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Additional information from: Peter Mackie
Gwybodaeth ychwanegol gan; Peter Mackie

Equality, Local Government and Communities Committee - Inquiry into homelessness

Further information requested following oral evidence by Dr. Peter Mackie, Cardiff University
22nd February 2018

My sincerest thanks again for the opportunity to give written and oral evidence to the National Assembly for Wales inquiry into rough sleeping. Following my oral evidence session I was invited to submit further information. In this second written response I provide information on:

- Examples of good practice of assertive outreach;
- Recommended innovative solutions for local authorities to overcome a lack of housing availability in the context of homelessness;
- My views on the Rough Sleeping Action Plan and the National Principles and Guidance for Housing First

Good practice in assertive outreach

- During the oral evidence session I commented on the importance of assertive outreach as part of an improved approach to assisting rough sleepers. I spent some time explaining how 'assertive' outreach (which aims to get people off the streets) differs to wider outreach work that often supports people to remain on the streets (eg. soup kitchens etc). I was keen to stress that some assertive outreach already exists in Wales – we are not starting from zero. I committed to provide further information on good practice. I would draw the Committee's attention to two key sources of information.

- First, I produced a report for Crisis in 2017 which reviewed international evidence on what works to end rough sleeping (see Evidence 1). Chapter 11 (pages 99-106) of this report discusses the effectiveness of different forms of street outreach.

- Second, I would point the Committee towards Cardiff Council's submission to the inquiry. The council's Homeless Outreach Team is now undertaking statutory homelessness assessments on the streets and is just one example of existing assertive outreach.

Innovative solutions to overcome lack of housing availability/access to the Private Rented sector

- During the oral evidence session I explained that assumptions are often made that there is insufficient housing available to accommodate homeless people, typically in the Private Rented Sector. While I certainly do not deny there is a shortage of affordable housing in many places, I pointed the Committee towards an example where a third sector organisation had implemented a pilot project with single homeless people and managed to secure many properties from private sector landlords that the local authority had previously failed to engage. I committed to provide further information on this example.

- Please find enclosed (see Evidence 2) an interim evaluation report for the Merthyr and Valleys Mind Step by Step project. The project sought to prevent and relieve homelessness for single homeless people in Rhondda Cynon Taff. The interim evaluation concluded that significant amounts of new private rented sector accommodation had been secured as a result of effective identification of and liaison with landlords and letting agents. This pilot project is currently being mainstreamed by the local authority.

Rough Sleeping Action Plan

- Prevention: I agree with the broad aims of the plan that the prevention of homelessness amongst rough sleepers should be a priority. I recommend Welsh Government makes links with ongoing work in this area in England and Scotland. It seems unlikely to me that the aims contained within the plan in relation to prevention will ultimately prevent rough sleeping – I do not think we fully understand what works to prevent rough sleeping. There is an

emerging international evidence base being drawn together by Professor Suzanne Fitzpatrick and I through our work with the UK Collaborative Centre for Housing Evidence. This will be published before December 2018.

- Support: The effectiveness of aims relating to support are dependent on Supporting People funded services. The Supporting People fund is no longer truly ring-fenced and the sector is forced to lobby to protect the funds on a regular basis, despite universal recognition across the UK of its importance. Moreover, while the type of support being advocated is appropriate, there is no requirement to provide this type of support. In the absence of a legal duty I do not envisage this type of support will be maintained – and may potentially never be implemented in some local authority areas. The detail of any guidance on support will be key but recent lessons show the importance of a] early/immediate access to support; b] that support must be 'sticky' – acknowledging that people will disengage and then reengage with support; and c] it should not be time-limited. In relation to guiding the wider public on the 'best' way to help rough sleepers I am unclear how this might be possible as there is no 'best way'. I would certainly hope to avoid blanket alternative giving responses.

- Outreach: I strongly welcome the move towards assertive outreach but how will we ensure this is available as it is not a statutory requirement. I fear the implementation of the Action Plan will leave some local authorities without assertive outreach services. On the issue of reconnections - this really must be seen as an option within a wider set of service options. I suggest consideration is given to different funding models to assist local authorities who are net recipients of homeless people from other areas – I highlighted this in my initial submission to the inquiry.

- Emergency accommodation: The Action Plan talks of access to safe emergency accommodation. It seems the problems associated with temporary accommodation go beyond safety and relate to wider suitability issues. Many homeless people choose not to take up temporary accommodation offers. Significant work will be required to ensure temporary accommodation is fit for purpose. Also, local authorities often only make temporary accommodation available to people with a local connection – this will need to be addressed. Importantly, there is no duty to provide temporary accommodation – this must be changed and will require an amendment to Welsh legislation. Notably, the Mackie review in 2012 recommended a duty to provide temporary accommodation to all homeless households. However, I strongly agree that temporary accommodation must be used as a very short term solution before move on to settled accommodation.

- Housing First: I would recommend that the wording is stronger here – Housing First should be the normal response/the *de facto* response to rough sleeping. How can this be ensured?

- Legislation: I feel strongly that a further iteration of legislative change is needed. Firstly, we need a duty to support. Secondly, we need a duty to provide temporary accommodation (and to secure rapid move on for all homeless households). Thirdly, while I support either abolishing priority need altogether or extending it to include rough sleepers – this will not resolve homelessness for this group as it similarly did not for offenders. We must amend what priority need entitles people to. The settled accommodation solution needs to be offered far sooner eg. in days not months or years.

- Measuring and monitoring: I strongly support plans here but would also welcome investment in the analysis of this data as Welsh Government is significantly under-resourced in this area. I would happily explore co-funding mechanisms for this between Cardiff University and Welsh Government.

- Joint working: Given rough sleeping is so closely related to issues of health, offending, social care etc, I would welcome the involvement of other Welsh Government departments and their explicit commitment to this plan. There is an assumption of joint working at local authority level but Welsh Government must surely set an example. What health funding or social care funding sits behind this plan?

- Promoting good practice: I support plans in this area and can help to resource and coordinate some of these commitments. For example, Welsh Government might collaborate with the UK Collaborative Centre for Housing Evidence to deliver the good practice event. I also recommend greater links with ongoing and fast-moving work in England and Scotland.

National Principles and Guidance for Housing First
- Firstly, it is important to state that I very strongly support a widespread shift towards a Housing First approach with rough sleepers across Wales. Housing First should be the *de facto* response. I firmly believe that adopting this approach will have a vast impact in reducing the number of rough sleepers in Wales, improving people's lives and their prospects. I offer several broad reflections on the principles set out by Welsh Government.

- Principles: It is worrying that Welsh Government states; 'as well as the 'pure' model in dispersed accommodation, in some cases HF is provided in a communal setting where support services are provided on site, often a conversion from a hostel'. I recommend we adopt the 'pure'/pathways model and avoid 'congregate' forms of Housing First. In my comprehensive review of Housing First evidence for Crisis (see Evidence 1) I concluded that scattered site provision is favourable – we should be aiming for this. In countries where hostels have been converted and congregate sites are used, there is often a later shift towards scattered sites (eg. in Finland) in recognition of the limitations of congregate site provision.

- The principles section also states; 'HF is designed specifically to help people who have high and complex needs, but are unable to benefit from a hostel or other temporary shared setting'. This implies that the de facto response should be hostels. I strongly recommend that HF should be the de facto response. Professor Suzanne Fitzpatrick also articulated this point during our oral evidence session.

- Implementation: The principles document states that 'local authorities and partners will need to decide to whom they offer a Housing First approach'. I fear that this may lead to selectivity, with more vulnerable and chaotic individuals excluded from the provision. Yet, it is exactly these individuals whom HF is designed for. My fears relating to selectivity are based on experiences elsewhere (eg. Common Ground in Australia) where selectivity resulted in the most vulnerable being excluded from the programme intended for that particular group (see Evidence 1). I would recommend close monitoring of who accesses Housing First, who does not, and the provision of guidance and support to local authorities making it clear which groups Housing First is intended for. We must remember this is a fairly big leap for most local authorities and there will be fears about using this approach with rough sleepers.

- Funding and duties: I would like to make an additional observation that other Housing First programmes have sometimes drifted from initial high success rates, often as funding for projects reduces and political attention wanes. Protections will need to be put in place to ensure success rates are retained. This might include outcomes-based funding, although this too can lead to selectivity. Additionally, if Housing First approaches are not required I reiterate concerns that some authorities will do this well and other may not implement the approach at all. Mechanisms must be put in place to ensure widespread delivery of Housing First.

Ending rough sleeping: what works?

An international evidence review

December 2017

Dr Peter Mackie, Cardiff University
Professor Sarah Johnsen and Dr Jenny Wood,
Heriot-Watt University

About Crisis

Crisis is the national charity for homeless people. We are committed to ending homelessness. Every day we see the devastating impact homelessness has on people's lives. Every year we work side by side with thousands of homeless people, to help them rebuild their lives and leave homelessness behind for good.

Through our pioneering research into the causes and consequences of homelessness and the solutions to it, we know what it will take to end it. Together with others who share our resolve, we bring our knowledge, experience and determination to campaign for the changes that will solve the homelessness crisis once and for all.

We bring together a unique volunteer effort each Christmas, to bring warmth, companionship and vital services to people at one of the hardest times of the year, and offer a starting point out of homelessness. We know that homelessness is not inevitable. We know that together we can end it.

About the authors

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Acknowledgements

Disclaimer: All views and any errors contained in this report are the responsibility of the authors. The views expressed should not be assumed to be those of Crisis.

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Acronyms

ACGA	Australian Common Ground Alliance
ACT	Assertive Community Treatment
AHURI	Australian Housing and Urban Research Institute
ASB	Antisocial Behaviour
ASBO	Antisocial Behaviour Order
B&B	Bed and Breakfast
CG	Common Ground
CHAIN	Combined Homelessness and Information Network
CSPO	Criminal Behaviour Orders
DCLG	Department of Communities and Local Government
DETR	Department of the Environment, Transport and Regions
DPPO	Designated Public Place Orders
EU	European Union
H&S	Hostels and Shelters
HF	Housing First
ICM	Intensive Case Management
IPNA	Injunction to Prevent Nuisance and Annoyance
LA	Los Angeles
LGBTQ	Lesbian, Gay, Bisexual, Trans and Queer
MTC	Modified Therapeutic Community
NFNO	No First Night Out
NSNO	No Second Night Out
PB	Personalised Budgets
PIE	Psychologically Informed Environment
PSPO	Public Space Protection Order
RCT	Random Control Trial
RRH	Rapid Rehousing
RSI	Rough Sleepers Initiative
RSU	Rough Sleepers Unit
SIB	Social Impact Bond
TAU	Treatment As Usual
TC	Therapeutic Community
TF	Treatment First
UK	United Kingdom
USA	United States

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Foreword

Executive summary

Introduction

The fact that increasing numbers of people are still sleeping on the streets in the UK is unacceptable. This is not inevitable and is the result of a societal and policy failure. If nothing is done to address the issue, rough sleeping is predicted to rise by a further 75 per cent within 10 years.

Yet we know the problem can be solved. Previous policy interventions such as the Rough Sleeper's Initiative and the Rough Sleepers Unit show what can be achieved with concerted effort.

To not do anything means thousands of people being left exposed to the devastating effects of rough sleeping. Rough sleepers are almost 17 times more likely to be victims of violence and 15 times more likely to have suffered verbal abuse compared to the general public. On top of this are the dire consequences for people's health and wellbeing.

So whilst we welcome current action by governments in Westminster, Scotland and Wales to tackle rough sleeping, more needs to be done. This new research gives us the five cornerstones of policy, that if adhered to, can end rough sleeping across Great Britain.

The evidence shows that a housing-led response which takes swift action to get rough sleepers off the street and working with outreach services that have suitable accommodation offers, all underpinned by person-centred support which responds to local housing markets and individual needs, does and can lead to success. National action groups and taskforces need to put these key principles into the local context and recognise the robust evidence base behind them.

While this report is focused on interventions to help people already experiencing rough sleeping, it also recognises the central role prevention plays in ending homelessness. Any strategy to address rough sleeping must be integrated within a homelessness prevention framework and sit alongside good quality short term emergency accommodation to enshrine rapid response and early action within national policy and local authority and voluntary sector practice.

Crisis, in its 50th anniversary year, has committed to produce a long term plan to end homelessness for good, including rough sleeping. Crisis believes that homelessness cannot be ended unless interventions and solutions are based on a stronger evidence base of 'what works'. Until now the evidence base on interventions was piecemeal and scattered. This new report shows us the way forward if we want to end rough sleeping for good and with partnership working and political will we know we can achieve this.

Jon Sparkes
Chief Executive, Crisis

The ongoing need for people to sleep rough on the streets of the UK is indicative of an unacceptable societal failure and recent homelessness projections[1] suggest that the scale of the issue is worsening. Ending rough sleeping is an increasing policy priority across the UK. Crisis, in its 50th anniversary year, has committed to produce a long term plan to end homelessness for good, including rough sleeping.

The existing evidence base on the effectiveness of interventions with rough sleepers is piecemeal and scattered, with key findings far from accessible to policy makers and practitioners. For this reason, Crisis commissioned this review of the existing international evidence base. The study aims to explore what works to end homelessness for rough sleepers. More specifically, it:

- identifies interventions designed to address the housing needs of rough sleepers

- assesses the impacts of rough sleeper interventions

- pinpoints key evidence limitations and gaps

- identifies key lessons for policy and practice

In this executive summary we briefly discuss the evidence review methodology and then present findings for each of the nine interventions examined, including: hostels and shelters; Housing First, Common Ground, Social Impact Bonds, Residential Communities, No Second Night Out, Reconnection, Personalised Budgets, and street outreach. The conclusions return to the core objectives of the review; identifying what works, what does not, the evidence gaps, and implications for policy and practice.

Research methods
This rapid evidence review combines two valuable traditions in assessing 'what works': the expert panel and the literature/systematic review. Interviews were conducted with 11 key informants – identified as experts in relation to their knowledge on

1   Whilst there has been an increase in the number of rough sleepers across Great Britain this hides regional variations. Most notably, these was a reduction in rough sleeping by more than 10% in Scotland between 2011 and 2016.

particular interventions or a particular country context – from the UK, US, Canada, Australia, Finland, Denmark, Germany, and France. Further to this, literature was identified through four main sources: academic databases (Scopus and Google Scholar), Grey literature websites (e.g. Crisis, Shelter, The Canadian Observatory on Homelessness, AHURI), references within reviewed literature, and the key informant interviews.

Evidence was only selected for inclusion if it focused on rough sleepers and assessed the impacts of a housing intervention. Moreover, studies were limited to those focused on people already rough sleeping (i.e. homelessness prevention was excluded). Relevant studies from 1990 onwards were included, regardless of their methodology. Ultimately, more than 500 sources informed the review (the bibliography) and just over 200 were cited (the reference list) in the report.

Hostels and shelters
- Hostels and Shelters (H&S) are intended to fulfil an emergency or temporary function. They are the predominant accommodation-based response to street homelessness in most Western countries. H&S vary substantially in terms of size, client group, type of building, levels and nature of support, behavioural expectations, nature and enforcement of rules, level of 'professionalisation', and seasonal availability. In some contexts, H&S are located within a staircase model whereby residents move through increasingly more 'normal' forms of transitional accommodation until they are deemed 'housing ready'.

- A substantial literature documenting homeless peoples' experiences in and perceptions of H&S exists, but there is a major dearth of research evaluating their effectiveness as an intervention. The most comprehensive evidence on

outcomes derives from RCTs which compare 'treatment as usual' (TAU) provisions (which typically involve some form of hostel or shelter) with Housing First. All of these have been conducted outside the UK and focus on one subgroup only (that being people with complex needs).

- As an emergency solution, H&S provide immediate relief from life on the street. Some rough sleepers successfully navigate their way through the H&S system and access independent accommodation, albeit a proportion subsequently return to H&S or street homelessness. H&S abandonment and eviction rates are typically very high.

- H&S protect residents from many of the risks associated with sleeping on the street, but present their own health-related hazards. The onset and/or escalation of drug misuse amongst residents is widely reported, the risk of communicable disease transmission high, and deterioration in mental health common. The management of antisocial behaviour is an ongoing challenge for staff.

- Evidence indicates consistently that many (and perhaps the majority of) homeless people find H&S intimidating or unpleasant environments. Some choose not to use H&S due to fears around personal safety and/or pessimistic views regarding their helpfulness in terms of offering a route out of homelessness. That said, a (to date unquantified) minority express a desire to remain in congregate H&S or supported accommodation in the long term.

- Concerns about using mainstream H&S tend to be particularly acute for young people, transgender people, and women. Homeless people with complex needs rarely fare well in standard H&S given their inability to cope with the rules and environment. There is a consensus that specialist

H&S, or alternative responses entirely, may be more appropriate for these subgroups (e.g. dedicated units with a training/employment focus for young people, or Housing First for individuals with complex needs etc.).

- Barriers to implementation include the high costs involved in running H&S, unstable funding streams, and a common dissonance between funding for housing and support which can make it difficult to offer residents the support they need. Moreover, a lack of move on housing stymies the system, preventing H&S from fulfilling their intended emergency or temporary functions and forcing them to operate as longer-term but unsustainable solutions to street homelessness.

- Key informants feel that H&S are generally ineffective interventions and their use should be avoided insofar as possible, at least in their current form. They point towards three main issues: they can be dangerous places; they are not suited to a wide range of groups facing multiple forms of exclusion, and they can be difficult to staff due to the challenging work environment. They conclude that shelters should only have a role if stays could be limited to exceptionally short periods of time and these lead directly into permanent housing. Beyond conventional H&S, key informants could see a role for supported housing, claiming that when it is provided as a longer-term solution outside of a staircase model, it can work well, although it is currently often hampered by a lack of move-on accommodation. There is a lack of evidence on the impacts of supported accommodation.

Housing First
- Housing First (HF) provides permanent housing to rough sleepers without preconditions regarding recovery from (or participation in treatment for)

substance misuse or mental health problems. Person-centered support is provided on a flexible basis for as long as individuals need it. HF was initially developed in the US and is being increasingly replicated in Canada, Europe and Australia, where it marks a significant departure from the traditional 'treatment first' or staircase approach. HF development in the UK has been modest to date, with only a limited number of small-scale projects currently operational.

- The evidence base on HF is exceptionally strong; far stronger than is true of any other housing-related intervention targeting rough sleepers in fact. The evidence includes a mix of large-scale Randomised Control Trials (RCTs) and smaller qualitative studies conducted in a range of international contexts. Further research is however needed to assess long-term impacts and effectiveness for subgroups. There is also scope to further understanding impacts on health and substance misuse, and influence of different programme structures on outcomes.

- HF is best known for its excellent housing retention outcomes, which are especially impressive given that the intervention targets homeless people with complex needs. Retention figures (measured in variable ways over different timeframes) range between 60-90 per cent, and typically coalesce around the 80 per cent mark. This is markedly higher than rates reported for Treatment as Usual (TAU) comparison groups.

- Other (non-housing) outcomes are much more modest. Improvements in physical and mental health are often documented, but tend not to be pronounced, nor significantly different from TAU comparison groups. Existing (slightly mixed) evidence indicates that HF may be equally and is sometimes more

effective than TAU in reducing levels of substance misuse, with many HF evaluations reporting overall reductions in alcohol and/or drug consumption. HF evaluations consistently report reductions in involvement in criminal activity. Many record improvements as regards quality of life, but these do not necessarily exceed those documented for TAU.

- Cost analyses, some of which have been conducted in the UK, indicate that HF is not a low-cost option, but creates potential for savings in the long term given cost offsets in the health and criminal justice systems in particular.

- Debates about fidelity feature significantly in the HF literature. Core to these have been assessments of the relative merits of scatter-site and congregate configurations. Comparisons of the two are few in number, but suggest that there are no significant differences in terms of housing retention or health outcomes. Involvement in substance misuse and/or criminal activity tends to be higher in congregate HF. Loneliness is more common in scatter-site HF, but the behavior of other residents in congregate HF can impede recovery. The majority of homeless people express a strong preference for scatter-site HF.

- HF has traditionally targeted homeless people with complex needs (that is, co-occurring substance misuse and/or mental health problems) and has proven to be highly effective as a housing solution for this group. There is limited evidence regarding outcomes for other subgroups of the homeless population, but adaptations have proven successful for young people and ethnic minorities.

- Key informant interviewees universally support HF. They echoed many of the literature review findings,

concluding that the evidence base is strong and the approach has particularly positive impacts on housing retention. However, they also raised several key points for policy makers to consider: 1] what constitutes Housing First and how loyal to the original model must a project be?; 2] The absence of high quality, flexible, multi-disciplinary and intensive support can undermine effectiveness; 3] Suitable housing is not always available for Housing First to be delivered; 4] Homeless people prefer scatter-site rather than congregate HF programmes; and 5] there are questions about the applicability of the model with other groups and at an earlier stage.

Common Ground

- Common Ground (CG) is a form of congregate site supported/supportive housing which is said to target highly vulnerable rough sleepers and places them in accommodation alongside people on low to moderate incomes (who do not have a history of homelessness) in a mixed community. On-site health and social support, retail and leisure facilities are provided alongside a 24 hour concierge service. CG was first developed in the US, and has been adopted as a national model in Australia.

- The evidence base on CG is very limited, despite assertions from some quarters that its expansion is an example of evidence-based policy. There have been no independent evaluations of the model in the US and the number of studies in Australia very small, albeit steadily growing. The process of discerning the outcomes of CG is further complicated by the fact that CG projects are sometimes described under the banner of HF.

- Variable housing retention rates are documented, from one report of 99 per cent in New York, to 74 per cent in Tasmania. High rates of eviction and abandonment have been

reported, and these attributed to poor fit between the model and the needs of certain (high needs) clients. Attrition rates appear to be declining over time in some projects, however.

- Health outcomes for CG residents show some signs of improvement, but the picture is mixed and more positive as regards psychological functioning than physical health. Mental health outcomes appear to be poorer in comparison to HF. Evidence on substance misuse is especially limited (restricted to one study) but suggests that this may not decline and may even increase in CG facilities, as compared with HF.

- Quality-of-life and social integration outcomes are generally positive for CG participants, with between 70 per cent and 90 per cent considering it their 'home'. However, restrictive rules and surveillance can lead to feelings of 'anti-community' amongst residents. Indeed, some evidence suggests divisions between supported and unsupported tenants, with a lack of interaction between the two types of resident.

- There is no evidence on different housing outcomes for subpopulations. Some evaluations nevertheless note that older tenants and women are more likely to view CG as 'home', and women and young people more likely to complain about aspects of anti-community, particularly the behaviour of those under the influence of alcohol or illicit substances.

- The key barrier to implementation is ensuring the right cross-sectoral relationships between agencies so as to provide the correct level of support to tenants. However, a key strength is that CG facilities provide new accommodation and so ease pressure on housing. In Australia, this is been provided at a particularly low cost.

- While key informants recognised the positive impacts of CG on housing retention and the important role played in support services in achieving this success, they held significant reservations about the congregate site model and the intrusive nature of support. Key informants did not support widespread development of the model.

Social Impact Bonds

- SIBs are a new form of financing social programs that gather private investments to fund specific providers to deliver a service or program. They are increasingly being used, or are at least being considered, in response to homelessness in a number of countries (including the US, Canada, Australia and Portugal), and have been trialed at a small scale in the UK.

- There is, as yet, limited evidence on SIB effectiveness. Further evaluation of their impact on outcomes in the homelessness field is needed. As literature points to an increasing number having started, there will likely be a better evidence base in the coming years.

- The only available evidence on outcomes is from the London SIB where 64 per cent of those remaining in the cohort at the end of the programme had achieved stable housing outcomes. It also exceeded expectations in housing sustainment at 12 and 18 months.

- Whilst volunteering and part time employment outcomes were not as successful as hoped, the London SIB performed substantially better than initially thought on full time employment. It may be that this funding mechanism incentivises targets traditionally not focused on by homelessness service providers.

- Caution should be exercised as regards the stability of outcomes

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over time, however, with the London SIB showing greater success in the first two years than in the final year. Long term evaluations are needed.

- The limited evidence shows that SIBs can be an effective funding mechanism, but complex agreements need to be put in place around the outcomes to be reached, and financial returns for different success rates.

- As SIBs generally fund existing, and usually evidence-based programs, it is reasonable to suppose that if they fund something such as Housing First or Common Ground they will receive the same, or similar results. However, it is possible that with a greater focus from providers on meeting predefined outcomes that performance may improve or decline in some areas.

- Key informants offered contradictory perspectives on the strengths and weaknesses of SIBs. Positive impacts were perceived to include: good outcomes for entrenched rough sleepers, access to new funds in order to expand services, more personalised services in some cases, and increased clarity and transparency around outcomes monitoring. However, challenges and limitations include: high targets that compromise service quality, limited innovation in service provision, and difficulties accessing the necessary data for outcomes monitoring. Despite the fairly balanced view of SIBs, there was broad agreement that the model could not be replicated more widely because of its complexity.

Residential communities
- The term residential community covers a range of configurations which accommodate homeless people in a congregate (but usually geographically isolated) environment, wherein the primary focus is not resolving street homelessness per

se but rather providing support relating to other areas of residents' lives. Two key models include: a) residential Therapeutic Communities (TCs) which are based on a well-established therapy model that supports clients to recover from substance misuse; and b) Emmaus communities which are described as self-financing mutually supportive communities where residents live and work together. Modified TCs (MTCs) have been implemented in homeless shelters within the US, and Emmaus communities operate in a number of rural locations in the UK.

- The effectiveness of the TC (and MTC) approaches in dealing with addiction in the general population is evidenced by a well-established body of evidence which includes rigorous (primarily quantitative) research, but it has been noted that further research is needed to be fully confident about the intervention's effectiveness in homeless shelters. The evidence base on Emmaus communities or similar projects is weak by comparison, being limited to a very small number of small-scale (primarily qualitative) evaluations.

- Evidence on TCs consistently indicates that the model is effective in reducing levels of substance misuse, mental health problems and involvement in criminality, including when employed in homeless shelters. Evaluations of Emmaus communities suggest that they can improve residents' quality of life by offering a sense of purpose, enabling skill development and enhancing feelings of self-worth but that the way of life is attractive to a fairly limited clientele. Evidence regarding the impact of either model of residential community on housing outcomes is negligible or non-existent.

- TCs have been shown to be effective in helping at least some homeless people with complex

needs overcome addiction, but attrition rates are very high. Emmaus Communities appear to be particularly attractive to and/or beneficial for: people with little formal education or work experience, ex-offenders, individuals with mild learning difficulties, and those with experience of or a liking for communal living. They are considered less suitable for: women, young people, ethnic minorities, and the 'most chaotic' or chronic street homeless people.

No Second Night Out
- Currently operating in England only, NSNO aims to assist those new to rough sleeping by providing an offer that means they do not have to sleep rough for a second night. There is widespread variation in the way NSNO principles are practiced, but it typically consists of some combination of assertive outreach, public engagement, support to access temporary accommodation and/or reconnection. Service users' needs are assessed in NSNO 'hubs'.

- The evidence base on NSNO is limited, consisting of small-scale evaluations of NSNO services in particular localities, together with a broader review of 20 projects. With one notable exception, these focus primarily on short-term housing outcomes and draw on interview, administrative and survey data.

- NSNO is effective in quickly finding the vast majority of service users temporary accommodation, with only a minority recorded as returning to the streets in the short term (in that locality, at least).

- Some service users have praised the treatment received and report benefiting from the support offered. Others, however, have been dissatisfied with the type and level of support received, refused offers of what they regarded as substandard accommodation, declined offers of

reconnection, and/or returned to rough sleeping or sofa surfing.

- Limited availability of housing can undermine the effectiveness of NSNO, with accommodation shortages being particularly acute in London and contributing to overly long hub stays. Long waits for rough sleepers to be 'found' and have their status confirmed by outreach workers also restrict its effectiveness in some contexts. Further to this, time-limited funding has been a key barrier to lasting implementation.

- Service providers recognise that, in practice, a wider client group than first time rough sleepers needs to be addressed. There is limited evidence of how NSNO works for different subgroups. More research in this area would be helpful.

- Only one key informant offered a view on NSNO. They were positive about the model and its success rate in supporting new rough sleepers to get off the streets and into accommodation. The stand-out characteristic of the approach is perceived to be the speed of assistance.

Reconnection
- Reconnection involves returning rough sleepers to their 'home' area. Some reconnections are 'international' in that they involve repatriating immigrants to their country of origin; others 'domestic' in that they relocate rough sleepers from somewhere they have no local connection to an area where they do have established connections within their home country. The level and nature of support involved with reconnections varies dramatically – from intensive assessment of needs and brokering of support in the recipient area at one extreme, to virtually nothing at the other.

- The escalation of reconnection in the UK, and England especially, has

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occurred in the absence of robust evidence regarding its effectiveness. Evidence regarding the impacts of reconnection is, at present, extremely weak – in large part because outcomes are recorded in only a very small minority of cases, and even then this is typically only to confirm that the individual involved has arrived in the destination area.

- The evidence which does exist (which is limited to a single study of reconnections within the UK) indicates that outcomes for rough sleepers vary dramatically. Some do access housing and re-engage with support services in the recipient area, but others sleep rough in the recipient area, return to the identifying area, or refuse the reconnection offer entirely. Most targeted individuals describe the process as distressing and bewildering, especially if they have no meaningful connection or believe they will be at risk of harm in the recipient area.

- Reconnections are most likely to be effective when targeted rough sleepers are newly homeless or recent arrivals to the identifying area (i.e. where they are first contacted on the street), have a (recent) history of service use in the recipient area (i.e. where they are reconnected to), and/ or have 'meaningful' connections in the recipient area. Conversely, reconnection appears least likely to work when: rough sleepers are resistant to the idea of returning; targeted individuals have a long history of homelessness; and/or recipient areas are geographically very distant from identifying areas. The provision of sufficiently intensive and tailored support is a critical ingredient in any successful reconnection.

- Barriers to implementation include: reticence or inability on the part of recipient areas to provide adequate services for reconnected rough

sleepers; the actions of non-interventionist support agencies which are said to undermine reconnection policies; and resistance on the part of rough sleepers themselves which is often borne out of unrealistic expectations or misinformation, negative experiences of services in the recipient area, and/ or fear that they will be at risk of harm if they return.

- Whilst there is widespread consensus that reconnection is appropriate in some cases – notably where rough sleepers have made an unplanned move and abandoned 'live' connections or services in their 'home' area – the limits and risks associated with reconnection raise important ethical questions. These include: denial of services to rough sleepers with no recognised local connection; uncertainty regarding the legitimacy and/or severity of risk to rough sleepers in recipient areas; inadequate service responses in some recipient areas; and the fragility or lack of support networks in recipient areas. These dilemmas are most acute when reconnection is employed as a 'single service offer'.

- Key informants were critical of the current reconnection model in the UK. There was no recognition of the positive experiences documented in the literature review, instead they highlighted concerns about the lack of support available in the receiving area and the lack of a focus on what is best for the individual. Informants were particularly negative about reconnections within the UK, whereas perspectives on international reconnections were mixed – largely because those who remain in the UK would have no recourse to public assistance.

Personalised Budgets
- Personalised Budgets have been used to support entrenched rough sleepers. Support workers have access to a budget for each rough

sleeper (£2,000-£3,000) which they can spend on a wide variety of items (from a caravan to clothing) in order to help secure and maintain accommodation. Importantly, rough sleepers identify their own needs and help to shape their own support plan.

- Personalised Budgets have only been implemented with homeless people in the UK and the evidence base is limited to a relatively small number of pilot project evaluations. Studies use administrative data analysis and qualitative interviews with service providers and service users.

- Housing outcomes are fairly well documented, with pilot projects generally securing and maintaining accommodation in around 40-60 per cent of cases, although this is potentially higher in Wales with most at least sourcing temporary accommodation. Significantly, the suitability of accommodation is determined by the rough sleeper, so housing outcomes are difficult to compare.

- Evidence of wider impacts is limited but qualitative data suggest many positive impacts beyond housing, including: health improvements and more appropriate access to healthcare, reductions in substance misuse, re-establishing positive social networks, improved self-esteem, increases in social welfare claims, and improved engagement with other services and agencies.

- There has been no analysis of whether the approach is more or less effective with particular subpopulations and the approach is yet to be trialed with the wider homeless population.

- Budgets available to individuals are between £2,000-£3,000, however the average budget spent on each individual (excluding costs of the support worker) was £794 in London and £434 in Wales. When staff time

was included in the London pilot project, the total cost per individual was £4,437 - around £1,300 more than the cost of delivering standard outreach provision. Qualitative data suggests projects may increase initial costs to the public purse, however in the longer term there are likely to be cost reductions.

- Five barriers to implementation were identified: i] uncertainty about what individual budgets can and should be spent on; ii] bureaucracy surrounding budget payments needs to be reduced, allowing swift access to budgets; iii] the increased workload for support workers relative to standard outreach provision needs to be recognised; iv] without access to accommodation and other specialist support the approach cannot succeed; v] replication and expansion will only be possible if additional funding is made available.

- Key informants highlighted that Personalised Budgets are in their infancy in the homelessness field and they agreed that the evidence base is relatively weak. Despite the limited evidence base, key informants were supportive of this person-centred approach and advocated wider implementation alongside housing-led solutions such as Housing First.

Street outreach
- Operating in some form in various countries, street outreach is an important component of many rough sleeper interventions (e.g. Housing First, Personalised Budgets etc.). In very broad terms, street outreach is the delivery of services to homeless people on the street. Assertive Outreach is a particular form of street outreach that targets the most disengaged rough sleepers with chronic support needs and seeks to end their homelessness. It can be defined by three distinctive facets: 1] The primary aim is to end homelessness; 2] Multi-disciplinary support; 3] Persistent, purposeful,

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assertive support. In some contexts enforcement is used alongside assertive outreach

- There is relatively limited evidence on the impacts of assertive outreach, however much is known about the characteristics of more effective services. A handful of key studies have been published on the Rough Sleepers Initiative and Rough Sleepers Unit programmes in England and Scotland and on Street to Home in Australia, and these provide some insight into housing outcomes but nothing on impacts on wider support needs nor service costs.

- Assertive Outreach has proven to significantly reduce the number of rough sleepers, with numbers reducing by approximately two thirds within three years under the Rough Sleeper Unit Programme in England and by more than a third within two years in the Scottish Rough Sleepers Initiative.

- The type of accommodation provided following Assertive Outreach impacts significantly on housing retention. First, where outreach leads to permanent, rather than temporary, accommodation tenancy sustainment outcomes are better. Second, accommodating rough sleepers in shared or congregate housing appears to be less effective and less desirable than self-contained options. There is no evidence on the longer term impacts of assertive outreach.

- The (limited) evidence on the impact of enforcement on rough sleepers indicates that, when combined with sufficiently intensive, tailored and high quality support it can offer a 'window of opportunity' prompting targeted individuals to accept offers of temporary accommodation and/ or engage more constructively with other services. It can, however, also displace rough sleepers, by 'pushing'

them into areas that are more dangerous and/or where they are more difficult for outreach workers to find and assist. Positive outcomes are more likely when a personally tailored and staged approach is adopted (wherein enforcement is used as a last resort).

- There has been limited examination of the impacts of assertive outreach on different population subgroups, however studies do point towards a key concern regarding outcomes for those who have no connection to the area. Research finds that assertive outreach is sometimes used to move people on and return them to 'home' areas, occasionally with little consideration of the circumstances they are being returned to.

- Key barriers to effective implementation of assertive outreach include: 1] the absence of a suitable permanent housing offer; 2] the absence of suitable multi-disciplinary support; 3] overcoming negative perceptions amongst rough sleepers about outreach services.

- Many key informants offered their views on assertive outreach services. They felt it was an important intervention, especially for those with the highest support needs. Their views reflected findings of the literature review, that success is underpinned by the availability of suitable permanent accommodation and a wide range of support.

Conclusion

- This review provides a detailed insight into the effectiveness of key interventions with rough sleepers. Reflecting across all interventions reveals important lessons about what works, what does not and the policy implications. We are also able to identify the gaps within the evidence base.

What works?

- Housing First: Housing First (HF)

targets homeless people with complex needs and has particularly good housing retention outcomes (around 80%). It is not a low cost option, but it does create potential for savings in the long term given cost offsets in the health and criminal justice systems in particular.

- Person-centred support and choice: Across several interventions, but particularly Personalised Budgets (PB), person-centred support including choice for the individual, has proven to be particularly effective in supporting entrenched rough sleepers into accommodation. There are also indications that this approach has positive impacts on wider support needs. In the case of PB, costs proved to be more than standard outreach support, however in the longer term there are likely to be cost reductions.

- Swift action: Interventions such as No Second Night Out (NSNO) and No First Night Out (NFNO) have highlighted the effectiveness of swift action in order to prevent or quickly end street homelessness. The majority of service users were found temporary accommodation by NSNO teams and it is likely this will reduce the number of rough sleepers who become entrenched. However, swift action alone is not sufficient; NSNO faced multiple challenges in relation to the lack of suitable move-on accommodation and problematic single-offers of reconnection.

- Cross-sectoral support: Many interventions, including Common Ground (CG), PB and HF, point towards the importance of developing effective collaborations between agencies and across sectors (e.g. housing, health, substance misuse, policing). This approach is key to providing the correct type and level of support for rough sleepers but is rarely achieved in practice.

- Assertive outreach: Assertive

outreach is a key component of several interventions (e.g. NSNO, PB, HF), particularly those targeting homeless people with complex needs and entrenched rough sleepers. Significantly, assertive outreach alone is insufficient, indeed potentially unethical, if it is not accompanied by a meaningful and suitable accommodation offer.

- Meeting wider support needs: Impacts of interventions such as HF on wider support needs such as physical and mental health, substance misuse and criminal activity are often documented, although outcomes are often not significantly different from Treatment As Usual (TAU) comparison groups. Whereas, interventions such as residential communities offer good outcomes for wider support needs but housing outcomes are often unreported.

What does not work?

- Unsuitable hostels and shelters: Hostels and Shelters (H&S) are intended to fulfil an emergency or temporary function and they vary substantially in terms of size and nature. The evidence base focuses on large-scale emergency accommodation, with limited support and often problematic move-on arrangements. Evidence indicates consistently that many (and perhaps the majority of) homeless people find H&S intimidating environments. Significantly, a lack of move on housing stymies the system, forcing H&S to operate as longer-term but unsustainable solutions to street homelessness. Beyond conventional H&S, there is a role for supported housing, on either a transitional or long-term basis, when it is provided as a solution outside of a staircase model.

- Unsuitable, absent or inadequate support: Providing the right support is a considerable challenge for homelessness services and the

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evidence review revealed multiple examples where support did not work effectively. Particular concerns have been raised about the ethicality and potential harmful impacts of single service offers, particularly the denial of key services to individuals with no local connection who refuse 'poor' single service offers of support (e.g. a poorly devised reconnection plan).

Policy implications
Current approaches to address rough sleeping are not as effective as they might (and need) to be. The development of an improved approach to ending homelessness must of course incorporate the views of rough sleepers and those who work with them, and take into account homelessness prevention, but the learning from this evidence review can play a key role in shaping a new approach. It suggests five key principles should underpin this approach:

1. *Recognise heterogeneity* – of individual rough sleepers' housing and support needs and their different entitlements to publicly funded support. Local housing markets and rough sleeper population profiles will also vary across the UK.
2. *Take swift action* – to prevent or quickly end street homelessness, thereby reducing the number of rough sleepers who develop complex needs and potentially become entrenched.
3. *Employ assertive outreach leading to a suitable accommodation offer* – by actively identifying and reaching out to rough sleepers and offering suitable accommodation.
4. *Be housing-led* – offering swift access to settled housing
5. *Offer person-centred support and choice* – via a client-centred approach based on cross-sector collaboration and commissioning.

There are clearly still gaps in the legislative frameworks for England, Wales and Scotland that would need to be addressed if we were to adhere to the five principles set out for ending rough sleeping in this report. While there is a history of progressive changes to homelessness legislation across the UK, this is a major barrier to overcome. Making amendments to legislation requires significant political support, is time consuming, and technically challenging.

The study identifies several barriers to implementing the proposed improved approach, including: 1] A lack of suitable settled accommodation within existing housing stock; 2] Difficulties accessing funding which is secure for the longer-term and can fund sustainable interventions; 3] Tendencies towards commissioning of support services in SILOs when there is a clear need for collaborative approaches between sectors (e.g. health, criminal justice etc); 4] Insufficient understanding about the effectiveness of interventions with different subgroups (e.g. Does Housing First work effectively with people who have low level support needs?); 5] Ineligibility of some rough sleepers to access publicly funded services; 6] If legislation is to be changed, this requires significant political support, is time consuming, and technically challenging; and 7] A shift towards person-centred support may be hampered by overly bureaucratic and burdensome processes.

Improving the evidence base
The review highlights six significant limitations and gaps in the evidence base on rough sleeping interventions, particularly in a UK context: 1] Research could be more rigorous, including larger-scale RCT-type experimental studies; 2] There is a serious lack of data on the effectiveness of a number of widely used interventions in the UK (e.g. hostels, shelters and reconnection);

3] There is a dearth of evidence on longer-term impacts of interventions; 4] There is scope to significantly improve our understanding of the effectiveness of interventions with different subgroups of the homeless population; 5] There is only limited knowledge on the impacts of different programme structures (e.g. congregate vs. scattered site models); 6] More could be done to quantify non-housing impacts (e.g. on health, substance misuse).

Summation
In the UK there is both an opportunity and a need for change in the way rough sleepers are assisted. The findings presented from this review should be used alongside the wider body of work being undertaken by Crisis with rough sleepers and those who work with them, to shape an improved approach and end rough sleeping. Moreover, we hope this synthesis will provide a reference point for policy makers, practitioners and researchers working with rough sleepers across the globe.

1

Ending rough sleeping: what works? An international evidence review

Introduction

2

Introduction

1.1 Introduction

The ongoing need for people to sleep rough on the streets of the UK is indicative of an unacceptable societal failure. Bramley's (2017) recent homelessness projections suggest that the issue is worsening: the number of people sleeping rough across Great Britain increased by nearly 50 per cent between 2011 and 2016[2] and is expected to rise by a further 75 per cent within 10 years. Rough sleeping is proven to detrimentally impact upon people's lives, including but not limited to their health, substance misuse, education, employment, social networks, and involvement in criminal offending.

Crisis, in its 50th anniversary year, has committed to produce a long term plan to end homelessness for good, including rough sleeping. Crisis believes that homelessness cannot be ended unless interventions and solutions are based on a stronger evidence base of 'what works'[3]. However, the existing evidence base on interventions with rough sleepers is piecemeal and scattered, with key findings far from accessible to policy makers and practitioners.

In response to this challenge, Crisis commissioned this review of the existing international evidence base. The study will feed into the wider body of work being undertaken by Crisis in its 50th anniversary year and will inform recommendations to Westminster and devolved governments. While the review is intended for a UK audience, it also provides a key resource on rough sleeping interventions for policy makers, practitioners and researchers elsewhere.

1.2 Research aim and objectives

The study aims to explore what works to end homelessness for rough sleepers. More specifically, the research:

- Identifies interventions designed to address the housing needs of rough sleepers
  The evidence review first identifies the range of different interventions that have been developed to address the housing needs of rough sleepers across the globe.

- Assesses the impacts of rough sleeper interventions
  For each intervention, the review analyses the known housing impacts. Consideration is also given to impacts on a wider range of issues (e.g. health, offending, employment) and any cost impacts.

- Pinpoints key evidence limitations and gaps
  The evidence review identifies the key evidence gaps and limitations in relation to each intervention and also more broadly across international rough sleeping interventions research.

- Identifies key lessons for policy and practice
  The study considers key lessons for policy and practice across the UK, including any barriers to policy implementation.

1.3 The UK policy context

This evidence review is timely as ending rough sleeping is an emerging policy priority across the UK. This section briefly introduces the homelessness policy and legislative context in each UK nation, with a particular focus on rough sleepers. We discuss the context in each UK nation separately as there is increasing recognition that 'there is no such thing as a UK experience in the housing field'[4]. Homelessness policy and legislation have diverged across the UK nations since the onset of devolution in 1999.

In England, the legislative framework, first introduced by the Housing (Homeless Persons) Act 1977, places a duty on local authorities to secure settled accommodation for homeless households deemed to be in priority need and unintentionally homeless. However, rough sleepers largely fall short of the vulnerability requirements that must be met in order to be deemed a priority, and are therefore offered limited statutory support. More recently, the Homelessness Reduction Act 2017 received royal assent and its commencement (April 2018) will change the duties placed upon local authorities. Local authorities will now be expected to take reasonable steps to help all households, including rough sleepers, albeit there will be no absolute duty to secure accommodation. While the legislation will have positive impacts on many single people, experiences in Wales,

2   Whilst there has been an increase in the number of rough sleepers across Great Britain this hides regional variations. Most notably, these was a reduction in rough sleeping by more than 10% in Scotland between 2011 and 2016.
3   Teixera, L. (2017) Ending homelessness faster by focusing on 'what works': towards a world-leading centre for homelessness impact, London: Crisis.

4   McKee, K., Muir, J. and Moore, T. (2017) Housing policy in the UK: the importance of spatial nuance, *Housing Studies*, 32(1): 60-72

where similar legislation already exists, suggest the impacts on rough sleepers may be limited.

In England, services for rough sleepers have often developed outside of the legislative framework, including; the Rough Sleepers Initiative in 1990, the Rough Sleepers Unit (1999) and No Second Night Out in 2011. Following the creation of the Rough Sleepers Unit in 1999, a specialist unit designed to drive cross-government co-operation and introduce new ways of tackling the problem, rough sleeping in England reduced by two thirds. That reduction was maintained for most of the 2000s[5]. Whilst the department was based in the Department of the Environment, Transport and the Regions (DETR) it bypassed the ordinary structures, reporting directly to the Permanent Secretary and accountable for its performance to Number 10. The Unit was disbanded and numbers of rough sleepers remained fairly constant until the end of the 2000s when numbers began to rise rapidly.

This trend of non-legislative innovation persists, with a catalogue of recent commitments by the Westminster Government towards the end of 2016, including; £20m for Homelessness Prevention Trailblazers, £20m in rough sleeping grants, £10m for Social Impact Bonds and further commitments at the end of 2017, including; £28m for three Housing First pilots projects and the establishment of a Homelessness Reduction Taskforce. One key challenge of non-statutory interventions is that they are often time-limited (e.g. Rough Sleepers Initiative) or fail to develop nationwide.

Scotland is the most progressive of the UK nations in relation to the rights conferred upon rough sleepers. The Housing (Scotland) Act 2001 placed a duty on local authorities to provide temporary accommodation for all homeless households and in the Homelessness Etc. (Scotland) Act 2003 there was a commitment to end the priority need test by the end of 2012, entitling all unintentionally homeless households to permanent accommodation. Scotland also introduced a housing support duty which commenced in 2013. Taken together, these legislative changes mean that rough sleepers in Scotland have a stronger set of housing entitlements than almost anywhere else in the world. Notably, only in Scotland has there been a reduction in rough sleeping over recent years[6].

Despite positive developments in Scotland, the legislative framework is crisis-focused and it was clear that the abolition of priority need would be difficult to achieve without a more preventative approach. In 2010 the Scottish Government supported local authorities to work together across five regional Housing Options Hubs in order to develop services that more effectively prevent homelessness – learning from approaches already pursued in England and Wales. More recently, the Scottish Government has shown an interest in pursuing the Housing First model, whilst also exploring the potential for 'preventative spend' and savings across budgets at a national level, e.g. criminal justice[7]. In parallel a Homelessness and Rough Sleeping Action Group has been established and will make recommendations to Scottish Government Ministers regarding the actions and solutions needed to eradicate rough sleeping and transform the use of temporary accommodation in Scotland.

Until recently the legislative framework in Wales was similar to the framework in England but in 2015 the Housing (Wales) Act 2014 commenced, bringing into law a more prevention-focused approach and extending assistance to all households, not only those in priority need[8]. The legislation does not extend an absolute right to housing to rough sleepers but local authorities are required to take reasonable steps to help secure accommodation. However, the absence of a right to temporary accommodation and support for rough sleepers, as there is in Scotland, has proven to limit any positive impacts on rough sleepers[9]. More recently there have been several funding announcements to support the implementation of prevention efforts across Welsh local authorities and perhaps most notably the Welsh Government is expected to publish an Action Plan on Rough Sleeping, which is likely to include a focus on Housing First.

In Northern Ireland the Housing (NI) Order 1988 places a statutory duty on the Northern Ireland Housing Executive (rather than individual local authorities) to provide interim and then permanent accommodation to households assessed as unintentionally homeless and in priority. The legislation is largely the same as in England (at least until the Homelessness Reduction Act 2017 commences in England). As is true in Scotland, homelessness prevention and housing options is a relatively recent development in Northern Ireland. The Housing Executive developed Housing Solutions and Support Teams tasked with attempting to prevent or relieve homelessness alongside the statutory homelessness assessment. Most recently in 2017, the Housing Executive published the latest five year homelessness strategy for Northern Ireland. The strategy continues to focus on Belfast and Londonderry/Derry where the majority of rough sleeping occurs. Significantly, the strategy also commits to examine the potential for Housing Led Pathway Models for chronic homeless people. This commitment builds on positive experiences of a Housing First pilot model developed under the previous strategy.

Reflecting across homelessness policy developments in the UK nations, three key points emerge. First, with the exception of Scotland, homelessness legislation has successively failed to give adequate protection to rough sleepers – with no duty on local authorities to provide temporary or permanent accommodation. Second, targeted interventions with rough sleepers have generally been developed outside of legislation, particularly in England (e.g. The Rough Sleepers Initiative), with many failing to develop nationwide or coming to an end. Third, across the entirety of the UK rough sleeping appears to be a strategic priority, with particular attention being given to the expansion of Housing First. This report is timely and it is anticipated that the findings will feed into these emerging policy agendas.

1.4 Structure of the report

Following this introductory chapter, Chapter 2 provides an overview of the evidence review methodology. Chapters 3-11 then discuss the findings in relation to nine key interventions, albeit we recognise that there is often significant overlap between interventions and their associated literatures. The interventions include:

• Hostels and shelters

• Housing First

• Common Ground

• Social Impact Bonds

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5 Fitzpatrick, S., Pawson, H., Bramley, G., Wilcox, S. and Watts, B. (2017) *The homelessness monitor: England 2017*, London: Crisis

6 Fitzpatrick, S., Pawson, H., Bramley, G., Wilcox, S. and Watts, B. (2015) *The homelessness monitor: Scotland 2015*, London: Crisis

7 Ibid.

8 Mackie, P.K., Thomas, I. and Bibbings, J. (2017) 'Homelessness prevention: reflecting on a year of pioneering Welsh legislation in practice', *European Journal of Homelessness*, 11(1) 81-107

9 Ibid.

• Residential communities

• No Second Night Out

• Reconnection

• Personalised Budgets

• Street outreach

In each of the findings chapters the discussion follows a similar structure. The intervention is initially described, before a reflection on the nature of the evidence base. The main content within each chapter is then a discussion of known outcomes and impacts – initially focusing on housing but also recognising any wider impacts (e.g. on health) that have been reported. The findings chapters also identify any known barriers to implementation of the approach. Before the final chapter summary, each chapter includes a synthesis of expert perspectives on the intervention.

Chapter 12 concludes the report. It summarises what is currently known about what works and what does not, identifies policy implications, and reflects on opportunities for an improved evidence base.

Research methods

2.1 The research design

Evidence reviews take many different forms and reflect the needs of the end user, the available budget and timescale. This review is a rapid evidence review, assessing, in a fairly comprehensive and systematic way, the best available evidence on what works to end rough sleeping. The review is not a 'gold standard' full systematic evidence review – largely due to the short timeframe for the work but also because much of the most relevant homelessness research would fall short of the 'quality' threshold typically set by systematic evidence reviews. Additionally, we wished to supplement the evidence base with qualitative perspectives of experts from across the globe – this approach combines the valuable insights of two traditions in assessing 'what works': the expert panel and the unbiased systematic review. Throughout the discussion of findings we have kept these two evidence sources clearly separated and they are only considered collectively in the concluding chapter.

The evidence review consisted of four phases. This chapter provides an overview of the approach and the methods employed in each of these phases:

- homelessness expert interviews

- evidence search

- evidence selection

- analysis and reporting.

2.2 Homelessness expert interviews

While a review of published studies constitutes the primary method for the evidence review, we also included interviews with 11 experts in the field of homelessness from across the globe. Their views were sought for two main reasons. First, in the homelessness field some intervention evaluations may not be identified through traditional searches and experts can play a useful role in identifying these potentially important studies. Second, we see value in gathering the qualitative perspectives of experts – these views can help to explain findings in the literature and also raise awareness of strengths or weaknesses perhaps not documented in the evidence base.

In-depth telephone interviews, lasting between 30 minutes and two hours were undertaken with 10 homelessness experts and one additional interview transcript from a previous study was analysed as secondary data (with permission from the interviewee). In total we were able to draw upon the perspectives of 11 expert interviewees. Respondents were identified as experts in relation to their knowledge on particular interventions or a particular country context. Most (7) interviewees were academics, whilst others (4) were in government or the third sector. Interviewees were located across the following countries: UK (4), USA, Canada, Australia, Finland, Denmark, Germany, and France.

2.3 Evidence search

The evidence search identified literature from four main sources. Each of these is briefly discussed and the search terms used are also identified.

Academic databases: We initially anticipated undertaking searches using two different academic databases (e.g. Scopus and IBSS), however studies of evidence review coverage have pointed towards the potential importance of using Google Scholar. Exploratory searches using Google Scholar indicated that it identifies some studies not picked up by databases such as Scopus. Consequently, we searched Scopus and Google Scholar in this review. We searched for the time period 1990-present, which is perhaps a longer time period than other reviews might have considered, however we were aware of particularly effective interventions having taken place during the 1990s (the Rough Sleepers Initiative, for example) and we wished to capture this literature. The following 12 combinations of search terms were used:

General search terms

Search Term 1		Search Term 2	Search no.
homeless OR rough sleep	AND	intervention OR program OR service	1
homeless OR rough sleep	AND	Systematic review OR evidence review	2

Intervention-specific search terms

Search Term 1		Search Term 2	Search no.
homeless OR rough sleep	AND	Hostel OR Shelter	3
		Transitional housing OR Supported housing OR Staircase	4
		Housing First	5
		Individual budget OR Personal budget	6
		Assertive outreach OR street outreach	7
		Common Ground	8
		Reconnection	9
		No Second Night Out	10
		Social Impact Bond OR SIB	11
		Therapeutic community	12

Grey literature websites: Recognising that a significant volume of homelessness research is not published by commercial academic publishers (classified as grey literature) and is unlikely to be identified through social science databases, the evidence search included a search of key UK and international housing and homelessness organisation websites, including: Crisis, Shelter, Homeless Link (UK), The Canadian Observatory on Homelessness (Canada), the National Alliance to End Homelessness (USA), AHURI (Australia), and FEANTSA's Research Observatory – including the European Journal of Homelessness (Europe).

References: Key references within reviewed literature, and not identified through other search mechanisms, were also searched.

Key informants: During interviews key informants were asked to identify any key studies on rough sleeper interventions, often within their particular country context. Again, where these had not been identified through other sources they were added to the evidence base for review.

2.4 Evidence selection
Our initial searches using the academic databases returned 493,078 results. In this brief subsection we describe the process and criteria used to select the literature for inclusion in the review. We followed three key stages in our selection process.

1. For each of the 12 searches listed above, results were sorted by relevance, then a maximum of 300

returns[10] were selected from both the Scopus and the Google Scholar searches. Hence, under any of the searches the maximum number of papers to be considered would be 600.
2. For each of the 12 searches, papers were then selected/excluded on the basis of their titles. At this stage any duplication between the Scopus and Google Scholar records were removed.
3. Finally, papers were selected/excluded on the basis of abstracts or full text reviews where necessary.

The following table identifies the selection criteria used to identify relevant papers.

General search terms

Criteria	Selection requirements
Study group	Studies must **focus on** people who **are rough sleepers/street homeless**. Studies of the broader homeless population were included only where the impacts on rough sleepers/street homeless could be clearly identified.
Study focus	Studies must meet three key requirements: • **Assess the impacts of an intervention**. Unless studies considered the impacts of an intervention they were excluded from the review. • Interventions must seek to address the **housing needs** of rough sleepers. However, interventions that address housing needs alongside wider support needs (eg health, offending etc) were included. • The **timing of interventions** is significant. Studies were limited to those focused on people already rough sleeping. This excluded homelessness prevention studies.
Methodology	Studies adopting either/both qualitative or/and quantitative methods were included. We did not exclude studies on the basis of research methods. Instead, a qualitative commentary was provided on the methods used when findings were reported.
Practicalities	Study reports must be available to the research team and published in English.

10   Based on the findings in Haddaway N.R., Collins A.M., Coughlin D., Kirk S. (2015) The Role of Google Scholar in Evidence Reviews and Its Applicability to Grey Literature Searching. PLoS ONE 10(9): e0138237. https://doi.org/10.1371/journal.pone.0138237

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Research methods **12**

Figure 1 illustrates the evidence selection process and quantifies the number of papers selected and excluded at each key stage. Ultimately, more than 500 sources informed the review [11] (the bibliography) and just over 200 were cited (the reference list) in the report. Significantly, in the academic databases searches we found only an 11 per cent overlap in the sources returned by Scopus and those returned by Google Scholar. This validates the decision to include Google Scholar in our search process.

2.5 Analysis and reporting

Evidence on each intervention was analysed separately, using the following broad framework to guide the analysis and reporting: i] a description of the intervention and any variations in implementation structures; ii] the nature of the evidence base, including methods used, scale of the study and geographical location; iii] impacts and outcomes on housing and wider support needs and any evidence on differentiated impacts for different population subgroups; iv] costs and cost implications; and v] any known barriers to implementation. Key informant perspectives on each intervention were analysed inductively and reported separately within each thematic chapter. This structure is followed in each of the intervention-specific chapters that follow, beginning with hostels and shelters.

Figure 1 — Evidence selection process

Academic databases

Total no. of results returned from academic databases
493, 078

Papers selected following title review
880

Papers selected following abstract and full text review
452

+

Other sources

Total no. of papers sourced from grey literature websites
27

+

Total no. of papers sourced from KIs and reference lists
54

=

Total no. of papers reviewed
533

11   Many papers were relevant but added no further detail to the c. 200 papers already cited and were therefore not included in the report.

Hostels and shelters

3.1 Defining the intervention

Hostels and Shelters (H&S) provide emergency or temporary accommodation. They exist in a wide variety of forms ranging, for example, from peripatetic volunteer-run emergency shelters which offer little more than a bed for the night on a first come first served basis in a building that normally serves another purpose (e.g. a church hall), to referral-only longer stays in high support units in purpose-built buildings run by professionally trained staff. H&S may be differentiated by the following key dimensions:

- number of beds – from small-scale with a few beds only, to several hundred beds

- type of building – from a single purpose built or converted building, to single room occupancy hotels, and dedicated apartment buildings

- form of accommodation – from large dormitories, to individual rooms, to congregations of individual self-contained units

- nature of support and services offered – from a bed (and possibly other basic subsistence such as food) only, to intensive personalised support addressing housing, health and other needs

- client group – from general needs to specific provision for subpopulations (e.g. young adults, women, or those with more or less complex support needs)

- behavioural expectations – from those operating on a relatively 'unconditional' basis , to those that actively encourage or even insist upon change in residents' behaviour and/or lifestyle

- nature and enforcement of rules – especially but not solely in relation to alcohol and drug use

- level of 'professionalisation' – from shelters run entirely by volunteers (with varying levels of training) to units operated by professionally trained paid staff; and/or

- seasonal availability – from cold weather shelters operating in winter only, to projects open all year.

All H&S are, in theory at least, intended to provide accommodation on an emergency or temporary basis. In many contexts, H&S are located within a staircase or 'continuum of care' model, whereby homeless individuals move through different forms of (increasingly 'normal') transitional accommodation until they are deemed 'housing ready' and allocated independent settled housing.

In all such cases, moves from one stage to another are premised upon evidenced change in circumstances or behaviour.[12] Some H&S operate independently of any such continuum or staircase, however.

This chapter comments on any differences in outcomes between H&S models where and insofar as the evidence base allows, however the evidence base is heavily focused on larger-scale emergency accommodation, with limited support and often problematic move-on arrangements. There was no significant literature on the outcomes of what would commonly be termed supported accommodation in the UK (This being referral-only, high support units in purpose-built buildings run by professionally trained staff).

3.2 The evidence base

There are a substantial number of academic sources that discuss H&S. These consist largely of qualitative studies focussing on the experience and perceptions of service users. Relevant literature includes a number of ethnographies which give detailed insight into experiences at the individual user or project level, but these and other qualitative studies of H&S tend not to assess data on housing, health or other outcomes. There are in fact few comprehensive or systematic evaluations assessing H&S effectiveness as an intervention, and this is particularly true of H&S

12   Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

with no move on provision.[13] Even for H&S operating within a broader staircase system there is a paucity of evaluative evidence beyond RCTs that compare 'treatment as usual' (TAU) (which typically includes at least some form of hostel and/or shelter) with Housing First. The wide variety of programmes on offer also means it is difficult to draw firm conclusions about what does and does not work. Albeit, as stated above, the evidence base is heavily focused on H&S which are large-scale, offer limited support, and often face problematic move-on arrangements.

Research on programmes for homeless people that involved H&S can be divided into 4 categories, including those that focus on:

1. Function and approach of the H&S;
2. H&S as a stepping stone to social reintegration;
3. The H&S as a place for other interventions around health, substance misuse etc.; and
4. Evaluations of specific H&S programmes.[14]

The vast majority of this research comes from the North American, UK, and European contexts. It should be noted that all of the RCTs assessing TAU outcomes have occurred outside of the UK.

3.3 Outcomes

The outcomes measured in evaluations of staircase programs (in particular) can differ substantially from one another. Thus, it should be noted that direct comparisons are not possible and this review gives an overview of patterns and trends only. Despite differences in measurement, housing outcomes are the most directly comparable outcome and may offer the greatest insight into the effectiveness of programs.[15]

Housing

Emergency H&S beds are not intended for long-term use, meaning that length of stay in housing in this context is sometimes capped at a certain number of consecutive days. Alternatively, individuals may stay in some forms of temporary H&S over the long term, marking a failure of the intervention to provide a link to more permanent solutions.[16] In the case of H&S associated with the staircase model, stays are expected to be longer, but an individual is required to move on after a period of stability – ranging between 3 months and 3 years[17] but depending on programme model, context, and

commissioning arrangements. [18] Alternatively, failure to comply with requirements (that often include sobriety and interacting with available support) may lead to an individual dropping down a step in their journey to permanent housing. This may involve returning to emergency forms of H&S, or even to the street.[19] Importantly, in recognition of these problems, evidence from the UK[20] and rest of Europe suggests a general move from large scale provision to much smaller H&S,[21] the establishment of dedicated resettlement teams,[22] and shift towards a harm reduction approach which does not require abstinence before someone can access permanent accommodation.[23] Many studies and evaluations of H&S measure whether individuals returned to emergency H&S or to the streets. This shows there is wide consensus that emergency H&S should never be a long-term option. However, the distinction between emergency H&S services and transitional housing may become blurred when emergency H&S stays lengthen, and with the wide variety of services on offer in some of these environments.[24]

Three evaluations following up the trajectories of those leaving emergency H&S/temporary accommodation are of note. One study with 70 participants in Georgia, USA found that 58 per cent were residing in stable housing situations at follow-up interviews one year after leaving.[25] A more robust study from England interviewed 400 individuals moving from temporary (a range of types) to permanent accommodation in London before the move, and then at 6 months, and 15 to 18 months afterwards. 73 per cent of respondents remained housed in the original accommodation in which they were rehoused across the 18 month period, and 8 per cent moved to a new tenancy. Of the remaining, 3 per cent were staying temporarily with relatives or friends, and 5 per cent had returned to H&S or the streets.[26] This suggests that move on from H&S can be successful, but is chronically underexplored – particularly in the long-term and in assessing who does and does not move on. The level of support provided to help individuals access permanent accommodation appears paramount to their move on

13 The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness*. London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.

14 utubise, R., Babin, P. and Grimard, C. (2009) 'Shelters for the Homeless: Learning from Research', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

15 Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

16 Culhane, D. P. and Metraux, S. (2008) 'Rearranging the Deck Chairs or Reallocating the Lifeboats? Homelessness Assistance and Its Alternatives', *Journal of the American Planning Association*, 74(1), pp. 111–121. doi: 10.1080/01944360701821618.
Deacon, A., Vincent, J. and Walker, R. (1995) 'Whose choice, hostels or homes? Policies for single homeless people', *Housing Studies*, 10(3), pp. 345–363. doi: 10.1080/02673039508720825.
The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness*. London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.

17 Barrow, S. and Zimmer, R. (1999) 'Transitional Housing and Services: A Synthesis', in Fosburg, L. and Dennis, D. (eds) *Practical Lessons: The 1998 National Symposium on Homelessness Research*. Washington DC: Department of Housing and Urban Development, pp. 11–31. Available at: http://www.urbancentre.utoronto.ca/pdfs/elibrary/1998_Transitional-Housing-S.pdf.

18 Johnsen, S. and Teixeira, L. (2010) 'Staircases, elevators and cycles of change:'Housing First'and other housing models for homeless people with complex support needs', *Crisis*, London.

19 Padgett, D., Henwood, B. F. and Tsemberis, S. J. (2016) *Housing first: ending homelessness, transforming systems, and changing lives*. Oxford ; New York: Oxford University Press.

20 Homeless Link (2017) *Support for single homeless people in England: Annual Review 2016*. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/Full%20report%20-%20Support%20for%20single%20people%202016.pdf.

21 Busch-Geertsema, V., Edgar, W., O'Sullivan, E. (2010) Homelessness and Homeless Policies in Europe: Lessons from Research, Available from: <http://noticiaspsh.org/IMG/pdf/4099_Homeless_Policies_Europe_Lessons_Research_EN.pdf>[Accessed: 3 December 2017}

22 Crane, M., Warnes, T. and Coward, S. (2011) *The FOR-HOME Study Moves to independent living Single homeless people's experiences and outcomes of resettlement*. Sheffield: University of Sheffield. Available at: https://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2011/craneetal2011forhomefinalreport.pdf.

23 Johnsen, S. and Teixeira, L. (2012) '"Doing it already?": stakeholder perceptions of Housing First in the UK', *International Journal of Housing Policy*, 12(2). Available at: http://www.tandfonline.com/doi/abs/10.1080/14616718.2012.681579.

24 Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

25 Glisson, G. and Fischer, R. (2001) 'Serving the Homeless: Evaluating the Effectiveness of Homeless Shelter Services', *Journal of Sociology and Social Welfare*, 28(4), pp. 89–97.

26 Crane, M., Warnes, T. and Coward, S. (2011) *The FOR-HOME Study Moves to independent living Single homeless people's experiences and outcomes of resettlement*. Sheffield: University of Sheffield. Available at: https://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2011/craneetal2011forhomefinalreport.pdf.

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success, [27] as does the affordability of the accommodation secured. [28] Thus, whether stays in emergency style H&S contribute to finding long-term permanent housing solutions is hard to ascertain due to the poor evaluative evidence base.[29] However, it is clear that many emergency H&S do not provide support to find permanent solutions and can lead to a concentration of many of the most complex needs clients.[30] It should also be noted that some H&S specifically run in the winter, with studies noting longer stays for people in poor weather conditions.[31] These sorts of shelter are less likely to be of a high quality.[32]

The success of programmes is not always measured in terms of long-term housing retention. Instead, short-term outcomes may be compared with programmes that provide support, without housing or no support at all. One example in New York found 62 per cent of residents of a transitional programme went on to some form of longer term housing compared with 35 per cent of those that received similar support but no housing.[33] Moreover, when housing outcomes and retention are taken into account, the type and quality is not always assessed critically, and as in the previous study focuses on whether an individual returns to the street or emergency shelter often in a timeframe 12 months or less.[34] Novak et al.[35] report data from several USA studies of staircase schemes in the 1990s which showed significantly poorer housing outcomes for single people as compared with families and a distinct dearth of independent evaluations. Thus, it is important to question not only whether housing is achieved, but also whether the housing outcomes are desirable, particularly in relation to the person in question. For instance, moving in with friends and family may be a good outcome for some, but unsuitable for others. Similarly, overcrowded

accommodation is not a good long-term outcome.[36]

An alternative measure of programme outcomes can be to assess the success of those that completed the programme against those that dropped out. For instance, USA studies found that participants who completed transitional housing programs were more likely to obtain permanent housing than those who did not.[37] Similar difficulties in comparability are illustrated by a study from Georgia, USA. Here, a programme of rapid rehousing (RRH) (providing quick access to a private rental tenancy with limited support for up to one year) was compared with a staircase programme. It found that 7.2 per cent of RRH clients return to shelter within 2 years, compared with 29.2 per cent of staircase clients. When controlling for several individual characteristics, the odds of returning to shelter were 2.5 times greater for staircase clients than for RRH clients. However differences in eligibility criteria mean those receiving RRH generally had lower support needs.[38] Finally, one evaluation reported that 92 per cent of residents who completed a staircase programme remained in the housing one year after discharge.[39] However,

as Novak et al.[40] points out, more than half of the sample of 228 individuals failed to complete the programme and high attrition rates are common, particularly for highly structured facilities.[41]

In the absence of large-scale, structured evaluations of emergency H&S systems, classifications of different types of shelter user offer insight into their role in addressing homelessness, and the lengths of stay of different types of people. In a seminal study, Culhane and Kuhn[42] clustered shelter use patterns from 2 USA cities into 3 typologies: chronic, episodic, and transitional. The transitional homeless population experienced homelessness once, for a short period of time; episodic homeless are people with the most episodes of shelter use, moving between H&S, jails, hospitals and other settings over time; and the chronic homeless population is entrenched in the shelter system, staying far beyond what can be considered temporary. Moreover, whilst transitional clients are more likely to be younger and have fewer physical disabilities, chronic shelter users are older and have the highest rates of behavioural health treatment and disability.[43] Similar

27   Hutubise, R., Babin, P. and Grimard, C. (2009) 'Shelters for the Homeless: Learning from Research', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada.* Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

28   Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada.* Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

29   The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness.* London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice. org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.

30   Culhane, D. P. and Metraux, S. (2008) 'Rearranging the Deck Chairs or Reallocating the Lifeboats? Homelessness Assistance and Its Alternatives', *Journal of the American Planning Association*, 74(1), pp. 111–121. doi: 10.1080/01944360701821618.

31   Hutubise, R., Babin, P. and Grimard, C. (2009) 'Shelters for the Homeless: Learning from Research', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada.* Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

32   See for example a night shelter in Glasgow explored in Littlewood, M. et al. (2017) *Eradicating 'Core Homelessness' in Scotland's Four Largest Cities: Providing an Evidence Base and Guiding a Funding Framework.* Pp.13 Edinburgh: Heriot-Watt University & Social Bite. Available at: https://www.sleepinthepark. co.uk/uploads/files/1509440950EradicatingCoreHomelessnessinScotlands4LargestCities.pdf.

33   Barrow, S. and Soto Rodriguez, G. (1996) *Interim Housing for Long-term Shelter Residents: A Study of the Kelly Hotel.* New York: Corporation for Supportive Housing.

34   Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada.* Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

35   Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada.* Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

36   Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada.* Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

37   Barrow, S. and Zimmer, R. (1999) 'Transitional Housing and Services: A Synthesis', in Fosburg, L. and Dennis, D. (eds) *Practical Lessons: The 1998 National Symposium on Homelessness Research.* Washington DC: Department of Housing and Urban Development, pp. 11–31. Available at: http://www. urbancentre.utoronto.ca/pdfs/elibrary/1998_Transitional-Housing-S.pdf.

38   Rodriguez, J. M. (2013) *Homelessness Interventions in Georgia: Rapid Re-Housing, Transitional Housing, and the Likelihood of Returning to Shelter.* Georgia: State Housing Trust Fund for the Homeless Georgia Department of Community Affairs. Available at: http://www.dca.state.ga.us/housing/specialneeds/ programs/downloads/HomelessnessRecurrenceInGeorgia.pdf (Accessed: 1 December 2017).

39   Murray, R. et al. (1997) 'One-year status of homeless mentally ill clients who completed a transitional residential program', *Community Mental Health Journal*, 33(1), pp. 43–50.

40   Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada.* Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

41   Busch-Geertsema, V., Edgar, W., O'Sullivan, E. & ... (2010) Homelessness and Homeless Policies in Europe: Lessons from Research, Available from: http://noticiaspsh.org/IMG/pdf/4099_Homeless_ Policies_Europe_Lessons_Research_EN.pdf

42   Culhane, D. P. and Kuhn, R. (1998) *'Patterns and determinants of public shelter utilization among homeless adults in New York City and Philadelphia', Journal of Policy Analysis and Management*, 17(1), pp. 23–43. doi: 10.1002/(SICI)1520-6688(199824)17:1<23::AID-PAM2>3.0.CO;2-J.

43   ibid

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findings have also been found in Canada, [44] a H&S in the UK,[45] and studies in the EU.[46] These studies show that, despite their temporary remit, episodic and chronic/longstay homeless populations generally use more than 50 per cent of available beds, with lengthy stays upwards of 4 years reported for some.[47] In Finland, descriptive evidence suggests some hostel users remained in this accommodation for decades, before all H&S were repurposed into congregate site Housing First in an attempt to combat their ineffectiveness.[48]

Whilst some H&S concentrate individuals with complex needs, evidence from a number of sources laments that some H&S may turn away individuals whose needs are deemed too high. Alternatively, with the staircase approach those with high support needs are more likely to struggle with the requirements of the programme.[49] While some H&S offer no or very basic services, those offered as part of a transitional housing service are generally better resourced, more comfortable, and provide a personalised approach to support. Thus, the sheltered population becomes fractioned with those able to convince officials that they will benefit from services gaining access to better quality centres, whilst those with the highest needs more likely to become entrenched in emergency H&S, or to return to the street.[50] However, there are some specialist H&S that work with people who have multiple and complex needs, [51] but these are relatively new developments and

demand typically exceeds supply, at least in the UK context.[52]

Health
In reviewing (primarily Canadian) research evidence, Hutubise et al.[53] state that the health of people using emergency H&S presents a serious challenge. Indeed, poor health at the outset or beginning of a transition to supported housing has been associated with exiting the programme.[54] Staying in H&S may have preferential health outcomes to living on the street. For instance, a study of sheltered and non-sheltered homeless women in LA found women on the streets were much more likely to have poor physical and mental health, and not access support.[55] However H&S can also contribute to poor health and even exacerbate certain conditions. For instance, the mortality rate varies from 2 times to 8 times higher than the rest of the general population (based on studies from the USA, Canada, and Denmark).[56] This is largely due to a combination of mental and physical health conditions that are prevalent amongst the homeless population, as well as a greater likelihood of problematic substance misuse. This

may be further exacerbated by a sense of helplessness and loss of control in the H&S environment.[57] Padgett et al.[58] describe how early emergency H&S in the USA were crowded, unsanitary and dangerous often leading weaker residents to be preyed upon and with AIDS, hepatitis and tuberculosis common along with usual respiratory problems, injuries, and skin infections. Indeed, one study suggests that routine exposure to blood in the H&S environment may explain the elevated levels of hepatitis C amongst homeless drug users.[59]

Staircase programmes often emphasise clinical outcomes for those with mental illness and may focus on moving individuals to post programme supportive housing and specialised residential care.[60] One study reported that more than three quarters of mentally ill residents took their medication regularly; virtually all were receiving income assistance and other help; and two thirds had no psychiatric crises whilst in residence. Almost 1/3 moved to boarding care site; 1/4 retained independent living; about 1/10 went to specialised care centres, back to family, or to other mental health

44   Acorn, S. (1993) 'Emergency shelters in Vancouver, Canada', *Journal of Community Health*, 18(5), pp. 283–291. doi: 10.1007/BF01321789.
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45   Deacon, A., Vincent, J. and Walker, R. (1995) 'Whose choice, hostels or homes? Policies for single homeless people', *Housing Studies*, 10(3), pp. 345–363. doi: 10.1080/02673039508720825.
46   Busch-Geertsema, V., Edgar, W., O'Sullivan, E. & ... (2010) Homelessness and Homeless Policies in Europe: Lessons from Research, Available from: http://noticiaspsh.org/IMG/pdf/4099_Homeless_Policies_Europe_Lessons_Research_EN.pdf
47   Rabinovitch, H., Pauly, B. and Zhao, J. (2016) 'Assessing emergency shelter patterns to inform community solutions to homelessness', *Housing Studies*, 31(8), pp. 984–997. doi: 10.1080/02673037.2016.1165801.
48   Y-Foundation (2017) *A Home of Your Own Housing First and ending homelessness in Finland*. Keuruu: Otava Book Printing Ltd.
49   See in particular: Hutubise, R., Babin, P. and Grimard, C. (2009) 'Shelters for the Homeless: Learning from Research', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).
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50   Arapoglou, V., Gounis, K. and Siatitsa, D. (2015) 'Revisiting the Concept of Shelterisation: Insights from Athens, Greece', *European Journal of Homelessness*, 9(2), pp. 139–156.
     Padgett, D., Henwood, B. F. and Tsemberis, S. J. (2016) *Housing first: ending homelessness, transforming systems, and changing lives*. Oxford ; New York: Oxford University Press.
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51   Johnsen, S. and Teixeira, L. (2010) 'Staircases, elevators and cycles of change:'Housing First'and other housing models for homeless people with complex support needs', *Crisis*, London.
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52   St Mungo's (2009) *Down and Out? The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness*. London: St Mungo's.
53   Hutubise, R., Babin, P. and Grimard, C. (2009) 'Shelters for the Homeless: Learning from Research', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).
54   Gabrielian, S. et al. (2016) 'Factors Associated With Premature Exits From Supported Housing', *Psychiatric services (Washington, D.C.)*, 67(1), pp. 86–93. doi: 10.1176/appi.ps.201400311.
55   Nyamathi, A. M., Leake, B. and Gelberg, L. (2000) 'Sheltered versus nonsheltered homeless women: Differences in health, behavior, victimization, and utilization of care', *Journal of General Internal Medicine*, 15(8), pp. 565–572. doi: 10.1046/j.1525-1497.2000.07007.x.
56   Barrow, S. M. et al. (1999) 'Mortality among homeless shelter residents in New York City', *American Journal of Public Health*, 89(4), pp. 529–534.
     Hwang SW (2000) 'Mortality among men using homeless shelters in toronto, ontario', *JAMA*, 283(16), pp. 2152–2157. doi: 10.1001/jama.283.16.2152.
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57   Burn, S. M. (1992) 'Loss of Control, Attributions, and Helplessness in the Homeless1', *Journal of Applied Social Psychology*, 22(15), pp. 1161–1174. doi: 10.1111/j.1559-1816.1992.tb02357.x.
58   Padgett, D., Henwood, B. F. and Tsemberis, S. J. (2016) *Housing first: ending homelessness, transforming systems, and changing lives*. Oxford ; New York: Oxford University Press.
59   Neale, J. and Stevenson, C. (2012) 'Routine exposure to blood within hostel environments might help to explain elevated levels of hepatitis C amongst homeless drug users: Insights from a qualitative study', *International Journal of Drug Policy*, 23(3), pp. 248–250. doi: 10.1016/j.drugpo.2012.01.002.
60   Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

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facilities respectively.[61] Despite health being a central focus of improvement for most staircase programmes, the lack of evaluative evidence outside of HF RCTs makes it difficult to draw conclusions on its effectiveness. However, a systematic review of housing and support for people with severe mental illness suggests there is little evidence of a difference in outcomes between residential care and independent housing with support. It thus recommends that individual choice may be the best way to determine the type of treatment a person receives.[62]

Substance misuse
A high proportion of H&S users have substance misuse issues. Different H&S may apply different rules to the consumption of drugs and alcohol[63], but abstinence is generally a requirement of H&S forming part of staircase programmes, particularly outside the European Union. Nonetheless, within the UK there remains a shortage of accommodation that allows users to move to abstinence at their own pace.[64] One study laments that individuals are required to address substance misuse in a relatively chaotic and unstable environment before they can access permanent housing.[65] Indeed, a further

qualitative study of the experience of drug using shelter users in England suggest users felt unsupported and wish for greater understanding from staff.[66] A key difficulty in addressing drug use may be boredom, as well as the temptation of being around other users.[67] There is clear tension in the literature around whether maintaining sobriety should be given precedence over harm reduction. This is brought into question by two studies which suggest transitional housing outcomes vary little between those that do and those that do not. Indeed, despite not reaching sobriety those that make it to permanent accommodation generally see a downward trajectory in their substance misuse.[68]

A qualitative study of drug users in Bristol and London found that H&S could be a safe haven for injecting drug users, characterised as a retreat from the chaos of the street. However, they are also risky environments that facilitate drug use and risk individuals forming networks and transitioning to new patterns of use which may increase the frequency of injecting. Thus, for some rough sleeping was a safer option than temporary housing with regards to managing their drug use.[69] Similarly, a study of 31 homeless people staying in supportive H&S in

Sheffield compare the group with 15 literally roofless individuals. 87 per cent of the roofless people had injected drugs in the past month compared with only 13 per cent of those in H&S. Whilst the use of heroin and crack cocaine in the past year was much lower for the sheltered population (32 per cent versus 100 per cent), 58 per cent of those living in H&S stated they started taking one new drug since they entered.[70]

Quality of life and social integration
Living conditions in H&S vary, and large H&S have been particularly linked with poor health and well-being.[71] Of concern is that large H&S are intimidating – especially for those with mental health difficulties or vulnerable to exploitation. Moreover, reports from the UK suggest people with high support needs are forced to go into large hostel accommodation because of a shortage of suitable places which can exacerbate the problems they present for all service users.[72] Numerous reports suggest that individuals would rather stay on the streets in many cases than access hostel accommodation, and this means that spare beds can exist alongside rough sleeping.[73] As well as the issues with substance misuse stated in the previous section,

the attitudes of workers and the structure of H&S may also create a context favourable to violent behaviour amongst users.[74] This must also be considered alongside the stigmatisation that can come from wider society from living in a hostel.

As previously stated, most H&S set rules and regulations for what is appropriate behaviour of service users and staff, as well as conditions of acceptance to the hostel such as abstinence, length of stay and personal characteristics. Other rules upon entry may govern whether individuals can stay during the daytime, rules around guests, and curfews. Failure to adhere to rules may result in penalties such as temporary exclusion, or eviction. Thus, whilst necessary for maintaining safety and security for some, restrictive rules can exclude those with the highest support needs, lead to frustration around the surveillance imposed on the lives of homeless people, and also signify how difficult H&S can be to manage.[75]

For H&S that comprise part of a staircase approach, there are more likely to be services that promote job readiness, health services, and are a key stepping stone to other interventions that can improve the

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62 Richter, D. & Hoffmann, H. (2017) Independent Housing and Support for People with Severe Mental Illness: Systematic Review, Acta Psychiatrica Scandinavica 136 (3): 269–279

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64 St Mungo's (2009) Down and Out? The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness. London: St Mungo's.

65 The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness*. London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice. org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.

66 Stevenson, C. (2014) 'A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation', *Journal of Substance Use*, 19(1–2), pp. 134–140. doi: 10.3109/14659891.2012.754508.

67 St Mungo's (2009) *Down and Out? The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness*. London: St Mungo's.

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72 St Mungo's (2009) *Down and Out? The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness*. London: St Mungo's.

73 For a recent example see Littlewood, M. *et al.* (2017) Eradicating *'Core Homelessness' in Scotland's Four Largest Cities: Providing an Evidence Base and Guiding a Funding Framework*. Edinburgh: Heriot-Watt University & Social Bite. Available at: https://www.sleepinthepark.co.uk/uploads/files/1509440950EradicatingCoreHomelessnessinScotlands4LargestCities.pdf.

74 Hutubise, R., Babin, P. and Grimard, C. (2009) 'Shelters for the Homeless: Learning from Research', in Hulchanski, J. D. *et al.* (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

75 Busch-Geertsema, V., Edgar, W., O'Sullivan, E. & ... (2010) Homelessness and Homeless Policies in Europe: Lessons from Research, Available from: http://noticiaspsh.org/IMG/pdf/4099_Homeless_Policies_Europe_Lessons_Research_EN.pdf

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quality-of-life and social integration of users. Indeed, a key indicator of success is a greater reliance from individuals on employment and earnings rather than income support programs.[76] For instance, In Denmark, H&S have a duty to draw up a plan of a person's stay and cover element such as health, financial circumstances and opportunities for employment, education or training. This then serves as a manual for the residency and as a basis for subsequent solutions and initiatives.[77] In other contexts, the extent of the work plan may be highly variable and could be based on concrete steps towards a goal, or softer indicators particularly for those with more complex needs.[78] Despite criticism of the hostel system in England, significant capital investment has been made into improving the physical conditions and creating stronger emphasis on work and learning.[79] Better quality physical environment is likely to lead to better outcomes.[80] Thus, whilst there is limited evaluative evidence on the

success of H&S, they can be the site of a number of effective interventions that are often evaluated separately.[81]

The key issue for participants in the staircase model is that the variance in service offer means that only some benefit from this integrated approach. Indeed, there is evidence from the UK that many services may only address mental health issues and nothing else, making progress unsustainable for service users with more complex needs.[82] Worryingly, the scarcity of provision creates higher thresholds to access housing and mental health treatment, leading to the cycle of high needs individuals ending up in large H&S with no move on.[83] Quality-of-life can also be compromised when individuals meeting certain goals are expected to move on. The stress of such a move may stunt an individual's progress, and lead to undue stress.[84] Moreover, failed attempts to move out of H&S can reinforce the feeling of failure for both service users and support workers and reduces the chances of individuals transitioning to

leading an independent life.[85] The lack of long-term outcomes research also calls into question the effectiveness of interventions around quality-of-life and social integration.[86]

Most fundamentally, critical views of H&S in some contexts suggest they can be total institutions, consuming all the time of the users and depriving them of freedom. It has been noted that the rules established about use of the hostel or shelter may control the identity of users, and keep them in a marginal position. These total institutions tend to alienate and depersonalise users, and can lead to a loss of autonomy that is then difficult to regain.[87] This is often termed 'Shelterisation'.[88] This occurs because homeless people are having to compete for a limited/inadequate/inappropriate emergency oriented resource. People are then either endlessly prepared for reintegration, or 'stored away' in specialised facilities that may develop their own sub cultures removed from wider society.[89]

Crime and anti-social behaviour
H&S often contain a high proportion of people with a criminal offending

history.[90] However, partaking in criminal and antisocial behaviour can be a reason for temporary or permanent exclusion from some H&S.[91] Shelter use is also associated with reincarceration in the USA. [92]

Survey evidence from the UK suggests that hostel staff spend a disproportionate amount of time managing the behaviour of people with highly complex needs which can be to the detriment of more meaningful one-to-one support for others.[93] Subsequent work[94] shows that clients are twice as likely to be evicted for bad behaviour than for arrears - the most important reason for eviction from London's H&S. With this, 48 per cent of clients who are evicted and 47 per cent of those that abandon are subsequently seen rough sleeping. These people all have complex support needs.[95]

Effectiveness for subpopulations
Certain groups such as the elderly, those with mental health problems, addictions, or physical health issues tend to stay for prolonged and repetitive periods in emergency

76 Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

77 Thorpe, E. (2008) *The role of housing and pathways into and out of homelessness Annual Theme 2008 Housing and Homelessness*. European Report. online: FEANTSA. Available at: http://www.feantsa.org/download/08_european_report_feantsa_housing_final_en8836616037029374941.pdf.

78 Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

79 The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness*. London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.

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81 Hutubise, R., Babin, P. and Grimard, C. (2009) 'Sheltrs for the Homeless: Learning from Research', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

82 St Mungo's (2009) *Down and Out? The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness*. London: St Mungo's.

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Johnsen, S. and Teixeira, L. (2010) 'Staircases, elevators and cycles of change:'Housing First'and other housing models for homeless people with complex support needs', *Crisis*, London.

85 Thorpe, E. (2008) *The role of housing and pathways into and out of homelessness Annual Theme 2008 Housing and Homelessness*. European Report. online: FEANTSA. Available at: http://www.feantsa.org/download/08_european_report_feantsa_housing_final_en8836616037029374941.pdf.

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91 The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness*. London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.

92 Metraux, S. and Dennis P. Culhane (2004) 'Homeless Shelter Use and Reincarceration Following Prison Release', *Criminology & Public Policy*, 3(2), pp. 139–160. doi: 10.1111/j.1745-9133.2004.tb00031.x.

93 ibid

94 Homeless Link (2010) *Staying in: understanding evictions and abandonments from London's hostels*. London: Homeless Link.

95 Homeless Link (2010) *Staying in: understanding evictions and abandonments from London's hostels*. London: Homeless Link.

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H&S.[96] In the USA, research shows that Caucasian people stay around half as long in H&S as black people,[97] and both Blacks and Hispanics are overrepresented.[98] Meanwhile, women stay for shorter stints but are more likely to feel unsafe and victimised in this environment,[99] and young people appear more likely to stay in H&S for short periods of time, and have a greater chance of moving to more long-term housing arrangements.[100] In Canada, immigrants[101] and aboriginal people[102] are underrepresented in H&S.

All homeless and marginally housed people are more likely to have experienced/experience sexual or physical assault than members of the general population. However, women and transgender people are more likely than men to be victimised in a hostel environment.[103] Mixed gender hostels can lead to tension, and potential victimisation.[104] The same is true for young adults, who may put themselves at risk by interacting with older, and more entrenched homeless individuals, or in many cases choose not to use H&S at all given their fears about doing so.[105]

With the above concerns, provision for specific communities such as women and youths has been documented across contexts. Many of the same issues come up as with the general population – pride in one's own independence, lack of support for those with complex needs, [106] restrictive rules, [107] and avoidance due to fear for personal safety or health.

However, specific provision does alleviate some of the more extreme reasons for fearing exploitation,[108] and can provide targeted interventions around employment and training particularly for young people.[109] For women, some evidence suggests they are less likely to gain good housing outcomes,[110] but in specific provision the communal living arrangements of transitional accommodation allows the time and space for women fleeing domestic violence to move forward, and provides a sense of community that aids in their feelings of safety and security, particularly as it does not allow men.[111] Provision for these subgroups is seriously lacking in some contexts.[112]

As noted above, it is now widely acknowledged that mainstream H&S are often poorly equipped to meet the needs of homeless people with complex needs (see also chapter on Housing First), as these individuals typically struggle to cope with the rules, expectations re engagement with support, and/or the communal environment.[113] That said, there have been a few small-scale attempts to develop more 'psychologically informed' hostels for this particular client group which are said to update and make more flexible the principle of the therapeutic community.[114] These have not yet been subject to detailed evaluation, but are said to broadly meet their aim of providing a different type of environment from standard hostels, albeit that it has been noted that it is difficult to put theoretical PIE (Psychologically Informed Environment) into practice in the current political and economic context in the UK.[115]

Another particular group that lacks provision is transgender people who may be forced to accept a gender identity determined by others for the sake of allocation, face a lack of support and understanding from staff, greater chance of exploitation, and may ultimately not find a place due to prejudice from staff. Mottet and

96   Rothwell, D. W. et al. (2017) 'Patterns of Shelter Use Among Men New to Homelessness in Later Life: Duration of Stay and Psychosocial Factors Related to Departure', *Journal of Applied Gerontology*, 36(1), pp. 71–93. doi: 10.1177/0733464815624154.

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100   Rabinovitch, H., Pauly, B. and Zhao, J. (2016) 'Assessing emergency shelter patterns to inform community solutions to homelessness', *Housing Studies*, 31(8), pp. 984–997. doi: 10.1080/02673037.2016.1165801.

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103   Kushel MB et al. (2003) 'No door to lock: Victimization among homeless and marginally housed persons', *Archives of Internal Medicine*, 163(20), pp. 2492–2499. doi: 10.1001/archinte.163.20.2492.

104   Deacon, A., Vincent, J. and Walker, R. (1995) 'Whose choice, hostels or homes? Policies for single homeless people', *Housing Studies*, 10(3), pp. 345–363. doi: 10.1080/02673039508720825. Fotheringham, S., Walsh, C. A. and Burrowes, A. (2014) '"A place to rest": the role of transitional housing in ending homelessness for women in Calgary, Canada', *Gender, Place & Culture*, 21(7), pp. 834–853. doi: 10.1080/0966369X.2013.810605.

105   Ha, Y. *et al.* (2015) 'Barriers and facilitators to shelter utilization among homeless young adults', *Evaluation and Program Planning*, 53, pp. 25–33. doi: 10.1016/j.evalprogplan.2015.07.001.

106   Moloko-Phiri, S. S., Mogale, R. S. and Hugo, J. (2017) '"A shelter is not a home": Voices of homeless women in the City of Tshwane', *Development Southern Africa*, 34(4), pp. 439–449. doi: 10.1080/0376835X.2017.1318048.

107   Curry, S. R. and Petering, R. (2017) 'Resident Perspectives on Life in a Transitional Living Program for Homeless Young Adults', *Child and Adolescent Social Work Journal*, 34(6), pp. 507–515. doi: 10.1007/s10560-017-0488-2. Fotheringham, S., Walsh, C. A. and Burrowes, A. (2014) '"A place to rest": the role of transitional housing in ending homelessness for women in Calgary, Canada', *Gender, Place & Culture*, 21(7), pp. 834–853. doi: 10.1080/0966369X.2013.810605.

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109   Hutubise, R., Babin, P. and Grimard, C. (2009) 'Shelters for the Homeless: Learning from Research', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press, pp. 43–60. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).

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115   Ibid.

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Ohle [116] therefore outline steps that can be taken to improve the provision for transgender people in H&S. Older people finding themselves homeless may also want a different kind of provision to younger people, and such provision can be limited.[117]

Service use and cost
Direct costs are available particularly from the USA context. Evidence suggests that H&S as an intervention reduces service use and cost versus rough sleeping,[118] particularly as part of a staircase programme. However, evidence also suggests they are expensive to run both as emergency[119] and as transitional[120] and are unlikely to contribute significantly in reductions to service use if on-site services are not provided. For instance, research shows that the annual cost for a shelter bed for a single adult ranges from $4100 in Atlanta to $19,800 in New York City, with the median cost per head, per year being $9300[121] In Dublin, emergency accommodation costs approximately €28,000 per year, with beds in supported temporary accommodation costing approximately €29,000 per year. In this context,

it is recommended that temporary accommodation be phased out in Ireland.[122] Despite the lack of direct studies of H&S costs in other contexts, studies of Housing First tend to compare the cost of providing TAU versus Housing First, and concludes that in the medium to long term, H&S are a more expensive approach (see Housing First chapter).

3.4 Barriers to implementation
Funding for H&S generally comes either from the public sector, or charitable donations. As such, funding can be transient, fluctuate with political priorities, and vary substantially between different projects. Indeed, funding for accommodation and service provision may differ, and a UK report suggests this can lead to complex commissioning arrangements, and both variance and instability of the service offer.[123] Such resource constraints and arrangements can lead to the exclusion of clients with more complex needs.[124] However, low threshold transitional schemes can better support these clients into permanent accommodation.[125]

Several reviews of housing as a route out of homelessness suggest there is consensus that long-term occupants of shelter should be found alternative solutions to both meet their housing needs and free up space for rough sleepers in a genuine emergency situation.[126] Moreover, a central debate is whether temporary housing is favoured in some communities due to a lack of available affordable housing units, rather than the need of individuals for support.[127] Yet, it should also be noted that some longstay hostel users do not wish to move to permanent housing.[128]

A report using data from 2016 in England shows that 34 per cent of projects reported that the main barrier to moving people into more permanent accommodation is a lack of affordable housing. Indeed, 30 per cent were ready to move on, with 27 per cent of that group having been waiting for 6 months or longer.[129] A different UK report suggests specific shortages of small units providing intensive support for those with serious mental health problems, units for women, drinkers, and people with substance misuse issues (that continue using).[130] In fact, affordable housing provision is an ongoing problem across contexts.[131]

3.5 Expert perspectives
Most key informants discussed hostels,

shelters or transitional forms of accommodation. Perspectives covered the same diverse range of hostel and temporary accommodation types included in the literature review and key informants acknowledged that H&S constitute a common intervention with rough sleepers in most western countries. And yet, there was broad consensus that these are generally not effective interventions and their use should be avoided insofar as possible, at least in their current form. One interviewee described H&S as the 'worst kind' of solution. Despite their widespread use, H&S are not an 'inevitable' part of the homelessness response, as evidenced by their absence in Finland – one of the few countries where homelessness is decreasing.

Key informants pointed to three main issues with H&S and these closely reflect the challenges identified in the literature review. First, H&S can be 'dangerous places' that ultimately cause harm to individuals who stay there. Several interviewees described how people were 'choosing' to sleep rough rather than access shelter provision. Second, there are concerns that the model is not suited to a significant range of groups, many of whom need more intensive support. Interviewees suggested that H&S are not suited to those with highly complex needs and who could

116 Mottet, L. and Ohle, J. (2006) 'Transitioning Our Shelters: Making Homeless Shelters Safe for Transgender People', *Journal of Poverty*, 10(2), pp. 77–101. doi: 10.1300/J134v10n02_05.
117 Crane, M. and Warnes, A. M. (2000) 'Policy and Service Responses to Rough Sleeping Among Older People', *Journal of Social Policy*, 29(1), pp. 21–36. doi: 10.1017/S0047279400005808.
Davis-Berman, J. (2011) 'Older Women in the Homeless Shelter: Personal Perspectives and Practice Ideas', *Journal of Women & Aging*, 23(4), pp. 360–374. doi: 10.1080/08952841.2011.611391
Holt, N., Christian, J. and Larkin, M. (2012) 'Maintaining Connectedness: Exploring the Experiences of Older Homeless Men Living in Hostel Accommodation: Experiences of older homeless men', *Journal of Community & Applied Social Psychology*, 22(6), pp. 485–501. doi: 10.1002/casp.1130.
118 Culhane, D., Metraux, S. and Hadley, T. (2002) 'The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections, and emergency shelter systems: The New York – New York initiative', *Housing Policy Debate*, 13(1), pp. 107–163.
119 The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness*. London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.
120 Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from and International Review*. Edinburgh: Scottish Government. Available at: http://www.gov.scot/Resource/Doc/233172/0063910.pdf.
121 Lewin Group. (2004). Costs of serving homeless individuals in nine cities. New York: Corporation for Supportive Housing
122 O'Sullivan, E. (2012) Ending Homelessness–A Housing-led Approach. Dublin: Department of Environment, Community and Local Government.
123 St Mungo's (2009) *Down and Out? The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness*. London: St Mungo's.
124 Homeless Link (2017) *Support for single homeless people in England: Annual Review 2016*. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/Full%20report%20-%20Support%20for%20single%20people%202016.pdf.
125 Barrow, S. and Zimmer, R. (1999) 'Transitional Housing and Services: A Synthesis', in Fosburg, L. and Dennis, D. (eds) *Practical Lessons: The 1998 National Symposium on Homelessness Research*. Washington DC: Department of Housing and Urban Development, pp. 11–31. Available at: http://www.urbancentre.utoronto.ca/pdfs/elibrary/1998_Transitional-Housing-S.pdf.

126 Culhane, D. P. and Metraux, S. (2008) 'Rearranging the Deck Chairs or Reallocating the Lifeboats? Homelessness Assistance and Its Alternatives', *Journal of the American Planning Association*, 74(1), pp. 111–121. doi: 10.1080/01944360701821618.
Thorpe, E. (2008) *The role of housing and pathways into and out of homelessness Annual Theme 2008 Housing and Homelessness*. European Report. online: FEANTSA. Available at: http://www.feantsa.org/download/08_european_report_feantsa_housing_final_en8836616037029374941.pdf.
127 Novac, S., Brown, J. and Bourbonnais, C. (2009) 'Transitional Housing Models in Canada: Options and Outcomes', in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*. Toronto, Ont.: Cities Centre Press. Available at: http://www.deslibris.ca/ID/223332 (Accessed: 24 November 2017).
128 Deacon, A., Vincent, J. and Walker, R. (1995) 'Whose choice, hostels or homes? Policies for single homeless people', *Housing Studies*, 10(3), pp. 345–363. doi: 10.1080/02673039508720825.
129 Homeless Link (2017) *Support for single homeless people in England: Annual Review 2016*. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/Full%20report%20-%20Support%20for%20single%20people%202016.pdf.
130 St Mungo's (2009) Down and Out? *The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness*. London: St Mungo's.
131 Busch-Geertsema, V., Edgar, W., O'Sullivan, E. & ... (2010) Homelessness and Homeless Policies in Europe: Lessons from Research, Available from: http://noticiaspsh.org/IMG/pdf/4099_Homeless_Policies_Europe_Lessons_Research_EN.pdf

sometimes pose a risk to staff and other clients. Equally, the intervention is often not suited to groups facing multiple forms of exclusion such as ethnic minorities, young people, people on the autism spectrum and those from the LGBTQ community. A number of gaps in provision were also highlighted for couples and those with pets. Third, H&S can be difficult to manage from a staffing perspective with high turnovers of staff as a result of the very challenging work environment.

Key informants were more ambiguous about the potential role of H&S where intensive and integrated support is available. An example provided of this was in Germany where some projects include specialist psychiatric support being embedded within the provision, without requirements made of clients to engage or access this support.

Key informants could see a role for supported housing, claiming that when it is provided as a longer-term solution outside of a staircase model, it can work well. There was discussion around the quality of support and building, but there was general agreement that when support was intensive, flexible and long-term, and accommodation was adequate and homely this model provided a good solution. The caveat here is that supported housing is currently still often used as part of a staircase model and transitions out of the accommodation are restricted by the lack of appropriate move on properties. Moreover, our review of the evidence base found no significant body of work on supported housing. This is a significant evidence gap.

Interviewees clearly hold the view that H&S in their current form are problematic, whereas more permanent supported accommodation has a potential role to play in solutions to rough sleeping. Notably, key informants did concede there may be a role for shelters if stays are limited

to exceptionally short periods of time and these lead directly into permanent housing.

3.6 Summary

- Hostels and Shelters (H&S) are intended to fulfil an emergency or temporary function. They are the predominant accommodation-based response to street homelessness in most Western countries. H&S vary substantially in terms of size, client group, type of building, levels and nature of support, behavioural expectations, nature and enforcement of rules, level of 'professionalisation', and seasonal availability. In some contexts, H&S are located within a staircase model whereby residents move through increasingly more 'normal' forms of transitional accommodation until they are deemed 'housing ready'.

- A substantial literature documenting homeless peoples' experiences in and perceptions of H&S exists, but there is a major dearth of research evaluating their effectiveness as an intervention. The most comprehensive evidence on outcomes derives from RCTs which compare 'treatment as usual' (TAU) provisions (which typically involve some form of hostel or shelter) with Housing First. All of these have been conducted outside the UK and focus on one subgroup only (that being people with complex needs).

- As an emergency solution, H&S provide immediate relief from life on the street. Some rough sleepers successfully navigate their way through the H&S system and access independent accommodation, albeit a proportion subsequently return to H&S or street homelessness. H&S abandonment and eviction rates are typically very high.

- H&S protect residents from many of the risks associated with sleeping on the street, but present their own health-related hazards. The onset

and/or escalation of drug misuse amongst residents is widely reported, the risk of communicable disease transmission high, and deterioration in mental health common. The management of antisocial behaviour is an ongoing challenge for staff.

- Evidence indicates consistently that many (and perhaps the majority of) homeless people find H&S intimidating or unpleasant environments. Some choose not to use H&S due to fears around personal safety and/or pessimistic views regarding their helpfulness in terms of offering a route out of homelessness. That said, a (to date unquantified) minority expressed a desire to remain in congregate H&S or supported accommodation in the long term.

- Concerns about using mainstream H&S tend to be particularly acute for young people, transgender people, and women. Homeless people with complex needs rarely fare well in standard H&S given their inability to cope with the rules and environment. There is a consensus that specialist H&S, or alternative responses entirely, may be more appropriate for these subgroups (e.g. dedicated units with a training/employment focus for young people, or Housing First for individuals with complex needs etc.).

- Barriers to implementation include the high costs involved in running H&S, unstable funding streams, and a common dissonance between funding for housing and support which can make it difficult to offer residents the support they need. Moreover, a lack of move on housing stymies the system, preventing H&S from fulfilling their intended emergency or temporary functions and forcing them to operate as longer-term but unsustainable solutions to street homelessness.

- Key informants feel that H&S are generally ineffective interventions and their use should be avoided insofar as possible, at least in their current form. They point towards three main issues: they can be dangerous places; they are not suited to a wide range of groups facing multiple forms of exclusion, and they can be difficult to staff due to the challenging work environment. They conclude that shelters should only have a role if stays could be limited to exceptionally short periods of time and these lead directly into permanent housing. Beyond conventional H&S, key informants could see a role for supported housing, claiming that when it is provided as a longer-term solution outside of a staircase model, it can work well, although it is currently often hampered by a lack of move-on accommodation. There is a lack of evidence on the impacts of supported accommodation.

Housing First

4.1 Defining the intervention

Housing First (HF) developed in the 1990s in the USA, and has been widely developed elsewhere since the early 2000s. It began as an intervention specifically to meet the needs of chronic homeless persons experiencing severe psychiatric symptoms.[132] Despite representing a small proportion of the homeless population, this group often utilise other services disproportionately, at significant cost to the public purse.[133] Since its origins, HF is now also increasingly used in other international contexts and/or adapted for other homeless sub-populations.

In direct contrast to the Treatment First (TF) philosophy which underpins the staircase model (requiring individuals to show 'housing readiness' before they move to permanent housing – see chapter on Hostels and Shelters), HF provides permanent housing to homeless people without

preconditions regarding recovery from (or participation in treatment for) issues such as substance misuse or mental health problems. HF is based around the principle of a human right to housing,[134] and Assertive Outreach is generally employed as a key feature of programme design. This means outreach teams persistently target individuals on the streets that would benefit from the programme, as part of a broader and integrated response to end an individual's homelessness (see chapter on Street Outreach for discussion of key elements and difference with traditional outreach). Person centred support is then available to tenants for as long as they need it,[135] with a level of 'stickiness' not seen in other models. Indeed, key to HF is that clients do not lose their housing if they choose not to access support, and harm reduction is taken above any other goals such as sobriety or abstinence. This focuses on reducing the negative consequences

of harmful behaviours rather than expecting them to stop completely.[136]

Whilst HF first developed as Pathways to Housing in the USA,[137] it has since been replicated to varying degrees of scale in Canada,[138] Australia[139] and Europe,[140] albeit with differing degrees of programme fidelity and programme 'drift'. A distinction can therefore be made between HF as a philosophy — providing housing as a first port of call

above any other intervention – and a specific programme following key tenets set out by either the Pathways Model,[141] or subsequent guides that have developed in different contexts.[142] Woodhall-Melnik and Dunn review the stated requirements of HF models across different contexts and conclude that certain core themes include:

- no requirement for consumers to demonstrate housing readiness

132   Tsemberis, S., Gulcur, L. and Nakae, M. (2004) 'Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis', *American Journal of Public Health*, 94(4), pp. 651–656. doi: 10.2105/AJPH.94.4.651.

133   Culhane, D. P., Metraux, S. and Byrne, T. (2011) 'A prevention-centered approach to homelessness assistance: a paradigm shift?', *Housing Policy Debate*, 21(2), pp. 295–315. doi: 10.1080/10511482.2010.536246.
Gaetz, S., Scott, F. and Gulliver, T. (2013) *Housing First in Canada: Supporting Communities to End Homelessness*. Toronto: Canadian Homelessness Research Network Press. Available at: https://yorkspace.library.yorku.ca/xmlui/handle/10315/29317.

134   Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.

135   Pearson, C., Montgomery, A. and … (2009) 'Housing stability among homeless individuals with serious mental illness participating in housing first programs', *Journal of Community …*, (Query date: 2017-09-25). Available at: http://onlinelibrary.wiley.com/doi/10.1002/jcop.20303/full.

136   Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.

137   Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.

138   Aubry, T., Nelson, G. and Tsemberis, S. (2015) 'Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the at Home—Chez soi Demonstration Project', *The Canadian Journal of Psychiatry*, 60(11), pp. 467–474. doi: 10.1177/070674371506001102

139   Kertesz, S. G. and Johnson, G. (2017) 'Housing First: Lessons from the United States and Challenges for Australia: Housing First', *Australian Economic Review*, 50(2), pp. 220–228. doi: 10.1111/1467-8462.12217.

140   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.
Pleace, N. (2016) *Housing First Guide Europe*. online: FEANTSA. Available at: http://housingfirstguide.eu/website/the_guide/.

141   Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.

142   This sets out specific standards for Europe, but also note specific differences between individual projects and how Housing First should respond to its context: Pleace, N. (2016) *Housing First Guide Europe*. online: FEANTSA. Available at: http://housingfirstguide.eu/website/the_guide/.

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- the provision of individualised supports; and

- incorporation of the principle of self-determination.[143]

Perhaps most relevant in the UK context, and based on the Housing First Guide for Europe,[144] are those principles endorsed by Housing First England,[145] including:

- flexible support is provided for as long as it is needed

- people have a right to a home

- housing and support are separated

- individuals have choice and control

- the service is based on people strengths, goals and aspirations

- an active engagement is used

- a harm reduction approach is used.

Debates about fidelity feature significantly in the HF literature. Not all models calling themselves HF conform to what others would consider the basic principles, with deviations potentially having negative effects on participants.[146] Though some would argue that HF must stick with the founding principles to count as

following this model, others suggest it is fidelity to the philosophy that offers most value. Thus, some commentators conclude that adaptations based on offering permanent housing without a need to demonstrate 'housing readiness', along with person centred support and choice may still be considered HF.[147]

A further distinction can be made between scattered site HF (with homes dispersed across the geographic area), and single site or congregate HF (a single building offering many homes). The different outcomes reported in relation to each are discussed below insofar as the evidence base allows. The final major distinction is whether participants are provided one of two support approaches:

- Assertive Community Treatment (ACT) where a team of multidisciplinary staff directly provide clinical and support services for clients with severe psychiatric disabilities and multiple needs.

or

- Intensive Case Management (ICM) where clinicians or other caseworkers take on a group of individuals (usually between 10 and 20) and coordinate a support

approach for moderately disabled clients.[148]

4.2 The evidence base
The quantity of evidence on HF far exceeds that for any other intervention targeting rough sleepers, and the quality is strong. A number of randomised controlled trials (RCTs) in North America offer compelling evidence of its effectiveness in resolving the homelessness of people with complex needs. [149] These include initial evaluations of the Pathways pilots in New York, with studies evaluating outcomes from between one and four years, and the At Home/Chez Soi (Chez Soi) project, which is the largest RCT of any HF intervention worldwide. It explored a diverse range

of local contexts in Canada and the outcomes of 2500 participants across 2 years.[150]

Evidence of the Australian experience is also increasing. National funds were committed to a scattered site housing programme entitled 'Streets to Home' that focused on chronically homeless individuals based on vulnerability to premature death.[151] Evaluations of these programs typically track individuals for one[152] or two years.[153] A limited number of small-scale studies have been conducted in the UK. These have included an evaluation of nine pilot projects in England,[154] and a small-scale pilot project in Glasgow which focused on individuals with active substance misuse problems..[155]

143 Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.
144 Pleace, N. (2016) *Housing First Guide Europe*. online: FEANTSA. Available at: http://housingfirstguide.eu/website/the_guide/.
145 Homeless Link (2016) *Housing First in England: The principles*. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/Housing%20First%20in%20England%20The%20Principles.pdf.
146 Gaetz, S., Scott, F. and Gulliver, T. (2013) *Housing First in Canada: Supporting Communities to End Homelessness*. Toronto: Canadian Homelessness Research Network Press. Available at: https://yorkspace.library.yorku.ca/xmlui/handle/10315/29317.
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Anderson-Baron, J. T. and Collins, D. (2017) 'Not a "forever model": the curious case of graduation in Housing First', *Urban Geography*, pp. 1–19. doi: 10.1080/02723638.2017.1375826.
147 Tsemberis, S. (2013) 'Housing First: Implementation, Dissemination, and Program Fidelity', *American Journal of Psychiatric Rehabilitation*, 16(4), pp. 235–239. doi: 10.1080/15487768.2013.847732.
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*

148 Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.
149 Gulcur, L. et al. (2003) 'Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes', *Journal of Community & Applied Social Psychology*, 13(2), pp. 171–186. doi: 10.1002/casp.723.
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. doi: 10.1177/1049731505282593.
Gulcur, L. et al. (2007) 'Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness', *Community Mental Health Journal*, 43(3), pp. 211–228. doi: 10.1007/s10597-006-9073-4.
Padgett, D. K. (2007) 'There's no place like (a) home: Ontological security among persons with serious mental illness in the United States', *Social Science & Medicine*, 64(9), pp. 1925–1936. doi: 10.1016/j.socscimed.2007.02.011.
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. 487–493. doi: 10.1176/appi.ps.51.4.487.
Tsemberis, S., Gulcur, L. and Nakae, M. (2004) 'Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis', *American Journal of Public Health*, 94(4), pp. 651–656. doi: 10.2105/AJPH.94.4.651.
Yanos, P. T. et al. (2007) 'Exploring the role of housing type, neighborhood 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. doi: 10.1080/09638230701496378.
150 Aubry, T., Nelson, G. and Tsemberis, S. (2015) 'Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the at Home—Chez soi Demonstration Project', *The Canadian Journal of Psychiatry*, 60(11), pp. 467–474. doi: 10.1177/070674371506001102.
Goering, P. et al. (2014) *National At Home/Chez Soi Final Report*. Calgary: Mental Health Commission of Canada. Available at: https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf.
151 Kertesz, S. G. and Johnson, G. (2017) 'Housing First: Lessons from the United States and Challenges for Australia: Housing First', *Australian Economic Review*, 50(2), pp. 220–228. doi: 10.1111/1467-8462.12217.
152 Parsell, C. and Tomaszewski, T. (2013) *Evaluation of the Brisbane Street to Home programme: Final Report*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs. Available at: http://wahousinghub.org.au/display/RES/2014/11/12/An+Evaluation+of+Brisbane+Street+to+Home%3A+Final+Report.
153 Johnson, G. and Chamberlain, C. (2015) *Evaluation of the Melbourne Street to Home programme: Final Report*. Melbourne: HomeGround Services. Available at: https://www.researchgate.net/profile/Chris_Chamberlain/publication/287735874_Evaluation_of_the_Melbourne_Street_to_Home_program_Final_Report/links/5679028e08ae502c99d6d913/Evaluation-of-the-Melbourne-Street-to-Home-program-Final-Report.pdf.
154 Bretherton, J. and Pleace, N. (2015) Housing first in England: An evaluation of nine services. York: Centre For Housing Policy, University of York. Available at: http://eprints.whiterose.ac.uk/83966/.
155 Johnsen, S. (2013) *Turning Point Scotland's Housing First Project Evaluation: Final Report*. Glasgow: Turning Point Scotland. Available at: http://www.turningpointscotland.com/wp-content/uploads/2014/02/TPS-Housing-First-Final-Report.pdf.

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This latter study is also included in wider literature on the European experience,[156] whereby national governments such as Denmark[157] and Finland[158] have also rolled out HF. Most recently, Crisis produced a full cost feasibility study of rolling out HF across the Liverpool city region.[159]

In addition to RCTs and other evaluative studies, systematic evidence reviews draw out the outcomes associated with HF across contexts.[160] It is notable that the strongest evidence is therefore concentrated within the North American context, with European and Australian evidence ever increasing through a variety of evaluative and descriptive study designs.

4.3 Outcomes
Housing

HF has been consistently proven to achieve high rates of housing retention. Studies report rates between around 60 per cent and 90 per cent across contexts, not factoring for the different scale of interventions, time periods measured, and often with some variance in fidelity to the core principles of HF,[161] but tend

nevertheless to coalesce around 80 per cent. Evaluations all argue that HF achieves superior retention rates to the dominant TF philosophy.[162] In general, smaller scale projects rolled out in specific areas, usually by third sector agencies have the highest retention rates. Importantly, few studies have yet evaluated housing retention over timescales longer than 2 years.

In their evidence review of quantitative studies, Woodhall-Melnik and Dunn[163] point out that studies focus on a range of groups, but particularly those with psychiatric symptoms, addictions or concurrent disorders. Indeed, studies of the Chez Soi RCT in Canada found those with concurrent disorders experience similar levels of housing retention as those who display psychiatric symptoms alone.[164] Over the two-year Chez Soi programme, HF service users spent 73 per cent of their time stably housed, compared to 32 per cent of those receiving Treatment as Usual (TAU). Superior housing outcomes were found for HF in all 5 cities, and in the last 6 months of the study, 62 per cent of HF participants were

housed all of the time, compared with 31 per cent of TAU participants.[165] Additionally, USA studies report rates of housing sustainment between 80 per cent and 88 per cent,[166] with one measuring housing retention across a 47 month period, providing the only medium-term outcomes published. It shows that approximately 68 per cent of HF clients retained housing across this period.[167] USA evidence further suggests low attrition rates of the Pathways model, with 85 per cent participants remaining in the programme over a period of 5 years.[168]

Importantly, an RCT was conducted in France entitled Un Chez Soi d'abord, and whilst no official evaluation is currently available in English, existing grey literature points to high rates of success,[169] reported to be 85 per cent retention after 2 years.[170] Experiments in the rest of Europe report retention rates between 79 per cent and 97 per cent, but these were interventions of varying sizes, with different populations, and variation in timing and design.[171]

A study of nine HF programs in England found 78 per cent of participants were still housed at the point of evaluation, but most of the HF services had been operational for less than three years and some for shorter periods, meaning assessment of long-term effectiveness was not possible. However, 74 per cent of current service users had been successfully housed for one year or more by five of the HF services. Whilst not quantified in the same way as other projects, the national scale HF approach in Finland has been attributed with effectively eliminating rough sleeping through drastically reducing the numbers of long-term homeless.[172] Meanwhile, a national programme in Denmark (whilst recognising limitations in the data) reports retention rates between 76 per cent and 95 per cent.[173]

Two published studies on the Streets to Home project in Australia show that after one year 95 per cent of clients sustained housing in Brisbane,[174] and after 2 years, 70 per cent of clients were housed, and 80 per cent had

156 Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.

157 Benjaminsen, L. (2013) 'Policy review up-date: Results from the Housing First based Danish homelessness strategy', *European Journal of Homelessness _ Volume*, (Query date: 2017-09-25). Available at: http://pure.sfi.dk/ws/files/207198/lb_review.pdf.

158 Y-Foundation (2017) *A Home of Your Own Housing First and ending homelessness in Finland*. Keuruu: Otava Book Printing Ltd.

159 Blood, I. et al. (2017) *Housing First Feasibility Study for the Liverpool City Region*. London: Crisis. Available at: https://www.crisis.org.uk/media/237544/housing_first_feasibility_study_for_the_liverpool_city_region_2017_es.pdf.

160 Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.

161 Pleace, N. (2016) *Housing First Guide Europe*. online: FEANTSA. Available at: http://housingfirstguide.eu/website/the_guide/.

162 Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.
Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.

163 Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.

164 Palepu, A. et al. (2013) 'Housing First Improves Residential Stability in Homeless Adults With Concurrent Substance Dependence and Mental Disorders', *American Journal of Public Health*, 103(S2), pp. e30–e36. doi: 10.2105/AJPH.2013.301628.
Urbanoski, K. *et al.* (2017) 'Effects of comorbid substance use disorders on outcomes in a Housing First intervention for homeless people with mental illness: Effectiveness of Housing First', *Addiction*. doi: 10.1111/add.13928.

165 Aubry, T., Nelson, G. and Tsemberis, S. (2015) 'Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the at Home—Chez soi Demonstration Project', *The Canadian Journal of Psychiatry*, 60(11), pp. 467–474. doi: 10.1177/070674371506001102.

166 Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.

167 Tsemberis, S., Gulcur, L. and Nakae, M. (2004) 'Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis', *American Journal of Public Health*, 94(4), pp. 651–656. doi: 10.2105/AJPH.94.4.651.

168 Stefancic, A. and Tsemberis, S. (2007) 'Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention', *The Journal of Primary Prevention*, 28(3–4), pp. 265–279. doi: 10.1007/s10935-007-0093-9.

169 Pleace, N. (2016) *Housing First Guide Europe*. online: FEANTSA. Available at: http://housingfirstguide.eu/website/the_guide/.

170 Result reported in conference presentation and relayed in blog: filipe (2017) '85 percent of homeless persons in France keep their home after two years', *Home_eu*, 17 April. Available at: http://www.home-eu.org/85-percent-homeless-persons-france-keep-home-two-years/ (Accessed: 1 November 2017).

171 Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.
Pleace, N. (2016) *Housing First Guide Europe*. online: FEANTSA. Available at: http://housingfirstguide.eu/website/the_guide/.

172 Y-Foundation (2017) *A Home of Your Own Housing First and ending homelessness in Finland*. Keuruu: Otava Book Printing Ltd.
Pleace, N. et al. (2015) *The Finnish Homelessness Strategy An International Review*. Helsinki: Ministry of the Environment. Available at: https://helda.helsinki.fi/bitstream/handle/10138/153258/YMra_3en_2015.pdf?sequence=5.

173 Benjaminsen, L. (2013) 'Policy review up-date: Results from the Housing First based Danish homelessness strategy', *European Journal of Homelessness _ Volume*, (Query date: 2017-09-25). Available at: http://pure.sfi.dk/ws/files/207198/lb_review.pdf.

174 Parsell, C. and Tomaszewski, T. (2013) *Evaluation of the Brisbane Street to Home programme: Final Report*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs. Available at: http://wahousinghub.org.au/display/RES/2014/11/12/An+Evaluation+of+Brisbane+Street+to+Home%3A+Final+Report.

been housed for one year or longer in Melbourne.[175] Overall, whilst studies vary in rigour and timeframe, they show consistently high housing retention.

Few studies compare the outcomes of scatter-site versus congregate configurations of HF, but on the basis of existing evidence there do not appear to be any clear differences between the two in relation to housing retention. An RCT comparing outcomes in both (congregate and scatter-site) configurations with TAU in Vancouver noted that the percentage of time in stable housing over 24 months was 74.3 per cent in congregate HF and 74.5 per cent in scatter-site HF (as compared with 26.3 per cent in TAU).[176] In a similar vein, residents housed in congregate and scatter-site HF who were supported by the same ACT team in Copenhagen shared similarly high housing retention rates, but more of the former had moved from the initial congregate setting they were housed in to another congregate site or to scattered housing.[177] Notably, participants in the Copenhagen project expressed a clear preference for scatter-site housing, and this preference has been reported in a number of other European countries.[178]

On a related note, some scholars, including those in Australia where the majority of HF programmes have taken the form of congregate housing, have cautioned that congregate HF compromises programme outcomes and can lead to unintended negative consequences such as: undermining service flexibility and reducing the capacity of services to respond to the diversity of client needs and choices, and limiting pathways to independence, family formation and connection and long-term stability.[179] For these reasons and in light of evidence that homeless people prefer scatter-site HF, whilst acknowledging that a small minority of homeless people may wish to be accommodated in communal environments, a number of commentators and campaigning organisations have called for congregate HF to be reserved for the minority of homeless people who express an explicit preference for this configuration.[180]

Health
Indicators of health may be measured quantitatively through standardised clinical health measures, or qualitatively by reviewing self-reported perceptions of service users. RCTs have typically found no or minimal benefit for standard physical

health measures,[181] though do note reductions in time spent in hospital.[182] Indeed, most studies show improvement both for individuals entering the housing intervention and for individuals entering traditional programs. A more positive general picture of health outcomes is found in qualitative evaluations, with Tsemberis[183] summarising that generally U.S.-based studies of the Pathways model show improvements in well-being. Importantly, Kertesz and Johnson[184] point out that most studies assess outcomes at 1 to 2 years and there are positive results in the control of HIV,[185] reduction in suicidality[186] (but not necessarily any more than TAU[187]) and in indicators of community functioning or well-being.[188] However,

it is important to recognise that HF clients are unlikely to see major health improvements due to the general severity of health conditions upon entry. Indeed, persons entering housing programs include many who are quite sick and a number die in housing shortly after moving in.[189]

In examining quantitative outcomes for mental health, Woodhall Melnik and Dunn[190] point out that in the original New York RCT there is some contradictory evidence. In one study, participants in HF experienced significantly greater perceived choice than those in continuum of care programming, with perceived choice significantly associated with reductions in symptoms of mental illness,[191] and

175   Johnson, G. and Chamberlain, C. (2015) *Evaluation of the Melbourne Street to Home programme: Final Report*. Melbourne: HomeGround Services. Available at: https://www.researchgate.net/profile/Chris_Chamberlain/publication/287735874_Evaluation_of_the_Melbourne_Street_to_Home_program_Final_Report/links/5679028e08ae502c99d6d913/Evaluation-of-the-Melbourne-Street-to-Home-program-Final-Report.pdf.

176   Somers, J., Moniruzzman, A., Paterson, M., Crrie, L., Rezansoff, S., Palepu, F. and Fryer, K. (2017) A randomised trial examining Housing First in congregate and scattered site formats. *PLOS ONE* 12(1): e0168745.

177   Benjaminsen, L. (2013) Rehousing Homeless Citizens with Assertive Community Treatment. Experiences from an ACT-programme in Copenhagen. Final Report for Housing First Europe project (Copenhagen: SFI The Danish National Centre of Social Research)

178   Busch-Geertsema, V. (2016) *Housing First*. Peer Review in Social Protection and Social Inclusion. Brussels; European Commission.

179   Verdouw, J. and Habibis, D. (2017) Housing First programs in congregate-site facilities: can one size fit all? *Housing Studies* DOI: 10.1080/02673037.2017.1346192.

180   Busch-Geertsema, V. (2016) *Housing First*. Peer Review in Social Protection and Social Inclusion. Brussels; European Commission
      Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.
      Homeless Link (2016) *Housing First in England: The principles*. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/Housing%20First%20in%20
      England%20The%20Principles.pdf.

181   Woodhall-Melnik, J. et al. (2015) 'The Impact of a 24 Month Housing First Intervention on Participants' Body Mass Index and Waist Circumference: Results from the At Home / Chez Soi Toronto Site Randomized Controlled Trial', *PLOS ONE*. Edited by C. M. Schooling, 10(9), p. e0137069. doi: 10.1371/journal.pone.0137069.
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182   Sadowski, L. S. *et al.* (2009) 'Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Trial', *JAMA*, 301(17), p. 1771. doi: 10.1001/jama.2009.561.
      Benston, E. A. (2015) 'Housing Programs for Homeless Individuals With Mental Illness: Effects on Housing and Mental Health Outcomes', *Psychiatric Services*, 66(8), pp. 806–816. doi: 10.1176/appi.ps.201400294.
      Stergiopoulos, V. *et al.* (2015) 'Effectiveness of Housing First with Intensive Case Management in an Ethnically Diverse Sample of Homeless Adults with Mental Illness: A Randomized Controlled Trial', *PLOS ONE*. Edited by B. Aleksic, 10(7), p. e0130281. doi: 10.1371/journal.pone.0130281.
      Fitzpatrick-Lewis, D. *et al.* (2011) 'Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review', *BMC Public Health*, 11(1). doi: 10.1186/1471-2458-11-638.

183   Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.

184   Kertesz, S. G. and Johnson, G. (2017) 'Housing First: Lessons from the United States and Challenges for Australia: Housing First', *Australian Economic Review*, 50(2), pp. 220–228. doi: 10.1111/1467-8462.12217.

185   Buchanan, D. et al. (2009) 'The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial', *American Journal of Public Health*, 99(S3), pp. S675–S680. doi: 10.2105/AJPH.2008.137810.

186   Collins, S. E. et al. (2016) 'Suicidality Among Chronically Homeless People with Alcohol Problems Attenuates Following Exposure to Housing First', *Suicide and Life-Threatening Behavior*, 46(6), pp. 655–663. doi: 10.1111/sltb.12250.

187   Aquin, J. P. et al. (2017) 'Effect of Housing First on Suicidal Behaviour: A Randomized Controlled Trial of Homeless Adults with Mental Disorders', *The Canadian Journal of Psychiatry*, 62(7), pp. 473–481. doi: 10.1177/0706743717694836.

188   Campo, P. et al. (2016) 'How did a Housing First intervention improve health and social outcomes among homeless adults with mental illness in Toronto? Two-year outcomes from a randomised trial', *BMJ Open*, 6(9), p. e010581. doi: 10.1136/bmjopen-2015-010581.

189   Henwood, B. F., Byrne, T. and Scriber, B. (2015) 'Examining mortality among formerly homeless adults enrolled in Housing First: An observational study', *BMC Public Health*, 15(1). doi: 10.1186/s12889-015-2552-1.

190   Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.

191   Greenwood, R. M. et al. (2005) 'Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness', *American Journal of Community Psychology*, 36(3–4), pp. 223–238. doi: 10.1007/s10464-005-8617-z.

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another found reduced incidence of psychiatric hospitalisation at 24 months.[192] In contrast, an analysis of the same data found no significant differences in psychiatric symptoms between those enrolled in HF and those receiving traditional housing support.[193] Data collected at 6 and 12 month intervals in a different (non-RCT) study in a Washington DC project found positive impacts on mental health outcomes for persons with concurrent disorders[194] whereas earlier findings from the New York study showed improvements for those with psychiatric symptoms only. Importantly, it should be noted that HF clients are unlikely to experience radical improvements in physical and mental health, due to the significant impact that prior experience of long-term homelessness is likely to have had.

The Chez Soi RCT found poorer outcomes in mental health for HF clients in a scattered site Canadian project than their TAU group, and no change in physical health either.[195] Whilst the final report states participants showed greater improvement in average community functioning and quality-of-life at 12 months as compared to TAU, the differences between groups were no longer present at 24 months.[196] In a

report of nine services in England, there was evidence of improvements in mental and physical health amongst service users. 43 per cent reported very bad physical health a year before HF, and this fell to 28 per cent when asked about current health. Slightly more than half (52 per cent) of the same group reported bad or very bad mental health before HF, falling to 18 per cent a year after housing.[197]

The Street to Home Melbourne evaluation states there was significant improvement in the participants' physical and mental health in the first 12 months (63 per cent said their general health was better, and 24 per cent reported moderate to extreme bodily pain after 12 months, as compared to 54 per cent at baseline), but in the following 12 months rate of improvement slowed. The number admitted to hospital in the preceding 3 months had declined from 32 per cent in the first interview to 11 per cent in the final interview, 2 years after housing.[198] In a study of five projects in Europe, improvements in mental health problems were reported for the majority of participants in Amsterdam (no exact figures supplied), Glasgow (50 per cent)[199] and Lisbon (a 52 per cent reduction in participants being admitted to psychiatric hospitals from

baseline to three-year follow-up).[200] In these, security of housing and reliability of support were held to be important factors in their recovery.[201] However, it should also be noted that in a Copenhagen project that started with congregate site provision, and moved to scatter site provision, staff reported positive changes of mental health for 25 per cent of service users, and negative changes for 29 per cent.[202] Across the evidence base HF has a similar impact on health as TAU – there appears to be no discernible difference nor significant impact. Thus, for people with severe mental illness individual choice may be the best way to determine whether a person receives HF or a more institutional form of care.[203]

The few studies comparing scatter-site and congregate configurations of HF have found minimal if any differences in health outcomes. In the Vancouver RCT (see above), no significant differences were found in relation to changes in overall health or psychiatric symptom severity, but there were significant differences in the severity of disability wherein greater improvement was reported in congregate HF.[204]

A year-long longitudinal quantitative study comparing scatter-site and

congregate HF in Sydney showed similar rates of improvement as regards psychological distress in each configuration.[205]

Substance misuse
Whether or not HF reduces substance misuse is a common question in the literature, but can be complicated by studies seeking to measure absolute reductions in use of drugs and alcohol, rather than the harm reduction philosophy that HF subscribes to. Thus, whilst reductions in drug and alcohol use are likely to point to harm reduction, it is not the primary goal of the intervention. RCTs provide the strongest evidence here, with a USA study that randomly assigned individuals to a range of treatment pathways finding that after 12 months participants in abstinence based housing had higher levels of drug abstinence.[206] In contrast, in analysing the same New York data with individuals experiencing homelessness and psychiatric symptoms,[207] another study found no difference in drug and alcohol use between those assigned to the control group and those who received HF. This is corroborated by similar results from the Chez Soi RCT.[208] However, one study reports reductions in alcohol use,[209] and another Canadian RCT found

192   Gulcur, L. et al. (2003) 'Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes', *Journal of Community & Applied Social Psychology*, 13(2), pp. 171–186. doi: 10.1002/casp.723.

193   Tsemberis, S., Gulcur, L. and Nakae, M. (2004) 'Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis', *American Journal of Public Health*, 94(4), pp. 651–656. doi: 10.2105/AJPH.94.4.651.

194   Tsemberis, S., Kent, D. and Respress, C. (2012) 'Housing Stability and Recovery Among Chronically Homeless Persons With Co-Occuring Disorders in Washington, DC', *American Journal of Public Health*, 102(1), pp. 13–16. doi: 10.2105/AJPH.2011.300320.

195   Cherner, R. A. et al. (2017) 'Housing First for Adults with Problematic Substance Use', *Journal of Dual Diagnosis*, 13(3), pp. 219–229. doi: 10.1080/15504263.2017.1319586.

196   Aubry, T., Nelson, G. and Tsemberis, S. (2015) 'Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the at Home—Chez soi Demonstration Project', *The Canadian Journal of Psychiatry*, 60(11), pp. 467–474. doi: 10.1177/070674371506001102.

197   Bretherton, J. and Pleace, N. (2015) Housing first in England: An evaluation of nine services. York: Centre For Housing Policy, University of York. Available at: http://eprints.whiterose.ac.uk/83966/.

198   Johnson, G. and Chamberlain, C. (2015) *Evaluation of the Melbourne Street to Home programme: Final Report*. Melbourne: HomeGround Services. Available at: https://www.researchgate.net/profile/Chris_Chamberlain/publication/287735874_Evaluation_of_the_Melbourne_Street_to_Home_program_Final_Report/links/5679028e08ae502c99d6d913/Evaluation-of-the-Melbourne-Street-to-Home-program-Final-Report.pdf.

199   Johnsen, S. (2013) *Turning Point Scotland's Housing First Project Evaluation: Final Report*. Glasgow: Turning Point Scotland. Available at: http://www.turningpointscotland.com/wp-content/uploads/2014/02/TPS-Housing-First-Final-Report.pdf.

200   Ornelas, J. (2013) *Casas Primeiro, Lisboa. Final Report for Housing First Europe Project (Lisbon)*.

201   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.

202   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.

203   Richter, D. & Hoffmann, H. (2017) Independent Housing and Support for People with Severe Mental Illness: Systematic Review, Acta Psychiatrica Scandinavica 136 (3): 269–279

204   Somers, J. M. *et al.* (2017) 'A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats', *PLOS ONE*. Edited by I. Puebla, 12(1), p. e0168745. doi: 10.1371/journal.pone.0168745.

205   Whittaker, E., Dobbins, T., Swift, W., Flatau, P. and Burns, L. (2017) First examination of varying health outcomes of the chronically homeless according to Housing First configuration. *Australia and New Zealand Journal of Public Health* 41:306-8.

206   Milby, J. B. et al. (2005) 'To House or Not to House: The Effects of Providing Housing to Homeless Substance Abusers in Treatment', *American Journal of Public Health*, 95(7), pp. 1259–1265. doi: 10.2105/AJPH.2004.039743.

207   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. doi: 10.1177/1049731505282593.

208   Somers, J. M., Moniruzzaman, A. and Palepu, A. (2015) 'Changes in daily substance use among people experiencing homelessness and mental illness: 24-month outcomes following randomization to Housing First or usual care: Substance use and Housing First: results of a randomized trial', *Addiction*, 110(10), pp. 1605–1614. doi: 10.1111/add.13011.

209   Kirst, M. *et al.* (2015) 'The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness', *Drug and Alcohol Dependence*, 146, pp. 24–29. doi: 10.1016/j.drugalcdep.2014.10.019.

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improvements for both TAU and HF clients, but slower progress for those in HF.[210] That evaluation states that this is an area to improve upon in future.[211] More recent USA RCTs complicate the picture, showing a strong effect on substance use with HF clients over 3 times less likely to use illicit drugs or abuse alcohol in the year after being housed compared with TF clients.[212] A 2012 RCT also finds HF increased the treatment compliance of mentally ill methadone patients - 51.6 per cent versus 20 per cent in TF was still in treatment after 3 years.[213]

Woodhall-Melnik and Dunn[214] find through reviewing (mostly USA) non-RCT studies that HF participants reported lower substance use than traditional modes of care.[215] Larimer et al.[216] report from a quasi-experimental study that collected data at 3, 6 and 12 months that the median number of drinks consumed dropped across the course of the study, with an approximate 2 per cent decrease per month in daily drinking while participants were housed.

In a review of nine HF services in England, there was some evidence of reductions in drug and alcohol use with 71 per cent of 60 service users reporting they would drink until they felt drunk a year prior to using HF, falling to 56 per cent when asked about current behaviour. When asked about illegal drug use, 66 per cent reported drug use a year prior to HF, falling to 53 per cent when asked about current behaviour. In-depth interviews found some progress away from drug and alcohol use, but not consistently for all service users.[217] Similarly, evaluation of the Melbourne Street to Home programme finds the proportion of participants using alcohol and other drugs did not change markedly over the 24 months of assessment, but fewer participants were using on a regular basis. This suggests that the provision of housing and ongoing support helps somewhat to reduce problematic substance misuse.[218]

While the evidence discussed above is slightly mixed, it indicates, on balance, that HF may be equally and is sometimes more effective than TF in reducing levels of substance misuse. Abstinence-based TF programmes can be more effective in helping individuals achieve abstinence, but these do of course have a very different remit (focussing on the treatment of substance misuse rather than the resolution of housing crises), and attrition rates in such programmes are typically high. On this subject, proponents of HF emphasise that the provision of stable housing offers a secure platform which fosters clients' recovery from addiction (and other issues such as mental health problems).[219]

On the issue of HF configuration, less favourable results regarding substance misuse have been found for congregate housing as compared to scattered site housing, and this is generally attributed to the aggregation of individuals with substance misuse histories which can make a move towards lower consumption more difficult.[220] In the Sydney longitudinal HF study, for example, the use of substances remained unchanged over 12 months in both configurations, but one third of congregate site participants reported greater than weekly injecting at follow up compared with 8 per cent of scatter-site participants.[221] The Vancouver RCT noted no difference between congregate and scatter-site HF in levels of substance misuse, but that improvements as regards recovery (which is not defined explicitly) was greater in communal HF.[222]

Criminal activity and anti-social behaviour

Woodhall-Melnik and Dunn[223] find in their systematic review that the quantitative evidence on the impact of HF on criminal activity is very strong and can therefore be considered fairly conclusive. The research shows reductions in participation in the criminal justice system for HF participants in both qualitative and quantitative analysis.[224] However use of the criminal justice system was measured in a variety of different ways from jail stays and bookings to arrests. Despite this, reductions appear consistent, with stable housing significantly reducing criminal activity that was previously associated with precarious housing and substance misuse issues.

In a review of nine HF programs in England, antisocial behaviour (ASB) fell from 78 per cent of participants reporting involvement a year prior to

210   Cherner, R. A. et al. (2017) 'Housing First for Adults with Problematic Substance Use', *Journal of Dual Diagnosis*, 13(3), pp. 219–229. doi: 10.1080/15504263.2017.1319586.

211   Aubry, T., Nelson, G. and Tsemberis, S. (2015) 'Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the at Home—Chez soi Demonstration Project', *The Canadian Journal of Psychiatry*, 60(11), pp. 467–474. doi: 10.1177/070674371506001102.

212   Padgett, D. K. et al. (2011) 'Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs', *Community Mental Health Journal*, 47(2), pp. 227–232. doi: 10.1007/s10597-009-9283-7.

213   Appel, P. W. et al. (2012) 'Housing First for Severely Mentally Ill Homeless Methadone Patients', *Journal of Addictive Diseases*, 31(3), pp. 270–277. doi: 10.1080/10550887.2012.694602.

214   Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.

215   Collins, S. E. et al. (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. 511–519. doi: 10.2105/AJPH.2011.300403.
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216   Larimer, M. E. (2009) 'Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems', *JAMA*, 301(13), p. 1349. doi: 10.1001/jama.2009.414.

217   Bretherton, J. and Pleace, N. (2015) Housing first in England: An evaluation of nine services. York: Centre For Housing Policy, University of York. Available at: http://eprints.whiterose.ac.uk/83966/.

218   Johnson, G. and Chamberlain, C. (2015) *Evaluation of the Melbourne Street to Home programme: Final Report*. Melbourne: HomeGround Services. Available at: https://www.researchgate.net/profile/Chris_Chamberlain/publication/287735874_Evaluation_of_the_Melbourne_Street_to_Home_program_Final_Report/links/5679028e08ae502c99d6d913/Evaluation-of-the-Melbourne-Street-to-Home-program-Final-Report.pdf.

219   Tsemberis, S. J. (2010) *Housing First: the Pathways model to end homelessness for people with mental health and substance use disorders*. Minnesota: Hazelden Publishing.

220   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.

221   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', *European Journal of Homelessness*, 8(1), pp. 13–28.
Housing First configuration. *Australia and New Zealand Journal of Public Health* 41:306-8.

222   Somers, J. M. et al. (2017) 'A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats', *PLOS ONE*. Edited by I. Puebla, 12(1), p. e0168745. doi: 10.1371/journal.pone.0168745.

223   Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.

224   Clifasefi, S. L., Malone, D. K. and Collins, S. E. (2013) 'Exposure to project-based Housing First is associated with reduced jail time and bookings', *International Journal of Drug Policy*, 24(4), pp. 291–296. doi: 10.1016/j.drugpo.2012.10.002.
DeSilva, M. B., Manworren, J. and Targonski, P. (2011) 'Impact of a Housing First Program on Health Utilization Outcomes Among Chronically Homeless Persons', *Journal of Primary Care & Community Health*, 2(1), pp. 16–20. doi: 10.1177/2150131910385248.
Hanratty, M. (2011) 'Impacts of Heading Home Hennepin's Housing First programs for long-term homeless adults', *Housing Policy Debate*, 21(3), pp. 405–419. doi: 10.1080/10511482.2011.594076.
Parsell, C. and Tomaszewski, T. (2013) *Evaluation of the Brisbane Street to Home programme: Final Report*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs. Available at: http://wahousinghub.org.au/display/RES/2014/11/12/An+Evaluation+of+Brisbane+Street+to+Home%3A+Final+Report.

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HF, to 53 per cent when asked about current behaviour. Whilst reductions were uneven across the populations, there was no evidence of increased engagement.[225] This is reiterated in an evaluation of a small scale project in Glasgow, where antisocial behaviour was reportedly lower and far less problematic than had been expected by stakeholders of the client group.[226] Evaluation of the Brisbane Street to Home programme note that 'neighbourhood problems' were the primary problems experienced by HF participants.[227] Meanwhile, a Canadian study reports ongoing difficult behaviour is one of the greatest challenges to staff working with HF schemes.[228] Thus, it seems that criminal activity largely declines with HF, with some variation between scattered site and congregate housing. ASB also seems to decline, but is far less studied in the literature.

When considering the influence of HF configuration, it is notable that residents living in scattered site housing seem to experience more significant decreases in involvement in criminal activity than those in congregate housing.[229] Indeed, the

12 month follow-up study of two HF programs in Sydney – one scattered site, and one congregate site – foundsignificant decrease for scattered site participants, and significant increase amongst congregate site participants.[230] There have been no such systematic comparisons in relation to ASB, but it should be noted that reports of disruptive behaviour (often fuelled by drug and alcohol abuse) were a significant source of complaint amongst residents in the congregate HF sites in Copenhagen.[231]

Quality of life and social integration
Social integration and community adjustment is less studied in the HF literature than other outcomes, yet there is some evidence in North American RCTs that HF enrolment was associated with greater perceived choice for individuals displaying psychiatric systems,[232] and that choice is a predictor of increased psychosocial integration.[233] Woodhall Melnik and Dunn[234] highlight a variety of studies that show improvements in participants' perceived quality-of-life

using a range of measures and scales. This includes RCTs in North America.[235]

Of note, a longitudinal Chez Soi analysis of perceived quality-of-life found significant improvements for both HF and TAU participants.[236] A different study found no difference in community adjustment between HF and TF participants.[237] An RCT in Ottawa [238] found TAU clients had greater increase in total quality-of-life, particularly an increase in family relations. The final report of the Chez Soi RCT states that HF participants showed greater improvement in community functioning and quality-of-life when based on quantitative findings at 12 months, but no longer at 24 months. However, qualitative findings from interviews show superior experiences for HF clients as opposed to TAU clients. The analysis found that living in stable housing and having positive social and supportive contacts were key factors behind positive life courses, and HF was useful in providing these precursors.[239]

A study of nine HF programs in England found some positive evidence around social integration and with re-establishing links with family across the course of the study. It also shows participants' views of HF were often positive. They saw the freedom, choice and sense of security from having their own home as the key strengths. They also valued the open ended, intensive and flexible support they were offered.[240] These findings are corroborated by two evaluations of Australian programs that found participants had started to feel at home in their new apartments[241] and were beginning to improve ties with family. Overall, the participants' social networks had improved significantly.[242] Importantly, for the groups commonly housed using HF, whilst other outcomes improve they are still likely to be living in poverty and lack viable employment options, generally due to ongoing high support needs and structural issues around

225   Bretherton, J. and Pleace, N. (2015) Housing first in England: An evaluation of nine services. York: Centre For Housing Policy, University of York. Available at: http://eprints.whiterose.ac.uk/83966/.
226   Johnsen, S. (2013) *Turning Point Scotland's Housing First Project Evaluation: Final Report*. Glasgow: Turning Point Scotland. Available at: http://www.turningpointscotland.com/wp-content/uploads/2014/02/TPS-Housing-First-Final-Report.pdf.
227   Parsell, C. and Tomaszewski, T. (2013) *Evaluation of the Brisbane Street to Home programme: Final Report*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs. Available at: http://wahousinghub.org.au/display/RES/2014/11/12/An+Evaluation+of+Brisbane+Street+to+Home%3A+Final+Report.
228   Kennedy, J., Arku, G. and Cleave, E. (2017) 'The experiences of front-line service providers of Housing First programme delivery in three communities in Ontario, Canada', *International Journal of Housing Policy*, 17(3), pp. 396–416. doi: 10.1080/14616718.2016.1248528.
229   Somers, J. M. *et al.* (2017) 'A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats', *PLOS ONE*. Edited by I. Puebla, 12(1), p. e0168745. doi: 10.1371/journal.pone.0168745.
230   Whittaker, E. *et al.* (2016) 'Associations of Housing First Configuration and Crime and Social Connectedness Among Persons With Chronic Homelessness Histories', *Psychiatric Services*, 67(10), pp. 1091–1097. doi: 10.1176/appi.ps.201500446.
231   Benjaminsen, L. (2013) Rehousing Homeless Citizens with Assertive Community Treatment. Experiences from an ACT-programme in Copenhagen. Final Report for Housing First Europe project (Copenhagen: SFI The Danish National Centre of Social Research)
232   Greenwood, R. M. *et al.* (2005) 'Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness', *American Journal of Community Psychology*, 36(3–4), pp. 223–238. doi: 10.1007/s10464-005-8617-z.
233   Gulcur, L. *et al.* (2007) 'Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness', *Community Mental Health Journal*, 43(3), pp. 211–228. doi: 10.1007/s10597-006-9073-4.
234   Woodhall-Melnik, J. R. and Dunn, J. R. (2016) 'A systematic review of outcomes associated with participation in Housing First programs', *Housing Studies*, 31(3), pp. 287–304. doi: 10.1080/02673037.2015.1080816.

235   Patterson, M. L., Moniruzzaman, A. and Somers, J. M. (2014) 'Community Participation and Belonging Among Formerly Homeless Adults with Mental Illness After 12 months of Housing First in Vancouver, British Columbia: A Randomized Controlled Trial', *Community Mental Health Journal*, 50(5), pp. 604–611. doi: 10.1007/s10597-013-9672-9.
      Greenwood, R. M. *et al.* (2005) 'Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness', *American Journal of Community Psychology*, 36(3–4), pp. 223–238. doi: 10.1007/s10464-005-8617-z.
236   Patterson, M. *et al.* (2013) 'Housing First improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia', *Social Psychiatry and Psychiatric Epidemiology*, 48(8), pp. 1245–1259. doi: 10.1007/s00127-013-0719-6.
237   Tsai, J., Mares, A. S. and Rosenheck, R. A. (2010) 'A multisite comparison of supported housing for chronically homeless adults: "housing first" versus "residential treatment first".', *Psychological Services*, 7(4), pp. 219–232. doi: 10.1037/a0020460.
238   Cherner, R. A. *et al.* (2017) 'Housing First for Adults with Problematic Substance Use', *Journal of Dual Diagnosis*, 13(3), pp. 219–229. doi: 10.1080/15504263.2017.1319586.
239   Aubry, T., Nelson, G. and Tsemberis, S. (2015) 'Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the at Home—Chez soi Demonstration Project', *The Canadian Journal of Psychiatry*, 60(11), pp. 467–474. doi: 10.1177/070674371506001102.
240   Bretherton, J. and Pleace, N. (2015) Housing first in England: An evaluation of nine services. York: Centre For Housing Policy, University of York. Available at: http://eprints.whiterose.ac.uk/83966/.
241   Parsell, C. and Tomaszewski, T. (2013) *Evaluation of the Brisbane Street to Home programme: Final Report*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs. Available at: http://wahousinghub.org.au/display/RES/2014/11/12/An+Evaluation+of+Brisbane+Street+to+Home%3A+Final+Report.
242   Johnson, G. and Chamberlain, C. (2015) *Evaluation of the Melbourne Street to Home programme: Final Report*. Melbourne: HomeGround Services. Available at: https://www.researchgate.net/profile/Chris_Chamberlain/publication/287735874_Evaluation_of_the_Melbourne_Street_to_Home_program_Final_Report/links/5679028e08ae502c99d6d913/Evaluation-of-the-Melbourne-Street-to-Home-program-Final-Report.pdf.

education, training and availability of suitable jobs.[243]

Thus, on the basis of the evidence available it seems that both HF and TAU can improve quality of life and social integration. Further long-term study is needed before any firm conclusions on the sustainability of any such gains may be made, however.

Evidence regarding the influence of HF configuration is mixed and a little contradictory. The Canadian Chez Soi study found improvements in quality-of-life regardless of whether participants were assigned to congregate or scattered site HF (or indeed TAU).[244] The same was true as regards both quality of life and 'social connectedness' measures for residents in both configurations in the longitudinal study in Sydney.[245] In Vancouver, no difference between the two configurations was found in relation to overall quality of life or physical community integration, but significant differences were noted as regards psychological community integration, wherein rates of improvement were higher

in congregate HF.[246] The social experimentation project in Europe found lower feelings of social isolation and loneliness in congregate site facilities than scattered site facilities, but cautions that some level of loneliness and difficulty integrating is likely to occur due to the complexity of participants' lives.[247] Indeed, congregate site facilities may reduce loneliness but may not contribute to recovery from drug and alcohol problems.[248] The absence of loneliness does not, of course, equate with (or translate to) the development of positive social networks in environments where all residents share vulnerabilities associated with substance misuse and/or mental health problems. Many of the same problems reported in hostels and shelters (particularly disruptive and/ or intimidating behaviour) are also reported in congregate HF.[249] Busch-Geertsema[250] cautions that social integration is likely to take far longer than many studies are able to analyse due to the nature of the group. Indeed, though for a minority of participants, some projects reported improved re-connections with family members or

estranged children,[251] the ability and/or inclination of individual service users to do so can be widely variable.[252]

Service use and costs
Ly and Latimer[253] conducted a systematic review of evidence on the costs associated with HF, particularly for clients with mental illness. They reviewed a mixture of published and unpublished studies, with some being RCTs, and others observational. They reported finding a mixed picture, with studies including a variety of programme configurations, huge variability in which services were taken into account (some focus purely on health services, some on criminal justice services etc.), as well as issues with how explicit studies are about their methods and perspectives. These issues aside, they conclude that HF interventions for homeless adults with mental illness lead to cost offsets, in that the cost of providing the HF service was lower than the combined cost for an individual to live on the street and access the expected level of support.

HF studies generally find that participants use fewer emergency

and criminal justice services than TAU clients,[254] and are more likely to remain in health treatment programs.[255] This suggests there may be cost savings for HF over TAU, particularly for those experiencing chronic homelessness. Importantly, some USA studies find that the costs saved in some areas such as health services, are offset by higher costs in case management.[256] Despite this, limited evidence in cost reductions from other areas means this should be treated with caution as all cost savings are dependent on the nature of the welfare state in the country studied.[257] For instance, in Finland the HF approach saves money overall, but they have required large amounts of sustained national funding both to subsidise housing and provide welfare to individuals that may not have received it beforehand.[258] As well as HF potentially increasing the services to which participants subscribe, costs of their support can be exacerbated as participants often enter at points of particular crisis.[259]

The final report on the Chez Soi RCT states that the HF intervention itself is costly at C$22,257 per person per year on average for the high needs

243   Poremski, D. et al. (2016) 'Effects of Housing First on Employment and Income of Homeless Individuals: Results of a Randomized Trial', Psychiatric Services, 67(6), pp. 603–609. doi: 10.1176/appi. ps.201500002.
Parsell, C. and Tomaszewski, T. (2013) Evaluation of the Brisbane Street to Home programme: Final Report. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs. Available at: There is some evidence however that scattered site housing leads to increased feelings of boredom and congregate site participants report greater improvements in 'social connectedness'. http://wahousinghub.org.au/display/RES/2014/11/12/ An+Evaluation+of+Brisbane+Street+to+Home%3A+Final+Report.
Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', European Journal of Homelessness, 8(1), pp. 13–28.
244   Patterson, M. et al. (2013) 'Housing First improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia', Social Psychiatry and Psychiatric Epidemiology, 48(8), pp. 1245–1259. doi: 10.1007/s00127-013-0719-6.
245   Whittaker, E., Dobbins, T., Swift, W., Flatau, P. and Burns, L. (2017) First examination of varying health outcomes of the chronically homeless according to Housing First configuration. Australia and New Zealand Journal of Public Health 41:306–8.
246   Somers, J. M. et al. (2017) 'A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats', PLOS ONE. Edited by I. Puebla, 12(1), p. e0168745. doi: 10.1371/journal.pone.0168745.
247   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', European Journal of Homelessness, 8(1), pp. 13–28.
248   Somers, J. M. et al. (2017) 'A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats', PLOS ONE. Edited by I. Puebla, 12(1), p. e0168745. doi: 10.1371/journal.pone.0168745.
Whittaker, E. et al. (2016) 'Associations of Housing First Configuration and Crime and Social Connectedness Among Persons With Chronic Homelessness Histories', Psychiatric Services, 67(10), pp. 1091–1097. doi: 10.1176/appi.ps.201500446.
249   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', European Journal of Homelessness, 8(1), pp. 13–28.
250   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', European Journal of Homelessness, 8(1), pp. 13–28.

251   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', European Journal of Homelessness, 8(1), pp. 13–28.
252   Johnsen, S. (2013) Turning Point Scotland's Housing First Project Evaluation: Final Report. Glasgow: Turning Point Scotland. Available at: http://www.turningpointscotland.com/wp-content/ uploads/2014/02/TPS-Housing-First-Final-Report.pdf.
253   Ly, A. and Latimer, E. (2015) 'Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature', The Canadian Journal of Psychiatry, 60(11), pp. 475–487. doi: 10.1177/070674371506001103.
254   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. doi: 10.1177/1049731505282593.
Srebnik, D., Connor, T. and Sylla, L. (2013) 'A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services', American Journal of Public Health, 103(2), pp. 316–321. doi: 10.2105/AJPH.2012.300867.
Tsemberis, S., Gulcur, L. and Nakae, M. (2004) 'Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis', American Journal of Public Health, 94(4), pp. 651–656. doi: 10.2105/AJPH.94.4.651.
255   Appel, P. W. et al. (2012) 'Housing First for Severely Mentally Ill Homeless Methadone Patients', Journal of Addictive Diseases, 31(3), pp. 270–277. doi: 10.1080/10550887.2012.694602.
256   Appel, P. W. et al. (2012) 'Housing First for Severely Mentally Ill Homeless Methadone Patients', Journal of Addictive Diseases, 31(3), pp. 270–277. doi: 10.1080/10550887.2012.694602.76/ps.2009.60.4.445.
257   Busch-Geertsema, V. (2014) 'Housing First Europe – Results of a European Social Experimentation Project', European Journal of Homelessness, 8(1), pp. 13–28.
Kertesz, S. G. and Johnson, G. (2017) 'Housing First: Lessons from the United States and Challenges for Australia: Housing First', Australian Economic Review, 50(2), pp. 220–228. doi: 10.1111/1467-8462.12217.
258   Y-Foundation (2017) A Home of Your Own Housing First and ending homelessness in Finland. Keuruu: Otava Book Printing Ltd.
259   Ly, A. and Latimer, E. (2015) 'Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature', The Canadian Journal of Psychiatry, 60(11), pp. 475–487. doi: 10.1177/070674371506001103.

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group, and C$14,177 per person for the medium needs group. These costs include all salaries, additional program expenses and rent supplements. For every C$10 invested in HF services, savings were $9.32 for high need clients and $3.42 for moderate need participants when compared with TAU. Indeed, whilst the direct costs of TAU were lower for high need clients, and more similar for moderate need clients, offsets in other services were significantly higher for HF clients (precise figures not available). Importantly, high need clients accounted for only 10 per cent of the sample.[260]

In the study of nine HF services in England, Bretherton and Pleace[261] provide indicative costings showing HF costs between £26 and £40 an hour. Assuming someone using a HF service would otherwise be accommodated in high intensity supported housing, potential annual savings range between £4794 and £3048 per person. This does not account for potential reductions in health and criminal justice costs. Thus, this analysis suggests that HF could deliver savings in public expenditure in excess of £15,000 per person per annum. The Joseph Rowntree Foundation recommends scaling up HF as the default option for homeless adults with complex needs in the UK. They estimate this could save around £200 million per annum after two years when taking the scale of the current population experiencing 'severe and multiple disadvantage' into account.[262]

A report by the Centre for Social Justice states that a HF project in greater Manchester concluded via cost benefit analysis that for every £1 invested in the HF project, they have realised outcomes worth £2.51. They further suggest that delivering HF would be cost neutral over the course of a single Parliament.[263] Moreover, a Crisis feasibility study on implementing HF at scale in the Liverpool city region points out that continued lack of supportive housing for the chronically homeless will likely only increase the costs of their support needs in the long term. They suggest their proposed model of a HF solution would cost around £12,607 per client per annum. This includes the costs of a local letting agency to source housing; mental health support, and a 24-hour wraparound core team. They conclude that this is likely to be three to five times more cost-effective than TAU.

Whilst HF should not be considered a low-cost option, it creates the potential for savings in the long term. More long-term, context specific studies are needed to fully ascertain the likely scale of these cost savings.[264] However, the growing data pool of UK specific studies is increasingly helpful for making the case for likely cost savings to service commissioners.

Effectiveness for subpopulations

Findings reported so far in this review largely relate to populations of chronically homeless people without necessarily reflecting upon the experience of subpopulations based on race, age, and gender. For instance, evaluation of the Melbourne

Street to Home programme finds that those who became homeless at an earlier age experienced poorer housing outcomes than those whose first homeless experience was as an adult. The authors concluded that this was accounted for by lower levels of cultural capital for those who entered homelessness younger.[265] A study of the national HF programme in Denmark also highlights the specific difficulties of dealing with young people who have often been in receipt of state interventions beforehand, and have received less familial support across the life course.[266]

The Chez Soi RCT provides the most robust evidence to date on how HF works for different subpopulations. Whilst quality-of-life improvements was found for both HF and TAU clients, one evaluation found greater difference in quality-of-life measures between HF and TAU for adults over the age of 50 with this age group more content when in HF.[267] Meanwhile, poorer outcomes in housing stability have been observed for aboriginal Canadians, for men over women, and for younger clients over older clients. However, none of these variables were significant enough in their theoretical model to predict whether or not a

specific individual would benefit from HF.[268]

Concerns over the effectiveness of HF for younger populations can be somewhat reduced by findings that housing retention results for the under 24 age group are significantly better for the HF group versus TAU (65 per cent to 31 per cent of days housed across the 24 month period).[269] Indeed, findings from Denmark also show that despite a different range of support needs; the person-centred, sticky support of HF can suit the younger client group.[270] Moreover, work on the youth population is picking up with Gaetz[271] setting out a HF framework for youth, noting that as well as supporting the complex needs of young people, HF for this demographic must also look at supporting young people in making the transition to adulthood.

Veterans are another population that has received attention in the USA, with a national programme offering superior housing retention and access to housing rates than TF.[272] Whilst one USA study also suggests TF works better for addressing the substance misuse problems of veterans,[273] this has been contested on grounds of

260   Goering, P. *et al.* (2014) *National At Home/Chez Soi Final Report.* Calgary: Mental Health Commission of Canada. Available at: https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf.

261   Bretherton, J. and Pleace, N. (2015) Housing first in England: An evaluation of nine services. York: Centre For Housing Policy, University of York. Available at: http://eprints.whiterose.ac.uk/83966/.

262   Joseph Rowntree Foundation (2016) *UK Poverty: Causes, Costs and Solutions,* York: Joseph Rowntree Foundation, p.238

263   The Centre for Social Justice (2017) *Housing First: Housing led solutions to rough sleeping and homelessness.* London: The Centre for Social Justice. Available at: https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf.

264   Ly, A. and Latimer, E. (2015) 'Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature', *The Canadian Journal of Psychiatry,* 60(11), pp. 475–487. doi: 10.1177/070674371506001103.

265   Johnson, G. and Chamberlain, C. (2015) *Evaluation of the Melbourne Street to Home programme: Final Report.* Melbourne: HomeGround Services. Available at: https://www.researchgate.net/profile/Chris_Chamberlain/publication/287735874_Evaluation_of_the_Melbourne_Street_to_Home_program_Final_Report/links/5679028e08ae502c99d6d913/Evaluation-of-the-Melbourne-Street-to-Home-program-Final-Report.pdf.

266   Benjaminsen, L. (2013) 'Policy review up-date: Results from the Housing First based Danish homelessness strategy', *European Journal of Homelessness _ Volume,* (Query date: 2017-09-25). Available at: http://pure.sfi.dk/ws/files/207198/lb_review.pdf.

267   Chung, T. E. *et al.* (2017) 'Housing First for older homeless adults with mental illness: a subgroup analysis of the At Home/Chez Soi randomized controlled trial: Housing First for older homeless adults', *International Journal of Geriatric Psychiatry.* doi: 10.1002/gps.4682.

268   Adair, C. E. *et al.* (2017) 'Outcome Trajectories among Homeless Individuals with Mental Disorders in a Multisite Randomised Controlled Trial of Housing First', *The Canadian Journal of Psychiatry,* 62(1), pp. 30–39. doi: 10.1177/0706743716645302.

269   Kozloff, N. *et al.* (2016) '"Housing First" for Homeless Youth With Mental Illness', *PEDIATRICS,* 138(4), pp. e20161514–e20161514. doi: 10.1542/peds.2016-1514.

270   Benjaminsen, L. (2013) 'Policy review up-date: Results from the Housing First based Danish homelessness strategy', *European Journal of Homelessness _ Volume,* (Query date: 2017-09-25). Available at: http://pure.sfi.dk/ws/files/207198/lb_review.pdf.

271   Gaetz, S. and Homeless Hub (2014) *A safe and decent place to live: towards a housing first framework for youth.* Available at: http://www.deslibris.ca/ID/242598 (Accessed: 2 November 2017).

272   Montgomery, A. E. *et al.* (2013) 'Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach To Hud-Vash: Housing Chronically Homeless Veterans', *Journal of Community Psychology,* 41(4), pp. 505–514. doi: 10.1002/jcop.21554.

273   Westermeyer, J. and Lee, K. (2013) *Residential Placement for Veterans With Addiction: American Society of Addiction Medicine Criteria vs. a Veterans Homeless Program.*

poor quality evidence.[274]

Finally, a Chez Soi trial report looks at the differences in outcome between Caucasian Canadians, and other study participants (non-Caucasian Canadians, and immigrants). It finds no difference in housing stability, probability of hospitalisation, and community functioning, between groups at the end of the 24 month study period, but non-Caucasian Canadians showed a worsening in the outcome of 'amount of money spent on alcohol', and immigrants to Canada experienced a greater reduction in the number of days spent experiencing problems associated with alcohol use when compared with other study participants.[275] A different Canadian study assessed the effectiveness of a HF intervention for ethnic minorities which included a greater focus on antiracism and empowerment. As compared with those in the TAU group, HF participants spent more time housed, and had greater improvements in community integration.[276] The Chez Soi results point to a need for further development of the HF model for different subpopulations.[277] The evidence base could be improved by conducting further studies of different subpopulations, including related to gender and sexuality where no studies were found.

4.4 Barriers to implementation
Barriers to implementation of HF can either be structural such as lack of appropriate housing, or due to attitudinal barriers of existing service providers, commissioners, or private landlords.[278] In a review of nine HF services in England, Bretherton and Pleace[279] highlight that the services were often in a precarious position as the funding was generally short-term and insecure. To secure better long-term commissioning, they suggest research may need to be brought up to a clinical level of proof. Kennedy et al.[280] suggest housing retention, and appropriate level of support could be improved by strengthening partnerships across agencies involved in HF programs, and supporting frontline staff – particularly to minimise staff turnover and improve the stability of the model. Crisis, in their feasibility study of implementing HF on scale in the Liverpool City Region corroborate a need for strong partnership working and building, and lament that if HF is the only way to get good quality social housing with support then the system could become overloaded. Thus, HF needs to be part of a housing led system response to homelessness.[281]

4.5 Expert perspectives
All but one of the key Informants provided perspectives on Housing First

and there was consensus around the strength of the evidence base.

Key informants echoed findings of the literature review, identifying geographical variations in implementation: in the USA and Finland it is an integral element of government policy, whereas in the UK it is limited to several small scale projects.

Definitional debates pervaded much of the discussion about Housing First. It was suggested that the USA tend to favour an abstinence and recovery based approach as opposed to harm reduction. Moreover, some projects labelled as Housing First (in the USA but also elsewhere) were accused of simply being tenancy support projects, that is, of having poor fidelity to HF principles. Some key informants were concerned that movement away from the core principles of Housing First would negatively impact upon housing outcomes and indeed who gets supported. On this issue, a number expressed particular reservations about the appropriateness and effectiveness of congregate versions of HF. They emphasised that congregate housing is not what the majority of homeless people 'want', and that problems widely reported in relation to hostel accommodation (particularly antisocial behaviour) are, perhaps unavoidably, replicated in congregate HF settings.

Despite debates about what constitutes Housing First, key informants repeated findings from the literature review that the broad approach works effectively with typically 'hard to house' individuals and has achieved high tenancy retention rates. Key informants felt the approach was particularly successful in instances where the model had become an integral element of government policy and strategy, and where a subsequent shift towards permanent housing and away from transitional housing was clearly visible. Moreover, its success was felt to lie in the fact that it is

largely client centred, choice driven and viewed as providing clients with respect and dignity.

Despite overwhelming support for the model, key informants identified three key challenges. First, suitable support is not always available. There was a common view that one of the fundamental features of a successful Housing First model was the presence of high quality, flexible, multi-disciplinary and intensive support but this requires resourcing and effective collaboration. Second, suitable housing is not always available. Third, one informant questioned whether the model could be adapted to be more preventative and available to a wider group of people, as it currently only intervenes with the hardest to house at crisis point.

There appears to be universal support for Housing First and its underlying philosophies amongst key informants, albeit that they recognise implementation challenges.

4.6 Summary
- Housing First (HF) provides permanent housing to rough sleepers without preconditions regarding recovery from (or participation in treatment for) substance misuse or mental health problems. Person-centered support is provided on a flexible basis for as long as individuals need it. HF was initially developed in the USA and is being increasingly replicated in Canada, Europe and Australia, where it marks a significant departure from the traditional 'treatment first' or staircase approach. HF development in the UK has been modest to date, with only a limited number of small-scale projects currently operational.

- The evidence base on HF is exceptionally strong; far stronger than is true of any other housing-related intervention targeting rough sleepers in fact. The evidence includes a mix of large-scale

274   Kertesz, S. G. et al. (2015) 'Housing First and the Risk of Failure: A Comment on Westermeyer and Lee (2013)', *The Journal of Nervous and Mental Disease*, 203(7), pp. 559–562. doi: 10.1097/NMD.0000000000000328.

275   Goering, P. et al. (2014) *National At Home/Chez Soi Final Report*. Calgary: Mental Health Commission of Canada. Available at: https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf.

276   Stergiopoulos, V. et al. (2015) 'Effectiveness of Housing First with Intensive Case Management in an Ethnically Diverse Sample of Homeless Adults with Mental Illness: A Randomized Controlled Trial', *PLOS ONE*. Edited by B. Aleksic, 10(7), p. e0130281. doi: 10.1371/journal.pone.0130281.

277   Goering, P. et al. (2014) *National At Home/Chez Soi Final Report*. Calgary: Mental Health Commission of Canada. Available at: https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf.

278   Johnsen, S. and Teixeira, L. (2010) 'Staircases, elevators and cycles of change: 'Housing First' and other housing models for homeless people with complex support needs', *Crisis*, London.

279   Bretherton, J. and Pleace, N. (2015) Housing first in England: An evaluation of nine services. York: Centre For Housing Policy, University of York. Available at: http://eprints.whiterose.ac.uk/83966/.

280   Kennedy, J., Arku, G. and Cleave, E. (2017) 'The experiences of front-line service providers of Housing First programme delivery in three communities in Ontario, Canada', *International Journal of Housing Policy*, 17(3), pp. 396–416. doi: 10.1080/14616718.2016.1248528.

281   Blood, I. et al. (2017) *Housing First Feasibility Study for the Liverpool City Region*. London: Crisis. Available at: https://www.crisis.org.uk/media/237544/housing_first_feasibility_study_for_the_liverpool_city_region_2017_es.pdf.

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Randomised Control Trials (RCTs) and smaller qualitative studies conducted in a range of international contexts. Further research is however needed to assess long-term impacts and effectiveness for subgroups. There is also scope to further understanding impacts on health and substance misuse, and influence of different programme structures on outcomes.

• HF is best known for its excellent housing retention outcomes, which are especially impressive given that the intervention targets homeless people with complex needs. Retention figures (measured in variable ways over different timeframes) range between 60-90 per cent, and typically coalesce around the 80 per cent mark. This is markedly higher than rates reported for Treatment as Usual (TAU) comparison groups.

• Other (non-housing) outcomes are much more modest. Improvements in physical and mental health are often documented, but tend not to be pronounced, nor significantly different from TAU comparison groups. Existing (slightly mixed) evidence indicates that HF may be equally and is sometimes more effective than TAU in reducing levels of substance misuse, with many HF evaluations reporting overall reductions in alcohol and/or drug consumption. HF evaluations consistently report reductions in involvement in criminal activity. Many record improvements as regards quality of life, but these do not necessarily exceed those documented for TAU.

• Cost analyses, some of which have been conducted in the UK, indicate that HF is not a low-cost option, but creates potential for savings in the long term given cost offsets in the health and criminal justice systems in particular.

• Debates about fidelity feature significantly in the HF literature. Core to these have been assessments of the relative merits of scatter-site and congregate configurations. Comparisons of the two are few in number, but suggest that there are no significant differences in terms of housing retention or health outcomes. Involvement in substance misuse and/or criminal activity tends to be higher in congregate HF. Loneliness is more common in scatter-site HF, but the behavior of other residents in congregate HF can impede recovery. The majority of homeless people express a strong preference for scatter-site HF.

• Housing First has traditionally targeted homeless people with complex needs (that is, co-occurring substance misuse and/or mental health problems) and has proven to be highly effective as a housing solution for this group. There is limited evidence regarding outcomes for other subgroups of the homeless population, but adaptations have proven successful for young people and ethnic minorities.

• Key informant interviewees universally support Housing First. They echoed many of the literature review findings, concluding that the evidence base is strong and the approach has particularly positive impacts on housing retention. However, they also raised several key points for policy makers to consider: 1] what constitutes Housing First and how loyal to the original model must a project be?; 2] The absence of high quality, flexible, multi-disciplinary and intensive support can undermine effectiveness; 3] Suitable housing is not always available for Housing First to be delivered; 4] Homeless people prefer scatter-site rather than congregate HF programmes; and 5] there are questions about the applicability of the model with other groups and at an earlier stage.

Common Ground

5.1 Defining the intervention

Common Ground (CG) is a congregate site, communal living arrangement that places ex–homeless individuals in purpose-built or converted housing alongside individuals on a low income (without a history of homelessness). It thus combines both 'supportive housing' for formerly homeless people with 'affordable housing' for members of the general population on low incomes. Developed in 1990 in New York City, since 2008 CG has been a national model adopted by the Australian government.[282]
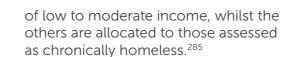
CG aims to create a mixed community to facilitate strong neighbourhoods and social connection. In the original USA model tenants pay 30 per cent of their income towards rent, whether the source is paid employment or social security benefits. On-site health and social support, retail, and leisure facilities are provided alongside a 24-hour concierge service.[283]

Five key components underpin the Australian Common Ground Alliance (ACGA):

- rapid access to high quality, affordable and permanent housing;

- separation of support and tenancy services;

- service values that target the most vulnerable homeless people through the use of the health based vulnerability index, to identify chronically homeless people who have debilitating medical health conditions.[284]

A widely reported example, CG in Brisbane, is a purpose designed and built 14 story building comprising 146 apartments, 3 retail spaces, and office space for the tenancy manager, clinical nurse and support provider. It also has a variety of communal areas, and is deliberately located in an economically, socially and geographically privileged neighbourhood. Half the apartments are allocated to individuals on the basis

of low to moderate income, whilst the others are allocated to those assessed as chronically homeless.[285]

Whilst a distinctive programme, CG is a form of single site supportive housing, and involves assertive outreach (see chapter on Street Outreach) to approach individuals on the streets or in temporary accommodation to receive permanent housing.[286] Like Housing First (HF) CG does not require tenants to exhibit sobriety or maintain abstinence, but does expect them to commit to the community

ethos of the model, and obey certain rules such as only having guests stay a certain number of nights per week.[287] Moreover, individuals leaving the CG accommodation would no longer receive the support offered to residents, which in a HF model is provided for as long as individuals wish/require it, regardless of whether they move home. Despite this difference, a number of sources particularly outwith academic evidence, describe CG as a congregate site form of HF, and this can complicate the process of extracting

282   Parsell, C. & Jones, A. (2014) Bold Reform or Policy Overreach? Australia's Attack on Homelessness: 2008–2013, International Journal of Housing Policy 14 (4): 427–443

283   Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', Brisbane (AU): Micah Projects Inc. Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.
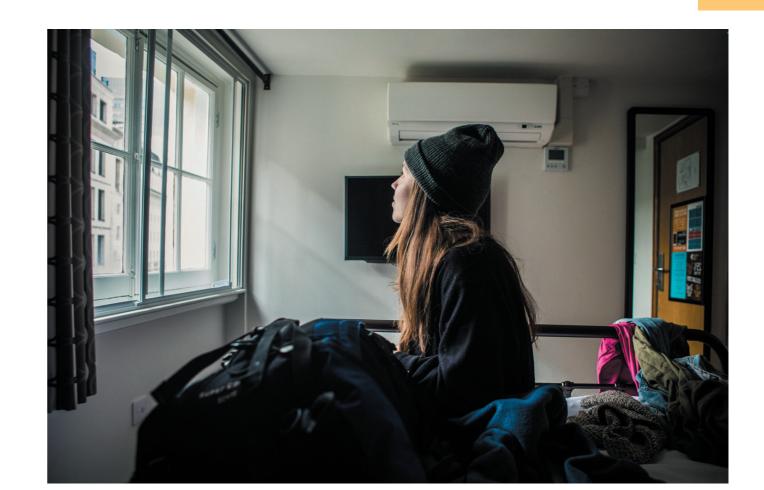
284   At the time of writing no website or official documentation can be found on the ACGA, but the principles are cited in Verdouw, J. and Habibis, D. (2017) 'Housing First programs in congregate-site facilities: can one size fit all?', Housing Studies, pp. 1–22. doi: 10.1080/02673037.2017.1346192.

285   Parsell, C., Petersen, M. & Moutou, O. (2015) Single-Site Supportive Housing: Tenant Perspectives, Housing Studies 30 (8): 1189–1209

286   HDFC, B. G. (no date) Breaking Ground | Street to Home, Breaking Ground. Available at: http://www.breakingground.org/our-programs/street-to-home/ (Accessed: 7 November 2017).

287   Jacobs, K. et al. (2015) 'Individualised and market-based housing assistance: Evidence and policy options', AHURI Final Report, (253), pp. 1–74.
      Parsell, C. and Moutou, O. (2014) An evaluation of the nature and effectiveness of models of supportive housing. (AHURI Positioning Paper). Available at: https://www.scopus.com/inward/record.uri?eid=2-s2.0-84905485607&partnerID=40&md5=379c893abf812e4fd330573e06b68cbd.
      Parsell, C., Petersen, M. and Moutou, O. (2015) 'Single-site supportive housing: tenant perspectives', Housing Studies, (Query date: 2017-09-26). Available at: http://www.tandfonline.com/doi/abs/10.1080/02673037.2015.1009874.
      Verdouw, J. and Habibis, D. (2017) 'Housing First programs in congregate-site facilities: can one size fit all?', Housing Studies, pp. 1–22. doi: 10.1080/02673037.2017.1346192.

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evidence that specifically relates to the features of CG.[288]

As of 2017 Breaking Ground (the new name for the USA branch of Common Ground) owned 18 buildings in New York, with some scattered site provision.[289] A 2003 report notes that Common Ground Crisis is a project modelled on the original CG service, purporting to house only single women who have experienced homelessness, and key workers such as nurses, teachers and public service workers.[290] In Australia, evidence from 2015 states there are 9 purpose-built CG buildings across 5 of Australia's 6 states.[291]. These have been enabled by a mix of public, private and philanthropic endeavours based on forging close links with Roseanne Haggerty, the founder of CG in New York.[292]

5.2 The evidence base
Whilst CG began in New York, no USA site has undergone independent evaluation, limiting the extent to which outcomes can be reported.[293] Nevertheless, development of CG, particularly in Australia, has been couched in terms of embracing evidence-based policies.[294] Concerns have been raised as to the extent of evidence supporting CG over other interventions, which could be further complicated by CG often being described under the banner of HF.[295] However, in recent years the number of evaluations has been steadily growing so that there are now a mixture of point in time qualitative works and pre-post survey and interview studies based on projects in Tasmania[296] and Brisbane[297] which the following section will draw on.

5.3 Outcomes
Housing
Reported housing retention rates vary across projects, with some reports suggesting exceptionally high rates – CG in New York boasts an overall rates of 99 per cent[298] – and independent evaluative evidence from Australia reporting significantly lower figures with a low of 74 per cent retention at 12 months or more, and some relatively high rates of abandonment/ eviction.[299]

Giving an overview of tenancy support programs and their success in Australia, one report states that in 2011-12 87.7 per cent, and in 2012-13 82.9 per cent of all CG tenancies for ex-rough sleepers were sustained and 1.8 per cent ended in eviction/ vacant possession.[300] Looking at specific programs, a report on the effectiveness of HF in Brisbane includes tracking the trajectories of 3 ex-homeless CG participants, of which two remained in the programme after 18 months. The report considers CG to be an effective part of the homelessness response, but the sparse evidence used offers no robust conclusions.[301]

More evidence is available for CG services in Tasmania which report that

between June 2012 and 31st October 2015 79 supported tenants have lived in the facility, with 39 of these individuals having current tenancies. 74 per cent of current ex-homeless tenants had a tenancy duration of at least 12 months, with 50 per cent of those with a start date of over a year ago having lasted the full 3 years of operation. When considering those that had exited supported tenancies, 66 per cent had a duration of under 12 months and 29 per cent had a duration of under 6 months. For the cohort with a tenancy duration under 6 months, their reason for leaving was put down to a poor fit between their needs and the support model. 46 per cent were vacated as a result of eviction or abandonment, while 37 per cent were vacated through mutual agreement. It is unclear what happened to the remaining 17 per cent, but 61 per cent of all exits involve the tenants securing another form of tenured accommodation in the community.[302] An earlier evaluation suggests 2 out of 16 vacations in 2013 related to behavioural uses and clients left before securing alternative accommodation.[303] This strongly suggests CG is not able to meet the needs of clients with more complex needs, despite national funding being allocated on this basis.[304] However, the

288   For an example see Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc.* Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.
         Tually, S., Skinner, V. & Faulkner, D. (2017) *The AdelAide Zero Project: Ending Street Homelessness in The Inner City*, Adelaide: Dunstan Foundation
         For a breakdown of the differences in the Australian context see: Verdouw, J. and Habibis, D. (2017) 'Housing First programs in congregate-site facilities: can one size fit all?', *Housing Studies*, pp. 1–22. doi: 10.1080/02673037.2017.1346192.
289   HDFC, B. G. (no date) *Breaking Ground | Our Buildings, Breaking Ground.* Available at: http://www.breakingground.org/our-buildings/ (Accessed: 7 November 2017).
290   Adkins, B. *et al.* (2003) *Women housing and transitions out of homelessness: A report for The Commonwealth Office of the Status of Women.* Queensland: AHURI Queensland Research Centre.
291   Parsell, C., Petersen, M. and Moutou, O. (2015) 'Single-site supportive housing: tenant perspectives', *Housing Studies*, 30(8), pp. 1189–1209.
292   McDonald, S. (2014) 'Social partnerships addressing affordable housing and homelessness in Australia', *International Journal of Housing Markets and Analysis*, 7(2), pp. 218–232. doi: 10.1108/ IJHMA-10-2012-0046.
293   Johnsen, S. and Teixeira, L. (2010) 'Staircases, elevators and cycles of change:'Housing First'and other housing models for homeless people with complex support needs', *Crisis*, London, (Query date: 2017-09-26).
294   Parsell, C., Fitzpatrick, S. and Busch-Geertsema, V. (2014) 'Common Ground in Australia: An Object Lesson in Evidence Hierarchies and Policy Transfer', *Housing Studies*, 29(1), pp. 69–87. doi: 10.1080/02673037.2013.824558.
         Parsell, C. and Jones, A. (2014) 'Bold reform or policy overreach? Australia's attack on homelessness: 2008–2013', *International Journal of Housing Policy*, 14(4), pp. 427–443. doi: 10.1080/14616718.2014.967923.
295   Ibid
296   Parsell, C. and Moutou, O. (2014) A*n evaluation of the nature and effectiveness of models of supportive housing.* (AHURI Positioning Paper). Available at: https://www.scopus.com/inward/record.uri?eid=2-s2.0-84905485607&partnerID=40&md5=379c893abf812e4fd330573e06b68cbd.
         Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016.* Melbourne: Lirata Consulting. Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.
         Verdouw, J. and Habibis, D. (2017) 'Housing First programs in congregate-site facilities: can one size fit all?', *Housing Studies*, pp. 1–22. doi: 10.1080/02673037.2017.1346192.
         Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)
297   Parsell, C., Petersen, M. & Moutou, O. (2015) Single-Site Supportive Housing: Tenant Perspectives, *Housing Studies* 30 (8): 1189–1209
         Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining

        tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc.* Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.
298   Breaking Ground (2015) *25 years 12,095 lives transformed.* New York: Breaking Ground. Available at: http://www.breakingground.org/files/BreakingGround_25-Year_Impact-Report.pdf.
299   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016.* Melbourne: Lirata Consulting. Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.
300   Zaretzky, K. & Flatau, P. (2015) *The Cost Effectiveness of Australian Tenancy Support Programs for Formerly Homeless People*, Melbourne: Australian Housing and Urban Research Institute Ltd Available from: <https://www.researchgate.net/profile/Paul_Flatau/publication/284168543_The_ cost_effectiveness_of_Australian_tenancy_support_programs_for_formerly_homeless_people/ links/564d9aa808aeafc2aaaff52a.pdf> [Accessed:
301   Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc.* Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.
302   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016.* Melbourne: Lirata Consulting, p.4 Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.
303   Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)
304   Ibid

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high rate of attrition is reported to be declining modestly over time.[305]

Health
Like other interventions, it is important to note that supported tenants in CG facilities have been specifically targeted for this intervention due to high levels of poor health. In Australia this is specifically related to likelihood of premature death, and therefore drastic health improvements are not expected.[306]

One study of the wider housing led approach (CG and HF) in Brisbane included three participants in CG accommodation and nine in HF, and reports promising signs of improvements in both mental and physical health for the 12 participants in both schemes, with no breakdown of the difference between.[307] Similarly, in a different study on supportive housing, that includes tenants from a CG site in Tasmania, 69.2 per cent of supported housing residents reported enjoying better health. This was a greater rate than for people in housing with outreach support and those allocated housing because of low wages, but there is no breakdown for CG residents in particular.[308]

Reports from CG in Tasmania provide a better level of certainty, and show relatively minor health improvements from a poor baseline standard.[309] One report states 34 per cent of

tenants showed a moderate or major improvement in physical functioning between first and last interviews for their outcomes report, whilst 20 per cent showed a moderate or major decline. The data also suggests minor gains in fitness and mobility. 27 per cent of tenants showed a moderate or major reduction in the impact of non-chronic physical health conditions, while 12 per cent showed a moderate or major increase. Importantly, 66 per cent in the pre-and post sample indicated that living in CG had a fairly or very positive effect on their physical health.[310]

In regards to mental health, the most robust report available from CG Tasmania shows very high prevalence of existing mental health conditions, and a clear mix in mental health trajectories for participants. In general, there was a clear trend towards more positive than negative outcomes and there is strong evidence of substantial reduction in impacts of high prevalence disorders such as anxiety and depression. The data shows a slight reduction in the daily impact of symptoms for those living with schizophrenia, but a small increase in bipolar disorder. Whilst clinical outcomes are mixed, greatest improvement was noted in tenants' ratings for self-respect, the use of personal strengths, skills or talents, and the belief and ability to make positive

life changes. The risk of self-harm also decreased.[311]

A comparative study of scattered site HF and CG in Sydney found that both groups reported similar rates of improvement for quality-of-life and psychological distress over the 12 months of being housed, but CG participants reported higher engagement with mental health specialists and emergency hospital visits for psychiatric reasons. The precise reason for this is unknown, but it could be that pressure to engage with services is higher in CG with more surveillance from staff, or that HF was more successful in stabilising participants' mental health problems.[312] Ultimately, clinical data on health improvements is lacking, but qualitative findings suggest a general trend towards better health.

Substance misuse
The taking of illicit drugs and alcohol is prohibited in the public areas of CG services, but abstinence and sobriety are not a condition of accommodation. One study of the wider housing led approach in Brisbane included 3 participants in CG accommodation and reports that in the overall sample substance misuse reduced when housed.[313] No breakdown of the difference between CG and other participants is available.

A study comparing outcomes for HF with CG in Sydney found no between-group difference for the specific substances used, but there was significant increase over time in the proportion of CG participants who injected more than weekly.[314] This suggests that CG, like congregate site HF may provide an environment that favours continued or increased substance misuse. However, no other available evidence makes claims about levels of substance misuse after entering CG programs.

Criminal activity and anti-social behaviour
An evaluation report of tenants living in Tasmania CG states residents participate less in criminal activity, and are less likely to be victims themselves than before they were housed. Fifty per cent of tenants in a pre-and post sample reported being a victim of crime in the 12 months prior to moving into CG, often on multiple occasions, whilst 18 per cent reported being a victim of crime in the 12 months prior to their last interview for the project.[315] There is also suggestion that CG reduces the incidence of residents coming into contact with the criminal justice system, but this report does not make it clear whether or not it is referring specifically to CG or to providing any form of permanent housing to homeless people.[316] That said, antisocial behaviour has been

305   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016*. Melbourne: Lirata Consulting, p.4 Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.

306   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016*. Melbourne: Lirata Consulting. Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.

307   Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc*. Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.

308   Parsell, C. and Moutou, O. (2014) *An evaluation of the nature and effectiveness of models of supportive housing*. (AHURI Positioning Paper). Available at: https://www.scopus.com/inward/record.uri?eid=2-s2.0-84905485607&partnerID=40&md5=379c893abf812e4fd330573e06b68cbd.

309   Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)

310   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016*. Melbourne: Lirata Consulting. Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.

311   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016*. Melbourne: Lirata Consulting. Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.

312   Whittaker, E. *et al.* (2017) 'First examination of varying health outcomes of the chronically homeless according to Housing First configuration', *Australian and New Zealand Journal of Public Health*, 41(3), pp. 306–308. doi: 10.1111/1753-6405.12631.

313   Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc*. Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.

314   Whittaker, E. *et al.* (2017) 'First examination of varying health outcomes of the chronically homeless according to Housing First configuration', *Australian and New Zealand Journal of Public Health*, 41(3), pp. 306–308. doi: 10.1111/1753-6405.12631.

315   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016*. Melbourne: Lirata Consulting. Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.

316   Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc*. Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.

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reported as a reason that some residents of CG do not feel safe in their accommodation,[317] and failure to fit with the programme or behave in pro-social ways has been associated with eviction from CG properties.[318] However, exact levels of anti-social behaviour or criminal activity are not reported in existing evaluations.

Quality-of-life and social integration

Due to the nature of the intervention, quality-of-life, social integration, and feelings of security and home are the focus of most evaluations. These suggest some positive findings, but also aspects of the community that tenants find difficult.

A study that included CG Tasmania suggests a positive impact on quality of life from being housed in CG, but does not make any direct comparison between that reported in CG and other forms of supportive housing.[319] An evaluation of tenant experiences (both supported and affordable) in a Brisbane CG complex highlights that the vast majority of participants surveyed considered the complex to be their home (90 per cent), with a sense of control and autonomy integral to this feeling. The congregate form also meant that the majority had friends in the building, and many found

the mix of activities available helpful in cultivating a sense of community and friendships.[320] An evaluation of Tasmania CG reports similar findings with 70 per cent of supported tenant survey respondents considering the facility home and 75 per cent agreeing that they would like to live there in the long term, with supported tenants appreciating the high level of security offered by the facilities and enjoying the emphasis on community integration and family reunification. Meanwhile, staff were positive about the program's structure in enabling both formal and informal support and interaction between staff and tenants.[321]

Despite the positive feelings explored above, over half of surveyed residents in Brisbane CG complained about aspects of anti-community, particularly related to the behaviour of those under the influence of alcohol and illicit substances. Feelings of anti-community were articulated more by younger people and females. Just over 25 per cent of surveyed tenants in Brisbane CG found the on-site concierge, CCTV and signing in and out of guests as markers of ontological insecurity.[322] For instance, such rules were reported to make it difficult to maintain or establish healthy relationships,[323] and led to a sense of

embarrassment from some supported tenants about inviting guests over at all. There was a tension in the Tasmanian facility with the program's emphasis on supporting residents to increase family reunification as the one-bedroom apartments and restrictive guest policy meant residents could not exercise a choice to live with someone else without exiting the programme. It furthermore found evidence of a lack of interaction between supported and unsupported tenants, and a feeling from some supported tenants that they were judged negatively by those without a history of homelessness.[324]

Whilst CG also intends to improve work and study opportunities for residents, an evaluation from Tasmania suggests goals of increased tenants' participation in education, training and work may not have been successful primarily because the outcomes are not well aligned with tenant needs.[325] Whilst tenants were generally happy with their housing, survey data suggest 60 per cent would like further assistance to participate in community or leisure activities.[326] Overall, this suggests CG can contribute to improved quality-of-life but not necessarily across every aspect of life, or for every group.

Service use and costs

It is unclear how CG compares to other interventions in terms of service use and cost. Official documentation for Breaking Ground in New York states $10,000 are saved per person per year from their activities, in comparison to individuals remaining on the street and using services such as emergency shelters, health and criminal justice at the expected rate.[327] Meanwhile, a report on the cost effectiveness of tenancy support programs in Australia states that in 2011–13 total spend for the Street to Home (assertive outreach) and CG programs was AU$13 million, at a cost of AU$10,618 per person supported.[328] The only other analysis of costs is for Brisbane housing led services, which does not distinguish between CG and HF.[329] A different report makes the vague assertion that CG in Brisbane has resulted in cost savings,[330] but Parsell et al.[331] comment that providing generous provision of communal spaces can be costly to maintain, and yields no rental income. Importantly, congregate site facilities such as CG are often supported by philanthropists and politicians due to the reductions in cost of providing all support on site versus a scattered provision. In Australia, costs were also saved as the construction company agreed to construct new facilities at cost price.[332]

317   Parsell, C., Petersen, M. and Moutou, O. (2015) 'Single-site supportive housing: tenant perspectives', *Housing Studies*, 30(8), pp. 1189–1209.

318   Planigale, M. and Rosauer, K. (2016) *Common Ground Tasmania Tenant Outcomes Report – January 2016*. Melbourne: Lirata Consulting. Available at: https://docs.wixstatic.com/ugd/0b8af8_ f3418fd35aea4bdfb3c4f06973993c8c.pdf.
      Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)

319   Parsell, C. and Moutou, O. (2014) *An evaluation of the nature and effectiveness of models of supportive housing*. (AHURI Positioning Paper). Available at: https://www.scopus.com/inward/record.uri?eid=2-s2.0-84905485607&partnerID=40&md5=379c893abf812e4fd330573e06b68cbd.

320   Parsell, C., Petersen, M. and Moutou, O. (2015) 'Single-site supportive housing: tenant perspectives', *Housing Studies*, 30(8), pp. 1189–1209.

321   Verdouw, J. and Habibis, D. (2017) 'Housing First programs in congregate-site facilities: can one size fit all?', *Housing Studies*, pp. 1–22. doi: 10.1080/02673037.2017.1346192.
      Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)

322   Parsell, C., Petersen, M. and Moutou, O. (2015) 'Single-site supportive housing: tenant perspectives', *Housing Studies*, 30(8), pp. 1189–1209.

323   Verdouw, J. and Habibis, D. (2017) 'Housing First programs in congregate-site facilities: can one size fit all?', *Housing Studies*, pp. 1–22. doi: 10.1080/02673037.2017.1346192.
      Parsell, C., Petersen, M. and Moutou, O. (2015) 'Single-site supportive housing: tenant perspectives', *Housing Studies*, 30(8), pp. 1189–1209.

324   Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)

325   Ibid, p.84

326   Ibid

327   Breaking Ground (2015) *25 years 12,095 lives transformed*. New York: Breaking Ground. Available at: http://www.breakingground.org/files/BreakingGround_25-Year_Impact-Report.pdf.

328   Zaretzky, K. & Flatau, P. (2015) *The Cost Effectiveness of Australian Tenancy Support Programs for Formerly Homeless People*, Melbourne: Australian Housing and Urban Research Institute Ltd Available from: https://www.researchgate.net/profile/Paul_Flatau/publication/284168543_The_ cost_effectiveness_of_Australian_tenancy_support_programs_for_formerly_homeless_people/ links/564d9aa808aeafc2aaaff52a.pdf

329   Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc*. Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.

330   Westoby, R. (2016) *Mental Health, Housing and Homelessness: A Review of Issues and Current Practices, 2016*, West End Brisbane: Micah Projects Inc Available from: http://micahprojects.org.au/ assets/docs/Publications/2017-Mental-Health-Housing-and-Homelessness.pdf

331   Parsell, C., Fitzpatrick, S. & Busch-Geertsema, V. (2014) Common Ground in Australia: An Object Lesson in Evidence Hierarchies and Policy Transfer, *Housing Studies* 29 (1): 69–87

332   Parsell, C., Fitzpatrick, S. and Busch-Geertsema, V. (2014) 'Common Ground in Australia: An Object Lesson in Evidence Hierarchies and Policy Transfer', *Housing Studies*, 29(1), pp. 69–87. doi: 10.1080/02673037.2013.824558.

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Common Ground **62**

Effectiveness for subpopulations
To date, there has been no evidence focussing on CG's effectiveness for subpopulations. One evaluation states women were both more likely than men to experience feelings of anti-community, and value a sense of community in CG,[333] and (particularly for women with a history of violent or dangerous housing contexts) to see it as their permanent home.[334] Older people appear more likely to value the security of congregate site facilities and they may also be helpful for young people working towards specific goals.[335] However, younger people appear more likely to see CG as a stable foundation from which to build on other aspects of their development such as education and training – not necessarily a long term home.[336] It has also been noted that Australians identifying as Aboriginal, Torres Strait Islander or both are more likely to be homeless than the general population and thus be in CG facilities.[337] Recognising this, CG Port Augusta has been developed in Adelaide as the first programme developed specifically to address the needs of local homeless aboriginal people.[338] No further information about the effectiveness of the model, for instance on housing retention, with different subgroups is currently available.

5.4 Barriers to implementation
A key feature of CG in Australia that has been lauded as instrumental to its success has been its approach of increasing the supply of affordable housing within a tight market. Padgett refers to CG as following a 'Business-model Lineage'[339] meaning it focuses on collaboration between state and non-state actors to meet its goals. This could have benefits for financing homelessness initiatives in a tight financial climate in the future. Indeed, the collaboration of public, private, and third sector organisations increased its attractiveness to the central government, and a private developer built each site at cost price.[340] Thus, CG can overcome the common barrier in housing led approaches of a lack of accommodation, provided parties are willing to make new construction affordable. However, a barrier to implementation may be the social mix required for CG, which can mean that those not in the supported accommodation category may see their accommodation as temporary in their transition out of affordable housing.[341] This could have impacts on the formation of a community. Indeed, as is true of other forms of congregate supported housing, institutionalisation

and stigmatisation are potential concerns.[342]

Key qualitative findings from an evaluation of Tasmanian CG services suggest a disparity in who CG is purported and funded to help, and whose applications are accepted for the program. From the perspective of senior management, the programme is supportive, not supported and tenants should have the ability to live independently and in a community environment from the outset. Thus, those with the highest support needs have frequently been rejected and the wider homelessness sector has had to find space for them in unsuitable accommodation intended for those with low support needs. With this, some high needs tenants also reported not getting all of the support they need to live independently such as help with shopping.[343] However, better collaboration between partners may resolve these issues by sharing expertise in supporting more vulnerable clients and providing greater transparency in the applications procedure. This need for improved partnerships is emphasised across the evaluation, particularly in regard to ensuring continuity of support for tenants.[344]

5.5 Expert perspectives
Two key informants from the USA and Australia provided qualitative perspectives on Common Ground, providing useful additional insights into an intervention which has been relatively poorly researched.

While the literature review made no significant mention of variations in the Common Ground model, one key informant was keen to point out that in the Australian context interventions

vary in their format between states and as a result of the alternative approaches pursued by different housing and support providers.

One of the perceived strengths of the model is that it provides permanent social housing. Key informants agreed with the literature review findings, suggesting that rough sleepers had managed to maintain tenancies for several years. They attribute the success of the model, not only to the availability of permanent accommodation but also the availability of on-site intensive support. However, concerns were also raised about the appropriateness of this support – echoing literature review findings which highlight the potentially paternalistic and intrusive nature of some of this support.

Key informants reiterated literature review findings that the intended 'social mix' between rough sleepers and low income tenants was not always achieved. One key informant suggested that there were difficulties finding and targeting low income households, albeit any lack of social mix within the congregate sites was not perceived to be a cause for concern.

While key informants recognised the positive housing impacts of Common Ground, significant reservations about the congregate site model and the intrusive nature of support, led them to conclude the model should not be established on a significantly wider scale.

5.6 Summary
• Common Ground (CG) is a form of congregate site supported/supportive housing which is said to target highly vulnerable rough sleepers and places

333 Parsell, C., Petersen, M. and Moutou, O. (2015) 'Single-site supportive housing: tenant perspectives', *Housing Studies*, 30(8), pp. 1189–1209.

334 Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)

335 Verdouw, J. and Habibis, D. (2017) 'Housing First programs in congregate-site facilities: can one size fit all?', *Housing Studies*, pp. 1–22. doi: 10.1080/02673037.2017.1346192.

336 Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)

337 Mason, C. and Grimbeek, P. (2013) 'A Housing First approach to homelessness in Brisbane: sustaining tenancies and the cost effectiveness of support services', *Brisbane (AU): Micah Projects Inc.* Available at: http://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.

338 Common Ground Adelaide (2017) *Our properties - Common Ground.* Available at: http://commongroundadelaide.org.au/what-we-do/our-properties/
Thredgold, C., Horne, S., Beer, A., Paris, C. & Tually, S. (2013) Showcasing Innovation: Case Studies of Recent Homelessness Initiatives, search.ror.unisa.edu.au Available from: http://search.ror.unisa.edu.au/record/UNISA_ALMA51119340350001831

339 Padgett, D., Henwood, B. & Tsemberis, S. (2016) *Housing First: Ending Homelessness, Transforming Systems, and Changing Lives*, Oxford: Oxford University Press p. 165

340 Parsell, C., Fitzpatrick, S. & Busch-Geertsema, V. (2014) Common Ground in Australia: An Object Lesson in Evidence Hierarchies and Policy Transfer, *Housing Studies* 29 (1): 69–87

341 Verdouw, J. & Habibis, D. (2017) Housing First Programs in Congregate-Site Facilities: Can One Size Fit All?, *Housing Studies*: 1–22

342 Busch-Geertsema, V. (2012) 'The potential of housing first from a European perspective', *European Journal of Homelessness*. Available at: http://www.fiopsd.org/wp-content/uploads/2013/01/Feantsa-EJH-6-2_WEB.pdf#page=211.

343 Verdouw, J., Stafford, J. & Habibis, D. (2014) *Evaluation of New Homelessness Support Services in Tasmania Report Five: Evaluation of Supported Accommodation Facilities – Common Ground Tasmania*, Tasmania: Housing and Community Research Unit (HACRU)

344 Ibid

them in accommodation alongside people on low to moderate incomes (who do not have a history of homelessness) in a mixed community. On-site health and social support, retail and leisure facilities are provided alongside a 24 hour concierge service. CG was first developed in the USA, and has been adopted as a national model in Australia.

- The evidence base on CG is very limited, despite assertions from some quarters that its expansion is an example of evidence-based policy. There have been no independent evaluations of the model in the USA and the number of studies in Australia very small, albeit steadily growing. The process of discerning the outcomes of CG is further complicated by the fact that CG projects are sometimes described under the banner of HF.

- Variable housing retention rates are documented, from one report of 99 per cent in New York, to 74 per cent in Tasmania. High rates of eviction and abandonment have been reported, and these attributed to poor fit between the model and the needs of certain (high needs) clients. Attrition rates appear to be declining over time in some projects, however.

- Health outcomes for CG residents show some signs of improvement, but the picture is mixed and more positive as regards psychological functioning than physical health. Mental health outcomes appear to be poorer in comparison to HF. Evidence on substance misuse is especially limited (restricted to one study) but suggests that this may not decline and may even increase in CG facilities, as compared with HF.

- Quality-of-life and social integration outcomes are generally positive for CG participants, with between 70 per cent and 90 per cent considering it their 'home'. However, restrictive

rules and surveillance can lead to feelings of 'anti-community' amongst residents. Indeed, some evidence suggests divisions between supported and unsupported tenants, with a lack of interaction between the two types of resident.

- There is no evidence on different housing outcomes for subpopulations. Some evaluations nevertheless note that older tenants and women are more likely to view CG as 'home', and women and young people more likely to complain about aspects of anti-community, particularly the behaviour of those under the influence of alcohol or illicit substances.

- The key barrier to implementation is ensuring the right cross-sectoral relationships between agencies so as to provide the correct level of support to tenants. However, a key strength is that CG facilities provide new accommodation and so ease pressure on housing. In Australia, this is been provided at a particularly low cost.

- While key informants recognised the positive impacts of CG on housing retention and the important role played in support services in achieving this success, they held significant reservations about the congregate site model and the intrusive nature of support. Key informants did not support widespread development of the model.

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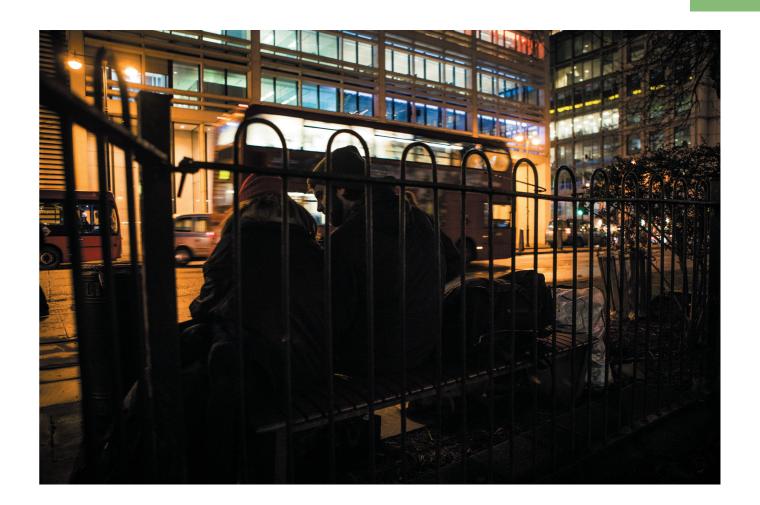Social Impact Bonds **66**

Social Impact Bonds

6.1 Defining the intervention

Social Impact Bonds (SIBs) are a funding mechanism for levying private capital to solve social issues. Whilst varying in structure, they involve securing private finance to support a (usually third sector) provider in delivering against predefined targets. Investors regain their investment from the public sector at agreed points when the target is reached, and receive an additional return on investment for performance beyond that target. SIBs are therefore a form of pay for performance financing and are increasingly used for projects that target social groups with more complex needs such as criminal offenders, chronically homeless people, and children in the care system. To secure private finance, proposed schemes are likely to follow an evidence based format and fund existing providers with a proven track record.[345]

6.2 The evidence base

The evidence base on the use of SIBs in relation to homelessness services is limited. Most literature makes a case for trying SIBs rather than evaluating existing projects.[346] An Australian report states only four SIBs globally have directly targeted homelessness, with one underway in Adelaide where an SIB is being used to fund Common Ground and associated services for 400 individuals. Another in Massachusetts seeks to provide 500 additional units of housing over six years to service 800 individuals in a Housing First approach.[347] Other literature suggests SIBs are under consideration or in progress in Denver, Colorado, which is establishing an RCT around SIBs and supportive housing for chronically homeless people,[348] and Queensland Australia.[349] MSc dissertations suggest potential for SIBs related to homelessness in Alberta,

Canada,[350] and across Portugal to deliver Housing First.[351]

The only project with an available evaluation is in London where charities Thames Reach and St Mungo's were appointed to help a group of 813 named chronic rough sleepers between 2012 and 2015.[352] The target population was split between the two service providers, and was designed to address a gap between two existing key initiatives, these being RS205 for rough sleepers with more complex needs, and No Second Night Out for those new to the streets (see chapter on No Second Night Out for discussion). It used a 'Navigator' model to provide a single link for participants to existing services. Navigators had

a personalised budget (see chapter on Personal Budgets for discussion) for each individual to help in taking an assertive, tailored approach rather than to deliver any single pre-specified intervention.[353]

6.3 Outcomes

The housing, health and employment outcomes described below are all reported in relation to the London SIB which aimed to:

• reduce rough sleeping;

• sustain accommodation;

• reconnect those with no right to remain in the UK;

345 Hooks, G. (2013) 'Social Impact Bonds: A Promising Tool for the Future of Permanent Supportive Housing', *Community Investments*, 25(1). Available at: http://www.frbsf.org/community-development/files/Hooks_CISP13.pdf.
MacKenzie, D. et al. (2017) *The funding and delivery of programs to reduce homelessness: the case study evidence*. AHURI Final Report. Australian Housing and Urban Research Institute Limited. doi: 10.18408/ahuri-5109201.

346 McGladrey, N. (2016) *Social Impact Bonds and Housing First: A match made for Alberta?* Master of Public Policy Dissertation. University of Calgary. Available at: https://dspace.ucalgary.ca/handle/1880/51709.

347 MacKenzie, D. *et al.* (2017) *The funding and delivery of programs to reduce homelessness: the case study evidence*. AHURI Final Report. Australian Housing and Urban Research Institute Limited. doi: 10.18408/ahuri-5109201.

348 Cunningham, M. *et al.* (2016) *Denver Supportive Housing Social Impact Bond Initiative*. Denver: Urban Institute. Available at: http://www.urban.org/sites/default/files/publication/79041/2000690-Denver-Supportive-Housing-Social-Impact-Bond-Initiative-Evaluation-and-Research-Design.pdf.

349 MacKenzie, D. *et al.* (2017) *The funding and delivery of programs to reduce homelessness: the case study evidence*. AHURI Final Report. Australian Housing and Urban Research Institute Limited. doi: 10.18408/ahuri-5109201.

350 McGladrey, N. (2016) *Social Impact Bonds and Housing First: A match made for Alberta?* Master of Public Policy Dissertation. University of Calgary. Available at: https://dspace.ucalgary.ca/handle/1880/51709.

351 Wahn, M. (2016) *Social impact bond feasibility study AEIPS intervention*. MSc Dissertation. Universidade Nova. Available at: http://run.unl.pt/handle/10362/17503.

352 Mason, P., Lloyd, R. and Nash, F. (2017) *Qualitative Evaluation of the London Homelessness Social Impact Bond (SIB) Final Report*. London: Department for Communities and Local Government.

353 Ibid

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- promote employment, education and training; and

- improve health and wellbeing.

The payment structure of the SIB sets a baseline target for the service at which providers receive payment, and then further payment for outcomes reached beyond this figure.[354] This section will therefore discuss the achieved outcome, and the extent to which it met targets for payment.

Housing

In total, just over half (53 per cent) of the 830 people achieved an accommodation or reconnection outcome, though this includes hostels for which no payment was made (20 of the 830). This figure rises to 71 per cent if those who lost contact or died during the service period are excluded from the calculation. 402 out of 830 were in stable accommodation – 64.3 per cent - of those remaining in the cohort at the end of the programme.

Reduction targets for the number of individuals sleeping rough were 258 in year one, 132 in year two, and 92 in year three. Actual performance saw 175 in year one, 124 in year two, and 102 in year three. This shows successful year-on-year reduction and going beyond targets in years one and two. Reconnection was another goal, with targets of 104 in year one, 50 in year two, and 24 in year three. Actual outcomes were 45, 40 and 29 respectively, delivering only 114 of the expected 178. It further fell behind the target on sustaining reconnections for more than 6 months.

Targets for entering stable accommodation were 94, 136, and 76 in each of the three years respectively, with actual performance of 139, 110, and 55. Thus, year one performance was ahead of schedule, continued to rise across the period,

but did not meet targets for years two and three. This means in total 304 individuals entered stable accommodation.

Twelve month housing sustainment targets were 115 and 104 in years two and three with actual achievements of 146 and 95, totalling 241 overall – ultimately ahead of target, but more successful in year two than in three. Targets for 18 month sustainment were 41 in year two and 113 in year three with actual achievement of 78 and 106. Again, surpassing targets in year two and falling behind in year three but ultimately exceeding expectation with 184 achieving 18 months in stable accommodation. These are positive achievements for a group that have been historically difficult to engage.

Health

Though health was an important intended outcome of the London SIB, difficulties in gaining access to the appropriate data meant it had to be excluded from the performance framework. Thus, providers were paid in lieu for this outcome whilst negotiations on data access are ongoing.[355]

Employment

Whilst the targets set for employment outcomes were low, reflecting the complexity of needs for the cohort, the final evaluation report shows underachievement for volunteering and part-time employment, but over achievement of full-time employment outcomes across the three-year programme. In total, they aimed for:

- 145 volunteering/self employed for 13 weeks, for which they achieved 33;

- 56 volunteering/self employed for 26 weeks for which they achieved 26;

- 37 to be in part time work for 13 weeks, for which they achieved 7;

- 31 to be in part time work for 26 weeks, for which they achieved 3

- 30 to be in full time work for 13 weeks, for which they achieved 53; and

- 25 to be in full time work for 26 weeks, for which they achieved 38.

Results were 77 per cent above the target for 13 weeks of full-time employment and 52 per cent above targets for 26 weeks.[356]

Service use and costs

A feasibility study of the London SIB before it began estimated that the costs incurred by the cohort across 5 years totalled £24 million. £5 million was therefore allocated to fund the SIB, and over the three-year period 79 per cent of the ultimate payment target was reached – taking into account that some targets were reached, some exceeded, and some not achieved.[357]

The SIB to fund Common Ground in Adelaide has seen the South Australian government make a AU$9 million commitment if service providers raise the initial capital to launch the programme.[358] For the SIB in Massachusetts to deliver Housing First, a total of US$1 million of philanthropic funding and US$2.5 million of private capital was raised, as well as leveraging existing government programs such as rental assistance payments to support

tenants.[359] A scoping report suggests that before housing, the mean annual health cost for the targeted individuals in this program is around US$26,124 per year, dropping to US$8500 after housing and should therefore make cost savings overall.[360]

6.4 Barriers to implementation

SIBs must have measurable and meaningful outcomes that the service provider, private investor and government stakeholders can agree upon. These need to be demonstrable within a reasonable timeframe, investors must have good reason to believe the SIB will succeed, and there needs to be a supportive political and legal environment to make them viable.[361]

The immaturity of the market within the UK may also be a barrier at present,[362] and a number of reports stress that setting too high a target on any specific element can lead to a disincentive for providers to focus on the most difficult of cases, and may lead them to cherry pick particular individuals for projects.[363] For instance, if employment outcomes are emphasised, but contingent largely on improving the health and housing stability of individuals first, then providers may abandon helping the most difficult clients into stable housing, and instead help those already housed to find employment. This is a key critique for the London SIB.[364] This can be overcome by setting more considered, evidence-based

354   Ibid
355   Ibid.
356   Ibid
357   Ibid
358   MacKenzie, D. et al. (2017) *The funding and delivery of programs to reduce homelessness: the case study evidence*. AHURI Final Report. Australian Housing and Urban Research Institute Limited. doi: 10.18408/ahuri-5109201.
359   Ibid
360   Finn, J. and Hayward, J. (2013) 'Bringing success to scale: Pay for success and housing homeless individuals in Massachusetts', *Community Development Investment Review*. Available at: http://www.frbsf.org/community-development/files/bringing-success-scale-pay-for-success-housing-homeless-individuals-massachusetts.pdf.
361   Gustafsson-Wright, E., Gardiner, S. and Putcha, V. (2015) *The Potential and Limitations of Impact Bonds: Lessons from the first 5 years of experience worldwide*. Washington DC: Brookings. Available at: https://www.brookings.edu/wp-content/uploads/2016/07/Impact-Bondsweb.pdf.
362   MacKenzie, D. et al. (2017) *The funding and delivery of programs to reduce homelessness: the case study evidence*. AHURI Final Report. Australian Housing and Urban Research Institute Limited. doi: 10.18408/ahuri-5109201.
363   Ibid
364   Mason, P., Lloyd, R. and Nash, F. (2017) *Qualitative Evaluation of the London Homelessness Social Impact Bond (SIB) Final Report*. London: Department for Communities and Local Government.

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outcomes and showing caution in setting high predefined targets. It may be better to focus on a few outcomes, rather than the raft of outcomes committed to in London.[365]

6.5 Expert perspectives

Social Impact Bonds are relatively new in the homelessness sector but four key informants still reflected in depth, often with contradictory perspectives, on the strengths and weaknesses of the model.

It is first worth noting that all informants were of the view that SIBs are a commissioning tool rather than an actual intervention. Moreover, some believe the outcomes focussed approach could be achieved through other means such as outcomes based contracting.

Despite these caveats, key informants identified four main benefits of SIBs. First, SIBs work well with entrenched rough sleepers, whose street lives are associated with high costs to public services. Second, SIBs enable new and increased funding to be leveraged that could not be accessed through other forms of outcomes-based commissioning. SIBs reportedly provide an opportunity to access funds that are tied up in trusts and foundations. Increased funds enable projects to be scaled up. Third, some key informants believe the outcome targets have led service providers to develop more personalised approaches in order to really understand what people need to get off the street. Fourth, there is a perception that paid for performance in the homelessness sector is potentially a positive idea as there is often a lack of clarity and transparency around outcomes monitoring.

While key informants clearly see potential benefits of SIBs, there was limited support to pursue the approach more widely due to the following key challenges and limitations. First, targets could be set very high and this raised concerns that the quality of solutions would be compromised. Second, informants questioned whether SIBs had led to significantly different and more effective approaches being taken. One informant felt strongly that a lot of 'middle men' benefited but the types of services being funded remained largely the same. Third, there were difficulties in securing the necessary consent and access to data which is key to any measurement of outcomes. Finally, and most significantly, key informants believed the model could not be replicated more widely because of its complexity.

6.6 Summary

- SIBs are a new form of financing social programmes that gather private investments to fund specific providers to deliver a service or program. They are increasingly being used, or are at least being considered, in response to homelessness in a number of countries (including the USA, Canada, Australia and Portugal), and have been trialed at a small scale in the UK.

- There is, as yet, limited evidence on SIB effectiveness. Further evaluation of their impact on outcomes in the homelessness field is needed. As literature points to an increasing number having started, there will likely be a better evidence base in the coming years.

- The only available evidence on outcomes is from the London

SIB where 64 per cent of those remaining in the cohort at the end of the programme had achieved stable housing outcomes. It also exceeded expectations in housing sustainment at 12 and 18 months.

- Whilst volunteering and part time employment outcomes were not as successful as hoped, the London SIB performed substantially better than initially thought on full time employment. It may be that this funding mechanism incentivises targets traditionally not focused on by homelessness service providers.

- Caution should be exercised as regards the stability of outcomes over time, however, with the London SIB showing greater success in the first 2 years than in the final year. Long term evaluations are needed.

- The limited evidence shows that SIBs can be an effective funding mechanism, but complex agreements need to be put in place around the outcomes to be reached, and financial returns for different success rates.

- As SIBs generally fund existing, and usually evidence-based programs, it is reasonable to suppose that if they fund something such as Housing First or Common Ground they will receive the same, or similar results. However, it is possible that with a greater focus from providers on meeting predefined outcomes that performance may improve or decline in some areas.

- Key informants offered contradictory perspectives on the strengths and weaknesses of SIBs. Positive impacts were perceived to include: good outcomes for entrenched rough sleepers, access to new funds in order to expand services, more personalised services in some cases, and increased clarity and

transparency around outcomes monitoring. However, challenges and limitations include: high targets that compromise service quality, limited innovation in service provision, and difficulties accessing the necessary data for outcomes monitoring. Despite the fairly balanced view of SIBs, there was broad agreement that the model could not be replicated more widely because of its complexity.

365   Edwards, C. (2014) *The opportunities and challenges for the homelessness sector in South Australia: Social impact bonds.* MSc Dissertation. Unknown. Available at: http://www.urbanaffairs.com.au/downloads/2015-2-17-1.pdf.
MacKenzie, D. *et al.* (2017) *The funding and delivery of programs to reduce homelessness: the case study evidence.* AHURI Final Report. Australian Housing and Urban Research Institute Limited. doi: 10.18408/ahuri-5109201.
Mason, P., Lloyd, R. and Nash, F. (2017) *Qualitative Evaluation of the London Homelessness Social Impact Bond (SIB) Final Report.* London: Department for Communities and Local Government.

Residential communities

7.1 Defining the intervention

The term residential community covers a range of configurations which accommodate homeless people in a congregate environment, physically isolated from outside influences, wherein the primary focus is not resolving street homelessness per se but rather providing support relating to other areas of residents' lives. Two key models include: a) residential Therapeutic Communities (TCs) which focus on rehabilitation from substance misuse; and b) Emmaus communities or similar which have an employment (and to lesser extent social integration) focus.

With regard to the first, a residential TC is a well-established therapy model that supports clients to recover and abstain from substance misuse. The traditional TC model utilises a social, psychological and self-help approach to treatment.[366] Both staff and residents are involved in development of a 'caring community' which challenges antisocial and problematic behaviours and aims to evoke psychological, social and behavioural change.[367] TCs are typically characterised as 'high-demand' environments which are highly structured and where privileges and rules of conduct are well defined.[368] Most aim for a global change in lifestyle including abstinence from illicit substances, elimination of antisocial behaviour, and evidence of employability, prosocial attitudes and values.[369]

Specially adapted versions of TC, known as Modified Therapeutic Communities (MTCs), have been developed for particular populations,[370] including homeless people, and these have been developed within some homeless shelters in the United States.[371] MTCs tend to adopt a more individualised approach and make fewer demands of residents than traditional TCs.[372] TC stays are typically quite long (between 15 and 24 months), but some MTC programmes, including those in at least some homeless shelters, operate over a shorter timeframe (e.g. six months).[373]

Emmaus communities, in contrast, are described as self-financing mutually supportive communities wherein residents (known as 'companions') live and work together. The vast majority of companions are homeless (or about to become so) when they first join.[374] Emmaus communities operate a social enterprise model, running businesses which are often based around re-selling second-hand furniture and goods. They aim to give formerly homeless people the chance to live and work alongside others, to learn to

366   Nuttbrock, L., Rahav, M., Rivera, J., Ng-Mak, D and Link, B. (1998) Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community, Psychiatric Services, 49(1): 68-76.
Bride, B. and Real, E. (2003) Project Assist: A Modified Therapeutic Community for homeless women living with HIV/AIDS and chemical dependency, Health and Social Work 28(2): 166-168.

367   Magor-Blatch, M., Bhullar, N., Thomson, B. and Thorsteinsson, E. (2014) A systematic review of studies examining effectiveness of therapeutic communities, Therapeutic Communities: The International Journal of Therapeutic Communities 35(4): 168-184.

368   Nuttbrock, L., Rahav, M., Rivera, J., Ng-Mak, D and Link, B. (1998) Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community, Psychiatric Services, 49(1): 68-76.

369   Stevens, S., Erickson, J., Carnell tent, J., Chong, J. and Gianas, P. (1993) A therapeutic community model for treatment of homeless alcohol and drug user is Tucson, Arizona, Alcoholism Treatment Quarterly 10(3-4): 21-33.

370   De Leon, G. (1995) Residential therapeutic communities in the mainstream: diversity and issues, Journal of Psychoactive Drugs 27(1): 3-33.

371   Liberty, H., Johnson, B., Jainchill, N., Ryder, J., Messina, M., Reynolds, S. and Hossain, M. (1997) Dynamic recovery: comparative study of therapeutic communities in homeless shelters for men.
Skinner, D. (2005) A modified therapeutic community for homeless persons with co-occurring disorders of substance abuse and mental illness in a shelter: an outcome study, Substance Use & Misuse 40: 483-497.

372   De Leon, G., Sacks, S., Staines, G. and McKendrick, K. (2000) Modified therapeutic community for homeless mentally ill chemical abusers: treatment outcomes. American Journal of Drug and Alcohol Abuse 26(3)L 461-480.

373   De Leon, G. (1995) Residential therapeutic communities in the mainstream: diversity and issues, Journal of Psychoactive Drugs 27(1): 3-33.
Stevens, S., Erickson, J., Carnell tent, J., Chong, J. and Gianas, P. (1993) A therapeutic community model for treatment of homeless alcohol and drug user is Tucson, Arizona, Alcoholism Treatment Quarterly 10(3-4): 21-33.
Egelko, S., Galanter, M., Dermatis, H., Jurewicz, E., Jamison, E., Dingle, S. and De Leon, G. (2002) Improved psychological status in a modified therapeutic community for homeless MICA men. Journal of Addictive Diseases 21(2): 75-92.

374   Clarke, A. (2010) Work as a route out of homelessness: a case study of Emmaus Communities, People, Place and Policy Online 4(3): 89-102.

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live as part of a community, to develop work experience, and improve self-esteem.[375] The approach is sometimes described in terms of 'giving homeless people a bed and a reason to get out of it'.[376] Companions forego welfare benefits and the communities operate a 'dry' policy as regards alcohol and drug use.[377] The vast majority of Emmaus companions are single White men.[378] There is no maximum length of stay, and it is generally accepted that some companions will not move on into independent living but remain resident in the long term. A similar model of community living and working is provided in some rural areas by Barka in Poland.[379]

7.2 The evidence base
The effectiveness of the TC (and MTC) approaches in dealing with addiction in the general population is evidenced by a well-established body of research which includes rigorous (primarily quantitative) studies[380], but it has been noted that further research is needed to be fully confident about TC effectiveness in homeless shelters.[381] The evidence base on Emmaus communities or similar projects

operated by organisations such as Barka is weak by comparison. Only a very small number of small-scale (primarily qualitative) evaluations of Emmaus have been conducted, and these limited to a few projects in England only.[382]

7.3 Outcomes
Housing
Housing-related outcomes are not generally recorded for TCs, albeit that one study in the USA noted that homeless people in the MTC experimental group were more likely to be placed into housing appropriate to their level of functioning after the programme than were the comparison group undergoing treatment in a general shelter.[383] It is also worth noting that TC drop-out rates are generally very high, with only 25-35 per cent of residents typically completing programmes[384]; no evaluations provide any detail regarding the post-exit housing status of those who drop out.

Rates of move-on to independent housing from Emmaus communities are not systematically recorded, but

are reported to be low in the few evaluations conducted.[385] Some commentators have pointed to a tension within Emmaus communities between the objective of supporting people to move on to independent living and recognising a companion's decision to remain in the long term as a 'valid life choice' in situations where they feel unable or do not want to live in 'normal' society.[386]

Health
The TC studies reviewed consistently identified reduced presence of mental illness symptoms amongst homeless residents of TC and MTCs as compared with those in standard treatment settings.[387] Literature on Emmaus communities does not document changes in health status.

Substance misuse
A review of MTC literature concluded that significantly greater reductions in substance misuse have been found for homeless people with co-occurring substance misuse problems treated in MTC programmes than for those in

treatment as customarily provided.[388] Literature on Emmaus communities does not document changes in substance misuse status.

Criminal activity and anti-social behaviour
TC evaluations consistently document reductions in post-treatment criminality, and this is also true for programmes targeting homeless people.[389] Literature on Emmaus communities does not make reference to changes in levels of criminal activity or antisocial behaviour.

Quality of life and social integration
TC literature does not offer commentary on quality of life and social integration outcomes. Evaluations of Emmaus communities in England indicate that living and working within these environments can add value to residents' lives, offering a sense of purpose and enhancing feelings of self-worth.[390] Some residents value the development of skills whilst they are resident in the communities, but they derive no direct

375   Bretherton, J. and Pleace, N. (2012) New growth for Emmaus, York: University of York.

376   Boswell, C. (2010) Routes out of poverty and isolation for older homeless people: possible models from Poland and the UK, European Journal of Homelessness, 4: 203-216.

377   Randall, G. and Brown, S. (2002) New Lives: An Independent Evaluation of Emmaus Communities in the UK. Cambridge: Emmaus UK.

378   Clarke, A. (2010) Work as a route out of homelessness: a case study of Emmaus Communities, People, Place and Policy Online 4(3): 89-102.

379   Boswell, C. (2010) Routes out of poverty and isolation for older homeless people: possible models from Poland and the UK, European Journal of Homelessness, 4: 203-216.

380   Magor-Blatch, M., Bhullar, N., Thomson, B. and Thorsteinsson, E. (2014) A systematic review of studies examining effectiveness of therapeutic communities, Therapeutic Communities: The International Journal of Therapeutic Communities 35(4): 168-184.
      Young, M. (2010) Developing Therapeutic Communities for the 21st century: bringing traditions together through borrowing and adaptation, Therapeutic Communities 31(1): 48-61.

381   Skinner, D. (2005) A modified therapeutic community for homeless persons with co-occurring disorders of substance abuse and mental illness in a shelter: an outcome study, Substance Use & Misuse 40: 483-497.
      De Leon, G. (1995) Residential therapeutic communities in the mainstream: diversity and issues, Journal of Psychoactive Drugs 27(1): 3-33.

382   Clarke, A. (2010) Work as a route out of homelessness: a case study of Emmaus Communities, People, Place and Policy Online 4(3): 89-102.
      Boswell, C. (2010) Routes out of poverty and isolation for older homeless people: possible models from Poland and the UK, European Journal of Homelessness, 4: 203-216.

383   Skinner, D. (2005) A modified therapeutic community for homeless persons with co-occurring disorders of substance abuse and mental illness in a shelter: an outcome study, Substance Use & Misuse 40: 483-497.

384   Liberty, H., Johnson, B., Jainchill, N., Ryder, J., Messina, M., Reynolds, S. and Hossain, M. (1997) Dynamic recovery: comparative study of therapeutic communities in homeless shelters for men.

385   Clarke, A. (2010) Work as a route out of homelessness: a case study of Emmaus Communities, People, Place and Policy Online 4(3): 89-102.

386   Ibid
      Randall and Brown 2002

387   De Leon, G., Sacks, S., Staines, G. and McKendrick, K. (2000) Modified therapeutic community for homeless mentally ill chemical abusers: treatment outcomes. American Journal of Drug and Alcohol Abuse 26(3)L 461-480.
      Liberty, H., Johnson, B., Jainchill, N., Ryder, J., Messina, M., Reynolds, S. and Hossain, M. (1997) Dynamic recovery: comparative study of therapeutic communities in homeless shelters for men.
      Nuttbrock, L., Rahav, M., Rivera, J., Ng-Mak, D and Link, B. (1998) Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community, Psychiatric Services, 49(1): 68-76.
      Magor-Blatch, M., Bhullar, N., Thomson, B. and Thorsteinsson, E. (2014) A systematic review of studies examining effectiveness of therapeutic communities, Therapeutic Communities: The International Journal of Therapeutic Communities 35(4): 168-184.
      Egelko, S., Galanter, M., Dermatis, H., Jurewicz, E., Jamison, E., Dingle, S. and De Leon, G. (2002) Improved psychological status in a modified therapeutic community for homeless MICA men. Journal of Addictive Diseases 21(2): 75-92.

388   Skinner, D. (2005) A modified therapeutic community for homeless persons with co-occurring disorders of substance abuse and mental illness in a shelter: an outcome study, Substance Use & Misuse 40: 483-497.

389   Liberty, H., Johnson, B., Jainchill, N., Ryder, J., Messina, M., Reynolds, S. and Hossain, M. (1997) Dynamic recovery: comparative study of therapeutic communities in homeless shelters for men.
      De Leon, G., Sacks, S., Staines, G. and McKendrick, K. (2000) Modified therapeutic community for homeless mentally ill chemical abusers: treatment outcomes. American Journal of Drug and Alcohol Abuse 26(3)L 461-480.
      Nuttbrock, L., Rahav, M., Rivera, J., Ng-Mak, D and Link, B. (1998) Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community, Psychiatric Services, 49(1): 68-76.

390   Clarke, A. (2010) Work as a route out of homelessness: a case study of Emmaus Communities, People, Place and Policy Online 4(3): 89-102.

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financial benefit from their work.[391] Some companions are reported to view the geographical isolation of Emmaus projects as beneficial, in that they offer distance from a harmful 'scene' where peer group influences encourage harmful drinking and drug-taking.[392] That said, tensions amongst residents do arise, and 'falling out' with fellow companions is a common reason for individuals leaving.[393] Some commentators have also questioned the extent to which Emmaus and other geographically isolated programmes can realistically foster social integration.[394]

Effectiveness for subpopulations
TCs have been used with homeless people with complex needs, including co-occurring mental health problems and involvement in substance misuse and/or criminal behaviour, but it has been noted that the combination of such vulnerabilities adds to the challenge of simultaneously dealing with them in one therapeutic context.[395]

Existing commentaries suggest that Emmaus Communities may be particularly attractive to and/or beneficial for: people with little formal education or work experience, those who have offended in the past and are at a high risk of re-offending, individuals with mild learning difficulties, and those with experience of or a liking for communal living.[396]

The groups for whom Emmaus communities have been said to be less suitable include: women, young people, ethnic minorities and the 'most chaotic' street homeless people.[397] Chronically homeless people in particular can be viewed as disruptive and as unable to make a positive contribution to the work that sustains the communities financially.[398]

Cost
Whilst there is no evidence comparing the cost of TCs with other accommodation-focused interventions for homeless people, some reports do indicate that they cost no more to operate[399] and offer greater cost-benefit[400] than other forms of substance misuse treatment programmes.

An economic evaluation of an Emmaus village using figures for 2006-7 indicated that whilst the surplus from its trading activities was not sufficient to meet the full costs of accommodating and supporting its companions, additional income from other sources (of which statutory sources included Housing Benefit and Supporting People) enabled the community to produce a total surplus of £19,089 after companions costs had been met.[401] The same evaluation estimated that the community was responsible for savings and benefits to society of around £31,252 per companion per year.

7.4 Barriers to implementation
Existing literature does not provide commentary on the barriers to implementation of either TCs or Emmaus communities.

7.5 Expert perspectives
No key informant interviewees commented on the use or effectiveness of residential communities.

7.6 Summary
- The term residential community covers a range of configurations which accommodate homeless people in a congregate (but usually geographically isolated) environment, wherein the primary focus is not resolving street homelessness per se but rather providing support relating to other areas of residents' lives. Two key models include: a) residential Therapeutic Communities (TCs) which are based on a well-established therapy model that supports clients to recover from substance misuse; and b) Emmaus communities which are described as self-financing mutually supportive communities where residents live and work together. Modified TCs (MTCs) have been implemented in homeless shelters within the USA, and Emmaus communities operate in a number of rural locations in the UK.

- The effectiveness of the TC (and MTC) approaches in dealing with addiction in the general population is evidenced by a well-established body of evidence which includes rigorous (primarily quantitative) research, but it has been noted that further research is needed to be fully confident about the intervention's effectiveness in homeless shelters. The evidence base on Emmaus communities or similar projects is weak by comparison, being limited to a very small number of small-scale (primarily qualitative) evaluations.

- Evidence on TCs consistently indicates that the model is effective

in reducing levels of substance misuse, mental health problems and involvement in criminality, including when employed in homeless shelters. Evaluations of Emmaus communities suggest that they can improve residents' quality of life by offering a sense of purpose, enabling skill development and enhancing feelings of self-worth but that the way of life is attractive to a fairly limited clientele. Evidence regarding the impact of either model of residential community on housing outcomes is negligible or non-existent.

- TCs have been shown to be effective in helping at least some homeless people with complex needs overcome addiction, but attrition rates are very high. Emmaus Communities appear to be particularly attractive to and/or beneficial for: people with little formal education or work experience, ex-offenders, individuals with mild learning difficulties, and those with experience of or a liking for communal living. They are considered less suitable for: women, young people, ethnic minorities, and the 'most chaotic' or chronic street homeless people.

391 Ibid
392 Ibid
393 Ibid
     Bretherton, J. and Pleace, N. (2012) New growth for Emmaus, York: University of York.
394 Johnsen, S. (2010) Residential communities for homeless people: how 'inclusive', how 'empowering'? European Journal of Homelessness, 4: 273-280.
395 Young, M. (2010) Developing Therapeutic Communities for the 21st century: bringing traditions together through borrowing and adaptation, Therapeutic Communities 31(1): 48-61.
396 Clarke, A. (2010) Work as a route out of homelessness: a case study of Emmaus Communities, People, Place and Policy Online 4(3): 89-102.
397 Ibid
398 Bretherton, J. and Pleace, N. (2012) New growth for Emmaus, York: University of York.
399 Skinner, D. (2005) A modified therapeutic community for homeless persons with co-occurring disorders of substance abuse and mental illness in a shelter: an outcome study, Substance Use & Misuse 40: 483-497.
400 De Leon, G. (1995) Residential therapeutic communities in the mainstream: diversity and issues, Journal of Psychoactive Drugs 27(1): 3-33.
401 Clarke, A., Markkanen, S. and Whitehead, C. (2008) An Economic Evaluation of Emmaus Village Carlton. Cambridge: University of Cambridge.

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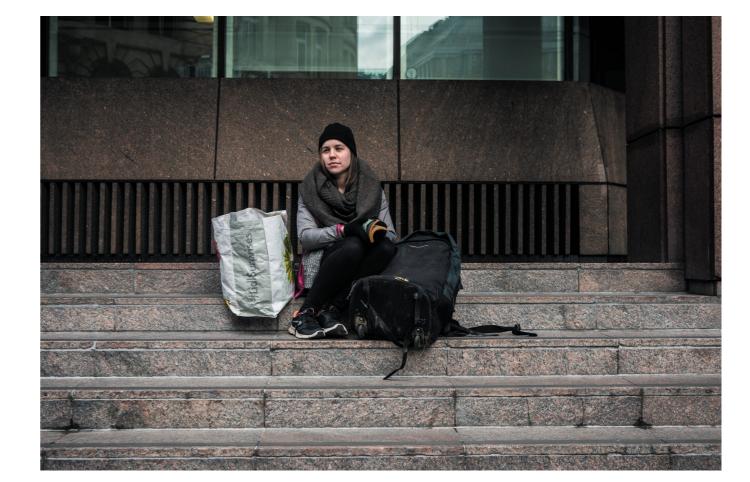# No Second Night Out

8.1 Defining the intervention

No Second Night Out (NSNO) aims to assist those new to rough sleeping by providing an offer that means they do not have to sleep rough for a second night. It began as a pilot project in London in 2011 and by 2014 all but two English local authorities had either committed to NSNO, or expressed a commitment to do so in the near future.[402] The principles of the model are:

- new rough sleepers should be identified and helped off the streets immediately so that they do not fall into a dangerous rough sleeping lifestyle.

- members of the public should be able to play an active role by reporting and referring people sleeping rough.

- rough sleepers should be helped to access a place of safety where their needs can be quickly assessed and they can receive advice on their options.

- rough sleepers should be able to access emergency accommodation

and other services, such as healthcare, if needed.

- if people have come from another area or country and find themselves sleeping rough, the aim should be to reconnect them back to their local community unless there is a good reason why they cannot return. There, they will be able to access housing and recovery services, and have support from family and friends.[403]

Homeless Link (who oversaw the initial funding allocations for NSNO) encourages local authorities to customise their approach to meet the needs of their specific client group.[404] Thus, NSNO can be delivered in a variety of ways – from consolidating existing services for rough sleepers,[405] to establishing specific programmes to help homeless people find work experience and employment opportunities.[406] Indeed, whilst NSNO is primarily aimed at new rough sleepers, some local areas have widened eligibility requirements to integrate help for entrenched rough

sleepers,[407] or established distinct new schemes for this group that they roll out alongside NSNO.[408]

NSNO typically operates through a mixture of Assertive Outreach (see Street Outreach chapter), a NSNO hub where staff can link individuals to accommodation and other support, and a telephone line by which members of the public and rough sleepers themselves can make a referral.[409] The aim is that no rough sleeper should spend more than 72

hours at a hub, but these are able to offer emergency accommodation along with washing facilities and food where necessary.[410] Those without a recognised connection to the local area may have their return home funded (see also Reconnection chapter).[411] NSNO is one of the only rough sleeper services in the UK that can help destitute migrants. This may be to re-establish a right to reside in the UK, assess whether an individual is entitled to welfare benefits, or make an offer of reconnection to their place

402   Homeless Link (2014) *No second night out across England*. London: Homeless Link.
403   Ibid.p.6
404   Ibid.
405   Ibid.
406   Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35791/.

407   Butler, D., Brown, P. and Scullion, L. (2014) *No Second Night Out: Derby City & Derbyshire. An evaluation for Riverside English Churches Housing Group* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35788/.
      Butler, D., Shannon, M. and Brown, P. (2015) *No second night out: Salford and gate buddies: an evaluation for riverside ECHG* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35789/.
408   Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35791/.
409   Homeless Link (2014) *No second night out across England*. London: Homeless Link.
410   Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report*. Broadway Homelessness and Support: London.
411   Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35791/.

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of origin.[412] In at least some locations, support is provided on a 'single service offer' basis, wherein refusal to comply with a specified plan (e.g. an offer of reconnection) renders a rough sleeper ineligible for support from all participating agencies in the area.[413]

8.2 The evidence base

The evidence base on NSNO is limited. It is based in England only and other than a few passing mentions in academic literature, comes entirely from grey sources which are primarily evaluations of the NSNO service in particular localities,[414] and one review of 20 projects across England.[415] These are based on administrative and survey data, as well as qualitative interviews.

As NSN0 is primarily concerned with helping individuals access accommodation, there is no robust evidence on how the approach affects physical and mental health, substance misuse, nor criminal offending and antisocial behaviour. Consequently, this review can only assess impacts on access to and retention of accommodation, and reflect on what is known about users' experience and quality of life whilst (and, where known, immediately after) using the service.

8.3 Outcomes

It should be noted that NSNO is not aiming at medium-term outcomes, and so all but one[416] report focuses on the short term.

Housing

Reports state that in London 86 per cent of new rough sleepers known to authorities were secured accommodation after the first night, and 78 per cent percent did not return to the street (in that locality, at least). There is no data available on longer-term housing outcomes. Across the rest of England, Homeless Link finds accommodation access and retention rates to be slightly lower, with 67 per cent securing accommodation after the first night and 78 per cent not returning to the street.[417]

Reports of local schemes suggest a high level of flexibility in the service is helpful in resolving complex accommodation needs, such as in Salford where they will find accommodation for individuals and their dogs.[418] Indeed for some, NSNO has helped them secure permanent accommodation from the outset.[419] There, service user interviews also consistently show high regard for the help and care they received and quick

responses after the referral.[420] More negative reports come from London where medium-term outcomes for service users suggest a much more mixed trajectory. There, some service users report their accommodation being removed at a later stage when the local authority reported to them that they are not deemed a to be in priority need (determined by local authorities to include families with children, 16 and 17-year-olds, pregnant women, care leavers aged 18 to 20, and other people classed as vulnerable based on a range of criteria), or choosing to sofa surf rather than stay in the temporary accommodation allocated to them.[421]

It is worth noting that NSNO has inspired development of a preventative programme which aims to reduce the number of people who sleep rough even for a single night. In London, an 18 month pilot entitled No First Night Out (NFNO) began in 2016. It uses the Local Authority Housing Options service to identify single people at imminent risk, and then refers them to the NFNO team to undertake intensive case work to prevent them rough sleeping. This includes mediating with accommodation providers, working on benefit claims, and providing access to emergency B&B accommodation, private rental access schemes and supported accommodation. Where appropriate, they are also referred to Crisis for learning opportunities. An

interim report of the first 3 months of operation suggests 9 people have been helped to access medium to long-term accommodation through the NFNO project – 6 having moved to private rental accommodation, and 3 into supported accommodation.[422]

Quality of life

Qualitative data from evaluations suggests that quality-of-life for those helped off the streets generally improved, with accommodation allowing some participants to return to education, recover from substance misuse, improve their relationships and enter employment and volunteering.[423] However, evaluations suggest that placing some individuals in temporary accommodation was difficult, particularly hostels where service users were either hesitant, or outright refused to enter an environment they saw as detrimental to their well-being.[424]

A review of medium-term outcomes for service users in London suggests that the use of substandard temporary accommodation for some impacted on the health and well-being of individuals. This included overly long stays in the NSNO hub emergency accommodation. It also states that some individuals were dissatisfied with the level of support they received, citing that greater help in finding employment and managing money and benefits would improve their

412 Petch, H., Perry, J. and Lukes, S. (2015) *How to improve support and services for destitute migrants*. cityofsanctuary.org (Query date: 2017-09-26). Available at: http://cityofsanctuary.org/wp-content/uploads/2015/02/how-to-improve-services-for-destitute-migrants.pdf.

413 Hough, J. and Jones, A. (2011) *No second night out: an evaluation of the first six months of the project*. London: Broadway, University of York and Crunch Consulting.

414 Butler, D., Brown, P. and Scullion, L. (2014) *No Second Night Out: Derby City & Derbyshire. An evaluation for Riverside English Churches Housing Group* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35788/.
Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report*. Broadway Homelessness and Support: London.
Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35791/.

415 Homeless Link (2014) *No second night out across England*. London: Homeless Link.

416 Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report*. Broadway Homelessness and Support: London.

417 Homeless Link (2014) *No second night out across England*. London: Homeless Link.

418 Butler, D., Shannon, M. and Brown, P. (2015) *No second night out: Salford and gate buddies: an evaluation for riverside ECHG* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35789/.

419 Butler, D., Brown, P. and Scullion, L. (2014) *No Second Night Out: Derby City & Derbyshire. An evaluation for Riverside English Churches Housing Group* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35788/.
Homeless Link (2014) *No second night out across England*. London: Homeless Link.

420 Butler, D., Brown, P. and Scullion, L. (2014) *No Second Night Out: Derby City & Derbyshire. An evaluation for Riverside English Churches Housing Group* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35788/.
Butler, D., Shannon, M. and Brown, P. (2015) *No second night out: Salford and gate buddies: an evaluation for riverside ECHG* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35789/.
Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35791/.

421 Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report*. Broadway Homelessness and Support: London.

422 Rice, B. (2016) *London Borough of Tower Hamlets, London Borough of Hackney & City of London No First Night Out – Help for Single Homeless People evaluation: interim summary report*. London: St Mungos.

423 Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report*. Broadway Homelessness and Support: London.

424 Butler, D., Brown, P. and Scullion, L. (2014) *No Second Night Out: Derby City & Derbyshire. An evaluation for Riverside English Churches Housing Group*. Available at: http://usir.salford.ac.uk/35788/.
Butler, D., Shannon, M. and Brown, P. (2015) *No second night out: Salford and gate buddies: an evaluation for riverside ECHG* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35789/.

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chances of not returning to the street.[425]

There is some evidence that NSNO workers were able to help individuals with more than housing needs, and help link some to health services they were not receiving before.[426] In fact, one initiative in greater Manchester reports promising signs that an associated work experience and employment scheme is benefiting the client base.[427]

Effectiveness for subpopulations
Across England, Homeless Link report that 17 per cent of clients were women, 20 per cent between ages 16 and 25, and the proportion of UK nationals was 75 per cent, with 20 per cent being from other European economic area countries and 5 per cent from outside Europe. In London the demographics of service users differed – they were more likely to be non-UK nationals and be male.[428] There is little evidence on how NSNO works for different subpopulations, but it is limited in what it can offer those without recourse to public funds. This can mean that destitute migrants who do receive some offer either accept an

offer of reconnection or return to the streets (see Reconnection chapter for exploration of the impacts of this).[429]

Service use and cost
There is no specific evidence on cost of the service.

8.4 Barriers to implementation
Time-limited funding has been a key barrier to lasting implementation of NSNO. The Homeless Transition Fund initially supported NSNO projects across England but when this funding ended some projects had to reduce their service offer, particularly in relation to temporary accommodation.[430]

The availability of temporary accommodation has also been a barrier to full implementation of the service, with agencies that have access to such accommodation not always linked up with the NSNO service, meaning that space exists but is not used effectively.[431] A further challenge has been the difficulty of securing permanent accommodation for people in receipt of housing benefit.[432] This crisis of both temporary and permanent accommodation availability

is most pronounced in London, where an evaluation of medium term impacts on service users highlights that a lack of accommodation means that increasingly, despite the remit of NSNO being wider than individuals in priority need, accommodation is still reserved for those groups.[433]

Another concern is that rough sleepers being referred to NSNO outreach workers sometimes wait long periods before being 'found', and may have to put themselves in particularly vulnerable positions to be observable. This, along with the difficulty that outreach workers may have in confirming an individual was rough sleeping renders the service less effective than intended.[434]

Local authorities have frequently identified problems with the eligibility criteria of NSNO, with many rough sleepers neither meeting the strict criteria of being new to the streets (and therefore qualifying for the service), nor having lived on the streets long enough to be considered entrenched and thereby qualifying for alternative programmes (e.g. Individualised Budgets or Housing First).[435] In practice, many NSNO programmes have found themselves supporting clients with a longer history of rough sleeping, and higher level of support needs, than had been anticipated.[436]

The survey participants in a Homeless Link report suggest that getting buy-in and agreement from all

partners involved in the scheme was the single biggest challenge in delivering NSNO.[437] A local example of Salford shows that a lack of a robust multiagency forum makes it difficult to deliver the holistic service that many providers feel is possible and necessary.[438] In Manchester such a forum exists.[439] In some areas, concerns have also been raised about the ethicality of single service offers and potential denial of key services to individuals with no local connection who refuse 'poor' offers of support (e.g. substandard emergency accommodation or poorly devised reconnection plan).[440]

8.5 Expert perspectives
NSNO is unique to the UK and not widely known, hence only one key informant provided a view on the intervention. The key informant felt there is sufficient evidence on the impacts of NSNO, largely in the form of individual project evaluations.

The informant was positive about the impacts of NSNO on achieving its goal of enabling new rough sleepers to get off the streets and into accommodation. They described how NSNO combines an important mix of actions, including: assertive outreach, the identification of options including reconnections, and where a solution cannot be found there is temporary accommodation available.

One interesting observation by the key informant was the very basic facilities

425   Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report.* Broadway Homelessness and Support: London.

426   Butler, D., Brown, P. and Scullion, L. (2014) *No Second Night Out: Derby City & Derbyshire. An evaluation for Riverside English Churches Housing Group* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35788/
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427   Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford. ac.uk/35791/.

428   Homeless Link (2014) *No second night out across England.* London: Homeless Link.

429   Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report.* Broadway Homelessness and Support: London.
Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford. ac.uk/35791/.

430   Butler, D., Shannon, M. and Brown, P. (2015) *No second night out: Salford and gate buddies: an evaluation for riverside ECHG* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35789/.

431   Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford. ac.uk/35791/.

432   Butler, D., Shannon, M. and Brown, P. (2015) *No second night out: Salford and gate buddies: an evaluation for riverside ECHG* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35789/.

433   Jones, J., Hough, J. and Broadway Homelessness and Support (2013) *No Second Night Out: A study of medium term outcomes Summary report.* Broadway Homelessness and Support: London.

434   Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford. ac.uk/35791/.

435   Ibid

436   Hough, J. and Jones, A. (2011) *No second night out: an evaluation of the first six months of the project.* London: Broadway, University of York and Crunch Consulting.

437   Ibid

438   Butler, D., Shannon, M. and Brown, P. (2015) *No second night out: Salford and gate buddies: an evaluation for riverside ECHG* Salford: University of Salford. Available at: http://usir.salford.ac.uk/35789/.

439   Turley, H., Scullion, L. and Brown, P. (2014) *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside* Salford: University of Salford. Available at: http://usir.salford. ac.uk/35791/.

440   Johnsen, S., Watts, B. and Fitzpatrick, S. (2016) *First Wave Findings: Homelessness.* Welfare Conditionality Study Briefing Paper. York: University of York. Available at: https://researchportal.hw.ac. uk/en/publications/first-wave-findings-homelessness

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offered within the NSNO building. They explained how the service makes the setting uncomfortable by adopting a 'sitting up' service approach. The stand-out characteristic of the approach is perceived to be the speed of assistance, including early identification on the streets and then a very swift solution, sometimes within hours.

The key informant did not identify the weaknesses and concerns raised in the literature review, however they did critique the timing of the intervention, suggesting that the service could act earlier to prevent rough sleeping. They explained that No First Night Out is now being implemented in some areas – this approach adopts the principles of No Second Night Out and embeds them within housing options departments for people who are presenting as at risk of homelessness.

8.6 Summary
- Currently operating in England only, NSNO aims to assist those new to rough sleeping by providing an offer that means they do not have to sleep rough for a second night. There is widespread variation in the way NSNO principles are practiced, but it typically consists of some combination of assertive outreach, public engagement, support to access temporary accommodation and/or reconnection. Service users' needs are assessed in NSNO 'hubs'.

- The evidence base on NSNO is limited, consisting of small-scale evaluations of NSNO services in particular localities, together with a broader review of 20 projects. With one notable exception, these focus primarily on short-term housing outcomes and draw on interview, administrative and survey data.

- NSNO is effective in quickly finding the vast majority of service users temporary accommodation, with only a minority recorded as returning

to the streets in the short term (in that locality, at least).

- Some service users have praised the treatment received and report benefiting from the support offered. Others, however, have been dissatisfied with the type and level of support received, refused offers of what they regarded as substandard accommodation, declined offers of reconnection, and/or returned to rough sleeping or sofa surfing.

- Limited availability of housing can undermine the effectiveness of NSNO, with accommodation shortages being particularly acute in London and contributing to overly long hub stays. Long waits for rough sleepers to be 'found' and have their status confirmed by outreach workers also restrict its effectiveness in some contexts. Further to this, time-limited funding has been a key barrier to lasting implementation.

- Service providers recognise that, in practice, a wider client group than first time rough sleepers needs to be addressed. There is limited evidence of how NSNO works for different subgroups. More research in this area would be helpful.

- Only one key informant offered a view on NSNO. They were positive about the model and its success rate in supporting new rough sleepers to get off the streets and into accommodation. The stand-out characteristic of the approach is perceived to be the speed of assistance.

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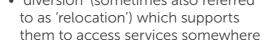# Reconnection

9.1 Defining the intervention

Reconnection essentially involves returning rough sleepers to their 'home' area. Some reconnections are 'international' in that they involve repatriating immigrants to their country of origin; others 'domestic' in that they relocate rough sleepers within their home country from somewhere they have no local connection to an area where they do have established connections. For the purposes of clarity, in this chapter the area within which a rough sleeper is targeted for reconnection (that is, the place they are reconnected *from*) is referred to as an 'identifying' area; the place they are reconnected to is referred to the 'recipient' area.

Reconnection policies are generally underpinned by aspirations to: prioritise the needs of 'local' rough sleepers in the context of restricted resources; force source areas to take responsibility for 'their' rough sleepers; reduce the potential for rough sleepers to become involved in damaging street lifestyles; and improve outcomes for homeless people by supporting them to move to areas where they are assumed to have access to informal social support and/or formal support services.[441]

Whilst there has been no assessment of the scale of its use internationally, reconnection is widely used in the UK (England especially)[442] and there are reports of it being employed in a number of cities elsewhere in Europe. [443] Domestic reconnections (from one urban centre to another) comprise the majority of reconnections from some areas in the UK, but in London these are outnumbered by international reconnections (involving moves abroad).[444] The policy emphasis on reconnection escalated rapidly after the inception and nationwide rollout of No Second Night Out principles in England.[445]

In the UK, reconnection is defined in policy as 'the process by which people sleeping rough who have a connection to another area … are supported to return to this area in a planned way'.[446] In practice, however, it is an umbrella term used to refer to a wide range of approaches including:

- 'reconnection (proper)' which supports rough sleepers to return to somewhere they have an established link;

- 'diversion' (sometimes also referred to as 'relocation') which supports them to access services somewhere else where they do not have a connection; and

- 'deflection' wherein they are advised to return 'home' but are not provided with support to do so.[447]

The balance of these approaches varies at the local level, as does the intensity of support provided. The provision of support does in fact range from intensive assessment of needs and brokering of support in the recipient area at one extreme, to virtually nothing (aside from the provision of a travel ticket) at the other.[448] It has been noted that levels of support are often greater in the lead-up to international reconnections than is true of domestic ones, albeit that there is rarely much if anything

in the way of follow-up after an individual's return to their home country.[449] In many cases, rough sleepers are denied access to local authority funded services (e.g. hostels and day centres) if they fail to comply with a reconnection offer (which is sometimes presented as a 'single service offer').[450]

9.2 The evidence base

Evidence regarding reconnection outcomes is, at present, extremely weak. Only one evaluation was identified in the review, and this focused on domestic reconnections (from one urban centre to another) within the UK only, albeit that it makes reference to (limited) data on international reconnections where this was available.[451] The study involved

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441 Johnsen, S. and Jones, A. (2015) The reconnection of rough sleepers within the UK: an evaluation. London: Crisis.
442 Ibid
443 Mostowska, M. (2015) Institutionalisation and deformalisation: reorganising access to service provision for homeless EU migrants, European Journal of Homelessness, 9(2): 113-136.
   Minas, R. and Enrith, N. (no date) Vulnerable EU Citizens – local solutions and strategies in European cities. Stockholm: Stockholm University.
444 Johnsen, S. and Jones, A. (2015) The reconnection of rough sleepers within the UK: an evaluation. London: Crisis.
445 ibid
446 Homeless Link (2014) Assessment and Reconnection Toolkit: good practice guidance for homelessness services. London: Homeless link.

447 Johnsen, S. and Jones, A. (2015) The reconnection of rough sleepers within the UK: an evaluation. London: Crisis.
448 Ibid
449 Ibid
450 Ibid
451 Ibid

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in-depth analysis of reconnection practices and experiences in four case study areas in England, and drew upon relevant statistics, interviews and focus groups with local key informants, frontline support providers, and rough sleepers targeted for or with experience of reconnection.

That study noted that outcomes are recorded for only a very small minority of people whom are reconnected, if at all. Resource constraints dictate that only a small minority of any reconnected individuals are 'checked up on' after the move. In fact, the most comprehensive source of data cited in the report (from CHAIN, in London), indicates that no outcome information was recorded for 89 per cent of domestic reconnections (from London to another area within the UK) between April 2011 and December 2013. More effort appears to be invested in recording outcomes for people reconnected abroad immediately after their departure, but even then this is restricted to recording whether the reconnection was 'confirmed', that is, the rough sleeper actually arrived in the destination area (true in 56 per cent of cases over the same timeframe). As a consequence, very little is known about the impacts of reconnection on rough sleepers' housing, health and other circumstances in either the short- or long-term.[452]

9.3 Outcomes
All of the evidence on outcomes referred to below is drawn from the study of domestic reconnections of rough sleepers within the UK referred to above.[453] Given the limited evidence available, this is restricted to an overview of impacts on housing and quality of life.

Housing
Whilst it was not possible to quantify precisely what proportion

of reconnected rough sleepers experience specific outcomes, the study suggested that rough sleepers tended to follow one of four general response trajectories, in that they either: i) comply with the reconnection offer, move to and remain in the recipient area; ii) comply with the reconnection offer and move to the recipient area but subsequently return to the identifying area; iii) refuse the reconnection offer and remain street homeless in the identifying area; or iv) refuse to be reconnected and make accommodation arrangements independently (e.g. sofa surf).

A number of reconnected individuals did sleep rough in the recipient area, even if only for a short time, given the inadequacy or unpalatability of services they were referred to. Further to this, the ability of those whom made alternative arrangements was, inevitably, contingent on them having the capabilities, confidence and/or contacts (e.g. family) to do so. Also notably, all of the individuals who were 'diverted' (see above) questioned the logic underpinning the intervention, and whilst their immediate accommodation needs were met, they remained ineligible for settled accommodation given their lack of local connection in the recipient area.

Quality of life
Individuals reconnected to another urban area within the UK generally reported being confused, upset and/or angry at the prospect of reconnection, in part due to lack of clarity regarding local connection assessment criteria, but most commonly because of the primacy accorded to last place of settled residence and comparative lack of recognition given to the presence of family in local connection assessments. Levels of anger and anxiety were most acute amongst those who believed they would be at risk of harm if they returned but had no

formal (police) evidence because they had not reported violence or threats thereof in the recipient area. There is at present no published evidence regarding the perceptions and experiences of people reconnected overseas.

Rough sleepers tend to interpret reconnections as an attempt on the part of local authorities to avoid taking responsibility for vulnerable individuals. This has had the unintended negative consequence of strengthening the resolve of many to 'fight the system' by refusing to engage with the reconnection process. That said, rough sleepers generally agreed that reconnection was justifiable in situations where rough sleepers had abandoned legitimate connections (e.g. positive family support and/ or services in their home area), were returning voluntarily, were not at risk of harm should they return, and were provided with sufficient support before, during and after the reconnection process. They universally and resolutely believed that no-one should be forced to return to an area where they felt that they would be at risk of physical or psychological harm, however.

Effectiveness for subpopulations
The existing evidence indicates that the demographic profile of rough sleepers affected by reconnection in the UK tend to reflect that of the rough sleeping population as a whole[454] and it seems that this may be true elsewhere in Europe with regard to gender at least.[455] The UK evaluation referred to above does not refer to impacts on particular demographic groups, but does indicate that reconnections are most likely to be effective when targeted rough sleepers are newly homeless or recent arrivals

to the identifying area (i.e. where they are first contacted on the street), have a (recent) history of service use in the recipient (i.e. destination) area, and/ or have 'meaningful' connections in the recipient area. Conversely, reconnection appears least likely to work when: rough sleepers are resistant to the idea of returning; targeted individuals have a long history of homelessness; and/or recipient areas are geographically very distant from identifying areas. Unsurprisingly, the provision of sufficiently intensive and tailored support is a critical ingredient in any successful reconnection; this often involves spending significant amounts of time brokering support in the recipient area.[456]

9.4 Barriers to implementation
Three main sources of barriers to reconnection have been identified.[457] First, a number of challenges are associated with recipient local authorities, particularly their reticence to recognise and accept responsibility for rough sleepers who are deemed to have legitimate local connections to the area and/or failure to provide adequate services for homeless people more generally. Second, reconnection policies are reportedly undermined by other service providers who object to the approach in principle and/or are not signed up to associated protocol. Here, criticism is most commonly targeted at non-interventionist (and often faith-based) soup runs, night shelters and/or open-door day centres who continue to offer rough sleepers support even if reconnection had been presented as a single service offer and refused. Third, resistance on the part of rough sleepers themselves is highlighted as a major challenge. This is often said to be borne of unrealistic expectations or misinformation,

452 Ibid
453 Ibid

454 Ibid
455 Mostowska, M. and Sheridan, S. (2016) Migrant women and homelessness, in Maycock, P. and Bretheron, J. (eds) Women's Homelessness in Europe. London: Palgrave Macmillan, pp.235-263.
456 Johnsen, S. and Jones, A. (2015) The reconnection of rough sleepers within the UK: an evaluation. London: Crisis.
457 Ibid

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negative experiences of services in the recipient area, and/or fear that they will be at risk of harm if they return.

There is widespread agreement that reconnection is appropriate in some circumstances, most notably where rough sleepers have made an unplanned move to an identifying area and abandoned 'live' connections or services in that area. The limits and risks associated with reconnection raise significant ethical questions, however, especially as regards: denial of services to rough sleepers with no recognised local connection; uncertainty regarding the legitimacy and/or severity of risk to rough sleepers in recipient areas (especially when no proof in the form of police records exist); inadequate service responses in some recipient areas; and the fragility or lack of rough sleepers' support networks in recipient areas. These ethical dilemmas are most acute when reconnection is employed as a 'single service offer'.[458]

9.5 Expert perspectives
Four key informants provided perspectives on the reconnection approach and they generally agreed with the conclusions of the literature review that the evidence base is weak.

Key informants recognised that reconnections can be both domestic and international. Views on domestic reconnections were mostly negative. Key informants highlighted two key issues. First, there is potential for people to be returned to an area in which they have very little support, resources or access to services. This concern echoes findings from the literature review. Second, informants questioned the motivations behind the intervention, particularly whether is it intended to benefit the local authority, reducing costs that may incur, or is it really in the best interests of the individual. One interviewee went on to suggest that single offer reconnection

services may be in conflict with a Human Rights based approach.

The position on international reconnections was more ambiguous. Key informants were more persuaded by the value of reconnections with individuals who would otherwise have no entitlement to public services or assistance in the UK. However, concerns remained about the potential quality of life a person may face on return to their country of origin. There was no clear consensus as to whether international reconnections should be promoted.

9.6 Summary
• Reconnection involves returning rough sleepers to their 'home' area. Some reconnections are 'international' in that they involve repatriating immigrants to their country of origin; others 'domestic' in that they relocate rough sleepers from somewhere they have no local connection to an area where they do have established connections within their home country. The level and nature of support involved with reconnections varies dramatically – from intensive assessment of needs and brokering of support in the recipient area at one extreme, to virtually nothing at the other.

• The escalation of reconnection in the UK, and England especially, has occurred in the absence of robust evidence regarding its effectiveness. Evidence regarding the impacts of reconnection is, at present, extremely weak – in large part because outcomes are recorded in only a very small minority of cases, and even then this is typically only to confirm that the individual involved has arrived in the destination area.

• The evidence which does exist (which is limited to a single study of reconnections within the UK) indicates that outcomes for

rough sleepers vary dramatically. Some do access housing and re-engage with support services in the recipient area, but others sleep rough in the recipient area, return to the identifying area, or refuse the reconnection offer entirely. Most targeted individuals describe the process as distressing and bewildering, especially if they have no meaningful connection or believe they will be at risk of harm in the recipient area.

• Reconnections are most likely to be effective when targeted rough sleepers are newly homeless or recent arrivals to the identifying area (i.e. where they are first contacted on the street), have a (recent) history of service use in the recipient area (i.e. where they are reconnected to), and/or have 'meaningful' connections in the recipient area. Conversely, reconnection appears least likely to work when: rough sleepers are resistant to the idea of returning; targeted individuals have a long history of homelessness; and/or recipient areas are geographically very distant from identifying areas. The provision of sufficiently intensive and tailored support is a critical ingredient in any successful reconnection.

• Barriers to implementation include: reticence or inability on the part of recipient areas to provide adequate services for reconnected rough sleepers; the actions of non-interventionist support agencies which are said to undermine reconnection policies; and resistance on the part of rough sleepers themselves which is often borne out of unrealistic expectations or misinformation, negative experiences of services in the recipient area, and/or fear that they will be at risk of harm if they return.

• Whilst there is widespread consensus that reconnection is appropriate in some cases – notably where rough sleepers have made an unplanned move and abandoned 'live' connections or services in their 'home' area – the limits and risks associated with reconnection raise important ethical questions. These include: denial of services to rough sleepers with no recognised local connection; uncertainty regarding the legitimacy and/or severity of risk to rough sleepers in recipient areas; inadequate service responses in some recipient areas; and the fragility or lack of support networks in recipient areas. These dilemmas are most acute when reconnection is employed as a 'single service offer'.

• Key informants were critical of the current reconnection model in the UK. There was no recognition of the positive experiences documented in the literature review, instead they highlighted concerns about the lack of support available in the receiving area and the lack of a focus on what is best for the individual. Informants were particularly negative about reconnections within the UK, whereas perspectives on international reconnections were mixed – largely because those who remain in the UK would have no recourse to public assistance.

458 Ibid

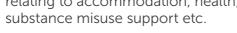# Personalised Budgets

10.1 Defining the intervention

Personalised Budgets aim to support entrenched, long-term rough sleepers to move off the streets and into accommodation.[459] Brown[460] describes the 'model participant' as someone for whom all other attempts to help secure stable accommodation have failed. In very broad terms, the intervention works by ensuring entrenched rough sleepers are assisted by a named support worker who has access to a budget (usually between £2,000[461]-£3,000[462]) to be spent very flexibly (ie. on a vast range of possible items) in order to help the individual secure and maintain accommodation.

Fundamental to the approach is the notion of choice and control – rough sleepers are encouraged to identify their own needs and to take action with ongoing support from a single support worker.[463] Together, individuals and their support workers must develop a support plan and the support worker connects the individual with a range of existing services

relating to accommodation, health, substance misuse support etc.

Individual budgets have been spent on items as varied as:[464]

- a caravan and pitch licence for an authorised travellers' site

- clothing to help with self-esteem

- college courses and pre-tenancy training

- mobile phones in order to stay in touch with workers

- travel to help reconnect with family

- furniture and televisions to personalise homes

- laptops and cameras to pursue meaningful occupation

- food and utilities when benefits were suspended.

To date, Personalised Budgets have only been implemented with homeless people in the UK, particularly in England and Wales. In 2008, the DCLG published its rough sleeping strategy document: *No One Left Out: communities ending rough sleeping*, which committed to pilot personalised support to long-term rough sleepers. Consequently, in 2009 four pilot projects were funded in London, Nottingham, Northampton, and Exeter/Devon.[465] The London pilot project was subsequently extended beyond the pilot period. In 2011 the Welsh Local Government Association Homelessness Network funded five Personal Budget pilot projects in Cardiff, Newport, Swansea, Bridgend and Anglesey/Gwynedd.[466] All studies
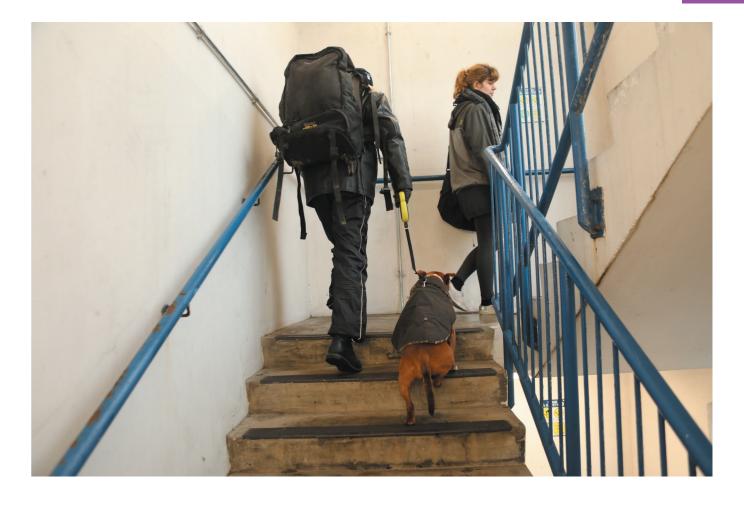
reviewed here relate to either the London or Welsh pilot projects.

It is important to recognise that the interventions in London and Wales appear to have targeted slightly different groups. In England, only one participant in the project was identified as having a substance misuse issue and, as we document later, this individual proved to be difficult to accommodate.[467] By contrast, in Wales the participants were described as experiencing multiple exclusion, having very often spent periods in prison, were very heavy alcohol drinkers and significant drug users.[468]

459 Blackender, L. and Prestige, J. (2014) Pan London personalised budgets for rough sleepers, *Journal of Integrated Care*, 22(1): 23-26

460 Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)

461 Brown, P. (2013) Right time, right place? An evaluation of the Individual Budget approach to tackling rough sleeping in Wales, Cardiff: Welsh Government

462 Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway

463 Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)

464 Blackender, L. and Prestige, J. (2014) Pan London personalised budgets for rough sleepers, *Journal of Integrated Care*, 22(1): 23-26

465 Ibid.

466 Brown, P. (2013) Right time, right place? An evaluation of the Individual Budget approach to tackling rough sleeping in Wales, Cardiff: Welsh Government

467 Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway

468 Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)

10.2 The evidence base

There are relatively few studies of Personalised Budget interventions with homeless people. However, the few available studies do provide useful insights into the housing impacts of a small number of pilot projects in England (particularly London) and Wales. The studies tend to use a combination of administrative data analysis and qualitative interviews with service providers and service users. Beyond the limited quantity of studies, there are two key limitations of the available data. First, whilst data on housing impacts are fairly good, data on other areas such as health and substance misuse are much weaker and never quantified. Second, the evidence base lacks longitudinal research – no studies have examined impacts beyond 18 months from the start of service provision. As Brown[469] states; 'long-term successes are, at this point, impossible to ascertain.'

10.3 Outcomes

Housing

The London pilot project attempted to work with 15 entrenched rough sleepers and after 18 months, 13 of 15 had accepted and engaged with the personal budget.[470] The project evaluation concluded that 7 of 15 people had been in accommodation between four and 11 months and an additional two people were making firm plans to do likewise.[471] Hence, the housing success rate is approximately 45-60 per cent. It is worth noting that in the London pilot 4 of the 15 people assisted had moved into accommodation but 3 subsequently returned to the street and another went to prison.[472]

In the extension of the London pilot project 37 individuals were offered personalised budgets and slightly worse housing outcomes were achieved. Sadly, two participants died shortly after being offered support but 14 of the entrenched rough sleepers maintained their accommodation for between 3 and 18 months, with a further three individuals awaiting accommodation. Hence, the success rate was approximately 40-50 per cent. The types of accommodation accessed in both the pilot and the extension projects included: local authority housing, supported accommodation, a caravan on a traveller's site, and Bed and Breakfast accommodation.[473]

Across the projects in Wales a total of 79 people were engaged and Brown[474] estimates that at least 33 people (42 per cent) were in 'stable' accommodation, which he defines as: living in some form of low support accommodation, living with a partner or supported by their family, living in their own accommodation with no or little support etc. Brown concludes that a further 40 per cent of project participants were accommodated in temporary accommodation, which tentatively suggests fewer remain on the streets than was true of the English experience.

Wider outcomes

The focus of the quantitative evidence on Personalised Budgets is on housing outcomes. However, there is important qualitative data which points towards wider impacts. This brief section summarises the evidence.

Health: All studies commented on the positive impacts of Personalised Budgets interventions on physical and mental health.[475] [476] Moreover, it is claimed in the Welsh projects that individuals subsequently engaged more appropriately with health and support services. These conclusions are reached solely on qualitative data – no studies sought to quantify these improvements.

Substance misuse: All studies concluded that Personalised Budgets reduced substance misuse[477] [478] by service users. However, these conclusions are again reached solely on qualitative data.

Quality of life and social integration: Studies of the London and Welsh pilot projects made firm conclusions about the non-tangible impacts of the Personalised Budget interventions.[479] [480] First, individuals developed more positive social networks, shifting away from those based around substance and alcohol use, and instead often reconnecting with family. Second, individuals experienced improved self-esteem and self-confidence, with many talking positively about their lives and making plans for the future. Third, people developed an increased ability to engage in personal care.

Employment and social welfare: The London pilot project led to 5 of 15 individuals starting new welfare benefit claims for the first time in many years and four of these were maintained.[481] [482]

Engagement with other services: Both the London[483] and the Wales[484] studies claim that individuals were linked with other support services and agencies and they had developed greater trust of these services than before. However, no study had sought to quantify the extent of the engagements with other services.

Effectiveness for subpopulations

Personalised Budgets have only been trialled with a relatively small sample of rough sleepers, all of whom were entrenched in their street lives. Given the profile of rough sleepers assisted and the relatively small sample size, there has been no analysis of whether the approach is more or less effective with particular subpopulations. Within the studies of Personalised Budgets the only concern raised was the limited effectiveness of the approach with rough sleepers facing substance misuse issues in the London pilot study.[485] However, substance misuse was a common issue for participants in the Welsh projects, hence it can be effective with this group. Significantly, Hough and Rice[486] raise the question as to whether the approach might

469   Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)

470   Blackender, L. and Prestige, J. (2014) Pan London personalised budgets for rough sleepers, *Journal of Integrated Care*, 22(1): 23-26

471   Ibid.

472   Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway

473   Blackender, L. and Prestige, J. (2014) Pan London personalised budgets for rough sleepers, *Journal of Integrated Care*, 22(1): 23-26

474   Brown, P. (2013) Right time, right place? An evaluation of the Individual Budget approach to tackling rough sleeping in Wales, Cardiff: Welsh Government

475   Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway

476   Brown, P. (2013) Right time, right place? An evaluation of the Individual Budget approach to tackling rough sleeping in Wales, Cardiff: Welsh Government

477   Ibid.

478   Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway

479   Ibid

480   Brown, P. (2013) Right time, right place? An evaluation of the Individual Budget approach to tackling rough sleeping in Wales, Cardiff: Welsh Government

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484   Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)

485   Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway

486   Ibid.

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be effective with the wider homeless population but this is yet to be piloted or researched.

Service use and costs
Fairly good data is available on the cost of Personalised Budgets. In the London pilot project there was a budget of £3,000 per person and in Wales the budget was £2,000 per person, excluding any costs of the support worker delivering the Personalised Budgets programme. Evaluations found only £794 was spent per person in London, albeit additional expenditure was anticipated within some support plans. The average individual budget spent in Wales was £434, significantly lower than the amount spent in England and well below the sum available.

In addition to the personal budget, the main cost of the intervention is staff time. When staff time and expenditure per person are combined the total cost per individual in England was £4,437. Hough and Rice[487] identify that this is approximately £1,300 greater than the cost of delivering standard outreach provision. In Wales, the projects were staffed by workers in existing support posts, who merged their work on the project with their existing caseloads.[488] Therefore, staff costs were not recorded.

Qualitative data across the different studies suggest that there are wider cost impacts.[489] [490] Personalised Budgets interventions reportedly increase initial costs to the public purse in two main ways: first, more benefit claims are made and second, there is higher initial engagement with other services (e.g. health). However, interviewees in the studies suggest there are likely to be longer term cost savings as a result of reductions in: engagement with outreach services, contact with police and the wider criminal justice system, and hospital admissions. To date, there has been no cost analysis of either short or longer-term cost impacts.

10.4 Barriers to implementation
The evidence base on Personalised Budgets makes few references to the barriers or challenges to implementation. However, five broad issues are identifiable. First, many support workers were unsure of what individual budgets could and should be spent on.[491] They require guidance and support in addressing these uncertainties in order to ensure they are used to achieve their full potential impact. To some extent, the learning from the London and Wales pilot projects will have reduced these uncertainties for commissioners and support workers. The second issue also relates to the spending of budgets. It appears important to minimise bureaucracy,[492] allowing immediate access to individual budget funds and autonomy for the support workers.

The third challenge is to rethink the workload and working practices of support workers.[493] The studies found that staff spent more time with Personalised Budget service users when compared to other service users – sometimes as much as 30-40 per cent more time per individual. Yet, workloads were not adjusted to reflect this reality. Fourth, Personalised Budgets interventions are reliant on strong collaborative working with other services and accommodation providers.[494] Without access to accommodation and other specialist support the approach cannot succeed.

Finally, the evaluations of Personalised Budgets in London and Wales concluded that they could only be replicated and expanded across England and Wales if additional funding was made available. To date it seems this has not been the case.

10.5 Expert perspectives
Two key informants offered perspectives on personalised budgets and both explained that the model was in its infancy in the homelessness sector, albeit it has been implemented more widely in the care field. Key informants explained there is a shortage of evidence on the outcomes of this model.

Informants generally agreed with the findings of the literature review and were not able to add a significant amount to the debate. Key informants suggested that Personalised Budgets enabled support workers to meet the needs of individuals that often fall outside of the typical range of provision and assistance. Examples were given of budgets being used to buy clothes for an individual who was recovering from mental illness and also for a veteran to visit their hometown and gain some closure from trauma they had experienced. Key informants were very positive about the person-centred approach which underpins Personalised Budgets as it enables people to overcome barriers that most professionals are unaware of or do not understand.

Key informants were supportive of wider development of Personalised Budgets, suggesting that they work best when they sit alongside housing-led solutions such as Housing First.

10.6 Summary
- Personalised Budgets have been used to support entrenched rough sleepers. Support workers have access to a budget for each rough sleeper (£2,000-£3,000) which they can spend on a wide variety of items (from a caravan to clothing) in order to help secure and maintain accommodation. Importantly, rough sleepers identify their own needs and help to shape their own support plan.

- Personalised Budgets have only been implemented with homeless people in the UK and the evidence base is limited to a relatively small number of pilot project evaluations. Studies use administrative data analysis and qualitative interviews with service providers and service users.

- Housing outcomes are fairly well documented, with pilot projects generally securing and maintaining accommodation in around 40-60 per cent of cases, although this is potentially higher in Wales with most at least sourcing temporary accommodation. Significantly, the suitability of accommodation is determined by the rough sleeper, so housing outcomes are difficult to compare.

- Evidence of wider impacts is limited but qualitative data suggest many positive impacts beyond housing, including: health improvements and more appropriate access to healthcare, reductions in substance misuse, re-establishing positive social networks, improved self-esteem,

487   Ibid.
488   Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)
489   Ibid.
490   Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway
491   Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)
492   Brown, P. (2013) Right time, right place? An evaluation of the Individual Budget approach to tackling rough sleeping in Wales, Cardiff: Welsh Government
493   Brown, P. (2016) Right time, right place? The experiences of rough sleepers and practitioners in the receipt and delivery of personalised budgets. In M. Fenger, J. Hudson and C. Needham (Eds.). *Social Policy Review 28, Policy Press* (pp. 191-210)

494   Hough, J. and Rice, B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot, York: JRF/Broadway

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increases in social welfare claims, and improved engagement with other services and agencies.

- There has been no analysis of whether the approach is more or less effective with particular subpopulations and the approach is yet to be trialed with the wider homeless population.

- Budgets available to individuals are between £2,000–£3,000, however the average budget spent on each individual (excluding costs of the support worker) was £794 in London and £434 in Wales. When staff time was included in the London pilot project, the total cost per individual was £4,437 - around £1,300 more than the cost of delivering standard outreach provision. Qualitative data suggests projects may increase initial costs to the public purse, however in the longer term there are likely to be cost reductions.

- Five barriers to implementation were identified: i] uncertainty about what individual budgets can and should be spent on; ii] bureaucracy surrounding budget payments needs to be reduced, allowing swift access to budgets; iii] the increased workload for support workers relative to standard outreach provision needs to be recognised; iv] without access to accommodation and other specialist support the approach cannot succeed; v] replication and expansion will only be possible if additional funding is made available.

- Key informants highlighted that Personalised Budgets are in their infancy in the homelessness field and they agreed that the evidence base is relatively weak. Despite the limited evidence base, key informants were supportive of this person-centred approach and advocated wider implementation alongside housing-led solutions such as Housing First.

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Street outreach **100**

Street outreach

11.1 Defining the intervention

Street outreach is an important component of many rough sleeper interventions (e.g. Housing First, Personalised Budgets etc.) and has therefore been discussed in several other chapters. However, street outreach has also received specific consideration within the literature, with studies focusing on defining the characteristics that make street outreach most effective at ending rough sleeping. This chapter particularly focuses on assertive street outreach as it is this form which lies at the heart of many other interventions and other forms of outreach are often not considered to be housing-focused interventions.

In very broad terms, street outreach is the delivery of services on the street, rather than requiring homeless people to attend a designated service centre.[495] The definition of assertive outreach is far more specific and it is often defined in relation to more generic street outreach. Assertive outreach is generally defined by three distinctive facets:

1. **The primary aim is to end homelessness**
   'Traditional' outreach programmes offer a huge range of services, from food provision to substance misuse support, but these services rarely have the primary objective of ending homelessness. Assertive outreach makes this the main priority and is therefore meant to have access to housing resources into which homeless people can be referred.[496]

2. **Multi-disciplinary support**
   Assertive outreach adopts an integrated approach to support, drawing upon a multi-disciplinary team, including health professionals, substance misuse workers, housing offers etc.[497]

3. **Persistent, purposeful, assertive**
   One of the key differences between assertive and traditional forms of street outreach is that assertive approaches involve persistently attempting to engage with people sleeping rough[498]. This marked a significant switch from what Randall

and Brown[499] termed a 'social work' approach, which sought to meet a wide range of needs on the street, to a more interventionist stance aimed at a very specific and limited goal of moving the client into accommodation.[500]

The target group of most assertive outreach programmes is chronically street homeless people.[501] For example, in Canada's Streets to Home programme, which includes an assertive outreach component, programme participants are expected to have failed to engage with less resource intensive programmes and have either severe substance misuse issues, a personality disorder, or untreated medical needs.[502]

Assertive outreach is used widely, with notable implementation and development in the UK, Australia, Canada, and the USA. Assertive Outreach arguably developed in its current form as part of the Rough Sleepers Initiative (RSI) in England during the early 1990s. RSI programmes included outreach

495   Phillips, R., Parsell, C., Seage, N. and Memmott, P. (2011) Assertive Outreach, AHURI Positioning Paper No. 136, AHURI
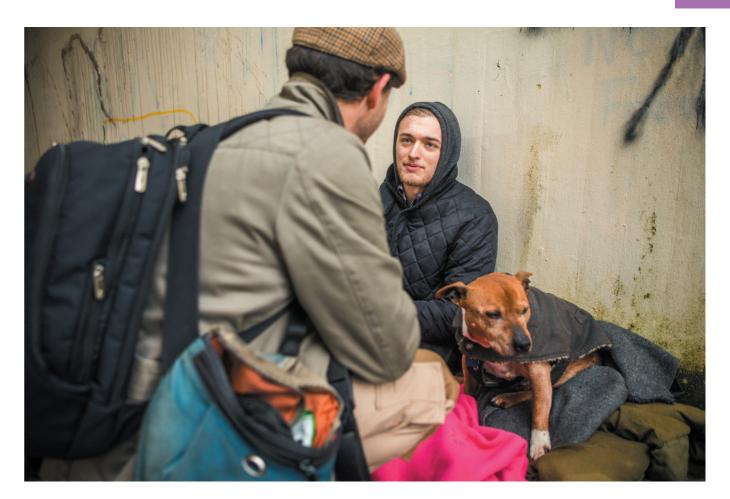496   Ibid.
      Coleman, A., MacKenzie, D. and Churchill, B. (2013) The role of outreach: responding to primary homelessness, Commonwealth of Australia
      Parsell, C., Tomaszewski, W. and Phillips, R. (2014) Exiting unsheltered homelessness and sustaining housing: a human agency perspective, *Social Science Review*, 88(2): 295-321
      Wilson, W. (2015) Rough Sleepers Initiative (RSI) 1990-1999, Commons Briefing papers SN07121.
      Phillips R. and Parsell C. (2012) The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No.179. Melbourne: Australian Housing and Urban Research Institute
497   Ibid.
498   Phillips, R., Parsell, C., Seage, N. and Memmott, P. (2011) Assertive Outreach, AHURI Positioning Paper

No. 136, AHURI
499   Randall, G. and Brown, S. (2002) Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate, London: ODPM
500   Coleman, A., MacKenzie, D. and Churchill, B. (2013) The role of outreach: responding to primary homelessness, Commonwealth of Australia
      Parsell, C., Tomaszewski, W. and Phillips, R. (2014) Exiting unsheltered homelessness and sustaining housing: a human agency perspective, *Social Science Review*, 88(2): 295-321
      Randall, G. and Brown, S. (2002) Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate, London: ODPM
501   Phillips R. and Parsell C. (2012) The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No.179. Melbourne: Australian Housing and Urban Research Institute
      Leopald, J. (2014) Innovations in NYC Health & Human Services Policy: Street homelessness and supportive housing, Urban Institute
502   Stergiopoulos, V., Dewa, C.S., Tanner, G., Chau, N., Pett, M. and Lyn Connelly, J. (2010) Addressing the Needs of the Street Homeless, *International Journal of Mental Health*, 39(1): 3-15

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work with homeless people, the development of new emergency hostel places and a range of temporary and permanent accommodation. The RSI aimed to make it unnecessary for people to sleep rough[503] and included targets for reductions in rough sleeper numbers.[504] In Australia, like Canada[505] and the USA,[506] assertive outreach was introduced alongside Housing First. Street to Home is the most prominent programme and has been introduced in several Australian states and territories since 2008. The programme is modeled on the RSI but links rough sleepers into permanent accommodation.[507]

In some contexts, including a number of cities in England and Wales, enforcement is used alongside assertive outreach in attempts to combat rough sleeping and/or activities associated with 'problematic street culture' such as begging and street drinking.[508] Enforcement measures used by local authorities in England, in different combinations and with varying degrees of integration with street outreach services, include: arrest under the Vagrancy Act 1824; Anti-Social Behaviour Orders (ASBO),

Public Spaces Protection Orders (PSPO), Criminal Behaviour Orders (CBO), Injunctions to Prevent Nuisance and Annoyance (IPNA), controlled drinking zones such as Designated Public Place Orders (DPPOs), Dispersal Orders, and designing out via 'defensive architecture'.[509] It is important to note that of these, 'harder' measures involving penalties such as fines and imprisonment affect only a small minority of homeless people,[510] and these are almost without exception targeted at individuals who are persistently involved in street drinking or 'aggressive' begging rather than rough sleepers.[511]

The use of enforcement in conjunction with assertive outreach is highly controversial.[512] There has nevertheless been in an increasing (but not unanimous) consensus amongst service providers in recent years that its deployment can be justified as a last resort if an individual continues to refuse offers of appropriate support and their activities are having a clear negative impact on other people (including other members of the street population).[513] Homeless people tend to support its use in these

circumstances also.[514] Opinion remains divided, however, regarding whether its use is justified if an individual's actions are harming themselves 'only' (for example, if a rough sleeper's health is deteriorating but they are not obviously affecting anyone else).[515]

11.2 The evidence base

There is relatively limited evidence on the impacts of assertive outreach, which is to be expected given that it is a component of wider programmes such as Housing First and it is therefore difficult to disentangle the impacts attributable to outreach services. In their review of outreach services, Olivet et al.[516] state that although there is a lack of quantitative research exploring the effectiveness of outreach services, much is known about the practice, so we are able to say more about the definition of assertive outreach and the barriers to implementation than we can conclude about outcomes. However, a handful of key studies have been published on the outcomes of the Rough Sleepers Initiative and Rough Sleepers Unit programmes in England and Scotland and on Street to Home in Australia and these provide the basis for our discussion of assertive outreach outcomes. The evidence base only discusses housing outcomes, so impacts on wider support needs and service costs are not discussed.

11.3 Outcomes
Housing

The primary measure of success in assertive outreach services in the UK has been the impact on numbers of rough sleepers and the evaluations of programmes in both England and

Scotland suggest the approach has had a significant positive impact. For example, Randall and Brown[517] concluded that between 1998 and 2001, during the implementation of the Rough Sleeper Unit, the number of rough sleepers reduced from an estimated 1,850 people sleeping rough on any single night in England to around 550 people. The impacts were less pronounced in Scotland but still very positive, with Fitzpatrick et al[518] concluding that the number of people sleeping rough reduced by more than a third between 2001 and 2003. While both studies recognise the limits of the quantitative data available, qualitative interviews with service providers support the broad quantitative trends.

An additional measure of housing impacts is the proportion of households assisted who go on to sustain their accommodation. Phillips and Parsell[519] conclude that the type of housing people move into after assertive outreach support has implications for their tenancy sustainment. Two issues can be identified within the literature. First, where permanent accommodation is provided, as opposed to temporary accommodation, tenancy sustainment rates are far greater. For example, Street to Home in Brisbane Australia, linked rough sleepers with permanent accommodation and it is reported that only 7 per cent of tenancies broke down, and in most instances these tenancies were then transferred to alternative housing.[520] By contrast, only 6 per cent of rough sleepers assisted by the Rough Sleeper Unit in England went straight from the street into permanent housing and this, along

503 Wilson, W. (2015) Rough Sleepers Initiative (RSI) 1990-1999, Commons Briefing papers SN07121

504 Randall, G. and Brown, S. (2002) Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate, London: ODPM

505 Stergiopoulos, V., Dewa, C.S., Tanner, G., Chau, N., Pett, M. and Lyn Connelly, J. (2010) Addressing the Needs of the Street Homeless, *International Journal of Mental Health*, 39(1): 3-15

506 Leopald, J. (2014) Innovations in NYC Health & Human Services Policy: Street homelessness and supportive housing, Urban Institute

507 Coleman, A., MacKenzie, D. and Churchill, B. (2013) The role of outreach: responding to primary homelessness, Commonwealth of Australia

508 Johnsen, S. and Fitzpatrick, S. (2007) The impact of enforcement on street users in England, York: Joseph Rowntree Foundation.
Sanders, B. and Albanese, F. (2017) An examination of the scale and impact of enforcement interventions on street homeless people in England and Wales, London: Crisis.

509 Johnsen, S., Watts, B. and Fitzpatrick, S. (2014) Conditionality Briefing: Homelessness and 'Street culture', Welfare Conditionality Study, York: University of York.
Sanders, B. and Albanese, F. (2017) An examination of the scale and impact of enforcement interventions on street homeless people in England and Wales, London: Crisis.

510 Sanders, B. and Albanese, F. (2017) An examination of the scale and impact of enforcement interventions on street homeless people in England and Wales, London: Crisis.

511 Johnsen, S. and Fitzpatrick, S. (2007) The impact of enforcement on street users in England, York: Joseph Rowntree Foundation.
Johnsen, S., Watts, B. and Fitzpatrick, S. (2014) Conditionality Briefing: Homelessness and 'Street culture', Welfare Conditionality Study, York: University of York.

512 Watts, B., Fitzpatrick, S. and Johnsen, S. (2017) Controlling homeless people? Power, interventionism and legitimacy. *Journal of Social Policy*, doi:10.1017/S0047279417000289.

513 Johnsen, S., Watts, B. and Fitzpatrick, S.(2016) First Wave Findings: Homelessness, Welfare Conditionality Study, York: University of York.

514 Ibid.

515 Ibid.

516 Olivet, J., Bassuk, E., Elstad, E., Kenney, R. and Jassil, L. (2010) Outreach and engagement in homeless services: a review of the literature, *The Open Health Services and Policy Journal*, 3: 53-70

517 Randall, G. and Brown, S. (2002) Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate, London: ODPM

518 Fitzpatrick, S., Pleace, N. & Bevan, M. (2005) Final evaluation of the Rough Sleepers Initiative, Edinburgh: Scottish Executive

519 Phillips R. and Parsell C. (2012) The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No.179. Melbourne: Australian Housing and Urban Research Institute

520 Ibid.

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with other factors, contributed to more than 40 per cent of those helped into accommodation returning to the street.[521]

The second issue is the form of housing provided to rough sleepers. Problems were reported on both the English and Australian programmes when rough sleepers were accommodated in shared or congregate forms of housing. For example, Randall and Brown[522] discuss how shared properties resulted in high turnover of properties, re-let times of four months on average due to the unpopularity of the accommodation, and tenancy failure rate of 26 per cent - twice as high as the rate in self-contained accommodation.

The (limited) evidence on the impact of enforcement on rough sleepers indicates that, when combined with sufficiently intensive, tailored and high quality support it can offer a 'window of opportunity' prompting targeted individuals to accept offers of temporary accommodation and/or engage more constructively with other services. It can, however, also displace rough sleepers, by 'pushing' them into areas that are more dangerous and/or where they are more difficult for outreach workers to find and assist.[523] Positive outcomes are more likely when a personally tailored and staged approach is adopted (wherein enforcement is used as a last resort), but outcomes are highly unpredictable in any individual case.[524]

It is important to note that there is no evidence on the longer term housing impacts of assertive outreach programmes.[525]

Effectiveness for subpopulations
There has been limited examination of the impacts of assertive outreach on different population subgroups, however studies do point towards a key concern regarding outcomes for those who have no connection to the area. This issue arises in both the UK and Australian studies. Research finds that assertive outreach is sometimes used to move people on and return them to 'home' areas, occasionally with little consideration of the circumstances they are being returned to. In the Australian context, this issue is apparently most pronounced with Indigenous rough sleepers.[526] In England, the evaluation of the RSU found that homeless people were sometimes sent to other areas without any arrangements being made for them at their destination.[527]

Service use and cost
Research provides no indication of service costs nor any indication of potential cost savings resulting from assertive street outreach.

11.4 Barriers to implementation
Studies identify several issues that are likely to affect the success of assertive outreach interventions. Most significantly, if assertive outreach is not accompanied by a suitable housing

offer, it will be of limited value.[528] First, there must be a sufficient supply of housing. Australian Street to Home services advised that more people could have been helped to exit rough sleeping had there been a greater supply of housing.[529] Second, the housing must be suitable. For example, in the UK assertive outreach often led to temporary accommodation which was less effective than the Australian permanent housing offer.[530] In considering suitability, there are also debates about the appropriateness of congregate forms of housing.[531]

Assertive outreach must also be accompanied by suitable support. The limited capacity of assertive outreach services in Street to Home Brisbane, Australia was recognised as a limitation of the approach and was attributed to tenancy failures and indeed a reluctance of some housing providers to even allocate accommodation.[532] Service providers are likely to have some difficulties overcoming negative perceptions of outreach services by the rough sleepers being targeted for support. Several studies that sought the views of homeless people found that they were often reluctant to engage with outreach services because services in the past had either tried to send them to undesirable institutional settings, or they had promised assistance and then failed to deliver.[533]

11.5 Expert perspectives
Seven key informants from six different countries discussed assertive or street outreach interventions, providing useful additional perspectives on a relatively under-researched intervention with rough sleepers.

The general consensus amongst interviewees is that assertive outreach is a mechanism to engage with individuals, before accessing other interventions, particularly Housing First. Informants felt it was very much needed, especially for those with the highest levels of support needs and some of the most entrenched and chronic rough sleepers who have not engaged with services previously.

Most notably, there was universal agreement from the informants that its success was underpinned and significantly dependant on the availability of permanent move on accommodation. Moreover, they suggested that outreach services work best when substance misuse, mental health and health services are embedded. These viewpoints echo the findings of the literature review.

Interviewees suggested that the approach builds relationships and trust with rough sleepers over a period of time and this helps to explain why services effectively engage those that have little involvement with

521   Randall, G. and Brown, S. (2002) Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate, London: ODPM
522   Ibid.
523   Johnsen, S. and Fitzpatrick, S. (2007) The impact of enforcement on street users in England, York: Joseph Rowntree Foundation.
       Sanders, B. and Albanese, F. (2017) An examination of the scale and impact of enforcement interventions on street homeless people in England and Wales, London: Crisis.
524   Johnsen, S. and Fitzpatrick, S. (2007) The impact of enforcement on street users in England, York: Joseph Rowntree Foundation.
525   Phillips R. and Parsell C. (2012) The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No.179. Melbourne: Australian Housing and Urban Research Institute
526   Parsell, C. (2011) Responding to People Sleeping Rough: Dilemmas and Opportunities for Social Work, *Australian Social Work*, 64(3): 330-345
527   Randall, G. and Brown, S. (2002) Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate, London: ODPM

528   Parsell, C. (2011) Responding to People Sleeping Rough: Dilemmas and Opportunities for Social Work, *Australian Social Work*, 64(3): 330-345
       Phillips R. and Parsell C. (2012) The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No.179. Melbourne: Australian Housing and Urban Research Institute
529   Ibid.
530   Parsell, C. (2011) Responding to People Sleeping Rough: Dilemmas and Opportunities for Social Work, *Australian Social Work*, 64(3): 330-345
531   Randall, G. and Brown, S. (2002) Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate, London: ODPM
       Phillips R. and Parsell C. (2012) The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No.179. Melbourne: Australian Housing and Urban Research Institute
532   Ibid
533   Parsell, C., Tomaszewski, W. and Phillips, R. (2014) Exiting unsheltered homelessness and sustaining housing: a human agency perspective, *Social Science Review*, 88(2): 295-321
       Lost, J.J., Levitt, A. and Porcu, L. (2010) Street to Home: The experiences of long-term unsheltered homeless individuals in an outreach and housing placement program, *Qualitative Social Work*, 10(2): 244-263
       Kryda, A.D. and Compton, M.T. (2009) Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless, *Community Mental Health Journal*, 45: 144-150

other services. The approach was also perceived to work particularly well at overcoming barriers including accessing the housing register, accessing health care and accommodation.

Specific examples of where it had worked well included outreach workers completing housing applications with the individual on a device on the street. Another example was the use of the Vulnerability Index Tool to measure and determine vulnerability in order to gain priority status within the housing system. The use of peers was also mentioned as being incredibly valuable in building trust and a relationship with rough sleepers.

There were few limitations or challenges to this approach, however all participants reiterated the point that the approach is seriously undermined when suitable accommodation is not offered or temporary shelter is the only option. There was a common view that the accommodation available had to be appropriate and of good quality otherwise the whole approach and method of actively targeting people could be deemed to be unethical and ineffective.

11.6 Summary
- Operating in some form in various countries, street outreach is an important component of many rough sleeper interventions (e.g. Housing First, Personalised Budgets etc.). In very broad terms, street outreach is the delivery of services to homeless people on the street. Assertive Outreach is a particular form of street outreach that targets the most disengaged rough sleepers with chronic support needs and seeks to end their homelessness. It can be defined by three distinctive facets: 1] The primary aim is to end homelessness; 2] Multi-disciplinary support; 3] Persistent, purposeful, assertive support. In some contexts

enforcement is used alongside assertive outreach

- There is relatively limited evidence on the impacts of assertive outreach, however much is known about the characteristics of more effective services. A handful of key studies have been published on the Rough Sleepers Initiative and Rough Sleepers Unit programmes in England and Scotland and on Street to Home in Australia, and these provide some insight into housing outcomes but nothing on impacts on wider support needs nor service costs.

- Assertive Outreach has proven to significantly reduce the number of rough sleepers, with numbers reducing by approximately two thirds within three years under the Rough Sleeper Unit Programme in England and by more than a third within two years in the Scottish Rough Sleepers Initiative.

- The type of accommodation provided following Assertive Outreach impacts significantly on housing retention. First, where outreach leads to permanent, rather than temporary, accommodation tenancy sustainment outcomes are far greater. Second, accommodating rough sleepers in shared or congregate forms of housing appear to be less effective and less desirable than self-contained options. There is no evidence on the longer term housing impacts of assertive outreach programmes

- The (limited) evidence on the impact of enforcement on rough sleepers indicates that, when combined with sufficiently intensive, tailored and high quality support it can offer a 'window of opportunity' prompting targeted individuals to accept offers of temporary accommodation and/ or engage more constructively with other services. It can, however, also

displace rough sleepers, by 'pushing' them into areas that are more dangerous and/or where they are more difficult for outreach workers to find and assist. Positive outcomes are more likely when a personally tailored and staged approach is adopted (wherein enforcement is used as a last resort.

- There has been limited examination of the impacts of assertive outreach on different population subgroups, however studies do point towards a key concern regarding outcomes for those who have no connection to the area. Research finds that assertive outreach is sometimes used to move people on and return them to 'home' areas, occasionally with little consideration of the circumstances they are being returned to.

- Key barriers to effective implementation of assertive outreach include: 1] the absence of a suitable permanent housing offer; 2] the absence of suitable multi-disciplinary support; 3] overcoming negative perceptions amongst rough sleepers about outreach services.

- Many key informants offered their views on assertive outreach services. They felt it was an important intervention, especially for those with the highest support needs. Their views reflected findings of the literature review, that success is underpinned by the availability of suitable permanent accommodation and a wide range of support

Conclusion

12.1 Introduction

This final chapter reflects on the findings across all interventions and draws conclusions about what works and what does not. Notably, as a consequence of the positive service innovations that have been implemented across the globe, there is much more to say about what works than what does not. This chapter also points towards areas for improvement in the evidence base, before finally identifying key lessons for policy and practice.

12.2 What works?

The evidence review points towards several clear messages about what works in meeting the housing needs of rough sleepers. In some instances, the review points towards wholescale adoption of an intervention, whist in other cases it points towards key principles or characteristics of a particular approach that might valuably be adopted more widely.
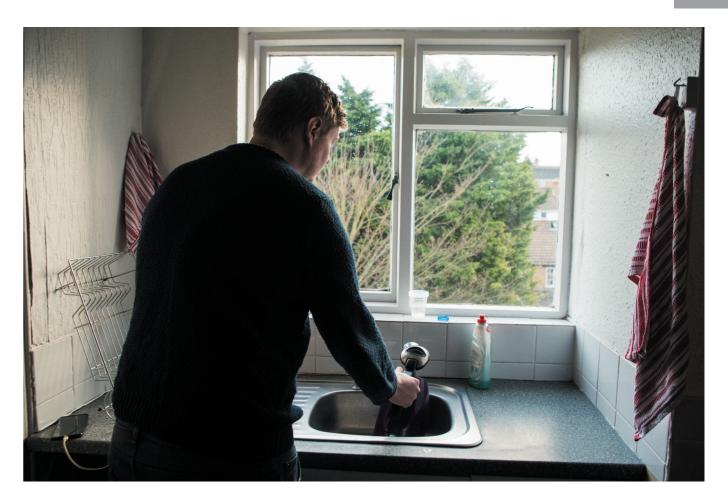
Housing First: There is an exceptionally strong evidence base on Housing First (HF) and we know it works when the key principles are adhered to. It has particularly good housing retention outcomes, which are especially impressive given that the intervention targets homeless people with complex needs. Retention figures typically coalesce around 80 per cent. HF is not a low cost option, but it does create potential for savings in the long term given cost offsets in the health and criminal justice systems in particular. As yet, there is limited evidence on the effectiveness of HF with other subgroups of homeless people.

Person-centred support and choice: Across several interventions, but particularly Personalised Budgets (PB), person-centred support including choice for the individual, has proven to be particularly effective in supporting entrenched rough sleepers into accommodation. While the evidence base is still limited, there are also indications that this approach has positive impacts on wider support needs. In the case of PB, the cost proved to be more than standard outreach support, however in the longer term there are likely to be cost reductions. The PB approach is yet to be trialed with the wider homeless population but key informants advocated wider implementation of this person-centred approach.

Swift action: Interventions such as No Second Night Out (NSNO) and No First Night Out (NFNO) have highlighted the effectiveness of swift action in order to prevent or quickly end street homelessness. The vast majority of service users were found temporary accommodation by NSNO teams and it is likely this will reduce the number of rough sleepers who develop complex needs and potentially become entrenched. However, swift action alone is not sufficient; NSNO faced multiple challenges in relation to the lack of suitable move-on accommodation and problematic single-offers of reconnection.

Cross-sectoral support: Many interventions, including Common Ground, PB and HF, point towards the importance of developing effective collaborations between agencies and across sectors (e.g. housing, health, substance misuse, policing). This collaborative approach appears to be key to providing the correct type and level of support for rough sleepers but is rarely achieved in practice.

Assertive outreach: Assertive outreach is a key component of several interventions, particularly those targeting homeless people with complex needs and entrenched rough sleepers. For example, NSNO, PB and HF all employ the approach – the key difference between these interventions is then the accommodation or service offer. Assertive outreach alone is insufficient, indeed potentially unethical, if it is not accompanied by a meaningful and suitable accommodation offer.

Meeting wider support needs: The impacts of interventions such as HF on wider support needs such as physical and mental health, substance misuse and criminal activity are often documented, although outcomes are often not significantly different from Treatment As Usual (TAU) comparison groups. Interventions such as residential communities appear to offer good outcomes on employment and substance misuse etc. but their housing outcomes are often unreported.

12.3 What does not work?

It is important to recognise what does not work in order to avoid ineffective interventions. The review identifies relatively few such interventions and approaches.

Unsuitable hostels and shelters: Hostels and Shelters (H&S) are intended to fulfil an emergency or temporary function and they vary substantially in terms of size, client group, type of building, levels and nature of support, behavioural expectations, nature and enforcement of rules, level of 'professionalisation', and seasonal availability. While there is a lack of research documenting their effectiveness in the UK,

there is a substantial literature documenting homeless people's experiences. The evidence base is heavily focused on larger-scale emergency accommodation, with limited support and often problematic move-on arrangements. There was no significant literature on the outcomes of what would commonly be termed supported accommodation in the UK (This being referral-only, high support units in purpose-built buildings run by professionally trained staff). Evidence indicates consistently that many (and perhaps the majority of) homeless people find H&S intimidating or unpleasant environments and this is particularly true for young people, transgender people, and women. Significantly, a lack of move on housing stymies the system, preventing H&S from fulfilling their intended emergency or temporary functions and forcing them to operate as longer-term but unsustainable solutions to street homelessness. Beyond conventional H&S, there is a role for supported housing, on either a transitional or long-term basis, when it is provided as a solution outside of a staircase model.

Unsuitable, absent or inadequate support: Providing the right support is a considerable challenge for homelessness services and the evidence review revealed multiple examples where support did not work effectively. First, over-intrusive support in accommodation settings can undermine service effectiveness – this was a particular issue within the Common Ground approach. Second, interventions such as NSNO and reconnections often lack adequate and suitable levels or types of support. For example, in some areas concerns have been raised about the ethicality and potential harmful impacts of single service offers, particularly the potential denial of key services to individuals with no local connection who refuse 'poor' single service offers of support (e.g. a poorly devised reconnection plan).

12.4 Improving the evidence base
One of the research objectives was to identify key limitations and gaps in the evidence base. The review reveals a great deal about the quantity of evidence on each intervention, the geographical distribution of the study sites, and the nature of the research methodologies being employed. Several key limitations in the evidence base are highlighted.

Research rigour: Research, particularly outside of the USA (and to a lesser extent Canada and Australia), are often small-scale, project-specific studies. There is an opportunity for a step-change in UK homelessness research. Small-scale and qualitative research has an important role to play but this should be complemented by larger-scale RCT-type experimental studies.

Evidence gaps for common interventions: There is a serious lack of data on the effectiveness of a number of widely used interventions in the UK. It is particularly concerning that the outcomes of interventions as common as hostels and shelters, supported accommodation, and reconnections have hardly been examined. Additionally, further evidence is needed on many smaller scale innovations such as Personalised Budgets and Social Impact Bonds.

Longer-term impacts: Across all interventions there is a dearth of evidence on longer-term impacts and yet information on longer-term outcomes is key to assessing the strengths and limitations of different approaches.

Effectiveness with subgroups: There is scope to significantly improve our understanding of the effectiveness of interventions with different subgroups of the homeless population as differentiated by age, gender, ethnicity, level/type of support needs etc. There is a notable absence of evidence on what works with migrants and in

particular those with No Recourse to Public Funds.

Impacts of different programme structures: Across most interventions there was great heterogeneity in implementation models but only limited knowledge regarding the consequences of these differences. For example, more evidence is needed on the different outcomes and experiences of congregate and scattered site Housing First programmes.

Quantifying non-housing impacts: While this evidence review focused on interventions targeted at addressing the housing needs of rough sleepers, most also impact to some extent on wider support needs and these can be crucial to longer term housing sustainment. Beyond the robust Housing First and Common Ground studies, there are few attempts to quantify the impacts of interventions on wider support needs (e.g. Personalised Budgets).

12.5 Policy implications
This evidence review is timely, given that across the four UK nations approaches to address rough sleeping are being re-examined. Rough sleeping has reemerged as a policy priority because the problem persists and in most instances is growing. A key goal should be the prevention of homelessness, and this would need to take into account structural causes given evidence that welfare reform in particular is at least in part responsible for the recent rise in rough sleeping levels.[534] However, this study focused on interventions targeting those already experiencing street homelessness. It finds that current approaches are not as effective as they might (and need) to be. Across the UK, unsuitable temporary accommodation still plays a key part in the provision for rough sleepers and in all UK

countries, except Scotland, there is no entitlement to settled accommodation. This review tells us that aspects of the current system are not working as they were intended and that alternative approaches can be more effective. In this final section of the review we set out the principles of an improved approach and the barriers to implementation.

An improved approach
It is important to recognise that the development of an improved approach to ending homelessness for rough sleepers cannot be based solely on an evidence review – it must also incorporate the views of rough sleepers themselves and those who work with them. Moreover, it must examine the prevention of homelessness. However, the learning from this evidence review can play a key role in shaping a new approach. The evidence suggests five key principles should underpin this approach:

1. **Recognise heterogeneity**
    Rough sleepers are a heterogenous group, with varying housing and support needs and different entitlements to access publicly funded support. Moreover, across the UK there is variation in both the profile of rough sleepers and the profile of local housing markets. An improved approach must take account of this heterogeneity.

2. **Swift action**
    Take swift action to prevent or quickly end street homelessness. This will reduce the number of rough sleepers who develop complex needs and potentially become entrenched.

3. **Assertive outreach leading to a suitable accommodation offer**
    Many rough sleepers will not seek out services. Actively identifying and

534   Fitzpatrick, S., Pawson, H., Bramley, G., Wilcox, S. & Watts, B. (2016) *The Homelessness Monitor: Great Britain 2016*, London: Crisis

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reaching out to rough sleepers and offering suitable accommodation will significantly reduce rough sleeping.

4. **Housing-led**
   Having swift access to settled housing has very positive impacts on housing outcomes when compared to the staircase approach. Housing First is particularly effective, most notably with homeless people with complex needs.

5. **Person-centred support and choice**
   Person-centred support, including choice for the individual, and based on cross-sector collaboration and commissioning will impact positively on housing outcomes, particularly for the most entrenched rough sleepers. Personalised Budgets is a good example of this approach.

Homelessness systems across the UK will need to be revised to incorporate *all* these principles – embedding just some of these principles will almost certainly mean people are failed. This systematic change is likely to require legislative reform. In our review of the policy context we identified how interventions such has the Rough Sleepers Initiative and Rough Sleepers Unit in England significantly reduced the number of people sleeping rough but changes in government and policy priorities resulted in a subsequent rise. Homelessness legislation in the UK provides a unique route, in the global context, through which these principles can be embedded and their impacts sustained. Of course, the detail of any legislative reforms will vary across the UK given the very different starting points.

Barriers to implementation
In this final section we consider some of the key barriers to implementing a new approach based on the principles set out above. Here we draw upon the

literature but also the perspectives of key informants and our own reflections.

Lack of settled accommodation: One of the recurring barriers across all interventions was the lack of affordable and suitable accommodation. Capital funding may be necessary to remove this barrier.

Funding: Three potential barriers were identified in relation to funding: 1] Increased sums required (in the short-term) - Effective interventions such as Housing first and Personalised Budgets are not low-cost options, but they do create potential for savings in the long term. 2] Cross-sector funding - Given that savings are often felt outside of housing, effective intervention may require funds to be released from health, criminal justice, and other sectors. 3] Long-term/secure funding - Time-limited funding has been a key barrier to lasting implementation of many interventions.

Effective collaboration and commissioning: The improved approach is premised on the availability of high quality, flexible, multi-disciplinary and intensive support. Some projects have not performed effectively due to this lack of support and collaboration. Ensuring effective collaboration between sectors will be a key challenge in a context where 'silo' commissioning arrangements predominate. Robust multiagency forums have improved the effectiveness of some interventions.

Addressing the needs of different subgroups: There has been little research on how interventions, such as HF or PB work or might work with different subgroups. For example, to date HF has been employed almost entirely with those with complex needs. There is no reason to believe that the principles would not 'work' with others but it is likely that the same level of resourcing will be unnecessary. Research is needed before widespread roll-out of any alternative approach.

Eligibility: Our proposals for an improved approach are premised on rough sleepers being eligible to access public funds. Where rough sleepers are ineligible to access public funds, alternative approaches may be necessary. Relatedly, some rough sleepers are denied services because they lack a local connection. Restrictions in entitlements to those with a connection to the area are understandable but have proven to be detrimental to the wellbeing of many rough sleepers. Alternative approaches to funding support for people who have no local connection exist and could be implemented to remove this barrier.[535]

Legislation: There are clearly still gaps in the legislative frameworks for England, Wales and Scotland that would need to be addressed if we were to adhere to the five principles set out for ending rough sleeping in this report. While there is a history of progressive changes to homelessness legislation across the UK, this is a major barrier to overcome. Making amendments to legislation requires significant political support, is time consuming, and technically challenging.

Bureaucracy: Some interventions, particularly those that encourage personalised support, can be hampered by overly bureaucratic processes and requirements. This is also a challenge affecting approaches underpinned by legislation. Every effort will need to be made to minimise bureaucratic hurdles.

12.6 Summary
In the UK there is both an opportunity and a need for change in the way rough sleepers are assisted. This evidence review has synthesised the evidence base on what works to meet the housing needs of rough sleepers and it points towards five key underpinning principles: recognize

heterogeneity, swift action, assertive outreach leading to a suitable accommodation offer, housing-led, and person-centred support and choice. We suggest these principles should be embedded within the different legislative frameworks across the UK in order to ensure lasting change. These findings should be used alongside the wider body of work being undertaken by Crisis with rough sleepers and those who work with them, to shape an improved approach and end rough sleeping. Moreover, we hope this synthesis will provide a reference point for policy makers, practitioners and researchers working with rough sleepers across the globe.

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Together
we will end
homelessness

EVALUATION OF STEP BY STEP

Initial Report

for The Oak Foundation, Merthyr and the Valleys Mind and Rhondda Cynon Taf County Borough Council

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CONTENTS

1. INTRODUCTION

PROJECT SUMMARY

Merthyr and the Valleys Mind (MatV Mind), in partnership with Rhondda Cynon Taf County Borough Council, has been funded by the Oak Foundation to develop a responsive solution to the needs of Single Homeless People considered vulnerable due to their mental health and substance misuse needs in Rhondda Cynon Taf and Merthyr Tydfil. This is the Step by Step project. The project is employing an advocacy approach to delivering services so that single homeless people can express their rights to achieve housing, health and vocational outcomes.

The project aims to bring lasting change to the lives of those considered vulnerable due their personal, social, health and housing circumstance. The advocate and support worker are working independently from the Housing Solutions Team, the NHS and vocational/training providers and remain objective in the interest of the beneficiary. They are proactively engaging those services in their duty to work with and safeguarding single homeless people, and to help them achieve sustained tenancies.

PURPOSE OF THE REPORT

The aim of this brief document is to present the data collected to date, and to provide some initial findings to inform service delivery. It is based on the following elements of the methodology:

- Analysis of RCT Housing Solutions data;

- Analysis of MaTV Mind project data (including housing status, mental well-being outcomes including the Warwick Edinburgh Mental Well-Being Scale, and vocational/employment data);

- Qualitative perspectives of those supported by the Step by Step project; and

- Qualitative perspectives of key stakeholders.

2. INITIAL FINDINGS – FREQUENCIES AND STATISTICS

The study team analysed the data that had been collated by Step-by-Step and that which had been received from Rhondda Cynon Taf CBC.

SERVICE USER DEMOGRAPHICS

Table 1 presents the sample demographics for those who partook in the Step by Step program and those who did not. As seen, those who participated in the Step by Step program were primarily of male gender (78.2%) and over 25 years of age (82.8%). Those who did not participate in the service were also primarily of male gender (69.8%) and over 25 years of age (69.8%). Further demographic details were available for those participating in the Step by Step program. Specifically, participants were primarily of a white ethnic background (97.7%), lived in the Taff area (40.7%) and were typically waiting for vocational outcomes to be achieved i.e. not in employment, education or training (64.7%).

Table 1 · Sample Demographics at initial appointment

		Step By Step (n=129)	Housing Team[1] (n=205)
Age	16-17 years		2.9% (n=6)
	18-24 years	17.2% (n=22)	27.3% (n=56)
	25+ years	82.8% (n=106)	69.8% (n=143)
	Age (M/SD)	37.25 years (12.07)	
Gender (n = 133)	Male	78.2% (n=104)	68.9% (n=142)
	Female	21.8% (n= 29)	
Ethnicity (n=87)	White	97.7% (n=85)	
	BA	1.1% (n=1)	
	Other	1.1% (n=1)	
Residential Area (n=86)	Rhondda	39.5 (n=34)	
	Cynon	19.8 (n=17)	
	Taff	40.7 (n=35)	
Vocational Status (n=17)	Employed	23.5% (n=4)	
	In training	5.9% (n=1)	
	Volunteering	5.9% (n=1)	
	Waiting	64.7% (n=11)	

HOUSING

Table 2 depicts housing status outcomes for participants of the Step by Step program at initial appointment, two month follow up and four month follow up. As presented, at initial appointment, the majority of respondents were homeless (71.6%) but at the two month follow up meeting this had dramatically reduced to only 20.3% of respondents, with the majority being housed in suitable accommodation (69.5%). At the four month follow up meeting, the amount of homeless respondents had decreased further to 5.7%, with those in suitable accommodation rising to 84.9%.

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[1] No comparisons available for ethnicity, residential area nor vocational status.

Table 2 · Step by Step housing status outcomes at initial appointment, two month follow up and four month follow up

Housing Status[2]	Initial appointment (n=88)	Two month follow up (n=59)	Four month follow up (n=53)
At risk of homelessness	25% (n=22)	5.1% (n=3)	0% (n=0)
Homeless	71.6% (n=63)	20.3% (n=12)	5.7% (n=3)
In suitable accommodation	3.4% (n=3)	69.5% (n=41)	84.9% (n=45)
Other[3]	0% (n=0)	5.1% (n=3)	9.4% (n=5)

Table 3 depicts the housing status for respondents who had support from the Council's housing team. As shown, at initial appointment 55.8% were homeless and 44.2% at risk of homelessness. The outcome at discharge of duty saw both rates fall to 16.2% of respondents being homeless, 0% being at risk of homelessness and 51.55% being in suitable accommodation. Comparing these rates to those of the Step by Step Program (Table 4) shows that at discharge of duty, Step by Step had more respondents in suitable accommodation (84.9%) than those supported by the housing team (51.5%) and significantly fewer respondents classified as having an 'other' housing status.

Table 3 · Housing Status Outcomes for the Housing Team at initial appointment and upon discharge

Housing Status	Initial appointment (n=206)	Outcome at discharge of duty (n=204)
At risk of homelessness	44.2%(n=91)	0% (n=0)
Homeless	55.8%(n=115)	16.2% (n=33)
In suitable accommodation		51.5% (n=105)
Other[2]		32.4% (n=66)

Table 4 · Comparisons in housing status between Step by Step program and housing team at case completion

Housing Status	Step By Step	RCT CBC Housing Team
	Four months after initial appointment (n=53)	Outcome at discharge of duty (n=204)
At risk of homelessness	0% (n=0)	0% (n=0)
Homeless	5.7% (n=3)	16.2% (n=33)
In suitable accommodation	84.9% (n=45)	51.5% (n=105)
Other	9.4% (n=5)	32.4% (n=66)

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[2] Chi Test (X²) of significance for differences between 'Housing Status' at initial appointment and four months following was not possible as 7 of the 12 cells had an expected count less than 5.

[3] Includes housing options of: assistance refused; non-cooperation; other reason; application withdrawn; and application withdrawn due to loss of contact.

As shown in Table 5, housing assistance provided by the Step by Step program involved provision of housing advice to all participants (100%: four month follow up). This was primarily at the initial appointment (97.7%). Over a four month period, 71.7% were further supported in securing alternative accommodation and 52.8% were supported in applying for housing benefit.

Table 5 · Housing assistance provided by the Step by Step program at initial appointment, Two month follow up and Four month follow up

Housing Data	Initial appointment	Two month follow up	Four month follow up
Given housing advice	97.7%	98.3%	100.0%
Helped to remain	2.3%	6.8%	7.5%
Helped to secure alternative accommodation	0%	57.6%	71.7%
Helped to access temporary accommodation	0%	8.5%	9.4%
Assisted to apply for housing benefit	1.1%	49.2%	52.8%

EMPLOYMENT AND TRAINING

Table 6 depicts that over a four month period, 56% of respondents were registered with employment, training or volunteer opportunity provider. This was a large increase on the 10.4% registered at initial appointment.

Table 6 · Vocational outcomes for Step by Step program at initial appointment, Two month follow up and Four month Follow up

Vocational Data	Initial appointment	Two month follow up	Four month follow up
Referred to volunteering, vocational and employment support[4]	5.4%	10.1%	18.2%
Registered with employment, training or volunteer opportunity provider	10.4%	40.4%	56%

HEALTH

Surprisingly, at initial appointment the majority of respondents were registered with a GP. This increased to 98.3% at two month follow up and then subsequently decreased to 94.2% at four month follow up. This decrease is suggestive of sample attrition.

From Table 8, Friedman's Test indicated that there was a statistically significant difference in WEMWBS scores across three time points (initial appointment, two month follow up and four month follow up).[5] Inspection of the mean scores showed an increase in WEMWBS scores from 31.48 at initial appointment to 44.03 two months

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[4] Total % of respondents who had their MH needs met and were supported to gain a referral to the Primary Care Mental Health Team

[5] Chi Test (X^2) (2, n=51) = 69.30, p<0.05)

follow up and a further increase to four months follow up to 46.78. The 2011 Health Survey for England (n=7,020) showed a mean average WEMWBS score for the general population of 51.61.

Table 7 · Health outcomes for Step by Step program at initial appointment, Two month follow up and Four month Follow up

Health Data	Initial appointment	Two month follow up	Four month follow up
Registered with a GP	93.1%	98.3%	94.2%
Supported to gain a referral to Primary Care Mental Health Services[6]	0%	4.4%	7.3%
DASPA[7]	1.2%	10.7%	6.6%
Referred to self-management courses[8]	0%	0%	0%
Commenced self-management course	0%	7.8%	8.5%

Table 8 · Mean WEMWBS Scores at T1, T2 and T3 for the Step By Step Program

	Initial appointment (n=88)	Two month follow up (n=59)	Four month follow up (n=53)
WEMWBS Score (M/SD)	31.48 (12.65)	44.03 (14.07)	46.78 (13.76)

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[6] Total % of respondents who were successfully referred to DASPA

[7] Total % of respondents who were successfully referred to a self-management course

[8] Total % of respondents who commenced a self-management course

3. INITIAL FINDINGS – INTERVIEWS WITH STEP BY STEP CLIENTS

The following short summary represents the key themes that have emerged from interviews with Step by Step clients to date.

FINDING OUT ABOUT STEP BY STEP

Four participants were referred to the Step by Step Program through the housing solutions team. One participant clearly described the process: *'When I went to the Council office one of the council guys said he should pass me on to the Step by Step programme'.* The process of referral was immediate: *'Basically there were people in the office that day that could help me'.*

REASONS FOR AGREEING TO HAVE ASSISTANCE FROM STEP BY STEP

Many participants agreed to have help from Step by Step as they were facing adverse circumstances:

I think I was suffering with depression due to the bereavement of the wife….. at that time i was living alone in the house and my mortgage and one thing and another….my finances went to pot because of the bereavement like…. the house was repossessed – lost that. I've now gone into rented accommodation.

What it was I was living in a bedsit and the Landlord took out this thing on the bedsit. What it was the students were coming and he wanted me out. So I went to Housing Solutions and they said I had 28 days to get out of there. The Landlord wanted me out there and then and he took the sink out. So what I done I videoed it all on my phone and I took it to Housing Solutions and showed them that he had taken the sink and this and that out. Then they said he had to reinstate it but then I went out one day and he put the latch on so I couldn't get back in there so I had to arrange with them then to get my stuff out of there and that's how I got involved with Step by Step then….

The last flat I had with the Council was repossessed and I had debt with the flat and the Council said no we can't help you, you got outstanding debt. So basically you're just a step away from living on the streets then. [I agreed to have help] because I had nothing at all. I was going to be homeless.

I've got no family support and I'd split up with my ex-girlfriend at the time. I'd been homeless for 6 months or more just living on sofas here and there of friends and family and I had to bite the bullet and I went down to see. I let it build up and I shouldn't have basically and I shouldn't have.

One participant described how they refused the help from Step by Step because of they felt that there would be time constraints on the service:

Well I was facing homelessness but then I just realised there was no way anyone was going to help me in time…. I had to make decisions to help myself because there was no way that the housing people were going to get around to it in time were they and I could sort it out myself….

However, as described earlier, this was not the case.

IMPACT UPON HOUSING STATUS BY STEP BY STEP

Four participants described how Step by Step assisted them with finding privately rented housing:

They helped me with finding housing…..there were three lots involved: Step by Step, Shelter Cymru and there was another one….Rhondda Cynon Taff Housing I think it was…. All in all though it's all worked. Between everyone it did work.

I got my own place [now]. They offered me one in Pontyclun which I turned down because I don't drive and then they offered me one in Treherbert which is easier for me because it's just a train ride down – my family live in Pontypridd see.

They said if you can get a number for a house that you like we can try getting you in there. So I got a number and passed it on to them and I was in my flat a month later.

The only way that they could help me as if I checked with a private accommodation.

Participants also described how Step by Step assisted them with pre-existing health conditions:

I now got an appointment to see the psychiatrist in RISMS. At the moment now I'm not getting no support. They've stopped supporting me so I got an appointment with the doctor first and then with the psychiatrist I think and I tell the psychiatrist I got no support I think….

They further were offered help with training and employment, but the majority of participants were not able to work due to varying health conditions. As described by one individual: *I'm a HGV driver by trade….I couldn't go back driving anyway. My mental state wouldn't allow me to do that.*

Interestingly, one individual who was able to work, described some challenges which they faced: *I find it quite hard the job searching every day basically. If I had a job everything would be sweet but I'm struggling I am to be honest but so is everybody else in they.* Notably, they were not having any employment support from Step by Step.

PERCEPTIONS OF STEP BY STEP STAFF

Service users were very positive about the support received from the Step By Step caseworkers in terms of their housing needs:

Very good, very good…... I couldn't fault them at all. There was no hassle nothing – lovely.

The [case worker] is brilliant. They helped me out a lot. They sorted my TV licence, my gas and electric. Putting it in my name for me.

They just gave me confidence to prove that I could get the place. The [case worker] stood next to me and made me feel comfortable…

I wouldn't have a roof over my head now if it wasn't for them basically…. I can't praise them enough because if it wasn't for them I probably would be on the streets of Cardiff or whatever. You felt like [the case worker] couldn't bend over enough backwards to help you and I really appreciated that at the time. I did say a massive thank you to [the case worker]. [The case worker]was really really good. Marvellous.

As such, they praised the staff and were grateful for the assistance they had received.

ENDING OF SUPPORT

Service users described how the support from Step by Step had ended. Even though the support had come to an end, three participants felt that: *I'm not getting the support now but if I need it I can always ring them.*

One participant however was unaware that the service had ended as: *I had no letter to say you are on your own type of thing. Nothing at all that was the bit… I don't understand that part.*

The first time this service user became aware that the service had ended was when he sent a text message to the case worker and received no reply. As such, this could be an area for improvement.

4. INITIAL FINDINGS – KEY INFORMANT INTERVIEWS

The following section represents the key issues that came from the initial analysis of the interviews that were undertaken with Step by Step staff, Housing Solutions staff and managers, and other key informants.

SUCCESS TO DATE

The project enjoys a high success rate, with many people supported to try and achieve sustainable housing outcomes who would otherwise be left with nothing. Importantly – and in contrast to the ways in which the new legislation is being implemented across Wales – far fewer people seem to fail to cooperate or disengage when they are supported by the project:

> *The Housing Solutions team tend to see people only once, whereas the Step by step team get to know the person far better and do a lot more hand-holding e.g. filling in benefits forms, accompanying them to viewings, meeting with landlords etc.*

> *Having a specific officer (a kind of single point of contact – case manager) for the entire journey makes the process easier. You would not have that in the housing solutions team.*

> *They have managed to get people engaged, which creates an opportunity to get those individuals further engaged with other services and start an upward spiral.*

This perception was shared by both the local authority staff and the Step by Step team – the sense that people are much more engaged with the service than would have been previously is a huge positive, and a vote of confidence in the vision behind the model. There is overwhelming support for the project to continue and there is already some thinking taking place about how the service could be further integrated within other housing services:

> *There is unanimous support for the continuation of the project because it has had such positive impacts with a large proportion of the local authority's most vulnerable clients.*

EXCELLENT LIAISON WITH LANDLORDS

The overall positive sense of achievement in respect of housing has been achieved by some excellent liaison with landlords – the project has managed to engage and gain access to landlords that the local authority has not previously engaged. The key factor here is the hand-holding provided by the team – filling in forms, accompanying people to interviews with landlords etc. makes a huge difference to the likelihood of a positive relationship being developed between landlords and their tenants:

> *The Step by Step team have built a very effective and 'trusting' relationship with private rented sector landlords. Landlords are now even approaching the Step by Step team with properties. The Step by Step team started to develop these relationships in the early days of the project when referrals were low. They have bought agents and landlords on board that haven't previously worked with the authority.*

> *They've built up an excellent relationship with landlords: they went out to landlords and estate agents initially, they go out to viewings, and they provide support during the start of the tenancy. From the support side it is better to have handholding from the start to much later, rather than handing over.*

> *They're breaking down the barriers with the landlords – it has opened up a lot of doors.*

One particular note of difference here when compared with the kinds of services that may have been in place previously is both the quantum of work done by the team to engage landlords and estate agents, and the way in which they have approached this in a more 'professional' way than other support services. The hand-holding is crucial, but it is time consuming, obviously, and there are issues about capacity of the service – more of which is commented upon below.

FOCUS ON HOUSING IMPACTS AND OUTCOMES

From the point of view of the local authority staff, there is very little awareness of any impacts beyond housing and the project is seen solely as a housing support project – albeit most know that the service is there to deal

with health and employment issues too.

Most of the effort rightly has been focused on housing, although the support staff have placed a fair emphasis on vocational outcomes, whilst health outcomes have not been focused on to the same extent. Internal referrals to other Merthyr and the Valleys Mind services have also been quite an important factor in supporting people.

> *They have managed to secure outcomes for some challenging individuals who have been repeat service users, and often reject engagement with other support providers. At least two repeat service users in a constant cycle have been accommodated/effectively supported by this service.*

> *Those they have helped to accommodate would probably not have been housed otherwise.*

> *I don't think the balance is right yet and I think there is always going to be the need to do very reactive things for people because when somebody presents in a desperate situation, I think the carer in us always wants to do the right thing in order to meet that particular need…I think whilst those critical things are done for people then that should be the hook in order to engage them in longer term stuff and other programmes of developing resilience in people can then be provided in the longer term*

> *My feelings are that you keep taking a horse to water at some point it will drink but don't get upset if it doesn't. You just take it tomorrow. And then when it works it's great but then I still see that as their success – if it works it is great. So that's how I offset it. If it works it is their success and if it fails it is their failure. I'm just a person in the background giving choices and options and sometimes I might think it's a terrible choice but that's their choice.*

> *Making referrals initially was difficult due to a lack of understanding of the project. Some staff found it difficult to 'sell' Step by Step. Equally, some people seek help and only want council housing – for these individuals they will never take up the referral. Currently, they do sell the project to clients but they always get a small number who say no but the majority say yes.*

> *It's constantly improving. Partly the case officers have a better understanding of who we are and what we do. They now understand we do vocational work, health work so there's a bit more substance to us. So we are sold better from them so that when we become involved the case officer will come straight upstairs if I'm available I'll go down and do it while they are there. We have lost people where trying to phone people once a referral comes through and contact them and get them back in people are dropping out of the service there. So I'll go down do the assessment.*

CAPACITY ISSUES

After initial uncertainties about referrals, pathways have now clarified and referrals have picked up. The challenge in this area however is that there is different interpretation as to the remaining capacity in the support service:

> *The Step by Step team have never reached the point where they have refused to take further referrals.*

> *Capacity may become an issue in the future. More people are taking up the service and there are only two members of staff. Step by step will need to know how and when to hand over to other services eg. tenancy support, without breaking the trust of landlords.*

Internally, there is a perception that spare capacity is reducing quite significantly, and that this is now becoming an issue to be dealt with – both in terms of internal performance management and expectation management with clients. Managing these capacity challenges and having appropriate hand-off points as early as possible to other services is going to remain an issue for the foreseeable future:

> *The referral process is straight forward. The Housing Solutions team pass the individual housing plan to the step by step team. The Housing Solutions and Step by Step team are then meant to continue to communicate regarding the client's options and outcomes.*

> *This is what the authority will consider affordable, so this is what we are working within. So we are managing the service users' expectations from day one which is important. It might not be what they want to hear but I believe honesty is a massive part of developing relationships and we are honest. And we tend to have the answers for the housing association officers before they even ask them.*

> *Three prongs to how you would manage capacity of service. So change the number of people being referred*

– so I don't see that changing. If anything it would increase as we see higher level of people presenting because they've got 56 days instead of 28. So I think that's always going to be there and increasing. Closing the case load quicker or the flipside is having more people to manage the case load. And last going off we were talking about working smarter to manage the case load more effectively and efficiently and ways of ending the relationship to go on to others whether that's a handover to another agency which is something that is in process as I say we've got a meeting on Friday with the Supporting People team and they send out to different agencies perhaps again something to feedback to them is improving how that system works. One person could do the assessment and pass them on to somebody else for the support and not even in the same organisation. So I think you lose on the consistency then and something to raise we are seeing that assessment as the handover and yet they may not get picked up for support until later on so they could be left at a critical point with no support for 2 or 3 weeks.

CLARITY OVER 'HAND-OVER' POINTS

One of the main points of contention for the service is getting clarity on when the support ends and cases are handed over to other tenancy support services. There have been some tensions with supporting people services and a number of problems have arisen. These are well on the way to being resolved, and it is important to do this speedily, as it will help with the overall capacity of the service:

One downside is the team were not referring into Supporting People services sufficiently. There is a grey area where step by step do some pre-tenancy work and the question is – when does this finish and tenancy support work start? At what point should step by step end in the pre-tenancy, tenancy, and longer term ongoing support stages? This is a fundamental question we must now consider. If we continue to fund or commission this service it might look more like an SP related service that works with the Housing Solutions team but it is a tenancy service - part of which is doing initial securing of a tenancy and then staying as long as needed.

When the Housing Solutions team discharge their duty, they must communicate this to the Step by Step team. Sometimes the solutions team have made their reasonable offer and it is declined (they may not like the area). Step by Step may continue but they need to be aware that finances might not follow if they then find PRS accommodation. This would be more problematic if the project was funded by the authority.

I don't know if they are clear on when their work should end – at what point does it get passed over and is that causing a capacity issue? I do think they should refer on more quickly.

A clear closing point is needed and that is coming from the Supporting People coming in and some people are still on our books three months after they've been in a tenancy because they've still got ongoing issues and perhaps that's when we should be using the advocacy worker or the floating support sooner…

5. SUMMARY

WHO IS BEING ASSISTED?

- The majority of single people accessing both Step by Step and Housing Solutions services were men (78% and 69% respectively) aged over 25 years (83% and 70% respectively).

THE REFERRAL PROCESS

- **A single gateway:** The single route into the service is through a referral by the Housing Solutions team. Referrals are picked up promptly by the Step by Step team – usually on the same day.

- **A slow start:** Initially there was confusion about the role of the Step by Step project and referrals were limited, however awareness of the service aims and its potential impacts has now improved significantly and the project has reached capacity.

ASSISTANCE PROVIDED

- **Overview:** The majority of the assistance offered by the Step by Step team relates to housing, however service users and Step by Step staff did discuss actions taken to secure employment and referrals were made to other Mind Cymru mental wellbeing services.

- **Access to the PRS:** The project has gained access to a wide range of private rented sector properties, many of which the local authority has not previously engaged. The key factor here is the volume of hand-holding provided by the team both with tenants and landlords – filling in forms, accompanying people to interviews with landlords etc.

- **Accessing Housing Benefit:** 53% of people were assisted to apply for housing benefit.

- **Step by Step staff:** Service users were very positive about the support received from the Step By Step caseworkers. They praised the staff and were grateful for the assistance they had received.

OUTCOMES

- The project is judged to be successful by all key informants and by service users. In fact, they have managed to secure outcomes for some challenging individuals who have been repeat service users. The housing outcomes are particularly significant.

- **Housing Outcomes:** A greater proportion of people assisted by the Step by Step team were homeless (rather than at risk of homelessness) when they sought help when compared to those approaching the Housing Solutions team (72% vs 56%). Welsh Government statistics show that homelessness services are far more likely to find suitable accommodation/a successful outcome where the person is at risk of homelessness rather than homeless, hence the Step by Step service might have been expected to achieve worse outcomes than the Housing Solutions team.

- To the contrary, we found that at discharge of duty the Step by Step service had far more people in suitable accommodation (85%) than those supported by Housing Solutions (52%). The Step by Step service also had significantly fewer service users classified as having an 'other' housing status.

- **Employment and Training Outcomes:** During the period of support, 56% of people were registered with an employment, training or volunteer opportunity provider. This was a large increase on the 10% registered at the initial appointment.

- **Health Outcomes:** Surprisingly, at initial appointment the majority of respondents were already registered with a GP. In relation to mental wellbeing, we documented an increase in WEMWBS scores from 31 at the initial appointment to 47 at the end of support, which is much closer to the average score for the general population of 52.

ENDING SUPPORT AND HANDING OVER

- **Uncertainties about service handover:** One of the main points of contention for the service is getting clarity on when the support ends and cases are handed over to other tenancy support services. There have been some tensions with supporting people services and a number of problems have arisen. Moreover, service users explained that they felt they could return to Step by Step staff if further issues developed, whereas in reality this could become problematic due to capacity issues.

- **Towards a resolution:** These hand-over points are well on the way to being resolved, and it is important to do this speedily, as it will help with the overall capacity of the service.