Good practice: briefing

Housing first

Bringing permanent solutions to homeless people with complex needs

Introduction

The housing first model was developed in the United States and has demonstrated high degrees of success in both housing and supporting those who are chronically street homeless with multiple and complex needs. It is founded on the principle of housing being a basic human right and provides permanent accommodation for people straight from the street. The model has no preconditions of addressing wider social care and support needs.

Many long-term and repeatedly homeless individuals have multiple and complex problems relating to drug and/or alcohol dependency, poor physical and mental health, contact with the criminal justice system, and histories of institutional care and traumatic life events.[1] Despite notable progress in the housing and support of these groups in the UK, there remains an ongoing problem of finding long-term and sustainable housing solutions for them.

In June 2008, the Government estimated that there were 483 people sleeping rough in England on any single night.[2] This is only a small reduction from 498 in 2007 and there has been no substantial and sustained reduction in the numbers for the last five years. Moreover, figures from the CHAIN database show that 1,189 individuals were verified as having slept rough in London between April and June 2008.[3]

As is evident from research to date, no single model of housing and support is likely to be effective for all homeless people with complex needs. Shelter has previously called for the consideration and development of new approaches.[4] The purpose of this briefing is not to advocate for any single model, but to examine the potential for the housing first approach to complement existing provision in the UK.

1 Fitzpatrick, S, and Klinker, S, *Research on single homelessness in Britain*, Joseph Rowntree Foundation, 2000.

2 Communities and Local Government (CLG), Rough sleeping estimate, June 2008.

3 Broadway, *Street to home quarterly report for London, 1st April to 30th June 2008*, 2008.

4 Shelter, *Shelter's response to the government discussion paper – rough sleeping ten years on: from the streets to independent living and opportunity*, 2008.

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Shelter

The traditional approach – 'housing readiness'

In the UK, the transition from street homelessness to independent living for those with complex needs often resembles a 'staircase'.[5] This can involve: initial contact with outreach workers or day centres; a move into direct-access hostels; a further move into second stage or specialist hostels (relating to support needs); progression to semi-independent or shared accommodation; and ultimately (once deemed 'housing ready'), taking an independent tenancy, with or without floating support.

Access to the initial stages of the staircase for those with substance use or mental health problems is usually dependent on engagement with treatment services ('treatment first')[6], and further progress requires demonstration of improvements in their substance use and mental health issues.

This approach has enabled large numbers of homeless people with multiple and complex needs to attain independent living successfully. However, for some it has been neither a successful, nor an attractive, route out of homelessness. The model does contain some weaknesses, outlined below.

- Not all stages in the model are consistently available, and in localities with no direct or quick access hostels there are long waits for housing. Those owed a homelessness duty by the local authority can gain immediate accommodation.[7] However, due to the strict requirements of the legislation, this option will be unsuccessful for many homeless people with complex needs. Equally, this perceived lack of success can deter many of those people experiencing homelessness with complex needs from even attempting to secure accommodation in this way.[8]
- Hostels tend to house a variety of people with widely differing support needs. The communal nature of hostels can create problems for particularly vulnerable homeless people. Conflict with other residents, or behavioural difficulties resulting from people's support needs, can end in eviction, or abandonment of the accommodation, and an inability or unwillingness to return.
- The housing readiness approach may involve continual movement of people through differing types of accommodation as their needs change both positively and negatively. Each stage of this transition can also trigger a recurrence of previous difficulties[9] and create something of a 'snakes and ladders' pathway to independent living.

The latter point is highlighted in relation to substance users. Hostels can house problematic drug and alcohol users who are at varying points of addressing their substance use. It is best practice not to mix users at different stages of their support programmes within the same accommodation, because keeping them separate can help to avoid a negative impact of one person's substance use on any progress made by others. Any positive progress made to cease substance use may require a move to alternative accommodation. At best, relapsing back into substance use would result in a return to previous accommodation; at worst, and more likely, it would result in eviction and a return to homelessness.

Hostels can be reluctant to house some of the more problematic substance users[10] and being housing ready can often equate to being 'drug/alcohol free'. For some, achieving and maintaining a drug and/or alcohol-free life can take many years to achieve, if at all, and so settled independent housing can become an unachievable goal.

Housing first

The housing first model of supported accommodation was primarily developed in New York by Pathways to Housing in the early nineties.[11] The approach stemmed from initiatives to meet the needs of the substantial population of chronically street homeless people with multiple and complex needs. The model has grown and developed in a number of US states due to its effectiveness in housing and supporting these groups.

5 Sahlin, I, 'The staircase of transition', *Innovation: The European Journal of Social Sciences*, Vol 18, No 2, 2005.

6 Padgett, D, Gulcur, L, and Tsemberis, S, 'Housing first services for people who are homeless with co-concurring serious mental illness and substance abuse', *Research on Social Work Practice*, Vol 16, No 1, 2006.

7 Part 7 Housing Act 1996, as amended by the Homelessness Act 2002.

8 *Shelter's response to the government discussion paper – rough sleeping ten years on: from the streets to independent living and opportunity*, op cit.

9 McNaughton, C, *Transitions through homelessness: lives on the edge*, Basingstoke: Palgrave Macmillan, 2008. Cited in: McNaughton, C, *Breaking cycles of multiple need homelessness in the UK: a comparative review of housing first approaches in the US*, 2008. To access this document, please see www.crfr.ac.uk/spa/papers/mcnaughton.pdf

10 McKeown, S, *Safe as houses: an inclusive approach for housing drug users*, Shelter, 2006.

11 For further information see www.pathwaystohousing.org

The housing first model operates by taking account of two key convictions:

1. housing is a basic human right, not a reward for clinical success
2. once the chaos of homelessness is eliminated from a person's life, clinical and social stabilisation occur faster and are more enduring.[12]

There are a range of different housing first programmes operating across the US, which are underpinned by the following common principles.

- Immediate (or relatively immediate), permanent accommodation is provided to service users directly from the streets, without the requirement of assessed housing readiness.

This is achieved by the housing first agency leasing private sector tenancies and renting these on to service users. This allows the agency to control access to housing and ensure it is targeted at the most vulnerable and complex cases. Typically these are people with mental health and/or substance use problems, who may not have alternative options or have not benefited from the traditional staircase approach. Tenancies are usually obtained and allocated on a scatter-site basis to avoid concentrations in any single locality.

- No preconditions of treatment access or engagement are made (housing first, not treatment first).

The model separates access to housing from engagement with services to address social care and support needs. It promotes consumer choice in engagement with these services, including the right to refuse. The programme only demands that service users pay rent, abide by the tenancy conditions, and agree to a visit by a support worker (usually) once a week.

- Comprehensive support services are offered and brought to the service user.

Typically, the support services will involve multi-disciplinary specialisms including: physical and mental health workers; drug and alcohol treatment workers; employment support workers; and peer workers. These are either employed within the housing first agency, or brokered from community-based services. Access to the support can also go beyond that normally associated with traditional floating support schemes, and may be available 24 hours a day, seven days a week.

- A harm-reduction approach is taken to dependency issues and abstinence is not required. However, the support agency must be prepared to support residents' commitments to recovery.

The model strongly supports consumer choice and empowerment, but will assertively encourage the management of dependency issues and advise service users of the possible adverse consequences of their actions.

- Support can 'float away' or return as needs arise and the housing is maintained even if the resident leaves the programme, for example through imprisonment or hospital admission.

In contrast to the staircase model, this approach has a number of benefits. The permanence of the housing and the approach to support, particularly for dependency and mental health issues, means that continual moves between different types of accommodation are not required as residents' support needs change. This has the positive effect of ensuring that any possible relapse does not result in eviction.

Occasionally, residents may move to different units within a housing first programme. Generally, this occurs where specific problems have arisen within a tenancy. However, any perceived failing of the tenancy does not prevent the resident from being allocated to a different unit.

Housing first programmes avoid mixing substance users at differing points of their recovery. They are also able to accommodate changes in the service users' personal situations, such as personal relationships or access to children who live elsewhere. Traditionally, these have been problematic issues to accommodate within a hostel.

Effectiveness

The growth of housing first programmes in the US has been due to their effectiveness in housing those who are chronically homeless with multiple and complex needs. In 2006, published findings from a four-year longitudinal research study comparing the housing first model with traditional treatment first programmes[13] identified the following issues.

- There was a significantly higher rate of housing retention for residents in the housing first model (88 per cent) than the treatment first model (47 per cent).

12 For further information see www.desc.org

13 *Housing first services for people who are homeless with co-concurring serious mental illness and substance abuse*, op cit.

- Despite treatment first participants being more likely to use treatment services, there was no significant difference between the two groups and their levels of drug and alcohol use. This is of particular note given the requirement of treatment first participants to address their substance use. Also, housing first participants did not increase their use of substances despite the lower use of treatment services and non-requirement to abstain.
- There were no significant differences between mental health symptoms and quality of life indicators for participants from treatment first or housing first programmes.
- The annual per capita costs of the housing first programme were around half those of treatment first programmes ($22,500 compared to $40,000–50,000). These savings were even greater when compared with the costs of institutional care.

Application in the UK?

The housing first model presents a particularly innovative use of the private rented sector at a time when increasing emphasis is being placed upon its use for households in housing need in the UK.[14] Furthermore, although it is still primarily a US initiative, elements of the model do exist in the UK.

Action Housing and Support Ltd, Derbyshire

Action's floating support services in Chesterfield, Bolsover, and North East Derbyshire, target substance users and people with offending backgrounds. It provides cross-tenure support to local authority, registered social landlord (RSL), and private sector tenants, in addition to owner occupiers. Generally, the service prioritises and focuses on people that tend to fall between other services due to the extent or complexity of their needs, such as substance users who have underlying mental health problems. Few referrals are refused and Action works with service users whose dependencies range from current and active use to those who are now drug/alcohol free.[15]

While Action does not control the housing of service users, it can provide support for up to two years (with some flexibility for extension). Service users who have left the scheme can be re-referred if difficulties arise. The scheme has achieved notable success; in each of the last three years, more than 90 per cent of people who have left the programme have maintained independent living.

BCHA, Bridge Project, Exeter

This project was developed as part of a strategic approach to address homelessness within the city, particularly that of long-term, repeat street sleepers. Exeter City Council commissioned BCHA as the support provider, Signpost Care Partnership as the housing provider, and Street Homeless Outreach Team as the referral agency. The organisations work in partnership in order to provide secure accommodation with high levels of support to homeless people directly from the streets.

Typically, service users have multiple and complex needs and previous conventional methods have failed to resolve their homelessness. The accommodation is made up of a mixture of dispersed shared and single RSL flats, with current capacity to support 17 service users. The accommodation is not permanent, but let for up to two years, providing long-term settled accommodation with the potential to move on to permanent social housing. The flats can accommodate single men, women, and couples, including those with pets. Access to support is available between 8am and 6pm five days a week, but can be provided seven days a week if service users require. The support is funded through a Supporting People contract.

BCHA are keen to progress and develop the model in other areas. The organisation has considerable experience in managing private sector leasing stock and there is significant potential for developments in this area.[16]

Coastal Homeless Action Group (CHAG), Triangle Tenancy Service, Suffolk

CHAG has developed an innovative model of utilising private rented sector tenancies for homeless people with multiple and complex needs, who traditionally find it difficult to access settled accommodation. The model is very similar to the housing first schemes in the US, with properties leased from private landlords and then rented on to homeless households. This enables quick access for service users, with no requirement to spend time in hostels or other transitional housing.

Floating support was also originally offered to service users under a Supporting People contract. However, cuts to this funding have meant that specialist support is now brokered in from local agencies.

14 Jones, E, *Fit for purpose? Options for the future of the private rented sector*, Shelter, 2007.

15 For more information see www.actionhousinguk.org

16 For further information see www.bcha.org.uk

Despite this, CHAG maintains an oversight of housing management to ensure that rent is paid, tenancy conditions are met, and issues such as neighbour conflicts are addressed.

Between 2005 and 2007, CHAG housed 134 people within this scheme, and only six of these tenancies failed. The relative success of the scheme has broken down traditional barriers among landlords to providing housing to homeless people, who are often seen as too risky or problematic to accommodate.[17]

These examples demonstrate how the UK is using elements of the housing first approach. However, any wider adoption and development of the approach in the UK would be subject to some substantial challenges.

Can we evidence the need?

Many of those experiencing homelessness who could potentially benefit from the housing first approach are hidden. This means that they may not be engaged with existing services or appear on datasets that influence strategy and provision. This is a particular problem when it comes to identifying and allocating resources.

Where would the funding come from?

Supporting People has provided a single funding stream for housing-related support, but this budget has experienced cuts and there is some uncertainty about its future within local area agreements (LAAs). However, the joint commissioning arrangements likely to arise from LAAs could provide opportunities to build the joint strategic and operational partnerships across the range of health and social care and support agencies to facilitate such provision for homeless people with complex needs.

Do we have a sufficient supply of permanent housing?

Current demand for permanent housing in the UK massively outstrips supply. However, programmes in both the US and the UK have found ways of obtaining permanent housing for homeless people with multiple and complex needs. Although this has primarily come from the private rented sector, social housing has also been utilised, and current Government commitments to increase the supply of social housing[18] could increase options in this area. However, careful balancing of the use of permanent housing would be needed, given the existing high numbers of individuals unable to move on from hostels and transitional housing due to a lack of permanent provision.[19] Work will also need to be done to address issues of previous arrears and abandonment, histories of substance use, offending and antisocial behaviour. These can often lead to exclusion from rehousing for homeless people with complex needs.

Conclusion

Housing first programmes have expanded markedly in the US, based on a growing evidence base of effectiveness in providing more permanent solutions to the needs of homeless people with multiple and complex needs. Elements of the approach are present in the UK, and achieving some success. However, in order to realise the opportunities the model may present, and support in its wider adoption, a similar evidence base will be required in the UK.

No single model will be appropriate for everyone and research and evaluation will need to identify for whom this approach may be most appropriate and effective. It will also need to identify potential cost benefit savings across a range of health, social care and support services to build the multi-disciplinary partnerships that will be required to meet the needs of homeless people with multiple and complex needs.

17 For further information see www.housingfirstuk.org.uk

18 HM Treasury, *Meeting the aspirations of the British people: 2007 pre-budget report and comprehensive spending review*, 2007.

19 Homeless Link, *National move on report*, 2005.

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