24 months[52]. Nonetheless, a decrease in psychiatric symptoms was recorded over 36 months for both programmes. Perceived choice also significantly accounted for decrease in symptoms[53].

- *Collaborative Initiative on Chronic Homelessness (11 sites; USA)* – statistically significant but small improvements in clinical status for all users over a 12-month period[54]. Over 24 months, there was no change in the mental health status of high drug and alcohol substance users, with some improvement in mental health amongst abstainers[55].

- *Comparison of three Housing First programmes (including Pathways) (USA)*[56] – found very limited improvements in psychiatric symptoms at 12 months across the projects (using 3 point Likert scale);

- *Housing First Europe* [57] – some early positive findings on improvements in mental health in three projects (Amsterdam, Glasgow and Lisbon), for example, over three-quarters of participants in Lisbon reported a positive impact on their mental health. However, ACT professionals in Copenhagen assessed that, whilst 25% of participants had more positive mental health, 29% had a more negative status. The same Danish Housing First evaluation reported that mental health problems were present among 60% of service users at first report and 64% at last report[58].

- *Housing First in Canada and quality of life*[59] - Participants randomised to Housing First (Vancouver At Home/ Chez Soi site) reported greater overall Quality of Life (QoL Interview 20 measure, including questions on family, leisure, living situation, safety and social) compared to Treatment As Usual group at 12 months (for both those in scattered and congregate housing).

In addition, there is some evidence that Housing First services can help improve mental health (including hospitalisations) both through direct provision of treatment and through using intensive case management to arrange access to treatment. A number of studies have indicated that the use of an ACT team designed specifically to help

51 Gulcur, L. *et al* (2003) op. cit.

52 Tsemberis, S., Gulcur, L. and Nakae, M. (2004) Housing First, Consumer Choice and Harm Reduction for Homeless Individuals with Dual Diagnosis, *American Journal of Community Psychology* 32, pp.305-317. 225 participants randomised into two groups.

53 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. 223-237.

54 Tsai, J., Mares, A.S. and Rosenheck, R.A. (2012). Does Housing Chronically Homeless Adults Lead to Social Integration? *Psychiatric Services* 63(5) pp. 427-434. Using the Medical Outcomes Study Short Form -12 (SF-12) from baseline to 12 months (p=<.001; n2p=.02 [partial eta-squared statistic]).

55 Edens, 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. Federally funded demonstration project across 11 sites providing permanent supported housing and primary and mental health services to chronically homeless people (including Housing First approaches but not exclusively so). No comparison group. Used Addiction Severity Index and Brief Symptom Inventory.

56 Pearson, C., Montgomery, A.E. and Locke, G. (2009) Housing Stability among Homeless Individuals with Serious Mental Illness Participating in Housing First Programs, *Journal of Community Psychology* 37 (3), p.404-417. 80 participants across 3 sites.

57 Busch-Geertsema, V. (2013) op. cit.

58 Benjaminsen, L. (2013a) op. cit.

59 Patterson, M. Moniruzzaman, A. Palepu, A. Zabkiewicz, D. Frankish, C.J. Krauz, M. and Somers, J.M. (2013) Housing First Improves Subjective Quality of Life among Homeless Adults with Mental Illness: 12-month Findings from a Randomised Controlled Trial in Vancouver, British Columbia, *Social Psychiatry and Psychiatric Epidemiology*, 9 June: DOI 10.1007/s00127-013-0719-6. 497 participants.

people with both mental health problems and problematic use of drugs and alcohol improves treatment options and access to treatment for chronically homeless people compared to brokered, less intensive arrangements (see also next section)[60]. For those Housing First services that rely on ICM and do not have an ACT team, or are using ICM approaches alongside ACT, there is the capacity to arrange access to both mental health and drug and alcohol services (assuming those services are available and can be accessed). Other reported benefits of both ACT and ICM services for homeless people with mental health problems include greater engagement with other forms of assistance, such as money management and debt advice[61].

The clearest evidence on the effectiveness of Housing First centres on research and evaluations reporting that Housing First achieves housing sustainment for chronically homeless people with mental health problems. As outlined in Chapter 1, Housing First services are able to house chronically homeless people who, under some previous models of homelessness service provision, were thought not to be capable of living in ordinary housing, even with access to mobile support. There are studies, for example from Canada[62], Denmark[63] and the USA[64] (see Chapter 1) that show previously chronically homeless people with severe mental illness and mental health problems can live in ordinary housing in the community with support from a Housing First service. This group of people still have severe mental illness and mental health problems, but the risks to well-being directly resulting from being homeless appear to have been removed by Housing First services.

Some research has argued that it is in providing suitable housing in which formerly chronically homeless people can start to build a (more) 'normal life', Housing First has been described as beginning a process of re-engaging with the World, and having a settled 'home' that most of us have. Padgett has described this in terms of the promotion of a sense of ontological security among the people using the Pathways Housing First service[65]:

> *Having a 'home' may not guarantee recovery in the future, but it does afford a stable platform for re-creating a less stigmatised, normalised life in the present.*

Other research has also suggested that Housing First can generate a sense of ontological security among formerly chronically homeless people with mental health problems and that this, in itself, can help promote recovery from mental illness. Having a home of their own has been interpreted as generating a sense of both personal and social 'stability' among users of Housing First services[66].

60 Caton, C.L.M., Wilkins, C. and Anderson, J. (2007) People who Experience Long Term Homelessness: Characteristics and Interventions, Presentation at the *National Symposium on Homelessness Research* http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm.

61 Nelson, G., Aubry, T. and LaFrance, A. (2007) A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness who have Been Homeless, *American Journal of Orthopsychiatry* 77 (3), pp. 350-361.

62 Goering, P *et al* (2012) op. cit.; Polvere, L., Macnaughton, E. and Piat, M. (2013) Participant Perspectives on Housing First and Recovery: Early Findings From the At Home/Chez Soi Project, *Psychiatric Rehabilitation Journal* 36(2), pp.110-112.

63 Benjaminsen, L. (2013a) op. cit.

64 Padgett, D. K., Gulcur, L. and Tsemberis, S. (2006) Housing First Services for People Who Are Homeless With Co-Occurring Serious Mental Illness and Substance Abuse, *Research on Social Work Practice* 16(1), pp. 74-83.

65 Padgett, D. (2007) op.cit. p. 1,934.

66 Watson, D.P. (2012) From Structural Chaos to a Model of Consumer Support: Understanding the Roles of Structure and Agency in Mental Health Recovery for the Formerly Homeless, *Journal of Forensic Psychology Practice* 12(4), pp. 325-348.

Implicit within the research arguing that Housing First is providing ontological security, there is an assumption that having a settled 'home' helps begin a process of recovery from mental illness. This argument flows from the logic of the design of Housing First services which, with their emphasis on harm reduction and choice, allow chronically homeless people to set the pace at which they might wish to try to make changes, one of which might be engagement with mental health services and developing the kinds of social support that can help reduce the risks of some forms of mental illness[67]. Evaluations of Housing First have sometimes made this point, noting that recovery from mental health problems may take years and expecting sudden improvements, for example after users of Housing First services have been housed for just one year, is not realistic[68]. It might be argued that expecting a Housing First service to deliver rapid improvements in mental health is not realistic, because treating mental health problems is complex and individuals may experience both periods of recovery and periods during which their condition deteriorates[69].

Encouragement of social support is in part sought by some Housing First services, including Pathways Housing First, using scattered site housing which is designed to integrate formerly chronically homeless people into the community (see Chapter 3). Equally, the delivery of ontological security may be seen as the beginning of a socially normalising process, removing some of the social distinctions between a formerly chronically homeless person and those around them by placing them in ordinary housing[70].

Some criticisms have been levelled at 'communal'[71] Housing First service models employed in Finland, the US and Denmark. Some academics and service providers have argued that living in a separate apartment block, which is only accessible to formerly chronically homeless people and has on-site support staff, creates a barrier between people using Housing First and the wider community, restricting potential social supports[72]. Conversely, there are those who argue that such living arrangements may reduce the risk of social isolation and also provide a peer group with shared experiences, although management difficulties associated with several high need individuals living in close proximity have been reported in Finland[73].

Arguments might also be made that communal Housing First provides more effective risk management – for people with severe mental illness – than the Pathways or ICM-only 'Light' Housing First services, because communal projects have staff who are in the same building. However, there is evidence of people with severe mental illness being successfully supported by Housing First services using scattered housing and an ACT approach[74]. Some recent Canadian work has also suggested benefits to mental health from both 'communal' and 'scattered housing' models of Housing First services[75].

67 Cohen, S. and Wills, T. (1985) Stress, Social Support and the Buffering Hypothesis, *Psychological Bulletin*, 98, pp. 310-357.

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

69 Pleace, N. (2013) *Evaluating Homelessness Services and Strategies: A Review* (Brussels: HABITACT) http://www.habitact.eu/files/activity/actionresearch/_evaluationreview_habitact.pdf

70 Tsemberis, S. (2010a) op. cit.

71 Also sometimes known as 'project based' Housing First or 'single site' Housing First.

72 Busch-Geertsema, V. (2013) op. cit.; Benjaminsen, L. (2013) op. cit.; Tsemberis, S. (2011) *Observations and Recommendations on Finland's "Name on The Door Project" from a Housing First Perspective* http://www.housingfirst.fi/files/1242/Tsemberis_2011_-_Observations_and_Recommendations.pdf.

73 Kettunen, 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/.

74 Benjaminsen, L. (2013) op. cit.

75 Patterson, M. et al. (2013) op.cit.

Criticisms of Housing First and impact on mental health

There are three main criticisms of the effectiveness of Housing First services in meeting the needs of people with mental health problems:

- Some studies suggest that chronically homeless people do not show improvements in mental health when they have been stably housed by a Housing First project[76].

- Housing First is successful at delivering housing sustainment for formerly chronically homeless people, but it is less successful in helping homeless people with mental health problems back into normal social and working life, delivering a *partial* reintegration based mainly on keeping people in ordinary housing[77].

- The standard of proof available for Housing First does not meet clinical requirements, the available studies are often less robust than the experimental studies (randomised control trials) used for medical research or there are methodological limitations with the experimental studies that have been conducted on Housing First services[78].

On the first point, the evidence base on the effect of Housing First on mental health is mixed, although it does appear to be more positive than negative (as described above). One problem with independent living is that it can be associated with poor social networks and loneliness. In Amsterdam, an evaluation of the Discus Housing First project using scattered housing reported quite high levels of people using it feeling isolated to varying degrees, for example 44% reported that they 'missed having a really good friend'[79]. However, overall, the evidence suggests that stabilisation of mental health, even possible improvements over time, are consistent with a Housing First approach. In other words, there is no evidence to suggest that chronically homeless people's mental health needs to be addressed before they can successfully live independently. There is also some emerging research to suggest that choice in service delivery may have a positive impact on mental health symptoms, although the exact relationships between Housing First and mental well-being is hard to observe:

> *Although program assignment was not associated with decreased psychiatric symptoms, Housing First was associated with smaller proportions of time homeless and greater perceived choice... Not surprisingly, the Housing First model is most strongly associated with changes in these types of structural outcomes, while, except for perceived choice in housing and treatment, its direct associations with psychological variables such as mastery and psychiatric symptoms have been more difficult to establish*[80].

It is also true that arguments that Housing First has no clear effect on mental health tend to refer to an evidence base that is often confined to quite short periods (see above). As noted, expecting what would in effect be quite rapid positive effects on mental health from being stably housed by Housing First may not be realistic.

76 Groton, D. (2013) Are Housing First Programs Effective? A Research Note, *Journal of Sociology and Social Welfare* 40, 1, pp.51-63.

77 Kertsez, S.G. et al (2009) op.cit.

78 Chilvers, R., MacDonald, G. and Hayes, A. (2009) *Supported Housing for People with Severe Mental Disorders* (The Cochrane Collaboration); Fitzpatrick-Lewis, D. Ganann, R., Krishnaratne, S., Ciliska, D., Kouyoumdjian, F. and Hwang, S.W. (2011) Effectiveness of Interventions to Improve the Health and Housing Status of Homeless People: A Rapid Systematic Review, *BMC Public Health*, 11(638).

79 Wewerinke, D., al Shamma, S. and Wolf, J. (2013) *Evaluation of Discus Housing First: The Netherlands* (Amsterdam: UMC St Radboud).

80 Greenwood, R.M., Schaefer-McDaniel, N.J., Winkel, G. and Tsemberis, S. (2004) op.cit, p. 234.

Equally, the argument that Housing First services can only achieve reintegration in terms of housing and thus represent an 'incomplete' service response to mental health problems among chronically homeless people has to be considered against some evidence that access to a stable home may help improve people's overall well-being[81]. There is also perhaps an intuitive sense among health service providers that someone facing mental health problems in their own home is in a better situation than someone who is facing mental health problems while living on the street or in emergency accommodation[82]. The *absence* of housing can create fundamental problems in terms of accessing care and in exposing someone to a wide range of potential risks to mental health, including gender-based violence, crime, violent crime, easy access to drugs and alcohol and also living without any personal or safe space[83]. Of course, housing needs to be adequate, safe and affordable to make a positive difference, or at least have the potential, to improve the life of a formerly chronically homeless person with mental health problems.

More generally, the idea that Housing First has at best very limited or variable effects on mental well-being arguably goes against current ideas about what is important in terms of the reintegration of people with mental health problems into society. While many of the validated measures employed to determine the success of resettlement of people with mental health problems pay relatively little direct attention to housing, the other forms of social integration they measure are often *dependent* on having a stable, adequate home in a suitable neighbourhood[84]. For example the Lehmann scale (quality of life index, QOLI), along with various other indicators, records information on privacy, personal safety, neighbourhood safety and the "amount of freedom you have where you live" in determining the quality of life of someone recovering from mental health problems[85]. Having a settled home may well not, in itself, be a total solution to the reintegration of someone with mental health problems into society; housing can provide, as Padgett[86] argues, a base from which continuity of treatment and the building up of social supports can start.

In relation to the standard of proof available on Housing First services, it is arguable that there are multiple standards as to what is regarded as 'scientific' proof. It has been pointed out that some evaluations have been conducted by Housing First service providers (with a possible conflict of interest)[87], however some of these studies have reported disappointing results so this may be unlikely. There are limitations with the evidence base for Housing First, which include sampling, validity and other aspects of methodology. However, there are similar issues with respect to the evidence base on other services that seek to resettle homeless people with mental health problems[88].

81 Padgett, D. (2007) op. cit.; Patterson, M. et al (2013) op. cit.

82 Pleace, N. and Quilgars, D. (1996) *Health and Homelessness in London: A Review* (London: The Kings Fund).

83 Connelly, J. and Crown, J. (1994) *Homelessness and Ill health: Report of a Working Party of the Royal College of Physicians* (London: Royal College of Physicians of London).

84 Pleace, N. with Wallace, A. (2011) *Demonstrating the Effectiveness of Housing Support Services for People with Mental Health Problems: A Review* (London: National Housing Federation) http://www.housing.org.uk/publications/browse/demonstrating-effectiveness-of-housing-support-services-for-mental-health.

85 Uttaro, T. and Lehman, A. (1999) Graded response modelling of the Quality of Life Interview, *Evaluation and Program Planning* 22, pp. 41-52.

86 Padgett, D. (2007) op. cit.

87 Groton, D. (2013) op. cit.

88 Pleace, N. with Wallace, A. (2011) op. cit.

Lessons from other services

The evidence base strongly suggests that a combination of housing and support tends to deliver the best outcomes when working with chronically homeless people with mental health problems. The evaluations of the London *Homeless Mentally Ill Initiative*[89] and the highly successful *Rough Sleepers Initiative* programmes in England all reported that a combination of flexible, on-going, case management within a harm reduction framework with access to suitable, affordable housing could improve the well-being of chronically homeless people with mental health problems[90]. Recent, innovative work with the use of personalised budgets for people living rough with mental health problems has also found that the combination of housing and support is effective in ending homelessness[91]. Equally, there is Irish, Italian and German evidence that a combination of housing and support can help improve well-being[92].

As noted in Chapter 1, the use of staircase or linear residential treatment services for both homeless people and for former patients of long-stay psychiatric hospitals has tended to have mixed outcomes. Successes have been achieved with chronically homeless people, but problems have occurred with abandonment of services and with people becoming 'stuck' in staircase based systems without being able to move on. One of the main alternatives to a housing-led or Housing First approach, the use of highly structured services requiring progression along a series of steps towards being 'housing ready', has been criticised as only succeeding with some chronically homeless people with mental health problems, in both Europe and the USA[93].

There is evidence that assertive community treatment (ACT) services, as employed in the Pathways model of Housing First in New York and also in Danish Housing First services, are effective in improving the mental well-being of homeless people, in both helping improve quality of life and also in reducing hospitalisation levels for mental health problems. ACT teams, operating on their own without the provision of housing, have however been found to be less effective than using ACT in combination with the provision of housing. There is similar evidence in respect of the use of intensive case management (ICM) services, which again can be linked to improvements in mental health, but again appears to more effective when combined with housing, as in most forms of Housing First services[94]. More generally, there is evidence that the use of ACT approaches is more effective than ordinary case management for homeless people with mental health problems, including some evidence that ACT teams may help reduce the severity of symptoms[95].

Other models of clinical and support interventions have been used with chronically homeless people with mental health problems. One such model is critical time intervention (CTI). The CTI approach uses a specialist worker whose role is to strengthen the ties that a chronically homeless person has to services, family and friends and also provide them with practical and emotional support after they leave emergency accommodation or transitional housing. A CTI worker is provided on a time-limited basis, such as nine months, unlike the on-going ACT and/or ICM support provided by a Housing First service.

89 Craig, T., Bayliss, E., Klein, O., Manning, P. and Reader, L. (1995) *The Homeless Mentally Ill Initiative: An Evaluation of Four Clinical Teams* (London: The Department of Health).

90 Lomax, D. and Netto, G (2008) op. cit.

91 Hough, J. and Rice, B. (2010*) Providing Personalised Support to Rough Sleepers: An evaluation of the City of London Pilot* (York: Joseph Rowntree Foundation).

92 Busch-Geertsema, V. (2005) op. cit.

93 Busch-Geertsema, V. and Sahlin, I. (2007) op. cit.; Pleace, N. (2008) op. cit.

94 Nelson, G., Aubry, T. and LaFrance, A. (2007) op. cit.

95 Coldwell, C.M. and Bender, W.S. (2007) The Effectiveness of Assertive Community Treatment for Homeless Populations with Severe Mental Illness: A Meta-Analysis, *American Journal of Psychiatry* 164(3), pp. 393-399.

Some research has suggested that CTI services improve well-being and housing stability while chronically homeless people are using CTI. In addition, it has been suggested that CTI has a lasting beneficial effect, i.e. even after they stop using CTI the well-being and housing sustainment of formerly chronically homeless people who have used a CTI service is better than for comparison or control groups who have not used CTI[96]. Other research has questioned the long term benefits of CTI for some chronically homeless people, suggesting that some may require longer term or on-going support[97]. In practice, this kind of short- or medium-term case management has been widely used in the resettlement of chronically homeless people in the UK, but the evidence base is restricted to a few observational studies and only very limited longitudinal analysis[98].

Housing First and Problematic Use of Drugs and Alcohol

The Housing First approach to drugs and alcohol

Housing First uses a harm reduction approach with a recovery orientation to provide support to chronically homeless people who use potentially harmful levels of legal and illegal drugs and who drink harmful levels of alcohol. What is now often regarded as chronic homelessness, i.e. recurrent and sustained living rough on the street and in emergency accommodation, has long been associated with people who drank more alcohol than is healthy. Since the 1980s, while the association with problematic drinking of alcohol has remained, levels of potentially harmful legal and illegal drug use among chronically homeless people have escalated across the economically developed World[99].

The two main approaches to the problematic use of drugs and alcohol are abstinence-based services and services which follow a harm reduction approach. Abstinence-based approaches can be pursued via detoxification services or through rehabilitation services. Detoxification tends to involve a relatively short (often residential) programme lasting 1-3 months and seek to end problematic use of alcohol and/or drugs that someone has become addicted to or dependent upon. By contrast, rehabilitation services tend to offer longer more extensive programmes. Rehabilitation includes the linear residential treatment models also known as 'staircase' services that seek to modify behaviour, making someone 'housing ready' and perhaps also 'work ready' by ending their use of drugs and alcohol and also addressing other support needs they may have, such as mental health problems. There are also 'buddy' based systems using peer support, such as the 12-step Alcoholics Anonymous programmes which again seek to modify behaviour by peer support from people who are recovering from problematic alcohol or drug use.

By contrast, harm reduction-led approaches are designed to focus on reducing the harm associated with problematic drug and alcohol use, not necessarily with ending drug and alcohol use. Drug and alcohol use are also seen as resulting from a complex interplay of needs, including issues such as the social

96 Susser E.S., Valencia, E., Conover, S., Felix, A., Tsai, W.Y. and Wyatt R.J. (1997) Preventing Recurrent Homelessness among Mentally Ill Men: A "Critical Time" Intervention after Discharge from a Shelter, *American Journal of Public Health* 87, pp. 256–262; Kasprow W.J. and Rosenheck, R.A. (2007) Outcomes of Critical Time Intervention Case Management of Homeless Veterans after Psychiatric Hospitalization, *Psychiatric Services* 58 (7), pp. 929-35.

97 Lennon, M.C., McAllister, W., Kuang, L. and Herman, D.B. (2005) Capturing Intervention Effects Over Time: Reanalysis of a Critical Time Intervention for Homeless Mentally Ill Men, *American Journal of Public Health* 95(10), pp. 1760–1766.

98 Pleace, N. (1997) 'Rehousing Single Homeless People' in R. Burrows., N. Pleace. and D, Quilgars (Eds) *Homelessness and Social Policy* (London: Routledge) pp. 159-171.

99 Pleace, N. (2008) op. cit.

and economic position of someone in society, rather than, as in abstinence-based approaches, a 'choice' to take drugs and use alcohol that must be 'corrected' by modifying behaviour.

Both approaches have been criticised as being ineffective and both approaches can report successes. In respect of homelessness, criticisms of harm reduction-led approaches include the continued use of drugs and alcohol, albeit at often lower levels than was previously the case, among chronically homeless people who are using harm reduction-led services. By contrast, those advocating harm reduction approaches argue that many chronically homeless people abandon or become stuck within abstinence-based services, unable ever to reach housing, because they cannot successfully follow the strict rules[100].

Housing First services follow a harm reduction framework with what is termed a recovery orientation. Services cannot sanction or condone illegal activity in terms of drug use, but it is acknowledged that drug use occurs, while open use of alcohol is permitted. Unlike abstinence-based approaches, use of drugs or alcohol does not result in a threat that services will be withdrawn, nor are people removed from a Housing First service because they have used drugs and alcohol.

The separation of housing and support (see Chapter 1) in Housing First means that access to housing and retention of housing is not conditional on someone stopping using drugs and/or alcohol. This tolerance of drug and alcohol use is accompanied by the provision of a range of support, either directly delivered or delivered jointly with other services, that will enable the people using a Housing First service to reduce, or seek to stop, their use of drugs and/or alcohol. A 'recovery orientation' in service design allows individuals to construct their own plans around where they want their life to go, and to exercise choices, while also providing access to support around drug and alcohol use when it is requested. The end goal of harm reduction services with a recovery orientation is essentially the same as that for abstinence-based services – the end of drug and alcohol-related harm to health and well-being - but rather than encouragement and, sometimes, compulsion to immediately cease all drug and alcohol use, harm reduction seeks to create an environment where an individual can stop using drugs and alcohol, or reduce their usage, when they choose to do so[101].

The effectiveness of Housing First

The available evidence on the effectiveness of Housing First services, from the main studies on Housing First, suggests that overall service utilisation is associated with stabilisation of drug and alcohol issues, rather than significant reductions or increases in drug and alcohol use. As with mental health, there is no evidence that drug and alcohol use increases following rehousing. Harm reduction tends to occur in two senses, first, formerly chronically homeless people with drug and alcohol problems are successfully living in their own homes and second, drug and alcohol use is being stabilised (and in some cases lessened).

- *Pathways to Housing versus Continuum of Care (USA)* – There was no significant difference between Housing First participants and control group on either alcohol or drug use (using Drug and Alcohol Follow-Back Calendar and Treatment Services Inventory) at 24 months[102]. The same finding was reported at 48 months, with Treatment First participants more likely to use treatment services (possibly reflecting programme requirements)[103].

100 Pleace, N. (2008) op. cit.

101 Tsemberis, S. (2010b) op. cit.

102 Tsemberis, S., Gulcur, L., Nakae, M. (2004) Housing First, Consumer Choice and Harm Reduction for Homeless Individuals with Dual Diagnosis, *American Journal of Community Psychology*, 32, pp305-317. 225 participants randomised into two groups.

The authors, however commented: *Given the systemic factors influencing an individual's ability and willingness to seek help for mental health and substance abuse problems, our findings of 'no significant difference' in substance use despite lower treatment service utilization and no program-specific restraints on substance use connotes clinical and programmatic significance favouring the housing first approach* (p.80).

- *Collaborative Initiative on Chronic Homelessness (11 sites; USA)* – over 12 months, small but statistic significant improvements in alcohol and drug use[104]; over 24 months, high substance users maintained higher, but declining, rates of substance abuse compared to abstainers[105].

- *Comparison of three Housing First programmes (including Pathways) (USA)*[106] – found very limited improvements in substance use at 12 months across the projects (using 3 point Likert scale);

- *Housing First Europe*[107] - 70% of participants self-reported a reduction in substance use (Amsterdam); staff assessed slightly higher proportions of users improving on substance use, than deteriorating, though most were unchanged (Copenhagen); reduction or cessation of substance use for minority of clients (Glasgow); half of users self-reported cessation or reduction in substance use (Lisbon); no change (Budapest).

Additional analysis on the Collaborative Initiative on Chronic Homelessness also demonstrated that there was no difference in alcohol or drug use over time between those participants who were placed immediately into housing, compared to those who were in transitional housing (staircase services) prior to permanent housing, but that the former reported experiencing more choice around treatment[108]. Other research in the US has suggested that higher fidelity to the Pathways Housing First model, i.e. closely following the Pathways Housing First philosophy, also seemed to have some beneficial effects on drug use. Reductions and cessation of use of opiates was associated with a service closely reflecting the philosophy of Pathways Housing First[109].

Some research has suggested that the nature of the client group utilising Housing First may be impacting on effectiveness levels. In the USA, an evaluation of Pathways Housing First services concluded that there were beneficial effects from the harm reduction approach being used by Housing First. However, the same research found that there was also some evidence that people with some of the most severe needs related to problematic drug and alcohol use were not engaging with Housing First, noting that:

103 Padgett, D. *et al* (2006) op. cit.

104 Tsai et al (2012) op.cit. Utilising Addiction Severity Index (p=<.01; n2p=.02?) and drug use (p<.01); Mares, A.S. and Rosenheck, R.A. (2009) Twelve Month Client Outcomes and Service Use in a Multisite Project for Chronically Homeless Adults, *Journal of Behavioural Health Services and Research* 37(2), pp. 167-183 - reported largely unchanged alcohol and drug use, but among baseline drug users, crack, cocaine and marijuana use decreased by 28-50% over 12 months.

105 Edens et al (2011) op.cit. Used Addiction Severity Index.

106 Pearson, C., Montgomery, A.E., Locke, G. (2009) Housing Stability among Homeless Individuals with Serious Mental Illness participating in Housing First programs, *Journal of Community Psychology* 37, 3, p.404-417. 80 participants across 3 sites.

107 Busch-Geertsema, V. (2013) op. cit. Note: most of these reports are reliant on self-reporting which is not likely to be as reliable as clinical measures.

108 Edens, 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.

109 Davidson, C., Neighbors, C., Hall, G., Hogue, A.,Cho, R., Kutner, B. and Morgenstern, J. (2013) Association of Housing First Implementation with Outcomes, presentation at the *International Homelessness Research Conference: Advancing the Policy and Practice of Crisis Response Systems*, University of Pennsylvania, 4th-5th June, 2013, http://www.sp2.upenn.edu/ihrc/.

Much lower rates in use of substance-abuse treatment services by Housing First participants can be viewed as both a reflection of lower need and of Pathways' harm reduction approach that tolerates low to moderate use without mandating detox and rehab treatment.[110]

In contrast, there is also some research showing that Housing First approaches can work well with people with very high use of drugs or alcohol. This includes some of the Housing First Europe projects, where the Glasgow project was working exclusively with people using hard drugs, and Copenhagen and Amsterdam where high proportions of people were using drugs and alcohol[111]. Some work with communal Housing First models in the USA have achieved actual reductions in alcohol consumption among chronically homeless people characterised by very heavy drinking. A specialist, intensive, communal Housing First project in Seattle has reported significant reductions in alcohol use, though it should be noted that this was a highly specialised project offering specific support, although within the harm reduction framework approach used by the Pathways Housing First model[112]. Another study in New York showed that a Housing First approach was able to end the homelessness of just over half of a group of formerly chronically homeless people who were dependent on methadone and had severe mental illness, a lower rate of housing sustainment than shown by other studies, but still much higher than the 20% of a comparison group not receiving Housing First services. Continued use of methadone treatment was also higher among the chronically homeless people receiving the Housing First service[113].

One limitation to the existing evidence base is that with the exception of some of the longer scale studies of the New York Pathways model[114], much of the current data is confined to people who have been using Housing First services for quite short periods of time. Some research has suggested that reductions in, or cessation of, drug and alcohol use by chronically homeless people can be dependent on a wide range of factors, including use of treatment and other factors like age, personal relationships, and housing situation[115].

Drug and alcohol use has also been associated with the feeling of a 'loss of control' that can accompany chronic homelessness, this loss of control is centred on the lack of the ontological security that most ordinary citizens have in their lives[116] and there are in addition links between homelessness, social isolation and drug use[117]. Some research has described the relationship between active drug use and homelessness as 'mutually reinforcing'[118]. An

110 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 (p. 231).

111 See Busch-Geertsema, V. (2013) op.cit.

112 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; Collins, S. E. et al (2012) op. cit.

113 Appel, P.W., Tsemberis, S., Joseph, H., Stefancic, A. and Lambert-Wacey, D. (2012) Housing First for Severely Mentally Ill Homeless Methadone Patients, *Journal of Addictive Diseases* 31, pp. 270-277.

114 Tsemberis, S. (2010a) op. cit.

115 Hartwell, S. (2003) Deviance over the Life Course: The Case of Homeless Substance Abusers, *Substance Use and Misuse* 38 (3-6), pp. 475-502; Henwood, B.F., Padgett, D.K.., Smith, B.T. and Tiderington, E. (2012) Substance Abuse Recovery After Experiencing Homelessness and Mental Illness: Case Studies of Change Over Time, *Journal of Dual Diagnosis* 8 (3), pp. 238-246.

116 Burlingham, B., Peake-Andrasik, M., Larimer, M., Marlatt, A. and Springer, C. (2010) A House is not a Home: A Qualitative Assessment of the Life Experiences of Alcoholic Homeless Women, *Journal of Social Work Practice in the Addictions* 10 (2), pp. 158-179.

117 Zlotnick C., Tam T. and Robertson M.J. (2003) Disaffiliation, Substance Use, and Exiting Homelessness, *Substance Use and Misuse* 38 (3-6), pp. 577-599.

118 Kemp P.A *et al* (2006) op. cit.

absence of housing, friends, family, sexual relationships and social support, as well as economic exclusion may all be a part of homelessness and associated drug and alcohol use, again meaning that the process of ending drug and alcohol use is a potentially complex one.

As with mental health, ending or reducing drug and alcohol use for chronically homeless people is a complex process, and it is likely that expecting near-immediate, large-scale, reductions in drug and alcohol use from Housing First services is unrealistic. At the time of writing, there is not enough long-term evidence on the impacts of Housing First service use to be clear exactly how much effect Housing First may have on drug and alcohol use. Housing First seeks to meet support needs that are associated with drug and alcohol use, such as an absence of ontological security and also a lack of social support and integration, through providing settled homes. It will be interesting to see whether or not reductions in drug and alcohol use become more common among people using Housing First when they have been in contact with a Housing First service for several years.

Criticisms of the Housing First approach to drugs and alcohol

Criticism of the Housing First approach to drug and alcohol use among chronically homeless people has been extensive. Critics of Housing First services have advanced three main sets of arguments:

- Housing First services tend not to engage with chronically homeless people making the heaviest use of drugs and alcohol. Rates of drug and alcohol use among Housing First service users are therefore 'automatically' lower than is the case for some other services for chronically homeless people that will work with any homeless person with drug and alcohol problems, no matter how severe those problems are. In addition, restrictions on access to some Housing First services – which are focused on people with diagnosed mental illness - have been criticised as blocking access to some forms of Housing First for homeless people with problematic drug and alcohol use[119].

- While there is no evidence to suggest Housing First services increase drug and alcohol use among the chronically homeless people using Housing First, the evidence of reductions in drug and alcohol use is limited. As reported above, any changes over time tend to be small. Others have claimed that Housing First reports success within 'narrow' terms, focusing on housing sustainment (ending homelessness) while downplaying the limits of the Housing First model in respect of drugs, alcohol and also mental health outcomes[120]. While some American research has reported successes in reducing drinking in communal Housing First projects for chronically homeless people with high rates of alcohol use (see above)[121], other Finnish research on the use of communal Housing First approaches has suggested that the presence of groups of chronically homeless people with drug and alcohol problems in a single building may sometimes be detrimental to recovery from problematic drug and alcohol use and also produce lower rates of housing sustainment[122].

- There are also those who argue that there are alternative approaches to Housing First available that can achieve better outcomes in terms of drug and alcohol use. Advocates of linear residential treatment or staircase models argue that these services seek to achieve more around drug and

119 Kertsez, S.G. *et al* (2009) op. cit.

120 Stanhope, V. and Dunn, K. (2011) The Curious Case of Housing First: The Limits of Evidence Based Policy, *International Journal of Law and Psychiatry* 32, pp. 275-282 and see also Chapter 1 of this report.

121 Larimer, M.E. *et al* (2009) op. cit.; Collins, S.E., Clifasefi, S.L., Dana, E.A. *et al* (2011) Where Harm Reduction Meets Housing First: Exploring Alcohol's Role in a Project-based Housing First Setting, *International Journal of Drug Policy* doi: 10.1016/j.drugpo.2011.07.010.

122 Kettunen, M. and Granfelt, R. (2011) op. cit.; Kettunen, M. (2012) Implementing Housing First in Finland, presentation at *Housing First Partners Conference,* New Orleans. http://hfpartnersconference.com/March_22_215_Single%20site%20HF%20Finland_Kettunen.pdf

alcohol use, in that they actively pursue abstinence from drugs and alcohol, meaning that a 'successful' user of one of these services emerges from chronic homelessness drug and alcohol free and thus 'housing ready'[123]. This is closely linked to arguments that a capacity to live independently is undermined by continued drug and alcohol use and that if a lasting solution to chronic homelessness is to be found, drug and alcohol use must cease[124].

These criticisms of Housing First are, like those made of the Housing First model in respect of mental illness, not without foundation. As seen above, there is evidence that results in respect of drug and alcohol use are limited, and most likely to result in stabilisation rather than large reductions in drug and alcohol use.

Staircase services can and have achieved successes, with people exiting these services free from the drug and alcohol use that had been associated with their chronic homelessness. When staircase services work, they deliver a tangible, clear gain in well-being, they stop drug and alcohol use in much the same way as Housing First services can claim to stop homelessness. The problem is that staircase services achieve only quite low rates of success, often losing between 40-70% of the chronically homeless people they seek to rid of drug and alcohol use and make 'housing ready', before the process of treatment has been completed. There is strong evidence that staircase services are abandoned by chronically homeless people who dislike what can be very strict regimes[125] and also of people becoming 'stuck' in these services, or being evicted from these services, because they cannot meet the criteria of becoming drug and alcohol free[126]. Defence of the linear residential treatment or staircase model has been and remains robust[127] and the staircase approach still predominates in much of the EU and OECD as a response to chronic homelessness. There are clear successes for approximately one third of the chronically homeless people[128]. However, the limitations of staircase approaches compared to Housing First in respect of achieving housing sustainment, in a context where staircase services are also *not* ending problematic drug and alcohol use for a majority of chronically homeless people, does limit the argument that they represent a more 'effective' response to drugs and alcohol use associated with chronic homelessness.

Alternative entirely treatment-led approaches, for example using abstinence-based or detoxification services without any housing element, effectively attempting to 'treat' drug and alcohol use while someone is still homeless, have if anything proven still less successful than staircase services[129].

However, it is clearly not the case that Housing First services represent an immediate or entirely effective solution to drug and alcohol use among chronically homeless people. There is enough evidence to suggest that drug and alcohol use can fall, and that some people may cease to use drugs and alcohol over time, but also that Housing First appears to only sometimes have a stabilising effect and for some service users, no effect, on drug and alcohol use. Housing First does however seek to address several problems, including lack of

123 Rosenheck, R. (2010) op. cit.

124 Goldfinger, S. M., Schutt, R.K. *et al.* (1999) Housing Placement and Subsequent Days Homeless among Formerly Homeless Adults with Mental Illness, *Psychiatric Services* 50(5) pp. 674-9.

125 Dordick, G. A. (2002) Recovering from Homelessness: Determining the "Quality of Sobriety" in a Transitional Housing Program, *Qualitative Sociology* 25 (1), pp. 7-32.

126 Pleace, N. (2008) op. cit.

127 Bebout, R. R. (1999) Housing Solutions: The Community Connections Housing Program: Preventing homelessness by Integrating Housing and Supports, *Alcoholism Treatment Quarterly* 17 (1-2), pp. 93-112; Edens, E.L. (2010) op. cit.

128 Lipton, 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.

129 Ibid.

ontological security and poor social supports, which are associated with problematic drug and alcohol use and the harm reduction model which it employs is not without supporting clinical evidence of effectiveness[130].

Lessons from other services

There is sufficient evidence to indicate that linear residential treatment or staircase services can work for some chronically homeless people and result in someone ending their use of drugs and alcohol. One issue it is important to be aware of is that while there are and have been staircase services that operate with strict, indeed even harsh, regimes and which are often ineffective for chronically homeless people[131], there are alternative staircase models that use a less strict, more supportive and choice-orientated approaches, including services in the US and Britain, for example[132]. These 'tolerant' staircase services may provide an option for those chronically homeless people with problematic drug and alcohol use, though this must be seen in a context in which there is growing evidence that being able to exercise choices about service use has a clear, positive effect on whether or not someone leaves chronic homelessness. Recent arguments made by the founder of Pathways Housing First have also suggested that while it may be desirable for Housing First services to form the core response to chronic homelessness, there should be scope to also use alternative service models if they might suit a particular individual better[133].

Another reason for caution in adopting any single approach to drug and alcohol use among chronically homeless people is some emerging evidence that these forms of homelessness may be more complex than was initially thought. In particular, some Danish and US research suggests the high cost, high risk group of 'chronically' homeless people that was found by US research in the 1990s may be made up of subgroups, or may be a highly complex and diverse population, meaning that no single service response may be entirely suitable[134]. This raises the possibility that there may be some people that Housing First does not suit and who would be better off in a 'tolerant' staircase approach. However, if chronic homelessness is more complex than first thought, both in terms of drug and alcohol use and also more generally, the relatively much more flexible and choice-led approach used by Housing First services may be advantageous because it should be able to adapt to different needs and preferences more easily than other service models.

Beyond this, the lessons from other approaches to drug and alcohol use among homeless people are less obvious. No single approach to reducing and ending problematic drug use or alcohol use has yet been developed, both in terms of 'chronically' homeless groups or in terms of the general population of EU or OECD countries[135]. Each approach, ranging from harm reduction to (enforced) abstinence and treatment has both advocates and detractors, while the evidence

130 McKeganey, N., Morris, Z., Neale, J. and Robertson, R. (2004) What are Drug Users Looking for when they Contact Drug Services: Abstinence or Harm Reduction? *Drugs: Education, Prevention and Policy* 11(5) pp. 423-435.

131 Sahlin, I. (2005) op. cit.

132 Pleace, N. (2008) op. cit.

133 Tsemberis, S. (2013a) op. cit.

134 Benjaminsen, L. (2013b) Testing a Typology of Homelessness Across Welfare Regimes, presentation at the *International Homelessness Research Conference: Advancing the Policy and Practice of Crisis Response Systems*, University of Pennsylvania, 4th-5th June, 2013 http://www.sp2.upenn.edu/ihrc/; Padgett, D. et al (2011) op. cit.; McAllister, W., Kuang, L. and Lennon, M.C. (2010) Typologizing Temporality: Time-Aggregated and Time Patterned Approaches to Conceptualising Homelessness, *Social Services Review* 84(2), pp. 225-255.

135 Pleace, N. (2008) op. cit.

base suggests at least limited strengths, and also weaknesses, in each of the two main philosophies that various models of drug and alcohol services follow[136].

Housing First and Physical Health

The promotion of ontological security through the provision of settled housing which is intended to be a 'home' instead of accommodation and the intention to promote social integration (see Chapter 3) that are integral to Housing First services, are both approaches associated with the promotion of public health. People in adequate, affordable and secure housing and who have access to a range of social supports generally have better health status than those who do not[137]. Health research, including work across Europe and within France, has suggested that poor social supports may negatively influence health even when someone has a high income, despite the strong associations between social economic status and health that exist in many economically developed countries[138].

Homelessness is associated with a wide range of risks to emotional, mental and physical well-being because it is associated with both the stress of lacking housing and also, when recurrent or sustained, with social isolation[139]. The 'buffering' hypothesis, that people with good emotional supports, including a sexual relationship, family relationships and friendship networks and who can access practical assistance, advice from those social supports, as well as feeling valued and emotionally secure, is now widely accepted as reducing the rates at which people experience illness and the rate at which they recover from illness[140]. Homelessness can also create barriers to health systems, even in contexts as in France or Britain, where access to free universal health care is central to public policy[141]. By promoting ontological security, enhancing social supports and also by directly providing, or arranging access to, health and support services, Housing First should, in theory, generate significant gains in physical health.

The evidence base for the influence of Housing First on physical health is limited. While there have been a considerable number of studies looking at the impact of Housing First services on housing sustainment and ending homelessness and in addition on mental health and problematic drug and alcohol use, changes in physical health have not been as thoroughly assessed. Many chronically homeless people using Housing First services do have poor physical health, this can be a result of living a homeless life for many years, may be a result of problematic drug and alcohol use or may sometimes predate homelessness. Housing First services do either directly provide or arrange access to primary health care and there is evidence of engagement with health services improving as a result of Housing First services[142]. However, evidence from the Collaborative Initiative to Help End Chronic Homelessness in the USA found no change in physical health status over 12 months following rehousing[143].

136 McKeganey, N. *et al* (2004) op. cit.

137 Berkman, L.F., Glass, T., Brissette, I. and Seeman, T.E. (2000) From Social integration to Health: Durkheim in the New Millennium, *Social Science and Medicine* 51, pp. 843-857; Pleace, N. and Quilgars, D. (1996) op. cit.

138 Cambois, E. and Jusot, F. (2010) Contribution of Lifelong Adverse Experiences to Social Health Inequalities: Findings from a Population Survey in France, *European Journal of Public Health* 21(5), pp. 667-673.

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

140 Cohen, S. and Wills, T. (1985) op. cit.

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

142 Tsemberis, S. (2010) op. cit.

143 Tsai et al (2012) op.cit. Utilising the Medical Outcomes Study Short Form-12 (physical health questions).

In Britain, where extensive research has been conducted into health care for people living rough or in emergency and supported accommodation for homeless people, there is a longstanding debate about the merits of providing specialised health services, which arguably separate and isolate homeless people from the general population and the merits and challenges in trying to enable homeless people to use the mainstream public health services. There is no simple answer to this debate, as there is evidence in favour of, and against, both of these approaches[144]. At present, it is unclear how much impact Housing First services may have on physical health, whether directly providing or arranging access to health services. However, formerly chronically homeless people may have chronic and limiting illnesses, perhaps preceding and perhaps worsened or sometimes caused by homelessness, which can be treated, but not cured. Some recent work on a small Housing First project in London found that among chronically homeless people with a very sustained history of homelessness, the 'damage' of conditions associated with intravenous drug use or high rates of alcohol consumption could not be reversed. While the Housing First service was able to provide housing stability and access to health services, some people using the service were going to continue to experience long term, limiting illness for the rest of their lives[145].

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

145 Pleace, N. and Bretherton, J. (2013) *Camden Housing First: A Housing First Experiment in London (*York: Centre for Housing Policy).

3. HOUSING FIRST AND SOCIAL INTEGRATION

Introduction

This chapter examines the evidence available on the extent to which Housing First projects have facilitated the social integration of formerly homeless people. The first part of the chapter looks at the concept and measurement of social integration. The chapter then moves on to describe the Housing First approach to social integration, reviews the existing evidence of effectiveness and also considers the lessons from other services.

Social Integration

Social integration is a complex concept and there is no one definition. However, it is widely agreed that social integration is a multi-dimensional concept and one that focuses on whether disadvantaged people are able to live, work, learn and participate in their communities to the extent that they wish to, and with as many opportunities as other members of the wider community.

For people experiencing sustained and recurrent homelessness there are many parallels with the experience of people with severe mental illness or mental health problems. Like chronically homeless people, as a result of their illness, people with mental health problems can become socially isolated and alienated and disconnected from the 'normal' relationships ordinary citizens have with their neighbours, the wider community and also with living a life that includes the social integration and economic participation that can come from paid work. The parallels[146] with the situations of people with mental health problems and chronically homeless people resulted in the 'staircase' and later 'Housing First' services targeted on chronically homeless people being based on earlier mental health service models[147]. Similarly, when seeking to promote, measure and understand social integration, both the design of Housing First services and the evaluation of Housing First services[148] has been heavily influenced by the lessons from mental health service provision and evaluation.

In a seminal paper, Wong and Solomon[149] developed a model of community integration for people with mental health problems which identified three main types of integration:

- **Physical integration** – extent to which people participate in activities, and use goods and services, in the community in a self-initiated manner;
- **Social integration** – extent to which people engage in social interaction with community members in normative settings, and the quantity/ quality of a person's social network;
- **Psychological integration** - extent to which people feel they are members of the community, feel emotionally connected to neighbours and exercise influence in the community.

146 O'Sullivan, E. (2008) Pathways through Homelessness: Theoretical and Policy Implications, in: J. Doherty and B. Edgar (eds.) *'In My Caravan, I Feel Like Superman': Essays in Honour of Henk Meert*, 1963–2006 (Brussels: FEANTSA), pp.71–100.

147 Tsemberis, S. (2010) op. cit.

148 Tsemberis, S., Rogers, E.S., Rodis, E., Dushuttle, P. and Skryha, V. (2003) Housing Satisfaction for Persons with Psychiatric Disabilities, *Journal of Community Psychology* 31(6), pp.581-590.

149 Wong, Y. L. I. and Solomon, P.L. (2002) Community Integration of Persons with Psychiatric Disabilities in Supportive Independent Housing: A Conceptual Model and Methodological Considerations, *Mental Health Services Research* 4(1) pp.13-28. This is identified as 'a leading model' of community integration in the field of psychiatric disability (Gulcur *et al*, 2007, op. cit., p.213).

Wong and Solomon also proposed a model which could systematically examine which features of independent housing programmes were predictive of different levels of community integration. Their work identifies four aspects of service design:

- **Housing environment** – including accessibility of community resources from home; supportiveness of community (for example, whether it is an accepting community), safety of neighbourhood;
- **Behavioural environment** – including programme policy/ rules; levels of choice and autonomy; service availability;
- **Support environment** – including quality of interaction among residents and staff; encouragement of personal expression; opportunities to focus on learning and work skills;
- **Personal factors** – including socio-demographic attributes; clinical characteristics; housing preferences.

All of the above can be hypothesised to impact on levels of community integration. For example, people may be more likely to access community resources if their homes are proximate to shops and facilities; they may also be more likely to participate in activities if encouraged to do so by support workers staff, and so on.

Ware *et al*[150] have argued for a redefinition of social integration to better capture social dimensions, focusing on the 'capabilities approach' which looks at what people can do and be in everyday life, and how their competencies and opportunities are shaped by social environments. From qualitative work, focused on people with severe mental illness, Ware *et al* define social integration as

> *...a process, unfolding over time, through which individuals who have been psychiatrically disabled increasingly develop and exercise their capacities for connectedness and citizenship.*[151]

Ware *et al* argue that this definition requires social change as well as looking at people's individual quality of life, for example, the (dis)incentives that can exist in welfare benefits system that may make it difficult for people to work.

Broadly speaking, American conceptions of what 'citizenship' and therefore of what an active, socially integrated citizen should be, parallel those found in EU member states. The idea that there is a relationship between a citizen and society, that society provides civil and political rights and (to varying degrees) social protection, in return for political and economic participation is near universal in democratic countries. A growing 'disconnection' between citizens and formal political participation is seen as a social problem in many EU member states[152].

However, in some French and European philosophical debates on social integration and the concept of citizenship[153], there is arguably more nuance and complexity, centred on the idea that 'exclusionary' situations can also be simultaneously 'supportive'. For example, an 'excluded' space, populated by a migrant population who are largely unemployed can also be a space in which there is extensive social support, which may counteract risks of sustained or recurrent

150 Ware, N.C., Hopper, K., Tugenberg, T., Dickey, B. and Fisher, D. (2007) Connectedness and Citizenship: Redefining Social Integration, *Psychiatric Services*, 58(4), pp. 469-474.

151 Ibid, p. 471.

152 Bouget, D. and Brovelli, G (2010) Citizenship, Social Welfare System and Social Policies in France, *European Societies* 4(2), pp. 161-184.

153 Blanc, M. (1998) Social Integration and Exclusion in France: Some Introductory Remarks from a Social Transaction Perspective, *Housing Studies,* 3(16), pp. 781-792; Blanc, M. (2008)The Impact of Social Mix Policies in France, *Housing Studies* 25(2), pp. 257-282.

homelessness[154]. Equally, arguments have sometimes been made that homelessness, particularly the sustained and recurrent homelessness experienced by chronic homeless people, while removed from mainstream social and economic life, also provides social support, in some senses a kind of 'community', to which a sense of 'belonging' develops. While, the idea that there is a consistent, distinctive homeless "culture" is not well evidenced[155], the idea that chronic homelessness means a 'total' lack of *any* form of social integration does need to be treated with caution.

It is also important to consider what is meant by 'social integration' in a wider sense. Social, and community, interactions have become increasingly complex in economically developed societies. Sociologists have long recognised that communities do not only develop around 'place', but also from shared interests and identities (with close-knit communities exhibiting all three dimensions)[156]. Further, there is evidence that dispersed networks of family, friends and also work related contacts, maintained using information and communication technologies, are an increasingly commonplace aspect of social integration in economically developed societies[157]. Exclusion, for chronically homeless people, might therefore exist in terms of connectedness to the community living around them, but also possibly because they may not have access to dispersed networks.

More generally, when considering the situation of formerly homeless people, it is also crucial to consider what levels of participation or integration is expected of others in the local and wider community – the extent to which it is a 'social norm' to be a member of a balanced, cohesive and socially interactive community[158].

Bearing these points in mind, this chapter focuses on four main sub-categories of social integration:

- *Passing* – community acceptance[159]
- *Joining* – community participation
- *Working* – economic participation
- *Voting* – political participation

The Review only identified a relatively small literature that addressed the social integration of homeless people. Due to the relative lack of available evidence around homelessness, a decision was made to incorporate lessons on social integration from other marginalised groups of people in society, particularly people with mental health problems. It is important to note that most of the studies reported below did not utilise a control or comparison group, nor did they compare results with wider population surveys which collected data on social integration indicators. This is a major gap in the literature.

Housing First and Social Integration

The Housing First approach to social integration

The Housing First approach to social integration centres on enabling chronically homeless people to live as independently as possible in normal housing in a normal neighbourhood. In the Housing First approach, social integration is seen to result from normalisation of housing and normalisation of living situation. Through facilitating formerly chronically homeless people to live in the same way as everyone else, with the same

154 Kaag, M. (2008) Mouride Transnational Livelihoods at the Margins of European Society: The Case of Residence Prealpino, Brescia, Italy, *Journal of Ethnic and Migration Studies* 34(2), pp.271–85.

155 O'Sullivan, E. (2008) op. cit.

156 See Means, R. and Evans, S. (2012) Communities of place and communities of interest? An exploration of their changing role in later life, *Ageing and Society* 32(8) pp.1300-1318.

157 Savage, M., Bagnall, G. and Longhurst, B. (2005) *Globalization and Belonging* (London: Sage).

158 Savage, M. *et al* (2005) op. cit.

159 'Passing' is a sociological and philosophical concept centred on the idea that someone is not visibly different, in appearance, behaviour and other characteristics from those around them, making the likelihood that they will be identified as 'different' and therefore at higher risk of experiencing stigmatisation and prejudice, see Goffman, E. (1963) *Stigma* (London: Penguin).

choices and opportunities for neighbourhood-based social interaction, Housing First seeks to promote social integration. This approach is summarised in the 2010 'Pathways' Housing First manual:

> *Pathways Housing First seeks to help clients integrate into their community as fully as possible, and the housing component plays an important role in achieving this goal.*[160]

> *The likelihood of stigma associated with being a member of a psychiatric treatment programme is reduced, because the programme is not visible on site, and clients live in normal settings. Clients frequently interact with their neighbours at the local market, Laundromat, movie theatre, coffee shop or park. The clients share the same community and socialization opportunities as their non-disabled neighbours.*[161]

Housing First services seek to promote social integration through placing people back into the community through the provision of a settled home, which is intended to provide ontological security and a 'base'[162] from which social integration can start to take place. Living in the community, in the same way as everyone else does, is intended to bring a Housing First service user into that community, making them a part of it[163]. The emphasis, in models such as Pathways Housing First, tends to be on *local* community and neighbourhood.

Most Housing First services do not *appear* to focus specific effort on social integration in terms of interventions directed at increasing participation in the local community. Generally, the extent to which the efforts of Housing First services to promote social integration are *described*, or evaluated, in the literature is limited. This may in part be because the initial focus of Housing First services is on housing sustainment and it is only after housing stability has been achieved that social integration might begin. However, the lack of discussion suggests that some examples of Housing First services are not, at least at the time of writing, focusing a great deal of attention on social integration.

The effectiveness of Housing First

Passing (acceptance)

One of the major barriers to housing for chronically homeless people, and indeed homeless people in general is the expectation or belief that they will present housing management problems. For the private landlord, there will often be concerns that a formerly homeless person will present with mental health problems and drug and alcohol problems, that they will be criminal, negligent in how they treat the housing, fail to pay the rent and be a 'bad neighbour' to those around them. For the social landlord, the concerns are often exactly the same, with an additional concern that housing large numbers of homeless people may create spatial concentrations of poverty, poor areas which have additional negative 'area effects' on the people living within them[164]. It is important not to fall into easy and inaccurate stereotypes, as there is considerable evidence that many - possibly the majority - of homeless people do *not* have high support needs[165], however where people do have severe mental illness, problematic drug and alcohol use, or (related or unrelated) challenging behaviour, this can be a potential barrier to social integration.

160 Tsemberis, S. (2010b) op. cit. p.53.

161 Tsemberis, S. (2010b) op. cit. p.54.

162 Padgett, D. (2007) op. cit.

163 Tsemberis, S. (2010b) op. cit.

164 Pleace, N. Teller, N. and Quilgars, D. (2011) *Social Housing Allocation and Homelessness*, EOH Comparative Studies on Homelessness (Brussels: FEANTSA).

165 O'Sullivan, E. (2008) op. cit.

These barriers relate to Housing First in two senses. First, Housing First provides access to housing which can guarantee the payment of rent to landlords. The Pathways Housing First service, as has been discussed elsewhere[166], uses sub-tenancy or lease arrangements, with the tenancy for a rented apartment being held by Pathways and formerly chronically homeless people holding a sub-tenancy. This also allows anyone experiencing difficulties with neighbours an opportunity to move to another apartment. Second, Housing First support services can potentially help overcome any issues around nuisance and bad behaviour that may be a barrier to formerly chronically homeless people living successfully in their own home.

Existing evidence suggests that nuisance or disruptive behaviour is not a major problem in most Housing First projects and/or that the project is effective in addressing any issues. The Housing First Europe project collected some information on reported neighbourhood conflicts[167]. In three projects (Copenhagen, Glasgow and Lisbon), conflicts were rare and were usually successfully resolved via the work of the project. For example, in Lisbon, the Housing First project brought together all partners to find a solution in the rare cases that an issue was presented. In Glasgow, staff also acted as intermediaries with relevant parties to avoid evictions in almost all cases and that:

> *...housing providers report that their initial anxieties about the risk of service users being involved in antisocial behaviour (as either victims or perpetrators) had not been borne out in practice.*[168]

However, in contrast, the Discus Housing First project in Amsterdam encountered high rates of nuisance behaviour, with nuisance being associated with 41 of the 100 Housing First apartments[169]. Although only a quarter (24%) of disputes were defined as serious, three service users fell out of the Discus service due to nuisance behaviour, but most of those given a second chance following more serious behaviour did not exhibit that behaviour again[170]. However, it should be noted that Amsterdam is part of a wider 'G4'[171] strategy that was partially targeted on reducing nuisance behaviour among street using homeless people: it is therefore possible that the service was aimed at those with challenging behaviour to a greater extent than the other Housing First Europe projects.

Some American studies have examined Housing First and criminal activity. One recent study looked at communal Housing First services[172]. Findings indicated that the number of days spent in prison and bookings fell among many chronically homeless people when they started to use Housing First services[173]. The

166 Johnson, G., Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia,* AHURI Final Report No. 184, (AHURI: Melbourne).

167 Busch-Geertsema, V. (2013) op. cit.

168 Johnsen, S. with Fitzpatrick, S. (2013) *Glasgow Housing First: Final Report for the Housing First Europe Project*, Unpublished. p22

169 Four main areas of nuisance reported: psychosis and drugs (13; 32%); noise, such as music or slamming of doors (12; 29%)-drugs and alcohol (11; 27%); psychosis (5; 12%). 41 problems were reported for 39 people. 123 people had lived in the apartments over the evaluation period. Wewerinke, D. et al (2013) op. cit.

170 Wewerinke, D. et al (2013) op. cit.

171 The four largest cities in the Netherlands, Amsterdam, The Hague, Rotterdam and Utrecht.

172 Clifasefi, S.L., Malone, D.K. and Collins, S. E. (2012) Exposure to Project-based Housing First is associated with Reduced Jail Time and Bookings, *International Journal of Drug Policy*, http://dx.doi.org/10.1016/j.drugpo.2012.10.002.

173 Ibid. Days spent in prison fell from a mean of 41 days to 18 days and prison bookings fell from a mean of 3.43 bookings to 1.49.

study found that the vast majority of convictions were 'misdemeanours', likely to be associated with homelessness. Earlier research has suggested there is a generally positive relationship entering accommodation with support and reductions in criminality, meaning the positive effect may not be confined to Housing First models[174].

Joining *(participation)*

There is some evidence that people using Housing First who are settled into scattered housing, start to exhibit what can be called 'normalised' behaviour as a result of ontological security, arising from having a settled home. What this means is that, essentially, they start to pay their household bills, organise their home, go to the shops, cook themselves food, go for a walk in the park and do many of the other things that people tend to do in their own homes. Recent research in London has suggested that even very high need chronically homeless people with a prolonged history of homelessness, people who have essentially never lived independently or had a home in an orthodox sense, start to *behave* in a very similar or identical way to 'housed' people once they are resettled into scattered housing[175]. USA qualitative research shows how rehoused people (in Housing First and other scattered housing) report increased feelings of privacy, independence and freedom to pursue interests[176].

In the Housing First Europe project[177], in four of the five projects (Amsterdam, Lisbon, Glasgow and Copenhagen), the projects encouraged and supported participants to access community resources, such as sports and recreation facilities, libraries, local cafes and restaurants, community events as well as specific health, drug and alcohol community programmes. However, the extent to which participants engaged in community activities differed considerably within any one project. For example, in Lisbon, almost half of the 45 interviewees reported having met people at a restaurant or coffee shop in the last month, one in seven had gone to a library or participated in sports/ recreation activities, but less than one out of ten had participated in a community event or attended a movie or concert. The small numbers and lack of comparison/ control groups with local population make interpretation of the results difficult.

Similarly, some details were collected on Housing First participants' contact with neighbours in two projects, Lisbon and Glasgow[178]. A minority of participants reported interactions with neighbours in both projects, and some participants reported a desire to maintain their privacy. Again, while unmeasured, it is possible that this behaviour is similar to other (non-Housing First) members of the community. In Lisbon, 71% stated that they felt at home in their neighbourhood and just over half (56%) reported a sense of belonging to their community.

A couple of recent US studies have also investigated social integration for the first time, with findings less than conclusive about the potential role of Housing First in this area. Tsai *et al*[179] tracked 550 chronically homeless adults with mental health problems across an 11-site Collaborative Initiative to Help End Chronic Homelessness (CICH) for one year after rehousing into permanent housing[180]. They recorded a small but statistically significant increase in community

174 Culhane, D., 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(1), pp.107-163.

175 Pleace, N. and Bretherton, J. (2013) op. cit.

176 Yanos, P. T., Barrow, S. 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) pp.133-150.

177 Busch-Geertsema, V. (2013) op. cit.

178 Ibid.

179 Tsai, J., et al (2012) op. cit.

180 It should be noted that the services did not have a specific focus on social integration per se.

participation (examining activities over the 'last two weeks') over the period, including increases in number of service users who used a bank; visited a grocery store; visited close friends, relatives or neighbours; went to a shopping centre or similar. However, there was no increase in activity in many other areas including use of public transport, libraries, and cultural events[181]. Social support also did not significantly change over time. Importantly, any changes in social integration were not found to be significant following changes in clinical symptoms, suggesting that the degree to which someone experiences social integration may be partly mediated by symptom changes[182].

An earlier study including 183 Housing First participants in New York examined community integration[183] after four years rehousing, compared to a services as usual (Continuum of Care services)[184]. This study found the Housing First project was statistically more likely to predict social integration[185] – one of the four domains of community integration examined - than the treatment as usual services. Some aspects of community integration were not predicted by Housing First (nor by other programme domains like mental health treatment) and the work was not longitudinal. Nonetheless, the authors concluded[186]:

> *Considering that our study found that a normalised residential arrangement was the only significant predictor of social integration, this would suggest that services may need to shift towards the provision of housing that most closely resembles that of the general population, for example independent scatter-site housing in the community. Additionally, housing agencies should encourage consumers to exercise choice regarding their lives, especially since this increased sense of autonomy leads to a greater sense of belonging and well-being. The Housing First model, with its emphasis on independent housing, consumer choice and empowerment, may therefore be particularly well suited for enhancing community integration.*

Overall, the limited evidence suggests that Housing First is likely to have some impact on community participation, but not on all aspects of integration. Other models that can offer independent housing may also have similar levels of success. However, as indicated in Chapter 2, many participants will continue to experience mental health problems and drug and alcohol issues, and this may hamper their progress on community integration.

The studies undertaken to date in this area are also rather limited in scope. Only one small study included a measure of neighbourhood cohesion[187], here measured by socio-economic disadvantage, residential stability and immigrant concentration (with only the latter factor found to be associated with community integration). However, more work is needed to explore possible neighbourhood effects, as well as the impact of poverty more generally. No studies have examined the role of dispersed networks on social integration.

181 Tsai, J. *et al* (2012) op. cit. Limited incomes may explain why some activities are not often pursued.

182 Tsai, J. *et al* (2012) op. cit., p. 432.

183 Also using Wong and Solomon's model, with an added domain of 'independence/ self-actualisation'.

184 Gulcur, L., Tsemberis, S., Stefancic, A. and Greenwood, R.M. (2007) Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness, *Community Mental Health Journal* 43(3) pp.211-228.

185 Ibid, Included two measures: satisfaction with social support and number of social network members.

186 Ibid, P.224

187 Yanos, P. T., Felton, B.J., Tsemberis, S. and Frye, V.A. (2007) Exploring the Role of Housing Type, Neighbourhood Characteristics, and Lifestyle Factors in the Community Integration of Formerly Homeless Persons Diagnosed with Mental Illness, *Journal of Mental Health* 16(6) pp.703-717.

For those living in communal, or 'single site' Housing First services, the capacity to participate in any community may be potentially undermined by living physically separate lives in a different form of accommodation to people around them and, through that, being marked as 'different'. There have also been reports of relatively less successful rates of housing sustainment in some communal models of Housing First, which means the stability and ontological security of a settled home is not achieved, and capacity to socially integrate is therefore limited.

Working *(economic participation)*

The evidence that is available at present does not suggest that Housing First services generate employment or other forms of formal economic participation at a high rate[188]. However, there are some indications that it may be possible for Housing First projects to have a greater impact in the area of training, education and other meaningful activity.

Early results from the Housing First Europe project found that very few participants were in paid work[189]. However, participation levels in training, education and other activities were more mixed. For example, only 13% of Copenhagen participants undertook any form of activity. However, 28% of participants were engaged in voluntary work in Amsterdam, and 32% of Lisbon Housing First participants were involved in job site training, educational courses or other meaningful activities.

The recent large study of Housing First outcomes in the USA (550 homeless people across 11 sites) found no significant differences in levels of employment among participants after one year, and a slight decrease in the number of people volunteering[190]. However, the study did find that Housing First service users who were participating in the community were also more likely to be working (and have better social supports). Whilst not all aspects of social integration are related[191], this finding may suggest that having a settled home may act as a 'gateway' to social inclusion for some people: the 'normalisation' of having a home facilitating becoming part of the community, which in turn can help people progress to the point where they can enter paid work. However, it is also possible that the association is in the other direction, with work facilitating better social supports and social inclusion.

Qualitative work on Housing First indicates that employment is often seen as a long-term goal by most service users (and staff)[192], something to work towards rather than to obtain immediately on rehousing. Canadian research on Housing First[193] explored how people's lives changed over 18 months following rehousing, and identified that people were less likely to be preoccupied with survival, and more likely to be 'future orientated'. Some goals also remained 'vague' at 18 months. Researchers concluded that Housing First was facilitating a 'sense of personhood' from which most (though not all) could begin to 'envision a different future'[194]. This Housing First programme is delivering a

188 Pleace, N. (2012) op. cit.; Johnson, G. *et al* (2012) op. cit.

189 Busch-Geertsema (2013) op.cit.

190 Tsai, J. *et al* (2012) op. cit.

191 Ibid. The study looked at the interrelationships between housing, work, social support, community participation, civic activity and religious faith.

192 Busch-Geertsema, V. (2013) op.cit.

193 Mental Health Commission of Canada (2012) *Beyond Housing: At Home/ Chez Soi Early Findings Report (*Mental Health Commission of Canada);

194 Polvere, L., Macnaughton, E. and Piat, M. (2013) op. cit.

number of specific Employment, Training and Education (ETE) programmes, for example: the Moncton 'At Home' Services which provides full-time vocational support to help people identify work opportunities, and a community employment project where participants are employed by the project to provide cleaning, packing and moving services (15 people employed). The traditional model of Housing First has not tended to deliver additional services of this nature; whilst yet to be fully evaluated, it is possible that specific assistance will be required in this area, over a significant period of time, to assist people to become employment-ready. Some evidence may soon become available on this, for example there have been experiments in combining a Housing First service with a supported employment programme in Seattle[195] and in Canada[196].

An existing body of research[197] suggests that chronically homeless people are often very distant from the point at which they can enter education, training or work related activity, or secure and maintain paid work. They may lack (recent) work experience and have limited educational attainment. Factors such as a criminal record, drug and alcohol problems or a history of such problems or a history of mental health problems may deter employers from offering work to formerly chronically homeless people, even in a situation in which they have been successfully rehoused by a Housing First service. There are also strong relationships between severe mental illness and problematic drug and alcohol use and unemployment.

Voting *(political participation)*

There is little evidence on which to base a discussion of the role of Housing First services in promoting political participation. The logic of Housing First as a means to enable political participation again centres on the security of a home forming the base from which community participation, economic activity and then political participation can be built. There is some evidence to support this idea, as for example reported in the recent large scale analysis of 550 Housing First service users conducted in the USA, although the increase over one year was from a minority of 21% of service users saying they did intend to vote to 31%, still a minority, saying they intended to vote[198].

Generally, however, the question of political participation is not one that has been explored by the research and evaluation that has been completed on Housing First services. This represents a gap in the evidence base on Housing First services.

Criticism of the role of Housing First in promoting social integration

It is generally agreed that there has been very little research that has examined the extent to which Housing First services have a positive impact on the social integration of chronically homeless people. Where research is available, the effects of Housing First on social integration are not always clear. This

195 http://wliha.org/sites/default/files/B9%20Housing%20First%20with%20SE-Yakima.pdf; http://www.slideshare.net/naehomelessness/16-supported-employment-increasing-employment-for-people-with-disabilities

196 Nelson, G.; Macnaughton, E.; Caplan, R.; Macleod, T.; Townley, G.; Piat, M.; Stefancic, A.; Tsemberis, S. and Goering, P. (2013) *Follow-up Implementation and Fidelity Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project: Cross-Site Report* Mental Health Commission of Canada.

197 Zuvekas, S.H. and Hill, S.C. (2000) Income and Employment Among Homeless People: The Role of Mental Health, Health and Substance Abuse, *The Journal of Mental Health Policy and Economics* 3, pp. 153–163; Cook, J.A. (2003) Employment Barriers for Persons With Psychiatric Disabilities: Update of a Report for the President's Commission, *Psychiatric Services* 57(10) pp.1391-1405; Kemp. P. and Neale. J. (2005) Employability and Problem Drug Users, *Critical Social Policy* 25 (1) pp.28-46; Mavromaras, K., King, D., Macaitis, K., Mallett, S. and Batterham, D. (2011) *Finding Work: Homelessness and Employment* (Melbourne: Australian Government).

198 Tsai, J. *et al* (2012) op. cit.

may in part be a result of poorly developed measures of community integration. Researchers in the field have called for further developments in this area, including consultation with service users on which aspects of community integration are important[199].

In the US, these arguments have been summarised in terms of establishing exactly *how* the ontological security potentially offered by a 'home', which is what Housing First delivers, lead to social integration. Someone using Housing First could take their sense of certainty, security and predictability which their home has given them and start forming relationships with neighbours, (re-) establishing contact with family, becoming active in the community, gain confidence and move on to work-related activity and eventually paid work. However, alternatively, Housing First participants may become socially isolated in their own tenancy and remain economically inactive.

Hopper has argued that there is insufficient evidence to underpin the Housing First idea that social integration will flow from living in the community in ordinary housing. She questions, for example, whether too much burden is being placed on the capacity, will and initiative of formerly chronically homeless individuals to 'make themselves' socially integrated[200]. A similar criticism has been advanced by Hansen Löfstrand and Juhila, arguing that Housing First services still define the behaviour of chronically homeless people as something that needs to be 'corrected' (albeit relatively slowly and flexibly), echoing the underlying logic of staircase services in the sense that it seeks to install and reinforce 'self-governing' behaviour that will make the people using Housing First 'responsible choice makers'[201].

These criticisms question one of the central elements of Housing First, that a 'connection' between living in ordinary housing and social integration cannot presume to exist. Further, there may be ethical considerations around whether such services should be pursuing or expecting 'normalisation' and social integration for people who were not formerly linked into society in this way. An argument has also been advanced that if Housing First services set up the same kinds of expectations around behaviour modification as are a feature of staircase services, there may be a risk of service failure in the same way[202].

At present, some earlier models of Housing First do ask participants to accept weekly visits, comply with terms of leases or tenancies and in the case of some services, there is an element of financial control over participants. Some newer models (for example, in Canada) provide direct assistance with learning, training and finding jobs. Other housing and support models, most particularly the Foyer model in Britain and France, have asked for service users to participate in employment and learning related initiatives as part of a 'contract' with the organisation. This is unlikely to sit easily with the overall Housing First philosophy of consumer choice. The philosophy of harm reduction might, however, be complemented by one which seeks to maximise people's opportunities, offering services to assist with social integration if and when participants are ready to engage with them.

Finally there is the question of what might be termed 'internal' arguments among advocates of Housing First as to whether different models of Housing First are better at promoting social integration than others. A

199 Gulcur, L. et al (2007) op.cit.

200 Hopper, K. (2012) The Counter Reformation that Failed? A Commentary on the Mixed Legacy of Supported Housing, *Psychiatric Services* 63(5), pp.461-463.

201 Hansen Löfstrand, C. and Juhila, K. (2012) The Discourse of Consumer Choice in the Pathways Housing First Model, *European Journal of Homelessness* 6(2), pp.47-68.

202 Dordick, G. (2002) op. cit.; Sahlin, I. (2005) op. cit.

key debate among providers and advocates of Housing First services centres on the extent to which communal Housing First services, also known as 'single site' or 'project-based' Housing First, can promote community acceptance and participation ('passing' and 'joining'). The issue is to what extent a communal Housing First service, based within a specially-built or modified block of apartments in which all, or the bulk of residents are formerly chronically homeless people, can be part of a community.

Residents of a communal Housing First project could be argued to be highly visible and thus unable to 'pass' in the community as 'ordinary neighbours' because they are known to live in separate, specialist supported housing which, in turn, might undermine their capacity to participate within (join) community life[203]. There is also some growing evidence that housing sustainment levels in communal or single site models of Housing First may sometimes be less than for scattered site approaches (see Chapter 1). By contrast, there are those who argue that communal models can act as sources of social support in their own right, creating communities of support, in effect a kind of 'mini-neighbourhood' within the building and that, with the right policies in place, it is also possible to socially integrate formerly chronically homeless people living in communal Housing First models into the neighbourhoods surrounding them[204].

Key experts tend to agree that communal models may better meet the needs of a small minority of marginalised homeless people who cannot cope in scattered housing[205].

Lessons from Other Services

Homelessness services

Other European evidence on (non-Housing First) housing and support models for homeless people also suggests very mixed results in terms of community integration following rehousing. Considerable British research has indicated that homeless people may often be socially isolated with low levels of economic activity[206]. Some research, however, has argued that independent accommodation remains the essential ingredient in the social integration process because of the 'power of 'normality' associated with it[207].

Homelessness services have a long history of providing specialist support with training, education and accessing employment in some European countries and in the USA[208]. There is some evidence to suggest that employment-led services, i.e. homelessness services that attempt to secure paid work for homeless people without *also* addressing housing need, tend to meet with limited success. Barriers to paid employment for chronically homeless people, ranging from capacity

203 Tsemberis, S. (2011) op. cit.; Kettunen, M. (2012) op. cit.; Busch-Geertsema, V. (2013) op. cit.

204 Social Innovation Europe interview with Juha Kaakinen 2011. http://www.socialinnovationeurope.eu/magazine/local-development-and-communities/interviews/ending-homelessness-finland.

205 Tsemberis, S. (2012) Housing First: Basic Tenets of the Definition Across Cultures, *European Journal of Homelessness* 6(2), pp. 169-173; Busch-Geertsema, V. (2012) The Potential of Housing First from a European Perspective, *European Journal of Homelessness* 6(2), pp.209-216.

206 Jones, A. and Pleace, N. (2010) op. cit.; Crane, M., Warnes, A.M. and Coward S. (2011) *Moves to Independent Living: Single Homeless People's Experiences and the Outcomes of Resettlement* (Sheffield: Sheffield Institute for Studies on Ageing, University of Sheffield).

207 Tosi, A. (2005) Re-housing and Social Reintegration of Homeless People: A Case Study from Milan, *Innovation: the European Journal of Social Sciences* 18 (2), pp.183-203.

208 Mares, A.S. and Rosenheck, R.A. (2006) Attitudes towards Employment and Employment Outcomes among Homeless Veterans with Psychiatric and Substance Abuse Problems, *American Journal of Psychiatric Rehabilitation* 9, pp. 145—166.

to do some kinds of work through to negative employer attitudes, also remain significant[209]. Employment services for people with a mental health problem, which have met with some success in the EU and the USA[210], have been drawn upon when trying to design employment interventions for chronically homeless people, but these services are primarily designed for housed populations. There are also limitations to the existing EU evidence base, centred on a lack of longitudinal data showing the extent to which any jobs which homeless people secure are sustained[211].

Services for people with mental health problems and other client groups

Community mental health services have addressed social integration issues for their clients for many decades. In Europe and the USA, post-institutionalisation programmes have provided a range of day services designed to provide meaningful activity and also assist re-integration of former psychiatric patients into society. There has also been an assumption, also evident in Housing First services, that supportive independent housing is the most effective means to pursue social integration[212]. However, until Wong and Solomon's paper[213], there had been little attempt to define social integration for people with mental health problems, with it generally being investigated as a one-dimensional concept[214]. For example, research had focused on physical integration, especially location and living situation, or social support and quality of life. Considerable research had highlighted the tendency towards the residential segregation of people with severe mental illness in the USA, although more recent evidence has suggested that this may have lessened over time[215]. The most recent research has suggested that people diagnosed with severe mental illness in some USA cities may have relatively good geographic access to, and availability of, community resources that they see as important (for example, supermarkets, public transport, health facilities) compared to the general population[216]. Another recent study, however, found that mental health consumers had lower scores (relatively small differences though statistically significant) on indicators of objective community integration than other community members (on measures of physical, social and citizenship integration). However, this difference was not explained by psychiatric factors, and length of time in residence was a key factor in facilitating the social integration of mental health consumers[217].

Within disability studies[218], citizenship principles underlie the focus on community integration, with opportunities to participate in the community to the same extent as people without disabilities seen as a right for people with disabilities[219]. Services are therefore designed to provide people with the most normalised living environment, supported by the appropriate services to enable them to make use of community services and facilities. The 'Social Model' of disability emphasises the

209 Jones, A. and Pleace, N. (2010) op. cit.

210 Knapp, M., Patel, A., Curran, C., Latimer, E. *et al* (2013) Supported Employment: Cost-effectiveness across Six European Sites, *World Psychiatry* 12(1), pp. 60-68.

211 Jones, A. and Pleace, N. (2010) op. cit.

212 Carling, P.J. (1992) Homes or Group Homes?: Future Approaches to Housing, Support, and Integration for People with Psychiatric Disabilities, *Adult Residential Care Journal* 6(2), pp. 87-96.

213 Wong, Y. L. I. and Solomon, P.L. (2002) op. cit.

214 Tsai, J. and Rosenheck, R. (2012) op. cit.; Gulcur, L. *et al* (2007) op. cit. Wong and Solomon (2002) note that community integration as a concept is more developed in the field of learning disabilities.

215 Metraux, S., Caplan, J.M., Klugman, D. and Hadley, T.R. (2007) Assessing Residential Segregation among Medicaid Recipients with Psychiatric Disability in Philadelphia, *Journal of Community Psychology* 35(2), pp.239-255.

216 Metraux, S., Brusilovskiy, E., Prvu-Bettger, J. A., Wong, Y-L,I. and Salzer, M.S. (2012) Geographic Access to and Availability of Community Resources for Persons Diagnosed with Severe Mental Illness in Philadelphia, USA, *Health and Place* 18,pp.621-629.

217 Yanos, P.T., Stefancic, A. and Tsemberis, S. (2012) Objective Community Integration of Mental Health Consumers Living in Supported Housing and of Others in the Community, *Psychiatric Services*, 63(5), pp.438-444.

218 Studies that examine the needs of, and services for, people with physical impairments, mental health problems and/or learning disabilities.

219 Racino, J.A. (1995) Community Living for Adults with Developmental Disabilities: A Housing and Support Approach, *Journal of the Association for Persons with Severe Handicaps* 20 (4), pp. 300-310.

role of society and need for social change to overcome the barriers for individuals from disabling policies and practices. This model could be useful for Housing First services in the same way as many disability services which respect people's autonomy and self-direction in life, whilst at the same time attempting to remove societal barriers that may prevent people from participating in society due to prejudice, discrimination and policies and practices that are insufficiently sensitive to the needs of vulnerable people.

There are a number of models of low intensity support services that have been used for other client groups to enhance people's community participation and social networks[220]. In particular, befriending services (including peer support models) have been utilised for a range of client groups, including people with alcohol problems, young homeless people and people with mental health problems. These have been shown to have some positive impacts on people's participation levels, although take-up of services are often low and success is highly dependent on the befriender establishing a trusted relationship with service users[221]. Mutual support networks have also been developed for people with learning disabilities and mental health problems, whereby a worker facilitates links between people living in independent tenancies[222]. Whilst these have had some success, they centre on service users making and maintaining links, something that may not always be beneficial where people are trying to move away from drug and alcohol dependency.

In some senses, practice elsewhere might be subject to some of the same criticisms that might be directed at Housing First. There is an element of uncertainty, even vagueness, around what is meant by 'social integration'. In 2007, Gulcur *et al* concluded that community integration was a concept that still needed a 'clearly articulated conceptual framework'[223].

220 Quilgars, D. (2000) *Low Intensity Support Services: A Systematic Review of Effectiveness* (York: Joseph Rowntree Foundation).

221 Quilgars, D., Johnsen, S. Pleace, N., Beecham, J. and Bonin, E. (2011) *Supporting Independence? Evaluation of the Teenage Parent Supported Housing Pilot* (London: Department for Education).

222 Simons, K. (1998) *Living Support Networks: An Evaluation of the Services Provided by Keyring* (Brighton: Pavilion Publishing); Quilgars, D. (1998*) A life in the Community: Home-Link: Supporting People with Mental Health Problems in Ordinary Housing* (Bristol/ York: The Policy Press/ Joseph Rowntree Foundation).

223 Gulcur, L. *et al* (2007) op. cit.

4. CONCLUSIONS

Introduction

The first part of this final chapter considers the extent to which existing research and evaluation demonstrates that Housing First services do improve health and social integration. The second part of the chapter considers what it is practical and realistic for Housing First services to deliver, how Housing First might be enhanced and also discusses the relationships that Housing First services must have with other services in order to be fully effective. The chapter then moves on to consider whether there are other questions about Housing First services that need to be asked and how these questions may relate to the role of Housing First in promoting health, well-being and social integration.

The Research Questions

As noted in Chapter 1, the research questions for this Review were as follows.

- What types of support are provided in Housing First to promote health and well-being? How effective are these supports? Are there ways in which these supports could be enhanced?
- What types of support are provided in Housing First to promote social and economic inclusion? How effective are these supports? Are there ways in which these supports could be enhanced?
- Are there lessons from other areas of policy and practice that may be useful in enhancing the effectiveness of Housing First and other services in promoting health and well-being, and social and economic integration?

The overall evidence on the impact of Housing First on health is mixed. Some evidence points to improvements, however the most consistent evidence points to the stabilisation of both mental health and drug and alcohol issues. The evidence is clear that Housing First does not, overall, lead to any deterioration in mental health or increases in the use of drugs and alcohol. There is no evidence at present to indicate that Housing First improves physical health, although engagement with health services may be achieved.

There is evidence that Housing First is at least as good as Treatment First approaches in addressing mental health (whilst being more successful on housing sustainment). There are also some successes recorded for projects specifically focussed on particular types of drug or alcohol use, for example, communal services for heavy alcohol users.

The evidence indicates that improvements in health status are more likely over time (a number of years), signally the importance of long-term (ideally five years and longer) studies to measure the impact of Housing First. However, the evidence suggests that improvements are very gradual, and if this continues over a longer period, suggests that the majority of Housing First clients are likely to continue to need support with health issues into the future (as indeed the model ensures).

Some research indicates a link between perceived feelings of 'choice' and mental health status. Stabilisation of drug and alcohol issues is also achieved within a service environment that does not insist on treatment. Whilst the relationship between choice and other variables requires further exploration, it suggests that the delivery philosophy/ mode of Housing First is important in predicting outcomes.

The evidence on Housing First and social integration is weaker than for health status. Unlike mental health and drug and alcohol issues, most Housing First does not incorporate any specific services to achieve social and economic integration. Rather the housing component is seen as the key to achieving this goal, in terms of living in normal community settings and sharing the same socialisation and community opportunities as others. Generally, the extent to which the efforts of Housing First services to promote social integration are *described*, or evaluated, in the literature is limited.

Social integration is poorly defined in most studies; conceptual development, alongside better measures of social integration, is needed to adequately assess the impact of services in this area. Most studies do not utilise a control or comparison group, making it difficult to assess the levels of integration compared to other members of the community. Studies are also rarely longitudinal. Future evaluations need to incorporate service users' priorities in terms of social integration.

There is some limited evidence that Housing First models may have a positive impact on criminality, and that where experienced, any issues of nuisance or disruptive behaviour may be effectively addressed by services. There are also a couple of studies which show small but statistically significant increases in community participation, on some domains, for Housing First participants. Available evidence does not suggest that Housing First services currently impact on levels of economic participation. However, there are early indications that it may be possible for Housing First projects to have an impact in the area of training, education and other meaningful activity. Generally, qualitative work indicates that employment is often a long term goal for Housing First participants, and that Housing First allows them to begin the process of integration.

There is a lack of evidence on the question of political participation amongst Housing First service users.

Opinions about the strength of the evidence base for Housing First services varies. In the USA, Federal Government regards the Housing First approach as a proven, evidence-based, policy response that is effective in ending chronic homelessness. The United States Interagency Council on Homelessness (USICH) 2010 homelessness strategy, *Opening Doors*, which was updated in 2012, notes that:

> *For people experiencing chronic homelessness, the research is clear that permanent supportive housing using a Housing First approach is the solution.*[224]

Yet not all those who work in the field of homelessness research and service evaluation in the USA are convinced that Housing First is the best response to chronic homelessness[225], criticising the evidence base and questioning whether Housing First services can end the homelessness of some groups of chronically homeless people with high needs. Outside the USA, opinion about Housing First tends to be divided in a different way, with a general consensus that Housing First is effective at ending chronic homelessness. However, some researchers and service providers outside the USA express doubts about the extent to which Housing First services can meet other needs - centred on health, well-being and social integration - once it has effectively housed a chronically homeless person. In their recent policy review on whether Housing First services would be suitable for Australia, Johnson *et al* comment on what they regard as the more limited evidence of success for Housing First in respect of promoting health, well-being and social integration:

224 USICH (2010) *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* (Washington DC: USICH) p.18.
225 Rosenheck, R. (2010) op. cit.

> *While Tsemberis and others argue that such findings are to be expected when stable housing not abstinence is the core goal, one could also argue that at face value the broader and equally important goals of recovery and social inclusion are not being met.*[226]

One conclusion of this Review is that neither of these interpretations of Housing First is entirely correct. An argument that Housing First is a solution to chronic homelessness can be fairly easily sustained, Housing First services successfully take people off the streets and out of emergency accommodation who have been recurrently homeless, or continually homeless, for long periods of time. Further, Housing First services also end homelessness for the great majority of the people they work with, most of whom have high support needs, including poor mental health, problematic drug and alcohol use and poor physical health. However, Housing First does not solve absolutely all chronic homelessness and, rather more importantly, has different rates of success in dealing with the consequences of homelessness once re-housing has occurred, including promoting health, well-being and social integration.

While there is some evidence that Housing First has sometimes limited or mixed effects on health, well-being and social integration, there is also evidence of beneficial effects. Arguing that Housing First has little or no impact on health and social integration is not really feasible because there is now too much evidence that suggests that Housing First can have a beneficial effect.

However, there are some limitations to the evidence base on the extent to which Housing First improves health and social integration. In addition, there are some issues with how Housing First is designed to work that are important to bear in mind when interpreting the currently available evidence.

The evidence base for Housing First is less clear and comprehensive in respect of health, well-being and social integration than it is in respect of delivering housing sustainment. One reason for this simply reflects the research and evaluation that has been done, as a substantial part of the existing work has looked mainly at how effectively Housing First services end chronic homelessness. The nature of the available evidence can be explained by the need to test Housing First as an effective solution to recurrent and sustained homelessness among chronically homeless people before other research questions could be asked. If Housing First had not been demonstrated as effective at ending chronic homelessness in the USA, Housing First would have been abandoned as an approach. The fact that questions about health and social integration are now being asked is a result of the success that Housing First services have shown in ending chronic homelessness, they are questions about how much further Housing First can build on this success and how comprehensive a solution to chronic homelessness it can be.

The other point that may be important here is that Housing First may take longer to generate positive effects on health, well-being and social integration than to deliver housing sustainment. As discussed in Chapters 2 and 3, improvements in health and in social integration may take time, as people who have been without ontological security and living outside normal social and economic life, because they have lacked their own homes, may take time to adjust. Another issue here may be that people will show improvements in

226 Ibid, p. 9-10.

health, well-being and social integration at different rates, for example because they have different forms of support needs, characteristics and experiences. Expecting marked improvements in health or social integration at, for example, six months or even one year after re-housing may not be logical[227].

There is enough evidence to be confident that the ontological security generated by living in ordinary housing in an ordinary neighbourhood which scattered-site Housing First delivers can and does benefit health and social integration, albeit with sometimes mixed or limited effects. There is uncertainty, although the evidence base is more restricted, as to whether communal/single site models of Housing First that use a purpose-built housing that is physically separated from the surrounding community, can also deliver these positive effects.

While the potential of Housing First to deliver health and social integration for chronically homeless people has been demonstrated, again noting that the extent of positive effects can be mixed and are not necessarily present for all Housing First service users, some criticism of the Housing First approach can be made. This criticism centres on the precision with which the benefits associated with a normal life in normal housing in a normal community can be defined, measured and then demonstrated. What is arguably less than entirely clear at present is by what *mechanism* people returned to normal housing in normal neighbourhoods by Housing First services start to re-integrate into society, show improvements in their mental health or to reduce or stop their use of drugs and alcohol.

While there is statistical analysis looking at quality of life of Housing First service users and other attempts at quantitatively analysing social integration, health and social support alongside housing satisfaction[228], the information is not often very nuanced or detailed. In addition, the conclusions can be rather 'obvious', housing in a hostile or 'toxic' neighbourhood characterised by high rates of nuisance and criminal behaviour will not lead to positive outcomes in health or social integration, nor will bad quality and/or unaffordable housing be likely to be associated with gains in health. Conversely, good quality, affordable housing in a neighbourhood that is highly socially cohesive and integrated would be expected to lead to better outcomes in terms of health, social integration and housing sustainment. Yet the relationships are not always simple, success can occur where it apparently should not and failure where it should be less likely[229].

What makes the difference in terms of health and social integration is associated with these broad statistical indicators, but the processes may be complex, individual and linked to the detail of individual circumstances of people housed by Housing First services, as well as related to their own specific needs, characteristics and experiences. More qualitative analysis, understanding the experience of being housed by Housing First services, looking at social integration and at health from individual perspectives, may help improve the evidence base on Housing First and enable better understanding of Housing First's 'normalisation' of housing designed to lead to 'normalisation' of other aspects of life, sometimes helps health and social integration and sometimes does not help or delivers mixed effects. The results of the major evaluation of Housing First services in four sites in France, which is due to report in June 2015, will look at these questions and will hopefully add significantly to the existing evidence base (see Chapter 1).

227 Padgett, D. (2007) op. cit.; Padgett, D. *et al* (2011) op. cit.

228 Tsemberis, S.; Rogers, E.S.; Rodis, E.; Dushuttle, P. and Skryha, V. (2003) Housing Satisfaction for Persons with Psychiatric Disabilities, *Journal of Community Psychology* 31(6), pp.581-590.

229 Pleace, N. with Wallace, A. (2011) op. cit.

Enhancing Housing First

Goal-setting and assessment of Housing First services

A central question when considering the role of Housing First services in enhancing health and social integration is how far the Housing First service model has to go in order to be judged a 'success'. One point here centres on whether it is a fair test of Housing First to expect the service model to deliver high levels of sustained improvement in mental health, problematic drug and alcohol use and social integration. The founder of the original Pathways Housing First project in New York has noted the following in relation to what it may be reasonable to expect a Housing First service to deliver:

> *It is important here to revisit the mission of HF [Housing First]: it is to end homelessness for people with complex needs. Of course, the ideal outcome would be to end homelessness and solve all problems related to mental health, addiction, and social exclusion, but we are not there yet... beyond a program intervention [a Housing First service], larger shifts in social contexts and policies are needed to achieve greater success in alleviating poverty, facilitating recovery, and promoting social inclusion.*[230]

Prominent European homelessness researchers, such as Busch-Geertsema, have also argued that it is not realistic to expect homelessness services to deliver 'total' solutions to homelessness. He argues there are inherent limits to what any homelessness service can be expected to achieve and that setting objectives that are unrealistic is ultimately unhelpful[231].

Realism is important in assessing what Housing First can achieve and also what the goals for a Housing First service should be. One issue with Housing First as a service response at the moment is arguably that it does not have clear upper limits with respect to health and social integration. One reason for this is that there is theoretical potential within Housing First services to achieve what might be termed the 'maximum' achievable, such as full recovery from mental health problems, abstinence from drugs and alcohol or exercising more control over use, economic reintegration and social integration, essentially restoring a chronically homeless person to the position and well-being enjoyed by any citizen who is able to live an independent life.

In practice, however, Housing First services are often working with people who do not have good health, who may have ongoing mental health problems and who are alienated and removed from the society in which they live. The potential to achieve the 'maximum' in terms of health and social integration, while theoretically and sometimes practically possible, may set what may be an *unrealistic* goal for some of the people using Housing First services. If 'good health' and a high level of social integration become operational targets, Housing First services may find themselves falling short, because for example the health of some chronically homeless people may be permanently damaged and they may not be in a position where they can work or in which a high degree of social integration is possible. While there is much to be said in favour of strength-based and choice-led approaches that recognise ability, capacity and seek to enable independence, Housing First is at the same time a long term solution to the needs of a high need group, who while benefitting from independence, may in some cases always require some support.

230 Tsemberis, S. (2012) op. cit. p172.

231 Busch-Geertsema, V. (2005) op. cit.

In the UK, the homelessness service sector has sought to counter the problem of unrealistic targets in respect of health and social integration through the development of measures designed to show 'distance travelled'. These measures, such as the Homeless Star[232], use numeric scales to show that someone is moving closer to (for example) better mental health, reduction in drug use or being able to re-enter paid employment. However, while potentially useful in some respects, measures like the Homelessness Star use the same logic as staircase services, assuming 'total recovery' is possible and set that as the ultimate goal for services, so when 'distance' is measured it is always in the context of assuming what may be an unrealistic target is achievable. There are also limitations to the robustness of some of the outcome monitoring systems that try to record distance travelled by homeless people[233].

Enhancing Housing First in respect of health and social integration may in the first instance involve recognising that Housing First will achieve *different levels* of success when promoting and enabling better health and social integration. For some people using Housing First, there may be maximum success, for others distance will be travelled towards better health and greater social integration, but that distance may vary and there may be limits to how far it is realistic for them to go. Once the likelihood of variable outcomes is accepted, attention can then be paid to how outcomes in health and social integration can be enhanced. Clear recognition that achievable goals may vary between each person using a Housing First service is the first step to becoming more precise about what Housing First services can achieve, what is realistic and how a realistic level of performance in relation to health and social integration outcomes should be defined and then monitored. To enhance performance, clear, realistic goals must be set and robustly tested using validated measures.

One area to explore is the operation of Housing First services themselves. Here there is a need for more systematic evaluation in the European context, as there are some unanswered questions about the utility of communal/single site Housing First services versus scattered site approaches using ordinary housing in respect of promoting health and social integration. Further, a tendency exists within the EU to use intensive case management (ICM) only models of Housing First, with only Denmark, France and Ireland experimenting with services using an ACT (assertive community treatment) model. One reason for using an ICM approach is because Western EU countries tend to have highly developed health, social care and welfare systems, meaning that the necessary services can (in theory) be accessed through intensive case management. By contrast, the 'welfare state in miniature'[234] which is represented by an ACT team was within a Housing First model developed in the context of relatively more restricted access to health and welfare services in the USA. Enhancement of Housing First will involve determining which combination of services provides the best outcomes in terms of health and social integration.

232 http://www.outcomesstar.org.uk/homelessness/

233 Pleace, N. (2013) op cit.

234 Pleace, N. (2008) op. cit.

Relationships with other services

Finally there is the question of relationships with other services and how that might be used to enhance Housing First. Using the example of the Pathways Housing First model, it is possible to envisage a fairly large-scale service that combines support with housing sustainment, drug and alcohol use, medical services and psychiatric services with support with social integration and within that economic integration. Other models of Housing First are simpler and smaller, using ICM-led approaches that require joint working with health and other services in order to function, because the Housing First service itself cannot provide all the support needed (this is also true for people using the ICM service provided by a Pathways Housing First model).

Enhancing the outcomes of Housing First in respect of health and social integration may involve taking a critical look at how other services work. At the most basic level, this involves assessment and monitoring of the links and referral arrangements between Housing First services and emergency accommodation, it may also involve how Housing First services might interact with single-site, supported housing which some chronically homeless people, albeit probably a minority, may arguably need or simply prefer to live in.

Choice in the nature of relationships with other services may also be important. One of the reasons why Housing First appears to be successful at ending chronic homelessness is that it is a choice-led model, which creates a potential for tension if services with which Housing First is working do not respond positively to formerly chronically homeless people trying to exercise choices. A Housing First service using an ICM approach might encounter difficulties if the only drug service available to homeless people were abstinence-based, as while a Housing First service user would be free to actively choose that option, support would not be available for someone who wanted a harm-reduction led drugs service. Equally, any service that dehumanised and did not respect homeless people would be unlikely to have a successful working relationship with a Housing First service with effectively the opposite philosophy.

Housing First therefore requires both access to services and also services that are compatible with the broad Housing First philosophy. A Housing First service that tried to operate in a context where attitudes and service responses to homelessness were highly traditional, i.e. effectively blaming individual behaviour for homelessness and seeing (enforced) behavioural modification as the answer, might struggle to develop good quality working relationships and therefore find that it faced significant challenges in promoting health and social integration.

Further Questions about Housing First

Cost-effectiveness

While there are various claims made that Housing First services are cheaper to operate than some existing service models, such as staircase services, the evidence about the costs and cost effectiveness of Housing First is still incomplete. On a night-by-night basis, scattered-site Housing First is generally cheaper than specialist supported homelessness accommodation with dedicated staffing, because this model of Housing First uses ordinary housing and mobile support workers. However, users of scattered-site Housing First services may spend far longer in a Housing First service than some of the alternatives. The evidence is not extensive on communal or single-site Housing First models, although some research has suggested a significant saving[235]. Evidence that Housing First can generate

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

significant cost savings for emergency health services and the criminal justice system[236] has come under criticism in the USA. Although there can be reductions in the use of psychiatric services and in contact rates with the Police and courts, it has been argued that it is only a subgroup of chronically homeless people who have high rates of contact with such services[237]. Visible savings from Housing First, in for example reducing emergency medical service costs, requires a population who are making heavy use of emergency medical services, which not all chronically homeless people will be. It has even been argued that Housing First has been successfully marketed as an idea to US policymakers on the basis that it 'saved money' for other services when this was only true for the specific group of chronically homeless people who made heavy use of emergency medical services[238].

Evidence that suggests Housing First saves public money by being cheaper than some existing service models, by reducing use of expensive emergency medical services and by reducing contact between chronically homeless people and criminal justice services. Early results from the large-scale Canadian evaluation of Housing First services have for example suggested equivalent savings - per 1,000 chronically homeless people using Housing First services - of $2.9 million CAD (€1.61 million) just from the reductions in emergency accommodation and further, though smaller, savings from reduced visits to hospital emergency visits ($245,000, €180,460)[239].

Debates about the extent to which Housing First is financially beneficial will continue. What is clear, from the current evidence base, is that Housing First represents a more *efficient* use of public money than alternative services because Housing First ends chronic homelessness at a higher rate than has been achieved by other service models. Alongside this consideration, it has also been argued, from within the USA, that assessing Housing First and other homelessness services simply in financial terms is not productive. While costs must ultimately be considered, the point of services such as Housing First is primarily to end the unique distress of chronic homelessness and not to save money[240].

It is arguable that the evidence base on the cost effectiveness of Housing First is incomplete. While new research such as the ongoing multisite French evaluation (see Chapter 1) may add more light to the debates about costs, the logic and morality of raising 'cost effectiveness' as the *primary* reason for promoting Housing First is perhaps questionable. Costs must, in the context of the current austerity and likelihood of ongoing fiscal constraint, be a concern for governments throughout the EU, but the costs of interventions to stop chronic homelessness have to be balanced against the economic, social, cultural and political costs, the distress for a society as a whole when that society is witness to visible, chronic homelessness.

What is also arguably important in debates about costs is to resist the obvious temptation to reduce the intensity and duration of the support offered by Housing First services. A time-limited, low-intensity, mobile-support service in which workers support many homeless people at once with only very limited hours of contact is *not* a Housing First service. Housing First is always a relatively intensive service model, even when it is a 'light' model that uses ICM but does not employ an ACT team, more support is provided, more intensively and flexibly and for longer than in many other services using mobile support delivered to ordinary housing. Reducing the level and duration of support may have negative effects on the capacity of Housing First services to promote health and social integration[241].

236 Tsemberis, S. (2010) op. cit.

237 Kertesez, S.G. and Weiner, S.J. (2009) op. cit.

238 Stanhope, V. and Dunn, K. (2011) op. cit.

239 www.fcm.ca/Documents/presentations/2012/AGM2012/Housing_First_in_Five_Canadian_Cities_Outcomes_and_Successes_of_Large_Scale_Social_Innovation_EN.pdf

240 Culhane, D.P. (2008) op. cit.

241 Pleace, N. and Bretherton, J. (2012) op. cit.

The consequences of adopting a choice-led approach

Finally there are some outstanding questions about the limits of choice in Housing First services. Hansen Löfstrand and Juhila[242], centres on the idea that Housing First follows a specific set of 'normalisation' protocols, which are fundamentally similar to the conceptions of a 'normal citizen' which represented the goal that earlier, staircase services set to achieve through behavioural modification. Whether this argument actually applies to Housing First to the extent where Housing First can be actually seen as having directly comparable goals to a staircase approach is a matter for debate, but the point that homelessness services are all, including Housing First services, working towards a goal of 'normalisation' is well made. Housing First itself is designed to be tolerant - very tolerant of some aspects of behaviour, including a refusal to accept psychiatric treatment or reduce use of alcohol and drugs. While Housing First services also exercise some controls, such as weekly visits and, in the case of the Pathways Housing First model, some financial controls over chronically homeless people to ensure rent is paid, the tolerance of Housing First arguably exceeds the extent to which any control is exercised. While the difference may be relative rather than absolute, Housing First gives a degree of choice and control – centred on the separation of housing and support and, in services that use it, scattered-site housing – that has not existed before in homelessness services.

Choice and the separation of housing and support appear to greatly increase the efficiency of Housing First as a means to end chronic homelessness. Results in respect of health, well-being and social integration are more variable, and as made clear in this review, there is evidence both of successes and more restricted and mixed outcomes. A challenge for Housing First may arise as time passes and some service users do not move very far forward in terms of better mental health, reductions in drug and alcohol use and in terms of social integration. This is essentially a question centred on how far policymakers, service commissioners and the public will *tolerate* Housing First services that only *sometimes* generate what might be termed the 'maximum' of full recovery in terms of mental health, abstinence from drugs and alcohol and someone living independently and working in paid employment.

The cultural imperative, throughout the economically developed World and no less present in Western Europe, to 'correct' the behaviour of people who have 'made themselves or kept themselves homeless' is a powerful one. The desire to pursue behavioural modification is the underpinning 'logic' of staircase services, albeit a 'logic' that is not actually supported by any real evidence that chronically homeless people exercise some sort of conscious 'choice' to become or remain homeless. Adopting Housing First means moving away from what are essentially pre-modern ideas that homelessness is caused by conscious individual choice, about recognising chronically homeless people are a vulnerable part of common humanity and meeting their needs accordingly. That means facing down criticisms, which will arise, that Housing First services essentially provide free, supported good quality housing to people indulging in problematic drug and alcohol use for which they are expected to do nothing. For example, some social workers in Finland have characterised Housing First as 'bottle first'[243].

Enabling choice for homeless people, as represented by Housing First services may therefore be a politically risky decision and a decision that therefore needs to be well evidenced. Monitoring and evaluation, effectively demonstrating that Housing First is working will be necessary if the policy is to be pursued.

242 Hansen Löfstrand, C. and Juhila, K. (2012) op. cit.

243 Kettunen, M. (2012) op. cit.

APPENDIX 1: SEARCH STRATEGIES

Searches were run to identify the literature on the impacts of social, health and community support in Housing First models.

Firstly, a search of all 'systematic research reviews' in the subject area of homelessness was conducted, in order to provide background on research already conducted in this field. No date limit was applied to these searches (see 1 below). A second, more extensive set of searches was then conducted, which aimed to identify research of all study designs on community integration for the homeless and supported housing.

The base search strategy was constructed on the Ovid interface and then adapted to the other resources searched. This search included the following components:

1. (supported housing terms OR homelessness terms) AND integration terms
2. supported housing terms AND (social support OR resettlement terms)
3. 'Housing First' terms

Search terms were identified by scanning key papers identified at the beginning of the project, through discussion with the review team and the use of database thesauri. The creation of the search strategy was an iterative process originally using Ovid databases and then adapted as appropriate to the other sources searched.

References were managed and de-duplicated using Endnote software.

Records found:

1258 (after de-duplication)

Limits:

No date limit for systematic review searches

Publication date: 1990+ for community integration of the homeless searches

Databases searched:

Applied Social Sciences Index and Abstracts (ASSIA) (Proquest)

The Campbell Library

Cochrane Central Register of Controlled Trials (The Cochrane Library)

Cochrane Database of Systematic Reviews (The Cochrane Library)

Database of Abstracts of Reviews of Effects (DARE)

EconLit (Ovid)

EMBASE (Ovid)

MEDLINE (Ovid)

NHS Economic Evaluation Database (The Cochrane Library)

PAIS International (Proquest)

PsycINFO (Ovid)

Social Care Online

Social Policy and Practice (Ovid)

Social Science Citation Index (Web of Knowledge)

Social Services Abstracts (Proquest)

1. Background systematic review search

The Campbell Library
http://www.campbellcollaboration.org/library.php
Date range: all years
Date searched: 19/02/13
20 records found - 1 relevant record after handsifting

homeless/all fields OR homelessness/all fields

The Cochrane Library - Cochrane Database of Systematic Reviews
Date range: all years. Issue 1 of 12, January 2013
Date searched: 19/02/13
13 records found - 1 relevant record after handsifting

homeless*:ti,ab,kw

Database of Abstracts of Reviews of Effects (DARE)
http://www.crd.york.ac.uk/
Date range: all years - 19 Feb 2013
7 records found - 3 relevant records after handsifting

(homeless*):TI

MEDLINE (Ovid)
Date range: 1946-February Week 1 2013
39 records

1 systematic$ review$.ti,ab. (42081)
2 meta-analysis as topic/ (12410)
3 meta-analytic$.ti,ab. (3017)
4 meta-analysis.ti,ab,pt. (53820)
5 metanalysis.ti,ab. (115)
6 metaanalysis.ti,ab. (941)
7 meta analysis.ti,ab. (40014)
8 meta-synthesis.ti,ab. (157)
9 metasynthesis.ti,ab. (98)
10 meta synthesis.ti,ab. (157)
11 meta-regression.ti,ab. (1648)
12 metaregression.ti,ab. (206)
13 meta regression.ti,ab. (1648)
14 (synthes$ adj3 literature).ti,ab. (1160)
15 (synthes$ adj3 evidence).ti,ab. (3240)
16 integrative review.ti,ab. (658)
17 data synthesis.ti,ab. (6543)
18 (research synthesis or narrative synthesis).ti,ab. (515)
19 (systematic study or systematic studies).ti,ab. (6671)
20 (systematic comparison$ or systematic overview$).ti,ab. (1602)
21 evidence based review.ti,ab. (1092)
22 comprehensive review.ti,ab. (5650)
23 critical review.ti,ab. (10098)
24 quantitative review.ti,ab. (415)

25 structured review.ti,ab. (407)
26 realist review.ti,ab. (33)
27 realist synthesis.ti,ab. (19)
28 or/1-27 (122110)
29 review.pt. (1745397)
30 medline.ab. (47851)
31 pubmed.ab. (21531)
32 cochrane.ab. (23481)
33 embase.ab. (21412)
34 cinahl.ab. (7660)
35 psyc?lit.ab. (850)
36 psyc?info.ab. (8408)
37 (literature adj3 search$).ab. (20688)
38 (database$ adj3 search$).ab. (18942)
39 (bibliographic adj3 search$).ab. (1008)
40 (electronic adj3 search$).ab. (6386)
41 (electronic adj3 database$).ab. (7741)
42 (computeri?ed adj3 search$).ab. (2341)
43 (internet adj3 search$).ab. (1435)
44 included studies.ab. (4769)
45 (inclusion adj3 studies).ab. (4835)
46 inclusion criteria.ab. (27586)
47 selection criteria.ab. (16903)
48 predefined criteria.ab. (896)
49 predetermined criteria.ab. (647)
50 (assess$ adj3 (quality or validity)).ab. (34359)
51 (select$ adj3 (study or studies)).ab. (32567)
52 (data adj3 extract$).ab. (23366)
53 extracted data.ab. (5135)
54 (data adj2 abstracted).ab. (2709)
55 (data adj3 abstraction).ab. (696)
56 published intervention$.ab. (90)
57 ((study or studies) adj2 evaluat$).ab. (90435)
58 (intervention$ adj2 evaluat$).ab. (5115)
59 confidence interval$.ab. (182870)
60 heterogeneity.ab. (80737)
61 pooled.ab. (37362)
62 pooling.ab. (6686)
63 odds ratio$.ab. (122098)
64 (Jadad or coding).ab. (108628)
65 or/29-64 (2336514)
66 29 and 65 (1745397)
67 review.ti. (229552)
68 67 and 65 (140701)
69 (review$ adj4 (papers or trials or studies or evidence or intervention$ or evaluation$)).ti,ab. (87872)
70 28 or 66 or 68 or 69 (1827849)
71 letter.pt. (779581)
72 editorial.pt. (321041)
73 comment.pt. (522572)
74 71 or 72 or 73 (1216030)
75 70 not 74 (1794420)
76 exp *Homeless Persons/ (4557)
77 Housing/ or Public Housing/ (13345)
78 75 and 76 and 77 (39)

Social Care Online
http://www.scie-socialcareonline.org.uk
Date range: all years to 13 Feb 2013
45 records found - 6 relevant records after handsifting

(freetext="homeless*" or topic="homeless people" or topic="homelessness") and content="research review"

2. Targeted search (all study designs)

Applied Social Sciences Index and Abstracts (ASSIA) (Proquest)
Date range: 1990 - date
130 records

Social Services Abstracts (Proquest)
Date range: 1990 - date
124 records

PAIS International (Proquest)
Date range: 1990 - date
26 records

(ti,ab("supported housing" OR "supportive housing" OR "supported living" OR "supportive living" OR "homeless*") AND ti,ab("community integration" OR "community reintegration" OR "community re-integration" OR "community participation" OR "community inclusion" OR "social integration" OR "social reintegration" OR "social re-integration" OR "social participation" OR "social inclusion" OR "neighbo*rhood integration" OR "neighbo*rhood reintegration" OR "neighbo*rhood re-integration" OR "neighbo*rhood participation" OR "neighbo*rhood inclusion" OR "economic integration" OR "economic reintegration" OR "economic re-integration" OR "economic participation" OR "economic inclusion" OR "housing sustainment" OR "assertive community treatment" OR "intensive case management" OR "critical time intervention" OR "harm reduction" OR "recovery orientation")) OR ti,ab("housing first")

ti,ab("supported housing" OR "supportive housing" OR "supported living" OR "supportive living") AND ti,ab(resettle* or "social support")

Key:
* - truncation
ti,ab - search in title and abstract fields
" " - phrase searching

Cochrane Central Register of Controlled Trials (The Cochrane Library)
Date range: 1990 - Issue 1 of 12, January 2013
64 records

NHS Economic Evaluation Database (The Cochrane Library)
Date range: 1990 - Issue 1 of 4, January 2013
1 record

#1 (supported or supportive) next/2 (housing or living):ti,ab,kw (Word variations have been searched)
#2 homeless*:ti,ab,kw (Word variations have been searched)
#3 "community integration" or "community reintegration" or "community re-integration":ti,ab,kw (Word variations have been searched)
#4 "social integration" or "social reintegration" or "social re-integration":ti,ab,kw (Word variations have been searched)
#5 "community participation" or "community inclusion":ti,ab,kw (Word variations have been searched)
#6 "social participation" or "social inclusion":ti,ab,kw (Word variations have been searched)
#7 "neighb*rhood integration" or "neighb*rhood reintegration" or "neighb*rhood re-integration":ti,ab,kw (Word variations have been searched)
#8 "neighb*rhood participation" or "neighb*rhood inclusion":ti,ab,kw (Word variations have been searched)
#9 "economic integration" or "economic reintegration" or "economic re-integration":ti,ab,kw (Word variations have been searched)
#10 "economic participation" or "economic inclusion":ti,ab,kw (Word variations have been searched)
#11 "housing sustainment":ti,ab,kw (Word variations have been searched)
#12 "assertive community treatment":ti,ab,kw (Word variations have been searched)
#13 "intensive case management":ti,ab,kw (Word variations have been searched)
#14 "critical time intervention":ti,ab,kw (Word variations have been searched)
#15 "harm reduction":ti,ab,kw (Word variations have been searched)
#16 "recovery orientation":ti,ab,kw (Word variations have been searched)
#17 ("mental health" or "mental* ill*") next/4 resettle*:ti,ab,kw (Word variations have been searched)
#18 (alcohol* or drug or drugs) next/4 resettle*:ti,ab,kw (Word variations have been searched)
#19 "social support" next/4 resettle*:ti,ab,kw (Word variations have been searched)
#20 #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19
#21 (#1 or #2) and #20
#22 resettle* or "social support":ti,ab,kw (Word variations have been searched)
#23 #1 and #22
#24 "housing first":ti,ab,kw (Word variations have been searched)
#25 #21 or #23 or #24

Key:
* - truncation
ti,ab,kw - search in title, abstract and keyword fields
" " - phrase searching
next/4 - within four words

Embase
Date range: 1990 to 2013 Week 06
320 records

EconLit
Date range: 1990 - January 2013
15 records

HMIC Health Management Information Consortium
Date range: 1990 to November 2012
28 records

MEDLINE In-Process & Other Non-Indexed Citations and MEDLINE
Date range: 1990 to January Week 5 2013
282 records

PsycINFO
Date range: 1990 to February Week 1 2013
412 records

Social Policy and Practice
Date range: 1990 to 201301
208 records

1 ((supported adj2 housing) or (supportive adj2 housing) or (supported adj2 living) or (supportive adj2 living)).ti,ab. (2523)
2 homeless$.ti,ab. (27437)
3 (community integration or community reintegration or community re-integration).ti,ab. (2577)
4 (community participation or community inclusion).ti,ab. (5351)
5 (social integration or social reintegration or social re-integration).ti,ab. (7072)
6 (social participation or social inclusion).ti,ab. (8053)
7 (neighbo?rhood integration or neighbo?rhood reintegration or neighbo?rhood re-integration).ti,ab. (37)
8 (neighbo?rhood participation or neighbo?rhood inclusion).ti,ab. (16)
9 (economic integration or economic reintegration or economic re-integration).ti,ab. (295)
10 (economic participation or economic inclusion).ti,ab. (183)
11 housing sustainment.ti,ab. (0)
12 assertive community treatment.ti,ab. (1914)
13 intensive case management.ti,ab. (976)
14 critical time intervention.ti,ab. (75)
15 harm reduction.ti,ab. (6244)
16 recovery orientation.ti,ab. (226)
17 ((mental health or mental$ ill$) adj4 resettle$).ti,ab. (85)
18 ((alcohol$ or drug or drugs) adj4 resettle$).ti,ab. (11)
19 (social support adj4 resettle$).ti,ab. (3)
20 or/3-19 (32160)
21 (1 or 2) and 20 (1008)
22 (resettle$ or social support).ti,ab. (76297)
23 1 and 22 (117)
24 housing first.ti,ab. (194)
25 21 or 23 or 24 (1269)
26 limit 25 to yr="1990-Current" (1260)

Key:
$ - truncation
? - truncation within a word
ti,ab - search in title and abstract fields
adj4 - within 4 words (either direction)
yr= - publication year
(132) - results set = 132 records

Social Care Online
http://www.scie-socialcareonline.org.uk
Date range 1990 - date
120 records

(topic="supported housing" or topic="homelessness") AND (freetext="community integration" or freetext="community reintegration" or freetext="community re-integration" or freetext="community participation" or freetext="community inclusion" or freetext="social integration" or freetext="social reintegration" or freetext="social re-integration" or freetext="social participation" or freetext="social inclusion" or freetext="neighbourhood integration" or freetext="neighborhood integration" or freetext="neighbourhood reintegration" or freetext="neighborhood reintegration" or freetext="neighbourhood re-integration" or freetext="neighborhood re-integration" or freetext="neighbourhood participation" or freetext="neighborhood participation" or freetext="neighbourhood inclusion" or freetext="neighborhood inclusion" or freetext="economic integration" or freetext="economic reintegration" or freetext="economic re-integration" or freetext="economic participation" or freetext="economic inclusion" or freetext="housing sustainment" or freetext="assertive community treatment" or freetext="intensive case management" or freetext="critical time intervention" or freetext="harm reduction" or freetext="recovery orientation") AND publicationdate>1990
or
freetext="housing first" AND publicationdate>1990
or
topic="supported housing" and (freetext="resettle*" OR freetext="social support") AND publicationdate>1990

Key:
* - truncation
freetext= - search all fields
topic= - search topic fields only

Social Science Citation Index (Web of Knowledge)
Date range: 1990 - date
720 records

#1 TS=("supported housing" OR "supportive housing" OR "supported living" OR "supportive living" OR "homeless*")
#2 TS=("community integration" OR "community reintegration" OR "community re- integration" OR "community participation" OR "community inclusion" OR "social integration" OR "social reintegration" OR "social re-integration" OR "social participation" OR "social inclusion" OR "neighbo$rhood integration" OR "neighbo$rhood reintegration" OR "neighbo$rhood re-integration" OR "neighbo$rhood participation" OR "neighbo$rhood inclusion" OR "economic integration" OR "economic reintegration" OR "economic re-integration" OR "economic participation" OR "economic inclusion" OR "housing sustainment" OR "assertive community treatment" OR "intensive case management" OR "critical time intervention" OR "harm reduction" OR "recovery orientation")
#3 #1 AND #2
#4 TS=("housing first")
#5 TS=("supported housing" OR "supportive housing" OR "supported living" OR "supportive living" OR "homeless*") AND TS=(resettle* OR "social support")
#6 #3 or #4 or #5

Key:
* - truncation
$ - truncation within a word
TS= - topic search (title, abstract, keywords)
" " - phrase search

NOTES

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