'*Housing First*' or 'treatment first'? Considering successful strategies for the resettlement of homeless people

Abstract: '*Housing First' programmes in the US involve the provision of mainstream scatter sited permanent housing at the initial stage of support for homeless individuals with multiple needs. This is in contrast to dominant approaches (in the US and Europe) that assert the need for successful treatment (usually in temporary congregate accommodation) prior to resettlement. Evaluations of Housing First indicate however that even those considered the most difficult to house can, with help, successfully maintain a mainstream tenancy of their own.*

It is asserted here that one locally based agency managing both the housing and assertively providing holistic non time-limited support packages may be important factors in the success rate of Housing First programmes. However a further caveat is added - that to robustly assess the effectiveness of Housing First (and homelessness policy per se) what 'success' refers to in the resettlement of formerly homeless people requires continued consideration.

Keywords: Homelessness policy, mainstream housing, resettlement

Introduction

The US *Housing First* approach involves providing individuals who are homeless (not only rough sleeping but broadly defined as being inadequately housed, such as living in a hostel) and have multiple needs (such as substance misuse; mental ill health) with a permanent mainstream tenancy immediately on enrolment to a programme. Once in housing, support is assertively provided (Felton, 2003) but there is no obligation on the part of the client to comply with or access treatment prior to resettlement. Access to mainstream housing is separated from treatment compliance, and viewed as an essential component required for individuals to be capable of managing multiple needs (Tsemberis *et al,* 2004). Rather than becoming 'housing ready', housing is viewed as an essential component that is possible regardless of the support needs a homeless individual manifests.

Housing First is in contrast to prevailing programmes operating in the US (and UK) where treatment to manage multiple needs is deemed necessary prior to resettlement. On the far side of this spectrum sits *Continuum of care* approaches advocating a 'staircase' out of homelessness, (Sahlin, 1998) 'treatment first' (Padgett *et al*, 2006) and the need for a phased resettlement (Seal, 2005) case managed, with multiple agencies working together (Pleace, 2008). With this approach it is intended that individuals work through stages of supported accommodation and treatment before reaching a point where they are deemed capable (by support workers and housing providers) of independent living. However if an individual is unsuccessful, for example not maintaining sobriety or not engaging with support services, they are prevented from moving along the continuum and will remain homeless (McNaughton, 2008).

Housing First and *Continuum of Care,* whilst contrasting, illustrate the spectrum of provision that is used to address multiple needs homelessness. Robust evaluations of *Housing First* programmes in the US have found a much higher success rate of long rate resettlement than *Continuum of Care* programmes operating in the same context (Tsemberis & Eisenberg,

2000; Padgett *et al*, 2006). Yet 'treatment first' ideology continues to dominate homelessness policy.

The intention here is not to evaluate this US model, but to examine it further and assess what can be gleamed that may be applicable – or challenging – for homelessness policy elsewhere. It is postulated in this paper that by identifying *which* components of *Housing First* are significant and *why* these components may contribute to greater housing stability, then a clearer framework for the genesis of successful interventions can be arrived at that cuts across the plurality of services and approaches currently operating in different contexts. This framework would contribute to more effectively addressing multiple needs homelessness in these different contexts. A three stage approach is taken to do so: firstly, *Housing First* is described and significant components drawn out; secondly, two detailed case studies of *Housing First* programmes operating in New York are presented, to illustrate these components in operation; and, thirdly, why these components may contribute to successful outcomes in the resettlement of the most chaotic of the homeless population is considered.

Housing First

The evidence gathered in support of the US model of *Housing First* in recent years has been impressive. Randomized large scale studies comparing *Housing First* with traditional 'treatment first' approaches report significantly higher rates of housing stability among *Housing First* clients (Tsemberis & Eisenberg, 2000). Tsemberis *et al* (2004) report a housing retention rate of approximately 88 percent over four years among clients in a *Housing First* programme, a figure that challenges assumptions that drug using or mentally ill

homeless people are incapable of maintaining their own independent tenure, and that compared to a retention rate of just 47% of control group clients in treatment first programmes, at the end of four year study. Further, Culhane and colleagues (2002) have demonstrated the cost effectiveness of permanent supportive housing programmes, such as *Housing First,* for stabilising the most in need and chronically homeless shelter population. In their analysis of large scale data sets, they concluded that homeless mentally ill people used $40,451 of services in a year. This *reduced* by $16,281 when provided with permanent housing, mainly due to a decrease in emergency service uptake and arrest. The cost of providing housing and support to the same clients was found to be $17,200 per year, and therefore it cost a net amount of $919 per year to provide permanent housing and support, and greatly reduced pressure on mainstream emergency services. Similar findings from an analysis of *Housing First* in Denver have also been reported (Perlman & Parvensky, 2006). However caution has been noted by Culhane (forthcoming) that these studies have focussed on only those who have extremely high service utilisation. The same cost offsets may not be evident if such studies were completed with the 'mainstream' homeless population whom have less intense contact with additional social and health services.

Never the less in light of the evidence of both greater success and cost effectiveness, *Housing First* programmes in the US have proliferated and increased funding for permanent supported housing programmes has been made available as part of the Department of Housing and Urban Development's policy to address chronic homelessness (Culhane & Metraux, 2008).

Projects in other countries manifest elements of *Housing First* and the incorporation of housing and social support is certainly not unique to US *Housing First* projects. *Housing First* programmes have been implemented in Toronto, Canada (Toronto Shelter Support & Housing Administration, 2007). Parallels can also be drawn with, for example: social rental

agencies in Belgium, with welfare and support provided to vulnerable individuals by agencies that let privately rented properties in which to accommodate their clients. This property is rented at below market price, the landlord in return receives the assurance of rent payment and maintenance of the tenancy by the social rental agencies (De Decker, 2002). Another example is Coastal Homeless Action Group (CHAG) in Ipswich, UK. They facilitate access to permanent privately rented tenancies for homeless/multiple needs clients. CHAG hold the leases for these properties and sub-let them to their clients. The rent is paid by Housing Benefit. Some Local Authorities in the UK use the private rented sector to house homeless and low-income households, although this is usually only households deemed capable of maintaining their own tenancy and not manifesting additional support needs (Quilgars, 2008). The explicit applicability of *Housing First* to the UK context has been explored elsewhere (Atherton & McNaughton, forthcoming). The point to take here is that there are elements of *Housing First* evident outside of the US but little coherent drive towards it. It is in the US that the model explicitly referred to as *Housing First* exists, that has become the basis of programmes in many states. Several of these have been the focus of robust evaluations. Given the evidence produced, this paper represents an examination of the US experiences in an attempt to isolate what may explain the apparent success of this approach and how it differs from mainstream provision. Two specific cases of *Housing First* projects in New York are given to do so.

Components of Housing First in the US

There is no single definition of *Housing First*. However, there are central features common to most of the US programmes (Pearson *et al*, 2007; Padgett *et al,* 2006) and important

components of *Housing First* can be identified from the literature. These are: (1) immediate access to permanent housing; (2) the provision of a range of services, which are separated from eligibility for housing or risk of eviction; and (3) working with clients who have been previously excluded from services. For example in some US jurisdictions information on individuals who have had repeated contact with emergency homeless services is passed on to a *Housing First* agency. The agency provides assertive outreach in an attempt to engage and enrol these individuals onto their programme, provide them with mainstream housing, and with support to maintain this. *Housing First* programmes therefore work with clients who have been excluded or have been unable to access accommodation through the usual means.

To illustrate how the three important components operate in practice two case studies of *Housing First* programmes in New York are outlined below. These cases are taken from data collected during a research trip by one of the authors in April this year. The fieldwork included in-depth interviews with staff and observational site visits. The two agencies used as cases are Pathways to housing and Project Renewal. The first was selected because they are pioneers of the *Housing First* approach and there is a considerable evidence base available on the outcomes of their work, whilst the second involves a different client group and thus provides a demonstration of the approach's potential versatility.

Case Studies of *Housing First* Programmes

Case study 1 - Pathways to housing

Pathways was founded by a psychologist in 1992, the aim being to provide permanent housing (and treatment) for chronically homeless and mentally ill people, in New York city. To be eligible to enrol on the Pathways programme clients must have: (1) A clinical disorder

such as depression, anxiety, or schizophrenia; (2). Be chronically homeless, so for example be known to have been in a shelter for two years or living on the streets for three months; and, (3) Be eligible for public assistance funds.

Pathways only work with those diagnosed with a severe mental illness. Their clients are eligible for public assistance as they are deemed permanently disabled (they are usually eligible for Medicaid (federal funding for health care in the US) and Department of Housing and Urban Development or Section 8 grants to pay for housing). Pathways thus work with individuals who have experienced long term homelessness and that have previously been unable to access or maintain mainstream services, due to their high support needs. Pathways accept clients who fit this criteria on a 'first come first served' basis, and make no prior assessment as to how able (or otherwise) clients are likely to be able to maintain a tenancy.

Once a client is accepted onto the Pathways programme (after referral from a homeless shelter, outreach agency, or hospital) they will be offered a permanent apartment as immediately as possible, often within a week. Once they agree on an apartment, they choose furnishing and household goods and are helped to move in and settle there. Pathways hold the lease of nearly 600 privately rented apartments. Their housing department locate and inspect the apartments, agree the lease, liaise with landlords, and are responsible for maintenance if repairs are required that the landlords are not liable for. Pathways have a 'bank' of apartments that clients can move into or between depending on their needs, without them ever being without their own mainstream housing or requiring the landlords permission for these moves. No greater than 10 percent of residents in any apartment block are fellow programme participants (Tsemberis & Eisenberg, 2000). Their clients have been unable to access private rented tenancies previously because they could not guarantee the rent, had no references or credit rating, or because landlords did not want to house people with support needs, that have a history of institutional living and long term homelessness. By going through Pathways these

limitations of access to private rented housing are obviated, and landlords are assured the properties will be managed and rent paid. Clients avoid any further time being spent in transitional or congregate accommodation such as homeless hostels, which had previously been their only housing option.

Pathways provide support to clients through localised ACT (Assertive Community Treatment) teams (Salyers & Tsemberis, 2007). ACT teams consist of nurses, psychiatrists, employment support workers, substance use support workers, peer workers, family specialists, and so on. All of the staff remain informed about and work with all of the clients as required in an integrated and holistic manner. Staff draw on their specialism, and also provide some group sessions such as music therapy, cooking, or relaxation for clients in community settings or the team's offices. The medical staff distribute and manage the clients' medication. The ACT team have at least 6 contacts with each client a month and approximately 80 per cent of these contacts are in the community (such as the client's apartment or cafes). So clients have access to integrated and holistic support services alongside mainstream scatter site housing. What is important, and differs from 'treatment first' approaches is that compliance with support services is not necessary for them to maintain their housing - for example, they may still be using substances.

The only stipulation is that six contacts are made with an ACT team staff member per month and that incomes are managed by Pathways. That is, the client's social security is paid to Pathways who then discuss the client's budget with them and distribute instalments to them as required. Clients will not be evicted from the programme unless they commit a serious crime or are violent towards the staff. Pathways have a retention rate of almost 90 per cent -the percentage of clients that maintain an apartment after enrolment. The support of the ACT team or length of time that someone can live in their apartment is indefinite, and should circumstances change (such as a partner moving in) this will be accommodated.

Pathways therefore implement three significant components of *Housing First* previously identified that differentiates it from traditional models of support for homeless people with multiple needs – access to permanent housing (in this case privately rented); integrated and holistic services (through their ACT teams); and a service to those previously excluded from other services.

Implementing *Housing First* in this manner is not without challenges. New York has a tight housing market making obtaining adequate and affordable apartments difficult. Most properties are located in the lower cost outer Boroughs. Staff also report difficulties with drug dealing taking place in the apartments necessitating the client to move to another location. So for example if one client is isolated in a certain location or in dispute with neighbours they will be moved seamlessly from this to another Pathways apartment in a different location without spending any time in transitional housing. A further complication is that Pathways is not exclusively a 'homelessness' agency, their main focus being support of the severely mentally ill. The eligibility criteria for their support mean that those homeless individuals with *other* support needs (such as active substance users without a diagnosis of mental ill health) cannot be offered support. To assess whether different client groups have significance to how different components of *Housing First* are implemented, a second case study (Project Renewal) is outlined below.

Case study 2 - Project Renewal

Another agency operating a *Housing First* programme in New York is Project Renewal. Formed in 1967, Project Renewal manages large shelters and congregate supportive housing in New York. They also provide training and rehabilitation services for homeless substance misusers. Their services have traditionally been abstinence-based, with clients expected to

have a sustained period of being 'clean and sober' to access them. Therefore it was a major shift (and a means to address a recognised gap in service provision) when they were one of the eleven agencies nationwide that successfully obtained pioneering HUD *Housing First* grants for permanent supportive housing in 2003. Project Renewal was the only one of these agencies that focuses on substance misusers as opposed to the severely mentally ill. Despite this substantive difference, Projects Renewals *Housing First* programme operates in a similar manner to Pathways.

Project Renewal's *Housing First* programme (In Homes Now) provide access to permanent mainstream housing as soon as someone is enrolled on the programme. In the same manner as Pathways, their apartments are privately rented. Project Renewal housing officers liaise with landlords, obtain the lease, and inspect the properties. Again only a limited number of apartments are rented within any one apartment block or street. Support to clients is provided by a central team of staff based at one office, in a holistic, integrated manner. Staff are trained in a range of specialisms, including substance misuse, family experts, counsellors, housing and so on. They are expected to provide a holistic package of care and advice to each client, they also have a psychiatric nurse that attends twice a week, and they hold classes and drop in sessions at their office. Clients are referred to the programme from Project Renewal shelters. These clients are chosen because they have been long term shelter residents, unable to remain abstinent or engage with support services previously. It is a harm reduction based programme, their clients therefore do not have to address or be reducing their addiction, or engage with substance misuse services, to obtain or maintain an apartment.

The support they offer is not time limited and clients can remain with them indefinitely. Project Renewal report a 75 per cent success rate for the In Homes Now *Housing First* programme – 75 per cent of those that have enrolled on the programme have either

maintained their apartments, moved to another stable tenancy, or into a long term substance use programme (and will return to an In Homes Now apartment on completion). There is no expectation that clients will enter substance use programmes. However, doing so is facilitated. So Project Renewal's *Housing First* programme: provides clients with permanent housing (once again, privately rented); provides integrated and holistic support services (but with less medical reach than that of Pathways); and, provides a service to clients that have been unable to access other services due to their active substance use.

Pathways and Project Renewal are both *Housing First* programmes both operating in similar contexts (New York) with similar clients (multiple need long term homeless) and with high rates of success. Almost all of Pathways clients have a dual diagnosis (with a history of substance misuse) and Project Renewals clients often have mental ill health, although not diagnosed as being as severe as that of Pathways clients. Therefore tangible difference between their client groups is limited. Both agencies also illustrate the three important components of *Housing First* identified here as differentiating this approach from traditional treatment first, in operation.

Both agencies offer immediate scatter sited permanent mainstream housing without treatment compliance. This housing is privately rented, with the agency holding the lease and acting as a mediator between the landlord and client. Both provide integrated and holistic support to their tenants based on principles of harm reduction. Stipulations to remain within programmes, such as requiring abstinence, engagement with services, progression to greater independence and less contact with support staff, for example, are kept to an absolute minimum. Both also share a higher success rate of long term resettlement than that reported by traditional programmes that require sobriety or treatment compliance, in the same city (Tsemberis & Eisenberg, 2000; Padgett *et al,* 2006; Pearson *et al,* 2007). Further, they tend to work with clients who have extremely high support needs, that have been unable to

previously engage with traditional services, posing questions as to *what* it is about how these programmes operate that explains their successful outcomes – outcomes which act to challenge the dominant orthodoxy stating that individuals should be assisted to be 'housing ready' prior to resettlement.

Why these components may lead to greater success in resettlement

So far three important components of *Housing First* projects have been identified. How these components are implemented in practice has been described. Understanding why these components are effective may provide a basis for developing practices in other cities or countries. In this section each component is considered one by one to draw out possible reasons for the contribution to long term resettlement made by these individual parts.

1 - Access to mainstream housing

An important element of *Housing First* is the type of housing for which clients are helped to attain tenancies. *Housing First* approaches represent a means to provide access to mainstream housing for those previously excluded, using government subsidies to pay for private rented tenancies, as part of a health and social support package for homeless people who have multiple needs. For the landlords the model provides a constant rental income and management of the tenancy (for example, Pathways housing department arrange repairs if the landlord is not liable). For the clients, the agency holding the lease and sub-letting it to them

provides a means to access the mainstream rented housing where a lack of reliable income and support needs had previously been a barrier.

The *type* of housing (rather than tenure) may be most significant. The *Housing First* approach utilises mainstream scatter sited housing and avoids institutionalisation. This may reduce the potentially stigmatising and residualising effect that can occur when a high concentration of vulnerable and excluded individuals are housed together (Fitzpatrick & Stephens, 1999). In the US social housing such as that known in the UK is scarce, yet whether multiple needs clients are provided with socially rented or privately rented tenancies the key outcome may be the avoidance of congregate institutional temporary accommodation, that has traditionally been the lot of homeless people with multiple needs. Such accommodation offers little comfort. Homeless hostels have been recognised as creating an environment in which people are brought into contact with others who are misusing drugs (Neale, 2001); hardly conducive to reducing or ceasing drug use or treatment of mental ill health, and the condition of homeless hostels have been widely criticised (Rosengard, 2001). The *Housing First* approach therefore offers the prospect of a means by which mainstream rented housing (private or social) can be utilised to provide an environment in which people with complex mental health and addiction problems are more integrated to the wider community.

Potentially, this provision of mainstream housing as a first step for those with multiple needs could have important ramifications for the psychological process of individuals trying to address 'deep' exclusion (Social Exclusion Action Plan, 2006). For example, compared to homelessness, having a house may in itself provide the motivation and stability to begin to address drug misuse or access health care. Having an independent mainstream tenancy may bring with it not only privacy but also a sense of security, which is an important part of motivating people to take control of their own lives (Padgett, 2007). Returning to

homelessness is extraordinarily demotivating (as has been discussed by participants in recent studies of transitions through homelessness in this journal (McNaughton & Sanders, 2007)).

Housing First therefore illustrates a model that can (and in various guises has) been used to provide mainstream housing to those that are otherwise excluded from this, and to individuals that have previously been deemed incapable of such independent living.

2 - Integrated and holistic services, separate for housing

Housing First programmes in the US consist of sizeable mulit-disciplinary teams to support clients including, nurses, psychiatrists, drug misuse councillors and peer supporters (Tsemberis *et al*, 2004), what Pleace has referred to as '*a welfare state in miniature'* (2008: 44). So a further distinction from traditional approaches is the integrated nature of the care clients receive. Both Pathways and Project Renewal offer each client the whole gambit of health, budgeting, social support and advice from one *Housing First* team. Clients can have contact with any of the staff on that team. The locus of this holistic support is one single integrated point of contact through the team's office space. This provides continuity for the service users, important because poor quality information and a lack of 'joined up' provision of care in the case management process is often criticised in reviews of homelessness services in the UK and elsewhere (Bevan & Van Doorn, 2002; Cranes & Warne, 2005; Pleace, 2008).

That the support provided is not time limited is also an important consideration - rather than move onto another agency once a single issue is resolved (as is often the case in continuum approaches) the clients develop a long term relationship with the support team even if their circumstances change. Clients are aware that this relationship is ongoing for as long as they require it, providing a degree of ontological stability. Given that the clients are

deeply excluded, with a range of support needs, and have previously found agencies difficult to engage with, this continuity and security are likely to be important factors in generating a positive relationship between them and the support staff.

An effective homelessness policy requires both components – housing and support. Providing housing or support on its own is not sufficient. This has long been recognised by homelessness researchers in the UK (Pleace, 1995) and beyond (Toro, 2007). Does *Housing First* really then offer anything new to our understanding? Perhaps instead it fills a gap. A particularly notable feature of the US experience of *Housing First* has been the focus on groups previously excluded from services, whose social and health problems seem deeply entrenched and particularly entractable. The significance of this is considered next.

3 - Providing a service to previously excluded groups

The most vulnerable and deeply excluded groups can be excluded from support services due to their problems, creating a vicious cycle (Rosengard *et al,* 2007; McNaughton, 2008). The shift in approach illustrated by *Housing First* provides a means with which to include individuals who continue to misuse substances or have high support needs into mainstream housing and challenges perceived orthodoxies regarding the capabilities of individuals with multiple needs to live independently. *Housing First* can therefore be seen as a means to plug a gap that previously existed and poses significant epistemic questions regarding the traditional provision of services to this group.

Questions could be posed as to how 'just' *Housing First* programmes in the US are however – that those with lesser support needs or that are maintaining sobriety continue to be excluded from housing, and may experience the damage of long term homelessness whilst

they work through treatment programmes. The extent to which the approach could be widened to be accessible to anyone who is homeless is unclear. Whilst permanent supportive housing programmes, such as *Housing First* have been found to be cost effective with the most in need – most notably due to a reduction in hospitalisation and use of emergency services that accompanies stable housing (Culhane *et al*, 2002; Gulcur *et al*, 2003) – realistically it may be prohibitively expensive to roll out to all groups and therefore has to be 'rationed' (Pearson *et al,* 2007).

This is a paradox at the heart of these programmes, with homeless individuals having to experience the effects of long term homelessness prior to becoming eligible for this support, and only then being eligible if they have failed in mainstream services. The insistence on a multiple need diagnosis means that some people will be left homeless until such time as they have more severe mental health or substance misuse problems. To provide universal access to *Housing First* may be untenably expensive, however by not doing so the problems that it is intended to address continue to be allowed to fester among all but the most severely in need. Prevention of these problems at entry point may be a greater use of resources for the future (Shinn & Baumohl, 1999). Further research and economic analysis is needed to provide ground on which to widen the debate.

Assessing 'success' in the resettlement process

A point of departure can also be made here by considering the extent to which *Housing First* really marks a 'successful' solution at all. When someone is stably housed they may be in a better position to access support services, and stabilise their lifestyle. However, what has been found in research on *Housing First* outcomes is little *significant* difference in behaviour

or outcome between those who enter *Housing First* or 'treatment first' programmes other than the level of housing stability they attain (Tsemberis *et al*, 2004; Pearson *et al*, 2007). Data has shown that *Housing First* clients compared to those in 'treatment first' programmes experienced reduced hospitalisation (Gulcur *et al,* 2006), however there was no significant difference between the groups with regard to psychiatric symptoms (Greenwood *et al*, 2005), level of substance use (Tsemberis *et al*, 2004) or quality of life (Yanos *et al,* 2007).

When homeless people with multiple needs are housed they are unlikely to find other individual and structurally generated problems such as poverty or mental illness evaporate. McNaughton (2008) in a recent study of transitions through homelessness in the UK, argued that those who were stably housed at the end of the research were 'trapped individuals', no longer making a transition out of homelessness, feeling as if they were making no transitions at all, perceiving themselves to have few opportunities for meaningful occupation of time, and experiencing an acute sense of isolation. Substance misuse and poor physical and mental health, continued to feature highly. It has been postulated by Somerville (1992) that when experienced by deeply excluded individuals homelessness may be a manifestation of 'rootlessness' (characterised by anomie, alienation and disassociation from society) rather than housing-related 'rooflessness'. Is it the rootlessness or rooflessness that needs to be tackled first? Can one be addressed without that other? And which strategies can be identified that are most successful for doing so? (For example, the principles of *Housing First*, or *Continuums of Care*).

Returning to US work this point was succinctly recognised by Shinn & Baumohl (1999) noting that practitioners should '*remember that preventing homelessness is not identical to ending poverty, curing mental illness, promoting economic self-sufficiency, or making needy people healthy, wealthy and wise'*. Rather the goals that are being pursued have to be kept '*clearly in mind'* (Shinn & Baumohl, 1999: 13-1). The nature of these goals appear

to fundamentally differ between *Housing First* and 'treatment first' approaches. *Housing First* is concerned with managing the multiple and complex needs that clients manifest so that these clients can maintain housing, whilst 'treatment first' postulates the importance of 'progress' and recovery from the problems that precede homelessness as the significant outcome.

So the evidence as to further benefits from *Housing First*, beyond that of maintaining housing (albeit an important outcome) remains underwhelming. Pearson and colleague's, (2007:xxvi) in their review of *Housing First* programmes conducted for HUD, were cautious with endorsement, recognising that whilst *'direct placement in housing solves the elemental problem of homelessness (..) the dilemma is that is does not necessarily resolve other issues that may impede housing success'*. They also note that any programmes where actions such as drug use are 'allowed' are problematic for government policies, and in tension with law and order agendas.

Housing First therefore can be viewed as a policy that provides the means to 'save' people from homelessness. As Culhane & Metraux (2008) argue, diverting resources into permanent supported housing programmes such as *Housing First* 'reallocates the lifeboats' more adequately, saving people from chronic homelessness, but does little to prevent the Titanic of poverty from sinking.

The complexity of the problems in focus indicate that, rather than a clear cut formula, a spectrum of services is required. Whilst by no means the perfect solution, a *Housing First* approach may represent a pragmatic means for working with homeless people with particularly challenging mental health or addiction problems. *Housing First* also challenges existing orthodoxies regarding the degree to which individuals with multiple needs can maintain living in mainstream housing.

Conclusion

In this paper an attempt to delineate some important components of this *Housing First* has been made. These components are: immediate access to mainstream permanent housing (in the cases presented here, privately rented); and integrated and holistic support services that are not time limited. Whilst not an explicit component of *Housing First,* it also provides a service for those excluded elsewhere. Case studies have been presented that illustrate how these components operate in practice. The next step has been to consider *why* these components contribute to greater housing stability and successful engagement with services. In this way lessons may be gleamed from *Housing First* that can be used in the development of homeless services operating across different contexts, and with differing constraints, elsewhere.

The following have been identified as important. Firstly, in the context of US social housing provision, using private rented tenancies managed by the support agency allows for immediate access to mainstream housing for those previously homeless and who would otherwise not be able to achieve their own tenancy. This housing provides a location for them to stabilise their life, and it has also been suggested generate motivation to do so (Padgett, 2007). Whether social rented or private rented, it is the provision of mainstream, scatter site permanent housing (as opposed to congregate, temporary, institutional accommodation) that marks a real departure in how multiple needs homelessness is addressed and managed. Secondly, support services being provided by the same agency that manages the housing, including a range of specialisms across the staff team, can provide more holistic, integrated and consistent support than that of a multi-agency approach. That this support is not time-

limited or controlling may also increase client's sense of security and trust, with potentially beneficial consequences.

Housing First approaches entails a switch in perspective that marks a policy departure regarding multiple needs homelessness – that people often deemed incapable of maintaining their own housing *are actually able to do so*. How these tenancies are resourced and allocated requires some form of rationing however, and the process behind this currently represented by *Housing First* programmes (working with only the most deeply excluded) may be questionable. Is it justifiable to exclude those who are not yet in such need?

Housing First therefore can be viewed as a model with which to approach multiple needs homelessness more effectively – a pragmatic means with which to manage the most in need of the homeless population - rather than a 'revolutionary' solution to the deep rooted problems they represent. Where *Housing First* may represent a revolutionary shift is in the challenge it poses to traditional approaches that deem individuals with multiple needs as incapable of living in mainstream housing – thus excluding them from a home of their own.

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