The Ambiguities, Limits and Risks of Housing First from a European Perspective

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❯ **Abstract_** *There is strong evidence that the Pathways Housing First model can move homeless people with sustained experiences of living rough, with problematic drug and alcohol use, and with severe mental illness straight into ordinary housing, and successfully sustain them in that housing. However, three questions can be raised about what 'Housing First' is delivering in a wider sense. The first question centres on what is meant by 'Housing First' as an ethos and as a model of service delivery, as there can be a lack of clarity about what these services are delivering. The second question centres on the extent to which Housing First services can address the needs of 'chronically homeless' people that exist alongside a fundamental requirement for sustainable housing. The third question centres on the wider role of the Housing First model, and whether the policy and research focus on Housing First is overemphasising one aspect of the wider social problem of homelessness.*

❯ **Keywords_** *Housing First, Homelessness Policy.*

Introduction

This paper begins by reviewing the origins of 'Housing First' before moving on to describe the New York Pathways Housing First model. The emergence of a wide range of Housing First services is then discussed. The paper then considers three questions, beginning with what 'Housing First' means and whether a better understanding of these services is required in order to understand and replicate success. The paper then considers whether the great gains in housing sustainability delivered by the Pathways model address all aspects of 'chronic' homelessness. Finally, the paper considers whether the current policy and research focus on Housing First models is overemphasising one aspect of homelessness.

The Origins of Housing First

During the 1950s and 1960s, the USA began to close its long-stay psychiatric hospitals. Initial resettlement of patients had mixed success and services were therefore developed to try to improve outcomes. The most commonly used was the 'staircase' model.

The staircase model moved people leaving psychiatric hospitals through a series of steps. The first step was not unlike the hospital, and each subsequent step brought former patients closer to ordinary housing, until they reached a point where they were living independently (Ridgway and Zipple, 1990). Treatment and other support services were reduced at each step. These steps could occur at a single site, but some services provided each step in a separate location. This model has also been called the 'linear resettlement model', the 'continuum of care' and a 'ladder' (Johnsen and Teixeira, 2010).

By the 1980s it was evident that the staircase approach was not always working well. Some staircase services had strict regimes, requiring compliance with treatment and banning alcohol or drug use. Those who did not follow the rules were not allowed to move between steps and could also be 'sent back' a step, or evicted, for breaking the rules. Evidence mounted that the strict rules in these services meant people were becoming 'stuck' on particular steps, often being evicted or opting to leave these services (Ridgway and Zipple, 1990).

A new service model emerged that showed patients could move straight from psychiatric hospital into ordinary housing, where they could live independently with help from floating support services (i.e. mobile support workers and clinical staff). This was initially termed a 'supported housing' approach. Supported housing was flexible in that the level of support provided could rise and fall as needed. In addition, because no fixed site infrastructure had to be built, supported housing

was cheaper than staircase services. The absence of a strictly enforced 'staircase' regime also seemed to deliver much better outcomes. Rates of housing sustainment by ex-patients using supported housing services were higher than those in staircase models (Ridgway and Zipple, 1990; Pleace with Wallace, 2011).

Drawing in particular from the work of Culhane and his colleagues, US policymakers had become convinced that homelessness took several forms. The US evidence base indicated that the bulk of US homelessness existed in a 'transitional' form, i.e. poor people with low support needs losing housing temporarily as a result of experiences like relationship breakdown and unemployment. It also suggested there was a much smaller group of 'chronically homeless' people with very high support needs who were very intensive users of emergency shelters and who spent a significant amount of time on the street (Kuhn and Culhane, 1998; Burt, 2003; Culhane and Metraux, 2008; O'Sullivan, 2008; Busch-Geertsema et al., 2010).

The small group of chronically homeless people had a mix of what Kemp et al. (2006) have described as 'mutually reinforcing' needs. Alongside sustained rooflessness, chronically homeless people also presented with high rates of severe mental illness, problematic drug and alcohol use, chaotic and anti-social behaviour, low level criminality and poor physical health (Cortes et al., 2010).

Chronically homeless people spent sustained periods in emergency accommodation, made disproportionate use of emergency medical, psychiatric and drug services, and were quite often involved in petty criminality, which meant that they got arrested and were subject to short term imprisonment at high rates (Culhane, 2008). In 2006, drawing on Culhane's work, The New Yorker told the story of 'Million Dollar Murray'. The article highlighted how one vulnerable individual's sustained experience of living rough had cost US taxpayers a very significant sum of money because 'Murray' made frequent use of emergency services and very often got arrested. This was contrasted with how much less it would have cost to provide Murray with settled housing and resettlement support, and how this might have prevented his eventual death on the street (Gladwell, 2006).

Both humanitarian and financial concerns led to a federal attempt to counteract chronic homelessness. Under a programme called the 'Continuum of Care', a series of staircase services for chronically homeless people were funded. Looking towards mental health services made sense, given the perceived pattern of need among chronically homeless people. What made somewhat less sense was opting for the staircase model, the effectiveness of which was being questioned even before the Continuum of Care programme was implemented (Wong et al., 2006).

The Continuum of Care programme had some success, but evaluations of these staircase services also showed that many chronically homeless people were not being resettled (Sosin et al., 1995; Orwin et al., 1999; Hoch, 2000). Service users were becoming stuck on particular steps, being evicted or abandoning services because of strict rules. EU research on staircase services for homeless people also began reporting similar findings (Sahlin, 2005; Busch-Geertsema and Sahlin, 2007; Atherton and McNaughton-Nicholls, 2008).

The Pathways Approach

In 1992, Dr Sam Tsemberis founded the Pathways organisation in New York. He argued that the lessons learned about 'supported housing' in mental health services should be employed in tackling chronic homelessness (Tsemberis, 2010a and 2010b).

Tsemberis argues that staircase models require service users to comply with psychiatric treatment and show sobriety because it is assumed they will 'value' independent housing that they have 'earned' (Tsemberis, 2010b). By contrast, the Pathways Housing First (PHF) approach is described by Tsemberis as grounded in the following operating principles (Tsemberis, 2010b,):

• Housing is a basic human right.

There should be:

• respect, warmth and compassion for service users;

• a commitment to working with service users for as long as they need;

• scattered site housing using independent apartments (i.e. homeless people should not be housed within dedicated buildings but within ordinary housing);

• separation of housing from mental health, and drug and alcohol services (i.e. housing provision is not conditional on compliance with psychiatric treatment or sobriety);

• consumer choice and self-determination;

• recovery orientation (i.e. delivering mental health services with an emphasis on service user choice and control; basing treatment plans around service users' own goals);

• a harm reduction approach (i.e. supporting the minimisation of problematic drug/alcohol use but not insisting on total abstinence).

PHF is not presented as a solution to all forms of homelessness. It is made clear that the service is designed for chronically homeless people. PHF requires service users to have a severe mental illness; otherwise they cannot access the welfare benefits that help fund the service (Tsemberis, 2010b).

PHF places formerly chronically homeless people in furnished apartments provided via the private rented sector. Housing must meet certain quality standards, and service users sign a tenancy agreement directly with the landlord or, very often, an agreement with PHF (i.e. the tenancy is held by PHF and the service user is sub-letting). This approach reduces any concerns about letting to formerly chronically homeless people as the tenancy agreement is between PHF and the landlord. However, a sub-letting agreement gives service users fewer rights than if they had their own tenancy (Tsemberis, 2010b). Housing is provided immediately (or as quickly as possible) and on an open-ended basis. There is no requirement for compliance with psychiatric treatment or for abstinence from drugs or alcohol. Housing provision is not entirely unconditional, however; service users must agree to a weekly visit from a PHF support worker and also to paying 30% of their monthly income towards rent (Tsemberis, 2010b).

There are two main elements to the floating support services provided by PHF. The first element is the team of programme support workers whose role is centred on support to sustain the service user in their housing. The second element is the inter-disciplinary team which combines Assertive Community Treatment (ACT) and Intensive Case Management (ICM) services, with the ACT element concentrating on people with the severest forms of mental illness. The interdisciplinary team includes a psychiatrist, a peer specialist (i.e. a former service user providing support), a health worker, a family specialist (centred on enhancing social support), a drug and alcohol worker and a supported employment specialist (Tsemberis, 2010b).

A series of longitudinal studies have shown that PHF has had much better resettle-ment and housing sustainment outcomes than the staircase model (Tsemberis, 1999; Tsemberis et al., 2004; Pleace, 2008; Atherton and McNaughton-Nicholls, 2008; Pearson et al., 2009; Johnsen and Teixeira, 2010; Tsemberis, 2010a). There is also evidence of cost effectiveness. PHF costs less than staircase models because no specialist accommodation has to be built. PHF service users also make less use of emergency shelters, less use of emergency medical services, and are less likely to get arrested than when they were homeless, all of which produce savings for the US Taxpayer (Culhane, 2008; Tsemberis, 2010b).

Diversity in 'Housing First' Services

Housing First has a core role at all levels of US homelessness policy (United States Interagency Council on Homelessness, 2010). In the EU, several Member States, including Denmark, Finland, France, Ireland and Sweden, have put Housing First at the centre of their national homelessness strategies.

As has been widely noted elsewhere, what is meant by 'Housing First' varies. The PHF model and other Housing First services can be quite different from one another (Atherton and McNaughton-Nicholls, 2008; Pleace, 2008; Johnsen and Teixeira, 2010; Busch-Geertsema, 2010; McNaughton-Nicholls and Atherton, 2011).

Projects described as 'Housing First' in the USA include dedicated blocks of specialist accommodation with on-site staffing, floating support services that do not provide or arrange housing, and various modified staircase models (Perlman and Parvensky, 2006; Pearson et al., 2007; Sadowski et al., 2009; Larimer et al., 2009; Kertesz and Weiner, 2009). A recent study reviewing grant applications from 11 service providers for US federal funding to develop Housing First services concluded that only two actually matched the PHF model (Kresky-Wolff et al., 2010). Finland has adopted a Housing First model that centres on the refurbishment of its existing emergency shelter system. This has involved replacing old fashioned direct access hostels with purpose built Housing First units at no small cost (Tanio and Fredrikson, 2009; Busch-Geertsema, 2010). Pathways itself has reacted to the diversity of Housing First services by issuing detailed guidance on what it now refers to as Pathways Housing First services (Tsemberis, 2010b), and it is also developing a PHF 'fidelity scale'.

Three Questions about Housing First

One: Service diversification

The first of three questions about Housing First centres on service diversification. On one level, it might be argued that it is the shared ethos of Housing First services that matters most. These services all share the assumption that chronically homeless people do not have to be sober and compliant with psychiatric treatment before they can be successfully re-housed, and that giving choice and control to service users will provide more sustainable exits from homelessness (Kertesz and Weiner, 2009; Edens et al., 2011).

However, getting a better understanding of the variation in Housing First services might be important. The extent to which there are potential flaws and limits in the various Housing First models now needs to be understood. There would be less to be concerned about if everyone were following the PHF model, which is relatively well

evidenced, but the reality is that they are not. Beyond the model drift from PHF throughout the USA, modification of PHF is equally evident in service pilots in the UK, and in the French and Finnish interpretations of Housing First (Johnsen and Teixeira, 2010; Busch-Geertsema, 2010; Houard, this volume). As the PHF model is often not what is actually being implemented, there is a need to understand properly what is being delivered by various Housing First services in order to assess which variants work well and which may work less well (Caton et al., 2007; Tabol et al., 2009).

Two: Potential limits of Housing First

The second question centres on the potential limits of Housing First. Looking specifically at PHF, it seems undeniable that there have been considerable successes in providing sustainable exits from homelessness for very vulnerable people. However the perspective on what constitutes a 'successful' service outcome for this group of homeless people can change according to one's point of view.

One issue is problematic drug and alcohol use. There is good evidence that PHF delivers 'harm reduction' (Tsemberis, 2010a; Edens et al., 2011). However, some argue that PHF and other Housing First models are not always very effective in counteracting the harm of problematic drug and alcohol use. This criticism has two elements; the first is that PHF tends not to engage with the heaviest users, and the second is that while drug use often stabilises and falls off to some degree among PHF service users, it does not stop (Kertesz et al., 2009; Tsai et al., 2010; Padgett et al., 2011).

Some argue that there should still be a place for services for homeless people whose drug and alcohol use directly threatens their well-being and who need to stop drinking or using drugs (Lipton et al., 2000; Kertesz et al., 2009; Tsai et al., 2010). Importantly, not all those services designed to end drug use have the harsh regimes of staircase services, and some draw heavily on the Housing First ethos, facilitating abstinence, but trying to do so while maximising choice and control (Caton et al., 2007; Kertesz and Weiner, 2009). The point of such arguments is to suggest that services designed always to achieve sobriety need not use strict or harsh regimes, and that such services might be the best option for homeless people with very severe drug and alcohol issues.

More generally, the harm reduction philosophy underpinning PHF may not always be viewed sympathetically by policy-makers. In the UK, for example, harm reduction policies that arose from concerns about HIV infection through needle sharing are now subject to criticism, with some arguing in favour of re-emphasizing abstinence-based approaches (Pleace, 2008). The PHF model will not sit very comfortably within a wider national strategy that is intended to deliver cessation of problematic drug use. Whether or not harm reduction is the best

approach is a very complex question on which views can be polarised, but there are those who will look at the underlying logic of the PHF harm reduction approach and question its effectiveness.

There are also some issues around worklessness and social isolation among people using PHF services (McNaughton-Nicholls and Atherton, 2011). Social isolation undermines quality of life and well-being. Sustained worklessness is also detrimental to well-being, though further policy concerns arise in regard to the financial cost of sustaining a formerly homeless, vulnerable person on welfare benefits for what may be a lifetime.

There is some evidence that access to sustainable independent housing provided by PHF gives people a base on which to build greater social interaction and economic activity (Padgett et al., 2006; Padgett, 2007; Tsemberis, 2010a), and worklessness and social isolation are also both issues that PHF actively seeks to address. However, there is not as yet any real evidence that PHF is effective at counteracting worklessness or social isolation (Tsemberis, 2010a). However, it must be noted that there is also little evidence that sustained worklessness or social isolation are being effectively counteracted by other homelessness service models (Jones and Pleace, 2010).

From a policy perspective, the capacity or otherwise of PHF and other Housing First models to deliver good outcomes in terms of enhancing take-up of paid work may become important. This would certainly be a concern for UK policy-makers. Realism is important, as factors like unemployment may have both structural and individual causes, and there are limits to what any one service can be expected to do (Busch-Geertsema, 2005). While PHF may not be able to achieve everything, the gains it can deliver in housing sustainability need always to be borne in mind.

In New York, delivering PHF costs less than delivering staircase services, as PHF does not require specialist accommodation to be built or adapted. Yet, as PHF delivers high quality, intensive support services on an open-ended basis, it is still quite expensive to run, even allowing for the cost savings it can produce elsewhere (Metraux et al., 2003). The costs for some other models of Housing First, such as the Finnish services which involve capital spending on buildings, are even higher (Busch-Geertsema, 2010).

There is some evidence from Europe and the USA that housing sustainability for vulnerable groups can be achieved via lower intensity floating support services (Pleace, 1995; Rosenheck et al., 2003; Busch-Geertsema, 2005). In the UK, people with mental health problems at risk of homelessness are frequently placed in ordinary housing and given low intensity floating support services using a case management model. The direct cost of these services in the UK is much less than PHF, but the

services are also incurring costs to UK taxpayers in the sense that they ensure access to welfare systems, including social housing and assistance with private rented housing costs, and the UK's free universal healthcare for service users.

It is unclear whether lower intensity floating support services could produce housing stability and a quality of life equivalent to that delivered by PHF at a lower cost. This is because the evidence base on these services is weaker than for PHF. In the UK, where these services are widely used, there are (England only) data indicating that low intensity floating support services do deliver housing stability. However, these data are restricted to service exit interviews (Centre for Housing Research, 2010), which means that it is not clear how well housing is being sustained once service contact ceases. Total costs for lower intensity floating support services are not clear either, in that while it is reasonably clear what direct service delivery costs, the use of case management may arguably 'maximise' the cost of service users to the wider welfare system. A longitudinal evaluation comparing the success of PHF and some existing EU services that use low intensity floating support and ordinary housing, looking at housing sustainment, quality of life and total costs, might be useful.

The nature of the independent living that PHF delivers might also be contrasted with what other floating support service models using ordinary housing provide. The use of sub-letting does mean that housing rights are more restricted than those for the general population and, while there is no requirement to use psychiatric and drug and alcohol services, access to housing is not unconditional. For example, PHF service users have fewer housing rights and are subject to more regulation than is the case for some vulnerable homeless people living in ordinary housing and using low intensity floating support services in the UK (Jones et al., 2002). However, all home-lessness services will have at least some rules, and the restrictions on the housing rights of some PHF service users need to be seen in this context.

Three: The nature of homelessness, and the operational assumptions of Housing First

The third question about Housing First centres on its operational assumptions and how we understand the nature of homelessness. Some US academics argue that the bulk of homeless people are not characterised by severe mental illness or by prob-lematic drug and alcohol use. The immediate causation of their homelessness can be many different things, including unemployment or relationship breakdown, but one underlying cause is always the same: these are people who are too poor to afford adequate housing. From this perspective, the main interventions needed to tackle the bulk of US homelessness are an increase in housing supply, better access to affordable housing, and better chances for poorer people to get work that offers a living wage (Culhane and Metraux, 2008; Shinn, 2009; Culhane et al., 2011).

The issue here is not really about PHF; it is, instead, a question surrounding what might be called the various distortions of the original PHF model that are now referred to as 'Housing First'. As the Housing First movement – again as something distinct from PHF – spreads across the US and into the EU, securing the attention of policy-makers and media, and taking centre-stage in strategic responses to homelessness, it brings with it a particular image of what 'homelessness' is. That image is of chaotic people with high support needs, a subset of the much larger US homeless population that Continuum of Care staircase services and then PHF were specifically designed for. This is a potentially dangerous image if it is presented in isolation, because it presents a very restricted picture of what homelessness is. Emphasising the characteristics of vulnerable individuals who represent a minority of homeless people downplays the scale of homelessness and the role of labour markets, welfare systems and limited access to affordable housing in homelessness causation (Anderson, 1993; Dordick, 2002).

Conclusion

PHF and other Housing First service models can deliver significant gains in housing stability for a high-cost, high-risk group of very vulnerable homeless people. The scale of this achievement must be acknowledged. However, PHF and other Housing First services are not a panacea, and they do not always meet all the needs of the people for whom they are intended (Lipton et al., 2000; Tsai et al., 2010). There may be other ways to get vulnerable people off the streets and into more stable accommodation and housing that might cost less. While PHF and other Housing First services are designed to deal with the most difficult aspect of homelessness, they are not intended to tackle the bulk of homelessness (Busch-Geertsema et al., 2010).

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